Health Financia	al Systems	PERRY COUNTY HOS			u of Form CMS-2552-10
This report is payments made	required by law (42 USC 1395 since the beginning of the co	g; 42 CFR 413.20(b)). Failust reporting period being d	re to report can resi leemed overpayments (ult in all interim 42 USC 1395g).	FORM APPROVED OMB NO. 0938-0050
	OSPITAL HEALTH CARE COMPLEX C		Provider CCN: 151322	Period: From 01/01/2015	
PART I - COST	REPORT STATUS				
Provider use only	1. [X] Electronically filed 2. [] Manually submitted co 3. [0] If this is an amended 4. [F] Medicare Utilization.	ost report I report enter the number of	f times the provider for low.	Date: 5/24/20	
Contractor use only	(1) As Submitted	6. Date Received:7. Contractor No.8. [N] Initial Report for9. [N] Final Report for the thick of the thick of	111	.NPR Date: .Contractor's Vendo .[0]If line 5, co number of tim	or Code: 4 lumn 1 is 4: Enter es reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 PERRY COUNTY HOSPITAL (151322) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

Encryption Information

ECR: Date: 5/24/2016 Time: 9:34 am huPTX00wH6qzxw30w3zfy:V3rwiw.0 C6wrr0ukHFo1:Md1o3N2SSsCobjx1x DRnN1yQudL0Kq4ce
PI: Date: 5/24/2016 Time: 9:34 am

PI: Date: 5/24/2016 Time: 9:34 am co.14vd5zuw7v4UtsiXRKLe1J8hfkO nNMR60nVimCutHf3:QnQRP2t5JSIpB mz4z05grvq0M09fL

(Signed)

Officer or Administrator of Provider(s)

Title 5/26/16

Date Title XVIII

			The second secon	11111	VATTT			1
			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	Hospital		0	-45,481	230,150	1	0	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	-8,047	0		0	5.00
6.00	Swing bed - NF		0				0	6.00
9.00	HOME HEALTH AGENCY I		0	0	-647		0	9.00
10.00	RURAL HEALTH CLINIC - TELL CITY I		0		76,260		0	
10.01	RURAL HEALTH CLINIC - PERRY CO FP II		0		6,453		0	
10.02	RURAL HEALTH CLINIC - TROY III		0		0			10.02
200.00	Total		0	-53,528	312,216	1	0	200.00
	. "	£!!	ملاما ممار السمام ما م	mmanuam fan th	a alamant of th	a above comple	v indicated	

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

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151322 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/24/2016 9:32 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: ONE HOSPITAL ROAD 1.00 PO Box: X 1.00 2.00 City: TELL CITY State: IN Zip Code: 47856-County: PERRY 2.00 Payment System (P, Component Name CCN CBSA Provi der Date T, O, or N)

XVIII XIX Number Number Certi fi ed Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PERRY COUNTY HOSPITAL 151322 99915 07/01/2004 Ν 0 3.00 Hospi tal Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF PERRY COUNTY HOSPITAL 15Z322 99915 07/01/2004 N 0 N 7.00 7 00 SWI NG 8.00 Swing Beds - NF 8.00

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PERRY COUNTY HOSPITAL

TELL CITY CLINIC

PERRY CO FAMILY

PRACTI CE

TROY CLINIC

9.00

10.00

11.00

12.00

13.00

14.00

15.00

15.01

15.02

16.00

17.00

	Renal Dialysis									18. 00
19. 00	Other									19.00
						From:		To:		
						1. 00		2.0	-	
	Cost Reporting Period (mm/dd/yyyy)					01/01/20	015	12/31/	'2015	20. 00
21. 00	Type of Control (see instructions)						9			21. 00
	Inpatient PPS Information					,				
22. 00	Does this facility qualify and is it					N		N		22. 00
	share hospital adjustment, in accord									
	for yes or "N" for no. Is this facil	, ,	-	2.06(c)(2	?) (Pi ckl e					
00.01	amendment hospital?) In column 2, en								-	00.04
22.01	Did this hospital receive interim un					N		N		22. 01
	period? Enter in column 1, "Y" for y reporting period occurring prior to									
	for no for the portion of the cost r									
	(see instructions)	eportring perrod occurrin	y on or a	ii tei octo	bbei i.					
22 02	Is this a newly merged hospital that	requires final uncompen	satad car	a navment	s to be	l N		N	1	22. 02
22.02	determined at cost report settlement							114		22.02
	or "N" for no, for the portion of th									
	in column 2, "Y" for yes or "N" for									
	or after October 1.	, то ене роготон от								
22. 03	Did this hospital receive a geograph	ic reclassification from	urban to	rural as	a result	l N		N		22. 03
	of the OMB standards for delineating	statistical areas adopt	ed by CMS	in FY201	5? Enter					
	in column 1, "Y" for yes or "N" for									
	prior to October 1. Enter in column	2, "Y" for yes or "N" fo	r no for	the porti	on of the					
	cost reporting period occurring on o	r after October 1. (see	instructi	ons) Does	this					
	hospital contain at least 100 but no			in accord	lance with					
	42 CFR 412.105)? Enter in column 3,									
23.00	Which method is used to determine Me						2	N		23.00
	1, enter 1 if date of admission, 2 i									
	method of identifying the days in th									
	used in the prior cost reporting per	<u>iod? In column 2, enter</u>	"Y" for	yes or "N	l" for no.					

In-State

Medi cai d

In-State

Medi cai d

Out-of

State

Medi cai d

Out-of

State

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Medi cai d

9.00

10.00

12.00

13.00

14 00 15.00

15.01

15.02

16.00

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Hospi tal -Based SNF

Hospi tal -Based HHA

17.00 Hospital -Based (CMHC) I

Separately Certified ASC

Hospital-Based Health Clinic - RHC

Hospital-Based Health Clinic - RHC

Hospital-Based Health Clinic - RHC

Hospital-Based Health Clinic - FQHC

Hospi tal -Based Hospi ce

Hospi tal -Based NF

11.00 Hospi tal -Based OLTC

Heal th	Financial Systems PERRY	COUNTY HO	SPI TAL			In Lieu	ı of For	m CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			CCN: 151322	Period: From 01/0			eet S-2	
						31/2015	Date/Ti		
		In-State	In-State	Out-of	Out-of	Medi ca		<u>016 9:3</u> Ither	am .
		Medi cai d	Medi cai d	State	State Medicaid	HMO da		di cai d	
		paid days	eligible unpaid	Medicaid paid days	eligible			days	
			days		unpai d				
25. 00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5. 00	0	6. 00	25. 00
20.00	Medicaid paid days in column 1, the in-state	`							20.00
	Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state								
	Medicaid eligible unpaid days in column 4, Medicaid								
	HMO paid and eligible but unpaid days in column 5.				Urban/I	 Rural S	Date of	Geogr	
27, 00		> -+-+		-116		00	2.	00	24 00
26.00	Enter your standard geographic classification (not woost reporting period. Enter "1" for urban or "2" fo		s at the beq	ginning of	tne	2			26. 00
27. 00	Enter your standard geographic classification (not w	age) status			st	2			27. 00
	reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif			орг г сарте,					
35. 00	If this is a sole community hospital (SCH), enter the			CH status in	۱	0			35. 00
	effect in the cost reporting period.				Begi r	ıni ng:	Endi	ng:	
24 00	Enter applicable beginning and ending dates of SCH s	tatus Subs	orint line	24 for numb		00	2.	00	36. 00
30.00	of periods in excess of one and enter subsequent date		script rine	30 TOT TIUIIII	Dei				30.00
37. 00	If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	r the numbe	er of period	ds MDH statu	ıs	0			37. 00
38. 00	If line 37 is 1, enter the beginning and ending date								38. 00
	greater than 1, subscript this line for the number of enter subsequent dates.	f periods i	n excess of	f one and					
	pirter subsequent dates.					/N	Υ/		
39. 00	Does this facility qualify for the inpatient hospita	l navment a	ndiustment f	for low volu		00 N	2.		39. 00
07.00	hospitals in accordance with 42 CFR §412.101(b)(2)(i	i)? Enter i	n column 1	"Y" for yes	5			•	07.00
	or "N" for no. Does the facility meet the mileage recEFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes								
40. 00	Is this hospital subject to the HAC program reduction	n adjustmer	nt? Enter "\	Y" for yes o	or I	N	N	J	40.00
	"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1			yes or "N" 1	for				
	W	,			'	V	XVIII		
	Prospective Payment System (PPS)-Capital					1. 00	2. 00	3. 00	
45. 00	Does this facility qualify and receive Capital payments to the 42 CER Section S412 2202 (case instructions)	nt for disp	proporti onat	te share in	accordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc	eption for	extraordi na	ary circums	tances	N	N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks	t. L, Pt. I	II and Wkst	t. L-1, Pt.	I through				
47. 00	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS cap	ital? Ente	er "Y for ye	es or "N" fo	or no.	N	N	N	47. 00
	ls the facility electing full federal capital paymen					N	N	N	48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	approved (GME programs	s? Enter "\	/" for yes	N		Т	56. 00
E7 00	or "N" for no.		na which re	aaldanta ln	anneared				F7 00
57. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo					1			57. 00
	is "Y" did residents start training in the first mon	th of this	cost report	ting periodí	? Enter "Y				
	for yes or "N" for no in column 2. If column 2 is "' "N", complete Wkst. D, Parts III & IV and D-2, Pt. I			t E-4. IT Co	DIUMN 2 IS				
58. 00	If line 56 is yes, did this facility elect cost reim			ans' service	es as				58. 00
59. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye			Pt. I.		N			59. 00
60.00	Are you claiming nursing school and/or allied health					N			60.00
	provider-operated criteria under §413.85? Enter "Y"	Y/N	IME	Direct GM		ME	Di rec	t GME	
		1 00	2. 00	2 00	1	00	5	00	-
61. 00	Did your hospital receive FTE slots under ACA	1. 00 N	2.00	3. 00	4.	0. 00	5.		61.00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)								
61. 01	Enter the average number of unweighted primary care		0.00		0. 00				61. 01
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								
	i nstructi ons)								
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0.00) (0. 00				61. 02
	and primary care FTEs added under section 5503 of								
	ACA). (see instructions)			I					

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA	Provi der		eriod: rom 01/01/2015 o 12/31/2015	Worksheet S-2 Part I Date/Time Pre 5/24/2016 9:3	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1. 00	2. 00	3. 00	4.00	5.00	
1. 03	Enter the base line FTE count fo and/or general surgery residents determining compliance with the instructions)	, which is used for		0.00	0. 00			61. 0
1. 04	Enter the number of unweighted p surgery allopathic and/or osteop current cost reporting period.(s	athic FTEs in the		0.00	0.00			61.0
1. 05	Enter the difference between the and/or general surgery FTEs and primary care and/or general surg 61.04 minus line 61.03). (see in	baseline primary the current year's ery FTE counts (line		0. 00	0. 00			61. 0
1. 06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	ard that is being that are nonprimary		0. 00				61. 0
			Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	Of the FTEs in line 61.05, speci			1. 00	2. 00	3. 00	4.00	61. 10
1. 20	for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count. Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted cou	r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61. 20
	ACA Descriptions Affection the Head	Lth December and Com		A -l:: +:	(LIDCA)		1.00	
2. 00	ACA Provisions Affecting the Hea Enter the number of FTE resident					od for which	0.00	62.00
	your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	funding (see instructs s that rotated from a riod of HRSA THC prog	tions) Teachi Iram. (:	ing Health Cent see instruction	er (THC) into		0.00	62.0
3. 00	Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ttings	during this co	instructions)		N	63. 0
					Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1. 00	2. 00	3.00	
4 00	Section 5504 of the ACA Base Yea period that begins on or after J	uly 1, 2009 and befor	e June	30, 2010.				44.0
4. 00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	n-priman all non I non-pr n column	ry care nprovider rimary care n 3 the ratio	0. 00	0. 00	0. 000000	04.0
	. Corami i di vi ded by (coi dimi	Program Name		ogram Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	

2.00

1.00

Unweighted FTEs Nonprovider Site

3. 00

Unweighted FTEs in Hospital

4.00

Ratio (col. 3/ (col. 3 + col. 4))

In Lieu of Form CMS-2552-10 Health Financial Systems PERRY COUNTY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151322 Worksheet S-2 Peri od: From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/24/2016 9:32 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0.000000 65.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col. Nonprovi der Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + col. FTFs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 0.000000 67.00 67.00 Enter in column 1, the program 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program

	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)								
						1. 00	2. 00	3.00	
	Inpatient Psychiatric Facility PA	PS				1.00	2.00	3.00	
	Is this facility an Inpatient Psy		PF), or does it conta	ain an IPF subp	rovi der?	N			70. 00
	Enter "Y" for yes or "N" for no.							_	
	If line 70 yes: Column 1: Did the recent cost report filed on or be							0	71. 00
	42 CFR 412.424(d)(1)(iii)(c)) Col								
	program in accordance with 42 CFF								
	Column 3: If column 2 is Y, indic								
	(see instructions)	1 3 3	3 3	, ,	•				
	Inpatient Rehabilitation Facility								
	Is this facility an Inpatient Ref		\prime (IRF), or does it co	ontain an IRF		N			75. 00
	subprovider? Enter "Y" for yes a If line 75 yes: Column 1: Did the		unnoved CME toooking n		maa+			0	76. 00
	recent cost reporting period endi							0	76.00
	no. Column 2: Did this facility								
	CFR 412.424 (d)(1)(iii)(D)? Enter								
	indicate which program year begar	n during tȟis cost re	eporting period. (see	instructions)					
MODI FO	0.0450.0								
MCRIF32	2 - 8.8.159.0								

Health Financial Systems PERRY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 151322	Peri od:	Worksheet S-2	2
			From 01/01/2015 To 12/31/2015		epared:
				5/24/2016 9:3	32 am
				1.00	+
Long Term Care Hospital PPS					
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes			. 10 5 1	N	80.00
81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.	r all of the	cost reporti	ng period? Enter	N	81. 00
TEFRA Provi ders					1
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)				N	85. 00
86.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	d unit) under	42 CFR Secti	ı on		86. 00
87.00 Is this hospital a "subclause (II)" LTCH classified under sec	ction 1886(d)	(1)(B)(iv)(I	I)? Enter "Y"	N	87. 00
for yes or "N" for no.			V	VIV	
			1.00	XI X 2. 00	+
Title V and XIX Services					
90.00 Does this facility have title V and/or XIX inpatient hospital	I services? E	nter "Y" for	N	Υ	90. 00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the	he cost renor	t either in	N	N	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appli	icable columr	١.			
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dualing trustions) Enter "Y" for year or "N" for pain the applications		ion)? (see		N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applical 93.00 Does this facility operate an ICF/IID facility for purposes of		nd XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column.					
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	and "N" for r	no in the	N	N	94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the appl	licable colum	nn.	0. 00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes	or "N" for r	no in the	N	N	96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the appl	licable colum	an.	0. 00	0.00	97.00
Rural Providers	r cable colui		0.00	0.00	3 77.00
105.00 Does this hospital qualify as a critical access hospital (CAI			Y		105. 00
106.00 f this facility qualifies as a CAH, has it elected the all-ifor outpatient services? (see instructions)	inclusive met	chod of payme	nt N		106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost	rei mbursemer	nt for I&R	N		107. 00
training programs? Enter "Y" for yes or "N" for no in column					
yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	25 and the p	program is co	st		
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 4:	2 N		108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Dh	0	-1 C	Di	
	Physi cal 1.00	Occupation 2.00	al Speech 3.00	Respiratory 4.00	+
109.00 of this hospital qualifies as a CAH or a cost provider, are	Y	Y	Y	N	109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital		on project (410A Demo)for	N	110. 00
the current cost reporting period? Enter "Y" for yes or "N"	101 110.				
			1. 00	0 2.00 3.00	
Miscellaneous Cost Reporting Information	HAIH C		16 1 1		445.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2.				0	115. 00
3 either "93" percent for short term hospital or "98" percen	t for long te	erm care (inc	l udes		
psychiatric, rehabilitation and long term hospitals providers	s) based on t	he definition	n in CMS		
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y"	for ves or "N	l" for no.	N		116. 00
117.00 Is this facility legally-required to carry malpractice insura	,		•		117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence poli	iov2 Enton 1	if the police	vis 0		118. 00
claim-made. Enter 2 if the policy is occurrence.	icy: Eliter i	ii the poirc	y 15 0		116.00
		Premi ums	Losses	Insurance	
		1. 00	2.00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		I	0 0	ıl C	0 118. 01

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARI	PERRY COUNTY E COMPLEX IDENTIFICATION DATA	Provi der CCN: 151322	Peri od:	w of Form CM Worksheet S	
70. 1 17.E 7.115 1.001 1 17.E 11.E7.E7.11 07.11.1	E domini EE/K BEIKKI O/KI FOK B/KI/K	1.101.401.0011.101022	From 01/01/2015	Part I	
			To 12/31/2015	Date/Time P 5/24/2016 9	
9 02 Aro mal practico promitime a	nd paid losses reported in a cost	contor other than the	1. 00 N	2.00	118.
Administrative and General and amounts contained ther	? If yes, submit supporting sched		14		
9.00 DO NOT USE THIS LINE	qualifies for the Outpatient Hold	d Harmless provision in AC	N	N	119.
§3121 and applicable amend "N" for no. Is this a rura	ments? (see instructions) Enter in I hospital with < 100 beds that qu ACA §3121 and applicable amendmen	n column 1, "Y" for yes or ualifies for the Outpatient		IV.	120.
1.00 Did this facility incur an patients? Enter "Y" for ye	d report costs for high cost implasor "N" for no.	antable devices charged to	Y		121.
Transplant Center Informat 5.00 Does this facility operate	a transplant center? Enter "Y" fo	or yes and "N" for no. If	N		125.
yes, enter certification d	ate(s) (mm/dd/yyyy) below.	-			101
	ified kidney transplant center, er n date, if applicable, in column 2				126.
7.00 If this is a Medicare cert in column 1 and terminatio	ified heart transplant center, ent n date, if applicable, in column 2	ter the certification date 2.			127.
3.00 f this is a Medicare cert	ified liver transplant center, ent n date, if applicable, in column 2	ter the certification date			128.
9.00 f this is a Medicare cert	ified lung transplant center, ente ate, if applicable, in column 2.	er the certification date i	n		129.
	ified pancreas transplant center, nation date, if applicable, in col				130.
1.00 If this is a Medicare cert	ified intestinal transplant center nation date, if applicable, in col	r, enter the certification			131.
2.00 If this is a Medicare cert in column 1 and terminatio	ified islet transplant center, ent n date, if applicable, in column 2	ter the certification date 2.			132.
	ified other transplant center, ent n date, if applicable, in column 2				133
1.00 f this is an organ procur	ement organization (OPO), enter th				134.
and termination date, if a	pplicable, in column 2.				
All Providers 0.00 Are there any related orgather chapter 10? Enter "Y" for	pplicable, in column 2. nization or home office costs as c yes or "N" for no in column 1. If mn 2 the home office chain number.	yes, and home office costs	Y		140.
All Providers D.00 Are there any related orgather chapter 10? Enter "Y" for are claimed, enter in column 1.00	nization or home office costs as c yes or "N" for no in column 1. If mn 2 the home office chain number. 2.0	yes, and home office costs (see instructions) 0	3. 00	of the	140.
All Providers D.00 Are there any related orgather 10? Enter "Y" for are claimed, enter in colustication 1.00 If this facility is part of	nization or home office costs as o yes or "N" for no in column 1. If mn 2 the home office chain number.	yes, and home office costs (see instructions) 0 lines 141 through 143 the	3. 00	of the	140.
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Health Financial Systems	PERRY C	OUNTY HOSPITAL			In Lie	u of Form CMS-	-2552-10
From 01/01/2015 To 12/31/2015						epared:	
						1.00	
Multicampus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	BSAs?	N	165. 00				
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 166. 00
						1.00	+
Health Information Technology (HIT) incentive in the Ar	merican Recovery and	l Reinves	tment Act		1.00	
167.00 s this provider a meaningful user						Υ	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and ís a me	eaningful user (line			er the		1168.00
168.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?					dshi p		168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction	ser (line 167 is "Y")				enter the	0.0	0169. 00
				В	egi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	egi nni ng date and enc	ling date for the re	porting	01	/01/2015	12/31/2015	170. 00
						1. 00	-
171.00 f line 167 is "Y", does this prov	ider have any days fo	or individuals enrol	Led in se	ection 197	16	1.00 N	171. 00
Medicare cost plans reported on Wk (see instructions)						14	171.00

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151322 Peri od: Worksheet S-2 From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/24/2016 9:32 am Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 3.00 1.00 2.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 05/01/2013 4.00 Υ C 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 N 7.00 Were nursing school and/or allied health programs approved and/or renewed during the 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part B Part A Description Y/N Date Y/N 1.00 2.00 3.00 PS&R Data Υ 03/08/2016 Υ 16.00 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 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 Ν 17.00 Ν Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional 18.00 Ν Ν 18.00 claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments Ν 19.00 made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. If line 16 or 17 is yes, were adjustments Ν Ν 20.00 made to PS&R Report data for Other? Describe the other adjustments:

Health Financial Systems PERRY CO PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Worksheet S-2
Part II
Date/Time Prepared:
5/24/2016 9:32 am
Part B
Y/N Provi der CCN: 151322 Peri od: From 01/01/2015 To 12/31/2015 Part A Description Y/N Date 2. 00 3.00 0 1.00

		U	1.00	2.00	3.00	
21. 00	Was the cost report prepared only using the		N		N	21. 00
	provider's records? If yes, see					
	instructions.					
	[1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EXCEPT CHILDRENS H	OSPITALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purpos				N	22. 00
23. 00	Have changes occurred in the Medicare deprec	ation expense due to apprais	als made durin	g the cost	N	23. 00
	reporting period? If yes, see instructions.					
24.00	Were new Leases and/or amendments to existing	g leases entered into during	this cost repo	rting period?	N	24. 00
05.00	If yes, see instructions					05.00
25.00	Have there been new capitalized leases enter	ed into during the cost repor	ting period? i	r yes, see	N	25. 00
27 00	instructions. Were assets subject to Sec. 2314 of DEFRA acqu	i mad dumi ma tha agat manamti	na noniodO If		N	26, 00
26.00	instructions.	arrea durring the cost reporti	ng perrou? II	yes, see	IV	26.00
27 00	Has the provider's capitalization policy cha	aged during the cost reportin	a portod2 lf v	os submit	N	27. 00
27.00	copy.	iged during the cost reportin	g perrous ir y	es, subilli t	IN	27.00
	Interest Expense					
28 00	Were new Loans, mortgage agreements or Letter	rs of credit entered into dur	ing the cost r	enortina	N	28. 00
20.00	period? If yes, see instructions.	3 of crear t circina finto dar	ring the cost i	cpor tring	IV.	20.00
29 00	Did the provider have a funded depreciation	account and/or bond funds (De	ht Service Res	erve Fund)	N	29. 00
27.00	treated as a funded depreciation account? If		21 001 11 00 1100			27.00
30.00	Has existing debt been replaced prior to its		debt? If yes,	see	N	30.00
	instructions.	3	, ,			
31.00	Has debt been recalled before scheduled matu	rity without issuance of new	debt? If yes,	see	N	31.00
	instructions.		•			
	Purchased Services					
32.00	Have changes or new agreements occurred in pa		d through cont	ractual	N	32. 00
	arrangements with suppliers of services? If					
33.00	If line 32 is yes, were the requirements of	Sec. 2135.2 applied pertainin	g to competiti	ve bidding? If	N	33. 00
	no, see instructions.					
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facili	ity under an arrangement with	provi der-base	d physi ci ans?	Υ	34. 00
	If yes, see instructions.					05.00
35. 00	If line 34 is yes, were there new agreements		ts with the pr	ovi der-based	N	35. 00
	physicians during the cost reporting period?	If yes, see instructions.)/ /N	D 1	
				Y/N	Date	
	u 066; 0 1			1. 00	2. 00	
27 00	Home Office Costs	22222222222222222222222222222222222222		l N		24 00
	Were home office costs claimed on the cost re		h	N N		36.00
37.00	If line 36 is yes, has a home office cost sta	atement been prepared by the	nome office?	N		37. 00
20.00	If yes, see instructions.	of the home office diff	from that of	l N		20.00
38. UU	If line 36 is yes, was the fiscal year end the provider? If yes, enter in column 2 the			N		38. 00
20 00	If line 36 is yes, did the provider render s			N		39. 00
J9. UU	fir tine 30 is yes, did the provider render so	ervices to other charif compon	ents: 11 yes,	IN		39.00

		T / IN	Date	
		1. 00	2. 00	
Home Office Costs				
36.00 Were home office costs claimed on the cost report?		N		36. 00
37.00 If line 36 is yes, has a home office cost statement been prepared by t	he home office?	N		37. 00
If yes, see instructions.				
38.00 If line 36 is yes , was the fiscal year end of the home office differe	nt from that of	N		38. 00
the provider? If yes, enter in column 2 the fiscal year end of the hom				l
39.00 If line 36 is yes, did the provider render services to other chain com	ponents? If yes,	N		39. 00
see instructions.				l
40.00 If line 36 is yes, did the provider render services to the home office	? If yes, see	N		40. 00
instructions.				
	1 00	0 /	00	1

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position	RI CH	FERRI ELL	41. 00
	held by the cost report preparer in columns 1, 2, and 3,			
	respecti vel y.			
42.00	Enter the employer/company name of the cost report	ALLIANT MANAGEMENT SERVICES		42.00
	preparer.			
43.00	Enter the telephone number and email address of the cost	5029923832	RFERRI ELL@ALLI ANTMANAGEMENT.	43.00
	report preparer in columns 1 and 2, respectively.		COM	

eal th	Financial Systems	PERRY COUNTY H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der	CCN: 151322	From 01/01/2015	Worksheet S-2 Part II Date/Time Pre 5/24/2016 9:3	pared:
		Part B					
		Date					
		4. 00					
	PS&R Data						
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	03/08/2016					16.00
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns						17. 00
8. 00	2 and 4. (see instructions) 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 cost report? If yes, see instructions.						18. 00
9. 00							19.00
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.00
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.00

		3.00	
	Cost Report Preparer Contact Information		
41.00	Enter the first name, last name and the title/position	REIMBURSEMENT MANAGER	41.00
	held by the cost report preparer in columns 1, 2, and 3,		
	respecti vel y.		
42.00	Enter the employer/company name of the cost report		42. 00
	preparer.		
	Enter the telephone number and email address of the cost		43.00
	report preparer in columns 1 and 2 respectively		1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 151322

From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/24/2016 9:32 am I/P Days / O/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Avai I abl e 4. 00 5.00 1.00 2.00 3.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 21 7, 665 54, 072. 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 IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 0 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 21 7,665 54, 072. 00 0 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 31.00 1,460 4, 992. 00 0 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 43.00 0 13.00 14.00 Total (see instructions) 25 9, 125 59, 064. 00 0 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 101.00 0 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 0 O 24.00 116,00 24 00 24. 10 HOSPICE (non-distinct part) 30.00 24.10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC - TELL CITY 88. 00 0 26.00 RURAL HEALTH CLINIC - PERRY CO FP RURAL HEALTH CLINIC - TROY 26. 01 88. 01 26.01 0 26. 02 88.02 0 26.02 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 Total (sum of lines 14-26) 27.00 27.00 25

28 00

29.00

30.00

31.00

32.00

32.01

33.00

0

Observation Bed Days

Employee discount days - IRF

Employee discount days (see instruction)

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

outpatient days (see instructions)

Ambul ance Trips

33.00 LTCH non-covered days

28 00

29. 00

30.00

31.00 32.00

Provi der CCN: 151322

				'	0 12/31/2013	5/24/2016 9: 3	
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 450	161	2, 253			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	104	0				2.00
2. 00 3. 00	HMO and other (see instructions)	184	0				2. 00 3. 00
4. 00	HMO IPF Subprovider HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	824	0	824			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	024	89	89			6.00
7. 00	Total Adults and Peds. (exclude observation	2, 274	250	3, 166			7. 00
7.00	beds) (see instructions)	2,217	250	3, 100			7.00
8. 00	INTENSIVE CARE UNIT	89	0	208			8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		179	179			13.00
14.00	Total (see instructions)	2, 363	429	3, 553	0.00	237. 27	14. 00
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	0.740	4 040	F 000	0.00	, 04	21. 00
22. 00	HOME HEALTH AGENCY	2, 718	1, 010	5, 923	0.00	6. 81	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0.00	0.00	23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	0	0	0	0.00	0.00	24. 00 24. 10
25. 00	CMHC - CMHC	٩	U	U			25. 00
26. 00	RURAL HEALTH CLINIC - TELL CITY	1, 664	0	5, 229	0.00	14. 30	
26. 01	RURAL HEALTH CLINIC - PERRY CO FP	63	0	1, 148	0.00		
26. 02	RURAL HEALTH CLINIC - TROY	0	0	169	0.00		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	ı .	Ŭ.	,	0.00	0.12	26. 25
27. 00	Total (sum of lines 14-26)				0.00	261. 32	
28. 00	Observation Bed Days		0	420			28. 00
29. 00	Ambul ance Trips	869					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	o	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared:

				To	12/31/2015	Date/Time Prep 5/24/2016 9:33	
		Full Time	,	Di sch	arges	7 0, 2 1, 20 10 , 10	Cann.
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	13.00	14. 00	Pati ents 15.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14.00	783	1, 00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		O	442	60	783	1.00
2.00	HMO and other (see instructions)			35	o		2. 00
3.00	HMO IPF Subprovider				o		3. 00
4.00	HMO IRF Subprovider				o		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6, 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	442	60	783	14. 00
15. 00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC - TELL CITY	0. 00					26. 00
26. 01	RURAL HEALTH CLINIC - PERRY CO FP	0. 00					26. 01
26. 02	RURAL HEALTH CLINIC - TROY	0. 00					26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28.00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 151322	
		From 01/01/2015 Part IV

		То	12/31/2015	Date/Time Prep 5/24/2016 9:32	
		·		Amount	
				Reported	
				1. 00	
	PART IV - WAGE RELATED COSTS		,		
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			532, 922	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan			0	6. 00
7.00	Employee Managed Care Program Administration Fees			0	7. 00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			2, 976, 066	8. 00
9.00	Prescription Drug Plan			0	9. 00
10.00	Dental, Hearing and Vision Plan			0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)			37, 296	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)			0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)			39, 085	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0	14. 00
15. 00	'Workers' Compensation Insurance			120, 296	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordi	nary accrual required by	/ FASB 106.	0	16. 00
	Non cumulative portion)				
	TAXES				
	FICA-Employers Portion Only			898, 167	17. 00
18. 00	Medicare Taxes - Employers Portion Only			0	18. 00
19. 00	Unemployment Insurance			0	19. 00
20.00	State or Federal Unemployment Taxes			0	20. 00
	OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Repor	ted on lines 1 through	1 above. (see	0	21. 00
	instructions))				
22. 00	Day Care Cost and Allowances			0	22. 00
23. 00	Tuition Reimbursement			0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)			4, 603, 832	24. 00
	Part B - Other than Core Related Cost				
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAI		In lie	eu of Form CMS-:	2552-10
	EALTH AGENCY STATISTICAL DATA	TERRY COUNT			Peri od:	Worksheet S-4	
			Component		From 01/01/2015 To 12/31/2015	Date/Time Pre	
					Home Health	5/24/2016 9: 3 PPS	2 am
					Agency I	113	
					1	00	
0.00	County				PERRY		0.00
		1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5. 00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00	Home Heal th Ai de Hours	0		1	0 0		1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	124.00		00 50.00 ployees (Full Ti		2. 00
		Enter the numb		Staff	Contract	Total	
		your normal	work week				
)	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0. 00	0. C 0. C		l .	
5. 00	Other Administrative Personnel			0.0			
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			0. C 0. C		l .	1
8. 00	Physical Therapy Service			0.0		l .	
9.00	Physical Therapy Supervisor			0.0			1
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0.0			1
12. 00	Speech Pathology Service			0.0	0.00	0.00	12. 00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0.0			1
15. 00	Medical Social Service Supervisor			0.0			1
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0. C 0. C			1
18.00	Other (specify)			0.0			1
40.00	HOME HEALTH AGENCY CBSA CODES			1			
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				1		19. 00
	reporting period.			45000			
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			15999			20. 00
	contains the first code).						
		Full Ep Without	With Outliers	 	s PEP Only	Total (cols.	
		Outliers			Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2.00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	987	52		50 11	1, 100	21. 00
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	405, 896 837	l ·		34 4, 488 2 0	l .	1
24. 00	Physical Therapy Visits Physical Therapy Visit Charges	247, 476	ł	1	-		
25. 00	Occupational Therapy Visits	603	l e	1	1 0	620	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	155, 430 14	l	1	0 0		26. 00 27. 00
28. 00	Speech Pathology Visit Charges	4, 089	l e	1	0 0	4, 089	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	2,022	0	•	0 0		29. 00 30. 00
31. 00	Home Health Aide Visits	103	13	1	0 0	116	31. 00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	21, 930 2, 550	1		0 0		1
33.00	29, and 31)	2, 550	104		11	2,710	33.00
34.00	Other Charges	0	l ~	•	0 0	_	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	836, 843	34, 934	21, 23	4, 488	897, 499	35. 00
36. 00	Total Number of Episodes (standard/non	129		2	21 2	152	36. 00
37. 00	outlier) Total Number of Outlier Episodes		2		0	l .	37. 00
38. 00	Total Non-Routine Medical Supply Charges	42, 616	2, 366	1, 96	497	47, 439	38. 00

	n Financial Systems FAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	PERRY COUNT		CCN: 151322	Peri od:	u of Form CMS- Worksheet S-8	
MATTS	STICAL DATA	TED HEALTH CEN		t CCN: 158516	From 01/01/2015 To 12/31/2015		epared
					Rural Health Clinic (RHC) I	Cost	
					1	00	-
	Clinic Address and Identification				1.	00	
. 00	Street				109 I N-66		1.
		-	C	ty	State	ZIP Code	
				. 00	2. 00	3. 00	
. 00	City, State, ZIP Code, County		TELL CITY		IN	47586	2.
	FOLIO ONLY D : 1: F I IIDII C					1.00	
00	FOHCs ONLY: Designation - Enter "R" for rural	l or "U" for u	rban		Cront Award	0	3.
					Grant Award 1.00	2. 00	
	Source of Federal Funds				1.00	2.00	
. 00	Community Health Center (Section 330(d), PHS	Act)			0		4.
00	Mi grant Health Center (Section 329(d), PHS Ad				0	l	5.
00	Health Services for the Homeless (Section 340		0		6.		
00	Appal achi an Regi onal Commissi on		0		7.		
00	Look-Alikes		0		8.		
00	OTHER (SPECIFY)				0		9.
2 00	Dana this facility annuts on their there are	DUC FOUCO F		"N"	1.00	2.00	10
0. 00	Does this facility operate as other than an I no in column 1. If yes, indicate number of or subscripts of line 11 the type of other opera	ther operation	s in column 2.	(Enter in	N	С	10.
	Subscripts of title if the type of other oper	1	nday	-	onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4. 00	5. 00	
	Facility hours of operations (1)						
1. 00	Clinic			06: 30	17: 00	06: 30	11.
					1. 00	2.00	
2. 00	Have you received an approval for an exception	on to the prod	uctivity stand	ard?	1.00	2.00	12.
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	n 9, section nn 2 the	N	O	
	Hulliber 3 ber ow.	-		Provi	der name	CCN number	
					1. 00	2. 00	
4. 00	Provider name, CCN number				1. 00	2. 00	14.
4. 00	Provider name, CCN number	Y/N	V	XVIII	XIX	2.00 Total Visits	14.
		Y/N 1.00	V 2.00				14.
	Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	1.00		XVIII	XIX	Total Visits	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	1.00		XVIII	XIX	Total Visits	14.
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2.00	XVIII	XIX	Total Visits	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2. 00 Con	XVIII 3.00	XIX	Total Visits	
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2.00 Coi 4 PERRY	XVIII 3.00	XI X 4. 00	Total Visits 5.00	
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Cool 4 PERRY Wedn	XVIII 3.00 unty 00 esday	XI X 4. 00	Total Visits 5.00	15.
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00 Col 4 PERRY Wedr	XVIII 3.00 anty 00 esday to	XIX 4.00 Thur	Total Visits 5.00	15.
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Cool 4 PERRY Wedn	XVIII 3.00 unty 00 esday	XI X 4. 00	Total Visits 5.00	15.

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH CEN	TER Provi der	CCN: 151322	Peri od:	Worksheet S-8	
STATISTICAL DATA		Componen	t CCN: 158516	From 01/01/2015 To 12/31/2015		
				Rural Health	Cost	
				Clinic (RHC) I		
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 Cl i ni c	06: 30	16: 00				11. 00

	Financial Systems TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	PERRY COUNTY		CCN: 151322	Peri od:	worksheet S-	
	TICAL DATA	TED HEALTH CENT		t CCN: 158517	From 01/01/2015 To 12/31/2015		epared:
					Rural Health Clinic (RHC) II	Cost	oz am
					1.	00	
	Clinic Address and Identification						
. 00	Street				315 MAIN STREE		1. (
				i ty	State	ZIP Code	
	Tar			. 00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County		TROY		I N	47588	2.0
						1.00	_
3. 00	FQHCs ONLY: Designation - Enter "R" for rural	l or "II" for url	han		,	1.00	3.0
. 00	Truncs oner. Designation - Enter R Tol Tural	01 0 101 011	Dali		Grant Award	Date	3. 0
					1. 00	2.00	+
	Source of Federal Funds				1.00	2.00	
1. 00	Community Health Center (Section 330(d), PHS	Act)			0		4.0
5. 00	Mi grant Health Center (Section 329(d), PHS Ad				0		5.0
. 00	Health Services for the Homeless (Section 340				0		6. 0
. 00	Appalachian Regional Commission	ŕ			0		7.0
3. 00	Look-Alikes						8. 0
00 .	OTHER (SPECIFY)				0		9. (
	I=				1.00	2. 00	
0. 00	Does this facility operate as other than an I no in column 1. If yes, indicate number of or subscripts of line 11 the type of other opera	ther operations	in column 2.	(Enter in	N		10.0
	subscripts of Title II the type of other opera	Sunc			londay	Tuesday	
		from	to	from	to	from	
		1.00	2. 00	3.00	4. 00	5. 00	
	Facility hours of operations (1)						
11.00	Clinic			08: 00	17: 00	08: 00	11.0
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In numbers below.	d in CMS Pub. 10 umn 1. If yes, e	00-04, chapte enter in colu	r 9, section mn 2 the	N		12. C
				Provi	der name	CCN number	
					1. 00	2. 00	
14.00	Provider name, CCN number						14. C
		Y/N	V	XVIII	XIX	Total Visits	
	T.,	1.00	2. 00	3. 00	4. 00	5. 00	
15. 00	Have you provided all or substantially all						15. C
	GME cost? Enter "Y" for yes or "N" for no in						
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)						
	(400 100 100 100 100 100 100 100 100 100		Co	unty			
				. 00			
2. 00	City, State, ZIP Code, County	F	PERRY				2. 0
		Tuesday	Wedr	nesday	Thur	sday	
		to	from	to	from	to	
		6. 00	7. 00	8. 00	9. 00	10.00	
	Facility hours of operations (1)	1		40.00		1.7.00	4
11.00	Clinic	17: 00	10: 00	19: 00	08: 00	17: 00	11.0

Health Financial Systems	PERRY COUNT	Y HOSPI	I TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH CEN	ITER F	Provi der	CCN: 151322	Peri od: From 01/01/2015	Worksheet S-8	
STATISTICAL DATA		(Component	t CCN: 158517	To 12/31/2015	Date/Time Pre 5/24/2016 9:3	
					Rural Health	Cost	
					Clinic (RHC) II		
	Fri	day		Sa	turday		
	from		to	from	to		
	11. 00	12	2. 00	13. 00	14. 00		
Facility hours of operations (1)							
11. 00 Clinic	08: 00	12: 00					11. 00

	_Financial_Systems TAL-BASED_RURAL_HEALTH_CLINIC/FEDERALLY_QUALIF	PERRY COUNTY		CCN: 151322	Peri od:	Worksheet S		
	TI CAL DATA	TED HEAETH GENT		it CCN: 158518	From 01/01/2015		-epai	
					Rural Health Clinic (RHC) III	Cost		<u> </u>
					1.	00		
	Clinic Address and Identification							
. 00	Street				18485 OLD STAT			1. (
				i ty	State	ZIP Code		
				. 00	2. 00	3. 00		
2. 00	City, State, ZIP Code, County	<u>L</u>	_EOPOLD		I N	47551	_	2. 0
						1.00		
	FOLIO ONLY D : 12 F 1 HDH C					1. 00		
. 00	FQHCs ONLY: Designation - Enter "R" for rura	or "U" for urk	oan	_			0	3. 0
					Grant Award	Date	_	
	Course of Fodous L Funds				1. 00	2. 00	_	
	Source of Federal Funds Community Health Center (Section 330(d), PHS	A a + \				1		1 (
. 00	Migrant Health Center (Section 330(d), PHS A				0			4. C
. 00	Health Services for the Homeless (Section 34)							6. 0
. 00	Appal achi an Regional Commission	O(u), FIIS ACT)						7. 0
. 00	Look-Alikes				0		- 1	8. 0
. 00	OTHER (SPECIFY)				0			9. (
. 00	OTTER (SI ECTIT)							7. 0
					1. 00	2.00		
0. 00	Does this facility operate as other than an	RHC or FOHC? Ent	ter "Y" for v	es or "N" for	N N		0 1	10. 0
0.00	no in column 1. If yes, indicate number of o subscripts of line 11 the type of other opera	ther operations	in column 2.	(Enter in				0. 0
	The type of the specific specific	Sund			onday	Tuesday		
		from	to	from	to	from		
		1.00	2. 00	3.00	4. 00	5. 00		
	Facility hours of operations (1)	<u>'</u>			<u> </u>			
1.00	Clinic			07: 00	16: 00	07: 00	1	11. C
					1. 00	2. 00		
2. 00 3. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 10 umn 1. If yes, e	00-04, chapte enter in colu	r 9, section mn 2 the	N			12. C
	numbers below.			Provi	der name	CCN number		
					1. 00	2. 00		
4. 00	Provider name, CCN number						1	14. C
		Y/N	V	XVIII	XIX	Total Visits		
		1.00	2. 00	3.00	4. 00	5. 00		
5. 00	Have you provided all or substantially all						1	15. 0
	GME cost? Enter "Y" for yes or "N" for no in							
	column 1. If yes, enter in columns 2, 3 and							
	4 the number of program visits performed by							
	Intern & Residents for titles V, XVIII, and							
	XIX, as applicable. Enter in column 5 the							
	number of total visits for this provider.							
	(see instructions)		Co	Linty				
		-		unty				
00	City State 7LB Code County	-		. 00				2 0
. 00	City, State, ZIP Code, County		PERRY	acday.	Ть			2. 0
		Tuesday		nesday T +o		rsday T +o		
		6. 00	7.00	8. 00	9.00	to 10.00		
	Facility hours of operations (1)	0.00	7.00	0.00	7. 00	10.00		
1 00	Clinic	16: 00	07: 00	11: 00	07: 00	16: 00	1	11.0
1.00	Torring .	1.5.55	,,. 50	11.1.00	JO 7 . 00	110.00	١,	1. (

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH CEN	TER Provi der	CCN: 151322	Peri od:	Worksheet S-8	
STATISTICAL DATA		Componer	t CCN: 158518	From 01/01/2015 To 12/31/2015		
				Rural Health	Cost	
				Clinic (RHC) III		
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 Cl i ni c	07: 00	15: 00				11. 00

Heal th	Financial Systems	PERRY COUNTY HOSE	PLTAL		In Lie	u of Form CMS-2	2552-10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA			CCN: 151322	Peri od:	Worksheet S-10	
					From 01/01/2015 To 12/31/2015	Date/Time Prep 5/24/2016 9:3	
						1. 00	
	Uncompensated and indigent care cost computat	i on					
1.00	Cost to charge ratio (Worksheet C, Part I lir		ded by li	ne 202 column	n 8)	0. 398181	1. 00
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid					2, 418, 047	2. 00
3.00	Did you receive DSH or supplemental payments				10	Y	3. 00
4.00	If line 3 is "yes", does line 2 include all [from Medicaid	17	Υ	4.00
5.00	If line 4 is "no", then enter DSH or suppleme	ental payments from	Medicaid			0	5.00
6.00	Medicaid charges					13, 441, 811	6. 00 7. 00
7. 00 8. 00	Medicaid cost (line 1 times line 6)	Modical d program (ino 7 min	us sum of Liv	and F. i.f.	5, 352, 274	8.00
8.00	Difference between net revenue and costs for < zero then enter zero)				nes 2 and 5; IT	2, 934, 227	8.00
	State Children's Health Insurance Program (SC	CHIP) (see instructi	ons for e	ach line)			
9.00	Net revenue from stand-alone SCHIP					0	
10.00			0	10.00			
11. 00	Stand-alone SCHIP cost (line 1 times line 10)	:	0				
12. 00	Difference between net revenue and costs for enter zero)	0	12. 00				
	Other state or local government indigent care						
13. 00	Net revenue from state or local indigent care		0	13. 00			
14. 00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)						14. 00
15.00	State or local indigent care program cost (li	ne 1 times line 14)				0	15. 00
16. 00	Difference between net revenue and costs for 13; if < zero then enter zero)	state or local indi	gent care	program (lin	ne 15 minus line	0	16. 00
	Uncompensated care (see instructions for each	n line)					
17.00	Private grants, donations, or endowment incom	me restricted to fur	ding char	ity care		0	17. 00
18.00	Government grants, appropriations or transfer	rs for support of ho	spital op	erati ons		0	18. 00
19. 00		and state and Local	i ndi gent	care program	ns (sum of lines	2, 934, 227	19. 00
	8, 12 and 16)			Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col . 2)	
				1.00	2. 00	3. 00	
20. 00	Total initial obligation of patients approved			805, 7	41 0	805, 741	20. 00
21. 00	charges excluding non-reimbursable cost center Cost of initial obligation of patients approxi			320, 8	31 0	320, 831	21. 00
	times line 20)						
22. 00	Partial payment by patients approved for char	rity care			0 0	0	
23. 00	Cost of charity care (line 21 minus line 22)			320, 8	31 0	320, 831	23. 00
						1. 00	
24. 00	Does the amount in line 20 column 2 include of			nd a Length o	of stay limit		24. 00
25 00	imposed on patients covered by Medicaid or ot			oaronio Longi	th of otov limit	0	25. 00
26. 00	00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limi 00 Total bad debt expense for the entire hospital complex (see instructions)						
26.00	Medicare bad debts for the entire hospital co					4, 781, 927 338, 844	
28. 00	Non-Medicare and non-reimbursable Medicare ba			s line 27)		4, 443, 083	
29. 00	Cost of non-Medicare and non-reimbursable Medicare ba				28)	1, 769, 151	
30.00			inse (TTTIE	i times iilk	. 20)	2, 089, 982	
	Total unreimbursed and uncompensated care cos		e 30)			5, 024, 209	
51.50	1.0 ca. a.m. o. mour oou arra arroomportoa car o coc	2. (17 prus 111	50)			0,021,207	31.00

	Financial Systems	PERRY COUNTY				u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
	Cost Center Description	Calarias	Other	Tatal (asl 1	Recl assi fi cati	5/24/2016 9: 3 Recl assi fi ed	2 am
	cost center bescription	Sal ari es	other	+ col . 2)	ons (See A-6)	Tri al Balance	
				1 001. 2)	0113 (000 71 0)	(col . 3 +-	
						col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		1 000 155			4 400 500	
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 002, 455	1, 002, 45		1, 133, 509 820, 685	1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	126, 054	4, 445, 172	4, 571, 22		820, 685 201, 352	4.00
5. 01	00540 ADMINISTRATIVE AND GENERAL	501, 264	2, 432, 564	2, 933, 82		3, 019, 021	5. 01
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL	1, 453, 559	1, 310, 818	2, 764, 37		3, 158, 473	5. 02
7. 00	00700 OPERATION OF PLANT	302, 068	1, 010, 697	1, 312, 76		1, 406, 809	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	847	84, 724	85, 57 ⁻		85, 592	8. 00
9.00	00900 HOUSEKEEPI NG	205, 429	66, 724	272, 15	211, 945	484, 098	9. 00
10.00	01000 DI ETARY	37, 780	582, 130	619, 910		242, 528	10. 00
11. 00	01100 CAFETERI A	0	0	(100, 100	408, 435	11. 00
13. 00	01300 NURSING ADMINISTRATION	579, 492	10, 889			679, 508	13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	191, 679	158, 520	350, 19	9 17, 206	367, 405	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 445 227	720 024	2 174 17	407 040	2 //1 110	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 445, 336 258, 549	728, 834	2, 174, 170 271, 020		2, 661, 110 299, 679	30. 00 31. 00
43. 00	04300 NURSERY	54, 786	12, 471 0	54, 78		299, 679 55, 182	43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	54, 760	U	54, 70	370	55, 162	43.00
50.00	05000 OPERATING ROOM	413, 207	502, 273	915, 480	115, 896	1, 031, 376	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	53, 189	0	53, 18		53, 574	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	878, 879	668, 560	1, 547, 43		1, 734, 630	54.00
60.00	06000 LABORATORY	626, 177	998, 791	1, 624, 96	268, 604	1, 893, 572	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	10, 387	106, 514	116, 90	1 74	116, 975	62.00
65. 00	06500 RESPI RATORY THERAPY	496, 250	284, 194	780, 44		1, 141, 593	65. 00
66. 00	06600 PHYSI CAL THERAPY	23, 979	444, 179	468, 15		472, 644	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	188, 745	188, 74		188, 745	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	122, 181	122, 18		122, 181	68. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	42, 862	325, 104	367, 96		330, 039	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	79, 689	2, 241, 009	2, 320, 69	111,000	111, 063 2, 371, 432	72.00
73.00	OUTPATIENT SERVICE COST CENTERS	77,007	2, 241, 009	2, 320, 040	50, 734	2, 371, 432	73.00
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	779, 852	449, 376	1, 229, 22	3 212, 212	1, 441, 440	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	124, 912	115, 046	239, 95		281, 419	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	20, 940	15, 135	36, 07	15, 853	51, 928	88. 02
90.00	09000 CLI NI C	261, 964	59, 939	321, 90	249, 846	571, 749	90.00
90. 01	09001 PAIN MANAGEMENT	83, 814	18, 784	102, 59		108, 865	90. 01
91. 00	09100 EMERGENCY	832, 124	1, 751, 802	2, 583, 92	538, 986	3, 122, 912	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	E14 200	200 (2)	022.00	2 014	010, 000	95. 00
95.00	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	514, 380 294, 527	308, 626 307, 870	823, 000 602, 39		819, 092 684, 563	
101.00	SPECIAL PURPOSE COST CENTERS	274, 321	307, 870	002, 34	02, 100	004, 503	101.00
113 00	11300 INTEREST EXPENSE		3, 060	3, 060	-776, 812	-773, 752	113 00
	11600 HOSPI CE	o	0	0,000		0	116. 00
118. 00		10, 693, 975	20, 757, 186	31, 451, 16	-551, 735	30, 899, 426	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	2, 412, 303	1, 198, 686				
	19201 MARKETI NG	16, 909	262, 665	279, 57		274, 191	
200.00	TOTAL (SUM OF LINES 118-199)	13, 123, 187	22, 218, 537	35, 341, 72	4 O	35, 341, 724	200. 00

 Heal th Financial
 Systems
 PERRY CO

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10

Provi der CCN: 151322 | Peri od: | Worksheet A | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: | From 01/01/2015 | Provider CCN: 151322 | Peri od: | Provider CCN: 151322 | Pro

				10 12/31/2015 Date/III 5/24/201	me Prepared: 16 9:32 am
	Cost Center Description	Adjustments	Net Expenses	0,21,20	7. 02 4.11
	'		For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-256, 747	876, 762		1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	862, 273	1, 682, 958	l control of the cont	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	201, 352	2	4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL	-828, 347	2, 190, 674	i	5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	0	3, 158, 473		5. 02
7.00	00700 OPERATION OF PLANT	-8, 051	1, 398, 758		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	85, 592	2	8. 00
9.00	00900 HOUSEKEEPI NG	0	484, 098		9. 00
10. 00	01000 DI ETARY	-128	242, 400		10. 00
11. 00	O1100 CAFETERI A	-95, 676	312, 759	•	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	679, 508	3	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-4, 759	362, 646		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	2, 661, 110		30. 00
31.00	03100 INTENSIVE CARE UNIT	0	299, 679	>	31.00
43.00	04300 NURSERY	0	55, 182	2	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	-111, 987	919, 389		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	53, 574	<u> </u>	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-77, 628	1, 657, 002	2	54. 00
60.00	06000 LABORATORY	0	1, 893, 572	2	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	116, 975		62. 00
65.00	06500 RESPI RATORY THERAPY	-180, 094	961, 499)	65. 00
66.00	06600 PHYSI CAL THERAPY	0	472, 644	Į.	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	188, 745		67. 00
68.00	06800 SPEECH PATHOLOGY	0	122, 181		68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-9, 653	320, 386		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	111, 063	3	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-2, 879	2, 368, 553	3	73. 00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC - TELL CITY	0	1, 441, 440		88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0	281, 419	,	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	0	51, 928	3	88. 02
90.00	09000 CLI NI C	0	571, 749	,	90.00
90. 01	09001 PAIN MANAGEMENT	0	108, 865		90. 01
91.00	09100 EMERGENCY	-1, 335, 541	1, 787, 371		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-8, 355	810, 737	7	95. 00
101.00	10100 HOME HEALTH AGENCY	-283	684, 280		101. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 I NTEREST EXPENSE	773, 752	0		113. 00
116.00	11600 H0SPI CE	0	0		116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1, 284, 103	29, 615, 323	3	118. 00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	4, 168, 107	,	192. 00
192. 01	19201 MARKETI NG	0	274, 191		192. 01
200.00	TOTAL (SUM OF LINES 118-199)	-1, 284, 103	34, 057, 621		200. 00
					-

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151322

					To 12/31/2015 Date/Time Pre 5/24/2016 9:3	
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5.00		
	2.00 A - CAFETRI A COST	3. 00	4. 00	5. 00		
1.00	CAFETERI A	11. 00	24, 861	383, 064		1. 00
	TOTALS		24, 861	383, 064		
	B - INTEREST EXPENSE			•		
1.00	NEW CAP REL COSTS-MVBLE	2. 00	0	778, 614		1. 00
0.00	EQUI P	0.00				0.00
2. 00	TOTALS — — — —		0			2. 00
	C - LEASE EXPENSE		U _I	778, 014		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	131, 054		1. 00
	FIXT			,		
2.00		0.00	O	0		2. 00
3.00		0. 00	0	0		3. 00
4.00		0.00	0	0		4.00
5.00		0. 00 0. 00	0	0		5. 00
6. 00 7. 00	+	0.00	0	0		6. 00 7. 00
8. 00		0.00	Ö	0		8. 00
9. 00	1	0.00	o	0		9. 00
10.00		0.00	o	0		10.00
11.00		0.00	0	0		11. 00
12.00		0.00	•	0		12. 00
	TOTALS		0	131, 054		
1 00	D - INSURANCE EXPENSE	2 00		42.071		1 00
1. 00	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	42, 071		1. 00
	TOTALS	+	$$ \dagger	42, 071		
	G - DRUGS CHARGED		-1	.=,		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	87, 034		1. 00
4.00		0. 00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00	TOTALS — — — —		- $ 0$			7. 00
	J - BILLABLE SUPPLIES		O _I	07,034		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	71, 782		1. 00
	PATI ENTS					
2.00	IMPL. DEV. CHARGED TO	72. 00	0	1, 046		2. 00
0.00	PATI ENT	0.00				0.00
3. 00 4. 00	+	0. 00 0. 00	0	0		3. 00 4. 00
6.00		0.00	0	0		6. 00
8. 00		0.00	o	Ö		8. 00
9.00		0.00	O	0		9. 00
10.00		0.00	O	0		10.00
11. 00		0. 00	0	0		11. 00
12.00		0.00	0	0		12.00
13. 00	TOTAL C — — — — —	0.00	0	0		13. 00
	TOTALS M - YELLOW PAGES		U	72, 828		
1.00	ADMINISTRATIVE AND GENERAL	5. 01	O	14, 362		1. 00
	TOTALS	+	 	14, 362		
	P - IMPLANTABLE DEVICE					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	110, 017		1. 00
	PATI ENT	+				
	TOTALS R - PAYROLL		U	110, 017		
1.00	ADMINISTRATIVE AND GENERAL	5. 01	O	115, 070		1. 00
2. 00	OTHER ADMINISTRATIVE AND	5. 02	o	398, 078		2. 00
	GENERAL					
3.00	OPERATION OF PLANT	7. 00	0	96, 272		3. 00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0	21		4. 00
5.00	HOUSEKEEPI NG	9.00	0	211, 945		5. 00
6. 00 7. 00	DI ETARY CAFETERI A	10. 00 11. 00	0	30, 543 510		6. 00 7. 00
7. 00 8. 00	NURSING ADMINISTRATION	13.00	0	89, 127		8. 00
9. 00	MEDICAL RECORDS & LIBRARY	16. 00	o	45, 684		9. 00
10. 00	ADULTS & PEDIATRICS	30.00	ő	493, 058		10. 00
11. 00	INTENSIVE CARE UNIT	31.00	Ō	29, 014		11. 00
12.00	NURSERY	43.00	О	396		12. 00
13. 00	OPERATING ROOM	50.00	0	154, 554		13. 00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	385		14.00
15. 00 16. 00	RADI OLOGY-DI AGNOSTI C LABORATORY	54. 00 60. 00	0	188, 902		15. 00 16. 00
10.00	LADUKATUKT	60.00	·	268, 604		10.00

Heal th Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 151322 Period: Worksheet A-6

r CCN: 151322 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 Date/Time Prepared: 5/24/2016 9: 32 am

					5/24/2016 9:32 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4.00	5. 00	
17.00	WHOLE BLOOD & PACKED RED	62.00	0	74	17. 00
	BLOOD CELLS				
18. 00	RESPI RATORY THERAPY	65.00	0	391, 089	18.00
19.00	PHYSI CAL THERAPY	66.00	0	5, 424	19.00
20.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	308	20.00
	PATI ENTS				
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	22, 065	21. 00
22.00	RURAL HEALTH CLINIC - TELL	88. 00	o	212, 212	22.00
	CITY				
23.00	RURAL HEALTH CLINIC - PERRY	88. 01	0	41, 461	23. 00
	CO FP				
24.00	RURAL HEALTH CLINIC - TROY	88. 02	0	15, 853	24. 00
25.00	CLINIC	90.00	0	250, 139	25. 00
26.00	PAIN MANAGEMENT	90. 01	o	6, 300	26. 00
27.00	EMERGENCY	91.00	o	560, 363	27. 00
28.00	HOME HEALTH AGENCY	101.00	o	85, 314	28. 00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	650, 859	29. 00
30.00	MARKETI NG	192. 01	o	8, 979	30.00
	TOTALS		— — — ō	4, 372, 603	
500.00	Grand Total: Increases		24, 861	5, 991, 647	

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 151322

					То	12/31/2015 Date/Time 5/24/2016	
		Decreases				., ., ., ., .,	
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - CAFETRIA COST	7.00	8.00	9.00	10.00		
1.00	DI ETARY	10.00	24, 861	383, 064	0		1.00
	TOTALS		24, 861	383, 064			
	B - INTEREST EXPENSE						
1.00	I NTEREST EXPENSE	113.00	0	776, 812			1. 00
2. 00	PHYSICIANS' PRIVATE OFFICES	<u> </u>	0	1, 802			2. 00
	TOTALS C - LEASE EXPENSE		0	778, 614			
1.00	ADMINISTRATIVE AND GENERAL	5. 01	0	100	9		1.00
2. 00	OTHER ADMINISTRATIVE AND	5. 02	Ö	3, 982	ó		2. 00
2.00	GENERAL	0.02	٩	0, 702			2.00
3.00	OPERATION OF PLANT	7. 00	0	2, 228	0		3. 00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	28, 478	0		4. 00
5.00	ADULTS & PEDIATRICS	30. 00	0	2, 035	0		5. 00
6. 00	OPERATING ROOM	50. 00	0	25			6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	528	1		7. 00
8. 00 9. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	0	29, 940	0		8. 00
9. 00 10. 00	DRUGS CHARGED TO PATIENTS	73.00	0	152 58, 348			9. 00 10. 00
11. 00	EMERGENCY	91. 00	o	236	1		11.00
12. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	Ö	5, 002			12.00
.2.00	TOTALS			131, 054			12.00
	D - INSURANCE EXPENSE	·	- 1	, , , , , , , , , , , , , , , , , , , ,	!		
1.00	ADMINISTRATIVE AND GENERAL	5. 01	0	42, 071	10		1. 00
	TOTALS		0	42, 071			
	G - DRUGS CHARGED						
1. 00	ADMINISTRATIVE AND GENERAL	5. 01	0	2, 068			1. 00
4.00	EMERGENCY	91.00	0	18, 378			4. 00
5.00	HOME HEALTH AGENCY	101.00	0	427	0		5. 00
6. 00 7. 00	PAIN MANAGEMENT PHYSICIANS' PRIVATE OFFICES	90. 01 192. 00	0	33 66, 128			6. 00 7. 00
7.00	TOTALS	192.00		87, 034			7.00
	J - BILLABLE SUPPLIES		<u> </u>	07,034			
1. 00	ADULTS & PEDIATRICS	30.00	0	4, 083	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	О	355	o		2. 00
3.00	OPERATING ROOM	50.00	0	38, 633	0		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 183			4. 00
6. 00	PHYSI CAL THERAPY	66. 00	0	786	1		6. 00
8.00	DRUGS CHARGED TO PATIENTS	73. 00	0	17	0		8. 00
9.00	CLINIC EMERCENCY	90.00	0	293	0		9.00
10. 00 11. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	2, 763 1, 185	0		10. 00 11. 00
12. 00	HOME HEALTH AGENCY	101.00	o	2, 721	0		12. 00
13. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	20, 809			13. 00
	TOTALS			72, 828			
	M - YELLOW PAGES						
1.00	MARKETI NG	192.01	0_	1 <u>4, 3</u> 62			1. 00
	TOTALS		0	14, 362			
	P - IMPLANTABLE DEVICE						
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	110, 017	0		1. 00
	TOTALS	+		11 0, 017			
	R - PAYROLL		<u> </u>	110,017			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 369, 874	0		1.00
2.00	AMBULANCE SERVICES	95.00	О	2, 729	o		2. 00
3.00		0.00	O	0	0		3. 00
4.00		0.00	0	0	0		4. 00
5. 00		0.00	0	0			5. 00
6. 00		0.00	0	0	0		6. 00
7.00		0.00	0	0	1		7. 00
8. 00 9. 00	+	0. 00 0. 00	0	0			8. 00 9. 00
10. 00		0.00	o	0	1		10.00
11. 00		0.00	Ö	0			11. 00
12. 00		0.00	o	0			12. 00
13. 00		0.00	Ö	Ö	O		13. 00
14.00		0.00	O	0	0		14. 00
15. 00		0.00	О	0	0		15. 00
16. 00		0.00	0	0			16. 00
17. 00		0.00	0	0			17. 00
18.00		0.00	0	0			18.00
19. 00 20. 00		0. 00 0. 00	0	0			19. 00 20. 00
20.00		0.00	0	0			20.00
	1	0.00	٦		١		1 21.00

Health Financial Systems RECLASSIFICATIONS PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 151322

						5/24/2016 9:3	32 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
22. 00		0.00	0	C	0		22. 00
23. 00		0.00	0	C	0		23. 00
24. 00		0.00	0	C	0		24. 00
25. 00		0.00	0	C	0		25. 00
26. 00		0.00	0	C	0		26. 00
27. 00		0.00	0	C	0		27. 00
28. 00		0.00	0	C	0		28. 00
29. 00		0.00	0	C	0		29. 00
30.00		0.00	0		00		30.00
	TOTALS		0	4, 372, 603	3		
500.00	Grand Total: Decreases		24, 861	5, 991, 647	7		500.00

PITAL In Lieu of Form CMS-2552-10
Provider CCN: 151322 | Period: | Worksheet A-7 | From 01/01/2015 | Part I

					To 12/31/2015	Date/Time Pre	
						5/24/2016 9:3	2 am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET					·	
1.00	Land	2, 945, 631	0	1	0	0	1
2.00	Land Improvements	1, 494, 906	0	1	0	0	2. 00
3.00	Buildings and Fixtures	10, 365, 854	0		0	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equipment	10, 682, 160	6, 132, 859		0 6, 132, 859	0	5. 00
6.00	Movable Equipment	11, 100, 348	471, 756	(0 471, 756	0	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	36, 588, 899	6, 604, 615		0 6, 604, 615	0	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	36, 588, 899	6, 604, 615		0 6, 604, 615	0	10.00
		Ending Balance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 945, 631	0				1. 00
2.00	Land Improvements	1, 494, 906	0				2. 00
3.00	Buildings and Fixtures	10, 365, 854	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	16, 815, 019	0				5. 00
6.00	Movable Equipment	11, 572, 104	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	43, 193, 514	0				8. 00
9.00	Reconciling Items	o	0				9. 00
10. 00	Total (line 8 minus line 9)	43, 193, 514	0				10. 00

Heal th	n Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151322	Peri od: From 01/01/2015 To 12/31/2015		pared:
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	`	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	<u>IN 2, LINES 1 a</u>	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 002, 455	0	1	0 0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0)	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	1, 002, 455	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	ind 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 002, 455				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0)			2.00
3.00	Total (sum of lines 1-2)	0	1, 002, 455				3. 00

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet A-7 Part III Date/Time Pre 5/24/2016 9:3	pared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS	T	Г	.1		
1. 00 NEW CAP REL COSTS-BLDG & FLXT	1	0		1 1.000000	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 0. 000000 1 1. 000000		2. 00 3. 00
3.00 Total (Suill of Titles 1-2)	ΔΙΙΩCΔ ⁻	TION OF OTHER O	Ι `ΔΡΙ ΤΔΙ		F CAPITAL	3.00
	ALLOGA	THOM OF OTHER C	ALL TAL	JONINIART O	OALLIAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
DART III DECONCIIIATION OF CARITAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 NEW CAP REL COSTS-BLDG & FLXT	INTERS			0 876, 762	0	1. 00
2.00 NEW CAP REL COSTS-BEDG & TTAT	0			0 881, 796	_	
3.00 Total (sum of lines 1-2)	0	0		0 1, 758, 558		3.00
or or protein (sam or rrings i 2)	3	Sl	JMMARY OF CAPI		22,010	0.00
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11. 00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	10.00	11.00	10.00	
1. 00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	876, 762	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	778, 614	0		0 0	1, 682, 958	2. 00
3.00 Total (sum of lines 1-2)	778, 614	0		o o	2, 559, 720	3. 00

In Lieu of Form CMS-2552-10
Worksheet A-8 Provi der CCN: 151322 | Peri od: | Workshee

				To	om 01/01/2015 12/31/2015	Date/Time Prep 5/24/2016 9:32	
				Expense Classification on To/From Which the Amount is		3/24/2010 4. 32	Z dili
					•		
	Cost Center Description	Basi s/Code (2) 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			NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1. 00
2. 00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter	В	-20, 744	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	10	2. 00
3.00	2) Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	21) Television and radio service		0		0. 00	0	8. 00
9. 00 10. 00	(chapter 21) Parking lot (chapter 21) Provider-based physician	A-8-2	0 -1, 699, 144		0. 00	0	
11. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	1, 950, 663			0	12. 00
13. 00 14. 00 15. 00	Laundry and linen service Cafeteria-employees and guests Rental of quarters to employee		0 -95, 676 0	CAFETERI A	0. 00 11. 00 0. 00	0 0 0	13. 00 14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than	В	-9, 653	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	
17. 00	patients Sale of drugs to other than	В	-2, 879	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-4, 759	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty		0		0. 00 0. 00	0	
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
24. 00	therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL			FIXT NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	EQUIP *** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
32. 00	limitation (chapter 14)	A		NEW CAP REL COSTS-BLDG & FIXT	1. 00	9	32.00

					To 12/31/2015	Date/Time Pre 5/24/2016 9:3	pared: 2 am	
		Expense Classification on Worksheet A						
		To/From Which the Amount is to be Adjusted						
					•			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.		
	I	1. 00	2. 00	3. 00	4. 00	5. 00		
33. 00	MISC INCOME	В	-23, 829	ADMINISTRATIVE AND GENERAL	5. 01	0	00.00	
33. 01			0		0.00		33. 01	
34. 00	MISC INCOME	В	-8, 355	AMBULANCE SERVICES	95. 00	l	34.00	
35. 00			0		0.00	l	35. 00	
36. 00	HHA ADVERTI SI NG	A		HOME HEALTH AGENCY	101. 00	0	36. 00	
37. 00	RECRUI TI NG	A	-112, 562	ADMINISTRATIVE AND GENERAL	5. 01	0	37. 00	
38. 00			0		0.00		38. 00	
39. 00	OLD BUILDING DEPRECIATION	A		NEW CAP REL COSTS-MVBLE EQUIP	2. 00	9	39. 00	
40.00	PHONE	A	-8, 051	OPERATION OF PLANT	7. 00	0	40.00	
41.00	PHONE	A	-1, 864	NEW CAP REL COSTS-BLDG &	1.00	9	41.00	
				FI XT				
42.00	DI ETARY	В	-128	DI ETARY	10.00	0	42. 00	
43.00	AHA	A	-3, 748	ADMINISTRATIVE AND GENERAL	5. 01	0	43.00	
45.00	NON-ALLOWABLE EXPENSE	A	-28, 486	ADMINISTRATIVE AND GENERAL	5. 01	0	45. 00	
45. 01			0		0.00	0	45. 01	
45. 02	MI SCELLANEOUS EXPENSE	A	-5, 322	ADMINISTRATIVE AND GENERAL	5. 01	0	45. 02	
45. 03	HAF FEES	A	-654, 400	ADMINISTRATIVE AND GENERAL	5. 01	0	45. 03	
45. 04			0		0.00	0	45. 04	
50.00	TOTAL (sum of lines 1 thru 49)		-1, 284, 103				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).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

Heal th	Financial Systems	PERRY COUN	TY HOSPITAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	8-1
OFFICE	COSTS			From 01/01/2015 To 12/31/2015		pared:
					5/24/2016 9:3	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANI ZATI ONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	2. 00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	1, 221	0	1.00
2.00	54. 00	RADI OLOGY-DI AGNOSTI C	MOBILE MRI	146, 449	152, 555	2.00
3.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	PERRY CO. MEMORIAL ASSOCIATI	1, 181, 796	0	3.00

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

0

PERRY CO. MEMORIAL ASSOCIATI

773, 752

2, 103, 218

0

152, 555

4.00

5.00

 or book poored to not to or and or an area or 2, the amount arronable chear a bo that carea the contains the time party									
			Related Organization(s) and/	or Home Office					
					l				
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2. 00	3. 00	4. 00	5. 00					
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

6. 00	В	PERRY CO AMBULA	100.00	0.00	6. 00
7.00	В	DSSI	100. 00	0.00	7. 00
8.00	В	PERRY CO ASSOCI	100. 00	0.00	8. 00
9.00	В	PERRY CO ASSOCI	100. 00	0.00	9. 00
10.00			0. 00	0.00	10.00
100.00	G. Other (financial or	OTHER			100.00
	non-financial) specify:				

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

113. 00 I NTEREST EXPENSE

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

4.00

Heal th	Financial Syste	ems		PERRY C	OUNTY HOS	PITAL				In Li€	eu of Form CMS	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANIZATIONS AND	HOME	Provi der	CCN:	151322	Peri o	d:	Worksheet A-	8-1
OFFICE	COSTS									01/01/2015		
									To	12/31/2015		
											5/24/2016 9:	32 am
		Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REC	QUIRED AS A RESULT	OF TRANS	SACTIONS W	/ITH R	ELATED C	RGANI Z	ZATIONS OR	CLAI MED	
	HOME OFFICE CO:	STS:										
1.00	1, 221	10										1. 00
2.00	-6, 106	0										2. 00
3.00	1, 181, 796	9										3.00
4.00	773, 752	11										4. 00
E 00	1 050 442	1	1									F 00

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

Related Organization(s)		
and/or Home Office		
Type of Business		
Type of Business		
6. 00		1
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00		6. 00
7.00		7. 00
8.00		8. 00 9. 00
9.00		9. 00
10.00		10.00
7. 00 8. 00 9. 00 10. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Provi der CCN: 151322

						0 12/31/2015	5/24/2016 9:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	50.00	OPERATING ROOM	111, 987	111, 987	0	0	0	1. 00
2.00	54. 00	RADI OLOGY-DI AGNOSTI C	71, 522	71, 522	0	0	0	2. 00
3.00	60.00	LABORATORY	16, 500	0	16, 500	0	0	3. 00
4.00	65. 00	RESPI RATORY THERAPY	180, 094	180, 094	0	0	0	4. 00
5.00	91. 00	EMERGENCY	1, 680, 583	1, 335, 541	345, 042	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2, 060, 686	1, 699, 144	361, 542		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	:
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		OPERATING ROOM	0		-	_		
2.00		RADI OLOGY-DI AGNOSTI C	0		0	0	1	
3.00		LABORATORY	0	0	0	0	0	0.00
4.00		RESPI RATORY THERAPY	0	0	0	0	0	1
5.00		EMERGENCY	0	0	0	0	0	0.00
6. 00	0. 00		0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	1
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		OPERATING ROOM	13.00			111, 987		1.00
2. 00		RADI OLOGY-DI AGNOSTI C		1	-	71, 522		2. 00
3. 00		LABORATORY			0	71,322		3. 00
4. 00		RESPI RATORY THERAPY			0	180, 094		4.00
5. 00		EMERGENCY			0	1, 335, 541		5.00
6. 00	0.00	LINE INCLINE			0	1, 333, 341		6.00
7. 00	0.00				0			7. 00
8. 00	0.00				n			8.00
9. 00	0.00				n			9.00
10. 00	0.00				0			10.00
200.00	3.00		0			1, 699, 144		200.00
200.00	I			1		1,0//,177	I	1 200. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der		Period: From 01/01/2015 To 12/31/2015	5/24/2016 9: 3	pared:
				 	Physical Therapy	Cost	
	DADT I CENEDAL INFORMATION					1. 00	
. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy nor therapist was on provider site (see inst	sor or therapist assistant was c	was on provid			52 780 333 7	2. 00
. 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther instructions)	rvisors or thera apy assistants (include only \	visits made b		316 695	5. 00 6. 00
. 00	Standard travel expense rate					5. 50	
. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8. 00
		1.00	2.00	3. 00	4. 00	5. 00	
	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	1, 069. 00 96. 00 36. 00	2, 017. 00 72. 00 36. 00	6, 840. 0 54. 0 27. 0	0.00	0. 00 0. 00	9. 00 10. 00 11. 00
2. 01 3. 00	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site)	0 0 0	121 0 4, 859	7, 09	0		12. 00 12. 01 13. 00
3. 01	Number of miles driven (offsite)	0	0		0		13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION	1: 10)				102 (24	1 4 00
4. 00 5. 00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					102, 624 145, 224	
	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 ar others)	line10)	ratory therapy	or lines 14-	16 for all	369, 360 617, 208	16.00
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 for lift the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	ne 10) or respiratory t or therapy or col or line 2, make n	umns 1-3 for p	hysical ther	apy, speech path		18. 00 19. 00 20. 00
	Weighted average rate excluding aides and tra	ainees (line 17		m of columns	1 and 2, line 9	0.00	21.00
2. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained					0	22. 00
3. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance			JTATION - PRO	VIDER SITE	617, 208	
4. 00	Therapists (line 3 times column 2, line 11)					11, 988	24.00
5. 00	Assistants (line 4 times column 3, line 11)					189	
6. 00 7. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)				and 4 for all	12, 177 1, 870	1
8. 00	Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	·	at the provide	er site (sum	of lines 26 and	14, 047	28. 00
9. 00	Therapists (column 2, line 10 times the sum of	of columns 1 and	12, line 12)			8, 712	
0. 00 1. 00	Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	•	and 20 for al	L others)		9, 558 18, 270	
2. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)				or sum of	0	32.00
3.00	Standard travel allowance and standard travel			1 21)		0	33.00
4. 00 5. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	expense (sum o	of lines 31 and	32)	ICES OUTSIDE PRO	0 18, 270 VIDER SITE	34. 00 35. 00
	Standard Travel Expense					44.07	0, 2-
6. 00 7. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)					11, 376 18, 765	ı
	rasi stanta (TINE O TINES COLUNII S. TINE II)					10. /051	ı 57.UU
8. 00	Subtotal (sum of lines 36 and 37)					30, 141	38.00

22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	O	22.00
23.00	Total salary equivalency (see instructions)	617, 208	23. 00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	11, 988	24. 00
25.00	Assistants (line 4 times column 3, line 11)	189	25. 00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	12, 177	26. 00
27. 00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1, 870	27. 00
28. 00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	14, 047	28. 00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	8, 712	29. 00
	Assistants (column 3, line 10 times column 3, line 12)	9, 558	
	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	18, 270	
	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	0	32. 00
02.00	columns 1-3, line 13 for all others)	· ·	02.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33. 00
	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	18, 270	35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PRO	VI DER SI TE	
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	11, 376	36. 00
	Assistants (line 6 times column 3, line 11)	18, 765	37. 00
38.00	Subtotal (sum of lines 36 and 37)	30, 141	38. 00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	5, 561	39. 00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line	s 44, 45,	
	or 46, as appropriate.		
	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
MCRI F3	2 - 8.8.159.0		

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES OUTSIDE SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151322	Peri od: From 01/01/2015 To 12/31/2015	Worksheet A-8 Parts I-VI Date/Time Pre 5/24/2016 9:33	-3 pared:
				Physical Therapy	Cost	
					1. 00	
46.00 Optional travel allowance and optional travel						46. 00
	Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4. 00	Total 5. 00	
PART V - OVERTIME COMPUTATION						
47.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0. (0.00	0.00	47. 00
48.00 Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48. 00
49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0. 00	0.0	0.00		49. 00
CALCULATION OF LIMIT	0.00	0.00	0.0	20 0.00	0.00	
50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0. 00	0.0	0. 00	0.00	50.00
51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0.00	0.00	0. (0.00	0.00	51.00
52.00 Adjusted hourly salary equivalency amount	72.00	54.00	0.0	0.00		52. 00
(see instructions) 53.00 Overtime cost limitation (line 51 times line		0		0 0		53. 00
52) 54.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54. 00
line 49 or line 53) 55.00 Portion of overtime already included in		0		0 0		55. 00
hourly computation at the AHSEA (multiply line 47 times line 52)		0				00.00
56.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	O	0		0 0	0	56. 00
					1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT				
57.00 Salary equivalency amount (from line 23)					617, 208	57. 00
58.00 Travel allowance and expense - provider site	(from lines 33,	34, or 35))			18, 270	58. 00
59.00 Travel allowance and expense - Offsite servi	ces (from lines	44, 45, or 46)		0	59. 00
60.00 Overtime allowance (from column 5, line 56)					0	60.00
61.00 Equipment cost (see instructions)					9, 580	1
62.00 Supplies (see instructions)						62. 00
63.00 Total allowance (sum of lines 57-62)					653, 999	
64.00 Total cost of outside supplier services (from	,				486, 413	
65.00 Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION	3 - IT negative,	enter zero)			0	65. 00
100.00 Line 26 = line 24 for respiratory therapy or	sum of Lines 24	and 25 for a	II others		12, 177	100 00
100.01 Line 27 = line 7 times line 3 for respiratory				others		100.00
100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	14, 047					
101.00 Line 27 = line 7 times line 3 for respirator	y therapy or sum	of lines 3 a	nd 4 for all	others	1, 870	101. 00
101.01 Line 31 = line 29 for respiratory therapy or					18, 270	
101.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION					20, 140	101. 02
						1400 00
102.00 Line 31 = line 29 for respiratory therapy or 102.01 Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line	18, 270 0	102. 00

UISIL	IABLE COST DETERMINATION FOR THERAPY SERVICES I DE SUPPLIERS	OKWI SHED DI	T T OVY GET	CCN: 151322	Peri od: From 01/01/2015 To 12/31/2015	Worksheet A-8 Parts I-VI Date/Time Pre 5/24/2016 9:33	pared:
					Occupati onal Therapy	Cost	ı
						1. 00	
. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides	c) (saa instruc	eti one)			52	1.00
. 00	Line 1 multiplied by 15 hours per week	s) (See This true	. (1 0113)			780	
. 00	Number of unduplicated days in which supervis					254	3. 00
. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see instr		on provider si	te but neithe	er supervisor	2	4.00
. 00	Number of unduplicated offsite visits - super	rvisors or ther				241	5. 0
. 00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther					436	6. 0
	instructions)	aprot mas not	processe dan ring		, (555		
. 00	Standard travel expense rate Optional travel expense rate per mile					5. 50 0. 00	
. 00	oper order traver expense rate per mire	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.0
. 00	Total hours worked	1.00	2. 00 3, 352. 00	3. 00 1. 714. 0	4. 00	5. 00	9. 0
0.00	AHSEA (see instructions)	0.00				0.00	
1. 00	Standard travel allowance (columns 1 and 2,	34. 13	34. 13	25. <i>6</i>	50		11. 00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
2.00	Number of travel hours (provider site)	0	60	14	14		12.00
2. 01 3. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0	2, 410	5, 75	58		12. 0 13. 0
3. 01	Number of miles driven (offsite)	0	0		0		13. 0°
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
4. 00 5. 00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0 228, 774	
6. 00	Assistants (column 3, line 9 times column 3,	line10)				87, 740	16. 0
7. 00	Subtotal allowance amount (sum of lines 14 ar others)	nd 15 for respi	ratory therapy	or lines 14-	·16 for all	316, 514	17. 0
8. 00	Aides (column 4, line 9 times column 4, line	10)				0	18. 0
9. 00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 fo		thorany or lin	oc 17 and 10	for all others)	0 316, 514	19. 00 20. 00
.0. 00	If the sum of columns 1 and 2 for respiratory						20.0
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on	lines 21 and	22 and enter on	line 23	
1. 00	Weighted average rate excluding aides and tra	inees (line 17		m of columns	1 and 2, line 9	0.00	21. 0
2. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained					0	22. 0
3. 00	Total salary equivalency (see instructions)					316, 514	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	IANCE AND TRAVE	L EXPENSE COMP	UTATION - PRO	OVI DER SITE		
4. 00	Therapists (line 3 times column 2, line 11)					8, 669	24. 0
5. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 2	M and 25 for a	II others)		51 8, 720	25. 00 26. 00
7. 00	Standard travel expense (line 7 times line 3				and 4 for all	1, 408	1
8. 00	others) Total standard travel allowance and standard	travel expense	at the provid	or sito (sum	of lines 26 and	10, 128	28. 00
.0. 00	27)	·	at the provid	Ci Si te (Sum	or Triics 20 and	10, 120	20.0
9. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		nd 2 line 12)			4, 095	29. 0
0.00	Assistants (column 3, line 10 times column 3,		id 2, 11116 12)			7, 371	
1.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns				or sum of	11, 466 0	31. 00 32. 00
2.00	columns 1-3, line 13 for all others)	s i anu z, iine	: 13 TOL LESPIT	атогу тпегару	OI Sulli OI	U	32.00
3.00	Standard travel allowance and standard travel			۵ (((((((((((((((((((12.074	33. 0
4. 00 5. 00		expense (sum	of lines 31 an	d 32)		12, 874 0	34. 00 35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMPU	TATION - SERV	ICES OUTSIDE PRO	OVI DER SITE	
6. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					8, 225	36. 0
7. 00	Assistants (line 6 times column 3, line 11)					11, 162	37.00
8. 00 9. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	n of lines 5 an	nd 6)			19, 387 3, 724	1
7. 50	Optional Travel Allowance and Optional Travel	Expense					
0.00	Therapists (sum of columns 1 and 2, line 12.0		2, line 10)			0	1
	Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	. 3, TITIE 10 <i>)</i>				0	41. 0
2. 00	Subtotal (Sull of Titles 40 and 41)						
	Optional travel expense (line 8 times the sun Total Travel Allowance and Travel Expense - C					0	43.0

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151322	Peri od: From 01/01/2015 To 12/31/2015	Worksheet A-8 Parts I-VI Date/Time Pre 5/24/2016 9:3	pared:
					Occupati onal Therapy	Cost	
						1. 00	
5. 00	Optional travel allowance and standard travel					3, 724	
5. 00	Optional travel allowance and optional travel	expense (sum Therapists	of lines 42 ar Assistants	nd 43 - see in Aides	nstructions) Trainees	Total	46. 0
		1.00	2. 00	3.00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION						
7. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0. (0.00	0.00	47. 0
3. 00	Overtime rate (see instructions)	0. 00	0.00	1			48. 0
9. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0. 00	0. 00	0. (0. 00		49. 00
	CALCULATION OF LIMIT			_			
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0. (0.00	0.00	50.00
1. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0. (0.00	0.00	51.00
2. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	68. 25	51. 19	0. (0.00		52. 0
3. 00	(see instructions) Overtime cost limitation (line 51 times line	06. 25	31. 19		0 0.00		53.0
4. 00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.0
5. 00	line 49 or line 53) Portion of overtime already included in	0	0		0 0		55. 0
J. 00	hourly computation at the AHSEA (multiply line 47 times line 52)	Ŭ	· ·				33.0
5. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	С		0 0	0	56.0
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			-	
2. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57,63)))		316, 514 12, 874 3, 724 0 203 333, 315	58. 0 59. 0 60. 0 61. 0 62. 0
3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (from your records) 5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION							64. C
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION							100. 0 100. 0 100. 0
01. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	1, 408 11, 466 12, 874	101. 0
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line	11, 466 0	102. 0 102. 0
	Line 35 = sum of lines 31 and 32					11, 466	l

EASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES	PERRY COUNTY FURNI SHED BY	Provi der CCN		Peri od:	Worksheet A-8	
UTSI D	E SUPPLI ERS				From 01/01/2015 To 12/31/2015	Date/Time Pre	
					Speech Pathology	5/24/2016 9: 3: Cost	2 am
						1. 00	
	PART I - GENERAL INFORMATION						
. 00 . 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instructi	ons)			52 780	1
. 00	Number of unduplicated days in which supervis					244	3.
. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		n provider site	out neithe	r supervisor	0	4.
. 00 . 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera				v thorany	60 0	
. 00	assistant and on which supervisor and/or the					0	0.
. 00	instructions) Standard travel expense rate					5. 50	7.
. 00	Optional travel expense rate per mile					0. 00	
		Supervi sors 1.00	Therapists A	ssi stants 3.00	Ai des 4. 00	Trai nees 5.00	
00	Total hours worked	779. 00	1, 199. 00	0.0	0.00	0. 00	
	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	78. 96 29. 61	59. 22 29. 61	0. 0 0. 0		0. 00	10.
	one-half of column 2, line 10; column 3,						
2. 00	one-half of column 3, line 10) Number of travel hours (provider site)	o	О		0		12
	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12 13
	Number of miles driven (offsite)	330 0	0		0		13
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,	,				61, 510 71, 005	
. 00	Assistants (column 3, line 9 times column 3,	line10)		44	47.6	0	16
7. 00	Subtotal allowance amount (sum of lines 14 ar others)	na 15 for respira	itory therapy or	lines 14-	16 for all	132, 515	17.
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	
	Total allowance amount (sum of lines 17-19 for	or respiratory th				132, 515	
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.					
1.00	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,			r columns	I and 2, II ne 9	0. 00	21
	Weighted allowance excluding aides and trained		line 21)			0 132, 515	22
	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW		EXPENSE COMPUTA	ΓΙΟΝ - PRO	VIDER SITE	132, 515	23
. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					7, 225	24
. 00	Assistants (line 4 times column 3, line 11)					0	25
. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3			,	and 4 for all	7, 225 1, 342	1
	others)						
. 00	Total standard travel allowance and standard 27)	travel expense a	it the provider	site (sum	of lines 26 and	8, 567	28
	Optional Travel Allowance and Optional Travel		0 1: 40)				
. 00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		2, line 12)			0	
. 00	Subtotal (line 29 for respiratory therapy or	sum of lines 29			6	0	
. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s I and 2, II ne	3 for respirato	ry tnerapy	or sum or	0	32.
	Standard travel allowance and standard travel			1)		8, 567	1
	Optional travel allowance and standard travel Optional travel allowance and optional travel			7		0	1
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL E	XPENSE COMPUTAT	ON - SERV	ICES OUTSIDE PRO	OVI DER SITE	-
. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					1, 777	
. 00	Assistants (line 6 times column 3, line 11)					0 1 777	37.
	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur	n of lines 5 and	6)			1, 777 330	
	Optional Travel Allowance and Optional Travel	Expense					
). 00 . 00	Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column		i, rine 10)			0	

Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)

Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45,

or 46, as appropriate.
44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)

45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

41.00

43.00

0 42.00

2, 107 44. 00

0 45.00

43.00

41.00 Assistants (column 3, line 12.01 times column 3, line 10)

Subtotal (sum of lines 40 and 41)

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	PERRY COUNTY FURNI SHED BY		CCN: 151322	Peri od: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 9:3	-3 pared:
					Speech Pathology	Cost	
						1. 00	
46. 00	Optional travel allowance and optional travel						46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or	0. 00	0.00	0.0	0.00	0.00	47. 00
	equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						
48. 00	Overtime rate (see instructions)	0. 00	0.00				48. 00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0. 00	0.0	0.00		49. 00
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0. 00	0.00	0.0	0.00	0.00	50.00
51. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52. 00	Adjusted hourly salary equivalency amount (see instructions)	59. 22	0. 00				52.00
53. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55. 00
56. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0		0 0	0	56. 00
	the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT				
57. 00 58. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 22	24 or 25))			132, 515 8, 567	
59. 00	Travel allowance and expense - Offsite service)		2, 107	
60.00	Overtime allowance (from column 5, line 56)					0	
61.00	Equipment cost (see instructions) Supplies (see instructions)					9	61. 00 62. 00
	Total allowance (sum of lines 57-62)					144, 643	
	Total cost of outside supplier services (from	n your records)				140, 015	64.00
65. 00	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	3 - if negative,	enter zero)			0	65.00
100.00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		7, 225	100.00
100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27							100. 01 100. 02
LINE 34 CALCULATION 101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							1 101. 00
101.00 Line 27 = Time 7 times fine 3 for respiratory therapy or sum of lines 3 and 4 for all others 101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 101.02 Line 34 = sum of lines 27 and 31							101. 01 101. 02
LINE 35 CALCULATION							
		oum of 1! 00	and 20 f			_	1100 00
102. 00	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				mns 1-3, line		102. 00 102. 01

| Peri od: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151322

				To	12/31/2015	Date/Time Pre 5/24/2016 9:3	
			CAPI TAL REL	ATED COSTS		372472010 7.3.	Z dili
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		for Cost	FLXT	EQUI P	BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	Ŭ	1.00	2.00	1. 00	171	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	876, 762	876, 762				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	1, 682, 958		1, 682, 958			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	201, 352	5, 600		217, 701		4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL	2, 190, 674	63, 655	· ·	8, 396		5. 01
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL	3, 158, 473	53, 894		24, 347	3, 340, 164	5. 02
7.00	00700 OPERATION OF PLANT	1, 398, 758	145, 768		5, 060		7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	85, 592	4, 836 8, 160		14	99, 725	8. 00 9. 00
10.00	01000 DI ETARY	484, 098 242, 400	43, 897	15, 663 84, 261	3, 441 216	511, 362 370, 774	10.00
11. 00	01100 CAFETERI A	312, 759	43, 677	04, 201	416		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	679, 508	3, 844	7, 379	9, 706		13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	362, 646	12, 963	24, 884	3, 211	403, 704	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				·		
30.00	03000 ADULTS & PEDI ATRI CS	2, 661, 110	135, 007	259, 148	24, 209	3, 079, 474	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	299, 679	21, 376		4, 331	366, 417	31. 00
43. 00	04300 NURSERY	55, 182	4, 649	8, 924	918	69, 673	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	040.000	00.050	450.004	/ 004	4 4/0 404	
50.00	05000 OPERATING ROOM	919, 389	82, 950		6, 921	1, 168, 484	50.00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	53, 574 1, 657, 002	18, 084 49, 708	34, 712 95, 416	891 14, 721	107, 261 1, 816, 847	52. 00 54. 00
60.00	06000 LABORATORY	1, 893, 572	16, 987	32, 606	10, 488		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	116, 975	0, 707	0	174		ı
65. 00	06500 RESPIRATORY THERAPY	961, 499	27, 650	_	8, 312		65. 00
66. 00	06600 PHYSI CAL THERAPY	472, 644	22, 798		402		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	188, 745	4, 909	9, 423	0	203, 077	67. 00
68. 00	06800 SPEECH PATHOLOGY	122, 181	2, 820	5, 414	0	130, 415	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	320, 386	683	1, 310	718		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	111, 063	0	0	0	111, 063	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 368, 553	10, 964	21, 046	1, 335	2, 401, 898	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - TELL CITY	1 441 440	0	0	12 042	1 454 502	00 00
88. 00 88. 01	08801 RURAL HEALTH CLINIC - TELL CITY	1, 441, 440 281, 419	0	-	13, 062 2, 092		88. 00 88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	51, 928	0	0	351	52, 279	•
90. 00	09000 CLINIC	571, 749	32, 844	_	4, 388		•
90. 01	09001 PAIN MANAGEMENT	108, 865	2, 568		1, 404	117, 767	90. 01
91. 00	09100 EMERGENCY	1, 787, 371	44, 791	85, 977	13, 938	1, 932, 077	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	810, 737	40, 394		8, 616		
101.00	10100 HOME HEALTH AGENCY	684, 280	4, 771	9, 158	4, 933	703, 142	101. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0	0	0		113. 00 116. 00
118.00		29, 615, 323	866, 570		177, 011	29, 544, 877	
110.00	NONREI MBURSABLE COST CENTERS	27,013,323	000, 570	1, 003, 374	177,011	27, 344, 077	1110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 274	17, 801	0	27, 075	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	4, 168, 107	0		40, 407		1
	19201 MARKETI NG	274, 191	918	1, 763	283		
200.00							200. 00
201.00	Negative Cost Centers		0		0		201. 00
202.00	TOTAL (sum lines 118-201)	34, 057, 621	876, 762	1, 682, 958	217, 701	34, 057, 621	202. 00

				10) 12/31/2015	5/24/2016 9:3	
	Cost Center Description	ADMI NI STRATI VE	Subtotal	OTHER	OPERATION OF	LAUNDRY &	<u> </u>
		AND GENERAL		ADMI NI STRATI VE	PLANT	LINEN SERVICE	
				AND GENERAL			
		5. 01	5A. 01	5. 02	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 ADMINISTRATIVE AND GENERAL	2, 384, 912					5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	251, 511	3, 591, 675	3, 591, 675			5. 02
7. 00	00700 OPERATION OF PLANT	137, 751	1, 967, 139		2, 239, 505		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	7, 509	107, 234		17, 817	139, 898	8.00
9. 00	00900 HOUSEKEEPI NG	38, 505	549, 867		30, 064	10, 822	9. 00
10.00	01000 DI ETARY	27, 919	398, 693	·	161, 731	0	10.00
11. 00	01100 CAFETERI A	23, 582	336, 757		101, 701	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	52, 742	753, 179	·	14, 164	0	13. 00
16. 00	1 1	30, 399	434, 103	·	47, 762	0	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	30, 377	434, 103	00, 103	47,702	U	10.00
30. 00	03000 ADULTS & PEDIATRICS	231, 881	3, 311, 355	458, 482	497, 411	43, 635	30. 00
31. 00	03100 I NTENSI VE CARE UNIT				·	-	
		27, 591	394, 008		78, 755	1, 346	
43. 00		5, 246	74, 919	10, 373	17, 128	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	07.00/	1 05/ 470	172.0(0	205 (1)	10.040	
50.00	05000 OPERATING ROOM	87, 986	1, 256, 470		305, 616	12, 042	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	8, 077	115, 338	·	66, 627	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	136, 807	1, 953, 654	·	183, 142	16, 366	
60.00	06000 LABORATORY	147, 108	2, 100, 761		62, 584	230	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	8, 821	125, 970		0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	79, 104	1, 129, 640	·	101, 872	805	65. 00
66. 00	06600 PHYSI CAL THERAPY	40, 632	580, 237		83, 995	4, 784	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	15, 291	218, 368	30, 235	18, 087	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	9, 820	140, 235	19, 417	10, 391	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 329	347, 426	48, 104	2, 515	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8, 363	119, 426	16, 535	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	180, 861	2, 582, 759	357, 604	40, 395	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	109, 523	1, 564, 025	216, 552	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	21, 348	304, 859	42, 210	0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	3, 937	56, 216		0	0	88. 02
90. 00	09000 CLI NI C	50, 603	722, 628		121, 007	3, 324	90.00
90. 01	09001 PAIN MANAGEMENT	8, 868	126, 635		9, 463	0,000	90. 01
91. 00	09100 EMERGENCY	145, 483	2, 077, 560		165, 025	46, 544	91.00
92. 00		110, 100	2,077,000		100, 020	10, 011	92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			1			72.00
95. 00		70, 577	1, 007, 861	139, 546	148, 825	0	95. 00
	10100 HOME HEALTH AGENCY	52, 946	756, 088		17, 578	_	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	32, 740	750,000	104, 000	17, 576	U	101.00
112 0	0 11300 INTEREST EXPENSE						113. 00
	0 11600 HOSPI CE		0	0	0	0	116. 00
118.00		2, 045, 120	29, 205, 085	_	2, 201, 954	139, 898	
118.00		2,045,120	29, 205, 085	3, 546, 380	2, 201, 954	139, 898	118.00
100.00	NONREI MBURSABLE COST CENTERS	2 020	20. 114	4 021	24.1/7	0	100 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 039	29, 114		34, 167		190. 00
	0 19200 PHYSICIANS' PRIVATE OFFICES	316, 884	4, 525, 398		0		192. 00
	1 19201 MARKETI NG	20, 869	298, 024		3, 384	0	192. 01
200.00			0	1			200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	2, 384, 912	34, 057, 621	3, 591, 675	2, 239, 505	139, 898	202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151322

					o 12/31/2015	Date/lime Pre 5/24/2016 9:3	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	Z alli
	oost contor becomparen	NOODENEEL THO	5.2.7	07.11 2 1 2 1 1 1 1 1	ADMI NI STRATI ON	RECORDS &	
						LI BRARY	
		9. 00	10.00	11. 00	13.00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL						5. 01
5. 02 7. 00	00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT						5. 02 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING	666, 886					9.00
10. 00	01000 DI ETARY	49, 213	664, 839				10.00
11. 00	01100 CAFETERI A	47, 213	004, 037	383, 384			11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 310	ő	24, 341	1		13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	14, 533	o	15, 406		571, 909	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,	-1		-	<u> </u>	
30.00	03000 ADULTS & PEDI ATRI CS	151, 356	629, 270	98, 781	436, 127	72, 674	30. 00
31.00	03100 INTENSIVE CARE UNIT	23, 964	35, 569	13, 434	59, 311	0	31. 00
43.00	04300 NURSERY	5, 212	0	3, 389	14, 964	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	92, 995	0	20, 582		0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	20, 274	0	3, 266		0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	55, 728	0	48, 404		192, 743	54.00
60.00	06000 LABORATORY	19, 044	0	43, 752	l l	157, 986	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	616	1	0	62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	30, 998 25, 559	0	28, 654 2, 927	l l	37, 917	65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	5, 504	0	2, 927 C		22, 118 0	67.00
68. 00	06800 SPEECH PATHOLOGY	3, 162	0	0	1	9, 479	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	765	0	2, 557	-1	0, 477	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	, , , ,	Ö	2,007	1	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	12, 292	o	6, 933	-1	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		-,	5,100	-,		
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	0	0	C	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0	0	C	0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	0	0	C	0	0	88. 02
90.00	09000 CLI NI C	36, 821	0	17, 686		28, 437	90. 00
90. 01	09001 PAI N MANAGEMENT	2, 879	0	5, 885		0	90. 01
91. 00	09100 EMERGENCY	50, 215	0	46, 771	206, 501	50, 555	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	4E 204	ol		ا	0	05 00
	10100 HOME HEALTH AGENCY	45, 286 5, 349	0	0			95. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	5, 347	<u>U</u>		ıl Ol		1101.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 H0SPI CE	ol	o	C	o	0	116.00
118.00	I I	655, 459	664, 839	383, 384	900, 278	571, 909	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 397	0	C	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0		192. 00
	19201 MARKETI NG	1, 030	0	C	0	0	192. 01
200.00	1 1						200. 00
201.00	1 1 9	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	666, 886	664, 839	383, 384	900, 278	571, 909	202.00

PERRY COUNTY HOSPITAL

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					o 12/31/2015	Date/Time Prepared: 5/24/2016 9:32 am
	Cost Center Description	Subtotal	Intern &	Total		37 247 2010 7. 32 am
		F	Residents Cost			
			& Post Stepdown			
			Adjustments			
		24. 00	25.00	26. 00		
	GENERAL SERVICE COST CENTERS				T	
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01	00540 ADMINISTRATIVE AND GENERAL					5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL					5. 02
7.00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00 10. 00
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON					13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	5, 699, 091	0	5, 699, 091		30.00
31.00	03100 I NTENSI VE CARE UNI T	660, 941	0	660, 941		31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	125, 985	U _I	125, 985		43. 00
50.00	05000 OPERATING ROOM	1, 952, 544	0	1, 952, 544		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	235, 894	0	235, 894		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 720, 536	0	2, 720, 536		54. 00
60.00	06000 LABORATORY	2, 675, 224	0	2, 675, 224		60.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	144, 028 1, 486, 294	0	144, 028 1, 486, 294		62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	799, 958	0	799, 958		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	272, 194	ő	272, 194		67. 00
68. 00	06800 SPEECH PATHOLOGY	182, 684	0	182, 684		68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	401, 367	0	401, 367		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	135, 961	0	135, 961		72.00
73. 00	O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	2, 999, 983	0	2, 999, 983		73. 00
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	1, 780, 577	0	1, 780, 577		88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	347, 069	Ö	347, 069		88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	64, 000	0	64, 000		88. 02
90.00	09000 CLI NI C	1, 108, 041	0	1, 108, 041		90. 00
90. 01	09001 PAIN MANAGEMENT	162, 396	0	162, 396		90. 01
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 930, 826	0	2, 930, 826		91.00
92.00	OTHER REIMBURSABLE COST CENTERS		O ₁			92.00
95.00	09500 AMBULANCE SERVICES	1, 341, 518	0	1, 341, 518		95. 00
101.00	10100 HOME HEALTH AGENCY	883, 701	0	883, 701		101. 00
	SPECIAL PURPOSE COST CENTERS	1			T	
	11300 INTEREST EXPENSE 11600 HOSPICE			C		113.00
118.00	1	29, 110, 812	0	29, 110, 812		116. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	27, 110, 012	<u> </u>	27, 110, 012		110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	77, 709	0	77, 709		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4, 525, 398	0	4, 525, 398		192. 00
	19201 MARKETI NG	343, 702	0	343, 702		192. 01
200. 00 201. 00	1 1	0	0	0		200. 00 201. 00
201.00		34, 057, 621	0	34, 057, 621		202. 00
202.00	1.5.7.2 (56 17.1.55 176 201)	0.,007,021	9	5., 557, 521	I.	1202.00

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151322

				10	12/31/2015	Date/lime Pre 5/24/2016 9:3	
			CAPLTAL REI	LATED COSTS		3/24/2010 9.3	Z alli
			OALLIAE REI	LATED COSTS			
	Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	•	Assigned New	FLXT	EQUI P		BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 600		16, 349	16, 349	1
5. 01	00540 ADMINISTRATIVE AND GENERAL	0	63, 655		185, 842	631	5. 01
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL	0	53, 894		157, 344	1, 829	1
7. 00 8. 00	00700 OPERATION OF PLANT	0	145, 768		425, 570	380	1
9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	4, 836		14, 119	1	8. 00 9. 00
10.00	01000 DI ETARY	0	8, 160 43, 897		23, 823 128, 158	258 16	1
11. 00	01100 CAFETERI A	0	43, 697		120, 130	31	11.00
13. 00	01300 NURSING ADMINISTRATION	0	3, 844	1	11, 223	729	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	12, 963		37, 847	241	16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		12, 703	24,004	37, 047	241	10.00
30. 00	03000 ADULTS & PEDIATRICS	0	135, 007	259, 148	394, 155	1, 818	30.00
31. 00	03100 NTENSI VE CARE UNI T	0	21, 376		62, 407	325	1
43. 00	04300 NURSERY	0			13, 573	69	1
	ANCILLARY SERVICE COST CENTERS		.,	-,,	,		1
50.00	05000 OPERATING ROOM	0	82, 950	159, 224	242, 174	520	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	18, 084		52, 796	67	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	49, 708	95, 416	145, 124	1, 106	54.00
60.00	06000 LABORATORY	0	16, 987	32, 606	49, 593	788	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	13	62.00
65.00	06500 RESPIRATORY THERAPY	0	27, 650	53, 075	80, 725	624	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	22, 798		66, 559	30	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	4, 909		14, 332	0	
68. 00	06800 SPEECH PATHOLOGY	0	2, 820		8, 234	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	683		1, 993	54	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	_	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	10, 964	21, 046	32, 010	100	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS		^		ما	004	00.00
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	0	-		0	981	1
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0	0		0	157	1
88. 02 90. 00	08803 RURAL HEALTH CLINIC - TROY 09000 CLINIC	0	22 044	0 63, 044	95, 888	26 330	1
90.00	09001 PALN MANAGEMENT	0	32, 844 2, 568		7, 498	105	1
91. 00	09100 EMERGENCY	0	44, 791		130, 768	1, 047	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		44, 771	03, 777	130, 700	1,047	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95 00	09500 AMBULANCE SERVICES	0	40, 394	77, 537	117, 931	647	95. 00
	10100 HOME HEALTH AGENCY	0			13, 929		101. 00
	SPECIAL PURPOSE COST CENTERS		.,	.,		4	1
113.00	11300 NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0	0	О	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	866, 570	1, 663, 394	2, 529, 964	13, 294	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 274	17, 801	27, 075		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	-	0		192. 00
	19201 MARKETI NG	0	918	1, 763	2, 681	21	192. 01
200.00					0		200. 00
201.00			0		0		201. 00
202.00	TOTAL (sum lines 118-201)	0	876, 762	1, 682, 958	2, 559, 720	16, 349	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				Т	o 12/31/2015	Date/Time Pre 5/24/2016 9:3	
	Cost Center Description	ADMI NI STRATI VE	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	z alli
	cost center beserretron		ADMI NI STRATI VE		LINEN SERVICE	11003EREEL TWO	
			AND GENERAL				
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	,					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL	186, 473					5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	19, 664					5. 02
7.00	00700 OPERATION OF PLANT	10, 770					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	587	l .		19, 028		8. 00
9.00	00900 HOUSEKEEPI NG	3, 010			1, 472	38, 399	9. 00
10. 00	01000 DI ETARY	2, 183			0	2, 834	10. 00
11. 00	01100 CAFETERI A	1, 844		•	0	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 123			0	248	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 377	2, 993	9, 603	0	837	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		,				
30. 00	03000 ADULTS & PEDIATRICS	18, 129			5, 935	8, 713	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	2, 157			183	1, 380	31. 00
43.00	04300 NURSERY	410	516	3, 444	0	300	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	6, 879			1, 638	5, 355	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	631	l .		0	1, 167	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 696			2, 226	3, 209	54.00
60.00	06000 LABORATORY	11, 501			31	1, 097	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	690			0	0	62.00
65. 00	06500 RESPI RATORY THERAPY	6, 185			110	1, 785	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 177			651	1, 472	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 196			0	317	67. 00
68. 00	06800 SPEECH PATHOLOGY	768	l .		0	182	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 902	,		0	44	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	654			0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	14, 140	17, 806	8, 122	0	708	73. 00
	OUTPATIENT SERVICE COST CENTERS			1			
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	8, 563			_	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	1, 669			0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	308			0	0	88. 02
90. 00	09000 CLI NI C	3, 956			452	2, 120	90.00
90. 01	09001 PAIN MANAGEMENT	693			0	166	90. 01
91.00	09100 EMERGENCY	11, 374	14, 323	33, 180	6, 330	2, 891	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	F 540		00.000		0.400	05.00
	09500 AMBULANCE SERVI CES	5, 518		1	0	2, 608	95. 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	4, 139	5, 212	3, 534	0	308	101. 00
112 00	11300 I NTEREST EXPENSE	T	I	I			113. 00
	11600 HOSPI CE		0	0	0	0	116. 00
118.00		159, 893		442, 731	19, 028	37, 741	
110.00	NONREI MBURSABLE COST CENTERS	157, 673	170, 301	442,731	17, 020	37,741	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	159	201	6, 870	ol	500	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	24, 789	l .		Ö		192. 00
	19201 MARKETI NG	1, 632	l .		ام		192. 01
200.00		1,032	2,000			37	200.00
201.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		0	0	n	Ω	201. 00
202.00		186, 473	178, 837	450, 281	19, 028	38, 399	
	1 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		1	1 .55, 201	, 520	33, 377	,

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				10	12/31/2015	5/24/2016 9:3	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	
	, , , , , , , , , , , , , , , , , , ,			ADMI NI STRATI ON	RECORDS &		
					LI BRARY		
		10.00	11. 00	13.00	16. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL						5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	1					5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	168, 458					10.00
11. 00	01100 CAFETERI A	0	4, 197				11. 00
13. 00	01300 NURSING ADMINISTRATION	0	266				13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY		169		54, 067		16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	107	<u> </u>	34,007		10.00
30. 00	03000 ADULTS & PEDIATRICS	159, 446	1, 081	11, 932	6, 870	730, 922	30.00
31. 00	03100 INTENSIVE CARE UNIT	9, 012	1, 001	1	0, 070	95, 785	31.00
43. 00	04300 NURSERY	9,012	37		0	18, 758	
43.00	ANCI LLARY SERVI CE COST CENTERS	U	37	407		10, 750	43.00
50. 00	05000 OPERATING ROOM	l ol	225	2, 486	ol	329, 387	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		36		ol	69, 282	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		530	1		231, 404	54.00
		0		- 1	18, 222		
60.00	06000 LABORATORY	0	479 7	- 1	14, 936	105, 491	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	,	0	0	1, 578	
65. 00	06500 RESPIRATORY THERAPY	0	314	1	3, 585	121, 599	
66. 00	06600 PHYSI CAL THERAPY	0	32		2, 091	94, 900	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	20, 987	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		896	13, 136	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28		0	6, 922	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	1, 477	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	76	0	0	72, 962	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	0	0		0	20, 326	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0	0		0	3, 928	
88. 02	08803 RURAL HEALTH CLINIC - TROY	0	0	0	0	722	88. 02
90.00	09000 CLI NI C	0	194	2, 136	2, 688	137, 076	90. 00
90. 01	09001 PAIN MANAGEMENT	0	64	0	0	11, 302	90. 01
91.00	09100 EMERGENCY	0	512	5, 649	4, 779	210, 853	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	163, 575	95. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	27, 493	101. 00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	0	0	0	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	168, 458	4, 197	24, 629	54, 067	2, 489, 865	118. 00
	NONREI MBURSABLE COST CENTERS	,		· ·			1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	34, 904	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	o	0	- 1	o	·	192. 00
	19201 MARKETI NG		0	1	o		192. 01
200.00		1	· ·		Ĭ	·	200. 00
201.00	,	n	n	0	n		201. 00
202.00		168, 458	4, 197	24, 629	54, 067	2, 559, 720	
	1 1 1 1 2 1 1 2 2 1 1		., ., .	2.,527	0.,007	_, 557, 720	,

Heal th Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151322 Period: Worksheet B

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151322 From 01/01/2015 Part II 12/31/2015 Date/Time Prepared: 5/24/2016 9:32 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMINISTRATIVE AND GENERAL 5. 01 5.01 00590 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 730, 922 30.00 03100 INTENSIVE CARE UNIT 0 31.00 95, 785 31.00 04300 NURSERY 0 18, 758 43.00 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 329, 387 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000 69, 282 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 231, 404 06000 LABORATORY 60.00 105, 491 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 578 62.00 06500 RESPIRATORY THERAPY 65.00 121, 599 65.00 06600 PHYSI CAL THERAPY 94, 900 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 20, 987 67.00 06800 SPEECH PATHOLOGY 68.00 13, 136 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 6, 922 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 1, 477 73.00 07300 DRUGS CHARGED TO PATIENTS 0 72, 962 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - TELL CITY 08801 RURAL HEALTH CLINIC - PERRY CO FP 88.00 000000 20, 326 88. 00 88. 01 3, 928 88 01 08803 RURAL HEALTH CLINIC - TROY 722 88.02 88.02 09000 CLI NI C 137, 076 90.00 90.00 09001 PALN MANAGEMENT 90.01 11, 302 90.01 09100 EMERGENCY 91.00 210, 853 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 0 163, 575 27, 493 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 0 116. 00 11600 HOSPI CE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 2, 489, 865 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 0 0 0 0 34, 904 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 27,823 192. 00 192. 01 19201 MARKETI NG 192. 01 7, 128 200.00 Cross Foot Adjustments 200. 00 0 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118-201) 2, 559, 720 202.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 151322	Peri od: Worksheet B-1	_	
		From 01/01/2015		
		T- 10/01/0015 D-+-/T: D		

COSTA	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Pre	
	_	CAPITAL RELA	TED COSTS	'	12/31/2013	5/24/2016 9: 3	
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		1.00	2. 00	4.00	5A. 01	5. 01	
	GENERAL SERVICE COST CENTERS	107.075			I I		
1. 00 2. 00 4. 00 5. 01 5. 02 7. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMINISTRATIVE AND GENERAL 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	107, 875 689 7, 832 6, 631 17, 935	107, 875 689 7, 832 6, 631 17, 935	501, 264 1, 453, 559	-2, 384, 912 0	31, 672, 709 3, 340, 164 1, 829, 388	5. 02
8. 00 9. 00 10. 00 11. 00 13. 00 16. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMINI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY	595 1,004 5,401 0 473 1,595	595 1, 004 5, 401 0 473 1, 595	847 205, 429 12, 919 24, 861 579, 492	0 0 0 0	99, 725 511, 362 370, 774 313, 175 700, 437 403, 704	8. 00 9. 00 10. 00 11. 00 13. 00
30. 00 31. 00 43. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	16, 611 2, 630 572	16, 611 2, 630 572		0	3, 079, 474 366, 417 69, 673	31. 00
50. 00 52. 00 54. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	10, 206 2, 225 6, 116	10, 206 2, 225 6, 116		0	1, 168, 484 107, 261 1, 816, 847	1
60. 00 62. 00 65. 00 66. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 090 0 3, 402 2, 805	2, 090 0 3, 402 2, 805	626, 177 10, 387 496, 250	0 0 0	1, 953, 653 117, 149 1, 050, 536 539, 605	60. 00 62. 00 65. 00
67. 00 68. 00 71. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	604 347 84	604 347 84	23, 777 0 0 42, 862	0 0 0	203, 077 130, 415 323, 097	67. 00 68. 00 71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0 1, 349	0 1, 349	79, 689	0	111, 063 2, 401, 898	1
88. 00 88. 01	08800 RURAL HEALTH CLINIC - TELL CITY 08801 RURAL HEALTH CLINIC - PERRY CO FP	0	0	779, 835 124, 912		1, 454, 502	1
88. 02 90. 00	08803 RURAL HEALTH CLINIC - TROY 09000 CLINIC	0 4, 041	0 4, 041	20, 940 261, 964	0	283, 511 52, 279 672, 025	88. 02 90. 00
90. 01 91. 00 92. 00	09001 PAIN MANAGEMENT 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	316 5, 511	316 5, 511	83, 814 832, 124		117, 767 1, 932, 077	90. 01 91. 00 92. 00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	4, 970 587	4, 970 587			937, 284 703, 142	
	11300 INTEREST EXPENSE 11600 HOSPI CE	0 106, 621	0 106, 621	0 10, 567, 904	0 -2, 384, 912	0 27, 159, 965	113. 00 116. 00 118. 00
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MARKETING	1, 141 0 113	1, 141 0 113	2, 412, 320		27, 075 4, 208, 514 277, 155	•
201. 00 202. 00	Negative Cost Centers	876, 762	1, 682, 958	217, 701		2, 384, 912	201. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I)	8. 127574	15. 601001	0. 016750 16, 349		0. 075299 186, 473	1
205.00	1 1 1			0. 001258		0. 005887	205. 00

	iciai Systems	PERRY COUNT	Y HUSPITAL		In Lie	u or form CMS-	
COST ALLOCA	TION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2015 Fo 12/31/2015		pared:
	Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL	(SQUARE	LAUNDRY & LINEN SERVICE (POUNDS OF	5/24/2016 9: 3 HOUSEKEEPI NG (SQUARE FEET)	32 am
			(ACCUM. COST	FEET)	LAUNDRY)		
		5A. 02	NO PBP) 5. 02	7. 00	8. 00	9. 00	
GENER	AL SERVICE COST CENTERS	JA. 02	3.02	7.00	0.00	7. 00	
	NEW CAP REL COSTS-BLDG & FIXT						1.00
	NEW CAP REL COSTS-MVBLE EQUIP						2.00
	EMPLOYEE BENEFITS DEPARTMENT						4. 00
	ADMINISTRATIVE AND GENERAL						5. 01
	OTHER ADMINISTRATIVE AND GENERAL	-3, 591, 675		1			5. 02
-	OPERATION OF PLANT	0	.,,	1			7. 00
	LAUNDRY & LINEN SERVICE	0		1		72 100	8. 00
	HOUSEKEEPI NG DI ETARY		549, 867 398, 693	1		73, 189 5, 401	
	CAFETERIA		336, 757	1		3, 401	1
	NURSING ADMINISTRATION	0				473	1
	MEDICAL RECORDS & LIBRARY	0		1		1, 595	1
	TENT ROUTINE SERVICE COST CENTERS		1017100	,	<u> </u>	., 0,0	10.00
	ADULTS & PEDIATRICS	0	3, 311, 355	16, 61	1 3, 794	16, 611	30.00
31.00 03100	INTENSIVE CARE UNIT	0	394, 008	2, 630	117	2, 630	31.00
43.00 04300	NURSERY	0	74, 919	572	2 0	572	43.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0		1		10, 206	
	DELIVERY ROOM & LABOR ROOM	0		1		2, 225	1
	RADI OLOGY-DI AGNOSTI C	0	,			6, 116	1
	LABORATORY	0		1		2, 090	1
	WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY	0		1	-	0	
•	PHYSICAL THERAPY	0		1		3, 402 2, 805	1
	OCCUPATIONAL THERAPY		218, 368	1		2, 803	1
	SPEECH PATHOLOGY		140, 235	1		347	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	347, 426	1		84	
	IMPL. DEV. CHARGED TO PATIENT	Ö		1		0	
	DRUGS CHARGED TO PATIENTS	0		1	9 0	1, 349	
	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC - TELL CITY	0	1, 564, 025	5	0	0	
	RURAL HEALTH CLINIC - PERRY CO FP	0			0	0	
	RURAL HEALTH CLINIC - TROY	0	56, 216		0	0	
	CLINIC	0	722, 628	1		4, 041	
	PAIN MANAGEMENT	0				316	1
	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 077, 560	5, 51	4, 047	5, 511	91. 00 92. 00
	REIMBURSABLE COST CENTERS						92.00
	AMBULANCE SERVICES	0	1, 007, 861	4, 970	0	4, 970	95. 00
	HOME HEALTH AGENCY	0					101.00
	AL PURPOSE COST CENTERS	_					1
	INTEREST EXPENSE						113. 00
116. 00 11600	HOSPI CE	0	(0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	-3, 591, 675	25, 613, 410	73, 534	12, 164	71, 935	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29, 114	1, 14			190. 00
	PHYSICIANS' PRIVATE OFFICES	-4, 525, 398) (0		192. 00
192. 01 19201		0	298, 024	113	0	113	192. 01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		2 501 475	2 220 50	120 000	444 004	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)		3, 591, 675	2, 239, 505	139, 898	666, 886	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)		0. 138458	29. 944710	11. 500987	9. 111834	203 00
204. 00	Cost to be allocated (per Wkst. B,		178, 837				204. 00
	Part II)		, 507	1 .55, 26	. , , 520	00,077	
205. 00	Unit cost multiplier (Wkst. B, Part		0. 006894	6. 020765	1. 564288	0. 524655	205.00
	[11]						

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2552-1
COST ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1
			F1 T0	rom 01/01/2015 0 12/31/2015	Date/Time Prepared:
				72/31/2013	5/24/2016 9:32 am
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	
	(MEALS	(FTE'S)	ADMI NI STRATI ON	RECORDS &	
	SERVED)		(5) 5507	LIBRARY	
			(DI RECT	(TIME	
	10.00	11 00	NRSI NG HRS)	SPENT)	
GENERAL SERVICE COST CENTERS	10.00	11. 00	13. 00	16. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01 00540 ADMINISTRATIVE AND GENERAL					5. 0
5. 02 00590 OTHER ADMINISTRATIVE AND GENERAL					5. 02
7.00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY	12, 430				10.00
11. 00 01100 CAFETERI A	O	12, 443	В		11.00
13.00 01300 NURSING ADMINISTRATION	0	790	6, 618		13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	500	0	181	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	11, 765	3, 206		23	30.00
31.00 03100 INTENSIVE CARE UNIT	665	436		0	
43. 00 04300 NURSERY	0	110	110	0	43.00
ANCILLARY SERVICE COST CENTERS				_1	
50. 00 05000 OPERATI NG ROOM	0	668		0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	106		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 571	1	61	54. 00
60. 00 06000 LABORATORY	0	1, 420		50	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	20		0	62.00
65. 00 06500 RESPIRATORY THERAPY	0	930	1	12	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	95 0		0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY		0		2	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		83		0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		00		o	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		225		Ö	73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		,1	<u> </u>	751 50
88. 00 08800 RURAL HEALTH CLINIC - TELL CITY	0	C	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC - PERRY CO FP	0	0	o	0	88. 01
88.02 08803 RURAL HEALTH CLINIC - TROY	O	0	o	0	88. 02
90. 00 09000 CLI NI C	0	574	574	9	90.00
90. 01 09001 PAI N MANAGEMENT	0	191	0	0	90. 01
91. 00 09100 EMERGENCY	0	1, 518	1, 518	16	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0	0	1	0	
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS					110.00
113. 00 11300 NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE	12 420	12 442	0 (10	0	116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	12, 430	12, 443	6, 618	181	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol		ol ol	0	190. 00
190.00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN		0		0	
192. 01 19201 MARKETI NG		0		0	192. 00
200.00 Cross Foot Adjustments	٥	0	ή	O I	200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	664, 839	383, 384	900, 278	571, 909	202. 00
Part I)	304, 037	303, 304	,00,270	371, 707	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	53. 486645	30. 811219	136. 034754	3, 159. 718232	203. 00
204.00 Cost to be allocated (per Wkst. B,	168, 458	4, 197		54, 067	204. 00
Part II)	,	.,		2 ., 207	00
205.00 Unit cost multiplier (Wkst. B, Part	13. 552534	0. 337298	3. 721517	298. 712707	205. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151322		Worksheet C
		From 01/01/2015	

					To 12/31/2015	Date/Time Pre 5/24/2016 9:3	pared: 2 am
			Ti tl	e XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 699, 091		5, 699, 09	0 0	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	660, 941		660, 94		0	31.00
43.00	04300 NURSERY	125, 985		125, 98	35 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 952, 544		1, 952, 54	4 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	235, 894		235, 89	04	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 720, 536		2, 720, 53	66 0	0	54.00
60.00	06000 LABORATORY	2, 675, 224		2, 675, 22	24 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	144, 028		144, 02	.8	0	62. 00
65.00	06500 RESPIRATORY THERAPY	1, 486, 294	0	1, 486, 29	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	799, 958	0	799, 95	68	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	272, 194	l e	272, 19		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	182, 684	l e	182, 68		0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	401, 367		401, 36		0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	135, 961		135, 96		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 999, 983		2, 999, 98	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		•				ĺ
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	1, 780, 577		1, 780, 57	7 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	347, 069		347, 06	9 0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	64,000		64, 00	0	0	88. 02
90.00	09000 CLI NI C	1, 108, 041		1, 108, 04		0	90.00
90. 01	09001 PAIN MANAGEMENT	162, 396		162, 39		0	90. 01
91.00	09100 EMERGENCY	2, 930, 826		2, 930, 82		0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	683, 067		683, 06		0	92.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	<u> </u>			
95.00	09500 AMBULANCE SERVI CES	1, 341, 518		1, 341, 51	8 0	0	95. 00
101.00	10100 HOME HEALTH AGENCY	883, 701		883, 70)1	0	101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>			
113.00	11300 NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0			0		116. 00
200.00		29, 793, 879	0	29, 793, 87	9 0		200. 00
201.00		683, 067		683, 06			201. 00
202.00	1	29, 110, 812	l e				202. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		,		١		

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151322	Period: Worksheet C From 01/01/2015 Part I
		11 011 01/01/2015 Fall L 1

					o 12/31/2015	Date/Time Pre 5/24/2016 9:3	
			Ti tl	e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
						Ratio	
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	2, 671, 517		2, 671, 517			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	429, 125		429, 125			31. 00
43.00	04300 NURSERY	136, 398		136, 398			43. 00
	ANCILLARY SERVICE COST CENTERS				1		
50. 00	05000 OPERATING ROOM	614, 453	5, 101, 077			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	438, 735	324, 674			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 368, 237	15, 218, 016			0. 000000	
60.00	06000 LABORATORY	1, 362, 040	8, 299, 264		I	0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	106, 699	164, 806		I	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	1, 233, 658	2, 035, 136			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	461, 392	1, 734, 489		I	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	351, 914	633, 650		I	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	68, 941	429, 994		I	0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 537, 694	2, 371, 572			0. 000000	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	118, 707			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 999, 086	8, 596, 295	12, 595, 381	0. 238181	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	0	889, 661				88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0	177, 819				88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	0	27, 582				88. 02
90.00	09000 CLI NI C	5, 350	546, 911			0. 000000	1
90. 01	09001 PAIN MANAGEMENT	0	226, 435			0. 000000	
91. 00	09100 EMERGENCY	219, 099	6, 391, 223			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	40, 468	436, 538	477, 006	1. 431988	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	2, 614, 276			0. 000000	1
101.00	10100 HOME HEALTH AGENCY	0	1, 726, 519	1, 726, 519			101. 00
	SPECIAL PURPOSE COST CENTERS				1		
	11300 I NTEREST EXPENSE	_	_	_			113. 00
	11600 H0SPI CE	0	0	0			116. 00
200.00		15, 044, 806	58, 064, 644	73, 109, 450			200. 00
201.00	1 1	45.044.55	50 0/4 · · ·	70 400 :			201. 00
202.00	Total (see instructions)	15, 044, 806	58, 064, 644	73, 109, 450	ı I		202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151322	From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/24/2016 9:32 am	

INPATIENT ROUTINE SERVICE COST CENTERS				10 12/31/2013	5/24/2016 9: 32 am
INPATI ENT ROUTI NE SERVI CE COST CENTERS 11.00			Title XVIII	Hospi tal	
INPATLENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTERSI VE COST CENTERS 31.00 31.00 03100 INTERSI VE COST CENTERS 31.00	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.					
30.00		11. 00			
31.00 03100 INTENSIVE CARE UNIT					
43.00					
ANCILLARY SERVICE COST CENTERS					
50.00					43. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00					
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 65. 00 06000 LABORATORY 0. 0000000 65. 00 06500 RESPIRATORY THERAPY 0. 000000 65. 00 06500 RESPIRATORY THERAPY 0. 000000 66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 68. 00 06800 SPEECH PATHOLOGY 0. 000000 071. 00 071. 00 071. 00 071. 00 071. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 71. 00 000000 000000000000000000000000000					
60. 00 06000 LABORATORY 0. 000000 60. 00					
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 065. 00 06500 RESPI RATORY THERAPY 0.000000 066. 00 06500 RESPI RATORY THERAPY 0.000000 066. 00 06600 PHYSI CAL THERAPY 0.000000 06700 06600 PHYSI CAL THERAPY 0.000000 06700 06200 06700 0CCUPATI ONAL THERAPY 0.000000 071.00 06800 SPEECH PATHOLOGY 0.000000 071.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 072.00 07200 MPL. DEV. CHARGED TO PATIENTS 0.000000 072.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 072.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 000000 000000 00000000	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
65. 00	60. 00 06000 LABORATORY	0. 000000			60.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 68. 00 68. 00 68. 00 68. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
67. 00	65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
71. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
SECOND SUBSTITUTE SERVICE COST CENTERS SERVICE SERVICE COST CENTERS SERVICE SERV	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
88. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
88. 01	OUTPATIENT SERVICE COST CENTERS				
88. 02	88.00 08800 RURAL HEALTH CLINIC - TELL CITY				88. 00
90. 00	88.01 08801 RURAL HEALTH CLINIC - PERRY CO FP				88. 01
90. 01 09001 PALN MANAGEMENT 0. 000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000 92. 00 07HER REI MBURSABLE COST CENTERS 0. 000000 95. 00 095.	88.02 08803 RURAL HEALTH CLINIC - TROY				88. 02
91. 00		0. 000000			90.00
92. 00	90. 01 09001 PAI N MANAGEMENT	0. 000000			90. 01
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPICE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	91. 00 09100 EMERGENCY	0. 000000			91.00
95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
101.00	OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS 113.00 1 NTEREST EXPENSE 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
113. 00	101.00 10100 HOME HEALTH AGENCY				101. 00
116. 00 11600 200. 00 Subtotal (see instructions) 201. 00 Less Observation Beds					
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
201.00 Less Observation Beds 201.00					
202.00 Total (see instructions) 202.00					
	202.00 Total (see instructions)				202.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151322	Peri od: Worksheet C		
		From 01/01/2015 Part I		
		To 12/21/2015 Data/Tima Draparad.		

				To 12/31/2015	Date/Time Pre 5/24/2016 9:3	pared: 2 am	
			Ti t	le XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	ATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	5, 699, 091		5, 699, 09	1 0	5, 699, 091	30. 00
31. 00 031	00 INTENSIVE CARE UNIT	660, 941		660, 94	1 0	660, 941	31. 00
43.00 043	OO NURSERY	125, 985		125, 98	5 0	125, 985	43.00
	ILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	1, 952, 544		1, 952, 54	4 0	1, 952, 544	50. 00
52. 00 052	OO DELIVERY ROOM & LABOR ROOM	235, 894		235, 89	4 0	235, 894	52.00
54. 00 054	OO RADI OLOGY-DI AGNOSTI C	2, 720, 536		2, 720, 53	6 0	2, 720, 536	54.00
60.00 060	000 LABORATORY	2, 675, 224		2, 675, 22	4 0	2, 675, 224	60. 00
62. 00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	144, 028		144, 02	8 0	144, 028	62. 00
65. 00 065	000 RESPI RATORY THERAPY	1, 486, 294	0	1, 486, 29	4 0	1, 486, 294	65. 00
66.00 066	000 PHYSI CAL THERAPY	799, 958	0	799, 95	8 0	799, 958	66. 00
67. 00 067	OO OCCUPATIONAL THERAPY	272, 194	0	272, 19	4 0	272, 194	67. 00
68. 00 068	SOO SPEECH PATHOLOGY	182, 684	0	182, 68	4 0	182, 684	68. 00
71. 00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	401, 367		401, 36	7 0	401, 367	71. 00
72. 00 072	00 IMPL. DEV. CHARGED TO PATIENT	135, 961		135, 96	1 0	135, 961	72. 00
73. 00 073	OO DRUGS CHARGED TO PATIENTS	2, 999, 983		2, 999, 98	3 0	2, 999, 983	73. 00
OUT	PATIENT SERVICE COST CENTERS						1
88. 00 088	OO RURAL HEALTH CLINIC - TELL CITY	1, 780, 577		1, 780, 57	7 0	1, 780, 577	88. 00
88. 01 088	01 RURAL HEALTH CLINIC - PERRY CO FP	347, 069		347, 06	9 0	347, 069	88. 01
88. 02 088	303 RURAL HEALTH CLINIC - TROY	64,000		64, 00	0 0	64, 000	88. 02
90.00 090	000 CLINIC	1, 108, 041		1, 108, 04	1 0	1, 108, 041	90. 00
90. 01 090	001 PALN MANAGEMENT	162, 396		162, 39	6 0	162, 396	90. 01
91. 00 091	00 EMERGENCY	2, 930, 826		2, 930, 82	6 0	2, 930, 826	91. 00
92. 00 092	OO OBSERVATION BEDS (NON-DISTINCT PART)	683, 067		683, 06	7	683, 067	92. 00
OTH	ER REIMBURSABLE COST CENTERS				<u>.</u>		1
95. 00 095	OO AMBULANCE SERVICES	1, 341, 518		1, 341, 51	8 0	1, 341, 518	95. 00
101.00 101	OO HOME HEALTH AGENCY	883, 701		883, 70	1	883, 701	101. 00
SPE	CIAL PURPOSE COST CENTERS				<u>.</u>		1
113. 00 113	000 I NTEREST EXPENSE						113. 00
116. 00 116	HOSPI CE	0			0	0	116. 00
200.00	Subtotal (see instructions)	29, 793, 879	0	29, 793, 87	9 0	29, 793, 879	200. 00
201.00	Less Observation Beds	683, 067		683, 06	7	683, 067	201. 00
202. 00	Total (see instructions)	29, 110, 812	0	29, 110, 81	2 0	29, 110, 812	202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151322		Worksheet C
		From 01/01/2015	

						To 12/31/2015	Date/Time Pre 5/24/2016 9:3	pared: 2 am
				Ti t	le XIX	Hospi tal	PPS	
			Cl	narges				
	Cost Center Description	I npati ent	Out	pati ent	Total (col. 6	Cost or Other	TEFRA	
					+ col. 7)	Ratio	Inpati ent	
							Ratio	
		6. 00		7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00	03000 ADULTS & PEDIATRICS	2, 671, 517			2, 671, 51		1	30.00
31. 00	03100 I NTENSI VE CARE UNI T	429, 125			429, 12		1	31. 00
43.00	04300 NURSERY	136, 398			136, 39	8		43. 00
	ANCI LLARY SERVI CE COST CENTERS							1
50.00	05000 OPERATING ROOM	614, 453		5, 101, 077			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	438, 735		324, 674			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 368, 237		5, 218, 016			0. 000000	1
60.00	06000 LABORATORY	1, 362, 040		8, 299, 264			0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	106, 699		164, 806			0. 000000	
65.00	06500 RESPI RATORY THERAPY	1, 233, 658		2, 035, 136	3, 268, 79	0. 454692	0. 000000	
66.00	06600 PHYSI CAL THERAPY	461, 392		1, 734, 489			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	351, 914		633, 650	985, 56	4 0. 276181	0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	68, 941		429, 994	498, 93	5 0. 366148	0.000000	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 537, 694		2, 371, 572	3, 909, 26	6 0. 102671	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0		118, 707	118, 70		0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 999, 086		8, 596, 295	12, 595, 38	0. 238181	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	0		889, 661	889, 66	1 2. 001411	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0		177, 819	177, 81	9 1. 951811	0.000000	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	0		27, 582	27, 58	2. 320354	0.000000	88. 02
90.00	09000 CLI NI C	5, 350		546, 911	552, 26	1 2. 006372	0.000000	90.00
90. 01	09001 PAIN MANAGEMENT	0		226, 435	226, 43	5 0. 717186	0.000000	90. 01
91.00	09100 EMERGENCY	219, 099		6, 391, 223	6, 610, 32	0. 443371	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	40, 468		436, 538	477, 00	6 1. 431988	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS					<u> </u>		1
95.00	09500 AMBULANCE SERVICES	0		2, 614, 276	2, 614, 27	6 0. 513151	0.000000	95. 00
101.00	10100 HOME HEALTH AGENCY	o		1, 726, 519	1, 726, 51	9	1	101.00
	SPECIAL PURPOSE COST CENTERS							1
113.00	11300 I NTEREST EXPENSE							113. 00
	11600 HOSPI CE	0		0		0	ı	116. 00
200.00	Subtotal (see instructions)	15, 044, 806	5	8, 064, 644	73, 109, 45	o	i	200. 00
201.00	Less Observation Beds			-			ı	201.00
202.00	Total (see instructions)	15, 044, 806	5	8, 064, 644	73, 109, 45	0	i	202. 00

Heal th	Financial Systems	PERRY COUNTY HOSE	PLTAL	In Lie	u of Form CMS-2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 5/24/2016 9:32 am

				5/24/2016 9:32 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 341621			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 309001			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 164024			54. 00
60. 00 06000 LABORATORY	0. 276901			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 530480			62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 454692			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 364299			66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0. 276181			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 366148			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 102671			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1. 145349			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 238181			73. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC - TELL CITY	2. 001411			88. 00
88.01 08801 RURAL HEALTH CLINIC - PERRY CO FP	1. 951811			88. 01
88.02 08803 RURAL HEALTH CLINIC - TROY	2. 320354			88. 02
90. 00 09000 CLI NI C	2. 006372			90.00
90. 01 09001 PAI N MANAGEMENT	0. 717186			90. 01
91. 00 09100 EMERGENCY	0. 443371			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 431988			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 513151			95. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113. 00
116. 00 11600 H0SPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Heal th Financial	Systems		PERRY	COUNTY HOS	SPI TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF (OUTPATIENT SERVICE	COST TO CHAR	SE RATIOS NET	0F	Provi der C	CN: 151322		Worksheet C
REDUCTIONS FOR M	MEDICAID ONLY						From 01/01/2015	Part Date/Time Prenared

				To	12/31/2015	Date/Time Pre 5/24/2016 9:3	
			Ti t	le XIX	Hospi tal	PPS	2 4111
	Cost Center Description	Total Cost	Capital Cost	Operating Cost		Operating Cost	
	·	(Wkst. B, Part		Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col. 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 952, 544			0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	235, 894	69, 282	166, 612	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 720, 536	231, 404	2, 489, 132	0	0	54.00
60.00	06000 LABORATORY	2, 675, 224	105, 491	2, 569, 733	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	144, 028	1, 578	142, 450	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	1, 486, 294	121, 599	1, 364, 695	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	799, 958	94, 900	705, 058	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	272, 194	20, 987	251, 207	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	182, 684	13, 136	169, 548	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	401, 367	6, 922	394, 445	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	135, 961	1, 477	134, 484	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 999, 983	72, 962	2, 927, 021	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	1, 780, 577	20, 326	1, 760, 251	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	347, 069	3, 928	343, 141	0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	64,000	722	63, 278	0	0	88. 02
90.00	09000 CLI NI C	1, 108, 041	137, 076	970, 965	0	0	90.00
90. 01	09001 PAIN MANAGEMENT	162, 396	11, 302	151, 094	0	0	90. 01
91.00	09100 EMERGENCY	2, 930, 826	210, 853	2, 719, 973	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	683, 067	114, 847	568, 220	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			•			
95.00	09500 AMBULANCE SERVICES	1, 341, 518	163, 575	1, 177, 943	0	0	95. 00
101.00	10100 HOME HEALTH AGENCY	883, 701	27, 493	856, 208	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	0	C	0	0	0	116. 00
200.00	Subtotal (sum of lines 50 thru 199)	23, 307, 862	1, 759, 247	21, 548, 615	0	· O	200. 00
201.00	Less Observation Beds	683, 067	114, 847	568, 220	0	0	201. 00
202.00	Total (line 200 minus line 201)	22, 624, 795	1, 644, 400	20, 980, 395	0	· O	202. 00

Health Financial Systems	PERRY COUNTY HOS	SPI TAL	u of Form CMS-2552-10	
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 151322	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part II Date/Time Prepared:

						5/24/2016 9:	32 am
				tle XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges				
		Capital and		Cost to Charg			
			Part I, colum	n Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6. 00	7.00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 952, 544	5, 715, 53	0. 34162	1		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	235, 894	763, 40	0. 30900	1		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 720, 536	16, 586, 25	0. 16402	4		54.00
60.00	06000 LABORATORY	2, 675, 224	9, 661, 30	4 0. 27690	1		60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	144, 028	271, 50	0. 53048	O		62. 00
65.00	06500 RESPI RATORY THERAPY	1, 486, 294	3, 268, 79	0. 45469	2		65.00
66.00	06600 PHYSI CAL THERAPY	799, 958	2, 195, 88	0. 36429	9		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	272, 194	985, 56	0. 27618	1		67. 00
68.00	06800 SPEECH PATHOLOGY	182, 684	498, 93	0. 36614	8		68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	401, 367	3, 909, 26	0. 10267	1		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	135, 961	118, 70	7 1. 14534	9		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 999, 983	12, 595, 38	1 0. 23818	1		73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC - TELL CITY	1, 780, 577	889, 66	1 2.00141	1		88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	347, 069	177, 81	1. 95181	1		88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	64, 000	27, 58	2. 32035	4		88. 02
90.00	09000 CLI NI C	1, 108, 041	552, 26	1 2. 00637.	2		90.00
90. 01	09001 PAIN MANAGEMENT	162, 396		0. 71718	6		90. 01
91.00	09100 EMERGENCY	2, 930, 826	6, 610, 32	0. 44337	1		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	683, 067	477, 00	1. 43198	8		92. 00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>			•		
95.00	09500 AMBULANCE SERVI CES	1, 341, 518	2, 614, 27	0. 51315	1		95. 00
101.00	10100 HOME HEALTH AGENCY	883, 701					101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0		0. 00000	0		116. 00
200.00		23, 307, 862	69, 872, 41				200. 00
201.00	1 1 ,	683, 067		ol			201. 00
202.00		22, 624, 795	l .				202. 00

∐oal +b	Financial Systems	PERRY COUNT	V LINCE	DI TAI		In Lie	eu of Form CMS-2	2552 10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA					Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II	pared:
				Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total	Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost				Program	(column 3 x	
		(from Wkst. B,	Part		(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
	T	1.00		2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	329, 387		5, 715, 530	1		7, 774	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	69, 282		763, 409	1		l	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	231, 404		6, 586, 253	1	· ·		54.00
60.00	06000 LABORATORY	105, 491		9, 661, 304	0. 01091	9 794, 640	8, 677	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 578		271, 505	0. 00581	2 61, 045	355	62. 00
65.00	06500 RESPI RATORY THERAPY	121, 599		3, 268, 794	0. 03720	00 799, 752	29, 751	65. 00
66.00	06600 PHYSI CAL THERAPY	94, 900		2, 195, 881	0. 04321	7 153, 109	6, 617	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	20, 987		985, 564	0. 02129	85, 252	1, 815	67. 00
68.00	06800 SPEECH PATHOLOGY	13, 136		498, 935	0. 02632	18 31, 329	825	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 922		3, 909, 266	0. 00177	1 687, 309	1, 217	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 477		118, 707	0. 01244	2 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	72, 962	1.	2, 595, 381	0.00579	2, 125, 831	12, 315	73. 00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC - TELL CITY	20, 326		889, 661	0. 02284	7 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	3, 928		177, 819	0. 02209	0 0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	722		27, 582	0. 02617	6 0	0	88. 02
90.00	09000 CLI NI C	137, 076		552, 261	0. 24820	937	233	90.00
90. 01	09001 PAIN MANAGEMENT	11, 302		226, 435	0. 04991	3 0	0	90. 01
04 00	DOLOG EMEDOENOV	040 050	i		0 00406	0 400	1 000	04 00

210, 853

114, 847

1, 568, 179

226, 435 6, 610, 322

65, 531, 615

477, 006

0. 031898

0. 240766

9, 198

5, 473, 116

90. 01 91. 00

92.00 0

95.00

293

78, 434 200. 00

91. 00 09100 EMERGENCY
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

95. 00 | 09500 | AMBULANCE SERVICES | Total (lines 50-199)

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		Provi der	CCN: 151322	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre 5/24/2016 9:3	pared:
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	, ,	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1		· -	
50. 00	05000 OPERATI NG ROOM	0	0		0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC - TELL CITY	0	0		0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0	0		0 0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	0	0		0 0	0	88. 02
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
90. 01	09001 PALN MANAGEMENT	0	0		0 0	0	90. 01
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0		0 0	0	200. 00
					•		•

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	PERRY COUNT		CCN: 151322	Peri od:	u of Form CMS-2 Worksheet D	
	SH COSTS		1		From 01/01/2015	Part IV	
					To 12/31/2015	Date/Time Pre 5/24/2016 9:3	pared:
			Ti t	le XVIII	Hospi tal	Cost	z alli
	Cost Center Description	Total		Ratio of Cost		Inpati ent	
		Outpati ent	(from Wkst. C		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .	3	
		4)	,	ŕ	7)		
		6.00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	5, 715, 53			134, 892	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	,			4, 334	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	16, 586, 25			585, 488	54.00
60.00	06000 LABORATORY	0	9, 661, 30			794, 640	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	271, 50			61, 045	
65.00	06500 RESPI RATORY THERAPY	0	3, 268, 79			799, 752	
66.00	06600 PHYSI CAL THERAPY	0	2, 195, 88			153, 109	
67.00	06700 OCCUPATI ONAL THERAPY	0	985, 56			85, 252	
68.00	06800 SPEECH PATHOLOGY	0	498, 93			31, 329	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 909, 26	6 0.00000	0. 000000	687, 309	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	118, 70	7 0. 00000		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12, 595, 38	0.00000	0.000000	2, 125, 831	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	0	007700			0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0	177, 81			0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	0	27, 58	1		0	88. 02
90.00	09000 CLI NI C	0	552, 26	1		937	90.00
90. 01	09001 PAIN MANAGEMENT	0	226, 43	1		0	90. 01
91.00	09100 EMERGENCY	0	6, 610, 32	•		9, 198	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	477, 00	6 0. 00000	0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	65, 531, 61	5		5, 473, 116	200.00

Health Financial Systems	PERRY COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 151322	From 01/01/2015	Worksheet D Part IV Date/Time Prepared:

						10	12/31/2015	5/24/2016 9:	
				Ti tl	e XVIII		Hospi tal	Cost	
	Cost Center Description	I npati ent	Out	patient	Outpati ent				
		Program		rogram	Program				
		Pass-Through	CI	harges	Pass-Through				
		Costs (col. 8			Costs (col.	9			
		x col. 10)			x col. 12)				
		11. 00		12. 00	13. 00				
	ANCILLARY SERVICE COST CENTERS				ı				
50.00	05000 OPERATI NG ROOM	0		0	1	0			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0		Ü	1	0			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		Ü	1	0			54.00
60.00	06000 LABORATORY	0		Ü	1	0			60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		U	1	0			62. 00
65. 00	06500 RESPIRATORY THERAPY	0		U	1	0			65. 00
66.00	06600 PHYSI CAL THERAPY	0		Ü	1	0			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		U	1	0			67. 00
	06800 SPEECH PATHOLOGY	0		Ü		0			68. 00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		U		0			71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0		U		0			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	l U		0		U			73. 00
00.00					ı				- 00.00
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	0		U		0			88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP 08803 RURAL HEALTH CLINIC - TROY	0		U		0			88. 01 88. 02
88. 02 90. 00	09000 CLINIC	0		0		0			90.00
90.00	09000 CET NI C 09001 PALN MANAGEMENT	0		0		0			90.00
	09100 PATN MANAGEMENT	0		0		0			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0			91.00
92.00	OTHER REIMBURSABLE COST CENTERS	l d			1	U			92.00
05 00	09500 AMBULANCE SERVICES				1				95. 00
200.00		0		0	J	0			200.00
200.00	[[Total (Titles 50-199)	١		U	11	U			J200. 00

Health Financial Systems	PI TAL	In Lie	Lieu of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151322	Peri od:	Worksheet D

From 01/01/2015 | Part V To 12/31/2015 | Date/Time Prepared: 5/24/2016 9:32 am Title XVIII Hospi tal Cost Costs Charges Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Services (see Ratio From Rei mbursed Rei mbursed (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 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 341621 1, 818, 047 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.309001 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 0 164024 0 5, 115, 356 54 00 0 60.00 06000 LABORATORY 0.276901 0 3, 119, 417 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.530480 158, 338 0 62.00 65.00 06500 RESPIRATORY THERAPY 0.454692 962.384 0 65.00 0 872, 867 06600 PHYSI CAL THERAPY 66.00 0. 364299 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0. 276181 140, 867 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.366148 0 26, 148 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 680, 053 Ω 71 00 71 00 0.102671 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 1.145349 0 113, 402 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 3, 920, 175 9,045 0 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - TELL CITY 08801 RURAL HEALTH CLINIC - PERRY CO FP 88 00 88 00 0.000000 0 88. 01 0.000000 0 88.01 08803 RURAL HEALTH CLINIC - TROY 0.000000 88. 02 88. 02 90.00 09000 CLI NI C 2.006372 0 90.00 164, 735 0 90.01 09001 PAIN MANAGEMENT 0 90.01 0.717186 0 0 91.00 09100 EMERGENCY 0. 443371 1, 213, 879 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 431988 92.00 92.00 0 283, 844 0 0 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0.513151 200.00 Subtotal (see instructions) 0 18, 589, 512 9,045 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

18, 589, 512

9, 045

0 202. 00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems		PERRY COUNTY HOS	PITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN: 151322	From 01/01/2015	Worksheet D Part V Date/Time Prepared:

					To 12/31/2015	Date/Time Pre 5/24/2016 9:3	
			Ti tI	e XVIII	Hospi tal	Cost	
	·	Cos	sts				
	Cost Center Description	Cost	Cost	1			
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7.00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	621, 083	()			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	()			52. 00
	05400 RADI OLOGY-DI AGNOSTI C	839, 041	()			54.00
	06000 LABORATORY	863, 770	l .)			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	83, 995	()			62. 00
	06500 RESPI RATORY THERAPY	437, 588)			65.00
	06600 PHYSI CAL THERAPY	317, 985)			66. 00
	06700 OCCUPATI ONAL THERAPY	38, 905)			67. 00
	06800 SPEECH PATHOLOGY	9, 574)			68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 822	C)			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	129, 885)			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	933, 711	2, 154				73. 00
	OUTPAȚI ENT SERVI CE COST CENTERS						
	08800 RURAL HEALTH CLINIC - TELL CITY	0	()			88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0	C)			88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	0	C)			88. 02
90. 00	09000 CLI NI C	330, 520	C)			90. 00
90. 01	09001 PAIN MANAGEMENT	0	C)			90. 01
91. 00	09100 EMERGENCY	538, 199	C)			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	406, 461	C				92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0					95. 00
200.00	Subtotal (see instructions)	5, 620, 539	2, 154				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)	5, 620, 539	2, 154				202. 00

Health Financial Systems	PERRY COUNTY HO	SPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTH	HER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151322		Worksheet D
			From 01/01/2015	
		Component CCN, 1E7222	To 10/01/001E	Doto/Time Dropored.

			Component	CCN: 15Z322 T	o 12/31/2015	Date/Time Pre 5/24/2016 9:3	
			Ti tl	e XVIII S	wing Beds - SNF		2 (1111
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(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	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 341621	0	C	0	0	00.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 309001	0	C	0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 164024	0	C	0	0	54. 00
	06000 LABORATORY	0. 276901	0	C	0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 530480	l .	C	0	0	62. 00
	06500 RESPI RATORY THERAPY	0. 454692		C	0	0	65. 00
	06600 PHYSI CAL THERAPY	0. 364299	0	C	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0. 276181	0	C	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 366148	0	C	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 102671	0	C	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	1. 145349	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 238181	0	C	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC - TELL CITY	0. 000000				0	00.00
	08801 RURAL HEALTH CLINIC - PERRY CO FP	0. 000000				0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	0. 000000				0	88. 02
90.00	09000 CLI NI C	2. 006372	0	C	0	0	90. 00
90. 01	09001 PAIN MANAGEMENT	0. 717186	0	C	0	0	90. 01
91.00	09100 EMERGENCY	0. 443371	0	C	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 431988	0	C	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 513151		C)		95. 00
200.00			0	C	0	0	200. 00
201.00				[C	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	C	0	0	202. 00

Heal th Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151322 From 01/01/2015 Part V

Component CCN: 15Z322 To 12/31/2015 Date/Time Prepared:

Title XVIII Swing Beds - SNF Cost			Component	CCN. 132322	10 12/31/2	5/24/2016 9:	
Cost Center Description			Ti tl	e XVIII	Swing Beds -	SNF Cost	
Rel imbursed Services Not Subject To Ded. & Coins. Subject To		Cos					
ANCILLARY SERVICE COST CENTERS Subject To Ded. & Colns. (see Inst.)	Cost Center Description						
Subject To Ded. & Coin s. (See inst.) Ded. & Coin s. (See inst.) Subject To Ded. & Coin s. (See inst.) See inst.) S							
Ded. & Coins. See inst. Ded. & Coins. Ded.							
See inst. (see inst.							
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS				-			
50. 00 05000 0PERATING ROOM 0 0 0 0 0 0 0 0 0	ANOLLI ADV CEDVI CE COCT CENTEDO	6.00	7.00				
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0				1			
54. 00		0	0				
60. 00 06000 LABORATORY 0 0 0 0 62. 00 62. 00 66. 00 62. 00 66		0	0				
62. 00			0				
65. 00			0				
66.00 06600 PHYSICAL THERAPY 0 0 0 0 67.00 67.00 67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 6800 SPEECH PATHOLOGY 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 771.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 772.00 07300 DRUGS CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				
67. 00		0	0				
68. 00 06800 SPEECH PATHOLOGY 0 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 772. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 0 772. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 773. 00 00 00 00 00 00 0 0 0 0 0 0 0 0 0 0		0	0				
71. 00			0				
72. 00			0				
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC - TELL CITY 0 0 0 88. 01 08801 RURAL HEALTH CLINIC - PERRY CO FP 0 0 0 88. 02 08803 RURAL HEALTH CLINIC - TROY 0 0 0 90. 00 09000 CLINIC 0 0 0 90. 01 09001 PAIN MANAGEMENT 0 0 0 91. 00 09100 EMERGENCY 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 00 07500 AMBULANCE SERVICES 0 200. 00 09100 Cess PBP Clinic Lab. Services-Program 0 00 001 O01 O01 O01 O01 O01 001 O01 O01 O01 O01 O01 001 O01 O01 O01 O01 002 O03 O03 O03 O03 003 O04 O05 O05 004 O05 O05 O05 005 O05 O05 O05 007 O07 O07 O07 008 O07 O07 O07 009 O07 O07 0		0	0				
SECTION SUPPLY SERVICE COST CENTERS			0				
88. 00 88. 01 88. 01 88. 01 88. 01 88. 02 88. 02 88. 02 88. 02 90. 00 90. 01		U					73.00
88. 01 08801 RURAL HEALTH CLINIC - PERRY CO FP 0 0 0 88. 01 88. 02 08803 RURAL HEALTH CLINIC - TROY 0 0 0 90. 00 09000 CLINIC 0 0 0 90. 01 09001 PAI N MANAGEMENT 0 0 0 91. 00 09100 EMERGENCY 0 0 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 95. 00 09500 AMBULANCE SERVICES 0 200. 00 Subtotal (see instructions) 0 0 201. 00 Cless PBP Clinic Lab. Services-Program 0 001 Only Charges 0 0 002 003 003 003 003 003 004 005 005 005 006 007		0	0				88 00
88. 02 08803 RURAL HEALTH CLINIC - TROY 0 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 01 90. 00 90.			0				
90. 00		0	0				
90. 01		0	0				
91.00 09100 EMERGENCY 0 0 0 0 0 0 0 0 0		0	0				
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92. 00		0	0				
OTHER REIMBURSABLE COST CENTERS 95.00 200.00 Subtotal (see instructions) 0 0 0 200.00 201.00 Class PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0		0	0				
95. 00				l .			72.00
200.00 Subtotal (see instructions) 0 0 200.00 Less PBP Clinic Lab. Services-Program 0 0 0 1 201.00		0					95.00
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges			0				
Only Charges			_				
		0	0				202. 00

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT ROUTINE SERVI	CE CAPITAL COSTS	Provi der		Peri od:	Worksheet D	
				rom 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/24/2016 9:3	
_		Ti t	le XIX	Hospi tal	PPS	2 (111
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	_	Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CE	ITERS					
30.00 ADULTS & PEDIATRICS	730, 922	173, 379	557, 543	2, 673	208. 58	30. 00
31.00 INTENSIVE CARE UNIT	95, 785	5	95, 785	208	460. 50	31. 00
43. 00 NURSERY	18, 758	3	18, 758	179	104. 79	43.00
200.00 Total (lines 30-199)	845, 465	5	672, 086	3, 060		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CE						
30.00 ADULTS & PEDIATRICS	161	33, 581				30. 00
31.00 INTENSIVE CARE UNIT	C	0	1			31. 00
43. 00 NURSERY	179		1			43. 00
200.00 Total (lines 30-199)	340	52, 338	3			200. 00

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Pre 5/24/2016 9:3	
			le XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
	26)	0)	2)			
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	<u>'</u>		•			
50. 00 05000 OPERATING ROOM	329, 387	5, 715, 530	0. 05763	0 130, 020	7, 493	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	69, 282	763, 409	0. 09075	3 78, 480	7, 122	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	231, 404	16, 586, 253	0. 01395	2 108, 864	1, 519	54.00
60. 00 06000 LABORATORY	105, 491	9, 661, 304	0. 01091	9 164, 922	1, 801	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 578	271, 505	0. 00581			62. 00
65. 00 06500 RESPI RATORY THERAPY	121, 599	3, 268, 794	0. 03720	0 142, 291	5, 293	65. 00
66. 00 06600 PHYSI CAL THERAPY	94, 900	2, 195, 881			228	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	20, 987	985, 564	0. 02129	4 832	18	67. 00
68. 00 06800 SPEECH PATHOLOGY	13, 136		0. 02632	8 705	19	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 922	3, 909, 266	0. 00177	1 153, 948	273	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 477	118, 707	0. 01244	2 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	72, 962	12, 595, 381	0. 00579	3 306, 997	1, 778	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TELL CITY	20, 326	889, 661	0. 02284	7 0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC - PERRY CO FP	3, 928	177, 819	0. 02209	0 0	0	88. 01
88. 02 08803 RURAL HEALTH CLINIC - TROY	722	27, 582	0. 02617	6 0	0	88. 02
90. 00 09000 CLI NI C	137, 076	552, 261	0. 24820	9 410	102	90. 00
90. 01 09001 PAI N MANAGEMENT	11, 302	226, 435	0. 04991	3 0	0	90. 01
91. 00 09100 EMERGENCY	210, 853	6, 610, 322	0. 03189			
92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	114 847	477 006	0 24076	6 5 076	1 222	92 00

114, 847

1, 568, 179

0. 240766

477, 006

65, 531, 615

1, 155, 702

5, 076

1, 222

28, 503 200. 00

92.00

95.00

91. 00 09100 EMERGENCY
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

95. 00 | 09500 | AMBULANCE SERVICES | Total (lines 50-199)

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015		
		T: 1	I - VIV	11: 4-1	5/24/2016 9: 3 PPS	<u> 2 am</u>
C+ C+ D	N C-11		le XIX	Hospi tal		
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adj ustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 03000 ADULTS & PEDIATRICS	0	0	1	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0)	0	0	43.00
200.00 Total (lines 30-199)	0	0)	0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpatient		
	Days	5 ÷ col . 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		
30. 00 03000 ADULTS & PEDIATRICS	2, 673	0.00	16	1 0		30. 00
31.00 03100 INTENSIVE CARE UNIT	208	0.00)	0 0		31.00
43. 00 04300 NURSERY	179	0.00	17	9 0		43.00
200.00 Total (lines 30-199)	3, 060		34			200. 00
		1		1	1	

	NT/OUTPATIENT ANCILLARY SE	PERRY COUNTY RVI CE OTHER PASS		CCN: 151322	Peri od:	worksheet D	
THROUGH COSTS					From 01/01/2015 To 12/31/2015		pared:
						5/24/2016 9: 3	2 am
		1		le XIX	Hospi tal	PPS	
Cost Center	Description	Non Physician N	ursing School	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
ANCI LLARY SERVI CE	COST CENTERS						
50. 00 05000 OPERATING RO	OOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROC	M & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI	AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY		0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD	& PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65. 00 06500 RESPI RATORY	THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSICAL THE	RAPY	0	0		0 0	0	66. 00
67. 00 06700 0CCUPATI ONAL	THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHO	DLOGY	0	0		0 0	0	68. 00
71.00 07100 MEDICAL SUPF	PLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. (0	0		0	0	72.00
73. 00 07300 DRUGS CHARGE		0	0		0 0	0	73.00
OUTPATIENT SERVICE							
38.00 08800 RURAL HEALTH		0	0		0	0	
	I CLINIC - PERRY CO FP	0	0		0	0	88. 01
38. 02 08803 RURAL HEALTH	I CLINIC - TROY	0	0		0	0	88. 02
90. 00 09000 CLI NI C		0	0		0	0	90.00
90.01 09001 PAIN MANAGEN	IENT	0	0		0	0	90. 01
91. 00 09100 EMERGENCY		0	0		0	0	91.00
	BEDS (NON-DISTINCT PART)	0	0		0 0	0	92. 00
OTHER REI MBURSABLE							
95.00 09500 AMBULANCE SE			-				95.00
200.00 Total (lines	5 50-199)	0	0		0 0	0	200. 00

	Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10								
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der		Peri od:	Worksheet D			
THROUG	SH COSTS				From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	parod:		
					10 12/31/2013	5/24/2016 9:3	pareu. 2 am		
			Ti t	le XIX	Hospi tal	PPS			
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent			
	·	Outpati ent	(from Wkst. C,		Ratio of Cost	Program			
		Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges			
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.				
		4)			7)				
		6. 00	7. 00	8. 00	9. 00	10.00			
	ANCILLARY SERVICE COST CENTERS	1					1		
50.00	05000 OPERATI NG ROOM	0	5, 715, 530			130, 020			
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	763, 409	•		78, 480			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	16, 586, 253			108, 864			
60.00	06000 LABORATORY	0	9, 661, 304	1		164, 922			
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	271, 505	1		8, 078			
65.00	06500 RESPI RATORY THERAPY	0	3, 268, 794	1		142, 291			
66. 00	06600 PHYSI CAL THERAPY	0	2, 195, 881			5, 287			
67. 00	06700 OCCUPATI ONAL THERAPY	0	985, 564	1		832			
68. 00	06800 SPEECH PATHOLOGY	0	498, 935	1		705			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 909, 266	0.00000	0. 000000	153, 948	71. 00		
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	118, 707			0			
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12, 595, 381	0.00000	0. 000000	306, 997	73. 00		
	OUTPATIENT SERVICE COST CENTERS								
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	0	889, 661	0.00000	0. 000000	0	00.00		
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP	0	177, 819	0.00000	0. 000000	0	88. 01		
88. 02	08803 RURAL HEALTH CLINIC - TROY	0	27, 582	0.00000	0. 000000	0	88. 02		
90.00	09000 CLI NI C	0	552, 261	0.00000	0. 000000	410	90.00		
90. 01	09001 PAIN MANAGEMENT	0	226, 435	0.00000	0. 000000	0	90. 01		
91.00	09100 EMERGENCY	0	6, 610, 322	0.00000	0. 000000	49, 792	91.00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	477, 006	0.00000	0. 000000	5, 076	92.00		
	OTHER REIMBURSABLE COST CENTERS								
	09500 AMBULANCE SERVI CES						95. 00		
200.00	Total (lines 50-199)	0	65, 531, 615	5		1, 155, 702	200. 00		

Health Financial Systems	PERRY COUNTY HOSPITAL				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER P	ASS	Provi der	CCN: 151322	Period: From 01/01/2015	Worksheet D Part IV	
					To 12/31/2015	Date/Time Prep 5/24/2016 9:32	
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	0u	tpati ent	Outpati ent			

						5/24/2016 9:3	32 am	
				Title >	XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati er	nt 0	utpati ent			
		Program	Program		Program			
		Pass-Through	Charges		ss-Through			
		Costs (col. 8			sts (col. 9			
		x col. 10)		X	col. 12)			
		11. 00	12. 00		13. 00			
	ANCILLARY SERVICE COST CENTERS							
	05000 OPERATING ROOM	0		O	C			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0		O	C	P		52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0		O	C	P		54. 00
	06000 LABORATORY	0		0	C			60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	C			62. 00
65. 00	06500 RESPI RATORY THERAPY	0		0	C			65. 00
	06600 PHYSI CAL THERAPY	0		0	C			66. 00
	06700 OCCUPATI ONAL THERAPY	0		0	C			67. 00
	06800 SPEECH PATHOLOGY	0		0	C			68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	C			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	0		0	C			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0				73. 00
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC - TELL CITY	0		0	C			88. 00
	08801 RURAL HEALTH CLINIC - PERRY CO FP	0		0	C			88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY	0		0	C			88. 02
90.00	09000 CLI NI C	0		0	C			90.00
90. 01	09001 PALN MANAGEMENT	0		0	C			90. 01
91.00	09100 EMERGENCY	0		0	C			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	C			92. 00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES							95. 00
200.00	Total (lines 50-199)	0		0	C)		200. 00

Health Financial Systems	PERRY COUNTY HOSI	PITAL	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151322	Peri od:	Worksheet D

	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	F	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 9:3	pared:
			Ti t	le XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		1.00	0.00	(see inst.)	(see inst.)	F 00	
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	1.00	2.00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.044704		F00 F00			
	05000 OPERATING ROOM	0. 341621		500, 593		0	00.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 309001	0	1,		0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 164024	0	2, 053, 950		0	0 00
	06000 LABORATORY	0. 276901	0	1, 176, 512		0	00.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 530480		5, 151		0	62. 00
	06500 RESPIRATORY THERAPY	0. 454692		225, 048		0	65. 00
	06600 PHYSI CAL THERAPY	0. 364299		202, 510		0	66. 00
	06700 OCCUPATI ONAL THERAPY	0. 276181		125, 114		0	67. 00
	06800 SPEECH PATHOLOGY	0. 366148		76, 361		0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 102671		479, 840	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	1. 145349		1	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 238181	0	1, 545, 325	5 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	1	i .	1		_	
	08800 RURAL HEALTH CLINIC - TELL CITY	2. 001411				0	
	08801 RURAL HEALTH CLINIC - PERRY CO FP	1. 951811				0	
	08803 RURAL HEALTH CLINIC - TROY	2. 320354			_	0	88. 02
	09000 CLI NI C	2. 006372		60, 793	0	0	90.00
	09001 PAI N MANAGEMENT	0. 717186			0	0	90. 01
	09100 EMERGENCY	0. 443371		.,,		0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 431988	0	30, 254	1 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	T	T _	1	.		
	09500 AMBULANCE SERVICES	0. 513151	1			_	95. 00
200.00			0	8, 350, 005	0	0	200.00
201. 00					0		201. 00
202 22	Only Charges			0.250.225		_	202 00
202.00	Net Charges (line 200 +/- line 201)		0	8, 350, 005	5 0	1 0	202. 00

Health Financial Systems		PERRY	In Lieu of Form C			
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provider CCN: 151322		Worksheet D
					From 01/01/2015	

				To 12/31/2015	Date/Time Pre 5/24/2016 9:3	pared: 2 am
		Ti t	le XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
· ·	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	171, 013	0				50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	15, 271	0				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	336, 897	0				54.00
60. 00 06000 LABORATORY	325, 777	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 733	0				62.00
65. 00 06500 RESPIRATORY THERAPY	102, 328	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	73, 774	0				66. 00
67. 00 06700 OCCUPATIONAL THERAPY	34, 554	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	27, 959	0				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	49, 266	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	368, 067	0				73. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC - TELL CITY	0	0				88. 00
88.01 08801 RURAL HEALTH CLINIC - PERRY CO FP	0	0				88. 01
88.02 08803 RURAL HEALTH CLINIC - TROY	0	0				88. 02
90. 00 09000 CLI NI C	121, 973	0				90.00
90. 01 09001 PAI N MANAGEMENT	0	0				90. 01
91. 00 09100 EMERGENCY	704, 103	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	43, 323					92.00
OTHER REIMBURSABLE COST CENTERS			•			
95. 00 09500 AMBULANCE SERVICES	118, 572					95. 00
200.00 Subtotal (see instructions)	2, 495, 610					200.00
201.00 Less PBP Clinic Lab. Services-Program	0	_				201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	2, 495, 610	0				202. 00
	1	'				•

Health Financial Systems	PERRY COUNTY HOS	PITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151322		Worksheet D-1	
			From 01/01/2015		
				Date/Time Prepared:	
				5/24/2016 9:32 am	
		Title XVIII	Hospi tal	Cost	

		Title XVIII	Hospi tal	5/24/2016 9:3 Cost	2 am		
	Cost Center Description	THE WITT	nospi tui	'			
	PART I - ALL PROVIDER COMPONENTS			1. 00			
	INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days,			3, 586	1. 00		
2.00	Inpatient days (including private room days, excluding swing-be			2, 673	2.00		
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.). IT you have only pr	ivate room days,	0	3. 00		
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		2, 253	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private room	r 31 of the cost	824	5. 00			
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	daya) aftar Dagambar	01 of the cost	0	6. 00		
6.00	reporting period (if calendar year, enter 0 on this line)	days) at tel December	of the cost	U	0.00		
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	89	7. 00		
0.00	reporting period	D D D D	1 -6 +1+	0	0.00		
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	or the cost	0	8. 00		
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 450	9. 00		
40.00	newborn days)	<i>(</i> 1			40.00		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	824	10. 00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00		
	December 31 of the cost reporting period (if calendar year, ent						
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00		
	after December 31 of the cost reporting period (if calendar yea	r, enter O on this line	e)				
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14. 00 15. 00		
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0			
	SWING BED ADJUSTMENT				10.00		
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00		
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00		
10.00	reporting period		10.00				
19. 00	Medicaid rate for swing-bed NF services applicable to services	132. 00	19. 00				
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	132.00	20. 00				
	reporting period						
21. 00	Total general inpatient routine service cost (see instructions)	21 -6 -11		5, 699, 091			
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	31 of the cost report	ing period (line	0	22. 00		
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00		
24.00	x line 18)	24 - 5 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	(1:	11 740	24.00		
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	3) of the cost reporti	ng period (iine	11, 748	24.00		
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00		
27, 00	x line 20)			1 251 0/0	27.00		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		1, 351, 860 4, 347, 231			
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The Et initiae Title Eey		1,017,201	27.00		
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0			
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00		
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000			
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00			
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00			
34. 00	Average per diem private room charge differential (line 32 minu	, ,	tions)	0.00			
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)		0.00	35. 00 36. 00			
37. 00	General inpatient routine service cost net of swing-bed cost an	4, 347, 231	37. 00				
	27 minus line 36)						
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 626. 35	38. 00		
39. 00	Program general inpatient routine service cost (line 9 x line 3	8)		2, 358, 208	39. 00		
40.00	Medically necessary private room cost applicable to the Program	•		2 359 309	40.00		
41.00	Total Program general inpatient routine service cost (line 39 +	1111e 4U)		2, 358, 208	41.00		

<u>H</u> eal th	Financial Systems	PERRY COUNTY	' HOSPI TAL		In Lie	eu of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi d	ler CCN: 151322	Period: From 01/01/2015	Worksheet D-1		
					To 12/31/2015	Date/Time Pre		
			Т	itle XVIII	Hospi tal	5/24/2016 9: 3: Cost	<u> 2 alli </u>	
	Cost Center Description	Total	Total	Average Per		Program Cost (col. 3 x col.		
		Inpatrent Cost	inpatient υ	ays Diem (col. 1 col. 2)	÷	(COI. 3 X COI. 4)		
40.00	INUDGEDY (1) II WA WIW II	1.00	2. 00	3.00	4. 00	5. 00	40.00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0 0.0	00 0	0	42. 00	
43.00	INTENSIVE CARE UNIT	660, 941		208 3, 177.	50 89	282, 806	43. 00	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00	
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00	
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00	
	cost center bescription					1. 00		
48. 00	Program inpatient ancillary service cost (Wk					1, 433, 167	•	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruc	tions)		4, 074, 181	49. 00	
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (f	rom Wkst. D, sun	n of Parts I and	0	50. 00	
51. 00	<pre> </pre>	atient ancillar	v services	(from Wkst D s	sum of Parts II	0	51. 00	
01.00	and IV)		y 301 11 003	(Trom Mot. b,	am or rares rr			
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	,	lated non	nhysisian anastk	notict and	0	52. 00 53. 00	
55.00	medical education costs (line 49 minus line		rateu, non-	priysi ci ari anesti	letist, and	U	33.00	
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F4 00	
54.00	Program discharges Target amount per discharge					0.00		
56. 00	Target amount (line 54 x line 55)				>	0	56. 00	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount	(line 56 minus	line 53)	0	57. 00 58. 00	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996	, updated and co	ompounded by the			
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport un	dated by th	o markot baskot		0.00	60. 00	
61. 00	0.00	61.00						
62. 00	0	62. 00						
63.00 Allowable Inpatient cost plus incentive payment (see instructions)								
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of	the cost reporti	ng period (See	1, 340, 112	64. 00	
/F 00	instructions)(title XVIII only)	+£+ D	21 +-				/F 00	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 or th	e cost reportino	period (See	0	65. 00	
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus lin	e 65)(title XVII	I only). For	1, 340, 112	66. 00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 3	1 of the cost re	eporting period	0	67. 00	
40.00	(line 12 x line 19)	a accta after D	acamban 21	of the cost rone	unting ported		40.00	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31	or the cost repo	orting period		68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70. 00	
71. 00	Adjusted general inpatient routine service c		ine 70 ÷ li	ne 2)			71. 00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x	line 35)			72. 00 73. 00	
74.00	Total Program general inpatient routine serv	ice costs (line	72 + line	73)			74. 00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (fro	m Worksheet B, F	Part II, column		75. 00	
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00	
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00	
79. 00	Aggregate charges to beneficiaries for exces		rovi der rec	ords)			79. 00	
80.00	Total Program routine service costs for comp		ost limitat	ion (line 78 mir	nus line 79)		80.00	
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00	
83.00	Reasonable inpatient routine service costs (see instruction	•				83. 00	
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00	
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instructions					420	87. 00	
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 626. 35	88. 00	
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				683, 067	89. 00	

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/24/2016 9:3	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	730, 922	4, 347, 231	0. 16813	5 683, 067	114, 847	90.00
91.00 Nursing School cost	0	4, 347, 231	0.00000	0 683, 067	0	91.00
92.00 Allied health cost	0	4, 347, 231	0.00000	0 683, 067	0	92.00
93.00 All other Medical Education	0	4, 347, 231	0. 00000	0 683, 067	0	93. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151322	Period: From 01/01/2015	Worksheet D-1	
			Date/Time Pre 5/24/2016 9:3	
	Title XIX	Hospi tal	PPS	
Cost Center Description				

		Title XIX	Hospi tal	5/24/2016 9: 3: PPS	2 am
	Cost Center Description	II tie xix	поѕрі таі	PPS	
	<u> </u>			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	eveluding newborn)		3, 586	1. 00
2.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			2, 673	2.00
3. 00	Private room days (excluding swing-bed and observation bed days	3 ,	ivate room days,	0	3. 00
	do not complete this line.	, J			
4.00	Semi-private room days (excluding swing-bed and observation bed		04 6 11	2, 253	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through Decembe	r 31 or the cost	824	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room	davs) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	89	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 2	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) at tel becember 5	1 of the cost		0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	161	9. 00
40.00	newborn days)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)	,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	89	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar yea				13.00
14.00	Medically necessary private room days applicable to the Program			0	
15. 00	Total nursery days (title V or XIX only)			179	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			179	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00
	reporting period	g			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	132.00	10 00
19.00	reporting period	thi dugir beceiliber 31 or	the cost	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	132.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing paried (line	5, 699, 091 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost report	ing period (inte	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	11, 748	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)	3			
26. 00	Total swing-bed cost (see instructions)			1, 351, 860	
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		4, 347, 231	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3,	0	29. 00
	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		-,	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	4, 347, 231	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 626. 35	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	•		261, 842	1
40.00	Medically necessary private room cost applicable to the Program	•		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 +	1111e 40 <i>)</i>		261, 842	41.00

Heal th	Financial Systems PERRY COUNTY HOSPITAL In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 151322 Period: From 01/01/2015	Worksheet D-1	
	To 12/31/2015		
	Title XIX Hospital	PPS	2 4111
	Cost Center Description Total Total Average Per Program Days Inpatient Cost Inpatient Days Diem (col. 1 ÷	Program Cost (col. 3 x col.	
	col. 2)	4)	
42.00	1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 125,985 179 703.83 179	5. 00	42.00
42.00	NURSERY (title V & XIX only) 125, 985 179 703.83 179 Intensive Care Type Inpatient Hospital Units	125, 986	42.00
43.00	INTENSIVE CARE UNIT 660, 941 208 3, 177. 60	0	
44. 00 45. 00	CORONARY CARE UNIT		44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT		46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description		47. 00
	COST CENTER DESCRIPTION	1.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	322, 684	
49.00	PASS THROUGH COST ADJUSTMENTS	710, 512	49.00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	52, 338	50. 00
51. 00	III Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	28, 503	51. 00
F0 00	and IV)		
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	80, 841 629, 671	
00.00	medical education costs (line 49 minus line 52)	027,071	00.00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54. 00
55. 00	Target amount per discharge		55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	59. 00
60.00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00		0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62.00	Relief payment (see instructions)	0	
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST		63. 00
64. 00		0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
// 00	instructions)(title XVIII only)		// 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00		11, 748	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
40.00	(line 13 x line 20)	11 740	40.00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	11, 748	69. 00
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71. 00 72. 00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
	26, line 45)		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limitation		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82. 00 83. 00
84. 00	Program inpatient ancillary services (see instructions)		84. 00
85.00	Utilization review - physician compensation (see instructions)		85.00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87.00		420	
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 626. 35 683, 067	
			•

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/24/2016 9:3	
		Tit	le XIX	Hospi tal	PPS	<u>z am</u>
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	730, 922	4, 347, 231	0. 16813	5 683, 067	114, 847	90.00
91.00 Nursing School cost	0	4, 347, 231	0.00000	0 683, 067	0	91.00
92.00 Allied health cost	0	4, 347, 231	0.00000	0 683, 067	0	92.00
93.00 All other Medical Education	0	4, 347, 231	0.00000	0 683, 067	0	93.00

	RRY COUNTY HOSPITAL			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151322	Peri od: From 01/01/2015	Worksheet D-3	3
			To 12/31/2015	Date/Time Pre	nared.
			10 12/31/2013	5/24/2016 9: 3	
	Ti tl	e XVIII	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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 423, 106		30.00
31. 00 03100 INTENSIVE CARE UNIT			193, 092		31.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					٠
50. 00 05000 OPERATI NG ROOM		0. 34162		46, 082	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 30900	.,	1, 339	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16402		96, 034	
60. 00 06000 LABORATORY		0. 27690		220, 037	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 53048		32, 383	
65. 00 06500 RESPI RATORY THERAPY		0. 45469		363, 641	
66. 00 06600 PHYSI CAL THERAPY		0. 36429		55, 777	
67. 00 06700 OCCUPATIONAL THERAPY		0. 27618		23, 545	
68. 00 06800 SPEECH PATHOLOGY		0. 36614		11, 471	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 10267		70, 567	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		1. 14534		0	
73.00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0. 23818	31 2, 125, 831	506, 333	/3.00
88. 00 08800 RURAL HEALTH CLINIC - TELL CITY		0.00000	20	0	88. 00
88.01 08800 RURAL HEALTH CLINIC - TELL CITY		0.00000			
88.02 08803 RURAL HEALTH CLINIC - PERRY CO FP		0.00000		0	
90. 00 09000 CLINIC		1		-	
90. 00 09000 CELNIC 90. 01 09001 PALN MANAGEMENT		2. 00637 0. 71718		1, 880 0	1
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.44337		4, 078 0	1
		1. 43198	38 0	0	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES					95. 00
			E 470 114	1 422 1/7	
Total (sum of lines 50-94 and 96-98)	only charges (line (1)		5, 473, 116	1, 433, 167	200.00
201.00 Less PBP Clinic Laboratory Services-Program (only charges (line 61)		F 472 11/		
202.00 Net Charges (line 200 minus line 201)			5, 473, 116		202. 00

	Financial Systems	PERRY COUNTY HOSPITAL			eu of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151322	Peri od:	Worksheet D-3	
		Componen	t CCN: 15Z322	From 01/01/2015 To 12/31/2015	Date/Time Pre	nared:
		Остронен	1 0014. 102022	10 12/01/2010	5/24/2016 9: 3	
		Ti tl		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	LANGATI ENT. DOUTLANE OFFICE COOT OFFITEDO		1.00	2. 00	3. 00	
00.00	INPATIENT ROUTINE SERVICE COST CENTERS					00.00
	03000 ADULTS & PEDIATRICS			0		30.00
	03100 INTENSIVE CARE UNIT			0		31.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS					43. 00
50. 00	05000 OPERATING ROOM		0. 3416	21 246	84	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 3410.		0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1640		1	1
60.00	06000 LABORATORY		0. 27690			
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 53048		10, 773	62.00
65. 00	06500 RESPIRATORY THERAPY		0. 4546		"	
66. 00	06600 PHYSI CAL THERAPY		0. 3642			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 27618			
	06800 SPEECH PATHOLOGY		0. 3661			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1026			
	07200 IMPL. DEV. CHARGED TO PATIENT		1. 1453		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 23818		90, 074	73. 00
	OUTPATIENT SERVICE COST CENTERS		•			1
88.00	08800 RURAL HEALTH CLINIC - TELL CITY		0.0000	00	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - PERRY CO FP		0.00000	00	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC - TROY		0.00000	00	0	88. 02
90.00	09000 CLI NI C		2. 0063	72 52	104	90.00
90. 01	09001 PAIN MANAGEMENT		0. 71718		l	90. 01
	land and EMEROEMON		0 4400	7.4	1	1 04 00
91.00	09100 EMERGENCY		0. 4433	71 0	0	91.00

202. 00

95. 00 400, 189 200. 00 201. 00

1, 402, 189 1, 402, 189

95.00 200. 00 201. 00

202.00

09500 AMBULANCE SERVICES
Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Heal th	Financial Systems	PERRY COUNTY HOSPITAL		In lie	eu of Form CMS-	2552-10
Title XIX				CCN: 151322			
Title XIX							
Title XIX					To 12/31/2015		epared:
NAME Cost Center Description Ratio of Cost Inpatient To Charges Program Program Cost Color 1 x col 2 2 2 2 2 2 2 2 2			Ti +	le XIX	Hosni tal		12 alli
NPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	11.0				
NPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3							
NPATI ENT ROUTINE SERVICE COST CENTERS 2.0, 560 30.00 3.0					Charges	(col. 1 x col.	
NPATI_ENT ROUTI NE SERVICE COST CENTERS 220, 560 31.00 30.00 30.00 30.00 AULITS & PEDI ATRICS 26, 290 31.00							
30. 00				1.00	2. 00	3. 00	
31.00 03100 INTENSI VE CARE UNI T 26,290 43.00 A300 NURSERY 0 0 43.00 A300 NURSERY 3.00 A300 NURSERY 3.00 A300 NURSERY 3.00 A300 NURSERY 3.00 A300							
43.00					· ·	l e	
ANCILLARY SERVICE COST CENTERS						l e	
50. 00					0		43.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.309001 76, 480 24, 250 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.164024 108, 864 17, 856 54. 00 60. 00 06000 LABORATORY 0.276901 164, 922 45, 667 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.530480 8, 078 4, 285 62. 00 65. 00 06500 RESPI RATORY THERAPY 0.454692 142, 291 64, 699 65. 00 66. 00 06700 00000 LABORATIONAL THERAPY 0.364299 5, 287 1, 926 66. 00 67. 00 06700 00000 DASPITIONAL THERAPY 0.276181 832 230 67. 00 68. 00 08800 SPECH PATHOLOGY 0.364299 5, 287 1, 926 66. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.102671 153, 948 15, 806 71. 00 72. 00 07200 DRUE AL SUPPLI ES CHARGED TO PATI ENT 1, 145349				0.04477	100 000	14.440	
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0. 164024 108, 864 17, 856 54. 00 60. 00 06000 LABORATORY 0. 276901 164, 922 45, 667 60. 00 62. 00 06500 RESPI RATORY THERAPY 0. 454692 142, 291 64, 699 65. 00 06600 PHYSI CAL THERAPY 0. 364299 5, 287 1, 926 66. 00 06600 PHYSI CAL THERAPY 0. 276181 832 230 67. 00 67. 00 06600 OCCUPATI ONAL THERAPY 0. 276181 832 230 67. 00 0700 OCCUPATI ONAL THERAPY 0. 366148 705 258 68. 00 06800 SPEECH PATHOLOGY 0. 366148 705 258 68. 00 06800 SPEECH PATHOLOGY 0. 102671 153, 948 15, 806 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 1. 145349 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 1. 145349 0 0 72. 00 07200 DRUGS CHARGED TO PATI ENT 1. 145349 0 0 0 72. 00 07200 DRUGS CHARGED TO PATI ENT 1. 145349 0 0 0 72. 00 07200 DRUGS CHARGED TO PATI ENT 1. 145349 0 0 0 72. 00 07200 DRUGS CHARGED TO PATI ENT 1. 145349 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC - TELL CITY 2. 001411 0 0 88. 00 08800 RURAL HEALTH CLINIC - TELL CITY 2. 001411 0 0 88. 01 08801 RURAL HEALTH CLINIC - TENTY 2. 006372 410 823 90. 00 90. 00 09000 CLINIC 2. 006372 410 823 90. 00 90. 00 09000 CLINIC 0. 0000 09000 DATI ENT 0. 00000 000000							1
60. 00 06000 LABORATORY 0. 276901 164, 922 45, 667 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 530480 8, 078 4, 285 62. 00 65. 00 06500 RESPIRATORY THERAPY 0. 364492 142, 291 64, 699 65. 00 66. 00 06500 RESPIRATORY THERAPY 0. 364499 5, 287 1, 926 66. 00 67. 00 06700 0CCUPATIONAL THERAPY 0. 276181 832 230 67. 00 68. 00 0800 SPEECH PATHOLOGY 0. 366148 705 258 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 102671 153, 948 15, 806 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 07300 07300 07300 07300 07300 07300 07300 07300							
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.530480 8,078 4,285 62. 00 65. 00 RESPIRATORY THERAPY 0.454692 142,291 64,699 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.364299 5,287 1,926 66. 00 06700 0CCUPATI ONAL THERAPY 0.276181 832 230 67. 00 06800 SPEECH PATHOLOGY 0.366148 705 258 68. 00 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.102671 153,948 15,806 71. 00 07300 DRUGS CHARGED TO PATIENTS 0.238181 306,997 73,121 072.00 07300 DRUGS CHARGED TO PATIENTS 0.238181 306,997 73,121 073.00 08800 RURAL HEALTH CLINIC - TELL CITY 2.001411 0 0 88. 01 08801 RURAL HEALTH CLINIC - PERRY CO FP 1.951811 0 0 88. 01 88. 01 08803 RURAL HEALTH CLINIC - TROY 2.320354 0 0 88. 01 09000 CLINIC CLI							
65.00 06500 RESPIRATORY THERAPY 0.454692 142, 291 64, 699 65.00 66.00 PHYSI CAL THERAPY 0.364299 5, 287 1, 926 66.00 67.00 06600 PHYSI CAL THERAPY 0.364299 5, 287 1, 926 66.00 07.00 06000 PHYSI CAL THERAPY 0.276181 832 230 67.00 07.00 06000 SPEECH PATHOLOGY 0.366148 705 258 68.00 07.00 07.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.102671 153, 948 15, 806 71.00 07.00 07.00 IMPL. DEV. CHARGED TO PATIENTS 0.102671 153, 948 15, 806 71.00 07.00 07.00 DRUGS CHARGED TO PATIENTS 0.238181 306, 997 73, 121 73.00 07.00 DRUGS CHARGED TO PATIENTS 0.238181 306, 997 73, 121 73.00 07.00 DRUGS CHARGED TO PATIENTS 0.238181 0.06, 997 73, 121 73.00 07.00 DRUGS CHARGED TO PATIENTS 0.238181 0.06, 997 07.00 07.00 DRUGS CHARGED TO PATIENTS 0.238181 0.06, 997 07.00 07.00 DRUGS CHARGED TO PATIENTS 0.238181 0.06, 997 07.00 07.00 DRUGS CHARGED TO PATIENTS 0.238181 0.06, 997 07.00 07.00 DRUGS CHARGED TO PATIENTS 0.238181 0.06, 997 07.00 07.00 DRUGS CHARGED TO PATIENTS 0.238181 0.00 07.00 08.00 DRUGS CHARGED TO PATIENTS 0.00 07.00 DRUGS CHARGED TO PATIENTS 0.00 DRUGS CHARGED TO PATIENTS 0.00 DRUGS CHARGED TO PATIENTS 0.00 07.00 DRUGS CHARGED TO PATIENTS 0.00 DRUGS C							1
66. 00 06600 PHYSICAL THERAPY 0. 364299 5, 287 1, 926 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 276181 832 230 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 366148 705 258 68. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 102671 153, 948 15, 806 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1. 145349 0. 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 0. 00 990 DRUGS CHARGED TO PATIENTS 0. 238181 0. 00 0. 0							1
67. 00							
68. 00							1
71. 00							
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 1. 145349 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 000							
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238181 306, 997 73, 121 73. 00 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00						l	
Section Service Cost Centers Service Co							
88. 00				0. 2001	31 000, 777	70, 121	70.00
88. 01 08801 RURAL HEALTH CLINIC - PERRY CO FP 1.951811 0 0 88. 01 88. 02 08803 RURAL HEALTH CLINIC - TROY 2.320354 0 0 88. 02 90. 00 09000 CLINIC 2.006372 410 823 90. 00 90. 01 09001 PAI N MANAGEMENT 0.717186 0 0 90. 01 91. 00 09100 EMERGENCY 0.443371 49, 792 22, 076 91. 00 92. 00 09200 08SERVATION BEDS (NON-DISTINCT PART) 1.431988 5, 076 7, 269 95. 00 09500 AMBULANCE SERVICES 95. 00 200. 00 Total (sum of lines 50-94 and 96-98) 1, 155, 702 322, 684 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00				2, 0014	11 0	0	88. 00
90. 00						0	
90. 01	88. 02	08803 RURAL HEALTH CLINIC - TROY		2. 3203!	54 0	0	88. 02
91. 00 09100 EMERGENCY 0.443371 49,792 22,076 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.431988 5,076 7,269 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 1,155,702 322,684 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00 0.443371 49,792 22,076 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 93. 00 94.	90. 00	09000 CLI NI C		2. 0063	72 410	823	90.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1. 431988 5, 076 7, 269 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00 0 0 0 0 0 0 0 0 0	90. 01	09001 PALN MANAGEMENT		0. 71718	36 0	0	90. 01
OTHER REIMBURSABLE COST CENTERS 95.00	91. 00	09100 EMERGENCY		0. 4433	71 49, 792	22, 076	91.00
95. 00	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 43198	5, 076	7, 269	92.00
200.00 Total (sum of lines 50-94 and 96-98) 1,155,702 322,684 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00		OTHER REIMBURSABLE COST CENTERS					
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00							
					1, 155, 702	322, 684	
202.00 Net Charges (line 200 minus line 201) 1,155,702 202.00			gram only charges (line 61)		0		1
	202. 00	Net Charges (line 200 minus line 201)			1, 155, 702		202. 00

Health Financial Systems	PERRY COUNTY HOS	PI TAL		In L	eu of Form	CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 151	Period: From 01/01/201 To 12/31/201	Worksheet 5 Part B 5 Date/Time 5/24/2016	Prepared:
		T: +1	o V//LLL	Hospi tal	Co	nc t

			To 12/31/2015	Date/Time Pre 5/24/2016 9:3	
		Title XVIII	Hospi tal	Cost	
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			5, 622, 693	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2. 00
3.00	PPS payments			0	3. 00
4.00	Outlier payment (see instructions)	:>		0	4. 00
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	TORS)		0. 000 0	5. 00 6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	ı
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			5, 622, 693	11. 00
	Reasonable charges				
12. 00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	ymant for sarvices on	a chargo basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		a ona gazar a		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	•
18.00	Total customary charges (see instructions)		44) /	0	18.00
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	If line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)		, (
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		5, 678, 920	
22. 00	Interns and residents (see instructions)			0	ł
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 8 and 9)	ctions)		0	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			<u> </u>	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			58, 135	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			3, 077, 018	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of lines 22	and 23] (see	2, 543, 767	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		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)			2, 543, 767	1
31. 00	Primary payer payments			820	ı
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)		2, 542, 947	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	3)		0	33.00
	Allowable bad debts (see instructions)			458, 721	ł
35. 00	Adjusted reimbursable bad debts (see instructions)			298, 169	1
36.00	,	ctions)		318, 926	1
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 841, 116 0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 841, 116 56, 822	40. 00 40. 01
41. 00	Interim payments			2, 554, 144	
42. 00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)			230, 150	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92. 00	The rate used to calculate the Time Value of Money				92. 00
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)		l	0	94. 00

Health Financial Systems PE
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 151322 | Period: | Worksheet E-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: | 5/24/2016 9: 32 am

					5/24/2016 9: 32	<u> 2 am </u>
		Ti tl	e XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1, 00	2.00	3, 00	4.00	
1.00	Total interim payments paid to provider		3, 190, 81	1	2, 253, 044	1. 00
2.00	Interim payments payable on individual bills, either)	o	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/07/2015	525, 000	12/07/2015	301, 100	3. 01
3.02				O	0	3. 02
3.03)	0	3. 03
3.04)	0	3.04
3.05)	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		()	0	3. 50
3.51)	o	3. 51
3.52)	0	3. 52
3.53)	0	3. 53
3.54)	o	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		525, 000)	301, 100	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 715, 81	1	2, 554, 144	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	T	ı		_	
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				O O	0	5. 02
5. 03		1		0	0	5. 03
	Provi der to Program		ı	-		
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51					0	5. 51
5. 52 5. 99	Subtatal (sum of lines E O1 E 40 minus sum of lines					5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98))	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER	1			230, 150	6. 01
6. 02	SETTLEMENT TO PROVIDER	1	45, 48 ⁻		230, 130	6. 02
6. 02 7. 00			3, 670, 330		2, 784, 294	7. 00
7.00	Total Medicare program liability (see instructions)		3, 070, 331		2, 784, 294 NPR Date	7.00
				Contractor Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
0.00	Indino of Sofiti detoi	1		1	1 1	0.00

PITAL In Lieu of Form CMS-2552-10

Provider CCN: 151322 | Period: | Worksheet E-1
From 01/01/2015 | Part I
To 12/31/2015 | Date/Time Prepared: 5/24/2016 9:32 am Health Financial Systems PE
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		· ·			5/24/2016 9: 3	2 am
				wing Beds - SNF	Cost	
		Inpatier	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 482, 294	1	0	1.00
2.00	Interim payments payable on individual bills, either				0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					ļ
	Program to Provider	T		-1	_	
3. 01	ADJUSTMENTS TO PROVIDER	12/07/2015	242, 900		0	3. 01
3. 02					0	3. 02
3. 03					0	3. 03
3. 04					0	3. 04
3.05)	0	3. 05
	Provi der to Program			.1		
3.50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51					0	3. 51
3. 52					0	3. 52
3. 53					0	3. 53
3.54			0.40.000		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		242, 900)	0	3. 99
4 00	3. 50-3. 98)		1 705 107		0	4 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 725, 194	+	U	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					1
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02					0	
5. 03					0	5. 03
	Provi der to Program			1		
5.50	TENTATI VE TO PROGRAM		(0	5.50
5. 51					0	5. 51
5.52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
6.02	SETTLEMENT TO PROGRAM		8, 047	7	0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 717, 147	7	0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	T		0	1. 00	2. 00	
8.00	Name of Contractor					8.00

Heal th	Financial Systems PERRY COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 151322	Peri od: From 01/01/2015	Worksheet E-1 Part II			
			To 12/31/2015				
		Title XVIII	Hospi tal	Cost			
1.00							
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00	Total hospital discharges as defined in AARA §4102 from Wks		14	783	1. 00		
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		1, 539	2. 00 3. 00		
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		2, 461	4. 00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			73, 109, 450	5. 00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			805, 741	6. 00		
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I	1	7. 00		
8. 00	lline 168 Calculation of the HIT incentive payment (see instructions)				8. 00		
9. 00	Sequestration adjustment amount (see instructions)			, ',	9. 00		
10.00		a (soo instructions)		1	10.00		
10.00							
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions)						
	30.00 Initial/interim HIT payment adjustment (see instructions) 0 31.00 Other Adjustment (specify) 0						
	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ne)	1	31. 00 32. 00		
32.00	parance due provider (Time 6 (OF Time 10) militas Time 30 and	Title 31) (See Histiaction	13)	1)	32.00		

Heal th Financi	al Systems			PITAL			In Lieu of Form CMS-2552-10				
CALCULATION OF	REIMBURSEMENT SETTLEMEN	T -	SWING BEDS		Provi der	CCN:	151322			Worksheet	E-2
								From	01/01/2015		
					Component	CCN	l: 15Z322	To	12/31/2015	Date/Ti me	Prepared:
					•					5/24/2016	9:32 am

		30mporterre 30M. 102322	127 017 2010	5/24/2016 9: 3	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 353, 513	0	1
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A		404, 191	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru				
4.00	Per diem cost for interns and residents not in approved teaching	program (see		0. 00	4. 00
	instructions)			_	
5.00	Program days		824	0	5. 00
6.00	Interns and residents not in approved teaching program (see inst			0	0.00
7.00	Utilization review - physician compensation - SNF optional method	d only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 757, 704	0	
9.00	Primary payer payments (see instructions)		0	0	
10. 00	Subtotal (line 8 minus line 9)		1, 757, 704	0	
11. 00	Deductibles billed to program patients (exclude amounts applicable)	le to physician	0	0	11. 00
	professional services)			_	
			1, 757, 704	0	
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	5, 513	0	13. 00
44.00	for physician professional services)			•	44.00
	80% of Part B costs (line 12 x 80%)		1 750 101	0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1, 752, 191	0	15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
	Pioneer ACO demonstration payment adjustment (see instructions) 410A RURAL DEMONSTRATION PROJECT		0	Ü	16. 50 16. 55
			0	0	
17. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	17.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	tions)	0	0	18.00
	Total (see instructions)	trons)	1, 752, 191	0	19.00
19. 00	Sequestration adjustment (see instructions)		35, 044	0	19.00
	Interim payments		1, 725, 194	0	20.00
	Tentative settlement (for contractor use only)		1, 723, 194	0	21.00
	Balance due provider/program (line 19 minus lines 19.01, 20, and	-8, 047	0	21.00	
23. 00	Protested amounts (nonallowable cost report items) in accordance		-0, 047	0	23. 00
23.00	chapter 1, §115.2	WI III CWS PUD. 15-2,	٩	U	23.00
	Chapter 1, 3110.2		1		ı

Health Financial Systems	PERRY COUNTY HOSPITAL		In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi o	der CCN: 151322	From 01/01/2015	Worksheet E-3 Part V Date/Time Prep 5/24/2016 9:32		
	Т	Title XVIII	Hospi tal	Cost		

				5/24/2016 9:33	2 am			
		Title XVIII	Hospi tal	Cost				
	<u> </u>							
				1. 00				
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR V - CAL	ADT A SERVICES - COST	DEL MRI IDSEMENT	1.00				
1.00	Inpatient services	ART A SERVICES - COST	KLIWDOKSLWLNI	4, 074, 181	1. 00			
		2)						
2.00	Nursing and Allied Health Managed Care payment (see instruction	5)		0	2. 00			
3.00	Organ acqui si ti on			0	3. 00			
4.00	Subtotal (sum of lines 1 through 3)			4, 074, 181 0	4. 00 5. 00			
5.00								
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 114, 923	6.00			
	COMPUTATION OF LESSER OF COST OR CHARGES							
	Reasonable charges							
7.00	Routine service charges			0	7. 00			
8.00	Ancillary service charges			0	8. 00			
9. 00	Organ acquisition charges, net of revenue			0				
10.00	Total reasonable charges			0				
10.00				U	10.00			
	Customary charges							
11. 00	Aggregate amount actually collected from patients liable for pa				11. 00			
12. 00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	12.00			
	had such payment been made in accordance with 42 CFR 413.13(e)							
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00			
14.00	Total customary charges (see instructions)			0	14.00			
15.00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00			
	instructions)		, ,					
16.00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00			
	instructions)		, ,					
17. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-				
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 40)		0	18. 00			
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	11110 47)		4, 114, 923				
20. 00	Deductibles (exclude professional component)							
				410, 363				
21. 00	Excess reasonable cost (from line 16)			0	21. 00			
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 704, 560				
23. 00	Coinsurance			0	23. 00			
24. 00	Subtotal (line 22 minus line 23)			3, 704, 560				
25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		62, 577	25. 00			
26.00	Adjusted reimbursable bad debts (see instructions)			40, 675	26.00			
27.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		43, 570	27. 00			
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	ŕ		3, 745, 235	28. 00			
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00			
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50			
29. 99	Recovery of Accelerated Depreciation			0	29. 99			
				-				
30.00	Subtotal (see instructions)			3, 745, 235				
30. 01	Sequestration adjustment (see instructions)			74, 905				
31. 00	Interim payments			3, 715, 811				
32. 00	Tentative settlement (for contractor use only)			0	32. 00			
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, an			-45, 481	33. 00			
34.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	34.00			
	§115. 2							

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Peri od: Worksheet G From 01/01/2015 To 12/31/2015 Date/Time Prepared: Provi der CCN: 151322

			'	0 12/31/2013	5/24/2016 9:3	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	OUDDENT ACCETO	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	1, 096, 706	0	0	0	1. 00
2.00	Temporary investments	1,096,706	1	_	0	2.00
3. 00	Notes recei vabl e			0	0	3. 00
4. 00	Accounts receivable	10, 240, 800	Ö	0	0	4. 00
5.00	Other recei vable	1, 055, 451		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-3, 856, 422	0	0	0	6. 00
7.00	Inventory	1, 026, 740	0	0	0	7. 00
8. 00	Prepai d expenses	624, 503		0	0	8. 00
9.00	Other current assets	4, 936, 813		0	0	9.00
10.00	Due from other funds	15 124 501	ľ		0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	15, 124, 591	0	0	0	11. 00
12. 00	Land	1 0	0	0	0	12. 00
13. 00	Land improvements				0	13. 00
14.00	Accumul ated depreciation	0	0	0	0	14.00
15.00	Bui I di ngs	43, 193, 514	0	0	0	15. 00
16.00	Accumulated depreciation	-22, 795, 777	0	0	0	16. 00
17. 00	Leasehold improvements	0	· -	0	0	17. 00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment Accumulated depreciation	0	0	0	0	19.00
20. 00 21. 00	Automobiles and trucks	0	0	0	0	20. 00 21. 00
22. 00	Accumulated depreciation			0	0	22. 00
23. 00	Major movable equipment		ĺ	0	Ö	23. 00
24.00	Accumul ated depreciation	0	0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	_	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	20, 397, 737	0		0	29. 00 30. 00
30.00	OTHER ASSETS	20, 391, 131		U	0	30.00
31. 00	Investments	0	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	1, 975, 000		0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	1, 975, 000			0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	37, 497, 328	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	905, 894	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	926, 518		0	0	38. 00
39. 00	Payrol I taxes payable	720,010	٥	0	0	39. 00
40.00	Notes and Loans payable (short term)	42, 210	0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0		0	43. 00
44. 00 45. 00	Other current liabilities	534, 077		_	0	
45.00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	2, 408, 699	0	U	0	45. 00
46. 00	Mortgage payable	Ι ο	0	0	0	46. 00
47. 00	Notes payable	3, 749, 258			0	
48.00	Unsecured Loans	0		0	0	48. 00
49. 00	Other long term liabilities	0	0		0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	3, 749, 258			0	50. 00
51. 00	Total liabilites (sum of lines 45 and 50)	6, 157, 957	0	0	0	51. 00
52. 00	CAPITAL ACCOUNTS General fund balance	31, 339, 371	Ι			52. 00
53. 00	Specific purpose fund	31, 339, 3/1	0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0 00	replacement, and expansion	21 220 271			_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	31, 339, 371 37, 497, 328		0	0	
00.00	[59]	37, 477, 320				00.00
	1 *	•	•		1	•

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provi der CCN: 151322

Worksheet G-1 From 01/01/2015

12/31/2015 Date/Time Prepared: 5/24/2016 9:32 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 31, 418, 635 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -79, 264 2.00 3.00 Total (sum of line 1 and line 2) 31, 339, 371 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9. 00 10.00 Total additions (sum of line 4-9) 10.00 31, 339, 371 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 0 12.00 0 0 0 0 13.00 13.00 14.00 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 31, 339, 371 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 0 0 Subtotal (line 3 plus line 10) 11.00 11.00 12.00 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 0 19.00 Fund balance at end of period per balance 19.00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

			10 12/31/2015	5/24/2016 9:3	
	Cost Center Description	Inpatient	Outpati ent	Total	L dill
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	2, 807, 91	5	2, 807, 915	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER			0	4. 00
5. 00 6. 00	Swing bed - SNF Swing bed - NF		0	0	5. 00 6. 00
7. 00	SKILLED NURSING FACILITY		U	U	7. 00
8. 00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	2, 807, 91	5	2, 807, 915	
	Intensive Care Type Inpatient Hospital Services	_, _,	-1	=/ = / / / / / /	
11. 00	INTENSIVE CARE UNIT	429, 12	5	429, 125	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	429, 12	5	429, 125	16. 00
47.00	11-15)	0.007.0		0 007 040	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 237, 04		3, 237, 040	
18.00	Ancillary services	11, 810, 76		64, 436, 553	
19. 00 20. 00	Outpatient services RURAL HEALTH CLINIC - TELL CITY		0 0 889, 661	0 889, 661	19. 00 20. 00
20. 00	RURAL HEALTH CLINIC - PERRY CO FP		0 177, 819	177, 819	
20. 01	RURAL HEALTH CLINIC - TROY		0 27, 582	27, 582	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 27,332	27,002	21. 00
22. 00	HOME HEALTH AGENCY		1, 726, 519	1, 726, 519	
23. 00	AMBULANCE SERVICES		0 2, 614, 276	2, 614, 276	
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		0 0	0	
27. 00	PRO FEES	101, 36		2, 601, 690	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	15, 149, 17	0 60, 561, 970	75, 711, 140	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		35, 341, 724		29. 00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)		0 35, 341, 724		30.00
31.00	ADD (SECTION		o l		31. 00
32. 00			o I		32. 00
33. 00			o l		33. 00
34. 00			o l		34. 00
35. 00			0		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	NON-OPERATI NG EXPENSES	5, 266, 59	8		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40. 00			0		40.00
41. 00			0		41. 00
42. 00	Total deductions (sum of lines 37-41)		5, 266, 598		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	30, 075, 126		43. 00
	to Wkst. G-3, line 4)	1	1		

Hoal th	Financial Systems PERRY COUNTY HOS	SDI TAI	Inlia	u of Form CMS-2	0552_10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 151322	Peri od:	Worksheet G-3	10
			From 01/01/2015 To 12/31/2015	Date/Time Prep 5/24/2016 9:3	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			75, 711, 140	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			43, 136, 410	2. 00
3.00	Net patient revenues (line 1 minus line 2)			32, 574, 730	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		30, 075, 126	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			2, 499, 604	5. 00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			-281, 080	7. 00
8. 00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking Lot receipts			0	12.00
13. 00	Revenue from laundry and linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16. 00
17. 00	J			0	17. 00
18. 00				0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00				0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23.00
24.00	OTHER REVENUE			305, 131	24.00
24. 01	NON-OPERATI NG REVENUE			4, 297, 181	24. 01
25.00	Total other income (sum of lines 6-24)			4, 321, 232	25. 00
26.00	Total (line 5 plus line 25)			6, 820, 836	26.00
27.00	NON-OPERATI NG EXPENSE			6, 900, 100	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			6, 900, 100	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-79, 264	29. 00

	HHA NONREIMBURSABLE SERVICES					
15. 00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19. 00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0	0	21.00
	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	82, 166	684, 563	-283	684, 280	24.00

leal th	Financial Systems		PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provi der HHA CCN:	CCN: 151322 157177	Peri od: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part I Date/Time Pre 5/24/2016 9:3	pared:
						Home Health	PPS	z alli
			Capital Rela	ted Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	PI ant Operation & Maintenance		Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4. 00	4A. 00	
1 00	GENERAL SERVICE COST CENTERS							4 00
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2. 00	Capital Related - Movable Equipment	0		C			0	2. 00
3.00	Plant Operation & Maintenance	0	0	C	1	0	0	
4. 00 5. 00	Transportation Administrative and General	0 315, 643	0	(1	0 0	315, 643	4. 00 5. 00
	HHA REIMBURSABLE SERVICES							
6. 00 7. 00	Skilled Nursing Care Physical Therapy	186, 673 73, 023	0	(0 0	186, 673 73, 023	
3. 00	Occupational Therapy	32, 887	0	C	1	0 0	32, 887	
9. 00	Speech Pathology	21, 019	0	C		0 0	21, 019	9. 00
0.00	Medical Social Services	691	0	C	1	0 0	691	
1.00	Home Health Aide Supplies (see instructions)	54, 344 0	0	(1	0 0	54, 344	11.00
	Drugs		0	C	1	0	0	
14. 00	DME	Ö	Ö	Č		0 0	0	14. 00
	HHA NONREI MBURSABLE SERVI CES							
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	(•	0 0	0	15. 00 16. 00
7. 00	Private Duty Nursing		o	(1	0 0	0	17. 00
8. 00	Clinic	0	0	C		0 0	0	18.00
	Health Promotion Activities	0	0	C	1	0 0	0	19.00
	Day Care Program Home Delivered Meals Program	0	0	(1	0 0	0	20.00
	Homemaker Service		0	(1	0 0	0	22.00
	All Others (specify)	Ö	Ö	Č	1	0 0	Ō	23. 00
24. 00	Total (sum of lines 1-23)	684, 280	0	C		0 0	684, 280	24.00
		Administrative & General	lotal (cols. 4A + 5)					
		5. 00	6.00					
	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &		1					1 1 00
1.00	Fixtures							1.00
2. 00	Capital Related - Movable							2.00
	Equipment							1
3. 00 1. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	315, 643						5. 00
	HHA REIMBURSABLE SERVICES	,						
. 00	Skilled Nursing Care	159, 838	346, 511					6.00
7. 00 3. 00	Physical Therapy Occupational Therapy	62, 525 28, 159	135, 548 61, 046					7. 00 8. 00
9. 00	Speech Pathology	17, 997	39, 016					9. 00
	Medical Social Services	592	1, 283					10.00
	Home Health Aide	46, 532	100, 876					11.00
	Supplies (see instructions) Drugs	0 0	0					12. 00 13. 00
14. 00		0	0					14.00
	HHA NONREIMBURSABLE SERVICES]
	Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16. 00 17. 00
	LLLL VOLE DULLY INDUSTRIAL							

18.00

19. 00

20.00 21.00

22. 00 23.00 24.00

18.00 Clinic

Private Duty Nursing

19.00 | Health Promotion Activities

20.00 Day Care Program
21.00 Home Delivered Meals Program

22.00 Homemaker Service
23.00 All Others (specify)
24.00 Total (sum of lines 1-23)

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - HHA STATISTICAL BASI	S	Provi der (CCN: 151322		Worksheet H-1	
				From 01/01/2015		
		HHA CCN:	157177	To 12/31/2015	Date/Time Prep	ared:
					5/24/2016 9: 32	am
				Home Health	PPS	
				Agency I		

						Home Health Agency I	PPS	
		Capital Rel	ated Costs			Agency		
		oupi tui kei	atea eests					
		BI dgs &	Movabl e	PI ant	Transportatio	n Reconciliation	Administrative	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
		(Ì	(SQUARE FEET)			, ,	
		1.00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS				•			
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	(0		3. 00
4.00	Transportation (see	0	0	(O		4. 00
	instructions)							
5.00	Administrative and General	0	0	(315, 643	368, 637	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	(1	0	186, 673	1
7.00	Physi cal Therapy	0	0	(0	73, 023	
8.00	Occupational Therapy	0	0	(0	32, 887	
9.00	Speech Pathology	0	0	(0	21, 019	1
10.00	Medical Social Services	0	0	(0	691	
11. 00	Home Health Aide	0	0	(0	54, 344	1
12.00	Supplies (see instructions)	0	0	()	0	0	
13.00	Drugs	0	0	-	1	0	0	
14.00	DME	0	0	()	0	0	14. 00
	HHA NONREIMBURSABLE SERVICES		•					
	Home Dialysis Aide Services	0	ı	(1	0	0	1
16.00	Respi ratory Therapy	0	0	(0	0	
	Private Duty Nursing	0	0	(0	0	
18. 00	Clinic	0	0	(0	0	1
	Health Promotion Activities	0	0	(0	0	19. 00
20. 00	Day Care Program	0	0	(0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	(0	0	21. 00
22. 00	Homemaker Service	0	0	(0	0	22. 00
	All Others (specify)	0	0	(0	0	23. 00
24. 00	Total (sum of lines 1-23)	0	0	(-315, 643	368, 637	
25. 00	Cost To Be Allocated (per	0	0	()	O	315, 643	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.00000	0	0. 856243	26.00

Worksheet H-2 Part I Date/Time Prepared: 5/24/2016 9:32 am From 01/01/2015 To 12/31/2015 HHA CCN: 157177

Home Health

18.00

19.00

20.00

21.00

5, 349

						Agency I	FF3	
			CAPITAL REL	ATED COSTS		rigeriey i		
	Cost Center Description	HHA Trial	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	oost conton beschiptren	Bal ance (1)	FLXT	EQUI P	BENEFITS	ous coca.	AND GENERAL	
		0	4.00	0.00	DEPARTMENT	4.0	F 04	
1 00	Administratives and Consent	0	1.00	2.00	4.00	4A	5. 01	1 00
1.00	Administrative and General	0	4, 771	9, 158	4, 933	18, 862		1.00
2.00	Skilled Nursing Care	346, 511	0	0	_	,		2. 00
3.00	Physi cal Therapy	135, 548	0	0	0			3. 00
4.00	Occupational Therapy	61, 046	0	0	0			4. 00
5.00	Speech Pathology	39, 016	0	0	0	39, 016		5. 00
6.00	Medical Social Services	1, 283	0	0	0	,		6. 00
7. 00	Home Health Aide	100, 876	0	0	_			7. 00
8.00	Supplies (see instructions)	0	0	0	0		0	8. 00
9. 00	Drugs	0	0	0	0	_	0	9. 00
10. 00	DME	0	0	0	0	_	이	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0		0	11. 00
12. 00	Respiratory Therapy	0	0	0			0	12. 00
13. 00	Private Duty Nursing	0	0	0	0		0	13.00
14. 00	Clinic	0	0	0	0	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16. 00	Day Care Program	0	0	0	0	_	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00	Homemaker Service	0	0	0	0	0	0	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
20. 00	Total (sum of lines 1-19) (2)	684, 280	4, 771	9, 158	4, 933			20. 00
21. 00	Unit Cost Multiplier: column					0. 000000		21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places. Cost Center Description	Subtotal	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	oost center bescriptron		ADMI NI STRATI VE	PLANT	LINEN SERVICE	TIOOSEREELTING	DILIAN	
			AND GENERAL		ETTEN GENTT GE			
		5A. 01	5. 02	7. 00	8. 00	9. 00	10.00	
1.00	Administrative and General	20, 282	2, 808	17, 578	0	5, 349	0	1. 00
2.00	Skilled Nursing Care	372, 602	51, 589	0	0	0	0	2.00
3.00	Physi cal Therapy	145, 755	20, 181	0	0	0	0	3.00
4.00	Occupational Therapy	65, 643	9, 089	0	0		0	4. 00
5.00	Speech Pathology	41, 954	5, 809	0	0	_	0	5. 00
6.00	Medical Social Services	1, 380	191	0	· ·	0	0	6. 00
7. 00	Home Health Aide	108, 472	15, 019	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	_	0	8. 00
9. 00	Drugs	0	0	0	_		0	9. 00
10.00	DME	0	0	0	_		0	10.00
11. 00	Home Dialysis Aide Services	0	0	0		0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	미	12.00
13.00	Private Duty Nursing	0	0	0	0		0	13.00
14. 00	Clinic	0	0	0	0		0	14. 00
15. 00	Health Promotion Activities	0	0	0	0		0	15. 00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	0		0	17. 00

0

104, 686

17, 578

756, 088

0. 000000

18.00 Homemaker Service

19.00 All Others (specify) 20.00 Total (sum of lines 1-19) (2)

21.00 Unit Cost Multiplier: column

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

0

0

883, 701

13.00

14.00

15.00

16.00

17 00

18.00

19.00

20.00

21.00

(1) Column O, line 20 must agree with Wkst. A, column 7, line 101.

0

0

0

0

46,017

0.054934

Private Duty Nursing

Day Care Program

Homemaker Service

6 decimal places.

All Others (specify)

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-19) (2)

Unit Cost Multiplier: column

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

13.00

14.00

15.00

16.00

17.00

19.00

20.00

Clinic

⁽²⁾ Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO H	HHA COST CENTERS STATISTICAL Provider CCN: 151322	
D.1.0.1.0		From 01/01/2015 Dart II

151322 | Peri od: From 01/01/2015 | Part II 157177 | To 12/31/2015 | Date/Time Prepared: 5/24/2016 9:32 am | PPS BASIS HHA CCN:

					Agency I	PPS	
	CAPITAL REL	ATED COSTS			Agency		
Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	
	1 00	2 00		5A 01	5 01	5A 02	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description	1. 00 587 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 587 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.016749 LAUNDRY & LINEN SERVICE	00 00 00 00 00 00 00 00 00 00 00 00 00	346, 511 135, 548 61, 046 39, 016 1, 283 100, 876 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 00
	AND GENERAL (ACCUM. COST NO PBP)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	FEET)	SERVED)		
	5. 02	7. 00	8. 00	9. 00	10.00	11. 00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	20, 282 372, 602 145, 755 65, 643 41, 954 1, 380 108, 472 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	587 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00

Heal th	Financial Systems		PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	TION OF GENERAL SERVICE COSTS	TO HHA COST CENT			N: 151322 157177	Peri od: From 01/01/2015 To 12/31/2015	Worksheet H-2 Part II Date/Time Pre 5/24/2016 9:3	pared:
						Home Health Agency I	PPS	
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS) 13.00	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16, 00					
1.00	Administrative and General	13.00	0					1. 00
2.00	Skilled Nursing Care	0	0					2. 00
3.00	Physi cal Therapy	0	0					3. 00
4.00	Occupational Therapy	0	0					4. 00
5.00	Speech Pathology	0	0					5. 00
6.00	Medical Social Services	0	0					6. 00
7.00	Home Health Aide	0	0					7. 00
8.00	Supplies (see instructions)	0	0					8. 00
9.00	Drugs	0	0					9. 00
10.00	DME	0	0					10.00
11. 00	Home Dialysis Aide Services	0	0					11. 00
12.00	Respi ratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15. 00	Health Promotion Activities	0	0					15. 00
16. 00	Day Care Program	0	0					16. 00
17. 00	Home Delivered Meals Program	0	0					17. 00
18. 00	Homemaker Service	0	0					18. 00
19. 00	All Others (specify)	0	0					19. 00
20.00	Total (sum of lines 1-19)	0	0					20. 00
21. 00	Total cost to be allocated	0	0					21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000					22. 00

APPORTIONMENT OF PATIENT SERVICE COS Cost Center Description			Provi der				
Cost Center Description			HHA CCN:		Peri od: From 01/01/2015 To 12/31/2015	Worksheet H-3 Part I Date/Time Prep 5/24/2016 9:32	pared:
Cost Center Description			Ti tl	e XVIII	Home Health Agency I	PPS	2 4111
	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Ancillary Costs (from	Total HHA Costs (cols. + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col.	
	0	1.00	Part II) 2.00	2.00	4.00	4)	
PART I - COMPUTATION OF LESSE		1.00 PROGRAM COST, A	GGREGATE OF TH	3.00 IE PROGRAM LIN	4.00 ITATION COST, OF	5. 00 R	
BENEFICIARY COST LIMITATION Cost Per Visit Computation							
1.00 Skilled Nursing Care	2. 00	447, 493		447, 49	1, 852	241. 63	1.00
2.00 Physical Therapy	3. 00						
3.00 Occupational Therapy	4.00		l e			116. 62	
4.00 Speech Pathology 5.00 Medical Social Services	5. 00 6. 00	1		50, 38 1, 65		1, 291. 97 0. 00	
6.00 Home Health Aide	7. 00			130, 27			
7.00 Total (sum of lines 1-6)		883, 701	C	1			7. 00
				Program Visit			
Cost Contor Description	Cost Limits	CDSA No. (1)	Dort A		ert B		
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t Deductibles Coinsurance	& Deductibles		
	0	1.00	2.00	3. 00	4. 00	5. 00	
Limitation Cost Computation		15000					
8.00 Skilled Nursing Care 9.00 Physical Therapy		15999 15999	C I				8. 00 9. 00
10.00 Occupational Therapy		15999		1			10.00
11. 00 Speech Pathology		15999	Ċ	1	4		11. 00
12.00 Medical Social Services		15999	c		6		12.00
13.00 Home Health Aide		15999	C	1			13.00
14.00 Total (sum of lines 8-13)			C	=,		5 11 (1 0	14. 00
Cost Center Description	From Wkst. H-2 Part I, col.	(from Wkst.		Total HHA Costs (cols.		Ratio (col. 3 ÷ col. 4)	
	28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Record)	÷ COI . 4)	
	0	1.00	2.00	3.00	4. 00	5. 00	
Supplies and Drugs Cost Compu							
15.00 Cost of Medical Supplies	8.00		l .	1	0 0	0.000000	
16.00 Cost of Drugs	9. 00	Program Visits		Cost of	5 19	0. 263158	16.00
		11 Ogram VI SI LS		Servi ces			
		Par			Part B		
Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
		Deductibles &			Deductibles &	Deductibles &	
	6. 00	Coi nsurance 7.00	Coi nsurance 8.00	9. 00	Coi nsurance 10.00	Coi nsurance 11.00	
PART I - COMPUTATION OF LESSE							
BENEFICIARY COST LIMITATION							
Cost Per Visit Computation	-				0 0/5 ===		
1.00 Skilled Nursing Care	0				0 265, 793		1.00
2.00 Physical Therapy 3.00 Occupational Therapy	0 0		l e		0 149, 850 0 72, 304		2. 00 3. 00
4.00 Speech Pathology		1	ł		0 18, 088		4.00
	0	1	ł		0 0		5. 00
5.00 Medical Social Services	0	116	ł		0 6, 433		6. 00
	1 ^	2, 718			0 512, 468		7. 00
5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6)	0		8. 00	9. 00	10.00	11.00	
5.00 Medical Social Services 6.00 Home Health Aide		7 00					
5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6)		7. 00	0.00	7.00	10.00	11. 00	
5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description		7.00	0.00	7.00	10.00	11.00	8. 00
5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 8.00 Skilled Nursing Care 9.00 Physical Therapy		7.00	0.00	7.00	10.00	11.00	9.00
5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 8.00 Skilled Nursing Care 9.00 Physical Therapy 10.00 Occupational Therapy		7.00	0.00	7.00	10.00	11.00	9. 00 10. 00
5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description 8.00 Skilled Nursing Care 9.00 Physical Therapy 10.00 Occupational Therapy 11.00 Speech Pathology		7.00	0.00	7.00	10.00	11.00	9. 00 10. 00 11. 00
5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description 8.00 Skilled Nursing Care 9.00 Physical Therapy 10.00 Occupational Therapy 11.00 Speech Pathology 12.00 Medical Social Services		7.00	3.00	7.00	10.00	11.00	9. 00 10. 00 11. 00 12. 00
Medical Social Services Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology		7.00	3. 00	7.00	10.00	11.00	9. 0 10. 0 11. 0

Heal th	Financial Systems		PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF PATIENT SERVICE COST	S		HHA CCN:	CCN: 151322 157177		5/24/2016 9:3	pared:
					e XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Not Subject to	t B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9.00	10.00	11. 00	
	Supplies and Drugs Cost Computa		1	1	1			
	Cost of Medical Supplies Cost of Drugs	0	902			0 0 237	0	
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LI	MITATION COST, OF	R	
	Cost Per Visit Computation		,					
1.00	Skilled Nursing Care	265, 793						1.00
2.00	Physi cal Therapy	149, 850						2.00
3.00	Occupational Therapy Speech Pathology	72, 304						3. 00 4. 00
4. 00 5. 00	Medical Social Services	18, 088 0						5.00
6.00	Home Health Aide	6, 433						6.00
7. 00	Total (sum of lines 1-6)	512, 468						7.00
7.00	Cost Center Description	312, 400				·		7.00
	oost denter bescriptron	12. 00						
	Limitation Cost Computation		·					
8.00	Skilled Nursing Care							8. 00
9.00	Physi cal Therapy							9. 00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology							11. 00
12.00	Medical Social Services							12. 00
13.00	Home Health Aide							13. 00
14.00	Total (sum of lines 8-13)	I	1					14.00

Health Financial Systems		PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE	COSTS		Provi der		Peri od:	Worksheet H-3	
			HHA CCN:		From 01/01/2015 To 12/31/2015	Part II Date/Time Pre	pared:
						5/24/2016 9: 3	
			Ti tl	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Descript	ion From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4. 00		
PART II - APPORTIONMENT O	COST OF HHA SERVI	CES FURNISHED B	BY SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66. 00	0. 364299	C		0 col. 2, line 2.	. 00	1. 00
2.00 Occupational Therapy	67. 00	0. 276181	C		0 col. 2, line 3.	. 00	2. 00
3.00 Speech Pathology	68. 00	0. 366148	C		0 col. 2, line 4.	. 00	3. 00
4.00 Cost of Medical Supplies	71. 00	0. 102671	[C		0 col. 2, line 1!	5. 00	4. 00
5.00 Cost of Drugs	73. 00	0. 238181	19	·	5 col. 2, line 10	5. 00	5. 00

th Financial Systems PERRY COUNTY HOS CULATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 151322	Period:	eu of Form CMS-2 Worksheet H-4
SOLATION OF THIS RETWINDORSEMENT SETTLEMENT			From 01/01/2015	Part I-II
	HHA CCN:	157177	To 12/31/2015	Date/Time Pre 5/24/2016 9:3
	Ti tl e	e XVIII	Home Health	PPS
<u> </u>			Agency I	
		Don't A	Par Not Subject to	t B Subject to
		Part A		Deductibles &
			Coi nsurance	Coi nsurance
		1. 00	2. 00	3. 00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	ARY CHARGES	S		
Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)	T		0 237	0
Total charges	-		0 759	
Customary Charges				
Amount actually collected from patients liable for payment for	servi ces		0 0	0
on a charge basis (from your records)				
Amount that would have been realized from patients liable for p for services on a charge basis had such payment been made in ac with 42 CFR §413.13(b)			0 0	0
Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000
Total customary charges (see instructions)			0 759	
Excess of total customary charges over total reasonable cost (c	omplete		0 522	0
only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	ifline		0 0	0
Primary payer amounts			0 0	0
			Part A	Part B
			Servi ces 1.00	Servi ces 2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00
Total reasonable cost (see instructions)			0	237
OO Total PPS Reimbursement - Full Episodes without Outliers			0	
700 Total PPS Reimbursement - Full Episodes with Outliers			0	7, 883
			()	7, 022
•				
Total PPS Reimbursement - PEP Episodes			0	1, 152
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	1, 152 1, 053
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes			0 0	1, 152 1, 053 0
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			000000000000000000000000000000000000000	1, 152 1, 053
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments			000000000000000000000000000000000000000	1, 152 1, 053 0 0
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments			000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments OXygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur	ance)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 0
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Overygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21)	ance)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 0 0 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	ance)		0	1, 152 1, 053 0 0 0 0 0 0 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)	ance)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)	ance)		0	1, 152 1, 053 0 0 0 0 0 0 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments OXygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	ŕ		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins	tructions)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661 0 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line	tructions)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tructions)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	tructions)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pi oneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)	tructions)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661 438, 661 0 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pi oneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions)	tructions)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661 438, 661 0 438, 661 0 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pi oneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)	tructions)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661 438, 661 0 438, 661
Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total OPS Outlier Payments DE Payments DE Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Interim payments (see instructions)	tructi ons) 27)		000000000000000000000000000000000000000	1, 152 1, 053 0 0 0 0 0 438, 661 0 438, 661 438, 661 438, 661 438, 661 8, 769 430, 539

Health Financial Systems PERRY COUNTY HOST ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10

PROGRAM BENEFICIARIES

				Home Health Agency I	PPS	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider			0	430, 539	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	Program to Provider			0	0	3. 01
3. 01				0	0	3. 01
3. 02				0		3. 02
3. 04				0		3. 04
3. 05				0	0	3. 05
	Provider to Program					
3.50				0	0	3.50
3. 51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	430, 539	4. 00
	TO BE COMPLETED BY CONTRACTOR		1			
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider		1			
5. 01				0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.03	Provider to Program			U	U	5.03
5. 50	1 Tovi dei 10 1 Togi alli			0	0	5. 50
5. 51				0	l ol	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	647	6. 02
7. 00	Total Medicare program liability (see instructions)			0	429, 892	7. 00
	,,,,,			Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8.00	Name of Contractor					8. 00
					·	

ANALYS	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED) Provi der	CCN: 151322	Peri od:	Worksheet M-1	
HEALTH	CENTER COSTS		Component	CCN: 158516	From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 9:3	pared: 2 am
					Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs		1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	0.00	2.00	4.00	4)	
	FACILITY HEALTH CARE STAFE COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	24E 011	0	245 0	11 0	24E 011	1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	265, 811 0	0		0 0	265, 811 0	1. 00 2. 00
3.00	Nurse Practitioner	35, 705	0		-	35, 705	
4.00	Visiting Nurse	35, 705	0		0 0	35, 705	4.00
5.00	Other Nurse	0	0		0 0	0	
6. 00	Clinical Psychologist	0	0		0 0	0	6.00
7. 00	Clinical Social Worker	0	0		0 0	0	7.00
8. 00	Laboratory Techni ci an	0	0		0 0	0	8.00
9. 00	Other Facility Health Care Staff Costs	0	0		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	301, 516	0		-	301, 516	
11. 00	Physician Services Under Agreement	0	0		0 0	0	11. 00
12. 00	Physician Supervision Under Agreement	o	0	•	o o	0	12. 00
13. 00	Other Costs Under Agreement	o	0		0 0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	o	0		0 0	0	14.00
15. 00	Medical Supplies	o	0		0 0	0	15.00
16. 00	Transportation (Health Care Staff)	o	0		0 0	0	16.00
17. 00	Depreciation-Medical Equipment	o	0		0 0	0	17.00
18. 00	Professional Liability Insurance	0	0		0 0	0	18.00
19. 00	Other Health Care Costs	0	0		0 0	0	19. 00
20. 00	Allowable GME Costs	0	0		0 0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0	1	0	0	21.00
22. 00	Total Cost of Health Care Services (sum of	301, 516	0	301, 5 ⁻	16 0	301, 516	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS	ام		ı			
23. 00	Pharmacy	0	0		0 0	0	
24. 00	Dental	0	0		0 0	0	
25. 00	Optometry	0	0		0 0	0	25. 00
26. 00	All other nonreimbursable costs	0	0		0 0	0	26.00
27. 00 28. 00	Nonallowable GME costs	U	0		0 0	0	27. 00 28. 00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	U	Ü			Ü	28.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	ol	0		0 0	0	29. 00
30.00	Administrative Costs	478, 336	449, 376			1, 139, 924	30.00
31.00	Total Facility Overhead (sum of lines 29 and	478, 336	449, 376			1, 139, 924	31.00
51.00	30)	470, 330	777, 370	'~''	12,212	1, 137, 724] 31.00

Health Financial Systems	PERRY COUNTY HOS	PITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL HE HEALTH CENTER COSTS	EALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 151322	Peri od: From 01/01/2015	Worksheet M-1
HEACHT CENTER COSTS		Component CCN: 158516	To 12/31/2015	
			Rural Health	Cost

						Rural Health		
		۸ -۱: الحب الح	N-+	F		Clinic (RHC)	I	
		Adjustments		Expenses Ilocation				
				5 + col.				
			(COI .	6)				
		6. 00		7. 00				
	FACILITY HEALTH CARE STAFF COSTS	0.00		7.00	l			
1.00	Physi ci an	0		265, 811				1.00
2.00	Physician Assistant	0		0				2.00
3.00	Nurse Practitioner	0		35, 705				3.00
4.00	Visiting Nurse	0		00,700				4. 00
5. 00	Other Nurse	0		0				5. 00
6.00	Clinical Psychologist	0		0				6. 00
7. 00	Clinical Social Worker	0		0				7. 00
8.00	Laboratory Techni ci an	0		0				8. 00
9. 00	Other Facility Health Care Staff Costs	0		0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0		301, 516				10.00
11. 00	Physician Services Under Agreement	0		0	1			11. 00
12. 00	Physician Supervision Under Agreement	0		o				12.00
13. 00	Other Costs Under Agreement	0		o				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0		o				14. 00
15. 00	Medical Supplies	0	İ	o				15. 00
16.00	Transportation (Health Care Staff)	0		o				16. 00
17.00	Depreciation-Medical Equipment	0		o				17. 00
18.00	Professional Liability Insurance	0		o				18. 00
19.00	Other Health Care Costs	0		o				19. 00
20.00	Allowable GME Costs	0		o				20.00
21.00	Subtotal (sum of lines 15 through 20)	0		o				21. 00
22.00	Total Cost of Health Care Services (sum of	0		301, 516				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICS							
23. 00	Pharmacy	0		0				23. 00
24. 00	Dental	0		0				24. 00
25. 00	Optometry	0		0				25. 00
26. 00	All other nonreimbursable costs	0		0				26. 00
27. 00	Nonallowable GME costs	0		0				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		0				28. 00
	through 27)							-
20.00	FACILITY OVERHEAD							20.00
29. 00	Facility Costs	0		0 1, 139, 924				29. 00 30. 00
30.00	Administrative Costs	0	1					
31. 00	Total Facility Overhead (sum of lines 29 and 30)	0		1, 139, 924				31. 00
32. 00	Total facility costs (sum of lines 22, 28	0		1, 441, 440				32. 00
32.00	and 31)	Ü		1, 441, 440				32.00
	Tana 51)		1	'	1			1

	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDER	RALLY QUALIFIED	Provi der	CCN: 151322	Peri od:	Worksheet M-1	
HEALTH	CENTER COSTS		Component	CCN: 158517	From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 9:3	
					Rural Health Clinic (RHC) II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassificati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2.00	2.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2. 00	3. 00	4.00	5.00	
1. 00	Physi ci an	ol	0		0 0	0	1.00
2. 00	Physician Assistant	o	0		0 0	Ö	
3. 00	Nurse Practitioner	57, 517	0	57, 5	17 0	57, 517	
4. 00	Visiting Nurse	0	0	, ,	0 0	0	
5. 00	Other Nurse	0	0		0 0	0	5.00
6. 00	Clinical Psychologist	0	0		0 0	0	6.0
7. 00	Clinical Social Worker	0	0		0 0	0	7.0
8. 00	Laboratory Techni ci an	0	0		0 0	0	8.00
9. 00	Other Facility Health Care Staff Costs	0	0		0 0	0	9. 0
10.00	Subtotal (sum of lines 1 through 9)	57, 517	0	57, 5	17 0	57, 517	10.0
11. 00	Physician Services Under Agreement	0	0		0 0	0	11. 0
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	
13. 00	Other Costs Under Agreement	0	0		0 0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15. 00	Medical Supplies	0	0		0 0	0	
16. 00	Transportation (Health Care Staff)	0	0		0 0	0	
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	
18.00	Professional Liability Insurance	0	0		0 0	0	
19.00	Other Health Care Costs Allowable GME Costs	0	0		0	0	
20. 00 21. 00	Subtotal (sum of lines 15 through 20)	0	0		0 0		
21.00	Total Cost of Health Care Services (sum of	57, 517	0	57, 5	٥	57, 517	
22.00	lines 10, 14, and 21)	37, 317	Ü	57,5	17	37,317	22.0
	COSTS OTHER THAN RHC/FQHC SERVICS						
23. 00	Pharmacy	0	0		0 0	0	23.0
24. 00	Dental	0	0		0 0	0	24. 0
25. 00	Optometry	O	0		0 0	0	25. 0
26. 00	All other nonreimbursable costs	0	0		0 0	0	26. 0
27. 00	Nonallowable GME costs	0	0		0 0	0	
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. 0
	through 27)						
20.00	FACILITY OVERHEAD	ol	0		0 0	_	29. 0
29. 00	Facility Costs	-1	ŭ	100 4	-	0	
30.00	Administrative Costs	67, 395 67, 395	115, 046 115, 046		· ·	223, 902 223, 902	
31. 00	Total Facility Overhead (sum of lines 29 and 30)	07, 395	115, 046	182, 4	41, 461	223, 902	31.0
32. 00	Total facility costs (sum of lines 22, 28	124, 912	115, 046	239, 9	58 41, 461	281, 419	32. 0
JZ. 00	and 31)	124, 712	113, 040	237, 7	41, 401	201, 417	1 32.0

Health Financial Systems	PERRY COUNTY H	OSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL	HEALTH CLINIC/FEDERALLY QUALIFIED	Provider CCN: 151322		Worksheet M-1
HEALTH CENTER COSTS			From 01/01/2015	
		Component CCN: 158517	To 12/31/2015	
				5/24/2016 9:32 am
			Rural Health	Cost
		I	Clinia (DUC) II	

				Rural Health Cost	
		A 1: 1 1	LN . E	Clinic (RHC) II	
		Adjustments	Net Expenses		
			for Allocatio		
			(col. 5 + col		
		/ 00	6)		
	FACILITY HEALTH CARE STAFF COSTS	6. 00	7.00		
1.00	Physi ci an		1	0	1.00
2. 00	Physician Assistant	0	l .	o o	2. 00
3. 00	Nurse Practitioner	Ċ	57, 51		3. 00
4. 00	Vi si ti ng Nurse	Ċ	1	0	4. 00
5. 00	Other Nurse	Ċ		0	5. 00
6. 00	Clinical Psychologist			0	6.00
7. 00	Clinical Social Worker			0	7. 00
			(0	
8.00	Laboratory Technician	C	l .	0	8. 00
9.00	Other Facility Health Care Staff Costs	C	I .	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	C	57, 51		10.00
11. 00	Physician Services Under Agreement	C	l .	0	11. 00
12. 00	Physician Supervision Under Agreement	C)	0	12. 00
13. 00	Other Costs Under Agreement	C)	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	C)	0	14. 00
15. 00	Medical Supplies	C)	0	15. 00
16. 00	Transportation (Health Care Staff)	C)	0	16. 00
17. 00	1 '	C)	0	17. 00
18. 00		C)	0	18. 00
19. 00	Other Health Care Costs	C)	0	19. 00
20.00	Allowable GME Costs	C)	0	20. 00
21. 00	Subtotal (sum of lines 15 through 20)	C	l .	0	21. 00
22. 00	Total Cost of Health Care Services (sum of	C	57, 51	7	22. 00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICS		1	-1	
23. 00	,	C		0	23. 00
24. 00	Dental	C)	0	24. 00
25. 00	Optometry	C)	0	25. 00
26. 00	All other nonreimbursable costs	C)	0	26. 00
27. 00	Nonallowable GME costs	C)	0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	C)	0	28. 00
	through 27)				_
	FACILITY OVERHEAD				
	Facility Costs	C	I .	0	29. 00
30.00	Administrative Costs	C	223, 90	l .	30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	C	223, 90	2	31. 00
32. 00	30)		201 41	0	32. 00
32.00	Total facility costs (sum of lines 22, 28 and 31)	C	281, 41	الخ	32.00
	and or,		I		1

	GIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDEI I CENTER COSTS	RALLY QUALIFIED		CCN: 151322 t CCN: 158518	Peri od: From 01/01/2015 To 12/31/2015	Worksheet M-1 Date/Time Pre	
			Componen	L CCN. 136316	10 12/31/2015	5/24/2016 9:3	
					Rural Health	Cost	
					Clinic (RHC) III		
		Compensation	Other Costs		1 Reclassificati		
				+ col . 2)	ons	Trial Balance (col. 3 + col.	
						4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS		2.00	0.00	1.00	0.00	
1.00	Physi ci an	0	C		0 0	0	1.00
2. 00	Physician Assistant	o	C		0 0	0	2.00
3. 00	Nurse Practitioner	13, 447	C	13, 4	47 0	13, 447	3.00
4. 00	Visiting Nurse	o	C		0 0	0	4.00
5. 00	Other Nurse	0	C		0	0	5. 00
6. 00	Clinical Psychologist	0	C)	0	0	
7. 00	Clinical Social Worker	0	C		0	0	
3. 00	Laboratory Techni ci an	0	C		0	0	
9. 00	Other Facility Health Care Staff Costs	0	C		0	0	
10.00	Subtotal (sum of lines 1 through 9)	13, 447	C	13, 4		13, 447	1
11.00	Physician Services Under Agreement	0	C)	0 0	0	
12.00	Physician Supervision Under Agreement	0	C	1	0 0	0	
13.00	Other Costs Under Agreement	0	C		0 0	0	
14. 00 15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0			0 0	0	
16. 00	Transportation (Health Care Staff)	0				0	
17. 00	Depreciation-Medical Equipment	0				0	
18. 00	Professional Liability Insurance	ol	Č		0 0	Ö	
19. 00	Other Health Care Costs	ol	C		0 0	o o	
20. 00	Allowable GME Costs	ō	C		0 0	Ō	
21. 00	Subtotal (sum of lines 15 through 20)	o	C		0 0	0	21.00
22. 00	Total Cost of Health Care Services (sum of	13, 447	C	13, 4	47 O	13, 447	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS						
23. 00	Pharmacy	0	C		0 0	0	
24. 00	Dental	0	C)	0 0	0	
25. 00	Optometry	0	C)	0	0	
26. 00	All other nonreimbursable costs	0	C	2	0	0	
27. 00	Nonallowable GME costs	0	C	2	0 0	0	
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	۷	C	'	0	0	28. 00
	FACILITY OVERHEAD	l		1		L	1
29. 00	Facility Costs	ol	C		0 0	0	29. 00
30.00	Administrative Costs	7, 493	15, 135		-1		
31. 00	Total Facility Overhead (sum of lines 29 and	7, 493	15, 135				31.00
	30)	,	-,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
32. 00	Total facility costs (sum of lines 22, 28	20, 940	15, 135	36, 0	75 15, 853	51, 928	32.00
	and 31)			1		I	1

Health Financial Systems	PERRY COUNTY HOS	PITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL H	HEALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 151322	Peri od: From 01/01/2015	Worksheet M-1
HEALTH GENTER COSTS		Component CCN: 158518		
			Rural Health	Cost

					Rural Health Cost	
		Adiustments	Not F	xpenses	Clinic (RHC) III	
		Adjustments		l ocati on		
				5 + col.		
			,			
		6. 00		6) . 00		
	FACILITY HEALTH CARE STAFF COSTS	0.00	/	. 00		
1.00	Physician	0	1	0		1.00
2.00	Physician Assistant	0	()	0		2.00
3.00	Nurse Practitioner	0	()	13, 447		3. 00
	l e	0	()			1
4.00	Visiting Nurse	0]	0		4. 00
5.00	Other Nurse	0	'	0		5. 00
6.00	Clinical Psychologist	0	2	0		6. 00
7.00	Clinical Social Worker	0	9	0		7. 00
8.00	Laboratory Techni ci an	0		0		8. 00
9.00	Other Facility Health Care Staff Costs	0		0		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0)	13, 447		10.00
11. 00	Physician Services Under Agreement	0		0		11. 00
12.00	Physician Supervision Under Agreement	0		0		12.00
13.00	Other Costs Under Agreement	0		O		13. 00
14.00	Subtotal (sum of lines 11 through 13)	0		o		14.00
15.00	Medical Supplies	0		o		15. 00
16.00	Transportation (Health Care Staff)	0		ol		16. 00
17.00	Depreciation-Medical Equipment	0	ol	ol		17. 00
18.00	Professional Liability Insurance	0	ol	ol		18. 00
	Other Health Care Costs	0		o		19. 00
20. 00	Allowable GME Costs	0		o		20.00
21. 00	Subtotal (sum of lines 15 through 20)	0		o		21. 00
22. 00	Total Cost of Health Care Services (sum of	0		13, 447		22. 00
22.00	lines 10, 14, and 21)	J	Ί	10, 11,		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS					
23. 00	Pharmacy	0		0		23. 00
24. 00	Dental	0		0		24. 00
25. 00	Optometry	0	()	0		25. 00
26. 00	All other nonreimbursable costs	0	()	0		26. 00
27. 00	Nonal Lowable GME costs	0	()	0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	()	0		28. 00
20.00	through 27)	Ü	Ί	۷		20.00
	FACILITY OVERHEAD					
29. 00		0	1	0		29. 00
30.00	Administrative Costs	0	()	38, 481		30.00
	l e	0	()			
31. 00	Total Facility Overhead (sum of lines 29 and	0	Ί	38, 481		31. 00
22.00	30)	_	J	E1 000		22.00
32. 00	Total facility costs (sum of lines 22, 28	0	Ί	51, 928		32. 00
	and 31)		I	l		I

ALLOCA	Financial Systems TION OF OVERHEAD TO RHC/FQHC SERVICES	PERRY COUNTY			CCN: 151322	Peri od:	u of Form CMS-2 Worksheet M-2	
						From 01/01/2015		
			(Component	CCN: 158516		Date/Time Pre 5/24/2016 9:3	
						Rural Health	Cost	
		N I CETE	I +	\(\frac{1}{2} \cdot \cdo	D 1 11 11	Clinic (RHC) I	0 1 6	
		Number of FTE Personnel	Total	Visits		Minimum Visits		
		Per Sonner			Standard (1)	(col. 1 x col. 3)	4	
		1.00	2	2. 00	3.00	4.00	5. 00	
	VISITS AND PRODUCTIVITY							
	Posi ti ons							1
1. 00	Physi ci an	1. 05		3, 856	4, 20	00 4, 410		1.00
2. 00	Physi ci an Assi stant	0.00		0	2, 10	00		2.00
3. 00	Nurse Practitioner	0. 91		1, 373				3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 96		5, 229		6, 321	6, 321	4.00
5. 00	Visiting Nurse	0. 00		0			0	
5. 00	Clinical Psychologist	0. 00		0			0	6. 00
7. 00	Clinical Social Worker	0. 00		0			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00		0			0	7.0
7. 02	Diabetes Self Management Training (FQHC	0. 00		0			0	7. 02
0 00	only)	1.04		F 220			/ 221	0.00
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	1. 96		5, 229			6, 321	8. 00
9. 00	Physician Services Under Agreements	•		0			0	9.00
7. 00	Triysi et air set vi ees under Agreements		l				U	7. 00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	RHC/FQHC SERV	/I CES					
10.00	Total costs of health care services (from Wks	st. M-1, col. 7	7, line	22)			301, 516	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)				0	11.00
12. 00	Cost of all services (excluding overhead) (se		and 11	1)			301, 516	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided						1. 000000	
14.00	Total facility overhead - (from Wkst. M-1, co						1, 139, 924 339, 137	
15. 00	, , , , , , , , , , , , , , , , , , ,							
16. 00	Total overhead (sum of lines 14 and 15)						1, 479, 061	16.00
17. 00							0	
	Subtotal (see instructions)	40 11 :-					1, 479, 061	
19.00							1, 479, 061	
20.00	Total allowable cost of RHC/FQHC services (se	um of lines 10	and 19	1)			1, 780, 577	J 20. 00

	Financial Systems	PERRY COUNT	Y HOSPITAL		In Li€	eu of Form CMS-2	2552-10		
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi dei	CCN: 151322	Peri od:	Worksheet M-2			
			Componer	nt CCN: 158517	From 01/01/2015 To 12/31/2015				
					Rural Health	Cost			
		Number of FTE	Total Visits	Droducti vi t	Clinic (RHC) II y Minimum Visits	Greater of			
		Personnel	lotal visits		(col. 1 x col.				
		T CT SOTTICE		Januara (1	3)	4			
		1, 00	2, 00	3.00	4. 00	5. 00			
	VISITS AND PRODUCTIVITY	11.99				0.00			
	Posi ti ons						1		
1.00	Physi ci an	0.00		0 4, 2	00 0		1.00		
2.00	Physi ci an Assi stant	0. 53	1, 14	8 2, 1	00 1, 113		2. 00		
3.00	Nurse Practitioner	0.00		0 2, 1	00		3. 00		
4.00	Subtotal (sum of lines 1 through 3)	0. 53	1, 14	8	1, 113	1, 148	4.00		
5.00	Visiting Nurse	0.00		0		0	5. 00		
6.00	Clinical Psychologist	0.00		0		0	6. 00		
7.00	Clinical Social Worker	0.00		0		0	7. 00		
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		0		0	7. 01		
7.02	Diabetes Self Management Training (FQHC	0. 00		0		0	7. 02		
	onl y)								
8.00	Total FTEs and Visits (sum of lines 4	0. 53	1, 14	8		1, 148	8. 00		
	through 7)								
9. 00	Physician Services Under Agreements			0		0	9. 00		
						1, 00			
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	DUC/EOUC SEDV	II CEC			1.00			
10. 00	Total costs of health care services (from Wk:					57, 517	10.00		
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0 37, 317	11.00		
12. 00	Cost of all services (excluding overhead) (si					57, 517			
13. 00	Ratio of RHC/FQHC services (line 10 divided)		and 11)			1. 000000			
14. 00	Total facility overhead - (from Wkst. M-1, co					223, 902			
15. 00									
16. 00									
17. 00									
18. 00						0 289, 552			
	Overhead applicable to RHC/FQHC services (Iii	ne 13 x line 18	3)			289, 552			
	Total allowable cost of RHC/FQHC services (si					347, 069			
			,						

ALLOCA	Financial Systems TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi	der	CCN: 151322	Peri od:	Worksheet M-2	
						From 01/01/2015		
			Compo	onent	CCN: 158518	To 12/31/2015	Date/Time Prep 5/24/2016 9:33	
						Rural Health	Cost	
		Number of FTE	T-+-! \/:-			Clinic (RHC) III	C	
		Personnel	Total Vis	SETS		Minimum Visits (col. 1 x col.		
		Per Sonner			Standard (1)	3)	4	
		1.00	2.00		3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY	1.00	2.00		0.00		0.00	
	Posi ti ons							İ
1.00	Physi ci an	0.00		0	4, 20	0 0		1.00
2.00	Physi ci an Assi stant	0.00		0	2, 10	0		2.00
3.00	Nurse Practitioner	0. 08		169	2, 10	0 168		3. 00
4.00	Subtotal (sum of lines 1 through 3)	0. 08		169		168	169	4.00
5.00	Visiting Nurse	0.00		0			0	5.00
6.00	Clinical Psychologist	0.00		0			0	6.00
7.00	Clinical Social Worker	0. 00		0			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00		0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0. 00		0			0	7. 02
	onl y)							
8.00	Total FTEs and Visits (sum of lines 4	0. 08		169			169	8. 00
0 00	through 7)			0			0	0.00
9.00	Physician Services Under Agreements			U			U	9. 00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O RHC/FQHC SERV	'I CES					
10.00				1			13, 447	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)				0	11.00
12.00	Cost of all services (excluding overhead) (se	um of lines 10	and 11)				13, 447	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided	by line 12)					1. 000000	13.00
14. 00	Total facility overhead - (from Wkst. M-1, co	ol. 7, line 31)					38, 481	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instruc	tions)				12, 072	15. 00
16. 00	Total overhead (sum of lines 14 and 15)						50, 553	
17. 00	Allowable GME overhead (see instructions)						0	17. 00
	Subtotal (see instructions)						50, 553	
	Overhead applicable to RHC/FQHC services (li						50, 553	
20.00	Total allowable cost of RHC/FQHC services (si	um of lines 10	and 19)				64, 000	I 20.00

Heal th	Financial Systems PERRY COUNTY HOS	SPI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 151322	Peri od:	Worksheet M-3	1002 10
		Component CCN: 158516	From 01/01/2015	Date/Time Prep 5/24/2016 9:32	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	0.03		4 700 577	
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line			1, 780, 577	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line	: 15)		1 700 577	2. 00 3. 00
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			1, 780, 577 6, 321	4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		0, 321	5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	110 7)		6, 321	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			281. 69	7. 00
	in a grant of the control of the con		Cal cul ati on (11.00
			Dri or to	On on After	
			Prior to January 1	On on After January 1	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	0.00	80. 44	8. 00
9. 00	Rate for Program covered visits (see instructions)	, , ,	281. 69	281. 69	9. 00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from c	contractor records)	0	1, 664	10.00
11. 00	Program cost excluding costs for mental health services (line 9	x line 10)	0	468, 732	11. 00
12.00	Program covered visits for mental health services (from contrac		0	0	12.00
13. 00	Program covered cost from mental health services (line 9 x line	: 12)	0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions)		0	0	14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)			0	15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a	•		468, 732	16. 00 16. 01
16. 01 16. 02	Total program charges (see instructions)(from contractor's reco Total program preventive charges (see instructions)(from provid			223, 554 3, 740	
16. 02	Total program preventive charges (see Histractions)(From providing			7, 842	16. 02
16. 03	Total Program non-preventive costs ((Time 16.02/Time 16.07) times 1 1.03			363, 365	16. 03
10.01	(Titles V and XIX see instructions.)	and rej trines . coj		000, 000	10.01
16. 05	Total program cost (see instructions)			371, 207	16. 05
17.00	Primary payer amounts			0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (records)	from contractor		6, 684	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)	(from contractor		42, 626	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			371, 207	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst. M	1-4, line 16)		0	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)	•		371, 207	22. 00
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıctions)		0	24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25. 00
25. 50 26. 00	Pioneer ACO demonstration payment adjustment (see instructions)			271 207	25. 50 26. 00
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			371, 207 7, 424	26. 00 26. 01
26. 01				7, 424 287, 523	
28. 00				207, 523	28. 00
29. 00		ind 28)		76, 260	
30. 00	Protested amounts (nonallowable cost report items) in accordance			0	30. 00
	chapter I, §115.2		l l		

Heal th	Financial Systems PERRY COUNTY HOS	DI TAI	Inlia	u of Form CMS-2	0552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FOHC SERVICES	Provi der CCN: 151322	Peri od:	Worksheet M-3	2332-10
		Component CCN: 158517	From 01/01/2015 To 12/31/2015	Date/Time Prep 5/24/2016 9:3:	
		Title XVIII	Rural Health Clinic (RHC) II	Cost	
			[
				1. 00	
4 00	DETERMINATION OF RATE FOR RHC/FOHC SERVICES	00)		0.47.070	4 00
1. 00 2. 00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line Cost of vaccines and their administration (from Wkst. M-4, line			347, 069 0	1. 00 2. 00
3. 00	Total allowable cost excluding vaccine (line 1 minus line 2)	15)		347, 069	3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			1, 148	4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)	•		1, 148	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			302. 32	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to	On on After	
			January 1	January 1	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	0.00	80. 44	8. 00
9. 00	Rate for Program covered visits (see instructions)		302. 32	302. 32	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from co	ontractor records)	0	63	10. 00
11. 00	Program cost excluding costs for mental health services (line 9		o	19, 046	11. 00
12. 00	Program covered visits for mental health services (from contrac	•	o	0	12. 00
13. 00	Program covered cost from mental health services (line 9 x line	,	O	0	13. 00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)			0	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and	,		19, 046	
16. 01	Total program charges (see instructions)(from contractor's reco			8, 215	16. 01
16. 02 16. 03	Total program preventive charges (see instructions)(from provided Total program preventive costs ((line 16.02/line 16.01) times I			326 756	16. 02 16. 03
16. 03	Total Program non-preventive costs ((Time 16.02/Time 16.01) times 1			14, 511	16. 03
10.01	(Titles V and XIX see instructions.)	and rej trines . ee)		11,011	10.01
16. 05	Total program cost (see instructions)			15, 267	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (records)	from contractor		151	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)) (from contractor		1, 548	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			15, 267	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst. M	-4, line 16)		0	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			15, 267	22. 00
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00		ctions)		0	24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25. 00 25. 50
25. 50 26. 00	Pioneer ACO demonstration payment adjustment (see instructions) Net reimbursable amount (see instructions)			15, 267	25. 50 26. 00
26. 01	Sequestration adjustment (see instructions)			305	
27. 00	Interim payments			8, 509	27. 00
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 27, a			6, 453	29. 00
30. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-II,		0	30. 00
	chapter I, §115.2				

	Financial Systems PERRY COUNTY HO TION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	OSPITAL Provider CCN: 151322	Peri od:	u of Form CMS-2 Worksheet M-3	
		Component CCN: 158518	From 01/01/2015 To 12/31/2015	Date/Time Prep 5/24/2016 9:32	pared: 2 am
		Title XVIII	Rural Health Clinic (RHC) III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1.00	
	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lir	ne 20)		64, 000	1. C
. 00	Cost of vaccines and their administration (from Wkst. M-4, lir	ne 15)		0	2. 0
	Total allowable cost excluding vaccine (line 1 minus line 2)			64, 000	3. (
. 00	Total Visits (from Wkst. M-2, column 5, line 8)	· 0)		169 0	4. (5. (
	Physicians visits under agreement (from Wkst. M-2, column 5, I Total adjusted visits (line 4 plus line 5)	The 9)		169	6. (
	Adjusted cost per visit (line 3 divided by line 6)			378. 70	7. (
. 00	najusted cost per visit (The o divided by The o)		Cal cul ati on		7. (
			Prior to	On on After	
			January 1	January 1	
	B		1. 00	2. 00	
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	80. 44	8. (
	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		378. 70	378. 70	9.
0. 00	Program covered visits excluding mental health services (from	contractor records)	0	0	10.
	Program cost excluding costs for mental health services (line		0	0	11.
	Program covered visits for mental health services (from contra		0	0	12.
	Program covered cost from mental health services (line 9 x lin		0	0	13.
	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions		٩	0	14. 15.
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0	16.
	Total program charges (see instructions)(from contractor's rec			0	16.
	Total program preventive charges (see instructions)(from provi			0	16.
	Total program preventive costs ((line 16.02/line 16.01) times			0	16.
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	3 and 18) times .80)		0	16.
6. 05	Total program cost (see instructions)			0	16.
7. 00	Primary payer amounts			0	17.
8. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		0	18.
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		0	19.
0. 00	Net Medicare cost excluding vaccines (see instructions)			0	20.
	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	21.
	Total reimbursable Program cost (line 20 plus line 21)			0	22.
- 1	Allowable bad debts (see instructions)			0	23.
	Adjusted reimbursable bad debts (see instructions)			0	23.
	Allowable bad debts for dual eligible beneficiaries (see instr OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	24. 25.
	DIHER ADJUSIMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	3)		0	25. 25.
- 1	Net reimbursable amount (see instructions)	• /		0	26.
	Sequestration adjustment (see instructions)			Ö	26.
	Interim payments			0	27.
	Tentative settlement (for contractor use only)			0	28.
	Balance due component/program (line 26 minus lines 26.01, 27,			0	29.
0.00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-II,		0	30.

Health Financial Systems	PI TAL			In Lieu of Form CMS-2552-1				
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVIDER FOR SERVICES	Provi der	CCN:	151322		od: 01/01/2015	Worksheet	M-5
RENDERED TO PROGRAM DENEFT CLARTES		Component	CCN:	158516		12/31/2015		
					Rur	al Health	Co	st
					Clir	nic (RHC) I		

Clinic (RHC) Part B mm/dd/yyyy Amou		ı
mm/dd/yyyy Amou 1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	0 87, 523	
1.00 2.0 1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	0 87, 523	
1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	87, 523	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		
the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	0	2.0
"NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		
3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		l
revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		
payment. If none, write "NONE" or enter a zero. (1)		3.0
		l
Program to Provider		ł
J .		١
3.01	0	
3.02	0	
3.03	0	
3. 04	0	3.0
3.05	0	3.0
Provider to Program		
3.50	0	
3.51	0	
3. 52	0	3. 5
3. 53 3. 54	0	3. 5
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	0	3.5
· ·	87, 523	4.0
4.00 Total Interim payments (sum of Times 1, 2, and 3.99) (transfer to worksheet M-3, fine 2	87, 523	4.0
TO BE COMPLETED BY CONTRACTOR		ı
5.00 List separately each tentative settlement payment after desk review. Also show date of		5.0
each payment. If none, write "NONE" or enter a zero. (1)] 5. 0
Program to Provider		1
5.01	0	1 5. c
5.02	o	
5.03	0	
Provider to Program		
5.50	0	5.5
5. 51	0	5. 5
5.52	0	5. 5
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	0	5. 9
p.00 Determined net settlement amount (balance due) based on the cost report. (1)		6.0
o. 01 SETTLEMENT TO PROVI DER	76, 260	6.0
5.02 SETTLEMENT TO PROGRAM	0	6.0
7.00 Total Medicare program liability (see instructions)	63, 783	7.0
Contractor NPR [ate	
Number (Mo/Da		
0 1.00 2.0	0	
8.00 Name of Contractor		8.0

Health Financial Systems	PERRY (COUNTY HOSP	PLTAL				In Lie	u of Form (CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVIDER FOR	SERVI CES	Provi der	CCN: 15	51322			Worksheet	M-5
RENDERED TO PROGRAM BENEFICIARIES			Component	CCN- 1	158517		01/01/2015 12/31/2015		Prenared:
			00p00c				12, 01, 2010	5/24/2016	
						Run	al Health	Co	st

			Rural Health	Cost	
			Clinic (RHC) II	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to provider		1.00	8, 509	1. 00
2. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		8, 304	2.00
2.00	the contractor for services rendered in the cost reporting				2.00
	"NONE" or enter a zero	perrou. IT none, write			
3. 00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
0.00	revision of the interim rate for the cost reporting period.				0.00
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3. 0 ⁻
3. 02				0	3. 02
3.03				0	3. 03
3.04				0	3.04
3.05				0	3. 05
	Provider to Program				
3.50				0	3. 50
3.51				0	3. 5
3.52				0	3. 5.
3.53				0	3. 5
3.54				0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		8, 509	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR			1	
5.00	List separately each tentative settlement payment after des	sk review. Also show date of	`		5.00
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				
F 01	Program to Provider				ا ا د م
5. 01 5. 02				0	5. 0 5. 0
5. 02					5. 02
5.05	Provider to Program			U	3.0
5. 50	Frovider to Frogram			0	5. 50
5. 51					5.5
5. 52				0	5. 5.
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	08)		0	5. 9
6. 00	Determined net settlement amount (balance due) based on the			0	6. 00
6. 01	SETTLEMENT TO PROVIDER	, cost report. (1)		6, 453	6.0
6. 02	SETTLEMENT TO PROGRAM			0, 439	6.0
7. 00	Total Medicare program liability (see instructions)			14, 962	7.00
7.00	Total medical or program trabitity (see thistiaetrons)		Contractor	NPR Date	7.0
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8. 00	Name of Contractor				8. 0
	1	I .			