GRANT BLACKFORD MENTAL HEALTH, INC.

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-4021 Worksheet S Peri od. From 07/01/2020 Parts I-III AND SETTLEMENT SUMMARY 06/30/2021 Date/Time Prepared: То 11/24/2021 8:23 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/24/2021 Time: 8:23 am use only] Manually prepared cost report 2. [] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

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

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF 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 GRANT BLACKFORD MENTAL HEALTH, INC. (15-4021) 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.

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(Si gned)	BETH KACHEL
	Officer or Administrator of Provider(s)
	CFO
Title	9
	(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	0	0	-4, 984	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	0	0	0	-4, 984	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.

Image: 100 Image: 2.00 Image: 3.00 Image: 4.00 Hospital and Hospital Health Care Complex Address: Street: 505 WABASH AVENUE P0 Box: Zip Code: 46952 County: Image: 2.00 City: MARION State: IN Zip Code: 46952 County: Date Payment Image: 2.00 City: MARION State: IN Zip Code: 46952 County: County: T, C Image: 2.00 Component Name CCN CBSA Provider Date T, C Image: 2.00 Component Name CCN CBSA Provider Date T, C Image: 2.00 Subprovider - 1PF GRANT BLACKFORD MENTAL 154021 99915 4 08/12/1982 N 4.00 Subprovider - 1RF GRANT BLACKFORD MENTAL 154021 99915 4 08/12/1982 N 9.00 Hospital-Based SNF HOSpital-Based SNF Intervention Interventio	P 0 P 0 3. P 0 3. 9. 10. 11. 12. 2021 8:23 11. 2. 11. 2. 11. 2. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
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cost reporting period prior to October 1. Enter in column 2, "Y" for yes	
or "N" for no, for the portion of the cost reporting period on or after	
October 1.	
2. 03 Did this hospital receive a geographic reclassification from urban to N N N rural as a result of the OMB standards for delineating statistical areas	N 22.
adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no	
for the portion of the cost reporting period prior to October 1. Enter	
in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	
Does this hospital contain at least 100 but not more than 499 beds (as	
counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for	
yes or "N" for no.	
.04 Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas	22.
adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no	
for the portion of the cost reporting period prior to October 1. Enter	1
in column 2, "Y" for yes or "N" for no for the portion of the cost	
reporting period occurring on or after October 1. (see instructions)	
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yes or "N" for no.	
. 00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 N	
below? In column 1, enter 1 if date of admission, 2 if census days, or 3	23.
if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost	23.

	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provider CC	N: 15-4021	Perio		/2020	Works Part	heet S-	2
)/2021	Date/	Time Pr /2021 8	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-o Stat Medica eligit unpai	e nid ble	Medica HMO da		Other edi cai d days	
	1	1.00	2.00	3.00	4.00		5.00		6.00	
. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, 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.	0	0			0		0		0 24.
					Urb	an/Ri	ural S		of Geogr	-
. 00	Enter your standard geographic classification (not wa	ane) status	at the boo	inning of t	he	1.0	0 2	2	. 00	26.
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban ou enter the effective date of the geographic reclassifi	rural. age) status r "2" for r	at the enc ural. If ap	l of the cos			2			27.
00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status ir	1		0			35.
					B	<u>egi nn</u> 1. 0			di ng: . 00	-
00	Enter applicable beginning and ending dates of SCH s		cript line	36 for numb	er		0			36
00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	IS		0			37
01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)									37
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38.
						<u>Y/N</u> 1. 0			<u>//N</u> . 00	-
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (İi), or the mileage i)? Enter	(iii)? Ent requiremer in column 2	er in colum nts in ? "Y" for ye	n s	N	-		N	39
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y			N			N	40
							V 1.00	XVII 2.00	_	
							1.00			
00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	nt for disp	roportionat	e share in	accorda	ance			N	45
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks	eption for	extraordi na	nry circumst	ances		N	N	N	
00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of	eption for t. L, Pt. I capital? E	extraordina II and Wkst nter "Y for	nry circumst :. L-1, Pt. · yes or "N"	ances I throu for no	ıgh	N N N	N N N	N	46
00 00 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	eption for t. L, Pt. I capital? En t? Enter "'	extraordina II and Wkst nter "Y for Y" for yes	ary circumst :. L-1, Pt. : yes or "N" or "N" for	ances I throu for no no.	ıgh D.	N N N N	N	N	46 47 48
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. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks? Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pi year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting pi GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first more for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	eption for t. L, Pt. I capital? En t? Enter " approved G e to column rograms in cograms in cograms in codale CRs) I umn 2. beriod durin r yes or "N th of this (", complet (, if applic bursement for	extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct G mg which re " for no ir cost report e Worksheet cable. or physicia	ary circumst L-1, Pt. yes or "N" or "N" for 	ances I throu for no no. for yo hospita iltimata reducti approvo If colu > Enter olumn 2	ugh b. es or al on? ed umn 1 - "Y"	N N N N	N N N	N	46 47 48 56

 any programs that meet the instructions) Enter "Y" first is "Y", are you impacted the adjustement? Enter "Y" for adjuste	and allied health education e criteria under 42 CFR 413. for yes or "N" for no in col by CR 11642 (or subsequent C or yes or "N" for no in colu	(NAHE) 85? (s umn 1. CR) NAHE	see If column 1		eri od: rom 07/01/2020 o 06/30/2021 Worksheet A Li ne # 2.00	Worksheet S-2 Part I Date/Time Prep 11/24/2021 8: 2 Pass-Through Qual i fi cati on Cri teri on Code 3.00	pared: 23 am
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 any programs that meet the instructions) Enter "Y" first "Y", are you impacted the adjustement? Enter "Y" for adjustement? Enter "Y" for column 1. (see instruction 61.01 Enter the average number of FTEs from the hospital's 3 ending and submitted before instructions) 61.02 Enter the current year too FTE count (excluding OB/GN) 	e criteria under 42 CFR 413. for yes or "N" for no in col by CR 11642 (or subsequent C or yes or "N" for no in colu	85? (s umn 1. CR) NAHE umn 2.	see If column 1	Y/N	Line #	Qualification Criterion Code	
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 section 5503? Enter "Y" for column 1. (see instruction 61.01 Enter the average number of FTEs from the hospital's 3 ending and submitted before instructions) 61.02 Enter the current year to FTE count (excluding OB/GN) 	FTE slots under ACA		IME	Direct GME	IME	Direct GME	
 section 5503? Enter "Y" for column 1. (see instruction 61.01 Enter the average number of FTEs from the hospital's 3 ending and submitted before instructions) 61.02 Enter the current year to FTE count (excluding OB/GN) 	FIE slots under ACA	1.00	2.00	3.00	4.00	5.00	
 61.01 Enter the average number of FTEs from the hospital's 3 ending and submitted before instructions) 61.02 Enter the current year to FTE count (excluding OB/GY) 					0.00	0.00	61.00
61.02 Enter the current year to FTE count (excluding OB/G	of unweighted primary care 3 most recent cost reports						61. 01
	tal unweighted primary care YN, general surgery FTEs, ed under section 5503 of						61. 02
determining compliance wit	sidents, which is used for						61.03
61.04 Enter the number of unweig surgery allopathic and/or							61. 04
61.05 61.05	riod.(see instructions). een the baseline primary Es and the current year's al surgery FTE counts (line						61. 05
61.04 minus line 61.03). 61.06 Enter the amount of ACA § used for cap relief and/or care or general surgery.	5503 award that is being r FTEs that are nonprimary						61.06
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(1.10 Of the FTFe in Line (1.05	, specify each new program		1.00	2.00	3.00	4.00	(1 10
specialty, if any, and the for each new program. (see column 1, the program name program code. Enter in col	e number of FTE residents e instructions) Enter in e. Enter in column 2, the lumn 3, the IME FTE n column 4, the direct GME , specify each expanded , and the number of FTE ed program. (see				0.00		61. 10
	ogram code. Enter in column count. Enter in column 4,						
						1.00	
62.00 Enter the number of FTE re your hospital received HRS	the Health Resources and Ser esidents that your hospital SA PCRE funding (see instruc	trained tions)	in this cost	reporting peri			62.00
during in this cost report	esidents that rotated from a ting period of HRSA THC prop laim Residents in Nonprovide	gram. (s	<u>see instructio</u>		your hospital	0.00	62.01
63.00 Has your facility trained	residents in nonprovider se in column 1. If yes, comple	ettings	during this co			N Ratio (col. 1/	63.00
				FTĔs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
	ase Year FTE Residents in No			1.00 This base year	2.00 is your cost r	3.00 Teporting	
64.00 Enter in column 1, if line in the base year period, t resident FTEs attributable settings. Enter in column	after July 1, 2009 and befor e 63 is yes, or your facilit the number of unweighted nor e to rotations occurring in n 2 the number of unweighted d in your hospital. Enter in	ty train n-primar all non non-pr	ned residents Ty care nprovider Timary care	0.00	0.00	0. 000000	64.00

THE AND HOST THE HEALTH CARE COMPL	EX IDENTIFICATION DA	AIA Provider	Fr	eriod: com 07/01/2020	Workshe Part I		
			To	06/30/2021	Date/Ti 11/24/2	me Prej 021 8::	pared 23 am
	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (c	:ol. 3/	
			FTEs	FTEs in	(col. 3		
			Nonprovider Site	Hospi tal	4))	
-	1.00	2.00	3.00	4.00	5.0	0	1
00 Enter in column 1, if line 63			0.00	0.00		000000	65.
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3							
divided by (column 3 + column 4)). (see instructions)			Unweighted	Unwei ghted	Ratio (c	ol 1/	
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			Si te				-
Soction EEOA of the ACA Current)	Voor FTE Dooidont- !	n Nonnrovidar Cattin	1.00	2.00	3.0		
Section 5504 of the ACA Current N beginning on or after July 1, 207		n wonprovider Settir	igsEffective to	Cost reporti	ng perio	us	
	unweighted non-prima	ry care resident					
FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (c (col. 3 4))	+ col.	
FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column <u>column 2)). (see in</u>	3 the ratio of structions)	FTEs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 4) 5.0	+ col.)	-
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FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PP 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF column 3: If column 2 is Y, indic	PS ychiatric Facility (the facility have a afore November 15, 2 umn 2: Did this fac A12.424 (d)(1)(iii cate which program y y PPS habilitation Facilit	3 the ratio of structions) Program Code 2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTËs Nonprovi der Si te 3.00 0.00 intain an IPF subp sing program in t yes or "N" for m s cost reporting	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 4) 5. c 0 0 2. 00	+ col . 00 0000000 3.00	-

Health Financial Systems GRANT BLACKFORD MENTAL HEALTH, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4021 Peri od: Worksheet S-2 From 07/01/2020 Part I Date/Time Prepared: То 06/30/2021 11/24/2021 8:23 am 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 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. Ν 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 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 Ν Ν 90 00 ves or "N" for no in the applicable column. $|I\,s\,$ this hospital reimbursed for title V and/or XIX through the cost report either in 91 00 Ν γ 91 00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 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. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 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 Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 Υ Υ 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. Υ 98.01 98.01 Υ 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 γ 98.02 v 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) Ν 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. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν 98.04 Ν in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 γ 98.05 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? Ν 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 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) Ν 107.00 column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&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) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Ν 108.00 Physi cal Occupati onal Speech Respi ratory 1.00 2 00 3 00 4 00 109.00 If this hospital qualifies as a CAH or a cost provider, are 109.00 Ν Ν Ν Ν therapy services provided by outside supplier? Enter " for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A 110.00 Ν Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e.

ealth Financial Systems GRANT BLACKFORD MENTA DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AL HEALTH, II Provider C		Peri od:		u of Form CMS Worksheet S-	
			From 07/0 To 06/3	01/2020 30/2021	Part I Date/Time Pr 11/24/2021 8	
			1		2.00	_
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	t reporting umn 1 is Y, icipating in	period? Enter enter the column 2.	1	00 N	2.00	111. (
		1.00	2.	00	3.00	_
12.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting partice "Y" for yes or "N" for no in column 1. If column 1 is ' in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	eriod? "Y", enter	N				112. (
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers, the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) " percent ncludes) based on	N				0115.0
16.00 Is this facility classified as a referral center? Enter "Y" for "N" for no.	or yes or	N				116. (
17.00 s this facility legally-required to carry malpractice insuran "Y" for yes or "N" for no. 18.00 s the malpractice insurance a claims-made or occurrence polic		Y	2			117. 118.
if the policy is claim-made. Enter 2 if the policy is occurrent		Premiums	2	ses	Insurance	110.
8.01 List amounts of malpractice premiums and paid losses:		1.00 73,4		00	3.00	0 118.
			1.	00	2.00	-
8.02 Are malpractice premiums and paid losses reported in a cost conduct Administrative and General? If yes, submit supporting schedul and amounts contained therein. 9.00 D0 NOT USE THIS LINE			1	N		118.
0.001s this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in o "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y lifies for t	" for yes or he Outpatient		N	N	120.
1.00 Did this facility incur and report costs for high cost implan	table device	s charged to	1	N		121.
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.				N		122.
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	1	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00[f this is a Medicare certified kidney transplant center, entu- in column 1 and termination date if analisable in column 2	er the certi	fication date				126.
in column 1 and termination date, if applicable, in column 2. 7.00[If this is a Medicare certified heart transplant center, enter	r the certif	ication date				127.
in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter	r the certif	ication date				128.
in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter	the certifi	cation date i	n			129.
column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, en		ti fi cati on				130.
date in column 1 and termination date, if applicable, in colum 1.00 If this is a Medicare certified intestinal transplant center,	enter the c	erti fi cati on				131.
date in column 1 and termination date, if applicable, in colum 2.00 If this is a Medicare certified islet transplant center, enter		ication date				132.
in column 1 and termination date, if applicable, in column 2. 3.00Removed and reserved 4.00[f this is an organ procurement organization (0PO), enter the description date is applicable, is actume 2.	0P0 number	in column 1				133. 134.
and termination date, if applicable, in column 2.						
All Providers 0.00 Are there any related organization or home office costs as de						

	X IDENTIFICATION DATA	IENTAL HEALTH, INC Provider CCN					repared:
1.00		. 00			3.00		
If this facility is part of a cha				e name a	ind address	of the	
home office and enter the home of	<u>Fice contractor name and</u> Contractor's Name:	contractor numbe		otor's	Numbors		141 0
41.00Name: 42.00Street:	PO Box:		Contra	ctor's	Number :		141.0
43. 00 Ci ty:	State:		Zip Co	de:			143.0
	1						
						1.00	
44.00 Are provider based physicians' cos	sts included in Worksheet	t A?				Y	144.0
					1.00	2.00	_
45.00 If costs for renal services are cl	aimed on Wkst A line 7	74 are the costs	for		1.00	2.00	145.0
inpatient services only? Enter "Y							
no, does the dialysis facility in	clude Medicare utilizatio	on for this cost m	reporting				
period? Enter "Y" for yes or "N"							
46.00 Has the cost allocation methodolog				l E	N		146. 0
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o		15-2, chapter 40), <u>9</u> 4020)	· ·			
				I			
						1.00	
47.00 Was there a change in the statisti						N	147.0
48.00 Was there a change in the order of						N	148.0
49.00Was there a change to the simplifi	ed cost finding method?	Part A	<u>s or "N" T</u> Part B		Title V	N Title XIX	149. C
		1,00	2.00		3.00	4.00	-
Does this facility contain a prov	ider that qualifies for a			cation			
or charges? Enter "Y" for yes or							
55.00Hospi tal		N	N		Ν	N	155. (
56.00 Subprovider - IPF		N	N		N	N	156. (
57.00 Subprovider - IRF		N	Ν		N	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158. 0 159. 0
60.00HOME HEALTH AGENCY		N	N		N	N	160.0
61.00 CMHC			N		N	N	161.0
						1.00	
Multicampus	mpue beenitel that bee		oo in dif	Foront	CDCAe2	N	1/5 0
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that has o	one of more campus	ses in dii	rerent	CBSAS?	IN IN	165. C
	Name	County	State	Zip Cod	e CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
							DO 166. C
						0.0	
campus enter the name in column						0. (
campus enter the name in column O, county in column 1, state in						0. (
campus enter the name in column						0. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,						0. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)		i nom Dr				0.0	_
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI				nent Act		1.00	_
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 37.00 Is this provider a meaningful user	under §1886(n)? Enter	"Y" for yes or "N	N" for no.				167. (
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Health Financial Systems GRANT BLACKFORD MI HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-4021	Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/24/2021 8:	2 epared:
			Y/N	Date	
General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ente	1.00 r all dates in 1	2.00 the	
Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to th	ne beginning of	the cost	N		1.00
reporting period? If yes, enter the date of the change in	column 2. (see	instructions)			1.00
		Y/N	Date	V/I	
2.00 Has the provider terminated participation in the Medicara	Drogram2 lf	1.00 N	2.00	3.00	2.00
 2.00 Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, includi 	ımn 3, "V" for	N			3.00
contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provi officers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	offices, drug der or its of the board				3.00
		Y/N	Туре	Date	
		1.00	2.00	3.00	
 4.00 4.00 Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av 	for Compiled,	Y	A		4.00
5.00 column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5.00
			Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities			1.00	2.00	
6.00 Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	5	ne provider is			6.00
 7.00 Are costs claimed for Allied Health Programs? If "Y" see i 8.00 Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions. 		d during the	N N		7.00 8.00
9.00 Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ons.		N		9.00
10.00 Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00
11.00 Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.			N	Y/N	11.00
				1.00	
Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If ye	s. see instruct	tions.		Y	12.00
13.00 If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	Ň	13.00
14.00 If line 12 is yes, were patient deductibles and/or co-payn Bed Complement				N	14.00
15.00 Did total beds available change from the prior cost report				N N	15.00
	Y/N	rt A Date	Y/N	t B Date	
	1.00	2.00	3.00	4.00	
PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	09/08/2021	Y	09/08/2021	16.00
date of the PS&R Report used in columns 2 and 4 (see instructions)17.00 Was the cost report prepared using the PS&R Report for	N		N		17.00
totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					10.05
18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00
cost report? If yes, see instructions.					

Health Financial Systems

GRANT BLACKFORD MENTAL HEALTH, INC	С
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In Lieu of Form CMS-2552-10

ealth Financial Systems GRANT BLACKFORD MEN	NTAL HEALTH, IN	IC.	In Lie	u of Form CM	S-2552-10
IOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO		Period: From 07/01/2020 To 06/30/2021	Date/Time P	repared:
				11/24/2021	<u>8:23 am</u>
		ption	Y/N	Y/N	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R	()	1.00 N	3.00 N	20.00
20.00 f line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	IN IN	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
1.00 Was the cost report prepared only using the provider's	N N	2.00	N	1.00	21.00
records? If yes, see instructions.					2
		•			
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)			
Capital Related Cost				-	
2.00 Have assets been relifed for Medicare purposes? If yes, see					22.00
3.00 Have changes occurred in the Medicare depreciation expense	due to apprais	als made duri	ng the cost		23.00
reporting period? If yes, see instructions.					
4.00 Were new leases and/or amendments to existing leases entere	ed into during	this cost rep	orting period?		24.00
If yes, see instructions					
5.00 Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see		25.00
instructions.	a agat ranarti	ng noried2 If			24.00
(6.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	le cost reporti	ng period? II	yes, see		26.00
7.00 Has the provider's capitalization policy changed during the	e cost reportin	a period? If	ves submit		27.00
copy.		g period: II.	yes, subili t		27.00
Interest Expense					
8.00 Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporti na		28.00
period? If yes, see instructions.		9	5		
9.00 Did the provider have a funded depreciation account and/or	bond funds (De	bt Service Re	serve Fund)		29.0
treated as a funded depreciation account? If yes, see instr	ructions				
0.00 Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes,	see		30.0
instructions.					
1.00 Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31.00
instructions.					_
Purchased Services	wiego furnieko	d through con	traatual		
B2.00 Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		a through con	tractuar		32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app		a to competit	ive hidding? If		33. 0
no, see instructions.		g to competit	i ve braaring. Ti		00.0
Provi der-Based Physi ci ans					
4.00 Are services furnished at the provider facility under an ar	rangement with	provi der-bas	ed physicians?		34.0
If yes, see instructions.	J	P			
5.00 If line 34 is yes, were there new agreements or amended exi	sting agreemen	ts with the p	rovi der-based		35.0
physicians during the cost reporting period? If yes, see in	nstructions.				
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
6.00 Were home office costs claimed on the cost report?	anamad b. th	home off C			36.0
7.00 If line 36 is yes, has a home office cost statement been pr	epared by the	nome office?			37.0
If yes, see instructions.	Fico di Eforort	from that of			20 0
8.00 If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	I of the home o	ffice			38.0
9.00 If line 36 is yes, did the provider render services to othe					39.0
see instructions.		5115: 11 yes,			37.0
0.00 If line 36 is yes, did the provider render services to the	home office?	lf ves. see	N		40.0
II INSTRUCTIONS.					
instructions.				00	
	1.	00	2.	00	
Cost Report Preparer Contact Information	1.	00	2.		
Cost Report Preparer Contact Information 1.00 Enter the first name, last name and the title/position	TI NA	00	2. SEVERS		41.00
Cost Report Preparer Contact Information 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	1	00			41.00
 Cost Report Preparer Contact Information 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 	TINA				
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	1				
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	TINA BLUE AND CO LL		SEVERS		41.00
Cost Report Preparer Contact Information1.00Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.2.00Enter the employer/company name of the cost report preparer.	TINA				

Heal th	Financial Systems GR	ANT BLACKFORD MEN	NTAL HEALTH,	INC.	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE	Provi der	CCN: 15-4021	Period:	Worksheet S-2	
					From 07/01/2020 To 06/30/2021		pared: 23 am
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the ti	tle/position	MANAGER				41.00
	held by the cost report preparer in columns	s 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cos	t report					42.00
	preparer.						
43.00	Enter the telephone number and email addres	ss of the cost					43.00
	report preparer in columns 1 and 2, respec	ti vel y.					

HOSPI T	Financial Systems GRAN AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>T BLACKFORD MEN</u> AL DATA	Provider CC		Period: From 07/01/2020	u of Form CMS-: Worksheet S-3 Part I	
					To 06/30/2021	Date/Time Pre 11/24/2021 8:	
						I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	<u>Visits / Trips</u> Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	16	5, 8	40 0.00	0	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)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		16	5, 8	40 0.00	0	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	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1/	F 0	40 0.00		13.00
14.00 15.00	Total (see instructions) CAH visits		16	5,8	40 0.00	0	
16.00	SUBPROVIDER - IPF					0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24.10
25.00	CMHC - CMHC						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				27.0
28.00 29.00	Observation Bed Days					0	
30.00	Ambulance Trips Employee discount days (see instruction)						29.00
30.00	Employee discount days (see fistraction)						30.00
32.00	Labor & delivery days (see instructions)		0		0		32.0
32.00	Total ancillary labor & delivery room		0		J. J		32.0
	outpatient days (see instructions)						02.01
33.00	LTCH non-covered days						33.00
33 01	LTCH site neutral days and discharges						33.01

HOSPI T	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-4021		riod: om 07/01/2020 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/24/2021 8:	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time Equivalents		
	Component	Title XVIII	Title XIX	Total All Patients	-	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	-	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	359	324	2, 8	57			1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	1, 418 0	0 0					2.00 3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0	0		0			4.00 5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0.01	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	359	324	2, 8	57			7.00
8.00 9.00 10.00 11.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T							8.00 9.00 10.00 11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY							12.00 13.00
14. 00 15. 00	Total (see instructions) CAH visits	359 0	324 0	2, 8	57 0	0.00	166.34	15.00
16. 00 17. 00	SUBPROVI DER – I PF SUBPROVI DER – I RF							16.00 17.00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY							18.00 19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE							20.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)							22.00 23.00
24. 00 24. 10	HOSPI CE HOSPI CE (non-distinct part)				0			24.00 24.10
25.00 26.00	CMHC – CMHC RURAL HEALTH CLINIC							25.00 26.00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0	0		0	0.00 0.00	0.00 166.34	
28. 00 29. 00	Observation Bed Days Ambulance Trips	о	0		0			28.00 29.00
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF				0			30.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	0		0			32.00 32.01
33.00	LTCH non-covered days	0			-			33.00
	LTCH site neutral days and discharges	0						33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.		Provider C	CN: 15-4021	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/24/2021 8:2	pared:
		Full Time Equivalents	D		charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 16.00 17.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 24.00 26.25 27.00 28.00 29.00 30.00 31.00 32.01	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGI CAL INTENSI VE CARE UNIT SURGI CAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00	0		52 54 0 236 0 0 52 54	838	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 13.00 14.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 28.00 29.00 30.00 21.00 22.00 23.00 24.00 24.00 25.00 24.00 25.00 26.00 27.00 27.00 28.00 29.00 20.00 21.00 22.00 22.00 23.00 24.00 24.00 25.00 25.00 26.00 27.00 27.00 28.00 29.00 20.00 20.00 20.00 20.00 21.00 22.00 23.00 24.00 25.00 25.00 26.00 27.00 27.00 28.00 29.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 27.00 28.00 20.00 21.00 20.00 21.00 22.00 23.00 24.00 23.00 24.00 25.00 25.00 26.00 27.00 28.00 29.00 20.
33. 00	outpati ent days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

Health Financial Systems GRANT BLACKFORD MENTAL HEALTH, INC. In Lieu of Form CMS-2552-10								
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Period:	Worksheet A			
				rom 07/01/2020 o 06/30/2021				
		I			11/24/2021 8:	23 am		
Cost Center Description	Sal ari es	Other		Recl assi fi cati				
			+ col. 2)	ons (See A-6)	Trial Balance			
					(col. 3 +-			
	1.00	2.00	2.00	1.00	<u>col. 4)</u>			
	1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS	1	220 411	220 411	0	220 411	1 00		
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT	41 044	228, 411			228, 411			
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	41, 846	41, 539			83, 385			
5. 00 00500 ADMINI STRATI VE & GENERAL	939, 437	1, 875, 456			2, 814, 893			
7.00 00700 OPERATION OF PLANT	368, 997	210, 137			579, 134			
16. 00 01600 MEDI CAL RECORDS & LI BRARY	499, 264	13, 321	512, 585	0	512, 585	16.00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 ((2 0 4 2	242.014	1 007 / 57	1 0	1 007 (57			
30. 00 03000 ADULTS & PEDI ATRI CS	1, 663, 843	243, 814	1, 907, 657	0	1, 907, 657	30.00		
ANCI LLARY SERVI CE COST CENTERS		07.047	07.047	1	07.047	1 / 0 . 00		
	0	27, 347			27, 347	60.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	85, 525	85, 525	0	85, 525	73.00		
	2 502 024	201 570	2 0/2 /12	207.275	2 57(220			
90.00 09000 CLINIC	3, 582, 034	381, 579	3, 963, 613	-387, 275	3, 576, 338	90.00		
SPECIAL PURPOSE COST CENTERS	7 005 401	2 107 120	10 202 550	207.275	0.015.075	110.00		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 095, 421	3, 107, 129	10, 202, 550	-387, 275	9, 815, 275	118.00		
NONREI MBURSABLE COST CENTERS 194. 00 07950 RESI DENTI AL	2 022 201	240, 110	2 201 400	207.275	2 ((0 / 75	101 00		
	2,033,281	248, 119						
200.00 TOTAL (SUM OF LINES 118 through 199)	9, 128, 702	3, 355, 248	12, 483, 950	ט וי	12, 483, 950	200.00		

RECLASSI FI CATI ON AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-4021 Period: From 07/01/2020 To 06/30/2021 Worksheet A Date/Time Prepared: 11/24/2021 8: 23 am Cost Center Description Adjustments (See A-8) 6.00 Net Expenses For Allocation 6.00 Worksheet A Date/Time Prepared: 11/24/2021 8: 23 am 1.00 00100 NEW CAP REL COST CENTERS 1.00 00100 REW CAP REL COSTS-BLDG & FIXT 0 228, 411 1.00	Health Financial Systems GRAN	T BLACKFORD ME	NTAL HEALTH, INC		In Lie	u of Form CMS-:	2552-10
To 06/30/2021 Date/Time Prepared: 11/24/2021 8: 23 am Cost Center Description Adjustments (See A-8) Net Expenses For Allocation 1/24/2021 8: 23 am 1.00 00100 NEW CAP REL COSTS CENTERS 1.00 1.00 1.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 83, 385 4.00 5.00 00500 ADMINISTRATIVE & GENERAL -591, 250 2, 223, 643 5.00 7.00 00700 OPERATION OF PLANT 0 5.7, 134 7.00 16.00 116.00 MEDI CAL RECORDS & LI BRARY -3, 149 509, 436 16.00 1NPATI ENT ROUTINE SERVICE COST CENTERS 0 1, 907, 657 30.00 30.00 0 0 27, 347 0 60.00 7.00 0 0 27, 347 0 85, 525 73.00 0 0 0 27, 347 90.00 90.00 0 0 0 2, 512, 892 90.00 90.00 0 0 0 2, 512, 892 <td>RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O</td> <td>F EXPENSES</td> <td>Provider CCN</td> <td>N: 15-4021</td> <td></td> <td>Worksheet A</td> <td></td>	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN	N: 15-4021		Worksheet A	
Cost Center Description Adjustments (See A-8) 6.00 Net Expenses for Allocation 6.00 11/24/2021 8: 23 am 1.00 Center Description Adjustments (See A-8) 60.00 Net Expenses for Allocation 6.00 1000 1.00 00100 NEW CAP REL COSTS CENTERS 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 0 228, 411 1.00 00500 ADMINISTRATIVE & GENERAL 00500 -591, 250 2, 223, 643 5.00 7.00 007000 PERATION OF PLANT 0 0 579, 134 7.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 1, 907, 657 30.00 30.00 03000 ADGULTS & PEDIATRICS 0 1, 907, 657 30.00 30.00 OGOOD LABORATORY 0 27, 347 60.00 73.00 73.00 OGOOD CLINIC -1, 063, 446 2, 512, 892 90.00 90.00 SPECIAL PURPOSE COST CENTERS 118.00 SPECIAL PURPOSE COST CENTERS 90.00 118.00 118.00						Dato/Timo Pro	narod
General Service For Allocation 6.00 7.00 6.00 7.00 6.00 7.00 1.00 00100 New CAP REL COST CENTERS 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 0 00500 ADMINISTRATIVE & GENERAL -591,250 2,223,643 5.00 00700 OPERATION OF PLANT 0 579,134 7.00 16.00 01600 MEDI CAL RECORDS & LIBRARY -3,149 509,436 16.00 1NPATI ENT ROUTINE SERVICE COST CENTERS 0 1,907,657 30.00 30.00 03000 ADULTS & PEDIATRICS 0 27,347 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 85,525 73.00 0 07300 DRUGS CHARGED TO PATIENTS 0 85,525 73.00 0 00000 CLINIC -1,063,446 2,512,892 90.00 90.00 SPECIAL PURPOSE COST CENTERS 90.00 SPECIAL PURPOSE COST CENTERS 90.00 118.00 NONREL MBURSABLE COST CENTERS 118.00 118.00 118.00 <td></td> <td></td> <td></td> <td></td> <td>10 00/30/2021</td> <td></td> <td></td>					10 00/30/2021		
6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 0 228,411 1.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 83,385 4.00 5.00 00500 ADMI NI STRATI VE & GENERAL -591,250 2,223,643 5.00 7.00 00700 OPERATI ON OF PLANT 0 579,134 7.00 16.00 01600 MEDI CAL RECORDS & LI BRARY -3,149 509,436 16.00 1NPATI ENT ROUTI NE SERVI CE COST CENTERS 0 1,907,657 30.00 30.00 00000 OBOOG LABORATORY 0 27,347 60.00 60.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 85,525 73.00 0140.00 02000 CLI NI C -1,063,446 2,512,892 90.00 90.00 90.00 090000 CLI NI C -1,063,446 2,512,892 90.00 90.00 SPECI AL PURPOSE COST CENTERS 90.00 SUBTOTALS (SUM OF LINES 1 through 117) -1,657,845 8,157,430 118.00	Cost Center Description	Adjustments	Net Expenses				
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 0 228, 411 1.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 83, 385 4.00 5.00 00500 ADMI NI STRATI VE & GENERAL -591, 250 2, 223, 643 5.00 7.00 00700 OPERATI ON OF PLANT 0 579, 134 7.00 16.00 MEDI CAL RECORDS & LI BRARY -3, 149 509, 436 16.00 1NPATI ENT ROUTI NE SERVI CE COST CENTERS 0 1, 907, 657 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 1, 907, 657 30.00 60.00 06000 LABORATORY 0 27, 347 60.00 60.00 73.00 OTAGO DRUGS CHARGED TO PATI ENTS 0 85, 525 73.00 73.00 0 0 27, 347 -1, 063, 446 2, 512, 892 90.00 90.00 90.00 OPGODO CLINIC -1, 063, 446 2, 512, 892 90.00 90.00 SPECI AL PURPOSE COST CENTERS		(See A-8)	For Allocation				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 0 228, 411 1.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 83, 385 4.00 5.00 00500 ADMINI STRATIVE & GENERAL -591, 250 2, 223, 643 5.00 7.00 00700 OPERATION OF PLANT 0 579, 134 7.00 10.00 MEDI CAL RECORDS & LI BRARY -3, 149 509, 436 16.00 10.01 INPATI ENT ROUTI NE SERVICE COST CENTERS 0 1, 907, 657 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 1, 907, 657 30.00 ANCI LLARY SERVICE COST CENTERS 0 27, 347 60.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 85, 525 73.00 00 07300 DRUGS CHARGED TO PATI ENTS 0 85, 525 73.00 00 09000 CLI NI C -1, 063, 446 2, 512, 892 90.00 SPECI AL PURPOSE COST CENTERS 118.00 NONREI MBURSABLE COST CENTERS 118.00		6.00	7.00				
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 83,385 4.00 5.00 00500 ADMINISTRATIVE & GENERAL -591,250 2,223,643 5.00 7.00 00700 OPERATION OF PLANT 0 579,134 7.00 16.00 MEDICAL RECORDS & LIBRARY -3,149 509,436 16.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1,907,657 30.00 ANCILLARY SERVICE COST CENTERS 0 27,347 60.00 0.000 04000 RUGS CHARGED TO PATIENTS 0 85,525 73.00 0.0120 DRUGS COST CENTERS -1,063,446 2,512,892 90.00 90.00 SUBTOTALS (SUM OF LINES 1 through 117) -1,657,845 8,157,430 118.00 NONRE IMBURSABLE COST CENTERS - - - - -	GENERAL SERVICE COST CENTERS						
5.00 00500 ADMINISTRATIVE & GENERAL -591,250 2,223,643 5.00 7.00 00700 OPERATION OF PLANT 0 579,134 7.00 16.00 01600 MEDICAL RECORDS & LIBRARY -3,149 509,436 16.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1,907,657 30.00 ANCILLARY SERVICE COST CENTERS 0 27,347 60.00 60.00 06000 LABORATORY 0 27,347 60.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 85,525 73.00 00 07000 CLINIC -1,063,446 2,512,892 90.00 90.00 SPECIAL PURPOSE COST CENTERS 118.00 NONRE IMBURSABLE COST CENTERS 118.00	1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	C	228, 411				1.00
7.00 00700 OPERATI ON OF PLANT 0 579, 134 7.00 16.00 01600 MEDI CAL RECORDS & LI BRARY -3, 149 509, 436 16.00 10.00 INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 1, 907, 657 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 1, 907, 657 30.00 ANCI LLARY SERVI CE COST CENTERS 0 27, 347 60.00 60.00 07300 DRUGS CHARGED TO PATI ENTS 0 85, 525 73.00 00TPATI ENT SERVI CE COST CENTERS 0 90.00 85, 525 73.00 00TPATI ENT SERVI CE COST CENTERS -1, 063, 446 2, 512, 892 90.00 90.00 SPECI AL PURPOSE COST CENTERS -1 118.00 118.00 NONREI MBURSABLE COST CENTERS -1 118.00 118.00 118.00	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	C	83, 385				4.00
16.00 01600 MEDI CAL RECORDS & LI BRARY -3, 149 509, 436 16.00 1NPATI ENT ROUTI NE SERVI CE COST CENTERS 0 1, 907, 657 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 1, 907, 657 30.00 ANCI LLARY SERVI CE COST CENTERS 0 27, 347 60.00 60.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 85, 525 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 85, 525 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 0 85, 525 73.00 0 09000 CLI NI C -1, 063, 446 2, 512, 892 90.00 SPECI AL PURPOSE COST CENTERS -1 -1 118.00 118.00 NONREI MBURSABLE COST CENTERS -1 -1 118.00 118.00	5. 00 00500 ADMI NI STRATI VE & GENERAL	-591, 250	2, 223, 643				5.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 1,907,657 30.00 ANCI LLARY SERVI CE COST CENTERS 0 27,347 60.00 60.00 60.00 06000 LABORATORY 0 27,347 60.00 60.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 85,525 73.00 73.00 0UTPATI ENT SERVI CE COST CENTERS 0 85,525 73.00 73.00 0000 CLI NI C -1,063,446 2,512,892 90.00 90.00 5PECI AL PURPOSE COST CENTERS 90.00 SPECI AL PURPOSE COST CENTERS 118.00 118.00 NORRE MBURSABLE COST CENTERS 118.00	7.00 00700 OPERATION OF PLANT	C	579, 134				7.00
30. 00 03000 ADULTS & PEDIATRICS 0 1,907,657 30. 00 ANCILLARY SERVICE COST CENTERS 0 27,347 60. 00 60. 00 60. 00 06000 LABORATORY 0 27,347 60. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 85,525 73. 00 0UTPATIENT SERVICE COST CENTERS 0 90. 00 9000 CLINIC -1,063,446 2,512,892 90. 00 SPECIAL PURPOSE COST CENTERS 5 5 71. 00 90. 00 90. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -1,657,845 8,157,430 118. 00	16.00 01600 MEDICAL RECORDS & LIBRARY	-3, 149	509, 436				16.00
ANCI LLARY SERVICE COST CENTERS 0 27, 347 60.00 60.00 06000 LABORATORY 0 27, 347 60.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 85, 525 73.00 0UTPATIENT SERVICE COST CENTERS 0 85, 525 73.00 73.00 90.00 09000 CLINIC -1, 063, 446 2, 512, 892 90.00 SPECIAL PURPOSE COST CENTERS 90.00 SUBTOTALS (SUM OF LINES 1 through 117) -1, 657, 845 8, 157, 430 118.00 NONRE IMBURSABLE COST CENTERS 118.00 118.00 118.00 118.00 118.00	INPATIENT ROUTINE SERVICE COST CENTERS	_					
60.00 06000 LABORATORY 0 27, 347 60.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 85, 525 73.00 90.00 0000 CLINIC -1, 063, 446 2, 512, 892 90.00 90.00 SPECIAL PURPOSE COST CENTERS -1, 657, 845 8, 157, 430 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -1, 657, 845 8, 157, 430 118.00	30. 00 03000 ADULTS & PEDIATRICS	C	1, 907, 657				30.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 85,525 73.00 0UTPATIENT SERVICE COST CENTERS -1,063,446 2,512,892 90.00 90.00 09000 CLINIC -1,063,446 2,512,892 90.00 SPECIAL PURPOSE COST CENTERS 50000 50000 118.00 118.00 118.00 NONREI MBURSABLE COST CENTERS 118.00 118.00 118.00 118.00	ANCI LLARY SERVI CE COST CENTERS						
0UTPATI ENT_SERVICE_COST_CENTERS 90.00 9000 CLINIC -1,063,446 2,512,892 90.00 90.00 SPECIAL_PURPOSE_COST_CENTERS 91.00 92.00 90.00 90.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -1,657,845 8,157,430 118.00 NONRE_IMBURSABLE_COST_CENTERS 118.00 118.00 118.00 118.00	60. 00 06000 LABORATORY	C	27, 347				60.00
90. 00 09000 CLINIC -1,063,446 2,512,892 90.00 SPECIAL PURPOSE COST CENTERS 90.00 90.00 90.00 90.00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -1,657,845 8,157,430 118.00 NONREI MBURSABLE COST CENTERS 90.00 90.00 90.00 90.00	73.00 07300 DRUGS CHARGED TO PATIENTS	C	85, 525				73.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -1,657,845 8,157,430 118.00 NONRE MBURSABLE COST CENTERS	OUTPATIENT SERVICE COST CENTERS						
SUBTOTALS (SUM OF LINES 1 through 117) -1,657,845 8,157,430 118.00 NONRE MBURSABLE COST CENTERS 118.00 118.00 118.00	90. 00 09000 CLINIC	-1,063,446	2, 512, 892				90.00
NONREI MBURSABLE COST CENTERS	SPECIAL PURPOSE COST CENTERS						
	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 657, 845	8, 157, 430				118.00
194_00/07950/RESLDENTLAL -30_368 2_638_307 194_00	NONREI MBURSABLE COST CENTERS						
171. 00 07700 RESIDENTIAL	194. 00 07950 RESI DENTI AL	-30, 368	2, 638, 307				194.00
200.00 TOTAL (SUM OF LINES 118 through 199) -1, 688, 213 10, 795, 737 200.00	200.00 TOTAL (SUM OF LINES 118 through 199)	-1, 688, 213	10, 795, 737				200.00

Heal th	Financial Systems	GRANT BLACKFORD MENTAL HEALTH, INC.			NC.	In Lie	u of Form CMS-	2552-10
RECLASS	SEFECATIONS			Provider (CCN: 15-4021	Peri od:	Worksheet A-6)
						From 07/01/2020 To 06/30/2021	Date/Time Pre 11/24/2021 8:	
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A – MRO EXPENSE RECLASS							
1.00	RESIDENTIAL	194.00	<u>337, 1</u> 81	50, 094				1.00
	0		337, 181	50, 094				
500.00	Grand Total: Increases		337, 181	50, 094				500.00

Heal th	Financial Systems	GRAM	NT BLACKFORD N	IENTAL HEAL	TH, INC	2.	In Lieu	u of Form CMS-	2552-10
RECLASS	SEFECATIONS			Prov	der CCN		Period: From 07/01/2020	Worksheet A-6)
								Date/Time Pre 11/24/2021 8:	epared: 23 am
		Decreases							
	Cost Center	Line #	Sal ary	Othe	∩ Wk	kst. A-7 Ref.			
	6.00	7.00	8.00	9.00		10.00			
	A – MRO EXPENSE RECLASS								
1.00		90.00	337, 18	1 5	0, 094		C		1.00
	0		337, 18	1 5	0, 094				
500.00	Grand Total: Decreases		337, 18	1 5	0, 094				500.00

Heal th	Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	eu of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet A-7 Part I	pared:
				Acqui si ti on	S		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		_			
1.00	Land	406, 017	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	6, 256, 630	41, 268		0 41, 268	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	1, 917, 575	8, 998		0 8, 998	18, 904	5.00
6.00	Movable Equipment	490, 829	30, 000		0 30, 000	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	9, 071, 051	80, 266		0 80, 266	18, 904	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	9,071,051	80, 266		0 80, 266	18, 904	10.00
		Ending Balance	Fully				
		Ũ	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	406, 017	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	6, 297, 898	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1, 907, 669	0				5.00
6.00	Movable Equipment	520, 829	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	9, 132, 413	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	9, 132, 413	0				10.00

Heal th	Financial Systems GR	ANT BLACKFORD ME	NTAL HEALTH, IN	NC.	In Lie	u of Form CMS-	2552-10
RECONCI	LIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-4021	Period: From 07/01/2020 To 06/30/2021		pared:
			SL	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see i nstructi ons)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	228, 411	0		0 0	0	1.00
3.00	Total (sum of lines 1-2)	228, 411	0		0 0	0	3.00
		SUMMARY C	OF CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
1	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	C	228, 411				1.00
3.00	Total (sum of lines 1-2)	C	228, 411				3.00

Health Financial Systems GRAN	T BLACKFORD MEN	NTAL HEALTH, IN	IC.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2020 To 06/30/2021		pared: 23 am
	COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS		_			
1.00 NEW CAP REL COSTS-BLDG & FIXT	9, 132, 413	0	9, 132, 41	3 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	9, 132, 413		9, 132, 41			3.00
	ALLOCATI ON OF OTHER CAPI TAL SUMMARY OF CAPI TAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
	(00	d Costs	through 7)	0.00	10.00	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-	0		0 220 411	0	1 00
1.00 NEW CAP REL COSTS-BLDG & FIXT 3.00 Total (sum of lines 1-2)	0	, i i i i i i i i i i i i i i i i i i i		0 228, 411	0	1.00 3.00
3.00 Total (sum of times 1-2)	0	•	I JMMARY OF CAPI	0 228, 411	0	3.00
		30	JWWART OF CAPT	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	-		0 0	220, 111	1.00
3.00 Total (sum of lines 1-2)	0	0		0 0	228, 411	3.00

GRANT BLACKFORD MENTAL HEALTH, INC.

	Financial Systems	GRANT	BLACKFORD MENT	FAL HEALTH, INC.		u of Form CMS-2	2552-1
ADJUST	MENTS TO EXPENSES				Period: From 07/01/2020 To 06/30/2021	Worksheet A-8 Date/Time Prep	arodi
				Expense Classification or		11/24/2021 8:2	
			Т	o/From Which the Amount is			
	Cast Canton Description		Amount	Cost Conton	line #	Witcht A 7 Dof	
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			EW CAP REL COSTS-BLDG & IXT	1.00	0	1. 0
2. 00	2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0 *	** Cost Center Deleted ***	2.00	0	2.0
3.00	Investment income - other (chapter 2)		0		0.00	0	3.0
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.0
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.0
5.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.0
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.0
3. 00	Television and radio service (chapter 21)		0		0.00	0	8.0
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -1, 017, 016		0.00	0 0	9. 0 10. 0
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.0
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.0
	Laundry and linen service Cafeteria-employees and guests		0		0.00		13.C 14.C
15.00	Rental of quarters to employee and others		0		0.00	0	15. C
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. C
7.00	Sale of drugs to other than patients		0		0.00	0	17.0
8.00	Sale of medical records and abstracts		0		0.00	0	18. C
9. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. (
	Vending machines		0		0.00		20.0
1.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.0
2. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.0
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0 *	** Cost Center Deleted ***	65.00		23. C
4. 00	Adjustment for physical therapy costs in excess of	A-8-3	0*	** Cost Center Deleted ***	66.00		24.0
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0*	** Cost Center Deleted ***	114.00		25. 0
26. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT			EW CAP REL COSTS-BLDG & IXT	1.00	0	26. C
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			** Cost Center Deleted ***	2.00	0	27.0
	Non-physician Anesthetist		0	** Cost Center Deleted ***	19.00 0.00		28. 0 29. 0
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	** Cost Center Deleted ***	67.00		29. C 30. C
0. 99	limitation (chapter 14) Hospice (non-distinct) (see		OA	DULTS & PEDIATRICS	30.00		30. 9
81.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0 *	** Cost Center Deleted ***	68.00		31. C
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 0

Heal th	Financial Systems	GRAN	T BLACKFORD ME	NTAL HEALTH, INC.	In Lie	eu of Form CMS-:	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-4021	Peri od:	Worksheet A-8	
					From 07/01/2020 To 06/30/2021		narod
					10 00/ 30/ 2021	Date/Time Pre 11/24/2021 8:	23 am
				Expense Classification o	n Worksheet A	11/21/2021 01	
				To/From Which the Amount is			
			· ·				
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
22.00		1.00	2.00		4.00	5.00	22.00
	HAF EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		00.00
33.01	STORE REVENUE	В			90.00		00.01
33.02	PAYEE INCOME	В	-44, 197		90.00		33.02
33.03	CAFETERIA REVENUE	В			90.00		33.03
33.04	CASUALTY LOSSES (REVENUE)	В		ADMI NI STRATI VE & GENERAL	5.00		00.01
	MI SCELLANEOUS I NCOME	В		ADMI NI STRATI VE & GENERAL	5.00	-	33.05
	MI SCELLANEOUS I NCOME	В		MEDICAL RECORDS & LIBRARY	16.00		33.06
	MI SCELLANEOUS I NCOME	В		CLINIC	90.00		00.07
33.08	MI SCELLANEOUS I NCOME	В		RESI DENTI AL	194.00		33.08
33.09	SPONSORSHI P	A		ADMI NI STRATI VE & GENERAL	5.00		00.07
	SPONSORSHI P	A			90.00		00110
33.11	INTEREST INCOME	В		ADMI NI STRATI VE & GENERAL	5.00		33.11
	ADVERTI SI NG	A		ADMI NI STRATI VE & GENERAL	5.00		00112
33.13	ADVERTI SI NG	A			90.00		00.10
	NURSE PRACTITIONER	A			90.00		33.14
	PHYSI CI AN RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	00.10
50.00	TOTAL (sum of lines 1 thru 49)		-1, 688, 213	1			50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

Heal th	Financial Syste	ems GI	RANT BLACKFORD M	ENTAL HEALTH, I	NC.	In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (CCN: 15-4021	Period: From 07/01/2020 To 06/30/2021		epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		CLINIC	1, 017, 016			0 0	-	
2.00	0.00		0	-		0 0	-	
3.00	0.00		0			0 0	-	
4.00	0.00		0	-		0 0	0	
5.00	0.00		0	0		0 0	0	
6.00	0.00		0	0		0 0	0	
7.00	0.00		0	0		0 0	0	
8.00	0.00		0	, v		0 0	0	
9.00	0.00		0	0		0 0	0	
10.00	0.00		0	0		0 0	0	
200.00			1, 017, 016			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identi fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	0.00	0.00	0.00	Education	12	14.00	
1 00	1.00	2.00	8.00	9.00	12.00	13.00	14.00	1.00
1.00		CLINIC	0			0 0	-	
2.00	0.00		0			0 0	-	
3.00	0.00		0	-		0 0	0	
4.00	0.00		0	0		0 0	0	
5.00	0.00		0	-		0 0	0	
6.00	0.00		0	0		0 0	0	
7.00	0.00		0	0		0 0	0	
8.00	0.00		0	0		0 0	0	
9.00	0.00		0	0		0 0	0	
10.00	0.00		0			0 0	0	
200.00			0	0		0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adj ustment		
		Identifier	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		CLINIC	0			0 1, 017, 016		1.00
2.00	0.00							2.00
3.00	0.00		0					3.00
4.00	0.00		0	-				4.00
4.00 5.00	0.00							4.00 5.00
6.00	0.00			-				6.00
7.00	0.00		0	-				7.00
7.00 8.00	0.00							8.00
8.00 9.00	0.00		0	-				9.00
9.00 10.00	0.00							9.00
200.00	0.00		0			0 1,017,016		200.00
200.00	I	1	1 0	1 0	I	, i, i, i, i	I	200.00

	J	NT BLACKFORD MEN				u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021		pared: 23 am
			CAPI TAL				
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FLXT	BENEFITS		& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A col. 7)					
		0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS					•	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	228, 411	228, 411				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	83, 385	0	83, 38	15		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 223, 643	32, 193	8, 62	2, 264, 456	2, 264, 456	5.00
7.00	00700 OPERATION OF PLANT	579, 134	5, 691	3, 38	588, 211	156, 129	7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	509, 436	0	4, 58	514, 017	136, 436	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 907, 657	17, 544	15, 26	7 1, 940, 468	515, 058	30.00
	ANCI LLARY SERVI CE COST CENTERS						
60.00	06000 LABORATORY	27, 347			0 27, 347		60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	85, 525	0		0 85, 525	22, 701	73.00
	OUTPATIENT SERVICE COST CENTERS	-			- 1		
90.00	09000 CLI NI C	2, 512, 892	120, 419	29, 78	2, 663, 091	706, 864	90.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00		8, 157, 430	175, 847	61, 63	8, 083, 115	1, 544, 447	118. OC
	NONREI MBURSABLE COST CENTERS					1	
	07950 RESI DENTI AL	2, 638, 307	52, 564	21, 75	2, 712, 622	720, 009	
200.00					0		200.00
201.00			0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	10, 795, 737	228, 411	83, 38	10, 795, 737	2, 264, 456	202.00

Heal th	Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	eu of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/24/2021 8:	
	Cost Center Description	OPERATION OF PLANT	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		7.00	16.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	744, 340					7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	650, 453				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					_	
30.00	03000 ADULTS & PEDIATRICS	68, 542	309, 516	2, 833, 58	4 0	2, 833, 584	30.00
	ANCILLARY SERVICE COST CENTERS					_	
60.00	06000 LABORATORY	0	5, 924	40, 53	0 0	40, 530	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	18, 528	126, 75	4 0	126, 754	73.00
	OUTPATIENT SERVICE COST CENTERS					_	
90.00	09000 CLI NI C	470, 445	316, 485	4, 156, 88	5 0	4, 156, 885	90.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	538, 987	650, 453	7, 157, 75	3 0	7, 157, 753	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	07950 RESI DENTI AL	205, 353	0	3, 637, 98	4 0	3, 637, 984	194.00
200.00	Cross Foot Adjustments				0 0	0	200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	744, 340	650, 453	10, 795, 73	7 0	10, 795, 737	202.00

Heal th	Financial Systems GRAN	NT BLACKFORD ME	NTAL HEALTH, IN	C.	In Lie	eu of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/24/2021 8:	pared: 23 am
	Cost Center Description	Directly Assigned New Capital <u>Related Costs</u>		Subtotal	BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
		0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1	1				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	00.10	0 0		4.00
	00500 ADMI NI STRATI VE & GENERAL	0	32, 193	32, 19		32, 193	
	00700 OPERATION OF PLANT	0	5, 691	5, 69		2, 220	7.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	1, 940	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS		47.544	47.54	4	7.000	00.00
30.00	03000 ADULTS & PEDIATRICS	0	17, 544	17, 54	4 0	7, 323	30.00
(0.00	ANCI LLARY SERVICE COST CENTERS					100	1 / 0 . 00
	06000 LABORATORY	0	0				
73.00	07300 DRUGS CHARGED TO PATIENTS	0	<u> </u>		J0	323	73.00
90, 00	OUTPATIENT SERVICE COST CENTERS	0	120, 419	120, 41	9 0	10, 051	90.00
90.00	SPECIAL PURPOSE COST CENTERS	0	120, 419	120, 41	9 0	10,051	90.00
118.00		0	175, 847	175, 84	7 0	21.060	118.00
110.00	NONREI MBURSABLE COST CENTERS	0	175,047	175,04	0	21,700	1110.00
194 00	07950 RESI DENTI AL	0	52, 564	52, 56	4 0	10 233	194.00
200.00			52,504	52, 50		10,233	200.00
200.00			0		- - -	n –	201.00
202.00		0	228, 411	228, 41	1 0		202.00

Heal th	Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, IN	C.	In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	-	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/24/2021 8:	pared: 23 am
	Cost Center Description	OPERATION OF PLANT	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		7.00	16.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	7, 911					7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 940				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	728	924	26, 51	9 0	26, 519	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	0	18	12	1 0	121	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	55	37	8 0	378	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	5,000	943	136, 41	3 0	136, 413	90.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 728	1, 940	163, 43	1 0	163, 431	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	07950 RESI DENTI AL	2, 183	0	64, 98	0 0	64, 980	194.00
200.00	Cross Foot Adjustments				0 0	0	200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	7, 911	1, 940	228, 41	1 0	228, 411	202.00

	TION - STATISTICAL BASIS		Provider C	CN: 15-4021	Period:	Worksheet B-1	
					rom 07/01/2020		
				-	Го 06/30/2021	Date/Time Pre 11/24/2021 8:	
		CAPI TAL					
		RELATED COSTS		L			
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE		
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	(SQUARE FEET)	
		FEET)	SALARI ES)		CUST)	FEEI)	
		1.00	4, 00	5A	5.00	7.00	
GENER/	AL SERVICE COST CENTERS	1.00	1.00	0/1	0.00	7.00	
00100	NEW CAP REL COSTS-BLDG & FIXT	130, 997					1 1.
00400	EMPLOYEE BENEFITS DEPARTMENT	0	9, 086, 856				4.
00500	ADMINISTRATIVE & GENERAL	18, 463	939, 437	-2, 264, 45	6 8, 531, 281		5.
00700 00	OPERATION OF PLANT	3, 264	368, 997	(588, 211	109, 270	7
00 01600	MEDICAL RECORDS & LIBRARY	0	499, 264	l (514, 017	0	16
	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	10, 062	1, 663, 843	3	0 1, 940, 468	10, 062	30
	LARY SERVICE COST CENTERS	· · ·		1			
	LABORATORY	0	C		27, 347	0	
	DRUGS CHARGED TO PATIENTS	0	C		0 85, 525	0	73
	TIENT SERVICE COST CENTERS	1		1			
00 09000		69, 062	3, 244, 853	8	2, 663, 091	69, 062	90
	AL PURPOSE COST CENTERS						1
	SUBTOTALS (SUM OF LINES 1 through 117)	100, 851	6, 716, 394	-2, 264, 45	5, 818, 659	79, 124	1118
	I MBURSABLE COST CENTERS	00.44	0.070.4/0		0 740 (00	00.44/	1.0.4
	RESIDENTIAL	30, 146	2, 370, 462	<u>/</u>	2, 712, 622	30, 146	
D. 00 1. 00	Cross Foot Adjustments						200 201
	Negative Cost Centers Cost to be allocated (per Wkst. B,	228, 411	83, 385		2 24 454	744 240	
2.00	Part I)	228, 411	83, 385		2, 264, 456	744, 340	202
3. 00	Unit cost multiplier (Wkst. B, Part I)	1, 743635	0. 009176		0.265430	6. 811934	203
4.00	Cost to be allocated (per Wkst. B,		0		32, 193		
	Part II)						
5.00	Unit cost multiplier (Wkst. B, Part		0. 000000		0. 003774	0.072399	205
	11)						
5.00	NAHE adjustment amount to be allocated						206
	(per Wkst. B-2)						
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207

COST A	LLOCATION - STATISTICAL BASIS		Provider CCN: 15-4021	Peri od:	Worksheet B-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
					11/24/2021 8:	
	Cost Center Description	MEDI CAL				
		RECORDS &				
		LI BRARY				
		(GROSS				
		CHARGES)				
		16.00				
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	7, 013, 105				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	3, 337, 169				30.00
	ANCI LLARY SERVI CE COST CENTERS					
60.00	06000 LABORATORY	63, 877				60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	199, 770				73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	3, 412, 289				90.00
	SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	7, 013, 105				118.00
	NONREI MBURSABLE COST CENTERS					
194.00	07950 RESI DENTI AL	0				194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	5	650, 453				202.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 092748				203.00
204.00		1, 940				204.00
	Part II)	,				
205.00		0. 000277				205.00
206.00						206.00
	(per Wkst. B-2)					
207.00						207.00
	Parts III and IV)					
						•

Health Financial Systems	GRANT BLACKFORD MEN	TAL HEALTH, IN	IC.	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-4021	Period: From 07/01/2020 To 06/30/2021		pared: 23 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 833, 584		2, 833, 58	34 0	2, 833, 584	30.00
ANCI LLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	40, 530		40, 53	0 0	40, 530	1
73.00 07300 DRUGS CHARGED TO PATIENTS	126, 754		126, 75	64 0	126, 754	73.00
OUTPATIENT SERVICE COST CENTERS	F		r	1	-	
90. 00 09000 CLINIC	4, 156, 885		4, 156, 88		4, 156, 885	
200.00 Subtotal (see instructions)	7, 157, 753	0	7, 157, 75	53 0	7, 157, 753	1
201.00 Less Observation Beds	0			0	-	201.00
202.00 Total (see instructions)	7, 157, 753	0	7, 157, 75	0	7, 157, 753	202.00

Health Financial Systems G	RANT BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 07/01/2020 Fo 06/30/2021	Worksheet C Part I Date/Time Pre	pared:
		Titlo	XVIII	Hospi tal	11/24/2021 8: PPS	<u>23 am</u>
		Charges	XVIII		115	
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 337, 169		3, 337, 16	9		30.00
ANCI LLARY SERVI CE COST CENTERS						
60. 00 06000 LABORATORY	63, 877	0	63, 87	0. 634501	0.000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	199, 770	0	199, 77	0. 634500	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	3, 412, 289	3, 412, 28	9 1. 218210	0.00000	90.00
200.00 Subtotal (see instructions)	3, 600, 816	3, 412, 289	7, 013, 10	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	3, 600, 816	3, 412, 289	7, 013, 10	ō		202.00

Health Financial Systems	GRANT BLACKFORD MENT	AL HEALTH, INC.	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4021	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/24/2021 8:	pared:
		Title XVIII	Hospi tal	PPS	20 0111
Cost Center Description	PPS Inpatient Ratio 11.00		· · · · · · · · · · · · · · · · · · ·		
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCI LLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	0. 634501				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 634500				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	1. 218210				90.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems G	RANT BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-4021	Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
			e XIX	Hospi tal	11/24/2021 8: Cost	<u>23 am</u>
				Costs	COST	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 833, 584		2, 833, 5	34 0	2, 833, 584	30.00
ANCILLARY SERVICE COST CENTERS				- 1		
60. 00 06000 LABORATORY	40, 530		40, 53	30 0	40, 530	1
73.00 07300 DRUGS CHARGED TO PATIENTS	126, 754		126, 7	54 0	126, 754	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	4, 156, 885		4, 156, 8	35 0	4, 156, 885	
200.00 Subtotal (see instructions)	7, 157, 753	0	7, 157, 7	53 0	7, 157, 753	1
201.00 Less Observation Beds	0			0	-	201.00
202.00 Total (see instructions)	7, 157, 753	0	7, 157, 7	53 0	7, 157, 753	202.00

Health Financial Systems G	RANT BLACKFORD MEN	ITAL HEALTH, IN	IC.	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 11/24/2021 8:	pared:
		Titl	e XIX	Hospi tal	Cost	20 011
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 337, 169		3, 337, 16	9		30.00
ANCI LLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	63, 877	0	63, 87	7 0. 634501	0.00000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	199, 770	0	199, 77	0. 634500	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	3, 412, 289	3, 412, 28	9 1. 218210	0.00000	90.00
200.00 Subtotal (see instructions)	3, 600, 816	3, 412, 289	7, 013, 10	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	3, 600, 816	3, 412, 289	7, 013, 10	5		202.00

Health Financial Systems	GRANT BLACKFORD MENTAL HEALTH, INC.		In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4021	Period: Worksheet C From 07/01/2020 Part I To 06/30/2021 Date/Time Pr 11/24/2021 8		pared: 23 am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVI CE COST CENTERS					1
60. 00 06000 LABORATORY	0. 000000				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000				90.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems GRAI	NT BLACKFORD ME	NTAL HEALTH, II	NC.	In Lie	eu of Form CMS-:	2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:		
			e XVIII	Hospi tal	11/24/2021 8: PPS	23 am		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.			
	Related Cost (from Wkst. B,	Adjustment	Capital Related Cost	Days	3 / col. 4)			
	Part II, col.		$(col \cdot 1 - col$					
	26)		2)					
	1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS		1	1	-1	1			
30. 00 ADULTS & PEDIATRICS	26, 519		26, 51			•		
200.00 Total (lines 30 through 199)	26, 519		26, 51	9 2,857		200.00		
Cost Center Description	Inpatient	Inpatient						
	Program days							
		Capital Cost						
		(col. 5 x col. 6)						
	6,00	7.00	1					
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 ADULTS & PEDIATRICS	359	3, 332				30.00		
200.00 Total (lines 30 through 199)	359	3, 332	2			200. 00		

Health Financial Systems GRAN	T BLACKFORD MEN	NTAL HEALTH, IN	IC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider CO		Peri od:	Worksheet D	
				From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/24/2021 8:	pared: 23 am
		Title	XVIII	Hospi tal	PPS	25 am
Cost Center Description	Capi tal	Total Charges		_	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
60. 00 06000 LABORATORY	121	63, 877	0.00189	04 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	378	199, 770	0.00189	02 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLI NI C	136, 413	3, 412, 289	0.03997	7 0	0	90.00
200.00 Total (lines 50 through 199)	136, 912	3, 675, 936		0	0	200. 00

APPORTI ONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-4021 Period: From 07/01/2020 To 06/30/2021 Worksheet D Patri H I Date/Time Prepared: 11/24/2021 8: 23 am Cost Center Description Nursing School Adjustments Nursing School Adjustments Allied Heal th Post-Stepdown Adjustments Allied Heal th Cost Allied Heal th Medical All Other Medical INPATIENT ROUTINE SERVICE COST CENTERS 0	Health Financial Systems GRA	NT BLACKFORD ME	NTAL HEALTH, IN	NC.	In Lie	eu of Form CMS-	2552-10
To 06/30/2021 Date/Time Prepared: 11/24/2021 8: 23 am 11/24/2021 8: 23 am Title XVIII Hospital DPS To 06/30/2021 Date/Time Prepared: 11/24/2021 8: 23 am Title XVIII Hospital DPS Cost Center Description Nursing School Nursing School Allied Health Post-Stepdown Adjustments Allied Health Cost Allied Health Cost Allied Health Cost INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0000 0 <td>APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F</td> <td>ASS THROUGH COS</td> <td>TS Provider C</td> <td></td> <td></td> <td></td> <td></td>	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS	TS Provider C				
Introduction of the service cost center Description Introduction of							epared:
Cost Center Description Nursing School Post-Stepdown Adjustments Allied Health Post-Stepdown Adjustments Allied Health Cost Allied Health Education Cost 30.00 03000 ADULTS & PEDIATRICS 0						11/24/2021 8:	
Post-Stepdown Adj ustments Post-Stepdown Adj ustments Cost Medi cal Education Cost 30.00 INPATI ENT ROUTINE SERVICE COST CENTERS 1A 1.00 2A 2.00 3.00 30.00 OOOD ADULTS & PEDIATRICS 0 0 0 0 0 0 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 Cost Center Description Swing-Bed Adj ustment Anount (see instructions) Total Costs instructions) Total Costs instructions) Total Costs instructions) Total Patient Days Post-Stepdown Adj ustment Anount (see instructions) Inpatient Program Days 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 200.00 Total (lines 30 through 199) 0 0 0 0 0 200.00 Total (lines 30 through 199) 0 0 2.857 0.00 359 200.00 Total (lines 30 through 199) Inpatient Program Pass-Through Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) Post-Stepdown Adj ustments A.00 2.857 0.00							
Adj ustments Adj ustments Educati on Cost 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDI ATRICS 0 0 0 0 0 30.00 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 200.00 0 0 0 0 0 200.00 0 0 0 0 0 0 0 0 200.00 0	Cost Center Description						
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 0 2A 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 0							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 0							
30.00 O3000 ADULTS & PEDIATRICS 0		1A	1.00	2A	2.00	3.00	
200.00 Total (lines 30 through 199) 0		-	-	1	-	-	
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 30.00 03000 03000 ADULTS & PEDIATRICS 0 0 0 2,857 0.00 359 30.00 200.00 Total (lines 30 through 199) 0 2,857 0.00 359 30.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) Inpatient Program 2,857 0.00 359 30.00		C	0		0 0	, i i i i i i i i i i i i i i i i i i i	
Adj ustment Amount (see instructions) Construction Days 5 ÷ col. 6) Program Days 1 through 3, minus col. 4) 1 through 3, minus col. 4) 0 <td></td> <td>C</td> <td>00</td> <td></td> <td>00</td> <td></td> <td>200.00</td>		C	00		00		200.00
Amount (see instructions) 1 through 3, minus col. 4) 0 </td <td>Cost Center Description</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	Cost Center Description						
instructions) minus col. 4) 4.00 5.00 6.00 7.00 8.00 30.00 03000 ADULTS & PEDIATRICS 0 0 2,857 0.00 359 30.00 200.00 Total (lines 30 through 199) 0 2,857 0.00 359 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) V				Days	5 ÷ col. 6)	Program Days	
4.00 5.00 6.00 7.00 8.00 30.00 ADULTS & PEDIATRICS 0 0 2,857 0.00 359 30.00 200.00 Total (lines 30 through 199) 0 2,857 0.00 359 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
INPATI ENT_ROUTINE_SERVICE_COST_CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 2,857 0.00 359 30.00 200.00 Total (lines 30 through 199) 0 2,857 359 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) Inpatient 1 1		/					
30. 00 03000 ADULTS & PEDIATRICS 0 0 2,857 0.00 359 30.00 200. 00 Total (lines 30 through 199) 0 2,857 0.00 359 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8)		4.00	5.00	6.00	7.00	8.00	
200.00 Total (lines 30 through 199) 0 2,857 359 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8)				1		1	-
Cost Center Description Program Pass-Through Cost (col. 7 x col. 8)		C	0				
Program Pass-Through Cost (col. 7 x col. 8)			0	2, 85	7	359	200.00
Pass-Through Cost (col. 7 x col. 8)	Cost Center Description						
Cost (col. 7 x col. 8)							
<u>col. 8)</u>							
			(
9.00							
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS			1				
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00		C					
200.00 Total (lines 30 through 199) 0 200.00	200.00 Total (lines 30 through 199)	C					200.00

Health Financial Systems GRAN	T BLACKFORD ME	NTAL HEALTH, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021		narod
				10 00/ 30/ 2021	11/24/2021 8:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description				Allied Health		
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems GRAN	IT BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	5 Provider C		Period: From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/24/2021 8:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0		0 63, 877	0.000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 199, 770	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 3, 412, 289	0.000000	90.00
200.00 Total (lines 50 through 199)	0	0		0 3, 675, 936		200. 00

Health Financial Systems GRAN	T BLACKFORD MENT	AL HEALTH, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider C	CN: 15-4021	Peri od: From 07/01/2020 To 06/30/2021	Date/Time Pre	
		Title	× XVIII	Hospi tal	11/24/2021 8: PPS	<u>23 am</u>
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	0. 000000	0		0 152, 828	0	90.00
200.00 Total (lines 50 through 199)		0		0 152, 828	0	200. 00

Health Fina	ncial Systems GRAN	NT BLACKFORD MEN	NTAL HEALTH, IN	NC.	In Lie	u of Form CMS-:	2552-10
APPORTI ONME	INT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 07/01/2020 To 06/30/2021		
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI L	LARY SERVICE COST CENTERS						
60.00 06000	D LABORATORY	0. 634501	0		0 0	0	60.00
73.00 07300	D DRUGS CHARGED TO PATIENTS	0. 634500	0		0 0	0	73.00
OUTPA	ATIENT SERVICE COST CENTERS						1
90.00 09000	D CLINIC	1. 218210	152, 828		0 0	186, 177	90.00
200.00	Subtotal (see instructions)		152, 828		0 0	186, 177	200.00
201.00	Less PBP Clinic Lab. Services-Program		-		0 0		201.00
	Only Charges				-		
202.00	Net Charges (line 200 - line 201)		152, 828		o o	186, 177	202.00

Health Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, IN	NC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-4021	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/24/2021 8:	
			XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
60. 00 06000 LABORATORY	0	0				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						-
90. 00 09000 CLINIC	0	0				90.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges		0				
202.00 Net Charges (line 200 - line 201)		0	1			202.00

GRANT	BLACKFORD	MENTAL	HEALTH,	INC.	

In Lieu of Form CMS-2552-10

		Title XVIII	From 07/01/2020 To 06/30/2021 Hospi tal	Date/Time Pre 11/24/2021 8: PPS	
	Cost Center Description			115	
				1.00	
	PART I – ALL PROVIDER COMPONENTS				-
1.00	Inpatient days (including private room days and swing-bed day	rs excluding newborn)		2,857	1.00
2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line.	bed and newborn days)	rivate room days,	2, 857 0	2.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	2, 857 0	
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through Decembe	r 31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December :	31 of the cost	0	
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)		0	359	
	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc	tions)	3 ,	0	
	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI	enter 0 on this line)	3 ,	0	
	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V of XI	<u> </u>	<u> </u>	0	
	Medically necessary private room days applicable to the Progr	ear, enter 0 on this li	ne)	0	
15.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)		uuy <i>s)</i>	0	15.00
	SWING BED ADJUSTMENT			0	10.00
	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20.00
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ting period (line	2, 833, 584 0	1
	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportion	ng period (line 6	0	23.00
	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	er 31 of the cost report	ing period (line	0	24.00
	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.00
27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 2, 833, 584	
	General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		-	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)		0.00	•	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	0.00 0.00	•		
	Average per diem private room cost differential (line 34 x li			0.00	•
	Private room cost differential adjustment (line 3 x line 35)	- /		0.00	
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	ifferential (line	2, 833, 584	•
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		1	001 65	00.05
20 20 1	Adjusted general inpatient routine service cost per diem (see	instructions)		991.80	•
	Program general inpatient routine convice cast (line 0 x line	20)	1	2E4 0E4	20 00
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			356, 056 0	1

	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-4021	Peri od:	Worksheet D-1	1
					From 07/01/2020 To 06/30/2021	Date/Time Pre	
			Titl	e XVIII	Hospi tal	11/24/2021 8: PPS	23 a
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Day		÷	(col. 3 x col.	
		1.00	0.00	col 2)	4.00	4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
	Intensive Care Type Inpatient Hospital	llni ts				1	42
	INTENSIVE CARE UNIT	011113					43
	CORONARY CARE UNI T						44
	BURN INTENSIVE CARE UNIT						45
00	SURGICAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						_
00	Dragnam innationt anaillanu aanuisa a	at (Wkat D 2 and 2	Line 200)			1.00	10
	Program inpatient ancillary service co Total Program inpatient costs (sum of			ons)		356, 056	
	PASS THROUGH COST ADJUSTMENTS		see matructi	0113)			<u> </u>
	Pass through costs applicable to Progr	am inpatient routine	services (fro	m Wkst. D. su	n of Parts I and	3, 332	2 50
	III)						
00	Pass through costs applicable to Progr	am inpatient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	51
	and IV)						
	Total Program excludable cost (sum of					3, 332	
	Total Program inpatient operating cost medical education costs (line 49 minus		ated, non-pr	iysi ci an anesti	hetist, and	352, 724	1 53
	TARGET AMOUNT AND LIMIT COMPUTATION	s The 52)				1	
	Program di scharges					0	54
	Target amount per discharge					0.00	55
00	Target amount (line 54 x line 55)					0	56
	Difference between adjusted inpatient	operating cost and ta	rget amount (line 56 minus	line 53)	0	
	Bonus payment (see instructions)					0	
	Lesser of lines 53/54 or 55 from the c market basket	cost reporting period	ending 1996,	updated and c	ompounded by the	0.00	59
	Lesser of lines 53/54 or 55 from prior	vear cost report un	dated by the	market basket		0.00	60
	If line 53/54 is less than the lower of				the amount by	0.00	
	which operating costs (line 53) are le				2	-	
	amount (line 56), otherwise enter zero) (see instructions)	•		0		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentiv		ictions)			0) 63
	PROGRAM INPATIENT ROUTINE SWING BED CC Medicare swing-bed SNF inpatient routi		mbor 21 of th	o cost roport	ing pariod (Soo	0	64
00	instructions) (title XVIII only)	The costs thi ough bece		le cost report	ng period (see		04
00	Medicare swing-bed SNF inpatient routi	ne costs after Decemb	er 31 of the	cost reportin	g period (See	0	65
	instructions)(title XVIII only)						
00	Total Medicare swing-bed SNF inpatient	routine costs (line	64 plus line	65)(title XVI	ll only). For	0) 66
	CAH (see instructions)			C 11			
00	Title V or XIX swing-bed NF inpatient (line 12 x line 19)	routine costs through	December 31	of the cost r	eporting period	0	67
00	Title V or XIX swing-bed NF inpatient	routine costs after D	ecember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)			the boot rop	or ening por roa		
. 00	Total title V or XIX swing-bed NF inpa	atient routine costs (line 67 + lir	ie 68)		0) 69
	PART III - SKILLED NURSING FACILITY, C						
	Skilled nursing facility/other nursing	, ,)		70
	Adjusted general inpatient routine ser		ine /0 ÷ line	2)			71
	Program routine service cost (line 9 > Medically necessary private room cost		(line 14 v l	ine 35)			72
	Total Program general inpatient routir						74
	Capital -related cost allocated to inpa				Part II, column		75
-	26, line 45)		、				
	Per diem capital-related costs (line 7						76
	Program capital -related costs (line 9						77
	Inpatient routine service cost (line 7			-1-)			78
	Aggregate charges to beneficiaries for			· ·	aus lino 70)		79
	Total Program routine service costs for Inpatient routine service cost per die	•		n (IIIe /o MI	IUS ITTE /9)		80
	Inpatient routine service cost per une)				82
00	Reasonable inpatient routine service of	•	· .				83
	Program inpatient ancillary services (84
	Utilization review - physician compens	. ,	ns)				85
00	Total Program inpatient operating cost		rough 85)				86
. t	PART IV - COMPUTATION OF OBSERVATION E	ED PASS THROUGH COST					
ļ							
. 00	Total observation bed days (see instru Adjusted general inpatient routine cos	ictions)	ling 2)			0.00	

Health Financial Systems GRAN	T BLACKFORD ME	NTAL HEALTH, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2020	Worksheet D-1	
				To 06/30/2021	Date/Time Pre 11/24/2021 8:	pared: 23 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x 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	26, 519	2, 833, 584	0.00935	9 0	0	90.00
91.00 Nursing School cost	0	2, 833, 584	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 833, 584	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 833, 584	0. 00000	0 0	0	93.00

In Lieu of Form CMS-2552-10

alth Financial Systems GRANT	BLACKFORD MENTAL I	HEALTH, INC.	In Lie	u of Form CMS-2	2552-
OMPUTATION OF INPATIENT OPERATING COST	P	rovider CCN: 15-4021	Peri od:	Worksheet D-1	
			From 07/01/2020 To 06/30/2021	Date/Time Pre	naro
			10 00/ 30/ 2021	11/24/2021 8:	
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1.00	
PART I - ALL PROVIDER COMPONENTS					-
00 Inpatient days (including private room days an	d cwing bod days	oveluding newborn)		2, 857	1 1.
00 Inpatient days (including private room days an 00 Inpatient days (including private room days, e				2,857	
00 Private room days (excluding swing-bed and obs			rivate room davs	2,037	
do not complete this line.	civation bed days)	, in you have only p	rivate room days,	0	J.
00 Semi-private room days (excluding swing-bed an	d observation bed	days)		2, 857	4.
00 Total swing-bed SNF type inpatient days (inclu	ding private room	days) through Decemb	er 31 of the cost	0	5.
reporting period					
00 Total swing-bed SNF type inpatient days (inclu		days) after December	31 of the cost	0	6.
reporting period (if calendar year, enter 0 on 00 Total swing-bed NF type inpatient days (includ		dava) through December	n 21 of the east	0	7.
00 Total swing-bed NF type inpatient days (includ reporting period	ing private room c	lays) through becembe	i si oi the cost	0	1.
00 Total swing-bed NF type inpatient days (includ	ling private room (davs) after December	31 of the cost	0	8.
reporting period (if calendar year, enter 0 on		adys) arter becomber		0	0.
00 Total inpatient days including private room da		the Program (excludin	g swing-bed and	324	9.
newborn days) (see instructions)					
0.00 Swing-bed SNF type inpatient days applicable t			room days)	0	10.
through December 31 of the cost reporting peri				0	11
I.00 Swing-bed SNF type inpatient days applicable t December 31 of the cost reporting period (if cost reporting period)			room days) after	0	11.
2.00 Swing-bed NF type inpatient days applicable to			te room days)	0	12.
through December 31 of the cost reporting peri		sing (increating priva	to room dago)	0	
3.00 Swing-bed NF type inpatient days applicable to		only (including priva	te room days)	0	13.
after December 31 of the cost reporting period					
4.00 Medically necessary private room days applicab	le to the Program	(excl udi ng swi ng-bed	days)	0	
5.00 Total nursery days (title V or XIX only)				0	
5.00 Nursery days (title V or XIX only) SWING BED ADJUSTMENT				0	16.
7.00 Medicare rate for swing-bed SNF services appli	cable to services	through December 31	of the cost	0.00	1 17
reporting period		thi bugh becomber of		0.00	
3.00 Medicare rate for swing-bed SNF services appli	cable to services	after December 31 of	the cost	0.00	18.
reporting period					
9.00 Medicaid rate for swing-bed NF services applic	able to services t	through December 31 o	f the cost	0.00	19.
reporting period 0.00 Medicaid rate for swing-bed NF services applic	able to convigor a	after December 21 of	the cost	0.00	20
0.00 Medicaid rate for swing-bed NF services applic reporting period	able to services a	arter becember 31 01	the cost	0.00	20.
1.00 Total general inpatient routine service cost (see instructions)			2, 833, 584	21.
2.00 Swing-bed cost applicable to SNF type services		31 of the cost repor	ting period (line	0	
5 x line 17)	5		51 (
3.00 Swing-bed cost applicable to SNF type services	after December 31	1 of the cost reporti	ng period (line 6	0	23.
x line 18)				_	
4.00 Swing-bed cost applicable to NF type services	through December 3	31 of the cost report	ing period (line	0	24.
7 x line 19) 5.00 Swing-bed cost applicable to NF type services	after December 31	of the cost reporting	a period (line 8	0	25.
x line 20)	arter becember 31		g period (inic o	0	20.
5.00 Total swing-bed cost (see instructions)				0	26.
7.00 General inpatient routine service cost net of	swing-bed cost (li	ne 21 minus line 26)		2, 833, 584	27.
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
3.00 General inpatient routine service charges (exc		and observation bed c	harges)	0	
 0.00 Private room charges (excluding swing-bed char 0.00 Semi-private room charges (excluding swing-bed 				0	
. 00 General inpatient routine service cost/charge		ine 28)		0.000000	
. 00 Average private room per diem charge (line 29	•	1110 20)		0.00	
.00 Average semi-private room per diem charge (lin				0.00	
.00 Average per diem private room charge different		s line 33)(see instru	ctions)	0.00	
.00 Average per diem private room cost differentia	al (line 34 x line			0.00	
0.00 Private room cost differential adjustment (lin				0	
7.00 General inpatient routine service cost net of	swing-bed cost and	d private room cost d	ifferential (line	2, 833, 584	37.
27 minus line 36)					1
					-
PART II - HOSPITAL AND SUBPROVIDERS ONLY	UDOUCH COST AD LUCT	IMENITO			1
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS T				001 00	20
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS T 3.00 Adjusted general inpatient routine service cost	st per diem (see in	nstructions)		991.80 321.343	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS T	st per diem (see in (line 9 x line 38	nstructions) 3)		991. 80 321, 343 0	39.

Heal th	Financial Systems GRAN	IT BLACKFORD MEI	NTAL HEALTH, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO		eriod:	Worksheet D-1	
				F T	rom 07/01/2020 o 06/30/2021	Date/Time Pre	oared:
						11/24/2021 8:	
	Cost Contor Deparintion	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	Cost Center Description		Inpatient Days	9	Program Days	(col. 3 x col.	
		inputront obot		col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			0	48.00
	Total Program inpatient costs (sum of lines			ns)		321, 343	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00
51.00	III) Pass through costs applicable to Program inp	atient ancillar	rv services (fr	om Wkst D su	m of Parts II	0	51.00
01.00	and IV)		y services (11	om more. D, Su		0	01.00
52.00	Total Program excludable cost (sum of lines					0	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-phy	sician anesthe	tist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program discharges					0	54.00
	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus I	ine 53)	0	57.00
	Bonus payment (see instructions)	posting posied	anding 1004	ndated and com	acurded by the	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, u	puated and com	bounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line				2	0	61.00
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	the target		
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportin	g period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemh	per 31 of the c	ost reporting	neriod (See	0	65.00
00.00	instructions) (title XVIII only)			lost reporting		0	00.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
(7.00	CAH (see instructions)		. D	£ + +		0	(7.00
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	r the cost rep	bring period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31 of	the cost repor	ting period	0	68.00
	(line 13 x line 20)			·	0.1		
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil		•				70.00
71.00	Adjusted general inpatient routine service c						71.00
72.00	Program routine service cost (line 9 x line	71)					72.00
	Medically necessary private room cost applic	U	•	ne 35)			73.00
74.00 75.00	Total Program general inpatient routine serv			larkchoot P Do	ct II column		74.00 75.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	Tout the service	e costs (from w	ULKSHEEL D, PA	t II, corumn		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu			-)			78.00
79.00 80.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				sline 79)		79.00 80.00
81.00	Inpatient routine service cost per diem limi				s The TT		81.00
82.00	Inpatient routine service cost limitation (I)				82.00
83.00	Reasonable inpatient routine service costs (ıs)				83.00
84.00 85.00	Program inpatient ancillary services (see in		ne)				84.00 85.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
	Total observation bed days (see instructions					0	87.00
88.00	Adjusted general inpatient routine cost per o						88.00
07.00	Observation bed cost (line 87 x line 88) (se	e instructions)	1			0	89.00

Health Financial Systems GRAM	IT BLACKFORD ME	ENTAL	HEALTH, IN	IC.	In Lie	eu of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CC		Peri od:	Worksheet D-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/24/2021 8:	pared: 23 am
			Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Rou	utine Cost	column 1 ÷	Total	Observation	
		(fro	om line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x 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	26, 51	9	2, 833, 584	0.0093	59 0	0	90.00
91.00 Nursing School cost	(0	2, 833, 584	0.0000	0 00	0	91.00
92.00 Allied health cost		0	2, 833, 584	0.0000	0 00	0	92.00
93.00 All other Medical Education	(0	2, 833, 584	0.0000	00 00	0	93.00

Health Financial Systems	GRANT BLACKFORD	MENTAL HEALTH	, IN	C.	In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi de	r CC	CN: 15-4021	Period: From 07/01/2020	Worksheet D-3	
					To 06/30/2021		
		Ti	tle	XVIII	Hospi tal	PPS	
Cost Center Description				Ratio of Cos	t Inpatient	Inpati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS					392, 387		30.00
ANCI LLARY SERVI CE COST CENTERS							
60. 00 06000 LABORATORY				0.6345	01 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS				0. 6345	0 00	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC				1. 2182	10 0	0	90.00
200.00 Total (sum of lines 50 through 94 a	nd 96 through 98	3)			0	0	200.00
201.00 Less PBP Clinic Laboratory Services	-Program only ch	narges (line 6	1)		0		201.00
202.00 Net charges (line 200 minus line 20	1)				0		202.00

Health Financial Systems	GRANT BLACKFORD	MENTAL HE	EALTH, IN	IC.	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Pro	ovider CC	CN: 15-4021	Period: From 07/01/2020	Worksheet D-3	
					To 06/30/2021		
			Titl	e XIX	Hospi tal	Cost	
Cost Center Description				Ratio of Cos	t Inpatient	Inpati ent	
				To Charges		Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS					354, 132		30.00
ANCI LLARY SERVI CE COST CENTERS							
60. 00 06000 LABORATORY				0.63450	01 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS				0.63450	0 00	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC				1. 2182	10 0	0	90.00
200.00 Total (sum of lines 50 through 94 a	nd 96 through 9	98)			0	0	200.00
201.00 Less PBP Clinic Laboratory Services	-Program only c	harges (li	ne 61)		0		201.00
202.00 Net charges (line 200 minus line 20	1)				0		202.00

CALCUL	Financial Systems GRANT BLACKFORD MENTAL HEA ATION OF REIMBURSEMENT SETTLEMENT Prov	ider CCN: 15-4021	Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/24/2021 8:	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			-	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions))		0 186, 177	1.00 2.00
2.00	OPPS payments)		236, 451	
4.00	Outlier payment (see instructions)			200, 101	
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions	s)		0.000	
6.00	Line 2 times line 5			0	
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, c	ol. 13, line 200		0	
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	9)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
45 00	Customary charges	<u> </u>		0	1 4 5 00
15.00 16.00	Aggregate amount actually collected from patients liable for payment Amounts that would have been realized from patients liable for paym			0	15.00 16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	lient for services	on a chargebasi s	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18.00	Total customary charges (see instructions)			0	
19.00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds l	ine 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only if	line 11 exceeds l	ine 18) (see	0	20.00
20.00	instructions)			Ū	20.00
21.00	Lesser of cost or charges (see instructions)			0	
	Interns and residents (see instructions)	```		0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see instruction Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ons)		0 236, 451	23.00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			230, 431	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24	•	· ·	60, 684	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus instructions)	the sum of lines 2	2 and 23] (see	175, 767	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50	D)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			175, 767	
	Primary payer payments Subtotal (line 30 minus line 31)			0 175, 767	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			175,707	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			0	
35.00	Adjusted reimbursable bad debts (see instructions)	>		0	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruction Subtotal (see instructions)	ons)		0 175, 767	
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39.97	Demonstration payment adjustment amount before sequestration			0	
39.98	Partial or full credits received from manufacturers for replaced de	evices (see instru	ictions)	0	
39.99 40.00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 175, 767	
40.00	Sequestration adjustment (see instructions)			0	
	Demonstration payment adjustment amount after sequestration			0	
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			175, 767	1
	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.00	Tentative settlement-PARHM (for contractor use only)			0	42.00
43.00	Balance due provider/program (see instructions)			0	
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accordance wi	ith CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR			<u> </u>	
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)				91.00
92.00	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)			0	93.00 94.00
24. UU	Total (sum of lines 91 and 93)			0	1 74. U

				From 07/01/2020 To 06/30/2021	Date/Time Pre	
			XVIII	lloopitel	11/24/2021 8:2	23 an
		Inpatien		Hospi tal Pai	PPS rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
00	Total interim payments paid to provider		265, 5		175, 767	1. (
00	Interim payments payable on individual bills, either			0	0	2. (
ľ	submitted or to be submitted to the contractor for					
ľ	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero					2
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
ľ	for the cost reporting period. Also show date of each					
I	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				1	
	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	
05				0	0	3.
	Provider to Program			-1	-	
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	3
53 54				0	0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
,,	3. 50-3. 98)			0		
00	Total interim payments (sum of lines 1, 2, and 3.99)		265, 5	90	175, 767	4
ľ	(transfer to Wkst. E or Wkst. E-3, line and column as					
ſ	appropriate)					1
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
ſ	desk review. Also show date of each payment. If none,					
ſ	write "NONE" or enter a zero. (1) Program to Provider				1	1
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	
03				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0] 5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
~~	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
01	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6
	SETTLEMENT TO PROVIDER			0	0	
02	Total Medicare program liability (see instructions)		265, 5		175, 767	
00			203, 3	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4021	Period: From 07/01/2020	Worksheet E-3 Part II	
			To 06/30/2021	Date/Time Pre 11/24/2021 8:2	pare 23 a
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and m	nedical education payments)	324, 602] 1.
00	Net IPF PPS Outlier Payments			0	2.
00	Net IPF PPS ECT Payments			0	3.
00	Unweighted intern and resident FTE count in the most recent	t cost report filed on or	before November	0.00	4
	15, 2004. (see instructions)				
01	Cap increases for the unweighted intern and resident FTE co			0.00	4
	program or hospital closure, that would not be counted with	nout a temporary cap adjus	tment under 42		
00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	
00 00	New Teaching program adjustment. (see instructions) Current year's unweighted FTE count of I&R excluding FTEs i	n the new preason growth	ported of a "now	0.00 0.00	
00	teaching program" (see instuctions)	In the new program growth	period of a new	0.00	
00	Current year's unweighted I&R FTE count for residents withi	n the new program growth	neriod of a "new	0.00	7
00	teaching program" (see instuctions)	In the new program growth		0.00	'
00	Intern and resident count for IPF PPS medical education adj	ustment (see instructions))	0.00	8
00	Average Daily Census (see instructions)			7.827397	
. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised t	to the power of .5150 -1}.		0.00000	
. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	
. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11	1)		324, 602	1:
	Nursing and Allied Health Managed Care payment (see instruc	-		0	
	Organ acquisition (DO NOT USE THIS LINE)	,			1
	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	1
. 00	Subtotal (see instructions)			324, 602	1
. 00	Primary payer payments			0	1
. 00	Subtotal (line 16 less line 17).			324, 602	18
. 00	Deductibles			59, 012	19
. 00	Subtotal (line 18 minus line 19)			265, 590	20
	Coinsurance			0	
	Subtotal (line 20 minus line 21)			265, 590	
	Allowable bad debts (exclude bad debts for professional ser	rvices) (see instructions)		0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		0	
	Subtotal (sum of lines 22 and 24)			265, 590	
	Direct graduate medical education payments (see instruction	is)		0	
	Other pass through costs (see instructions)			0	
	Outlier payments reconciliation			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	anc)		0	
	Pioneer ACO demonstration payment adjustment (see instructi Demonstration payment adjustment amount before sequestratic			0	
	Total amount payable to the provider (see instructions)			265, 590	
	Sequestration adjustment (see instructions)			203, 370	
	Demonstration payment adjustment amount after sequestration	1		0	
	Interim payments			265, 590	
	Tentative settlement (for contractor use only)			0	
. 00	Balance due provider/program (line 31 minus lines 31.01, 31	1.02, 32 and 33)		0	
. 00	Protested amounts (nonallowable cost report items) in accor		chapter 1.	0	
	§115. 2		· · · · · ·		
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Worksheet E-3, Part II, line 2			0	
. 00	Outlier reconciliation adjustment amount (see instructions))		0	
2.00	The rate used to calculate the Time Value of Money			0.00	

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT Pro	ovider CCN: 15-4021	Period: From 07/01/2020	Worksheet E-3 Part VII	
			To 06/30/2021	Date/Time Prep 11/24/2021 8:2	pared: 23 am
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES END TITLES V ND Y	1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	LO TOK ITTELO V OK A	TX SERVICES		1
1.00	Inpatient hospital/SNF/NF services		321, 343		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)		321, 343	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		221 242	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		321, 343	0	7.00
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		354, 132		8.00
9.00	Ancillary service charges		0	0	9.00
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)		354, 132	0	12.00
12 00	CUSTOMARY CHARGES		0	0	1 1 2 00
13.00	Amount actually collected from patients liable for payment for se basis	rvices on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for pa	vment for services o	n O	0	14.00
	a charge basis had such payment been made in accordance with 42 C			0	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0	0. 000000	0.00000	15.00
16.00	Total customary charges (see instructions)		354, 132	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	32, 789	0	17.00
	line 4) (see instructions)				10.00
18.00	Excess of reasonable cost over customary charges (complete only i 16) (see instructions)	T line 4 exceeds lin	e 0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		321, 343	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provi			
22.00	Other than outlier payments	· · · ·	0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00 27.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	26.00 27.00
27.00	Customary charges (title V or XIX PPS covered services only)		0	0	27.00
	Titles V or XIX (sum of lines 21 and 27)		321, 343	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		321, 343	0	31.00
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	1
35.00	Utilization review	\	221 242	0	35.00
36.00 37.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY))	321, 343	0	36.00 37.00
37.00	Subtotal (line 36 ± line 37)		321, 343	0	37.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		321, 343	0	40.00
41.00	Interim payments		326, 327	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-4, 984	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				

	Financial Systems GRANT BLACKFORD MEN E SHEET (If you are nonproprietary and do not maintain	Provider C		Peri od:	Worksheet G	_
nd-ty ly)	ype accounting records, complete the General Fund column			From 07/01/2020 To 06/30/2021	Date/Time Pre	
<u> </u>		General Fund	Specific Purpose Fund	Endowment Fund	11/24/2021 8: Plant Fund	23 8
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS		1	-	-	
00	Cash on hand in banks	4, 826, 415		0 0	0	
00	Temporary investments	0	1	0 0	0	
00 00	Notes receivable	4 011 (72	1	0 0	0	
	Accounts receivable Other receivable	4, 811, 672		0 0	0	
	Allowances for uncollectible notes and accounts receivable	-2, 413, 138			0	
	Inventory	-2, 413, 130			0	
	Prepaid expenses	89, 911		0 0	0	
	Other current assets	0		0 0	0	
. 00	Due from other funds	C		0 0	0	10
00	Total current assets (sum of lines 1-10)	7, 314, 860)	0 0	0	11
	FIXED ASSETS					
00	Land	406, 017		0 0	0	12
	Land improvements	0		0 0	0	13
	Accumulated depreciation	C		0 0	0	
	Bui I di ngs	6, 297, 898		0 0	0	
	Accumulated depreciation	-4, 972, 804		0 0	0	
	Leasehold improvements	167, 368	1	0 0	0	
	Accumulated depreciation	-164, 853		0 0 0 0	0	
	Fixed equipment Accumulated depreciation	2, 087, 425 -1, 652, 971		0 0	0	1 .
	Automobiles and trucks	353, 461		0 0	0	
	Accumulated depreciation	-259, 596	1	0 0	0	
	Major movable equipment	20,,0,0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Minor equipment depreciable	C		0 0	0	
	Accumulated depreciation	C)	0 0	0	
	HIT designated Assets	C)	0 0	0	2
. 00	Accumulated depreciation	C		0 0	0	28
. 00	Mi nor equi pment-nondepreci abl e	C		0 0	0	29
	Total fixed assets (sum of lines 12-29)	2, 261, 945		0 0	0	30
	OTHER ASSETS					
	Investments	0		0 0	0	
	Deposits on Leases	0		0 0	0	
	Due from owners/officers	0		0 0	0	
	Other assets			0 0	0	
	Total other assets (sum of lines 31-34)	9, 576, 805		0 0 0 0	0	
	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	9, 570, 605		0 0	0	- 30
	Accounts payable	150, 315		0 0	0	37
	Salaries, wages, and fees payable	2, 152, 366		0 0	0	
	Payroll taxes payable	2, 102, 000		0 0	0	
	Notes and loans payable (short term)	2, 676		0 0	0	
	Deferred income	C)	0 0	0	
. 00	Accelerated payments	C)			42
00	Due to other funds	C		0 0	0	43
. 00	Other current liabilities	1, 822, 291		0 0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	4, 127, 648		0 0	0	45
	LONG TERM LIABILITIES					
	Mortgage payable	0		0 0	0	
	Notes payable	0		0 0	0	
	Unsecured Loans			0	0	
	Other long term liabilities	118		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	118	1	0 0	0	
	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	4, 127, 766	1	0 0	0	5
	General fund balance	5, 449, 039				52
	Specific purpose fund	5, 447, 039		0		53
	Donor created - endowment fund balance - restricted			~ 		54
	Donor created - endowment fund balance - restricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
. 00	Total fund balances (sum of lines 52 thru 58)	5, 449, 039		0 0	0	59
	Total liabilities and fund balances (sum of lines 51 and	9, 576, 805				60

Provi der CC Fund 2. 00 1, 782, 850 3, 666, 189 5, 449, 039 0 5, 449, 039	Special P	Period: From 07/01/2020 To 06/30/2021 urpose Fund 4.00 0 0 0 0 0 0 0 0 0 0 0 0	Date/Ti me Pre 11/24/2021 8: : Endowment Fund 5. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23 am 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2.00 1,782,850 3,666,189 5,449,039 0	3.00	4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Endowment Fund 5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
1, 782, 850 3, 666, 189 5, 449, 039 0			0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$
1, 782, 850 3, 666, 189 5, 449, 039 0			0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$
		0		13.00 14.00
0 5, 449, 039 Pl ant		0 0 0 0		15.00 16.00 17.00 18.00 19.00
7.00	8.00	-		
0 0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-4021	Period: From 07/01, To 06/30,			epared:
	Cost Center Description		Inpati ent	Outpati	ent	Total	
			1.00	2.00		3.00	
	PART I - PATIENT REVENUES						-
	General Inpatient Routine Services						1
1.00	Hospital		3, 337, 1	69		3, 337, 169	
2.00	SUBPROVIDER - IPF						2.0
3.00	SUBPROVIDER - IRF						3.0
4.00 5.00	SUBPROVIDER Swing bed - SNF			0		0	4.0 5.0
5.00 6.00	Swing bed - SNF			0			
7.00	SKILLED NURSING FACILITY			0		0	7.0
8.00	NURSING FACILITY						8.0
9.00	OTHER LONG TERM CARE						9.0
10.00	Total general inpatient care services (sum of lines 1-9)		3, 337, 1	69		3, 337, 169	
10.00	Intensive Care Type Inpatient Hospital Services		3, 337, 1	07		3, 337, 107	1 10. 0
11.00	I NTENSI VE CARE UNI T						1 11. 0
12.00	CORONARY CARE UNIT						12.0
13.00	BURN INTENSIVE CARE UNIT						13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.0
15.00	OTHER SPECIAL CARE (SPECIFY)						15.0
16.00	Total intensive care type inpatient hospital services (sum of	lines		0		0	16.0
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		3, 337, 1	69		3, 337, 169	17.0
18.00	Ancillary services		263, 6	47	0	263, 647	18.0
19.00	Outpatient services			0 3, 41	2, 289	3, 412, 289	19.0
20. 00	RURAL HEALTH CLINIC			0	0	0	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULANCE SERVICES						23.0
24.00	СМНС						24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.0
26.00	HOSPICE						26.0
27.00	RESIDENTIAL		a (aa a		D, 097		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	3, 600, 8	16 7, 29	2, 386	10, 893, 202	28.0
	G-3, line 1) PART II - OPERATING EXPENSES						-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			12, 48	2 050	[29.0
30.00	ADD (SPECIFY)			0	3, 930		30.0
31.00				0			31.0
32.00				0			32.0
33.00				0			33.0
34.00				0			34.0
35.00				0			35.0
36.00	Total additions (sum of lines 30-35)			-	0		36.0
37.00	DEDUCT (SPECIFY)			0	-		37.0
38.00				0			38.0
39.00				0			39.0
40.00				0			40.0
41.00				0			41.0
42.00	Total deductions (sum of lines 37-41)				0		42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		12, 48	3, 950		43.0
	to Wkst. G-3, line 4)	. ,					

Heal th	Financial Systems	GRANT BLACKFORD MENTA	L HEALTH, INC.	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-4021 Period:			Period: From 07/01/2020	Worksheet G-3		
To 06/30/2021					Date/Time Prepared: 11/24/2021 8:23 am	
			L		1172172021 011	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				10, 893, 202	1.00
2.00) Less contractual allowances and discounts on patients' accounts				3, 574, 787	2.00
3.00	0 Net patient revenues (line 1 minus line 2)				7, 318, 415	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)				12, 483, 950	4.00
5.00	Net income from service to patients (line 3 minus line 4)				-5, 165, 535	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, et	С			0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellaneous communication services				0	8.00
9.00					0	9.00
10.00					0	10.00
11.00					0	11.00
12.00					0	12.00
13.00					0	13.00
14.00					0	
15.00	J 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				0	15.00
16.00					0	16.00
17.00	5				0	17.00
18.00					0	18.00
19.00					0	19.00
20.00	5				0	20.00
21.00	5			0	21.00	
22.00				0	22.00	
23.00				0	23.00	
24.00					5, 280, 846	
24.50	5				2, 078, 829	
24.51					1, 472, 049	
25.00					8, 831, 724	
26.00					3, 666, 189	
					0	27.00
28.00					0	28.00
29.00	Net income (or loss) for the period (I	ine 26 minus line 28)			3, 666, 189	29.00