Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
This report is required by law (42 USC 1395g payments made since the beginning of the cos		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CO AND SETTLEMENT SUMMARY	IST REPORT CERTIFICATION Provider CCN: 15-	1322 Period: From 01/01/2019 Worksheet S Parts I-III To 12/31/2019 Date/Time Prepared: 6/8/2020 8: 34 am
PART I - COST REPORT STATUS		
Provider 1. [X] Electronically filed cuse only 2. [] Manually submitted cos		Date: 6/8/2020 Time: 8:34 am
3. 0] If this is an amended	report enter the number of times the prov Enter "F" for full or "L" for low.	ider resubmitted this cost report
use only (1) As Submitted 7 (2) Settled without Audit 8	 b. Date Received: Contractor No. [N] Initial Report for this Provider CO [N] Final Report for this Provider CCN 	10.NPR Date: 11.Contractor's Vendor Code: 4 CN12.[0]If Line 5, column 1 is 4: Enter number of times reopened = 0-9.
PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY IN ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONM PROVIDED OR PROCURED THROUGH THE PAYMENT DIR ADMINISTRATIVE ACTION, FINES AND/OR IMPRISON	IENT UNDER FEDERAL LAW. FURTHERMORE, IF S RECTLY OR INDIRECTLY OF A KICKBACK OR WERE	ERVICES IDENTIFIED IN THIS REPORT WERE
CERTIFICATION BY CHIEF FINANCIAL OFF	FICER OR ADMINISTRATOR OF PROVIDER(S)	
electronically filed or manually sub Expenses prepared by PERRY COUNTY HC ending 12/31/2019 and to the best of complete and prepared from the books except as noted. I further certify health care services, and that the s laws and regulations.	he above certification statement and that omitted cost report and the Balance Sheet DSPITAL (15-1322) for the cost reporting f my knowledge and belief, this report and s and records of the provider in accordance that I am familiar with the laws and regu services identified in this cost report we	and Statement of Revenue and period beginning 01/01/2019 and statement are true, correct, e with applicable instructions, lations regarding the provision of re provided in compliance with such
	above certification statement. I certify a statement to be the legally binding equi	
	(Si gned)	
	Officer or <i>i</i>	Administrator of Provider(s)
	Title	
	Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	597, 602	-417, 085	0	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	651, 658	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-135, 322		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-8, 265		0	10.01
10. 02	RURAL HEALTH CLINIC III	0		46, 932		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		0		0	10.03
200.00	Total	0	1, 249, 260	-513, 740	0	0	200.00
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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.

	TAL AND HOSPITAL HEALTH CARE COMPLEX	PERRY COUNTY I DENTI FI CATI ON DATA		ler CCN: 1	5-1322	Period: From 01/01/	2019	of For Workshe Part I Date/Ti 6/8/202	et S-2 me Pre	2 epared
	1.00	2.00		3.00		4	1.00			
	Hospital and Hospital Health Care Co									
00	Street: 8885 SR 237	P0 Box: X								1.
00	City: TELL CITY	State: IN		e: 47586		ty: PERRY	-			2.
		Component Name	CCN	CBSA	Provi der			nt Syst		
			Number	Number	Туре	Certi fi ed	V 1,	0, or XVIII		-
		1.00	2.00	3.00	4.00	5.00	6. 00	_		-
	Hospital and Hospital-Based Componer		2.00	3.00	4.00	5.00	0.00	1.00	0.00	
00	Hospi tal	PERRY COUNTY HOSPITAL	151322	99915	1	07/01/2004	N	0	Р	3.
0	Subprovider - IPF		101022							4.
00	Subprovider - IRF								l	5.
00	Subprovider - (Other)									6.
00	Swing Beds - SNF	PERRY COUNTY HOSPI TAL	15Z322	99915		07/01/2004	Ν	0	N	7.
		SWI NG								
0	Swing Beds - NF									8.
0	Hospital-Based SNF									9.
00	Hospital-Based NF Hospital-Based OLTC									10.
00		PERRY COUNTY HOSPITAL	157177	99915		06/13/1986	Ν	Р	N	12.
00		HHA	13/1//	77713		00/13/1900	IN			12.
00	Separately Certified ASC									13.
	Hospital-Based Hospice									14.
00	Hospital-Based Health Clinic - RHC	TELL CITY CLINIC	158516	99915		05/18/2015	Ν	0	N	15.
01	Hospital-Based Health Clinic - RHC	PERRY CO FAMILY	158517	99915		05/19/2015	Ν	0	N	15.
		PRACTI CE								
02	Hospital-Based Health Clinic - RHC	TROY CLINIC	158518	99915		11/23/2015	Ν	0	N	15.
02	 appital_Decod_liad_th_ClipicDUC	CANNEL TON CLUNIC	150510	00015		05 /04 /2014	N	0	N	15
03	Hospital-Based Health Clinic - RHC	CANNELTON CLINIC	158519	99915		05/06/2016	Ν		N	15.
00	Hospital-Based Health Clinic - FQHC									16.
	Hospital -Based (CMHC) I									17.
00										18.
00	Other									19.
						From:		То		-
-						1.00		2.0)()	
(1)							10			20
	Cost Reporting Period (mm/dd/yyyy)					01/01/2	019	12/31/		
	Type of Control (see instructions)						019			
					1.00	01/01/2	019	12/31/	/2019	
					1.00	01/01/2	019		/2019	
00	Type of Control (see instructions)	currently receiving pa	yments fo	r	1.00 N	01/01/2	019	12/31/	/2019	21.
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju	stment, in accordance w	ith 42 CF			01/01/2	019	12/31/	/2019	20. 21. 22.
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for	istment, in accordance w or yes or "N" for no. Is	ith 42 CF this			01/01/2	019	12/31/	/2019	21.
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00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	astment, in accordance w or yes or "N" for no. Is (412.106(c)(2)(Pickle am or yes or "N" for no. icompensated care paymen mm 1, "Y" for yes or "N eriod occurring prior to "for no for the portio er October 1. (see inst "requires final uncompe port settlement? (see i "for no, for the porti per 1. Enter in column 2 ie cost reporting period act reclassification fro ds for delineating stat tolumn 1, "Y" for yes or ig period prior to Octob no for the portion of t er October 1. (see inst tolumn 1, "Y" for yes or ig period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column	ith 42 CF this endment ts for th "for no October n of the ructions) nsated ca nstructio on of the , "Y" for on or af m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds (3, "Y" f	R is for 1. cost re ns) yes ter o reas no er as or	N N N	01/01/20 9 2.00 N N N	019	3. (/2019	21. 22. 22. 22. 22.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost rec Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	estment, in accordance w or yes or "N" for no. Is 412.106(c)(2)(Pickle am or yes or "N" for no. icompensated care paymen mm 1, "Y" for yes or "N eriod occurring prior to " for no for the portio er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti ber 1. Enter in column 2 the cost reporting period aic reclassification fro ds for delineating stat solumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column edicaid days on lines 24	ith 42 CF this endment ts for th "for no October n of the ructions) nsated ca nstructio on of the , "Y" for on or af m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds (3, "Y" f	R is for 1. cost re ns) yes ter o reas no er as or 5	N N N	01/01/2 9 2.00 N N N	019	3. (/2019	21. 22. 22. 22.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	Astment, in accordance w or yes or "N" for no. Is 412.106(c)(2)(Pickle am or yes or "N" for no. accompensated care paymen mm 1, "Y" for yes or "N ariod occurring prior to " for no for the portio er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti ber 1. Enter in column 2 the cost reporting period aic reclassification fro rds for delineating stat solumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column edicaid days on lines 24 of admission, 2 if cens	ith 42 CF this endment ts for th "for no October n of the ructions) nsated ca nstructio on of the , "Y" for on or af m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds (3, "Y" f and/or 2 us days,	R is for 1. cost re ns) yes ter o reas no er as or 5 or 3	N N N	01/01/20 9 2.00 N N N	019	3. (/2019	21. 22. 22. 22. 22.
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost rec Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	estment, in accordance w ryes or "N" for no. Is k412.106(c)(2)(Pickle am or yes or "N" for no. iccompensated care paymen mn 1, "Y" for yes or "N riod occurring prior to "for no for the portio er October 1. (see inst requires final uncompe port settlement? (see i "for no, for the porti- er 1. Enter in column 2 the cost reporting period dic reclassification fro- rds for delineating stat column 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column edicaid days on lines 24 of admission, 2 if cens of identifying the days	ith 42 CF this endment ts for th " for no October n of the ructions) nsated ca nstructio on of the , "Y" for on or af m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds (3, "Y" f and/or 2 us days, in this	R is for 1. cost re ns) yes ter o reas no er as or 5 or 3	N N N	01/01/20 9 2.00 N N N	019	3. (/2019	21. 22. 22. 22. 22.

Health Financial Systems PERRY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	COUNTY HOS		N 15 1000					2552-10
HUSPITAL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION D.		Provider CC			/2019 /2019	Part I Date/T 6/8/20	20 8: 34	epared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	State Medi cai d el i gi bl e unpai d	Medicai HMO day	rs Med	ither di cai d days	
24.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00	0	5.00	24.00
 24.00 f this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 f this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. 	0	c		0		0	(24.00
				Urban/Ru 1.0		Date of 2.		-
26.00 Enter your standard geographic classification (not w		at the be	ginning of		2	۷.	00	26.00
 cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassification 	age) status or "2" for r	ural. If a		st	2			27.00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			SCH status i		0			35.00
				Begi nn 1. 0		Endi 2.		1
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	e 36 for num	ber				36.00
37.00 If this is a Medicare dependent hospital (MDH), ente		er of perio	ods MDH stat	us	0			37.00
 is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f 								37.01
 instructions) 38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates. 								38.00
				Y/N		Y/		-
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? En e requireme	nter in colu ents in	mn		<u>2.</u> N		39.00
40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for				Ν	I	40.00
					V 1.00	XVIII 2.00	XIX 3.00	-
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payme	ent for disp	proporti ona	ite share in	accordance	N	N	N	45.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks 					N	N	N	46.00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen	•		2		N N	N N	N N	47.00 48.00
56.00 Is this a hospital involved in training residents in	approved G	ME program	ns? Enter "	Y" for yes	N			56.00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	or yes or "N oth of this Y", complet	l" for no i cost repor e Workshee	n column 1. ting period	lf column 1 ? Enter "Y				57.00
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I 58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f	or physici	ans' servic	es as				58.00
59.00 Are costs claimed on line 100 of Worksheet A? If ye			2, Pt. I.		N			59.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	F	eriod: rom 01/01/2019 o 12/31/2019	Worksheet S-2 Part I Date/Time Pre	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	6/8/2020 8:34 Pass-Through Qualification Criterion Code	
(0.00				1.00	2.00	3.00	(0.0)
60.00	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (structions)	N			60.0
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	-
61.00	Did your hospital receive FTE slots under ACA	N	2.00	0.00	0.00		61.0
61. 01	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care						61.0
1 02	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.0
51.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						01.0
51.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1 10			1.00	2.00	3.00	4.00	(1 1
51.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.1
51.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0.00	0. 00	61.2
	the direct GME FTE unweighted count.			I	1		
	ACA Provisions Affecting the Health Resources and Se	rvi ces	Administration	L (HRSA)		1.00	
62.00	Enter the number of FTE residents that your hospital	trai ne	d in this cost		iod for which	0.00	62.0
52.01	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc	a Teach gram. (ing Health Cen see instructio		o your hospital	0.00	62.0
63.00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c	67. (see instr	ructions)	N Dati a (aal	63.0
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Saction 5504 of the ACA Pace Year ETE Decidents in N	opprovi	dor Sottings	1.00	2.00	3.00	
64 00	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit	<u>re</u> June	30, 2010.	- Inis base yea	-		64 0
64.00	Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	all no all no non-p n colum	ry care nprovider rimary care n 3 the ratio		0.00	0.00000	04.0

	_EX IDENTIFICATION D	AIA Provider C	Fr	eriod: com 01/01/2019	Worksheet S-2 Part I	
			To	12/31/2019	Date/Time Pre 6/8/2020 8:34	epareo 1 am
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3			0.00	0.00	0. 000000	05.
divided by (column 3 + column 4)). (see instructions)			Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Voar ETE Posidonts i	n Nonnrovidor Sottin	1.00	2.00	3.00	
beginning on or after July 1, 20		in Nonprovider Settin	Igs Effective f		ing perious	
00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	0.00	0.00	0. 000000	66.
00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 3/ (col. 3 + col. 4))	
<pre>00 Enter in column 1 the number of o FTEs attributable to rotations oo Enter in column 2 the number of o FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program</pre>	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
00 Enter in column 1 the number of o FTEs attributable to rotations of Enter in column 2 the number of o FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. my care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
 OD Enter in column 1 the number of the FTEs attributable to rotations of Enter in column 2 the number of the FTEs that trained in your hospital (column 1 divided by (column 1 + OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	provider settings. my care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Rati o (col . 3/ (col . 3 + col . 4)) 5.00 0.000000	_
 OD Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of of FTEs that trained in your hospita (column 1 divided by (column 1 + OD Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the number of (column 4, 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 4, the settings. OD Inpatient Psychiatric Facility P OD Is this facility an Inpatient Psychiatric for the program for the program. 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u>	Provi der settings. ary care resident 3 the ratio of structions) Program Code 2.00 2.00 (1PF), or does it con	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N	Rati o (col . 3/ (col . 3 + col . 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.000000 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 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	0 67. 70.
 Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of of FTEs that trained in your hospita (column 1 divided by (column 1 + OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	The ratio of settings. The ratio of setuctions) Program Code 2.00 (IPF), or does it con approved GME teach 2004? Enter "Y" for silent (D)? Enter	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in yes or "N" for is s in a new teacl yes or "N" for is	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	0 67.

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1322	Period: From 01/01/2019	Worksheet S-2 Part I	2
		To 12/31/2019		
		1.0	0 2.00 3.00	_
0.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2 no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting period.	2004? Enter "Y" for yes ng program in accordan blumn 3: If column 2 is	or "N" for ce with 42 Y,	0 2.00 3.00 0	76.0
Long Term Care Hospital PPS			1.00	_
 1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes an 1.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. TEFRA Providers 		ng period? Enter	N N	80.0 81.0
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 5.00 Did this facility establish a new Other subprovider (excluded u		N	85.0 86.0	
 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7.00 Is this hospital an extended neoplastic disease care hospital or 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 	classified under sectio	n	Ν	87.
		V 1.00	XI X 2.00	_
Title V and XIX Services 0.00 Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column.	services? Enter "Y" for	N	Y	90.
.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applica	able column.	Ν	Ν	91.
00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable	e column.	N	N	92.
 00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column. 00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and 		N	N	93. 94.
applicable column. .00 If line 94 is "Y", enter the reduction percentage in the applic .00 Does title V or XIX reduce operating cost? Enter "Y" for yes or	cable column.	0. 00 N	0. 00 N	95. 96.
 applicable column. 00 If line 96 is "Y", enter the reduction percentage in the applic 00 Does title V or XIX follow Medicare (title XVIII) for the inter stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX. 	rns and residents post	0. 00 Y	0. 00 Y	97. 98.
01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			Y	98
02 Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "for title V, and in column 2 for title XIX.		Y	Y	98.
03 Does title V or XIX follow Medicare (title XVIII) for a critica reimbursed 101% of inpatient services cost? Enter "Y" for yes of			N	98
 for title V, and in column 2 for title XIX. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in column 2 for title XIX. 		N	N	98.
 in column 2 for title XIX. 05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu 			Y	98
<pre>column 2 for title XIX. 06 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. Rural Providers</pre>		Y	Y	98.
5.00Does this hospital qualify as a CAH? 5.00If this facility qualifies as a CAH, has it elected the all-inc	clusive method of payme	Y nt N		105. 106.
for outpatient services? (see instructions) 2.00 If this facility qualifies as a CAH, is it eligible for cost re- training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25	eimbursement for I&R (see instructions) If	N		107.
reimbursed. If yes complete Wkst. D-2, Pt. II. 8.00∣s this a rural hospital qualifying for an exception to the CRN	VA fee schedule? See 4	2 N		108.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPITAL Provider C	F	eriod: rom 01/01/2	2019	Workshe Part I	eet S-2	
		T	o 12/31/2	2019	Date/Ti 6/8/202		
	Physi cal	Occupati onal	Speech	1	Respi r	ratory	
109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 Y	2.00 N	3.00 N		4.0 N		109.00
				-	1.0	00	-
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes o	"N" for no. I	f yes,		N		110.00
			1.00		2.0)0	_
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the column 2.	N				111.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 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. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	If column 2 nt for long to rs) based on for yes or "I	is "E", enter erm care (inclu the definition W" for no.	in column des in CMS	N		0	115.00
117.00 s this facility legally-required to carry malpractice insur no.	ance? Enter '	'Y" for yes or	"N" for	N			117.00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	is	0			118.00
		Premiums	Losses	,	Insur	ance	
		1.00	2.00		3. C	00	
118.01 List amounts of malpractice premiums and paid losses:		285, 544		0			0118.01
			1.00		2.0	00	-
 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 DO NOT USE THIS LINE 			N				118.0
20.00 is this a SCH or EACH that qualifies for the Outpatient Hold			N		Ν		120.0
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen	ualifies for	•					
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla	ualifies for nts? (see ins	tructions)	Y				121.0
 \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 	ualifies for nts? (see ins antable device fined in §1903	tructions) es charged to B(w)(3) of the	Y Y		5. C)1	121.0 122.0
 \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 	ualifies for hts? (see ins antable device fined in §1903 l is "Y", ente	tructions) es charged to 8(w)(3) of the er in column 2			5. C)1	
 \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 	ualifies for hts? (see ins antable device fined in §1903 I is "Y", ent or yes and "N	tructions) es charged to 8(w)(3) of the er in column 2	Y		5. ()1	122. C
 §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyy) below. 26.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 	ualifies for hts? (see instantable device fined in §1900 l is "Y", ente or yes and "No hter the certi 2. ter the certi	tructions) es charged to 3(w)(3) of the er in column 2 f for no. If fication date	Y		5. ()1	122. 0 125. 0 126. 0
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 \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no. 23.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified lung transplant center, ent in column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified panceas transplant center, column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified panceas transplant center, date in column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified panceas transplant center, date in column 1 and termination date, if applicable, in col 	ualifies for hts? (see ins antable device fined in §1903 I is "Y", ente or yes and "N" hter the certifient ter the certifient er the certifient enter the certifient e	tructions) es charged to 3(w)(3) of the er in column 2 for no. If fication date fication date fication date cation date in tification	Y N		5. ()1	122. C 125. C 126. C 127. C 128. C 129. C 130. C
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 §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no. 23.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, enter column 1 and termination date, if applicable, in column 2 20.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 20.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 20.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 20.00 If this is a Medicare certified panceas transplant center, date in column 1 and termination date, if applicable, in col 31.00 If this is a Medicare certified panceas transplant center, 	ualifies for hts? (see inst antable device fined in §1900 lis "Y", ente bor yes and "N" hter the certifient ter the certifient enter the certifient enter the certifient enter the certifient ter the certifient enter the certifient ter ter ter ter ter ter ter ter ter ter	tructions) es charged to 3(w)(3) of the er in column 2 for no. If fication date fication date fication date cation date in rtification certification fication date	Y N		5. (01	122.0

Health Financial Systems	PERRY COUN	ITY HOSPI TAL				In Lieu	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-132			1/2019 1/2019	Worksheet S-2 Part I Date/Time Pre 6/8/2020 8:34	pared:
					1 (20	2.00	-
140.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	'N" for no in column 1. <u>e home office chain numb</u>	If yes, and home per. (see instruc	office c		<u>1. (</u> Y		2.00	140.00
1.00						3.00		
If this facility is part of a chai office and enter the home office of			ough 143 t	the name	e and a	address	of the home	
141.00 Name: 142.00 Street: 143.00 City:	Contractor's Name: PO Box: State:		Contr Zip C	actor's	s Numbe	er:		141.00 142.00 143.00
	otatoi							
							1.00	
144.00 Are provider based physicians' cos	sts included in Workshee	et A?					Y	144.00
					1. (00	2.00	1
145.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N"	' for yes or "N" for no clude Medicare utilizati	in column 1. If	column 1					145.00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	gy changed from the prev n column 1. (See CMS Pub	viously filed cos b. 15-2, chapter	t report? 40, §4020)) f	N	1		146.00
							1.00	-
147.00 Was there a change in the statisti	cal basis? Enter "Y" fo	or ves or "N" for	no.				N 1.00	147.00
148.00Was there a change in the order of							N	148.00
149.00 Was there a change to the simplifi	ed cost finding method?						N	149.00
		Part A 1.00	Part 2.00		<u> </u>		Title XIX 4.00	-
Does this facility contain a prov	der that qualifies for							-
or charges? Enter "Y" for yes or							3. 13)	
155.00Hospi tal		N	N		N		N	155.00
156.00Subprovi der – IPF 157.00Subprovi der – IRF		N	N N		N		N	156.00 157.00
158. 00 SUBPROVI DER						•		158.00
159. 00 SNF		Ν	N		Ν		Ν	159.00
160.00HOME HEALTH AGENCY 161.00CMHC		N	N N		N		N	160.00 161.00
			IN		IN	4	IN	101.00
							1.00	1
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more camp	uses in d	lifferen	nt CBSA	AS?	N	165.00
	Name	County	State	Zip Co	ode	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. 00	166.00
							1.00	-
Health Information Technology (HI	C) incentive in the Amer	rican Recovery an	nd Reinves	stment A	Act		1.00	
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Enter D5 is "Y") and is a mean	"Y" for yes or hingful user (lin	"N" for n	10.		he	Y	167.00 168.00
168.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful u	not a meaningful user, d ? Enter "Y" for yes or "	loes this provide N" for no. (see	instructi	ons)				168.01
transition factor. (see instruction		inu is nut a CAH	CITIE 105	IS N), ent	ei the	0.00	169.00
	,				Begi n		Endi ng	
170 00 Enton in columns 1 and 0 the SUD	oginning data and a li	a data for th	opost!		1. (00	2.00	170.00
170.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy)	beginning date and endin	ng date for the r	eporting					170.00

Health Financial Systems PERRY COUN	ITY HOSPI TAL	In Lie	u of Form CM	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Date/Time F	Prepared:
			6/8/2020 8:	<u>34 am</u>
		1.00	2.00	
171.00 If line 167 is "Y", does this provider have any days for section 1876 Medicare cost plans reported on Wkst. S-3, F		N		0171.00
"Y" for yes and "N" for no in column 1. If column 1 is ye 1876 Medicare days in column 2. (see instructions)		on		

iospi t	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Y HOSPITAL Provider C	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019		2 epared:
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	N for all NO r	esponses. En	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					_
I. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	o boginning of	the cost	N		1 1 0
1.00	reporting period? If yes, enter the date of the change in a					1.0
	proporting porrou. In yes, onter the date of the change in t	001 01111 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.		N			2.0
3. 00	Is the provider involved in business transactions, including management 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)					3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" a or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	R		4.0
5.00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5. C
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
5.00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lfves ist	he provider i	is N		6.0
	the legal operator of the program?					
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. C 8. C
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	n N		9.0
0. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	Ν		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.0
					Y/N 1.00	
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 0 13. 0
4.00		ents waived? I	fyes, see in	nstructions.	Ν	14.0
5.00	Did total beds available change from the prior cost reportion		yes, see ins t A		N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
16.00	PS&R Data 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	N		N		16.0
17.00	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	Y	02/28/2020	Y Y	02/28/2020	17. (
18.00	in columns 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	Ν		Ν		18.0
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. (

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1322	Period: From 01/01/2019	Worksheet S Part II	
				To 12/31/2019	Date/Time F 6/8/2020 8:	repared:
		Descri	ption	Y/N	Y/N	<u>54 alli</u>
		()	1.00	3.00	
0.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	N	20.0
		Y/N	Date	Y/N	Date	
1 00		1.00 N	2.00	3.00 N	4.00	21.0
1.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		IN		21.0
					1.00	_
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	IOSPI TALS)			
2 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22.0
3.00	Have changes occurred in the Medicare depreciation expense		sals made du	ring the cost	N	23.0
4.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entere	eporting period?	Ν	24.0		
5.00	If yes, see instructions Have there been new capitalized leases entered into during	2 If yes see	N	25.0		
	instructions.		• •			
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period?	It yes, see	Ν	26.0
7.00	Has the provider's capitalization policy changed during the copy.	e cost reportin	ng period? I	fyes, submit	Ν	27.0
0 00	Interest Expense	torod into du	ing the eee	t reporting	N	
	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.		C			28.0
9.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ebt Service	Reserve Fund)	N	29.0
0. 00	Has existing debt been replaced prior to its scheduled matu instructions.		debt? If ye	s, see	Ν	30.0
1. 00	Has debt been recalled before scheduled maturity without is	suance of new	debt? If ye	s, see	Ν	31.0
	instructions. Purchased Services					
2.00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through c	ontractual	Ν	32.0
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	N	33.0
4.00	Provider-Based Physicians Are services furnished at the provider facility under an ar	rangement with	n provider-b	ased physicians?	Y	34.0
	If yes, see instructions.	0	•			
5.00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		its with the	provi der-based	Ν	35.0
				Y/N 1.00	Date 2.00	
	Home Office Costs				21.00	
	Were home office costs claimed on the cost report?	anarad by the	home office	N ? N		36.0 37.0
7.00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	epared by the	nome office	? N		37.0
8.00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			f N		38.0
9. 00	If line 36 is yes, did the provider render services to othe see instructions.			s, N		39. (
0. 00	If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Ν		40.0
	instructions.					
	Cost Report Preparer Contact Information	1.	00	2.	00	
1.00	Enter the first name, last name and the title/position	CLINT		BRI LL		41. (
	held by the cost report preparer in columns 1, 2, and 3, respectively.					
2.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LL	С			42.0
	pi opui oi .	5029923500		CBRI LL@BLUEAND		43.0

Health Financial Systems	PERRY COUNTY	/ HOSPI TAL	In Lieu	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN: 15-1322	Period: From 01/01/2019 To 12/31/2019		pared:
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the t	itle/position	MANAGER			41.00
held by the cost report preparer in colum	ns 1, 2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the co	st report				42.00
preparer.					
43.00 Enter the telephone number and email addr	ess of the cost				43.00
report preparer in columns 1 and 2, respe	cti vel y.				

ISPITAL AND HOSPITAL HEALTH CARE COMP	LEX STATISTIC	AL DATA	Provider (:CN: 15-1322	Period: From 01/01/2019 To 12/31/2019		pare
						I/P Days / O/P Visits / Trips	
Component		Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
 Hospital Adults & Peds. (column: 8 exclude Swing Bed, Observation Hospice days) (see instructions for the portion of LDP room ava HMO and other (see instructions) 	n Bed and for col. 2 lable beds)	30.00	25	5 9, 1.	25 37, 032. 00	0	1.
00 HMO I PF Subprovi der 00 HMO I RF Subprovi der							3. 4.
00 Hospital Adults & Peds. Swing B	ed SNF					0	5.
00 Hospital Adults & Peds. Swing B						0	
00 Total Adults and Peds. (exclude beds) (see instructions)	observati on		25			0	
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT .00 BURN INTENSIVE CARE UNIT .00 SURGICAL INTENSIVE CARE UNIT .00 SURGICAL INTENSIVE CARE UNIT		31.00	(0 0.00	0	9 10 11
.00 OTHER SPECIAL CARE (SPECIFY) .00 NURSERY .00 Total (see instructions) .00 CAH visits .00 SUBPROVIDER - IPF		43.00	25	5 9, 1	25 37, 032. 00	0 0 0	14
.00SUBPROVIDER - IRF.00SUBPROVIDER.00SKILLED NURSING FACILITY.00NURSING FACILITY.00OTHER LONG TERM CARE							17 18 19 20 21
00 HOME HEALTH AGENCY 00 AMBULATORY SURGICAL CENTER (D. P)	101.00				0	23
.00 HOSPICE .10 HOSPICE (non-distinct part) .00 CMHC - CMHC		116.00 30.00	(0		24 24 25
 00 RURAL HEALTH CLINIC 01 RURAL HEALTH CLINIC II 02 RURAL HEALTH CLINIC III 25 FEDERALLY QUALIFIED HEALTH CENT 	D	88.00 88.01 88.02 89.00				0 0 0 0	26 26
00 Total (sum of lines 14-26) 00 Observation Bed Days 00 Ambulance Trips		67.00	25	5		0	27
.00 Employee discount days (see ins .00 Employee discount days - IRF .00 Labor & delivery days (see inst	ructions)		C		0		30 31 32
.01 Total ancillary labor & deliver outpatient days (see instruction .00 LTCH non-covered days							32
.01 LTCH site neutral days and disc	narges						33

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC		Period: From 01/01/2019 To 12/31/2019		epared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Patients	& Residents	Payrol I	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	932	60	1, 64	.7		1.0
00	for the portion of LDP room available beds)	151	204				
. 00	HMO and other (see instructions)	151	204 0				2.0
. 00 . 00	HMO IPF Subprovider HMO IRF Subprovider	0	0				4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	706	0	70	6		5.0
. 00	Hospital Adults & Peds. Swing Bed SNI Hospital Adults & Peds. Swing Bed NF	700	0	16			6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 638	60	2, 51	-		7.0
. 00	INTENSIVE CARE UNIT	0	0		0		8.0
. 00	CORONARY CARE UNIT						9. (
0. 00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY		8	9	9		13.
4.00	Total (see instructions)	1, 638	68	2, 61	5 0.00	214.60	14.
5.00	CAH visits	0	0		0		15.
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17.
8.00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.
0.00	NURSING FACILITY						20.
1. 00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY	3, 883	0	6, 53	. 00	10. 55	
3.00	AMBULATORY SURGI CAL CENTER (D. P.)						23.
4.00	HOSPI CE	0	0		0 0.00	0.00	
4. 10	HOSPICE (non-distinct part)				0		24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC	3, 402	0	15, 21			
6. 01	RURAL HEALTH CLINIC II	167	0	3, 42			
5. 02	RURAL HEALTH CLINIC III	515	0	2,73			
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.00	257.46	
8.00	Observation Bed Days		0	53	0		28.
9.00	Ambul ance Trips	1, 031					29.
0.00	Employee discount days (see instruction)				0		30.
1. 00	Employee discount days - IRF				0		31.
2.00	Labor & delivery days (see instructions)	0	1	3	0		32.
2.01	Total ancillary labor & delivery room outpatient days (see instructions)				0		32.
3.00	LTCH non-covered days	0					33.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019		pared
	Full Time		Di s	charges		
Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 3.00 INTENSIVE CARE UNIT 7.00 CORONARY CARE UNIT 7.00 CORONARY CARE UNIT 7.00 Total (see instructions) 3.00 INTENSIVE CARE UNIT 7.00 Total (see instructions) 7.01 Total (see instructions) 7.02 Total (see instructions) 7.03 UTHER SPECIAL CARE (SPECIFY) 7.04 SUBPROVIDER - IPF 7.05 SUBPROVIDER - IPF 7.06 SUBPROVIDER - IRF 7.07 ONURSING FACILITY 7.08 SUBPROVIDER - IRF 7.09 ONURSING FACILITY 7.00 OTHER LONG TERM CARE 7.01 HOSPICE (non-distinct part) 7.02 CMHC - CMHC 7.03 RURAL HEALTH CLINIC 11 7.04 RURAL HEALTH CLINIC 11 7.05 CHHC - CMHC 7.06 RURAL HEALTH CLINIC 11 7.07 Total (sum of lines 14-26) 7.08 Observation Bed Days 7.09 Ambulance Trips 7.00 Employee discount days (see instruction) 7.00 Employee discount days - IRF 	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0		94 20 41 55 0 94 20	562	15.1 16.1 17.1 18.1 19.1 20.1 21.1 22.1 23.1 24.1 25.1 26.1 26.1 26.1 26.1 27.1 28.2 29.1 30.1 31.1 32.1
 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 				0 0		32. 33. 33.

Heal th	Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	IEALTH AGENCY STATI STI CAL DATA		Provi der C	CN: 15-1322	Period: From 01/01/2019	Worksheet S-4	
			Component	CCN: 15-7177	To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
					Home Health	PPS	
					Agency I		
0.00	County				1. PERRY	00	0.00
0.00	oounty	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4.00	5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	2, 995	48	32 451	3, 928	1.00
2.00	Unduplicated Census Count (see instructions)	0.00		32. (30.00	261.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numb		Staff	Contract	Total	
		your normal	work week				
		()	1.00	2.00	3.00	
2 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		40.00	0.0	0 0 00	0.00	2 00
3.00 4.00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40.00	0.0			3.00 4.00
5.00	Other Administrative Personnel			0.8	0. 00	0.88	
6.00	Di rect Nursi ng Servi ce			2. 9			6.00
7.00 8.00	Nursi ng Supervi sor Physi cal Therapy Servi ce			0.0			1
9.00	Physical Therapy Supervisor			0.0			
10.00	Occupational Therapy Service			0. (
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.0			
12.00	Speech Pathology Supervisor			0.0			
14.00	Medical Social Service			0.0			14.00
15.00	Medical Social Service Supervisor			0.0			15.00
16.00 17.00	Home Health Aide Home Health Aide Supervisor			1.8			16.00 17.00
18.00	Other (specify)			0.0			
	HOME HEALTH AGENCY CBSA CODES			1			1
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost				1		19.00
	reporting period.						
20.00	List those CBSA code(s) in column 1 serviced			99915			20.00
	during this cost reporting period (line 20 contains the first code).						
		Full Ep Without	oisodes With Outliers	LUPA Enisodo	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	846	138		20 37	1, 041	21.00
22.00	Skilled Nursing Visit Charges	402, 870	65, 370	9,43		496, 094	22.00
23.00	Physical Therapy Visits	1, 148	303		1 9	1, 461	1
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	394, 082 738	104, 122 243		14 3, 096 0 1	501, 644 982	
26.00	Occupational Therapy Visit Charges	221, 094	72, 801		0 300	294, 195	
27.00	Speech Pathology Visits	93	83		0 0	176	
28.00	Speech Pathology Visit Charges Medical Social Service Visits	31, 912	28, 472		0 0	60, 384	
29.00 30.00	Medical Social Service Visits Medical Social Service Visit Charges	0	1, 955		0 0	5 1, 955	
31.00	Home Health Aide Visits	152	65	5	1 0	218	31.00
32.00	Home Health Aide Visit Charges	37, 892	16, 178			54, 319	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 977	837		22 47	3, 883	33.00
34.00	Other Charges	0	C		0 0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28,	1, 087, 850	288, 898	10, 03	31 21, 812	1, 408, 591	35.00
36.00	30, 32, and 34) Total Number of Episodes (standard/non	170			10 6	186	36.00
37.00	outlier) Total Number of Outlier Episodes		20		0	20	37.00
38.00		45, 918			25 1, 656		38.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	;
_			Component		From 01/01/2019 To 12/31/2019		
					RHC I	Cost	
					1	. 00	
1 00	Clinic Address and Identification				100 11 44		1 00
1.00	Street		Ci	ty	109 I N-66 State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		TELL CITY			47586	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		t Aword	0	3.00
					t Award .00	Date 2.00	
	Source of Federal Funds			1	. 00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
9.00			-				7.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				Ν	0	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type of bours)	r other operat	ion(s) and the	operating			
	hours.)	Sur	nday	Mo	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)		1	1		1	
11.00	CLINIC			06: 30	17:00	06: 30	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the prod	luctivity stand	ard?	N	2.00	12.00
	Is this a consolidated cost report as define				N	0	13.00
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report.	List the name	es of all provi	ders and			
	numbers below.			Provi	der name	CCN number	
					. 00	2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XI X	Total Visits	
45.00		1.00	2.00	3.00	4.00	5.00	45.05
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	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)		Cou	l inty		I	
				00			
2.00	City, State, ZIP Code, County		PERRY				2.00
		Tuesday		esday		rsday	
		to	from	to	from	to	
	Facility hours of operations (1)	6.00	7.00	8.00	9.00	10.00	
11, 00		17:00	06: 30	17:00	06: 30	17:00	11.00
	· · · · · · · · · · · · · · · · · · ·			•	1	•	

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Period:	Worksheet S-8	
		Component	CCN: 15-8516	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 8:34	pared: am
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)			_			
11. 00 CLINIC	06: 30	16: 00				11.00

Heal th	Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 01/01/2019 Fo 12/31/2019		epared: Lam
					RHC II	Cost	
					1	. 00	-
	Clinic Address and Identification						
1.00	Street		<u></u>	.	315 MAIN STRE		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		TROY			N 47588	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur:	al or "II" for	urban		1.00	3.00
5.00	Those the bhoeb tenes oner. Designation ent				Award	Date	3.00
	1			1.	. 00	2.00	
4 00	Source of Federal Funds	(- +)		1		1	1 4 00
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4.00
6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
9.00	UTHER (SPECIFT)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	0	10.00
	yes or "N" for no in column 1. If yes, indic 2.(Enter in subscripts of line 11 the type o						
	hours.)	i other operati		operating			
		Sun			nday	Tuesday	
		from 1.00	to 2.00	from 3.00	to 4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00		
11.00	CLINIC			08: 00	17: 00	08: 00	11.00
					1.00	2.00	
12.00	Have you received an approval for an excepti	on to the produ	uctivity stand	ard?	1.00 N	2.00	12.00
	Is this a consolidated cost report as define				N	0	
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report. numbers below.	List the names	s of all provi	ders and			
				Provid	ler name	CCN number	
				1.	. 00	2.00	
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1. 00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	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)						
				inty			
2.00	City Chata 71D Cada County			00			2.00
2.00	City, State, ZIP Code, County	Tuesday	PERRY Wedn	esday	Thu	rsday	2.00
		to	from	to	from	to	
		6. 00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	17:00	10: 00	19:00	08: 00	17:00	11.00
11.00		17.00	10.00	117.00	00.00	117.00	1 11.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1322	Period: From 01/01/2019	Worksheet S-8	
		Component	CCN: 15-8517	To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
	_			RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	12:00				11.00

Heal th	Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	8
			Component		From 01/01/2019 To 12/31/2019		epared:
						6/8/2020 8: 34	
					RHC III	Cost	
					1.	00	-
	Clinic Address and Identification						
1.00	Street		0	.	18485 OLD STAT		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		LEOPOLD	00		47551	2.00
					-1		
0.00		IDI C.		de ser		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" tor		Award	Date	3.00
					. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00 6.00	Migrant Health Center (Section 329(d), PHS A						5.00 6.00
8.00 7.00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(U), PHS ACT)					7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h	osni tal -based I	RHC or EOHC2 E	nter "V" for	1.00 N	2.00	0 10.00
10.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o	ate number of (other operatio	ns in column	14		
	hours.)						
		Sun			nday	Tuesday	
		from 1.00	to 2.00	from 3.00	to 4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			07: 00	16: 00	07: 00	11.00
12 00	Have you received an approval for an excepti	on to the produ	uctivity ctand	ard2	1.00 N	2.00	12.00
	Is this a consolidated cost report as define				N	C	
10.00	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report.	List the names	s of all provi	ders and			
	numbers below.			Provid	ler name	CCN number	
					. 00	2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
15.00	GME cost? Enter "Y" for yes or "N" for no in						15.00
	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)						
				inty	_		
2.00	City, State, ZIP Code, County		4. PERRY	00			2.00
2.00	orty, State, Zri code, county	Tuesday		esday	Thur	rsday	2.00
		to	from	to	from	to	
		6. 00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1)	16:00	07:00	11.00	07: 00	16:00	11.00
11.00	CLI NI C	16: 00	07: 00	11:00	07.00	16: 00	II.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Period: From 01/01/2019	Worksheet S-8	
		Component	CCN: 15-8518	To 12/31/2019	Date/Time Pre 6/8/2020 8:34	pared: am
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	15: 00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 15-1322 Period: From 01/01/2019 To 12/31/2019 Worksheet Date/Time 6/8/2020 Uncompensated and indigent care cost computation 1.00 1.00 Cost to charge ratio (Worksheet C, Part I Line 202 column 3 divided by Line 202 column 8) 0.34 Medicaid (see instructions for each Line) 2.00 Net revenue from Medicaid 2,963 Joid you receive DSH or supplemental payments from Medicaid? Y Y	e Prep	
To 12/31/2019 Date/Time 6/8/2020 Incompensated and indigent care cost computation 1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.34 Medicaid (see instructions for each line) 0.34 2.00 Net revenue from Medicaid 2,963 3.00 Did you receive DSH or supplemental payments from Medicaid? Y		arod
Uncompensated and indigent care cost computation 1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.34 Medicaid (see instructions for each line) 0.34 2.00 Net revenue from Medicaid 2,963 3.00 Did you receive DSH or supplemental payments from Medicaid? Y		
Uncompensated and indigent care cost computation 1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.34 Medicaid (see instructions for each line) 0.34 2.00 Net revenue from Medicaid 2,963 3.00 Did you receive DSH or supplemental payments from Medicaid? Y		
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.34 Medicaid (see instructions for each line) 2.00 Net revenue from Medicaid 2,963 3.00 Did you receive DSH or supplemental payments from Medicaid? Y		
Medicaid (see instructions for each line) 2.00 Net revenue from Medicaid 2,963 3.00 Did you receive DSH or supplemental payments from Medicaid? Y	5305	1.00
2.00Net revenue from Medicaid2,9633.00Did you receive DSH or supplemental payments from Medicaid?Y	0000	
	, 367	2.00
		3.00
4.00 f line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Y		4.00
5.00 f line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00 Medicaid charges 13,954		6.00
7.00 Medicaid cost (line 1 times line 6) 4,818 Alternational statements and easter for Medicaid program (line 7 minus our of lines 2 and 5 if (1.105)		7.00
8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,855 (< zero then enter zero)	, 080	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00 Net revenue from stand-al one CHIP	0	9.00
10.00 Stand-alone CHIP charges	0	10.00
11.00 Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then	0	12.00
enter zero)		
Other state or local government indigent care program (see instructions for each line)	0	40.00
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00 14.00
4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
5.00 State or local indigent care program cost (line 1 times line 14)	0	15.00
6.00 Difference between net revenue and cost for state or local indigent care program (line 15 minus line	-	16.00
13; if < zero then enter zero)		
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see		
instructions for each line)	0	17 00
 7.00 Private grants, donations, or endowment income restricted to funding charity care 8.00 Government grants, appropriations or transfers for support of hospital operations 		17.00 18.00
19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines)	-	19.00
8, 12 and 16)	, 000	17.00
Uninsured Insured Total (col		
patients patients + col. 2 1.00 2.00 3.00	2)	
I.00 I.00 <th< td=""><td></td><td></td></th<>		
	, 406	
		20.00
		20.00
20.00Charity care charges and uninsured discounts for the entire facility660,4060660(see instructions)Cost of patients approved for charity care and uninsured discounts (see228,0410228	, 041	
20.00Charity care charges and uninsured discounts for the entire facility660,4060660(see instructions)21.00Cost of patients approved for charity care and uninsured discounts (see228,0410228		20.00 21.00
20.00Charity care charges and uninsured discounts for the entire facility (see instructions)660,406066021.00Cost of patients approved for charity care and uninsured discounts (see instructions)228,041022822.00Payments received from patients for amounts previously written off as000	, 041 0	
20.00Charity care charges and uninsured discounts for the entire facility660,4060660(see instructions)Cost of patients approved for charity care and uninsured discounts (see228,041022821.00Instructions)Payments received from patients for amounts previously written off as0022.00Payments received from patients for amounts previously written off as00	0	21.00 22.00
20.00Charity care charges and uninsured discounts for the entire facility660,4060660(see instructions)Cost of patients approved for charity care and uninsured discounts (see228,041022821.00Instructions)Payments received from patients for amounts previously written off as00	0	21.00
20.00Charity care charges and uninsured discounts for the entire facility660,4060660(see instructions)Cost of patients approved for charity care and uninsured discounts (see228,041022822.00Payments received from patients for amounts previously written off as000	0	21.00 22.00
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660,406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228,041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 228 23.00 Cost of charity care (line 21 minus line 22) 228,041 0 228	0	21.00 22.00
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660,406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228,041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 0 23.00 Cost of charity care (line 21 minus line 22) 228,041 0 228 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? N	0	21.00 22.00 23.00 24.00
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660,406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228,041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 228 23.00 Cost of charity care (line 21 minus line 22) 228,041 0 228 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? N 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of N	0	21.00 22.00 23.00
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660,406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228,041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 228 23.00 Cost of charity care (line 21 minus line 22) 228,041 0 228 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? N 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit N	0	21. 00 22. 00 23. 00 24. 00 25. 00
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660,406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228,041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 228 23.00 Cost of charity care (line 21 minus line 22) 228,041 0 228 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? N 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 2,672 26.00 Total bad debt expense for the entire hospital complex (see instructions) 2,672	0,041	21.00 22.00 23.00 24.00 25.00 26.00
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660,406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228,041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 228 23.00 Cost of charity care (line 21 minus line 22) 228,041 0 228 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? N 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit N 26.00 Total bad debt expense for the entire hospital complex (see instructions) 2,672 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 721	0 , 041 0 , 743 , 085	21.00 22.00 23.00 24.00 25.00 26.00 27.00
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660,406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228,041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 228 23.00 Cost of charity care (line 21 minus line 22) 228,041 0 228 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 1.00 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 2,672 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 2,672 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 1,109	0 , 041 0 , 743 , 085 , 361	21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 27. 00 27. 01
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660,406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228,041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 0 23.00 Cost of charity care (line 21 minus line 22) 228,041 0 228 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 1.00 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 2,672 26.00 Total bad debt expense for the entire hospital complex (see instructions) 721 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 721 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 1,109 28.00 Non-Medicare bad debt expense (see instructions) 1,109	0 , 041 0 , 743 , 085 , 361	21.00 22.00 23.00 24.00 25.00 26.00 27.00
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660,406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228,041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 0 23.00 Cost of charity care (line 21 minus line 22) 228,041 0 228 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? N 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program? 2,672 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 2,672 27.00 Medicare allowable bad debts for the entire hospital complex (see instructions) 7,21 28.00 Non-Medicare bad debt spense (see instructions) 1,109 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 928	0 , 041 0 , 743 , 085 , 361 , 382 , 120	21.00 22.00 23.00 24.00 25.00 25.00 27.00 27.01 28.00
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 660, 406 0 660 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 228, 041 0 228 22.00 Payments received from patients for amounts previously written off as charity care 0 0 228 23.00 Cost of charity care (line 21 minus line 22) 228, 041 0 228 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 1.00 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 2,672 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 2,672 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 721 28.00 Non-Medicare allowable bad debts for the entire hospital complex (see instructions) 1,109 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 1,563 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 928 30.00 Cost of non-Medic	0 , 041 0 , 743 , 085 , 361 , 382 , 120 , 161	21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00

	inancial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1322	Period:	Worksheet A	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
					10 12/31/2019	6/8/2020 8: 34	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	ions (See	Trial Balance	
				· · ·	A-6)	(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ENERAL SERVICE COST CENTERS						
	D100 NEW CAP REL COSTS-BLDG & FIXT		2, 568, 424	2, 568, 42			1.00
	D200 NEW CAP REL COSTS-MVBLE EQUIP		0		0 1, 171, 672		2.00
	D400 EMPLOYEE BENEFITS DEPARTMENT	122, 273	2, 608, 017			2, 730, 028	4.00
	0540 ADMINISTRATIVE AND GENERAL	980, 586	2, 612, 728				5.01
	D590 ADMINISTRATIVE AND GENERAL - OTHER	1, 121, 507	2, 130, 890				5.02
	0700 OPERATION OF PLANT	257, 042	1, 365, 273				
	D800 LAUNDRY & LINEN SERVICE	0	80, 921	80, 92			8.00
	0900 HOUSEKEEPI NG	270, 945	97, 485			368, 430	
	1000 DI ETARY	0	648, 614				
		0	0		507, 076		
	1300 NURSING ADMINISTRATION	237, 542	1, 983			239, 525	
	1600 MEDI CAL RECORDS & LI BRARY	171, 072	64, 652	235, 72	4 -1, 016	234, 708	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	4 4 4 705	4 504 4/4			0.550.05/	
	3000 ADULTS & PEDIATRICS	1,641,785	1, 501, 164			3, 550, 956	1
	3100 I NTENSI VE CARE UNI T	257, 044	156, 772				31.00
	4300 NURSERY	29, 396	0	29, 39	6 0	29, 396	43.00
	NCI LLARY SERVI CE COST CENTERS	400 70/	4 000 050	4 (50 50)	100,440	4 470 474	50.00
	5000 OPERATING ROOM	428, 736	1, 230, 852				
	5200 DELIVERY ROOM & LABOR ROOM	28, 676	177, 713			206, 389	
	5400 RADI OLOGY-DI AGNOSTI C	810, 127	384, 216				
	5000 LABORATORY 5200 WHOLE BLOOD & PACKED RED BLOOD CELLS	720, 295	1, 169, 306			1	60.00 62.00
	6500 RESPIRATORY THERAPY	1,435	63, 071	64, 50 852, 42		64, 506 816, 082	
	6600 PHYSI CAL THERAPY	471, 715 417, 470	380, 710 110, 502				
	5700 OCCUPATIONAL THERAPY	159, 939	25, 804			185, 743	
	5800 SPEECH PATHOLOGY	89, 264	11, 544			100, 808	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	07,204	414, 927				
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	414, 927		145, 869		72.00
	7300 DRUGS CHARGED TO PATIENTS	77, 456	2, 858, 143				
	JTPATIENT SERVICE COST CENTERS	77,430	2,000,140	2,755,57	01,172	2,014,421	/ 5.00
88.00 08	B800 RURAL HEALTH CLINIC	1, 876, 009	993, 139	2, 869, 14	3 11, 298	2, 880, 446	88.00
	B801 RURAL HEALTH CLINIC II	421, 694	248, 035				
	3803 RURAL HEALTH CLINIC III	162, 317	265, 381	427, 69		425, 761	
	3802 RURAL HEALTH CLINIC IV	13, 987	4, 585			18, 572	
	9000 CLINIC	311, 851	86, 290			464, 741	90.00
	9001 PALN MANAGEMENT	0	0		0 0	0	
	9002 WOUND CARE	188, 695	105, 927	294, 62	93, 694		
	9003 ORTHOPEDIC CLINIC	79, 731	8, 339				
	9100 EMERGENCY	684, 936	1, 281, 261	1, 966, 19			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	THER REIMBURSABLE COST CENTERS	· · ·					1
	9500 AMBULANCE SERVICES	722, 743	320, 137	1, 042, 880	22, 176	1, 020, 704	95.00
101.0010	D100 HOME HEALTH AGENCY	629, 580	195, 291	824, 87			
SF	PECIAL PURPOSE COST CENTERS						1
113.0011	1300 INTEREST EXPENSE		1, 171, 672	1, 171, 67	2 -1, 171, 672	0	113.00
116.0011	1600 HOSPI CE	0	0	(0 0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	13, 385, 848	25, 343, 768	38, 729, 61	5 220, 979	38, 950, 595	118.00
NC	ONREIMBURSABLE COST CENTERS						
190.0019	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	9200 PHYSI CLANS' PRI VATE OFFI CES	1, 072, 721	273, 575	1, 346, 29	-220, 979	1, 125, 317	192.00
	9201 MARKETI NG	0	0		0 0	0	192.01
200.00	TOTAL (SUM OF LINES 118 through 199)	14, 458, 569	25, 617, 343	40, 075, 912	2 0	40, 075, 912	200.00

RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC	N: 15-1322	Peri od:	Worksheet A	
					From 01/01/2019	Data /Tima Dra	
					To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8)	For				
			Allocation				
		6.00	7.00				
~ ~	GENERAL SERVICE COST CENTERS	07.450	0 (10 000				
. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	-37, 459					1
. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-36, 535					2
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2//00/020				4
. 01	00540 ADMI NI STRATI VE AND GENERAL	-1, 108, 952	2, 455, 480				5
. 02 . 00	00590 ADMINISTRATIVE AND GENERAL - OTHER 00700 OPERATION OF PLANT	-891	3, 244, 521 1, 616, 681				5
. 00	00800 LAUNDRY & LINEN SERVICE	-891	80, 921				8
. 00	00900 HOUSEKEEPING	0	368, 430				9
0.00	01000 DI ETARY	-517	140, 759				10
1.00	01100 CAFETERIA	-104, 718					11
3.00	01300 NURSI NG ADMI NI STRATI ON	-104,710	239, 525				13
	01600 MEDICAL RECORDS & LIBRARY	-3, 543					16
0.00	INPATIENT ROUTINE SERVICE COST CENTERS	-5, 545	231, 103				
0.00		-240, 875	3, 310, 081				30
1.00		0					31
3.00	04300 NURSERY	0					43
0.00	ANCI LLARY SERVICE COST CENTERS		2,70,0				1.0
0.00	05000 OPERATING ROOM	-826, 465	652, 711				50
2.00	05200 DELIVERY ROOM & LABOR ROOM	-177, 713					52
4.00	05400 RADI OLOGY-DI AGNOSTI C	-46, 196	1, 147, 189				54
0.00	06000 LABORATORY	0	1, 888, 905				60
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	64, 506				62
5.00	06500 RESPI RATORY THERAPY	-251, 084	564, 998				65
6.00	06600 PHYSI CAL THERAPY	0	527, 548				66
7.00		0	185, 743				67
8.00		0	100, 808				68
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	,				71
2.00		0	145, 869				72
3.00	07300 DRUGS CHARGED TO PATIENTS	-1, 341	2, 873, 086				73
0 00	OUTPATIENT SERVICE COST CENTERS	10.0/0	0 070 077				
8.00 8.01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	-10, 369					88
		0	594, 126				
8.02	08803 RURAL HEALTH CLINIC III 08802 RURAL HEALTH CLINIC IV	-18, 572	425, 761				88 88
8.03 0.00		-18, 572 -25, 500	439, 241				90
0.00	09000 CETNIC 09001 PAIN MANAGEMENT	-20, 000	437, 241				90
	09001 PATN MANAGEMENT	-128, 414	259, 902				90
	09003 ORTHOPEDIC CLINIC	-120, 414	85, 335				90
1.00	09100 EMERGENCY	0	1, 963, 631				91
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1, 203, 031				92
50	OTHER REIMBURSABLE COST CENTERS		I				1 12
5.00	09500 AMBULANCE SERVICES	-1, 165	1,019,539				95
	10100 HOME HEALTH AGENCY	0					101
	SPECIAL PURPOSE COST CENTERS		· · · · ·				1
13.00	11300 INTEREST EXPENSE	0	0				113
14 00	11600 HOSPLCE	0	0				1116

116.00	11600 HOSPI CE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-3,020,309	35, 930, 286	118.00
	NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 125, 317	192.00
192.01	19201 MARKETI NG	0	0	192.01
200.00	TOTAL (SUM OF LINES 118 through 199)	-3, 020, 309	37,055,603	200.00

SSI FI CATI ONS			Provider CCN: 15-13		Worksheet A-6
				From 01/01/2019 To 12/31/2019	Date/Time Prepar
	Increases				6/8/2020 8: 34 ar
Cost Center	Line #	Sal ary	Other		
2.00	3.00	4.00	5.00		
A – CAFETERI A COST CAFETERI A	11.00	0	507, 076		
		0	507,076		
B - INTEREST EXPENSE					
NEW CAP REL COSTS-MVBLE	2.00	0	1, 171, 672		
EQUI P	+		1, 171, 672		
C - LEASE EXPENSE		U	1, 171, 072		
NEW CAP REL COSTS-BLDG &	1.00	0	44, 113		
FLXT	0.00				
	0.00 0.00	0	0		
	0.00	0	õ		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	Ő	Ő		1
	0.00	0	0		1
	0.00	0	0		1
	0.00 0.00	0	0		1
	0.00	0	0		1
	0.00	0	0		1
	0.00	0	0		1
	0.00	0	0		1
D - INSURANCE EXPENSE		0	44, 113		
NEW CAP REL COSTS-BLDG &	1.00	0	37, 305		
FI XT					
	0.00	0	0		
0 E - DRUGS CHARGED		0	37, 305		
DRUGS CHARGED TO PATIENTS	73.00	0	6, 327		
	0.00	0	0		
	0.00	0	0		
0 F - BILLABLE SUPPLIES		0	6, 327		
MEDICAL SUPPLIES CHARGED TO	71.00	0	401, 841		
PATI ENTS					
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
O G - IMPLANTABLE DEVICE		0	401, 841		
IMPL. DEV. CHARGED TO	72.00	0	145, 869		
PATI ENT					
		0	145, 869		
H - WOUND CARE RECLASS WOUND CARE	90.02	105, 887	0		
		105, 887	<u>0</u>		
I - RHC RECRUITING EXPENSE REC					
RURAL HEALTH CLINIC	88.00	0	5, 769		
TOTALS J - IV THERAPY		0	5, 769		
CLINIC	90.00	0	67, 237		
	/0.00	0	<u>67, 237</u>		
K - SURGEON RECLASS	1				
OPERATING ROOM	50.00	187, 103	<u>0</u>		
		187, 103	0		
L - TELL CITY RECLASS RURAL HEALTH CLINIC	88.00	5, 529	0		
PHYSICIANS' PRIVATE OFFICES	192.00	72, 011			
TOTALS		77, 540	<u>0</u>		
M - ICU RECLASS					
ADULTS & PEDIATRICS	<u>30.00</u>	25 <u>7,044</u> 257,044	<u>156, 352</u> 156, 352		
	1	207.044	100.302		1

	I FI CATI ONS		PERRY COUNTY		CCN: 15-1322	Period:	u of Form CMS-2552 Worksheet A-6
						From 01/01/2019 To 12/31/2019	Date/Time Prepare
		Decreases					6/8/2020 8:34 am
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref		
	6.00 A - CAFETERIA COST	7.00	8.00	9.00	10.00		
	DI ETARY	10.00	0	507,076		0	1.
0	0		0	507, 076		-	
	B - INTEREST EXPENSE		I			1	
io	INTEREST EXPENSE	1 <u>13.</u> 00	0	<u>1, 171, 672</u>		1	1.
(C – LEASE EXPENSE		0	1, 171, 672			
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	262		9	1.
	ADMI NI STRATI VE AND GENERAL	5. 01	0	1, 600		o	2.
	ADMINISTRATIVE AND GENERAL -	5. 02	0	7, 876		0	3.
	OTHER	7 00		4 740			
	OPERATION OF PLANT DIETARY	7.00 10.00	0	4, 743 262		0	4.
	MEDICAL RECORDS & LIBRARY	16.00	0	1, 016		0	6.
	ADULTS & PEDIATRICS	30.00	0	2,605		0	7.
	INTENSIVE CARE UNIT	31.00	0	294		o	8.
	OPERATING ROOM	50.00	0	915		0	9.
	RADI OLOGY-DI AGNOSTI C	54.00	0	958		0	10.
	LABORATORY RESPI RATORY THERAPY	60. 00 65. 00	0	696 15, 885		0	11.
	PHYSICAL THERAPY	66.00	0	262		0	13.
	DRUGS CHARGED TO PATIENTS	73.00	0	262		0	14.
	CLINIC	90.00	0	637		0	15.
	WOUND CARE	90. 02	0	262		0	16.
	EMERGENCY	91.00	0	1, 119		0	17.
	AMBULANCE_SERVICES	95.00	0	<u>4,459</u>		0	18.
1	0 – INSURANCE EXPENSE		0	44, 113	<u> </u>		
	ADMI NI STRATI VE AND GENERAL	5.01	0	19, 588	1	0	1.
	AMBULANCE SERVICES	95.00	0	17, 717		0	2.
C	0		0	37, 305			
	E - DRUGS CHARGED	5.04		4 005			
	ADMINISTRATIVE AND GENERAL WOUND CARE	5. 01 90. 02	0	1, 925 1, 667		0	1.
	ORTHOPEDIC CLINIC	90.02	0	2, 735		0	3.
	0		0	<u>6, 327</u>			
	F - BILLABLE SUPPLIES						
	ADULTS & PEDIATRICS	30.00	0	2, 784		0	1.
	INTENSIVE CARE UNIT	31.00	0	126		0	2.
	OPERATING ROOM RESPIRATORY THERAPY	50. 00 65. 00	0	366, 600 20, 458		0	3.
	PHYSICAL THERAPY	66.00	0	20, 438			5.
)O IF			0				
	WOUND CARE	90.02	0			0	
0		90.02 91.00	0	10, 264 <u>1, 4</u> 47			6.
	EMERGENCY		00	10, 264			6.
	EMERGENCY O G - IMPLANTABLE DEVICE	91.00	0	10, 264 <u>1, 447</u> 401, 841			6. 7.
	EMERGENCYO OO G - I MPLANTABLE DEVI CE MEDI CAL SUPPLI ES CHARGED TO		0	10, 264 <u>1, 4</u> 47			6. 7.
	EMERGENCY O G - IMPLANTABLE DEVICE	91.00	0	10, 264 <u>1, 447</u> 401, 841 145, 869 			6.7.
	EMERGENCY O G - IMPLANTABLE DEVICE MEDICAL SUPPLIES CHARGED TO PATIENTS	91.00	0	10, 264 <u>1, 447</u> 401, 841			6.7.
	EMERGENCY O G - IMPLANTABLE DEVICE MEDICAL SUPPLIES CHARGED TO PATIENTS O	91.00	0 0 0 0 0	10, 264 <u>1, 447</u> 401, 841 145, 869 			6. 7. 1.
	EMERGENCY O G - IMPLANTABLE DEVICE MEDICAL SUPPLIES CHARGED TO PATIENTS O H - WOUND CARE RECLASS PHYSICIANS' PRIVATE OFFICES O	<u>91.00</u> 71.00 <u>192.00</u>		10, 264 1, 447 401, 841 145, 869 145, 869		0 0 -	6. 7. 1.
	EMERGENCY O G - IMPLANTABLE DEVICE MEDICAL SUPPLIES CHARGED TO PATIENTS O H - WOUND CARE RECLASS PHYSICIANS' PRIVATE OFFICES O I - RHC RECRUITING EXPENSE RE	91.00 71.00 192.00 CLASS	0 0 0 0 0	10, 264 <u>1, 447</u> 401, 841 145, 869 145, 869 0 0			1.
	EMERGENCY O G - IMPLANTABLE DEVICE MEDICAL SUPPLIES CHARGED TO PATIENTS O H - WOUND CARE RECLASS PHYSICIANS' PRIVATE OFFICES O I - RHC RECRUITING EXPENSE RE ADMINISTRATIVE AND GENERAL	<u>91.00</u> 71.00 <u>192.00</u>	0 0 0 0 0	10, 264 <u>1, 447</u> 401, 841 145, 869 <u>145, 869</u> <u>0</u> <u>0</u> <u>0</u> <u>5, 769</u>		0 0 -	6. 7. 1.
	EMERGENCY	91.00 71.00 192.00 CLASS	0 0 0 0 0	10, 264 <u>1, 447</u> 401, 841 145, 869 145, 869 0 0			1.
	EMERGENCY O G - IMPLANTABLE DEVICE MEDICAL SUPPLIES CHARGED TO PATIENTS O H - WOUND CARE RECLASS PHYSICIANS' PRIVATE OFFICES O I - RHC RECRUITING EXPENSE RE ADMINISTRATIVE AND GENERAL	91.00 71.00 192.00 CLASS	0 0 0 0 0	10, 264 1, 447 401, 841 145, 869 145, 869 0 0 5, 769 5, 769 67, 237			1. 1.
	EMERGENCY O G - IMPLANTABLE DEVICE MEDICAL SUPPLIES CHARGED TO PATIENTSO O H - WOUND CARE RECLASS PHYSICIANS' PRIVATE OFFICES_O I - RHC RECRUITING EXPENSE RE ADMINISTRATIVE AND GENERAL TOTALSJ - IV THERAPY DRUGS CHARGED TO PATIENTSO	91.00 71.00 192.00 192.00 5.01	0 0 0 0 0	10, 264 1, 447 401, 841 145, 869 145, 869 145, 869 0 0 0 5, 769 5, 769			1. 1.
	EMERGENCY O G - IMPLANTABLE DEVICE MEDICAL SUPPLIES CHARGED TO PATIENTS O H - WOUND CARE RECLASS PHYSICIANS' PRIVATE OFFICES O I - RHC RECRUITING EXPENSE RE ADMINISTRATIVE AND GENERAL TOTALS J - IV THERAPY DRUGS CHARGED TO PATIENTS O K - SURGEON RECLASS	91.00 71.00 192.00 CLASS 5.01 73.00		10, 264 1, 447 401, 841 145, 869 145, 869 0 0 5, 769 5, 769 5, 769 67, 237 67, 237			6. 7. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
	EMERGENCY O G - IMPLANTABLE DEVICE MEDICAL SUPPLIES CHARGED TO PATIENTSO O H - WOUND CARE RECLASS PHYSICIANS' PRIVATE OFFICES_O I - RHC RECRUITING EXPENSE RE ADMINISTRATIVE AND GENERAL TOTALSJ - IV THERAPY DRUGS CHARGED TO PATIENTSO	91.00 71.00 192.00 192.00 5.01	0 _0	10, 264 <u>1, 447</u> 401, 841 145, 869 <u>145, 869</u> <u>145, 869</u> <u>5, 769</u> <u>5, 769</u> <u>67, 237</u> 67, 237			6. 7. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
	EMERGENCY	91.00 71.00 192.00 CLASS 5.01 73.00		10, 264 1, 447 401, 841 145, 869 145, 869 0 0 5, 769 5, 769 5, 769 67, 237 67, 237			6. 7. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
	EMERGENCY	91.00 71.00 192.00 CLASS 5.01 73.00 192.00	0 _0	10, 264 1, 447 401, 841 145, 869 145, 869 0 0 0 5, 769 5, 769 5, 769 5, 769 67, 237 67, 237 0			6. 7. 1. 1. 1. 1. 1. 1. 1. 1.
	EMERGENCY	91.00 71.00 192.00 CLASS 5.01 73.00	0 _0	10, 264 <u>1, 447</u> 401, 841 145, 869 <u>145, 869</u> <u>145, 869</u> <u>5, 769</u> <u>5, 769</u> <u>67, 237</u> 67, 237			6. 7. 1. 1. 1. 1. 1. 1. 1. 1. 1.
	EMERGENCY	91.00 71.00 192.00 192.00 73.00 73.00 88.01	0 _0	10, 264 1, 447 401, 841 145, 869 145, 869 0 0 0 5, 769 5, 769 5, 769 5, 769 67, 237 67, 237 0			6. 7. 1. 1. 1. 1. 1. 1. 1. 1. 1.
	EMERGENCY	91.00 71.00 192.00 CLASS 73.00 73.00 73.00 88.01 88.02	0 _0	$ \begin{array}{c} 10, 264 \\ \underline{1, 447} \\ 401, 841 \\ 145, 869 \\ \hline 145, 869 \\ \underline{0} \\ 67, 237 \\ 67, 237 \\ 67, 237 \\ \hline 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\$			6. 7. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 2.
	EMERGENCY	91.00 71.00 192.00 192.00 73.00 73.00 88.01	0 _0	10, 264 1, 447 401, 841 145, 869 145, 869 0 0 0 5, 769 5, 769 5, 769 5, 769 67, 237 67, 237 0			6. 7. 1. 1. 1. 1. 1. 1. 1. 1.

Health Financial Systems	PERRY COUNTY				eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019		pared:
			Acquisition	IS		
	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL A	SSET BALANCES					
1.00 Land	2, 755, 753	1,060,000		0 1, 060, 000		1.00
2.00 Land Improvements	73, 301	0		0 0	6, 971	2.00
3.00 Buildings and Fixtures	3, 275, 626	40, 747, 835		0 40, 747, 835	0	3.00
4.00 Building Improvements	0	0		0 0	0	4.00
5.00 Fixed Equipment	171, 558	2, 159, 159		0 2, 159, 159	0	5.00
6.00 Movable Equipment	11, 167, 498	5, 554, 389		0 5, 554, 389	0	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
8.00 Subtotal (sum of lines 1-7)	17, 443, 736	49, 521, 383		0 49, 521, 383	6, 971	8.00
9.00 Reconciling Items	0	0		0 0	0	9.00
10.00 Total (line 8 minus line 9)	17, 443, 736	49, 521, 383		0 49, 521, 383	6, 971	10.00
	Endi ng	Ful I y				
	Bal ance	Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL A						
1.00 Land	3, 815, 753	0				1.00
2.00 Land Improvements	66, 330	0				2.00
3.00 Buildings and Fixtures	44, 023, 461	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	2, 330, 717	0				5.00
6.00 Movable Equipment	16, 721, 887	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	66, 958, 148	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	66, 958, 148	0				10.00

Heal th	Financial Systems	PERRY COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019		pared:	
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see instructions)	instructions)		
		9.00	10.00	11.00	12.00	13.00		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 479, 112	0		0 89, 457	-145	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)	2, 479, 112			0 89, 457	-145	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1)					
		Capi tal -Rel at						
		ed Costs (see	9 through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 568, 424				1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
3.00	Total (sum of lines 1-2)	0	2, 568, 424				3.00	

Health Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part III Date/Time Prep 6/8/2020 8:34	pared: am
	COMF	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 -	instructions)		
	1.00	2.00	<u>col. 2)</u> 3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	50, 236, 261	0	50, 236, 26	0. 750264	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	16, 721, 887		16, 721, 887		0	2.00
3.00 Total (sum of lines 1-2)	66, 958, 148		66, 958, 148			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital-Relat ed Costs				
	6, 00	7.00	through 7) 8.00	9,00	10,00	
PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(2, 485, 766	37, 305	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	-36, 535	2.00
3.00 Total (sum of lines 1-2)	0	0	(2, 485, 766	770	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT	0		-145	ō 0	2, 612, 383	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	1, 171, 672				1, 135, 137	2.00
3.00 Total (sum of lines 1-2)	1, 171, 672	89, 457	-145	0	3, 747, 520	3.00

nanci al	Systems	

	nancial Systems ITS TO EXPENSES		PERRY COUNT	Provider CCN: 15-1322	Period: From 01/01/2019	u of Form CMS-2 Worksheet A-8	
					To 12/31/2019	Date/Time Pre 6/8/2020 8:34	pared am
				Expense Classification of To/From Which the Amount i			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00 1 m	vestment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1.
REI	L COSTS-BLDG & FLXT (chapter		0	FIXT	1.00	0	1.
REI	vestment income - NEW CAP L COSTS-MVBLE EQUIP (chapter	В	-101, 885	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.
	vestment income - other		0		0.00	0	3.
	hapter 2) ade, quantity, and time		0		0.00	0	4
	scounts (chapter 8) funds and rebates of		0		0.00	0	5
exp	penses (chapter 8) ntal of provider space by		0		0.00	0	6
sup	ppliers (chapter 8)						
sta 21)		A		ADMINISTRATIVE AND GENERAL		0	7
	levision and radio service hapter 21)	A	-891	OPERATION OF PLANT	7.00	0	8
00 Pro	rking lot (chapter 21) ovider-based physician justment	A-8-2	0 -1, 695, 385		0.00	0 0	9 10
00 Sal	le of scrap, waste, etc. hapter 23)		0		0.00	0	11
00 Rel	lated organization ansactions (chapter 10)	A-8-1	65, 350			0	12
00 Lau	undry and linen service	P	0		0.00	0	
00 Rer	feteria-employees and guests ntal of quarters to employee d others	B B		CAFETERIA ADMINISTRATIVE AND GENERAL	11. 00 5. 01	0	14 15
sup	le of medical and surgical pplies to other than tients		0		0.00	0	16
00 Sal	le of drugs to other than	В	-1, 341	DRUGS CHARGED TO PATIENTS	73.00	0	17
00 Sal	tients le of medical records and	В	-3, 543	MEDICAL RECORDS & LIBRARY	16.00	0	18
00 Nur edu	stracts rsing and allied health ucation (tuition, fees,		0		0.00	0	19
	oks, etc.) nding machines	В	-517	DI ETARY	10.00	0	20
int	come from imposition of terest, finance or penalty arges (chapter 21)		0		0.00	0	21
ove	terest expense on Medicare erpayments and borrowings to pay Medicare overpayments		0		0.00	0	22
00 Adj	justment for respiratory erapy costs in excess of mitation (chapter 14)	A-8-3	0	RESPI RATORY THERAPY	65.00		23
00 Adj	justment for physical erapy costs in excess of mitation (chapter 14)	A-8-3	0	PHYSI CAL THERAPY	66.00		24
00 Uti	ilization review - ysicians' compensation		0	*** Cost Center Deleted **	* 114.00		25
00 Dep	hapter 21) preciation – NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26
00 Dep	STS-BLDG & FIXT preciation - NEW CAP REL		0	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	27
00 Nor	STS-MVBLE EQUIP n-physician Anesthetist		0	EQUIP *** Cost Center Deleted **			28
00 Adj	ysicians' assistant justment for occupational erapy costs in excess of	A-8-3	0 0	OCCUPATIONAL THERAPY	0.00 67.00	0	29 30
lir .99 Hos	mitation (chapter 14) spice (non-distinct) (see structions)		0	ADULTS & PEDIATRICS	30.00		30

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33. 03WOUND CENTER-ADVERTISINGA-862-862WOUND CARE90. 02033. 0333. 04ADMI NI STRATI ON-CONTRI BUTI ONSA-12, 271ADMI NI STRATI VE AND GENERAL5. 01033. 0433. 05ADVERTISING - TELL CITYA-170RURAL HEALTH CLINIC88. 00033. 0533. 06HAF FEESB-833, 291ADMI NI STRATI VE AND GENERAL5. 01033. 0633. 07LOBBYING DUESA-4, 237ADMI NI STRATI VE AND GENERAL5. 01033. 0733. 08CANNELTON OFFSETA-18, 572RURAL HEALTH CLINIC IV88. 03033. 0833. 09OTHER ADJUSTMENTS (SPECI FY)0000033. 0950. 00TOTAL (sum of lines 1 thru 49)-3, 020, 309-3, 020, 30950. 00033. 09(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.(2)8asis for adjustment (see instructions).A-60 umn pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).Acost cannot be determined.BAmount Received - if cost cannot be determined.(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.(3)Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.							
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33. 06HAF FEESB-833, 291ADMINISTRATIVE AND GENERAL5. 01033. 0633. 07LOBBYING DUESA-4, 237ADMINISTRATIVE AND GENERAL5. 01033. 0733. 08CANNELTON OFFSETA-18, 572RURAL HEALTH CLINIC IV88. 03033. 0833. 09OTHER ADJUSTMENTS (SPECIFY)00030. 09033. 0950. 00TOTAL (sum of lines 1 thru 49)-3, 020, 309050. 0050. 0050. 00(1)Description - all chapter references in this column pertain to CMS Pub. 15-1.50. 0050. 0050. 0050. 00(2)Basis for adjustment (see instructions).A.Costs - if cost, including applicable overhead, can be determined.50. 0050. 00B.Amount Received - if cost cannot be determined(3)Additional adjustments may be made on lines 33 thru 49 and subscripts thereof						0	
33. 07 LOBBYING DUES A -4,237 ADMINISTRATIVE AND GENERAL 5.01 0 33.07 33. 08 CANNELTON OFFSET A -18,572 RURAL HEALTH CLINIC IV 88.03 0 33.08 33. 09 OTHER ADJUSTMENTS (SPECIFY) 0 0 0 0 0 33.09 50. 00 TOTAL (sum of lines 1 thru 49) -3,020,309 -3,020,309 50.00	33.05 ADVERTISING - TELL CITY	A	-170	RURAL HEALTH CLINIC	88.00	0	33.05
33.08 CANNELTON OFFSET A -18,572 RURAL HEALTH CLINIC IV 88.03 0 33.08 33.09 OTHER ADJUSTMENTS (SPECIFY) A -18,572 RURAL HEALTH CLINIC IV 88.03 0 33.09 50.00 TOTAL (sum of lines 1 thru 49) -3,020,309 -3,020,309 50.00 50.00 (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. - - - - - (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. -	33.06 HAF FEES	В	-833, 291	ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33. 09 OTHER ADJUSTMENTS (SPECIFY) (3) 0 0 0 33. 09 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.) -3,020,309 50.00 50.00 (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. 15-1.		A				0	
(3) TOTAL (sum of lines 1 thru 49) -3,020,309 50.00 50.00 TOTAL (sum of lines 1 thru 49) -3,020,309 50.00 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions). 50.00 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.		A	-18, 572	RURAL HEALTH CLINIC IV		0	
50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.) -3,020,309 50.00 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions). 50.00 A. Costs - if cost, including applicable overhead, can be determined. 6. Amount Received - if cost cannot be determined. 50.00 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. 50.00 50.00			0		0.00	0	33.09
(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.							
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.			-3, 020, 309				50.00
 (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. 							
 (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. 		l cocin thic co	lump portain t	CMS Dub 1E 1			L
 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. 			num pertain t	0 CMS PUD. 15-1.			
 B. Amount Received - if cost cannot be determined. (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. 			can be deter	mined			
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.							
				bscripts thereof.			

Heal th	Financial Systems	FY HOSPI TAL	In Lie	eu of Form CMS-	2552-10	
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1322	Period: From 01/01/2019	Worksheet A-8	3-1
OFFICE COSTS From 01/01/2019 To 12/31/2019 Date/Time 6/8/2020 8						
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	65, 350	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			65, 350	0	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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 the amount allowable should be indicated in column 4 not been nosted to Worksheet A columns 1 and/or 2 of this par

nas not	been posted to worksheet A,	corumns r and/or 2,	the amount a	riowable sn	nould be indicated in co	brumn 4 of this part	
					Related Organization(s)	and/or Home Office	
				_			
	Symbol (1)	Name	Perc	centage of	Name	Percentage of	
			Ov	wnershi p		Ownershi p	
	1.00	2.00		3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) A	AND/OR HOME O	FFICE:			

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

rermour					
6.00	В	PERRY CO AMBULA	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	OTHER			100.00
	non-financial) specify:				

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Health Financial Systems PERRY CO	UNTY HOSPITAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND	HOME Provider CCN: 15-1322	Period: From 01/01/2019	Worksheet A-8-1
OFFICE COSTS			Date/Time Prepared:

			6/8/2020 8: 3/	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			
1.00	65, 350	10		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	65, 350			5.00

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

nas not	been posted to worksheet A,	COLUMNS	i anu/oi	Ζ,	the amount	arrowabre	Should be	e murcateu	TH COLUMN 4 OF	this part.	
	Related Organization(s)										
	and/or Home Office										
		-									
	Type of Business										
	6.00										
	B. INTERRELATIONSHIP TO RELA	TED ORGAN	JI ZATI ON	S) A	AND/OR HOME	OFFLCE:					

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

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

i ei iibui	Sement under title Aviii.	
6.00		6.00
7.00 8.00		7.00
8.00		8.00
9.00		9.00
9.00 10.00 100.00		10.00
100.00		100.00

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

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

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

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

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

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

Heal th	Financial Syst	ems	PERRY COUN	TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period:	Worksheet A-8	3-2
						From 01/01/2019 To 12/31/2019		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	919, 196	240, 875	678, 321	0	0	1.00
2.00	50.00	OPERATING ROOM	826, 465	826, 465	C	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	177, 713	177, 713	C	0	0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	46, 196	46, 196	C	0	0	4.00
5.00	60.00	LABORATORY	6,000	0	6,000	0 0	0	5.00
6.00	65.00	RESPI RATORY THERAPY	251, 084	251, 084	C	0	0	6.00
7.00	90.00	CLINIC	25, 500	25, 500	C	0	0	7.00
8.00	90.02	WOUND CARE	127, 552	127, 552	C	0	0	8.00
9.00	91.00	EMERGENCY	1, 124, 698	0	1, 124, 698	0	0	9.00
10.00	0.00		0	0		0	0	10.00
200.00			3, 504, 404		1, 809, 019		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
			2	Limit	Continuing	Share of col.	Insurance	
				2.1.1.1	Education	12	i nour anoo	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	(0 0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	C	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	C	0 0	0	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	C	0 0	0	4.00
5.00		LABORATORY	0	0	C	0	0	5.00
6.00		RESPIRATORY THERAPY	0	0	(0	0	6.00
7.00			0	0	(0	7.00
8.00		WOUND CARE	0	0		~	0	8.00
9.00		EMERGENCY	0	0		-	0	9.00
10.00	0.00			0			0	10.00
200.00	0.00			0			-	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
		I denti fi er	Component	Limit	Di sal I owance	/ aj as tillorite		
		i dentri i en	Share of col.		bi sui i onunce			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0		(1.00
2.00		OPERATING ROOM	0	0	C			2.00
3.00		DELIVERY ROOM & LABOR ROOM	0	0	0			3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	0			4.00
5.00		LABORATORY	0	0	0			5.00
6.00		RESPI RATORY THERAPY	n	0	(6.00
7.00		CLINIC	0	0	(7.00
8.00		WOUND CARE		0	(8.00
9.00		EMERGENCY		0	0	,		9.00
9.00 10.00	0.00			0	(10.00
200.00	0.00							200.00

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	PERRY COUNTY FURNI SHED BY	HOSPITAL Provider Co	CN: 15-1322	In Lie Period: From 01/01/2019 To 12/31/2019 Physical Therapy	Date/Time Pre 6/8/2020 8:34	-3 pared:
	PART I – GENERAL INFORMATION					1.00	
1.00 2.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			52 780	1.00
3. 00 4. 00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	assistant was				0	3.00 4.00
5.00 6.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	apy assistants	(include only	visits made	e by therapy	0	5.00 6.00
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile					0. 00 0. 00	7.00 8.00
		Supervi sors	Therapi sts	Assi stant		Trai nees	
9.00	Total hours worked	1.00	2.00 460.75	3.00	4.00	5.00	9.00
10.00 11.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	0.00	400.73 84.94 42.47	0	. 00 0. 00 . 00 0. 00		
12. 00 12. 01 13. 00	one-half of column 3, line 10) Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site)	0 0 0	0 0 0		0 0 0		12.00 12.01 13.00
13.01	Number of miles driven (offsite)	0	0		0		13.01
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1						14.00
15.00 16.00 17.00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a	39, 136 0 39, 136	16.00				
18.00	others) Aides (column 4, line 9 times column 4, line					0	18.00
19.00 20.00	Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than	thology or	19.00 20.00				
	amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr	es 21-23.				r	21.00
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train					66, 253	
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO	VANCE AND TRAVE	L EXPENSE COM	PUTATION - F	PROVIDER SITE	66, 253	23.00
	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.00
	Assistants (line 4 times column 3, line 11)					0	
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				s 3 and 4 for all	0	
28.00	others) Total standard travel allowance and standard 27)	travel expense	at the provid	der site (su	um of lines 26 and	0	28.00
20,00	Optional Travel Allowance and Optional Travel		- 0				20,00
29.00 30.00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		a 2, Tine 12 ,)		0	29.00 30.00
31.00 32.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31.00 32.00
33.00 34.00	Standard travel allowance and standard trave Optional travel allowance and standard trave			nd 31)		0	33.00 34.00
35.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	l expense (sum	of lines 31 a	nd 32)	RVICES OUTSIDE PF	0	35.00
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su		d 6)			0	38.00 39.00
40.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, Assistants (sum of columns 1) and 2, line 12, l	01 times column	2, line 10)			0	1
41.00 42.00 43.00	Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41) Ontional travel expense (line 8 times the su		3 line 13 01	,		0	41.00 42.00 43.00
43.UU	Optional travel expense (line 8 times the su Total Travel Allowance and Travel Expense - (46, as appropriate.				bllowing three lir		43.00
44.00 45.00	Standard travel allowance and standard trave Optional travel allowance and standard trave						44.00 45.00

UTSI D	IABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider C			′31/2019	Date/Time Pre 6/8/2020 8:34	pared:
					Physi cal	Therapy	Cost	
							1.00	
6.00	Optional travel allowance and optional travel	expense (sum	of lines 42 a	nd 43 - see i	nstructi	ons)	0	46.00
	-	Therapi sts	Assi stants	Ai des		nees	Total	
		1.00	2.00	3.00	4.	00	5.00	
7.00	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting	0.00	0.00	0.0	0	0, 00	0.00	47.00
7.00	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		0.00	0.00	47.00
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	00	0.00		48.00
9.00	Total overtime (including base and overtime	0.00	0.00			0.00		49.00
	allowance) (multiply line 47 times line 48)							
	CALCULATION OF LIMIT			1	-			
0. 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. (00	0.00	0.00	50.00
1.00	line 47) Allocation of provider's standard work year for one full-time employee times the	0.00	0.00	0.0	00	0. 00	0.00	51.00
	percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	l		I				
2.00	Adjusted hourly salary equivalency amount	84.94	0.00	0.0	00	0.00		52.0
2.00	(see instructions)	01.71	0.00			0.00		02.0
3.00	Overtime cost limitation (line 51 times line	0	0		0	0		53. C
	52)							
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 hourly computation at the AHSEA (multiply	0	0		0	0		55.0
6. 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	56.0
	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					1.00	
7.00	Salary equivalency amount (from line 23)		100001112111				66, 253	57. C
3.00	Travel allowance and expense - provider site	(from lines 33	3, 34, or 35))				0	
9.00	Travel allowance and expense - Offsite service	ces (from lines	s 44, 45, or 4	6)			0	59.0
). 00	Overtime allowance (from column 5, line 56)						0	60.0
. 00	Equipment cost (see instructions)						2, 364	
2.00	Supplies (see instructions)						9,644	
	Total allowance (sum of lines 57-62)	Nour recorde)					78, 261	
+. 00 5. 00	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63						30, 878	65.0
5.00	LINE 33 CALCULATION	5 - TT negative	e, enter zero)				0	05.0
0 00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	all others			0	100.0
	Line 27 = line 7 times line 3 for respiratory				others			100.0
0. 01	Line 33 = line 28 = sum of lines 26 and 27							100. C
	LINE 34 CALCULATION			and 1 fam all	others		0	101. C
00. 02	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	/ therapy or su	um of lines 3 a	and 4 for all	0 11101 0			
00. 02 01. 00 01. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or				o thor o			
00. 02 01. 00 01. 01	Line 27 = line 7 times line 3 for respiratory							101. C 101. C
00. 02 01. 00 01. 01 01. 02	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	sum of lines 2	29 and 30 for a	all others			0	101. C
00. 02 01. 00 01. 01 01. 02 02. 00	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	sum of lines 2 sum of lines 2	29 and 30 for a	all others all others		, line	0	101. (

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre 6/8/2020 8:34	
		CAPI TAL REI	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	col. 7) 0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,612,383	2, 612, 383		-		1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 135, 137 2, 730, 028	12, 324	1, 135, 13 5, 35			2.00 4.00
5. 01 00540 ADMINI STRATI VE AND GENERAL	2, 455, 480	199, 366			2, 949, 213	1
5. 02 00590 ADMINI STRATI VE AND GENERAL - OTHER	3, 244, 521	164, 739			3, 718, 434	1
7.00 00700 OPERATION OF PLANT	1, 616, 681	499, 781			2, 388, 082	
8.00 00800 LAUNDRY & LINEN SERVICE	80, 921	4, 265			87, 039	
9. 00 00900 HOUSEKEEPI NG	368, 430	28, 679	12, 46	2 57, 400	466, 971	9.00
10. 00 01000 DI ETARY	140, 759	108, 788	47, 27		296, 818	
11. 00 01100 CAFETERI A	402, 358	0		0 0	402, 358	
13. 00 01300 NURSI NG ADMI NI STRATI ON	239, 525	5, 757			298, 108	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY	231, 165	31, 984	13, 89	8 36, 242	313, 289	16.00
30. 00 03000 ADULTS & PEDIATRICS	3, 310, 081	378, 946	164, 66	0 402, 272	4, 255, 959	30.00
31. 00 03100 I NTENSI VE CARE UNI T	3, 310, 081	378, 9 40 0		0 402,272	4,200,909	31.00
43. 00 04300 NURSERY	29, 396	15, 480		-	57, 830	1
ANCI LLARY SERVI CE COST CENTERS	2,70,0	10, 100	0,72	0,220	01,000	
50. 00 05000 OPERATI NG ROOM	652, 711	278, 537	121, 03	1 130, 466	1, 182, 745	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	28, 676	68, 339	29, 69	5 6, 075	132, 785	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 147, 189	140, 985		1 171, 626	1, 521, 061	
60. 00 06000 LABORATORY	1, 888, 905	58, 253			2, 125, 065	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	64, 506	0		0 304	64, 810	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	564, 998	87, 593 43, 072			790, 585	
67. 00 06700 OCCUPATI ONAL THERAPY	527, 548 185, 743	43,072			677, 777 246, 452	
68. 00 06800 SPEECH PATHOLOGY	100, 808	9, 830			133, 820	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	670, 899	0		0 0	670, 899	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	145, 869	0		0 0	145, 869	
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 873, 086	32, 133	13, 96	3 16, 409	2, 935, 591	73.00
OUTPATIENT SERVICE COST CENTERS	1 1			-		
88.00 08800 RURAL HEALTH CLINIC	2, 870, 077	0		0 398, 606	3, 268, 683	1
88.01 08801 RURAL HEALTH CLINIC II 88.02 08803 RURAL HEALTH CLINIC III	594, 126	0		0 73, 320	667, 446	
88. 03 08803 RURAL HEALTH CLINIC ITT	425, 761 0	0		0 33,977 0 0	459, 738 0	1
90. 00 09000 CLINIC	439, 241	106, 784			658, 491	1
90. 01 09001 PALN MANAGEMENT	0	000,701		0 0	0	1
90. 02 09002 WOUND CARE	259, 902	33, 732	14, 65	7 62, 407	370, 698	
90. 03 09003 ORTHOPEDIC CLINIC	85, 335	0		0 16, 891	102, 226	
91.00 09100 EMERGENCY	1, 963, 631	146, 209	63, 53	1 145, 104	2, 318, 475	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS				-		
95. 00 09500 AMBULANCE SERVICES	1,019,539	95, 952				
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	824, 871	12, 538	5, 44	8 0	842, 857	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 H0SPI CE	0	0		0 0	n	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	35, 930, 286	2, 582, 766			35, 707, 358	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29, 617	12, 86			190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 125, 317	0		0 180, 442	1, 305, 759	
192. 01 19201 MARKETI NG	0	0		0 0		192.01
200.00 Cross Foot Adjustments		-				200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	37, 055, 603) 2 612 202		0 0		201.00
202.00 TITAL (Sum TITES TTO LITUUGH 201)	37,000,003	2, 612, 383	1, 135, 13	7 2, 747, 707	37,000,003	1202.00

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST #	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2019 To 12/31/2019		
	Cost Center Description	ADMI NI STRATI V E AND GENERAL	Subtotal	ADMI NI STRATI E AND GENERAI - OTHER	_ PLANT	LAUNDRY & LINEN SERVICE	
		5. 01	5A. 01	5.02	7.00	8.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTAT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 ADMI NI STRATI VE AND GENERAL	2, 949, 213					5.01
5.02	00590 ADMINI STRATI VE AND GENERAL - OTHER	321, 537	4, 039, 971	4, 039, 97	1		5.02
7.00	00700 OPERATION OF PLANT	206, 500	2, 594, 582				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	7, 526	94, 565				
9.00	00900 HOUSEKEEPI NG	40, 379	507, 350	64, 86	9 48, 338	22, 371	9.00
10.00	01000 DI ETARY	25, 666	322, 484	41, 23	2 183, 362	0	10.00
11.00	01100 CAFETERI A	34, 792	437, 150	55, 89	4 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	25, 778	323, 886	41, 41	2 9, 704	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	27, 090	340, 379	43, 52	1 53, 909	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·		1			
30.00	03000 ADULTS & PEDIATRICS	368, 017	4, 623, 976				
31.00	03100 I NTENSI VE CARE UNI T	0	C		0 0		
43.00	04300 NURSERY	5, 001	62, 831	8, 03	4 26, 092	0	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	100.070	4 005 040	1(1.00	4 4 4 7 5	44.050	50.00
50.00	05000 OPERATING ROOM	102, 273	1, 285, 018				
52.00	05200 DELIVERY ROOM & LABOR ROOM	11, 482	144, 267				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	131, 528	1, 652, 589 2, 308, 821				
60.00 62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	183, 756 5, 604	2, 308, 821 70, 414				1
65.00	06500 RESPIRATORY THERAPY	68, 363	858, 948			-	
66.00	06600 PHYSI CAL THERAPY	58, 608	736, 385				1
67.00	06700 OCCUPATI ONAL THERAPY	21, 311	267, 763				1
68.00	06800 SPEECH PATHOLOGY	11, 572	145, 392				1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	58, 013	728, 912				
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	12, 613	158, 482				
73.00	07300 DRUGS CHARGED TO PATIENTS	253, 843	3, 189, 434			0	1
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	282, 646	3, 551, 329	454,06	9 0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	57, 715	725, 161	92, 71	8 0	0	88.01
88.02	08803 RURAL HEALTH CLINIC III	39, 754	499, 492	2 63, 86	5 0	0	88.02
88.03	08802 RURAL HEALTH CLINIC IV	0	C		0 0	-	
90.00	09000 CLINIC	56, 940	715, 431				1
90.01	09001 PAIN MANAGEMENT	0	C		0 0		
90.02	09002 WOUND CARE	32, 055	402, 753				
90.03	09003 ORTHOPEDIC CLINIC	8, 840	111, 066			-	
91.00	09100 EMERGENCY	200, 481	2, 518, 956		1 246, 436	28, 700	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		C				92.00
05 00	OTHER REIMBURSABLE COST CENTERS	100.062	1, 257, 247	1/0 75	0 161, 727	202	
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	100, 063 72, 883					95.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	12,003	915, 740	<u> </u>	0 21,132	0	
113 00	11300 INTEREST EXPENSE	1		1	1	1	113.00
	11600 HOSPI CE	0	C		0 0	0	116.00
118.00		2, 832, 629	35, 590, 774				
110.00	NONREI MBURSABLE COST CENTERS	2,002,027	00,070,771	1,001,00	2,010,100	110,011	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 674	46, 160	5, 90	2 49, 920	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	112, 910	1, 418, 669		0 0		192.00
	19201 MARKETI NG	0	C		0 0		192.01
200.00			C				200.00
201.00		0	C		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 949, 213	37, 055, 603	4, 039, 97	1 2, 926, 323	113, 844	202.00

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B	
					From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	pared:
						6/8/2020 8:34	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	MEDI CAL RECORDS &	
					N	LI BRARY	
		9.00	10. 00	11.00	13.00	16.00	
	GENERAL SERVICE COST CENTERS	1 1		1	1 1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.01	00540 ADMI NI STRATI VE AND GENERAL						5.01
5.02	00590 ADMINI STRATI VE AND GENERAL - OTHER						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	642, 928	F00 140				9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	41, 065 0	588, 143 0		1		10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 173	0				13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	12,073	0			465, 677	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	143, 045	588, 143	149, 420	219, 514	117, 874	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
43.00	04300 NURSERY	5, 843	0	(0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	105, 141	0	32, 23	9 47, 348	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	25, 796	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	53, 218	0		-	23, 284	54.00
60.00	06000 LABORATORY	21, 989	0			23, 284	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(-	0	62.00
65.00	06500 RESPI RATORY THERAPY	33,064	0	33, 70		32, 015	
66.00	06600 PHYSI CAL THERAPY	16, 259	0	24, 15		5, 821	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	7, 059 3, 710	0	11, 08 4, 87		0 5, 821	67.00 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0,021	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 130	0	14, 94	2 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08803 RURAL HEALTH CLINIC III	0	0			0	88.01 88.02
88.03	08802 RURAL HEALTH CLINIC IV	0	0			0	88.03
90.00	09000 CLINIC	40, 308	0	28, 62	42,052	132, 427	90.00
90.01	09001 PALN MANAGEMENT	0	0	(0 0	0	90.01
90.02	09002 WOUND CARE	12, 733	0	15, 34	3 0	0	90.02
90.03	09003 ORTHOPEDIC CLINIC	0	0		0 0	0	90.03
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	55, 190	0	47, 26	2 69, 438	125, 151	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	36, 219	0		0 0	0	95.00
	10100 HOME HEALTH AGENCY	4, 733	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 HOSPICE	621 749	0 500 143	402.04			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	631, 748	588, 143	493, 04	4 378, 352	465, 677	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 180	0		0	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192.00
192. Oʻ	19201 MARKETI NG	0	0		0 0		192.01
200.00							200.00
201.00		0	0 500 140	402.04			201.00
202.00) TOTAL (sum lines 118 through 201)	642, 928	588, 143	493, 04	4 378, 352	465, 677	202.00

	Financial Systems	PERRY COUNTY			In Lieu of Form CM	
COST AI	LOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1322	Period: Worksheet E From 01/01/2019 Part I To 12/31/2019 Date/Time F 6/8/2020 8: 6/8/2020 8:	Prepared:
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS			1		
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 ADMINISTRATIVE AND GENERAL - OTHER 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					1.00 2.00 4.00 5.01 5.02 7.00 8.00
10. 00 11. 00 13. 00 16. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY					9.00 10.00 11.00 13.00 16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	7, 102, 898	0	7 102 9	202	30.00
	03100 INTENSIVE CARE UNIT	7, 102, 898	0		0	30.00
	04300 NURSERY	102, 800	0			43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	2, 114, 775	0			50.00
	05200 DELIVERY ROOM & LABOR ROOM	303, 695	0			52.00 54.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	2, 245, 292 2, 807, 514	0	2, 245, 2 2, 807, 5		60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	79, 417	0	79,4		62.00
	06500 RESPI RATORY THERAPY	1, 216, 045	0			65.00
1	06600 PHYSI CAL THERAPY	951, 802	0	951,8		66.00
	06700 OCCUPATI ONAL THERAPY	351, 662	0	351,6		67.00
68.00	06800 SPEECH PATHOLOGY	194, 953	0	194, 9	953	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	822, 110	0	822, 1	110	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	178, 745	0	178, 7	745	72.00
	07300 DRUGS CHARGED TO PATIENTS	3, 678, 465	0	3, 678, 4	165	73.00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC	4,005,398	0			88.00
	08801 RURAL HEALTH CLINIC II 08803 RURAL HEALTH CLINIC III	817, 879 563, 357	0			88. 01 88. 02
	08802 RURAL HEALTH CLINIC IV	503, 357	0		0	88.02
	09000 CLINIC	1, 234, 472	0	•	-	90.00
	09001 PALN MANAGEMENT	0	0	., 20.,	0	90.01
	09002 WOUND CARE	539, 186	0	539, 1	186	90.02
90.03	09003 ORTHOPEDIC CLINIC	125, 267	0	125, 2	267	90.03
	09100 EMERGENCY	3, 413, 204	0	3, 413, 2	204	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	09500 AMBULANCE SERVICES	1, 616, 145	0			95.00
•	10100 HOME HEALTH AGENCY	1, 058, 691	0	1, 058, 6	591	101.00
	SPECIAL PURPOSE COST CENTERS			1		113.00
	11600 HOSPI CE	0	0		0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	35, 523, 772	0		2	118.00
+	VONREIMBURSABLE COST CENTERS	33, 320, 112	0	00,020,1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	113, 162	0	113, 1	162	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 418, 669	0			192.00
192.01	19201 MARKETI NG	0	0		0	192.01
		0	0	1		
200.00	Cross Foot Adjustments	0	0		0	200.00
200.00 201.00 202.00	Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)	0 0 37, 055, 603	0	37,055,6	0	200.00 201.00 202.00

Health Financial Systems	PERRY COUNTY	(HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre	pared:
		CAPI TAL REI	ATED COSTS		6/8/2020 8:34	am
Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 324			17, 679	4.00
5. 01 00540 ADMI NI STRATI VE AND GENERAL	0	199, 366			1, 337	5.01
5. 02 00590 ADMINI STRATI VE AND GENERAL - OTHER		164, 739			1, 529	5.02
7.00 00700 OPERATION OF PLANT	0	499, 781			350	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	4, 265			0	8.00 9.00
10. 00 01000 DI ETARY	0	28, 679 108, 788			369 0	10.00
11. 00 01100 CAFETERI A	0	108, 788		0 0	0	11.00
13. 00 01300 NURSING ADMINI STRATI ON	0	5, 757			324	13.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	31, 984			233	16.00
INPATIENT ROUTINE SERVICE COST CENTERS		01,701	10,07	10,002	200	10.00
30. 00 03000 ADULTS & PEDIATRICS	0	378, 946	164, 66	0 543, 606	2, 586	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
43.00 04300 NURSERY	0	15, 480	6, 72	6 22, 206	40	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	278, 537			839	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	68, 339			39	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	140, 985			1, 104	54.00
60. 00 06000 LABORATORY	0	58, 253			982	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL	LS 0	0			2	62.00
	0	87, 593			643	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	43, 072 18, 700			569 218	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	9, 830			122	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	-	, 030 0		0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	32, 133			106	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	2, 565	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	472	88.01
88.02 08803 RURAL HEALTH CLINIC III	0	0		0 0	219	88.02
88.03 08802 RURAL HEALTH CLINIC IV	0	0		0 0	0	88.03
90. 00 09000 CLINIC	0	106, 784	46, 40	0 153, 184	425	90.00
90. 01 09001 PALN MANAGEMENT	0	0		0 0	0	90.01
90. 02 09002 WOUND_CARE 90. 03 09003 ORTHOPEDIC_CLINIC	0	33, 732			402	90.02 90.03
90. 03 09003 ORTHOPEDIC CLINIC 91. 00 09100 EMERGENCY	0	0 146, 209		0 0 1 209, 740	109	90.03 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T)	140, 209	05, 55	0	734	92.00
OTHER REIMBURSABLE COST CENTERS	1)		I	9		72.00
95. 00 09500 AMBULANCE SERVICES	0	95, 952	41, 69	3 137, 645	0	95.00
101.00 10100 HOME HEALTH AGENCY	0	12, 538				101.00
SPECIAL PURPOSE COST CENTERS			•			
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through	117) 0	2, 582, 766	1, 122, 26	8 3, 705, 034	16, 518	118.00
NONREI MBURSABLE COST CENTERS	N		10 -		-	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE		29, 617				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 MARKETI NG	0	0		0 0		192. 00 192. 01
200.00 Cross Foot Adjustments	0	0		0 0		200.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0				200.00
202.00 TOTAL (sum lines 118 through 201)	0	2, 612, 383	1, 135, 13	7 3, 747, 520		
		2,012,000	1,100,10	. 3, 747, 320	17,077	-02.00

	Financial Systems	PERRY COUNT	Provider C	CN- 15 1222	Period:	u of Form CMS- Worksheet B	2552-10
ALLUU	ATTON OF CAPITAL RELATED COSTS		Provider C		From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	epared.
						6/8/2020 8:34	
	Cost Center Description		ADMI NI STRATI V E AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 01	- OTHER 5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	0101	0102	1100	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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 ADMINI STRATI VE AND GENERAL	287, 332					5.01
5.02	00590 ADMINI STRATI VE AND GENERAL - OTHER	31, 328					5.02
7.00	00700 OPERATION OF PLANT	20, 120					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	733				(1 100	8.00
9.00	00900 HOUSEKEEPI NG	3, 934				64, 183	
10.00	01000 DI ETARY	2, 501	2,747			4, 099	
11.00		3, 390			0 0	0	
13.00	01300 NURSING ADMINISTRATION	2, 512				217	1
16.00	01600 MEDICAL RECORDS & LIBRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2,639	2,900	13, 99	2 0	1, 205	16.00
30.00	03000 ADULTS & PEDIATRICS	35, 843	39, 396	165, 77	6 2, 593	14, 281	30.00
31.00	03100 I NTENSI VE CARE UNI T	0			0 2, 373	14, 201	1
43.00	04300 NURSERY	487	535			583	
43.00	ANCI LLARY SERVICE COST CENTERS	407	535	0,77	2 0	505	43.00
50.00	05000 OPERATING ROOM	9, 965	10, 947	121, 85	1 941	10, 496	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 119				2, 575	
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 815				5, 313	
60.00	06000 LABORATORY	17, 904				2, 195	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	546			0 0	2,175	
65.00	06500 RESPIRATORY THERAPY	6, 661	7, 317			3, 301	
66.00	06600 PHYSI CAL THERAPY	5, 710				1, 623	
67.00	06700 OCCUPATI ONAL THERAPY	2, 076		8, 18		705	
68.00	06800 SPEECH PATHOLOGY	1, 127				370	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 652			o o	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 229			0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	24, 732		14, 05		1, 211	
	OUTPATIENT SERVICE COST CENTERS		, ,		1		
88.00	08800 RURAL HEALTH CLINIC	27, 539	30, 254		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	5, 623	6, 178		o o	0	88.01
88. 02	08803 RURAL HEALTH CLINIC III	3, 873	4, 255		0 0	0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0	0		0 0	0	88.03
90.00	09000 CLINIC	5, 548	6, 095	46, 71	4 349	4, 024	90.00
90. 01	09001 PALN MANAGEMENT	0	0		0 0	0	90.01
90. 02	09002 WOUND CARE	3, 123	3, 431	14, 75	7 0	1, 271	90.02
90.03	09003 ORTHOPEDIC CLINIC	861	946		0 0	0	90.03
91.00	09100 EMERGENCY	19, 533	21, 459	63, 96	2 2, 401	5, 510	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS				-11		
	09500 AMBULANCE SERVI CES	9, 749					95.00
101.00	010100 HOME HEALTH AGENCY	7, 101	7, 801	5, 48	5 0	472	101.00
	SPECIAL PURPOSE COST CENTERS			1			
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0		0 0		116.00
118.00		275, 973	268, 785	746, 56	2 9, 523	63, 067	118.00
	NONREI MBURSABLE COST CENTERS				-		1.05 -
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	358		12, 95	/ 0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	11, 001	0		0		192.00
100 O	19201 MARKETING	0	0		0	0	192.01
		1	1	1	1		200.00
200.00		-				-	
200. 00 201. 00 202. 00	Negative Cost Centers	0 287, 332	0 269, 178	759, 51	0 0 9 9, 523		201.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCR: 15-132	Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lieu	u of Form CMS-	2552-10
ADMINISTRATIO ADMINISTRATIO ERECORDS & INCOMPACT 10:00 11:00 13:00 16:00 24:00 10:00 00000 10:00 16:00 24:00 10:00 00000 10:00 10:00 24:00 10:00 00000 10:00 10:00 20:00 10:00 00000 10:00 10:00 20:00 10:00 00000 10:00 00:0000 10:00 20:00 10:00 00:0000 00:000 00:0000 00:	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	1	From 01/01/2019	Part II Date/Time Pre	
Element Stewn C2 RDST Constraints 1.00 1.00 000000 REL COSTS-MIDE A FIXT 2.00 2.00 002000 REL COSTS-MIDE A FIXT 2.00 5.01 005401 AUMINISTRATIVE AND CEREPERAL 5.01 5.01 005401 AUMINISTRATIVE AND CEREPERAL 5.02 5.00 005500 AUMINISTRATIVE AND CEREPERAL 5.01 5.01 005500 AUMINISTRATIVE AND CEREPERAL 5.02 6.00 005001 LANDRY ALL LINE SERVICE 9.00 7.00 015000 DIETARY 212,997 1.16,607 11.00 011000 DISCECEPIRE 9.632 16,079 1.045,868 0.01300 NURSING ADMINISTRATIES 212,997 2,156 9.632 16,079 1.045,868 0.060 10.00 01300 NURSING ADMINISTRATIES 212,997 2,156 9.632 16,079 1.045,868 0.060 0.00 0.023 0.023 43.00 0.023 43.00 0.025 0.023 <t< td=""><td></td><td>Cost Center Description</td><td>DI ETARY</td><td>CAFETERI A</td><td>ADMI NI STRATI C</td><td>) RECORDS &</td><td>Subtotal</td><td></td></t<>		Cost Center Description	DI ETARY	CAFETERI A	ADMI NI STRATI C) RECORDS &	Subtotal	
1.00 00100 INET CAP REL COSTS-BUDG & FLXT 1.00 2.00 02020 MINT STRATIVE SEMPERTS DEPARTMENT 5.01 5.01 00400 END LOYE BENEFITS DEPARTMENT 5.01 5.02 00200 ADMINISTRATIVE AND GENRARL - OTHER 7.00 7.00 00700 DEPARTINO OF PLANT 7.114 5.02 009900 INDESINCE FILL 0 6.00 00400 DIFERMENT 0 7.114 7.00 00700 DIFERMENT 0 7.114 7.00 00700 DIFERMENT 0 7.114 7.00 0100 CAPETERIA 0 0 0 7.00 0100 CAPETERIA 0 0 0 0 7.00 0100 CAPETERIA 0 0 0 0 0 7.00 0110 CAPETERIA 0 0 0 0 0 0 0 0 <td< td=""><td></td><td></td><td>10.00</td><td>11.00</td><td>13.00</td><td>16.00</td><td>24.00</td><td></td></td<>			10.00	11.00	13.00	16.00	24.00	
2.00 00200 NEW CAP REL COSTS-MUBL FOUP 4.00 0400 (MUTOYEE BERTIS DEPARTMENT 5.01 05040 ADMINISTRATIVE AND GENERAL - OTHER 5.01 05040 ADMINISTRATIVE AND GENERAL - OTHER 5.02 05500 ADMINISTRATIVE AND GENERAL - OTHER 7.00 00700 (OPFRATINO OP FLANT 0.00 0000 DEL ARY 7.00 00700 (OPFRATINO OP FLANT 8.00 7.01 00 001 DEL ARY 7.01 0 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.114 1.00 7.01 7.00 7.00 7.00 7.00 7.00 7.00	1 00				1			1 1 00
4.00 00400 EMPLOYE BENEFITS DEPARTMENT 4.00 4.00 5.01 00540 ADMI MISTRATI VE AND GENERAL - OTHER 5.01 5.02 00590 ADMI MISTRATI VE AND GENERAL - OTHER 5.01 7.00 00700 OPERATION OF PENANT 8.00 0.0000 DORDERATION OF PENANT 8.00 0.0000 DORDERATION OF PENANT 0 7.114 1.0.00 10.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
5.01 00540 ADM IN STRATURE AND GERERAL. 5.02 00590 ADM IN STRATURE AND GERERAL. OTHER 7.00 00700 QPERATION OF PLANT 8.00 00800 AUMORY & LINE SERVICE 9.00 00900 HOUSEKEPI NG 9.00 00900 DIETARY 9.00 00900 DIETARY 9.00 00900 DIETARY 9.00 00900 AUMORY & LINE SERVICE 9.00 00900 AUMORY & LINE SERVICE 9.00 00900 AUMORY & LINE SERVICE 9.00 00900 AUMORY & LINE SERVICE 10.00 TILO ALTERIA 10.00 TILO A								
5.02 00590 ADM IN STRATI VE AND CREMERAL - 0THER 5.02 5.02 5.02 5.02 5.02 7.00 7.00 7.00 7.00 7.00 8.00 00600 [ALINDRY & LINEN SERVICE 9.00								
7.00 00700 DPERATION OF PLANT 7.00 7.00 8.00 8.00 00800 LAUNORY & LINEN SERVICE 9.01 0.0100 LANORY & LINEN SERVICE 9.01 9.00 01100 CAFETERIA 0 7.114 10.00 10.00 01000 LARSING AMM ISTRATION 0 17.00 0 67.070 10.00 01000 LARSING AMM ISTRATION 0 17.00 0								
9.00 00000 HOUSEREEPING 01100 CAFETERIA 0 0 7, 114 0 10.00 01000 LETARY 0 0 228 0 67, 079 10.00 01100 CAFETERIA 1 10.00 130, 00 130, 00 URSI NG ADMINI STRATI 0N 0 177 16, 607 10.00 0100 MEDI CAL RECORDS & LI BRARY 0 0 228 0 67, 079 10.045, 848 30.00 01600 MEDI CAL RECORDS & LI BRARY 0 0 228 0 67, 079 10.045, 848 30.00 0100 ADULTS & PEDI ATRICS 2 212, 997 2, 156 9, 635 16, 979 1, 045, 848 30.00 0130, 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
10.00 01000 DICOL QLETERY 212.997 114 10.00 13.00 01300 CAFETERIA 0 7.114 11.00 110.00 100.00 100.00 100.00 100.00 110.00 100.00	8.00	00800 LAUNDRY & LINEN SERVICE						8.00
11.00 01100 CAFETERIA 0 7, 114 11.00 13.00 01300 NRSIN GAMINISTRATION 0 228 0 67, 079 13.00 01000 MEDI CAL RECORDS & LIBRARY 0 228 0 67, 079 13.00 01000 ADULTS A PEDIATRICS 212, 997 2, 156 9, 635 16, 979 1, 06, 05, 00 0100 0100 INTENSI VE CARE UNIT 0 0 0 0 30.00 04300 NURSERY 0 0 0 0 30.00 04300 NURSERY 0 0 0 0 30.02 04300 NURSERY 0 0 6557, 150 50.00	9.00	00900 HOUSEKEEPI NG						9.00
13.00 01300 NURSING ADMINISTRATION 0 17 16.607 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 14.00 15.00 16.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 16.00 15.7150 50.00 16.00 13.00 1	10.00	01000 DI ETARY	212, 997					10.00
16. 00 01400 MEDICAL RECORDS & LIBRARY 0 228 0 67.079 16. 00 01.00 03000 ADULTS & PEDIATRICS 212, 997 2, 156 9, 635 16, 979 1, 045, 848 30. 00 31. 00 30. 02. 11 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00			0					
INPATI ENT NOUTINE SERVICE COST CENTERS 000 03000 ADULTS & PEDIATRICS 212,997 2,156 9,635 16,979 1,045,948 30.00 31.00 0300 INTERSIVE CARE UNIT 0 0 0 31.00 0,300,025 43.00 30.00 04300 URSERY 0 0 0 0 33.24 30.00 30.00 04300 URSERY 0 0 0 0 33.24 32.00 30.00 04300 OPERATING ROOM 0 465 0.0 557.150 50.00 40.00 SA00 PERIOLORY INERNOM 0.06000 LABORATORY 0 859 0 3.354 154.054 60.00 60.00 0.05000 LABORATORY 0 869 0 4.612 187.064 65.00 66.00 0.05000 EVEST RATORY THERAPY 0 466 0 4.612 187.064 65.00 66.00 0.0700 CULATIONAL THERAPY 0 466 0 16.0 0 17.00 72.00 72.00 72.00 72.01			0					
30. 00 03000 ADULTS & PEDIATRICS 212,997 2,156 9,635 16,979 1,045,948 30. 00 43. 00 01NTENSI VE CARE UNIT 0 0 0 30. 00 30. 00 643.00 NURSERY 0 0 0 0 30. 02 31. 00 643.00 NURSERY 0 0 0 0 0 30. 02 640.01 DESIDED (PERVIEE) 0 0 0 122, 997 2, 166 0 52. 00 52.00 0 0 0 122, 997 2, 016 0 122, 997 2, 166 0 0 122, 997 2, 166 0 0 16, 017 0 0 0 122, 997 2, 166 0 0 0 12, 997 2, 166 0 0 0 122, 997 2, 166 0 0 0 14, 45, 64 0 0 0 0 14, 45, 64 0 0 0 0 0 0 0 0 0 <td>16.00</td> <td></td> <td>0</td> <td>228</td> <td>3</td> <td>0 67,079</td> <td></td> <td>16.00</td>	16.00		0	228	3	0 67,079		16.00
31.00 03100 INTERSIVE CARE UNIT 0<	~~ ~~		010 007	0.454	0.00	F 4(070	4 045 040	0.00
43.00 0 0 0 30.623 43.00 ANCLUARY SERVICE COST CONTERS								1
INCLLLARY SERVICE COST CENTERS Image: Cost Centers ANCILLARY SERVICE COST CENTERS 0 466 2.078 0 552.00 52.00 OS200 DELLVERY PROM & LABOR ROOM 0 722 0 3.354 352.400 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 772 0 3.354 154.654 60.000 66.00 LABORATORY 0 859 0 3.354 154.654 60.00 66.00 DESDIO RESIPI RATORY THERAPY 0 486 0 4.1148 62.00 66.00 DESDIO CCUPATI ONAL THERAPY 0 349 0 838 96,195 66.00 0 0.00 0 0.4447 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 11.486 67.10 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00								
50.00 050000 05000 05000 <t< td=""><td>43.00</td><td></td><td>U</td><td>0</td><td>/</td><td></td><td>30, 023</td><td>43.00</td></t<>	43.00		U	0	/		30, 023	43.00
52 00 05200 DELIVERY ROM & LABOR ROM 0 0 132.892 52.00 54 00 65400 RADI CLORY - DI AGNOSTI C 0 792 0 3.554 3302.413 54.00 66.00 06000 RABDI CLORY - DI AGNOSTI C 0 0 0 1.148 62.00 65.00 06500 RESPI RATORY THERAPY 0 486 0 4.612 137.064 65.00 66.00 06600 RESPI RATORY THERAPY 0 486 0	50 00		0	465	2.07	8 0	557 150	50 00
54.00 OS400 RADIOLOGY-DIAGNOSTIC 0 792 0 3.354 302.413 54.00 00.00 OBCOOL ABDRATORY 0 859 0 3.354 60.00 062.00 NEDOL AB REATORY 0 859 0 0 0 11.48 62.00 065.00 DESCOL RESPIRATORY THERAPY 0 446 0 4.612 187.064 65.00 066.00 OFCOL PHYSICAL THERAPY 0 349 0 838 96.195 66.00 0.00 0.0700 OCUPATIONAL THERAPY 0 160 0 40.447 67.00 0.071.00 DICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 2.579 72.00 0.073.00 DRUGS CHARGED TO PATIENTS 0 216 0 0 0 2.579 72.00 0.0300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 2.579 72.00 88.00 08800 RURAL HEALTH CLINIC III			-					
60. 00 00000 LABORATORY 0 859 0 3.354 154, 054 60. 00 62. 00 062000 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 1,148 62.00 62.00 06000 PHYSI CAL THERAPY 0 3449 0 838 96, 195 66.00 0 0 0.000 0.00 0 0.00			0					
65.00 0A500 RESPIRATORY THERAPY 0 486 0 4,612 187,064 65.00 66.00 06600 PHYSICAL THERAPY 0 349 0 838 96,195 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 160 0 0 40,447 67.00 0 0 0 0 0 0 0 40,447 67.00 0 0 0 0 0 0 0 0 10,462 71.00 0 0 0 0 0 0 0 11,862 71.00 0 0 0 0 0 0 0 113,589 73.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 12,373 88.01 88.01 08800 RURAL HEALTH CLINIC 111 0 0 0 0 0 0 88.03 08.02 RURAL HEALTH CLINIC 111			0					
66 00 06000 PHYSICAL THERAPY 0 349 0 838 96,195 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 160 0 0 40,447 67.00 68.00 06800 SPEECH PATHOLOGY 0 70 0 838 22,167 68.00 07.00 0700 DOUTON LED CAL SUPPLIES CHARGE TO PATIENTS 0 0 0 27.200 073.00 ORUGS CHARGED TO PATIENTS 0 216 0 0 113,589 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 66.03 88.00 8800 RURAL HEALTH CLINIC II 0 0 0 12,273 88.01 88.00 08803 RURAL HEALTH CLINIC IV 0 0 0 0 88.00 88.00 90.00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	1, 148	62.00
67.00 COCUPATIONAL THERAPY 0 160 0 0 40, 447 67.00 068.00 06800 SPECH PATHOLOGY 0 70 0 888 22, 167 68.00 71.00 07100 MEDI CALS UPPLIES CHARGED TO PATIENTS 0 0 0 2, 579 72.00 00 0 0 113, 589 73.00 0 73.00 0 0 0 113, 589 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 12, 273 88.01 88.00 88.02 88.01 88.01 88.01 88.01 88.03 88.03 88.03 88.03 88.03 88.03 88.03 88.03 88.03 88.03 88.03 88.04 90.00 0 0 0 0 88.03 0.00 09000 CLINIC 0 0 13.846 19.077 23.76.75 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01	65.00	06500 RESPI RATORY THERAPY	0	486		0 4, 612	187, 064	65.00
68.00 06800 SPEECH PATHOLOGY 0 70 0 838 22, 167 68.00 70 0 0 0 11, 862 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 Comparison 73.00	66.00		0	349		0 838	96, 195	66.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 11, 662 71, 00 72.00 07300 IMPL. DEV. CHARGED TO PATIENT 0 0 0 2,579 72,00 00 07300 DOUTPATIENT SERVICE COST CENTERS 0 216 0 0 113,682 73,00 88.00 08600 RURAL HEALTH CLINIC 0 0 0 02183 88,01 88.01 08601 RURAL HEALTH CLINIC III 0 0 0 12,273 88,01 88.02 08803 RURAL HEALTH CLINIC III 0 0 0 88.02 88.03 88.02 90.00 09000 CLINIC 0 413 1, 846 19, 077 237, 675 90,00 90,01 90.01 09002 WOND CARE 0 221 0 71, 694 90,03 90,01 90,01 90,01 90,01 91,00 9200 90,03 90,003 90,003 90,003 90,003 90,003 90,003 90,003 90,003 90,003 90,003 90,00 90,01 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
72.00 07200 MPL DEV. CHARGED TO PATIENT 0 0 2.579 72.00 073.00 DRUGS CHARGED TO PATIENTS 0 216 0 0 113,589 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0.358 88.00 88.01 08800 RURAL HEALTH CLINIC II 0 0 0 0 2.739 88.01 88.02 08803 RURAL HEALTH CLINIC III 0 0 0 0 88.03 88.02 08802 RURAL HEALTH CLINIC IV 0 0 0 0 88.03 90.00 09000 CLINIC 0			0					
73.00 07300 DRUGS CHARGED TO PATLENTS 0 216 0 0 113,589 73.00 0UTPATLENT SERVICE COST CENTERS 0			0		1			
OUTPATIENT SERVICE COST CENTERS 88.00 OBBOOR RURAL HEALTH CLINIC O			0					
88.00 08800 RURAL HEALTH CLINIC 0 0 0 60,358 88.00 88.01 06801 RURAL HEALTH CLINIC II 0 0 0 12,273 88.01 88.02 RURAL HEALTH CLINIC III 0 0 0 0 88.01 88.02 RURAL HEALTH CLINIC IV 0 0 0 0 88.03 90.00 09000 CLINIC 0 0 0 0 0 90.01 09000 CLINIC 0 413 1,846 19,077 237,675 90.00 90.02 09002 WOND CARE 0 221 0 0 71,594 90.02 90.03 09030 REFRENCY 0 682 3,048 18,027 345,296 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92.00 92.01 92.03 95.00 0 0 0 92.00 92.00 92.0	/3.00		0	216		0 0	113, 589	/3.00
88.01 08801 RURAL HEALTH CLINIC II 0 0 0 12,273 88.01 88.02 08803 RURAL HEALTH CLINIC III 0 0 0 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0 88.03 90.00 09000 CLINIC 0 413 1,846 19,077 237,675 90.01 90.01 09001 PAIN MANAGEMENT 0 0 0 0 90.02 90.02 09003 ORTHOPEDIC CLINIC 0 0 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 0 11,916 90.02 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 682 3,048 18,027 345,296 91.00 92.00 09500 AMBULANCE SERVICES 0 0 0 0 203,713 95.00 101.00 INTER REIMBURSABLE COST CENTERS 0 0 0 0 113.00 113.00 1146.00 00 0 0 <td>88 00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>60.358</td> <td>88 00</td>	88 00		0	0			60.358	88 00
88.02 08803 RURAL HEALTH CLINIC I II 0 0 0 8.02 08002 RURAL HEALTH CLINIC I V 0			0					
88.03 08802 RURAL HEALTH CLINIC IV 0 <th< td=""><td></td><td></td><td>0</td><td></td><td></td><td>1</td><td></td><td></td></th<>			0			1		
90.00 09000 CLINIC 0 413 1,846 19,077 237,675 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.02 WUND CARE 0 0 0 0 0 90.03 00 0 90.03 00 0 0 0 0 0 0 90.03 00 0 0 0 0 1,916 90.03 90.03 00 0			Ő					
90. 02 09002 WOUND CARE 0 221 0 0 71, 594 90. 02 90. 03 09003 0RTHOPEDIC CLINIC 0 0 0 0 1, 916 90. 03 91. 00 09100 EMERGENCY 0 682 3, 048 18, 027 345, 296 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 682 3, 048 18, 027 345, 296 91. 00 92. 00 OPSCIO AMBULANCE SERVICES 0 0 0 0 203, 713 95. 00 101.00 HOME HEALTH AGENCY 0 0 0 0 38, 845 101. 00 101.00 HOME HEALTH AGENCY 0 0 0 0 138, 00 38, 845 101. 00 113.00 11300 INTEREST EXPENSE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 212, 997 7, 114 16, 607 67, 079 3, 678, 048 118. 00			0	413	1, 84	6 19,077	237, 675	
90.03 09003 0RTHOPEDIC CLINIC 0 0 0 1,916 90.03 91.00 09100 EMERGENCY 0 682 3,048 18,027 345,296 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 07100 09500 AMBULANCE SERVICES 0 0 0 0 203,713 95.00 09500 OP500 AMBULANCE SERVICES 0 0 0 0 38,845 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 38,845 101.00 113.00 11300 INTEREST EXPENSE 0 0 0 0 113.00 114.00 1060 HOSPICE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 212,997 7,114 16,607 67,079 3,678,048 118.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 12,162 192.00 192.01 19200 </td <td>90.01</td> <td>09001 PALN MANAGEMENT</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>90.01</td>	90.01	09001 PALN MANAGEMENT	0	0		0 0	0	90.01
91.00 OP100 EMERGENCY O 682 3,048 18,027 345,296 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 203,713 95.00 101.00 HOME HEALTH AGENCY 0 0 0 0 38,845 10.00 SPECIAL PURPOSE COST CENTERS 5 0 0 0 0 0 113.00 114.00 116.00 116.00 100 HORE REST EXPENSE 113.00 114.00 116.00			0	221		0 0	71, 594	90.02
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 0THER REI MBURSABLE COST CENTERS 95.00 0 0 0 203,713 95.00 101.00 HOME HEALTH AGENCY 0 0 0 0 38,845 101.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 0 0 0 0 113.00 116.00 11600 HOSPICE 0 0 0 0 116.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 116.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 118.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.01 192.01 192.01 192.01 192.01 0 0 0 0 0 192.01 0 0 0 0 0 0 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td>0 0</td><td></td><td></td></t<>			0			0 0		
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 203,713 95.00 101.00 HOME HEALTH AGENCY 0 0 0 38,845 101.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPERIAL PURPOSE 0 0 0 113.00 113.00 113.00 HOREST EXPERIAL PURPOSE 0 0 0 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 106.00 16.00 0 0 0 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 118.00 NONREI MBURSABLE COST CENTERS 118.00 190.00 190.00 190.00 190.00 190.00 192.01 190.00 192.01 192.01 192.01 192.01 192.01 192.01 192			0	682	3, 04	8 18, 027	345, 296	1
95.00 09500 AMBULANCE SERVICES 0 0 0 203,713 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 38,845 101.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 0 0 0 0 0 113.00 116.00 11600 HOSPICE 0 0 0 0 0 116.00 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 212,997 7,114 16,607 67,079 3,678,048 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 12,162 192.00 192.01 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 12,162 192.01 192.01 19201 MARKETI NG 0	92.00	· · · · · · · · · · · · · · · · · · ·						92.00
101.00 10100 HOME HEALTH AGENCY 0 <t< td=""><td>05 00</td><td></td><td></td><td></td><td>J</td><td></td><td>202 712</td><td></td></t<>	05 00				J		202 712	
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 116.00 11600 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 212,997 7,114 16,607 67,079 0 0 0 190.00 190.00 IFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 192.01 19200 192.01 19201 192.01 19201 192.01 19201 192.01 0 0 0 0 0 0 0 0 0 0 0 0 0 192.00 19201 192.01 19201 192.01 19201 192.01 0 0 0 0 0 0 0 0 0 0 0 0			°,	0		0		
113.00 INTEREST EXPENSE 0 0 0 0 113.00 116.00 11600 HOSPI CE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 212,997 7,114 16,607 67,079 3,678,048 118.00 NONREI MBURSABLE COST CENTERS 190.00 19200 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 57,310 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 12, 162 192.00 192.01 19201 MARKETI NG 0 0 0 0 192.00 0 0 0 192.00 0 0 0 192.00 0 200.00 0 0 0 192.00 0 0 0 0 0 192.00 0 0 0 0 0 192.00 0 0 0 0 0 0 0 192.00 0 0 0 0 0 0 0 0 0 0 0 <	101.00		0	0	/	0 0	38, 845	101.00
116.00 11600 HOSPI CE 0 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 212,997 7,114 16,607 67,079 3,678,048 118.00 NONREL MBURSABLE COST CENTERS 190.00 19200 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 57,310 190.00 192.00 19200 HYSI CLANS' PRI VATE OFFI CES 0 0 0 12,162 192.00 192.01 19201 MARKETI NG 0 0 0 0 192.01 200.00 Cross Foot Adj ustments 0 0 0 0 0 200.00 0 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 0 200.00 0 0 200.00 0 200.00 0 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00	113 00		<u> </u>					1113 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 212,997 7,114 16,607 67,079 3,678,048 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 57,310 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 12,162 192.00 192.01 19201 MARKETI NG 0 0 0 0 192.01 200.00 Cross Foot Adj ustments 0 0 0 0 0 200.00 0 0 200.00 0 0 200.00 0 200.00 0 0 0 200.00 0 0 200.00 0 0 200.00 0 0 200.00 0 0 200.00 0 0 200.00 0 0 200.00 0 0 200.00 0 0 200.00 0 201.00 0 201.00 0 0 201.00			0	0		0 0	0	
NORREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 57,310 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 12,162 192.00 192.01 19201 MARKETI NG 0			212, 997					
190.00 IPODO GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 57, 310 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 12, 162 192.00 192.01 19201 MARKETI NG 0 0 0 0 192.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			, ,,,,	.,			2, 3, 3, 3 10	1
192.01 19201 MARKETING 0 0 0 192.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0	190.00		0	0)	0 0	57, 310	190.00
200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	12, 162	192.00
201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0 0		
202.00 TOTAL (sum lines 118 through 201) 212,997 7,114 16,607 67,079 3,747,520 202.00			0	0		0 0		
	202.00	IOTAL (sum lines 118 through 201)	212, 997	7, 114	16,60	7 67,079	3, 747, 520	202.00

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL	In Lieu of Form CMS	-2552-10
	TION OF CAPITAL RELATED COSTS		Provi der CCN: 15-13		2002 10
				From 01/01/2019 Part II	
				To 12/31/2019 Date/Time Pr 6/8/2020 8:3	repared:
	Cost Center Description	Intern &	Total	0/0/2020 0.3	
		Residents	lota		
		Cost & Post			
		Stepdown			
		Adjustments			
		25.00	26.00		
	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 ADMINI STRATI VE AND GENERAL				5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER				5.02
	00700 OPERATION OF PLANT				7.00
	00800 LAUNDRY & LINEN SERVICE				8.00
	00900 HOUSEKEEPI NG				9.00
	01000 DI ETARY				10.00
	01100 CAFETERI A				11.00
	01300 NURSI NG ADMI NI STRATI ON				13.00
	01600 MEDICAL RECORDS & LIBRARY				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			
	03000 ADULTS & PEDI ATRI CS	0	1,045,848		30.00
	03100 I NTENSI VE CARE UNI T	0	0		31.00
	04300 NURSERY	0	30, 623		43.00
43.00	ANCI LLARY SERVICE COST CENTERS	0	30, 023		45.00
50.00	05000 OPERATING ROOM	0	557, 150		50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	132, 892		52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	302, 413		54.00
	06000 LABORATORY	0	154, 054		60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 148		62.00
	06500 RESPIRATORY THERAPY	0	187, 064		65.00
	06600 PHYSI CAL THERAPY	0	96, 195		66.00
	06700 OCCUPATI ONAL THERAPY	0	40, 447		67.00
	06800 SPEECH PATHOLOGY	0	22, 167		68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 862		71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	o	2, 579		72.00
	07300 DRUGS CHARGED TO PATIENTS	o	113, 589		73.00
	OUTPATIENT SERVICE COST CENTERS	L			
88.00	08800 RURAL HEALTH CLINIC	0	60, 358		88.00
88.01	08801 RURAL HEALTH CLINIC II	0	12, 273		88.01
88. 02	08803 RURAL HEALTH CLINIC III	0	8, 347		88.02
	08802 RURAL HEALTH CLINIC IV	О	o		88.03
	09000 CLINIC	О	237, 675		90.00
90.01	09001 PALN MANAGEMENT	О	o		90.01
	09002 WOUND CARE	0	71, 594		90.02
90.03	09003 ORTHOPEDIC CLINIC	0	1, 916		90.03
91.00	09100 EMERGENCY	0	345, 296		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
	OTHER REIMBURSABLE COST CENTERS	· · · · · ·			
	09500 AMBULANCE SERVI CES	0	203, 713		95.00
101.00	10100 HOME HEALTH AGENCY	0	38, 845		101.00
	SPECIAL PURPOSE COST CENTERS	· · · · · ·			
113.00	11300 INTEREST EXPENSE				113.00
	11600 HOSPI CE	О	o		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	О	3, 678, 048		118.00
	NONREI MBURSABLE COST CENTERS	н. — Ч			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57, 310		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	o	12, 162		192.00
	19201 MARKETI NG	0	o		192.01
200.00		0	Ö		200.00
201.00	Negative Cost Centers	0	o		201.00
202.00	TOTAL (sum lines 118 through 201)	0	3, 747, 520		202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	PERRY COUNTY	HOSPITAL	N. 15_1322 ₽	In Lie Period:	u of Form CMS-2 Worksheet B-1	
0001 6	LECONTION - STATISTICAL DASIS			F	rom 01/01/2019 o 12/31/2019		
				1	0 12/31/2019	6/8/2020 8: 34	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINISTRATIV E AND GENERAL (ACCUM. COST)	
		1.00	2.00	SALARI ES) 4. 00	5A. 01	5. 01	
	GENERAL SERVICE COST CENTERS		2100				
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMINISTRATIVE AND GENERAL 00590 ADMINISTRATIVE AND GENERAL - OTHER 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA	122, 517 578 9, 350 7, 726 23, 439 200 1, 345 5, 102 0	122, 517 578 9, 350 7, 726 23, 439 200 1, 345 5, 102 0	12, 969, 986 980, 586 1, 121, 507 257, 042 0 270, 945 0 0 0 0 0	-2, 949, 213 0 0 0 0 0 0 0 0 0 0 0	3, 718, 434 2, 388, 082 87, 039 466, 971 296, 818 402, 358	5.02 7.00 8.00 9.00 10.00 11.00
	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	270 1, 500	270 1, 500	237, 542 171, 072		298, 108 313, 289	
30. 00 31. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY	17, 300 17, 772 0 726	17, 300 17, 772 0 726	1, 898, 829 0 29, 396	0	4, 255, 959 0	30. 00 31. 00
	ANCILLARY SERVICE COST CENTERS				1		1
50.00 52.00 54.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	13, 063 3, 205 6, 612	13, 063 3, 205 6, 612	615, 839 28, 676 810, 127	0	1, 182, 745 132, 785 1, 521, 061	52.00
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 732 0	2, 732 0	720, 295 1, 435		2, 125, 065 64, 810	
65.00	06500 RESPI RATORY THERAPY	4, 108	4, 108	471, 715		790, 585	
66.00	06600 PHYSI CAL THERAPY	2, 020	2, 020	417, 470		677, 777	•
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	877 461	877 461	159, 939 89, 264		246, 452	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	07, 201 0 0	0	670, 899 145, 869	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 507	1, 507	77, 456	0	2, 935, 591	73.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	1, 881, 538	0	3, 268, 683	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	346, 091	0	667, 446	88.01
88. 02 88. 03	08803 RURAL HEALTH CLINIC III 08802 RURAL HEALTH CLINIC IV	0	0	160, 380		459, 738 0	88.02 88.03
90.00	09000 CLINIC	5, 008	5, 008	311, 851	, s	658, 491	90.00
90.01	09001 PAIN MANAGEMENT	0	0	0	0	0	90.01
	09002 WOUND CARE 09003 ORTHOPEDIC CLINIC	1, 582 0	1, 582 0	294, 582 79, 731			
91.00	09100 EMERGENCY	6, 857	6, 857	684, 936			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	4, 500	4, 500	C	0	1, 157, 184	95.00
101.00	10100 HOME HEALTH AGENCY	588	588	0			
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0	C	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	121, 128	121, 128	12, 118, 244	-2, 949, 213	32, 758, 145	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 389	1, 389	C	0	42, 486	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	851, 742	0	.,	
192.01 200.00	19201 MARKETING Cross Foot Adjustments	0	0	C	0 0	0	192.01 200.00
200.00	Negative Cost Centers	2, 612, 383	1, 135, 137	2, 747, 707	,	2, 949, 213	201.00
203.00 204.00		21. 322616	9. 265139	0. 211851 17, 679		0. 086471 287, 332	203.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part			0. 001363		0. 008425	
206.00	II) NAHE adjustment amount to be allocated						206.00
207.00	(per Wkst. B-2)						207.00
	Parts III and IV)						

	Financial Systems	PERRY COUNT				u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2019	Worksheet B-1	
				T	o 12/31/2019	Date/Time Pre 6/8/2020 8:34	
	Cost Center Description		ADMI NI STRATI V		LAUNDRY &	HOUSEKEEPI NG	
		n	E AND GENERAL - OTHER	PLANT (SQUARE	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	
			(ACCUM. COST	FEET)	LAUNDRY)	,	
		5A. 02	NO PBP) 5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	5A. 02	5.02	7.00	8.00	9.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5.01	00540 ADMI NI STRATI VE AND GENERAL						5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	-4, 039, 971					5.02
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE		_/ -/				7.00
9.00	00900 HOUSEKEEPI NG		507, 350			79, 879	1
10.00	01000 DI ETARY	C	322, 484		0	5, 102	1
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION		1077100		0	0 270	
	01600 MEDICAL RECORDS & LIBRARY					1, 500	1
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	C			2, 756	17, 772	1
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY			0 726	0	0 726	1
101 00	ANCI LLARY SERVICE COST CENTERS			, 20		, 20	
50.00	05000 OPERATING ROOM	C				13, 063	1
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC				0 1, 101	3, 205 6, 612	
60.00	06000 LABORATORY		2, 308, 821	2, 732	45	2, 732	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	c c	70, 414		0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		858, 948 736, 385		76 216	4, 108 2, 020	
67.00	06700 OCCUPATI ONAL THERAPY		267, 763		210	877	
68.00	06800 SPEECH PATHOLOGY	C	145, 392		0	461	68.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS				0	0	1
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS			-	0	0 1, 507	
10100	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				.,	
88.00	08800 RURAL HEALTH CLINIC	C				0	
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08803 RURAL HEALTH CLINIC III		725, 161 499, 492		0	0	
88.03	08802 RURAL HEALTH CLINIC IV	0	0		0	0	
90.00	09000 CLINIC	C	715, 431	5, 008		5, 008	1
90. 01 90. 02	09001 PALN MANAGEMENT 09002 WOUND CARE		0 402, 753	0 1, 582	0	0 1, 582	
90. 02 90. 03	09003 ORTHOPEDIC CLINIC		111,066		0	0	
91.00	09100 EMERGENCY	C	2, 518, 956	6, 857	2, 553	6, 857	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	C	1, 257, 247	4, 500	18	4, 500	95.00
	10100 HOME HEALTH AGENCY	C					101.00
112 00	SPECIAL PURPOSE COST CENTERS	1	1				112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0	0	0	0	113.00
118.00		-4, 039, 971	31, 550, 803				118.00
	NONREI MBURSABLE COST CENTERS			1 000		1 000	1.00.00
	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	-1, 418, 669	46, 160	1, 389 0			190.00 192.00
	19201 MARKETI NG	C	0	0	0		192.01
200.00							200.00
201.00 202.00			4 020 071	2 026 222	113, 844	612 020	201.00
202.00	Part I)		4, 039, 971	2, 926, 323	113, 044	642, 928	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 127859			8.048774	
204.00			269, 178	759, 519	9, 523	64, 183	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part		0. 008519	9. 327950	0. 940357	0. 803503	205.00
	1)				21.7.10007	2.00000	
206.00							206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lieu	u of Form CMS-2552-10
	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2019	Worksheet B-1
				To		Date/Time Prepared:
	Cost Center Description	DI ETARY (MEALS	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI O	MEDI CAL RECORDS &	6/8/2020 8: 34 am
		SERVED)	(112 0)	N (DI RECT	LI BRARY (TI ME	
				NRSING HRS)	SPENT)	
		10.00	11.00	13.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 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 ADMI NI STRATI VE AND GENERAL					5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER					5.02
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY	6, 865				10.00
	01100 CAFETERI A	0	12, 143			11.00
13.00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	0	29		220	13.00
16.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	389	0	320	16.00
30.00	03000 ADULTS & PEDI ATRI CS	6, 865	3, 680	76, 548	81	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	31.00
43.00	04300 NURSERY	0	0	0	0	43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	0	704	16, 511	0	F0.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	794 0		0	50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 352	-	16	54.00
60.00	06000 LABORATORY	0	1, 466		16	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	-	0	62.00
65.00		0	830		22	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	595 273		4	66.00 67.00
	06800 SPEECH PATHOLOGY	0	120		4	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	-	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	368	0	0	73.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	88.01
	08803 RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08802 RURAL HEALTH CLINIC IV	0	0	0	0	88.03
90. 00 90. 01	09000 CLINIC 09001 PAIN MANAGEMENT	0	705 0		91 0	90.00 90.01
90.01	09002 WOUND CARE	0	378	-	0	90.02
90.03	09003 ORTHOPEDIC CLINIC	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	1, 164	24, 214	86	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	0	0	95.00
	10100 HOME HEALTH AGENCY	0	0		0	101.00
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE					113.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 6, 865	0 12, 143	-	0 320	116.00 118.00
110.00	NONREIMBURSABLE COST CENTERS	0,805	12, 143	131, 737	520	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	192.00
	19201 MARKETI NG	0	0	0	0	192.01
200.00 201.00	3					200. 00 201. 00
201.00	5	588, 143	493, 044	378, 352	465, 677	201.00
	Part I)					
203.00		85. 672688	40. 603146		1, 455. 240625	203.00
204.00		212, 997	7, 114	16, 607	67, 079	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	31. 026511	0. 585852	0. 125871	209. 621875	205.00
200.00	II)	01.020011	0.00002	0.120071	207.021075	200.00
206.00						206.00
207 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					207.00
207.00	Parts III and IV)					207.00
	· · · · · · · · · · · · · · · · · · ·	I I		ı 1	I	I

Heal th	Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/8/2020 8:34	pared:
			Title	XVIII	Hospi tal	Cost	
					Costs	0001	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,	.,				
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDIATRICS	7, 102, 898		7, 102, 89	0 8	0	30.00
	D3100 I NTENSI VE CARE UNI T	0		.,	0 0	0	31.00
	D4300 NURSERY	102, 800		102, 80		0	43.00
	ANCI LLARY SERVICE COST CENTERS	102,000		102/00			10100
50.00	D5000 OPERATING ROOM	2, 114, 775		2, 114, 77	/5 0	0	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	303, 695		303, 69		0	52.00
	D5400 RADI OLOGY-DI AGNOSTI C	2, 245, 292		2, 245, 29		0	54.00
	26000 LABORATORY	2, 807, 514		2, 243, 21		0	60.00
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	79, 417		79, 41		0	62.00
	06500 RESPIRATORY THERAPY	1, 216, 045	0			0	65.00
	D6600 PHYSI CAL THERAPY	951,802	0	951, 80		0	66.00
	06700 OCCUPATI ONAL THERAPY	351,662	0	351,66		0	67.00
	D6800 SPEECH PATHOLOGY	194, 953	0	194, 95		0	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	822, 110	0	822, 11		0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	178, 745		178, 74		0	72.00
	D7300 DRUGS CHARGED TO PATIENTS	3, 678, 465		3, 678, 46		0	73.00
	DUTPATIENT SERVICE COST CENTERS	3,078,403		5, 070, 40	0	0	/3.00
	D8800 RURAL HEALTH CLINIC	4, 005, 398		4,005,39	0 8	0	88.00
	D8800 RURAL HEALTH CLINIC II	4, 003, 398		4,003,34		0	88.00
	D8803 RURAL HEALTH CLINIC III	563, 357		563, 35		0	88.02
	08802 RURAL HEALTH CLINIC IV	0 0 0 0 0		505, 50	0 0	0	88.02
	D9000 CLINIC	1, 234, 472		1, 234, 47	°	0	90.00
	D9000 PALN MANAGEMENT	1, 234, 472		1, 234, 47	0 0	0	90.00
	09002 WOUND CARE	539, 186		539, 18	°	0	90.01
	09003 ORTHOPEDIC CLINIC					0	90.02
	D9100 EMERGENCY	125, 267		125, 26		0	90.03
		3, 413, 204		3, 413, 20		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 301, 124		1, 301, 12	.4	0	92.00
		1 / 1 / 1 / 5		1 (1(1)	5 0	0	
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	1, 616, 145		1, 616, 14			
	SPECIAL PURPOSE COST CENTERS	1, 058, 691		1, 058, 69	1	0	101.00
			 [1			112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	_			0	0	113.00
		0		26 024 00	0		116.00
200.00	Subtotal (see instructions)	36, 824, 896	0				200.00
201.00	Less Observation Beds	1, 301, 124	_	1, 301, 12			201.00
202.00	Total (see instructions)	35, 523, 772	0	35, 523, 77	0	0	202.00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-1322	Peri od:	Worksheet C	
				From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	narad
				10 12/31/2019	6/8/2020 8: 34	am
		Title	XVIII	Hospi tal	Cost	
		Charges			0001	
Cost Center Description	I npati ent		Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 496, 069		2, 496, 06	9		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
43. 00 04300 NURSERY	87, 714		87, 71	4		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	836, 126	6, 808, 298	7, 644, 42			
52.00 05200 DELIVERY ROOM & LABOR ROOM	309, 828	161, 843	471, 67			
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 040, 896	20, 504, 009	21, 544, 90		0. 000000	54.00
60. 00 06000 LABORATORY	1, 427, 128	15, 184, 749	16, 611, 87		0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	41, 546	237, 837	279, 38			
65. 00 06500 RESPI RATORY THERAPY	980, 223	2, 631, 528	3, 611, 75		0. 000000	
66. 00 06600 PHYSI CAL THERAPY	453, 290	2, 247, 150	2, 700, 44	0 0. 352462	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	380, 841	796, 498	1, 177, 33		0. 000000	
68.00 06800 SPEECH PATHOLOGY	82, 656	417, 836	500, 49		0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 327, 683	3, 109, 657	4, 437, 34		0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	932	181, 404	182, 33		0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 461, 219	14, 245, 347	16, 706, 56	6 0. 220181	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	3, 532, 703	3, 532, 70			88.00
88.01 08801 RURAL HEALTH CLINIC II	0	1, 143, 331	1, 143, 33			88.01
88. 02 08803 RURAL HEALTH CLINIC III	0	537, 405	537,40			88.02
88.03 08802 RURAL HEALTH CLINIC IV	0	0		0		88.03
90. 00 09000 CLINIC	221, 703	1, 147, 872	1, 369, 57			
90. 01 09001 PALN MANAGEMENT	0	0		0 0.000000	0.00000	
90. 02 09002 WOUND CARE	20, 700	1, 987, 960	2,008,66		0.00000	
90. 03 09003 ORTHOPEDIC CLINIC	0	475,009	475, 00			
91.00 09100 EMERGENCY	282, 214	7, 499, 527	7, 781, 74			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	57, 685	654, 082	711, 76	7 1.828020	0.00000	92.00
OTHER REI MBURSABLE COST CENTERS		0.050.740	0.050.74	0 0 110000		0.5 0.0
95. 00 09500 AMBULANCE SERVICES	0	3, 858, 719	3, 858, 71		0. 000000	
101.00 10100 HOME HEALTH AGENCY	0	3,005,345	3, 005, 34	5		101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE	1					1112 00
	0	0		0		113.00
116.00 11600 HOSPI CE	12 500 452	0		0		116.00 200.00
200.00Subtotal (see instructions)201.00Less Observation Beds	12, 508, 453	90, 368, 109	102, 876, 56	2		200.00
201.00 Less observation Beds 202.00 Total (see instructions)	12, 508, 453	90, 368, 109	102, 876, 56	2		201.00
	12, 300, 433	70, 300, 109	102, 070, 30	<u> </u>	I	1202.00

Health Financial Systems	PERRY COUNTY I	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1322	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/8/2020 8:34	epared: Lam
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.000000				1 50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
					•
67. 00 06700 OCCUPATIONAL THERAPY	0.000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000				68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0.000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88.00
88.01 08801 RURAL HEALTH CLINIC II					88.01
88.02 08803 RURAL HEALTH CLINIC III					88.02
88.03 08802 RURAL HEALTH CLINIC IV					88.03
90. 00 09000 CLINIC	0. 000000				90.00
90.01 09001 PALN MANAGEMENT	0. 000000				90.01
90.02 09002 WOUND CARE	0. 000000				90.02
90. 03 09003 ORTHOPEDIC CLINIC	0. 000000				90.03
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					1
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					101100
113. 0011300 I NTEREST EXPENSE					1113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	1				202.00

Health Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-3	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/8/2020 8:34	epared:
		Ti tl	e XIX	Hospi tal	PPS	uni
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,	2				
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 102, 898		7, 102, 89	0 8	7, 102, 898	30.00
31.00 03100 INTENSIVE CARE UNIT	0			0 0	0	31.00
43.00 04300 NURSERY	102, 800		102, 80	0 0	102, 800	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 114, 775		2, 114, 77		2, 114, 775	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	303, 695		303, 69	5 0	303, 695	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 245, 292		2, 245, 29	2 0	2, 245, 292	54.00
60. 00 06000 LABORATORY	2, 807, 514		2, 807, 51	4 0	2, 807, 514	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	S 79, 417		79, 41	7 0	79, 417	
65. 00 06500 RESPI RATORY THERAPY	1, 216, 045	0	1, 216, 04	5 0	1, 216, 045	65.00
66. 00 06600 PHYSI CAL THERAPY	951, 802	0	951,80	02 0	951, 802	66.00
67.00 06700 OCCUPATI ONAL THERAPY	351, 662	0	351, 66	2 0	351, 662	67.00
68.00 06800 SPEECH PATHOLOGY	194, 953	0	194, 95	3 0	194, 953	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			822, 11		822, 110	•
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	178, 745		178, 74		178, 745	•
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 678, 465		3, 678, 46	5 0	3, 678, 465	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	4,005,398		4,005,39		4,005,398	
88.01 08801 RURAL HEALTH CLINIC II	817, 879		817, 87		817, 879	•
88.02 08803 RURAL HEALTH CLINIC III	563, 357		563, 35		563, 357	
88.03 08802 RURAL HEALTH CLINIC IV	0			0 0	0	
90. 00 09000 CLINIC	1, 234, 472		1, 234, 47		1, 234, 472	
90. 01 09001 PALN MANAGEMENT	0			0 0	0	
90. 02 09002 WOUND CARE	539, 186		539, 18		539, 186	
90. 03 09003 ORTHOPEDIC CLINIC	125, 267		125, 26		125, 267	
91. 00 09100 EMERGENCY	3, 413, 204		3, 413, 20		3, 413, 204	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 301, 124		1, 301, 12	4	1, 301, 124	92.00
OTHER REIMBURSABLE COST CENTERS				1		
95.00 09500 AMBULANCE SERVICES	1, 616, 145		1, 616, 14		1, 616, 145	
101.00 10100 HOME HEALTH AGENCY	1, 058, 691		1, 058, 69	1	1, 058, 691	101.00
SPECIAL PURPOSE COST CENTERS				1		
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	0	-		0		116.00
200.00 Subtotal (see instructions)	36, 824, 896				36, 824, 896	•
201.00 Less Observation Beds	1, 301, 124		1, 301, 12		1, 301, 124	
202.00 Total (see instructions)	35, 523, 772	0	35, 523, 77	2 0	35, 523, 772	202.00

Impatient Impatient Cost Center Description Impatient Charges Cost or Other Ratio Tell Impatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Tell Impatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Tell Impatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Tell Impatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Tell Impatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Tell Impatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Tell Impatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Tell Impatient Outpatient Total (col. 6 0 0 Oother Tell Impatient Outpatient Outpatient Total (col. 6 + col. 7) Cost or Other Tell Impatient Outpatient Outpatient Cost or Other Tell Tell Impatient Outpatie	heet C I Time Prep 020 8: 34 PPS FRA ti ent ti o . 00 0.000000	
INPATIENT ROUTINE SERVICE COST CENTERS 2,496,069 2,496,069 0 10 30.00 03000 ADULTS & PEDIATRICS 2,496,069 0 9.00 10 43.00 04300 NURSERY 87,714 87,714 87,714 87,714 0 <	Time Prep 020 8: 34 PPS FRA tient tio .00	am 30. 00 31. 00
Impatient Cost Center Description Inpatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Term Term Ratio 30.00 03000 ADULTS & PEDI ATRI CS 2, 496, 069 2, 496, 069 0 10 31.00 03000 ADULTS & PEDI ATRI CS 2, 496, 069 0 0 0 10 43.00 04300 NURSERY 87, 714 87, 714 87, 714 0 0 0 50.00 05000 OPERATI NG ROOM 836, 126 6, 808, 298 7, 644, 424 0, 276643 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 309, 828 161, 843 471, 671 0, 643870 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 040, 896 20, 504, 009 21, 544, 905 0, 104215 0 60.00 06000 LABORATORY 1, 427, 128 15, 184, 749 16, 611, 877 0, 169006 0 60.00 062000 WHOLE BLOOD & PACKED RED BLOOD CELLS 41, 546 237, 837 279, 383 0, 284259 0	020 8: 34 PPS FRA ti ent ti o . 00	am 30. 00 31. 00
Impatient Title XIX Hospital Cost Center Description Inpatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio The Ratio 0 0.00 7.00 8.00 9.00 10 6.00 7.00 8.00 9.00 10 30.00 03000 ADULTS & PEDIATRICS 2,496,069 2,496,069 8.00 9.00 10 31.00 03100 INTENSI VE CARE UNIT 0 0 0 0 0 4 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 1 0 1 0 0 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 0 0<	PPS FRA ti ent ti o . 00	30.00
Cost Center Description Inpati ent Outpati ent Total (col. 6 + col. 7) Cost or Other Ratio Te Inpa Ratio 30.00 03000 ADULTS & PEDI ATRI CS 03000 ADULTS & PEDI ATRI CS 2, 496, 069 2, 496, 069 0 10 43.00 04300 NURSERY 87, 714 87, 714 87, 714 0 0 50.00 05200 DELI VERY ROOM & LABOR ROOM 836, 126 6, 808, 298 7, 644, 424 0. 276643 0 51.00 05400 RADI OLOGY-DI AGNOSTI C 1, 040, 896 20, 504, 009 21, 544, 905 0. 104215 0 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41, 546 237, 837 279, 383 0. 284259 0 60.00 06500 RESPI RATORY HEADON CELLS 41, 546 237, 837 279, 383 0. 284259 0 <td>FRA ti ent ti o . 00</td> <td>31.00</td>	FRA ti ent ti o . 00	31.00
Cost Center Description Inpatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Tel Inpatient 30.00 03000 ADULTS & PEDIATRICS 6.00 7.00 8.00 9.00 10 30.00 03000 ADULTS & PEDIATRICS 2,496,069 2,496,069 0 0 10 31.00 03100 INTENSIVE CARE UNIT 0	ti ent ti o . 00	31.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 8.00 9.00 10 30.00 03000 ADULTS & PEDI ATRI CS 2,496,069 2,496,069 0 10 31.00 03100 INTENSI VE CARE UNI T 0 0 0 0 0 43.00 04300 NURSERY 87,714 87,714 87,714 10 40.01 DELI VERY ROOM 836,126 6,808,298 7,644,424 0.276643 0 52.00 05200 DELI VERY ROOM 836,126 6,808,298 7,644,424 0.276643 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,040,896 20,504,009 21,544,905 0.104215 0 60.00 06000 LABORATORY 1,427,128 15,184,749 16,611,877 0.169006 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41,546 237,837 279,383 0.284259 0 65.00 06500 RESPI RATORY THERAPY 980,223 2,631,528 3,611,751 </td <td>ti ent ti o . 00</td> <td>31.00</td>	ti ent ti o . 00	31.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 8.00 9.00 10 30.00 03000 ADULTS & PEDI ATRI CS 2,496,069 2,496,069 0	ti o . 00	31.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 2, 496, 069 2, 496, 069 0 31. 00 03100 I NTENSI VE CARE UNI T 0 0 0 0 43. 00 04300 NURSERY 87, 714 87, 714 87, 714 0 0 50. 00 05000 OPERATI NG ROOM 836, 126 6, 808, 298 7, 644, 424 0. 276643 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 309, 828 161, 843 471, 671 0. 643870 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 040, 896 20, 504, 009 21, 544, 905 0. 104215 0 60. 00 06400 LABORATORY 1, 427, 128 15, 184, 749 16, 611, 877 0. 169006 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41, 546 237, 837 279, 383 0. 284259 0 65. 00 06500 RESPI RATORY THERAPY 980, 223 2, 631, 528 3, 611, 751 0. 336691 0	. 00	31.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 2, 496, 069 2, 496, 069 31. 00 03100 I NTENSI VE CARE UNI T 0 0 0 43. 00 04300 NURSERY 87, 714 87, 714 0 ANCI LLARY SERVI CE COST CENTERS 836, 126 6, 808, 298 7, 644, 424 0. 276643 0 50. 00 052000 DERATI NG ROOM 309, 828 161, 843 471, 671 0. 643870 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 040, 896 20, 504, 009 21, 544, 905 0. 104215 0 60. 00 06000 LABORATORY 1, 427, 128 15, 184, 749 16, 611, 877 0. 169006 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41, 546 237, 837 279, 383 0. 284259 0 65. 00 065000 RESPI RATORY THERAPY 980, 223 2, 631, 528 3, 611, 751 0. 336691 0		31.00
30. 00 03000 ADULTS & PEDIATRICS 2, 496, 069 2, 496, 069 0 31. 00 03100 INTENSIVE CARE UNIT 0 0 0 43. 00 04300 NURSERY 87, 714 87, 714 0 ANCILLARY SERVICE COST CENTERS 836, 126 6, 808, 298 7, 644, 424 0. 276643 0 50. 00 052000 DELIVERY ROOM & LABOR ROOM 309, 828 161, 843 471, 671 0. 643870 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 040, 896 20, 504, 009 21, 544, 905 0. 104215 0 60. 00 06400 LABORATORY 1, 427, 128 15, 184, 749 16, 611, 877 0. 169006 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41, 546 237, 837 279, 383 0. 284259 0 65. 00 06500 RESPI RATORY THERAPY 980, 223 2, 631, 528 3, 611, 751 0. 336691 0). 000000	31.00
31.00 03100 INTENSIVE CARE UNIT 0 0 0 43.00 04300 NURSERY 87,714 87,714 87,714 87,714 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 836,126 6,808,298 7,644,424 0.276643 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 309,828 161,843 471,671 0.643870 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,040,896 20,504,009 21,544,905 0.104215 0 60.00 06000 LABORATORY 1,427,128 15,184,749 16,611,877 0.169006 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41,546 237,837 279,383 0.284259 0 65.00 06500 RESPI RATORY THERAPY 980,223 2,631,528 3,611,751 0.336691 0). 000000	31.00
43.00 O4300 NURSERY 87,714 87,714 ANCI LLARY SERVI CE COST CENTERS). 000000	
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 836, 126 6, 808, 298 7, 644, 424 0. 276643 0 52.00 05200 DELI VERY ROOM & LABOR 309, 828 161, 843 471, 671 0. 643870 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 040, 896 20, 504, 009 21, 544, 905 0. 104215 0 60.00 LABORATORY 1, 427, 128 15, 184, 749 16, 611, 877 0. 169006 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41, 546 237, 837 279, 383 0. 284259 0 65.00 06500 RESPI RATORY 980, 223 2, 631, 528 3, 611, 751 0. 336691 0). 000000	
50.00 05000 OPERATING ROOM 836, 126 6, 808, 298 7, 644, 424 0. 276643 0. 52.00 05200 DELIVERY ROOM & LABOR ROOM 309, 828 161, 843 471, 671 0. 643870 0. 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 040, 896 20, 504, 009 21, 544, 905 0. 104215 0. 60.00 06000 LABORATORY 1, 427, 128 15, 184, 749 16, 611, 877 0. 169006 0. 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41, 546 237, 837 279, 383 0. 284259 0. 65.00 06500 RESPI RATORY THERAPY 980, 223 2, 631, 528 3, 611, 751 0. 336691 0.). 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM 309,828 161,843 471,671 0.643870 0.643870 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,040,896 20,504,009 21,544,905 0.104215 0. 60.00 06000 LABORATORY 1,427,128 15,184,749 16,611,877 0.169006 0. 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41,546 237,837 279,383 0.284259 0. 65.00 06500 RESPI RATORY THERAPY 980,223 2,631,528 3,611,751 0.336691 0.		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 1,040,896 20,504,009 21,544,905 0.104215 0. 60.00 06000 LABORATORY 1,427,128 15,184,749 16,611,877 0.169006 0. 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41,546 237,837 279,383 0.284259 0. 65.00 06500 RESPI RATORY THERAPY 980,223 2,631,528 3,611,751 0.336691 0.	0. 000000	
60.00 06000 LABORATORY 1, 427, 128 15, 184, 749 16, 611, 877 0. 169006 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41, 546 237, 837 279, 383 0. 284259 0 65.00 06500 RESPI RATORY THERAPY 980, 223 2, 631, 528 3, 611, 751 0. 336691 0	0.00000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 41, 546 237, 837 279, 383 0. 284259 0. 65. 00 06500 RESPI RATORY THERAPY 980, 223 2, 631, 528 3, 611, 751 0. 336691 0.	0.00000	
65. 00 06500 RESPI RATORY THERAPY 980, 223 2, 631, 528 3, 611, 751 0. 336691 (0,00000	
	0. 000000	65.00
	0. 000000	
	0. 000000	
	0.00000	
	0.00000	
	0.00000	
	0.00000	
OUTPATI ENT SERVI CE COST CENTERS		
	0. 000000	88.00
88.01 08801 RURAL HEALTH CLINICII 0 1, 143, 331 1, 143, 331 0. 715348 0	0. 000000	88.01
	0. 000000	88.02
	0. 000000	
	0. 000000	90.00
	0. 000000	
90. 02 09002 WOUND CARE 20, 700 1, 987, 960 2, 008, 660 0. 268431 (0. 000000	90.02
90. 03 09003 ORTHOPEDIC CLINIC 0 475, 009 475, 009 0. 263715 0	0. 000000	90.03
	0. 000000	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 57,685 654,082 711,767 1.828020 (0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS		
95. 00 09500 AMBULANCE SERVICES 0 3, 858, 719 0. 418829 0	0. 000000	95.00
101.00 10100 HOME HEALTH AGENCY 0 3,005,345 3,005,345		101.00
SPECIAL PURPOSE COST CENTERS		
113.00 11300 I NTEREST EXPENSE		113.00
116.00 11600 HOSPI CE 0 0 0		116.00
200.00 Subtotal (see instructions) 12,508,453 90,368,109 102,876,562		200.00
201.00 Less Observation Beds		201.00
202.00 Total (see instructions) 12,508,453 90,368,109 102,876,562		202.00

Health Financial Systems	PERRY COUNTY I	HOSPI TAL	In Lieu	」of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1322	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/8/2020 8:34	epared: Lam
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					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. 276643				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 643870				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 104215				54.00
60.00 06000 LABORATORY	0. 169006				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 284259				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 336691				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 352462				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 298692				67.00
68.00 06800 SPEECH PATHOLOGY	0. 389523				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 185271				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 980306				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 220181				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	1. 133805				88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 715348				88.01
88.02 08803 RURAL HEALTH CLINIC III	1. 048291				88.02
88. 03 08802 RURAL HEALTH CLINIC IV	0. 000000				88.03
90. 00 09000 CLINIC	0. 901354				90.00
90. 01 09001 PALN MANAGEMENT	0. 000000				90.01
90. 02 09002 WOUND CARE	0. 268431				90.02
90. 03 09003 ORTHOPEDIC CLINIC	0. 263715				90.03
91. 00 09100 EMERGENCY	0. 438617				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 828020				92.00
OTHER REIMBURSABLE COST CENTERS	1. 020020				72.00
95. 00 09500 AMBULANCE SERVICES	0. 418829				95.00
101.00 10100 HOME HEALTH AGENCY	0. 41002 9				101.00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
201.00 Total (see instructions)					201.00
					1202.00

Health Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part II Date/Time Pre 6/8/2020 8:34	epared:
		Ti tl	e XIX	Hospi tal	PPS	an
Cost Center Description	Total Cost	Capital Cost	Operati ng	Capi tal	Operating	
	(Wkst. B,	(Wkst. B,	Cost Net of		Cost	
	Part I, col.	Part II col.	Capital Cos	t	Reducti on	
	26)	26)	(col. 1 -		Amount	
	1.00	0.00	col . 2)	1.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	2, 114, 775	557, 150	1, 557, 6	25 0	0	50.00
					0	
52.00 O5200 DELIVERY ROOM & LABOR ROOM	303, 695				-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 245, 292				0	
60.00 06000 LABORATORY	2, 807, 514				0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	79, 417				0	02.00
65. 00 06500 RESPI RATORY THERAPY	1, 216, 045				0	00.00
66.00 06600 PHYSI CAL THERAPY	951, 802				0	00.00
67.00 06700 OCCUPATI ONAL THERAPY	351, 662				0	01100
68.00 06800 SPEECH PATHOLOGY	194, 953				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	822, 110				0	11100
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	178, 745				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 678, 465	113, 589	3, 564, 8	76 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	-					
88.00 08800 RURAL HEALTH CLINIC	4,005,398				0	
88.01 08801 RURAL HEALTH CLINIC II	817, 879				0	
88.02 08803 RURAL HEALTH CLINIC III	563, 357	8, 347	555, 0	10 0	0	
88.03 08802 RURAL HEALTH CLINIC IV	0	0		0 0	0	88.03
90. 00 09000 CLINIC	1, 234, 472	237, 675	996, 7	97 0	0	90.00
90.01 09001 PALN MANAGEMENT	0	0		0 0	0	90.01
90. 02 09002 WOUND CARE	539, 186	71, 594	467, 5	92 0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	125, 267	1, 916	123, 3	51 0	0	90.03
91.00 09100 EMERGENCY	3, 413, 204	345, 296	3, 067, 9	0 80	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 301, 124	191, 580	1, 109, 5	44 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVICES	1, 616, 145	203, 713	1, 412, 4	32 0	0	95.00
101.00 10100 HOME HEALTH AGENCY	1, 058, 691	38, 845	1, 019, 8	46 0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
200.00 Subtotal (sum of lines 50 thru 199)	29, 619, 198	2, 793, 157	26, 826, 0	41 0	0	200.00
201.00 Less Observation Beds	1, 301, 124					201.00
202.00 Total (line 200 minus line 201)	28, 318, 074					202.00
				1 1		

	ancial Systems N OF OUTPATIENT SERVICE COST TO CHARGE RA		Y HOSPITAL Provider C	^N· 15_1322	Do	ri od:	Worksheet C	-2552-
	FOR MEDICALD ONLY	ATTOS NET OF	TTOVIDET C	GN. 13-1322		om 01/01/2019	Part II	
EDUCTIONS					То		Date/Time Pr	repared
							6/8/2020 8:3	34 am
				e XIX		Hospi tal	PPS	_
	Cost Center Description		Total Charges	Outpati ent				
		Capital and	(Worksheet C,	Cost to				
		Operating	Part I,	Charge Rati	0			
		Cost Reduction	column 8)	(col. 6 /				
		6. 00	7.00	col. 7) 8.00				
ANCI	LLARY SERVICE COST CENTERS	0.00	7.00	0.00				
	0 OPERATING ROOM	2, 114, 775	7, 644, 424	0. 2766	13			50.0
	DO DELIVERY ROOM & LABOR ROOM	303, 695		0. 2700				52.0
	0 RADI OLOGY-DI AGNOSTI C	2, 245, 292						54.0
	0 LABORATORY	2, 243, 292		0. 1690				60.0
	0 WHOLE BLOOD & PACKED RED BLOOD CELLS	79, 417	279, 383					62.0
	O RESPIRATORY THERAPY	1, 216, 045		0. 3366				65.0
	0 PHYSI CAL THERAPY	951,802						66.0
	O OCCUPATI ONAL THERAPY	351,662						67.
	O SPEECH PATHOLOGY	194, 953						68.0
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	822, 110						71.
	0 IMPL. DEV. CHARGED TO PATIENT	178, 745						72.0
	DO DRUGS CHARGED TO PATIENTS	3, 678, 465						73.0
	ATIENT SERVICE COST CENTERS	3, 070, 403	10,700,300	0.2201				- / 3. (
	O RURAL HEALTH CLINIC	4,005,398	3, 532, 703	1. 1338	05			88.0
	1 RURAL HEALTH CLINIC II	817, 879		0. 7153				88.0
	3 RURAL HEALTH CLINIC III	563, 357	537, 405					88.0
	22 RURAL HEALTH CLINIC IV	0						88.0
	O CLINIC	1, 234, 472	-					90.0
	1 PALN MANAGEMENT	1, 234, 472	1, 307, 373	0.0000				90.0
	2 WOUND CARE	539, 186	2,008,660					90.0
	3 ORTHOPEDIC CLINIC	125, 267	475,009					90.0
	O EMERGENCY	3, 413, 204						91.0
	O OBSERVATION BEDS (NON-DISTINCT PART)	1, 301, 124	711, 767	1.8280				92.0
	R REIMBURSABLE COST CENTERS	1,001,121	/11,707	1.0200	20			
	O AMBULANCE SERVICES	1, 616, 145	3, 858, 719	0. 4188	29			95.0
	O HOME HEALTH AGENCY	1, 058, 691	3,005,345					101.0
	I AL PURPOSE COST CENTERS	1,000,071	0,000,040	0.0022	57			-1
	O INTEREST EXPENSE							113. (
16.001160		0	0	0.0000	00			116. (
00.00	Subtotal (sum of lines 50 thru 199)	29, 619, 198	0					200.
01.00	Less Observation Beds	1, 301, 124						200.0
02.00	Total (line 200 minus line 201)	28, 318, 074						201.0

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019		pared:
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1		1	-	-	
50.00 05000 OPERATING ROOM	557, 150					
52.00 05200 DELIVERY ROOM & LABOR ROOM	132, 892					52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	302, 413					54.00
60. 00 06000 LABORATORY	154, 054					
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 148					
65. 00 06500 RESPI RATORY THERAPY	187, 064					•
66.00 06600 PHYSI CAL THERAPY	96, 195					
67.00 06700 OCCUPATI ONAL THERAPY	40, 447					•
68.00 06800 SPEECH PATHOLOGY	22, 167					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 862					
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 579				Ŭ	72.00
73.00 07300 DRUGS CHARGED TO PATI ENTS	113, 589	16, 706, 566	0.00679	99 1, 157, 664	7, 871	73.00
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	60, 358				-	
88.01 08801 RURAL HEALTH CLINIC II	12, 273				0	88. 01
88.02 08803 RURAL HEALTH CLINIC III	8, 347				0	88.02
88.03 08802 RURAL HEALTH CLINIC IV	0	0	0.0000		0	88.03
90. 00 09000 CLINIC	237, 675	1, 369, 575				
90. 01 09001 PALN MANAGEMENT	0	0	0.0000		0	90.01
90. 02 09002 WOUND CARE	71, 594				286	
90. 03 09003 ORTHOPEDIC CLINIC	1, 916				0	90.03
91.00 09100 EMERGENCY	345, 296					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	191, 580	711, 767	0. 26910	4, 410	1, 187	92.00
OTHER REIMBURSABLE COST CENTERS			1			05 00
95.00 09500 AMBULANCE SERVICES	2 550 500	02 420 715		2 (27 470	04 4/5	95.00
200.00 Total (lines 50 through 199)	2, 550, 599	93, 428, 715	1	3, 637, 479	84, 465	200.00

Health Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 6/8/2020 8:34	pared:
	_	Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & 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 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	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	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
88.02 08803 RURAL HEALTH CLINIC III	0	0		0 0	0	88.02
88.03 08802 RURAL HEALTH CLINIC IV	0	0		0 0	0	88.03
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 PALN MANAGEMENT	0	0		0 0	0	90.01
90. 02 09002 WOUND CARE	0	0		0 0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	0	0		0 0	0	90.03
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS]
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

APPORT IONNENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CON: 15-1322 Period: Find Cost To 12/31/2019 Period: Part IV Cost/CB/2020 Worksheet D Part IV CB/2020 Cost Center Description All Other Medical Cost Total Cost (Sum of Cols: 4) Total Cost Total Outpatient cols: 2, 3, and 4) Total Cost Worksheet D Part IV Cost Worksheet D Cost ANCILLARY SERVICE COST CENTERS All Other Education Cost Total 4) Total Cost Total Cost Cost	Health Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-	2552-10
Cost Center Description All Other Medical Education Cost Total (sum of cols. 4) Total (sum of cols. and 4) Total Outpatient Cost (sum of cols. and 4) Total Cost (col. 5 + col. 8) Total Cost (col. 5 + col. 7) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATING ROOM 05000 DELIVERY ROOM & LABOR ROOM 00 0 0 7.644.424 0.000000 50.00 50.00 05200 DELIVERY ROOM & LABOR ROOM 00 0 0 0 7.644.424 0.000000 50.00 60.00 CAUCULARY SERVICE COST CENTERS 0 0 0 27.00 8.00 50.00 05200 DELIVERY ROOM & LABOR ROOM 00 0 0 0 27.03 0.000000 50.00 60.00 00000 LABORATORY 00 0 0 0 27.03 0.000000 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 0 17.73.39 0.000000 68.00 71.00 07000 MEDICALS CHARGED TO PATIENTS		RVICE OTHER PAS			From 01/01/2019 To 12/31/2019	Part IV Date/Time Pre	
Medical Education (sum of cols. 1, 2, 3, and 4) Outpatient Cost (sum of cols. 2, 3, and 4) (from Wks7. col. 8) (from Wks7. col. 8) (from Wks7. col. 8) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATING ROOM 0 0 7.644.424 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 7.644.424 0.000000 52.00 54.00 05000 OPERATING ROOM 0 0 0 7.644.424 0.000000 52.00 54.00 05000 RDELIVERY ROOM & LABOR ROOM 0 0 0 7.644.424 0.000000 52.00 54.00 06000 LABORATORY 0 0 0 16.611.877 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 1.177.339 0.000000 62.00 66.00 06800 SPEECH PATHOLGY TONAL THERAPY 0 0 1.177.339 0.000000 62.00 71.00 07200 IMPL- DEV. CHARGED TO PATIENT 0 0<			Title	XVIII	Hospi tal	Cost	
Education Cost 1, 2, 3, and 4) Cost (sum of col s. 2, 3, and 4) ANCI LLARY SERVICE COST CENTERS 0 6.00 7.00 8.00 50.00 05000 DELIVERY ROM & LABOR ROOM 0 0 7.644.424 0.000000 52.00 50.00 05400 RADI LOGY-DI AGNOSTI C 0 0 0 7.644.424 0.000000 52.00 60.00 06000 LABORATORY 0 0 0 16.611.877 0.000000 66.00 60.00 06000 PLYSI CAL THERAPY 0 0 0 2.700.440 0.000000 66.00 60.00 06000 PLYSI CAL THERAPY 0 0 0 2.700.440 0.000000 66.00 61.00 06000 PLYSI CAL THERAPY 0 0 0 1.77.339 0.000000 66.00 66:00 06600 PLYSI CARCED TO PATI ENTS 0 0 1.437.331 0.000000 72.00 70:00 0 1.437.331 0.0000000 73	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
Cost 4) col s. 2, 3, and 4) col . 8) col . 7) ANCI LLARY SERVICE COST CENTERS		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 0PERATING ROOM 0 0 7.644,424 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 7.644,424 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 16.611,877 0.000000 54.00 60.00 06500 RESPI RATORY THERAPY 0 0 0 2,70,444 0.000000 65.00 65.00 06600 CAGOW HOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 2,700,440 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 1,773,339 0.000000 65.00 66.00 06700 PCUPATI IONAL THERAPY 0 0 0 1,773,339 0.000000 67.00 68.00 PHYSI CAL THERAPY 0 0 0 1,873,340 0.000000 71.00		Education	1, 2, 3, and		C, Part I,		
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ANCI LLARY SERVICE COST CENTERS 0 0 7.644,424 0.00000 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 471,671 0.00000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 21,544,905 0.000000 54.00 60.00 06600 LABORATORY 0 0 0 16,611,877 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 311,751 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 1,177,339 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 1,177,339 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 1,233,40 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 1,423,236,00000000 <td></td> <td>Cost</td> <td>4)</td> <td></td> <td>col. 8)</td> <td>col. 7)</td> <td></td>		Cost	4)		col. 8)	col. 7)	
ANCI LLARY SERVICE COST CENTERS Image: Control of the co							
50.00 05000 DPERATING ROOM 0 0 7, 644, 424 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 471, 671 0.000000 52.00 64.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 21, 544, 905 0.000000 54.00 65.00 06000 LABORATORY 0 0 0 16, 611, 877 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 3, 611, 751 0.000000 66.00 66.00 06400 PHYSI CAL THERAPY 0 0 0 1, 177, 339 0.000000 66.00 67.00 06400 PHYSI CAL THERAPY 0 0 0 1, 177, 339 0.000000 66.00 68.00 06400 SPECH PATHOLOGY 0 0 0 50.04, 92 0.000000 67.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 16, 706, 566 0.0000000 71.00 72.00 072001 MURLALHEALTH CLINIC 0 0		4.00	5.00	6.00	7.00	8.00	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 471, 671 0.000000 52.00 54.00 RADI OLGGY-DI AGNOSTI C 0 0 0 21, 544, 905 0.0000000 60.00 AGOOD LABORATORY 0 0 0 16, 611, 877 0.000000 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 279, 383 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 2, 700, 440 0.000000 66.00 66.00 OC4700 SPEECH PATHOLOGY 0 0 0 1, 177, 339 0.000000 67.00 67.00 OG700 OC4LAL SUPPLIES CHARGED TO PATI ENTS 0 0 4, 437, 340 0.000000 71.00 71.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 182, 336 0.000000 72.00 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 18, 7334 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENT 0 0 16, 706					- 1		
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 21, 544, 905 0.000000 54.00 60.00 06000 LABORATORY 0 0 16, 611, 877 0.000000 62.00 62.00 06500 RESPI RATORY 0 0 0 3, 611, 751 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 3, 611, 751 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 1, 177, 339 0.000000 67.00 67.00 0C0PATI TONAL THERAPY 0 0 0 1, 177, 339 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 4, 437, 340 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 182, 336 0.000000 72.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0 0 182, 336 0.000000 73.00 00 07300 DRUGS CHARGED TO PATI ENTS 0 0		0	0				
60.00 06000 LABORATORY 0 0 16, 611, 877 0.00000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 279, 383 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 3, 611, 751 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 2, 700, 440 0.000000 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 1, 177, 339 0.000000 67.00 68.00 OSE00 SPEECH PATHOLOGY 0 0 0 500, 492 0.000000 71.00 07100 MEDI LS CHARGED TO PATI ENTS 0 0 4, 437, 340 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 16, 706, 566 0.000000 73.00 08800 RURAL HEALTH CLINIC III 0 0 0 1, 143, 331 0.000000 88.01 88.00 08803 RURAL HEALTH CLINIC III 0 0 0 0.		0	0				
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 279,383 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 0 0 3,611,751 0.000000 65.00 66.00 06500 RESPIRATORY THERAPY 0 0 0 2,700,440 0.000000 66.00 67.00 0CUPATI ONAL THERAPY 0 0 0 1,177,339 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 500,492 0.000000 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 182,336 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 182,336 0.000000 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 14,437,340 0.000000 88.00 88.01 08800 RURAL HEALTH CLINIC C 0 0 11,43,331 0.000000 88.01 88.01 08803 RURAL HEALTH CLINIC III 0 0 0 0.000000 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
65.00 06500 RESPI RATORY THERAPY 0 0 3, 611, 751 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 2, 700, 440 0.000000 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 1, 177, 339 0.000000 66.00 68.00 0E800 SPEECH PATHOLOGY 0 0 0 50, 492 0.000000 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 4, 437, 340 0.000000 71.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0 0 0 16, 706, 566 0.000000 72.00 00 0DRUGS CHARGED TO PATI ENTS 0 0 0 16, 706, 566 0.000000 73.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 3, 532, 703 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 0 537, 405 0.000000 88.02 88.02 08803 RURAL HEALTH CLINIC IV 0 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
66.00 06600 PHYSI CAL THERAPY 0 0 0 2,700,440 0.00000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 1,177,339 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 500,492 0.000000 68.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 4,437,340 0.000000 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 0 0 182,336 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 16,706,566 0.000000 73.00 0 0 0 3,532,703 0.000000 88.00 90.00 0 0.000000 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>•</td>		0	0				•
67.00 06700 0CCUPATIONAL THERAPY 0 0 1,177,339 0.00000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 500,492 0.000000 68.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 4,437,340 0.000000 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 0 0 182,336 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 16,706,566 0.000000 73.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 1,143,331 0.000000 73.00 78.00 08801 RURAL HEALTH CLINIC 0 0 1,143,331 0.000000 88.01 88.01 08802 RURAL HEALTH CLINIC III 0 0 0 0.000000 88.02 88.03 08902 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.03 90.01 09001 PAI MANAGEMENT 0 0 0 0.000000 90.01		0	0				
68.00 06800 SPEECH PATHOLOGY 0 0 500, 492 0.000000 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 4, 437, 340 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 182, 336 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 16, 706, 566 0.000000 73.00 0 0 08800 RURAL HEALTH CLINIC 0 0 3, 532, 703 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 0 537, 405 0.000000 88.02 88.02 08802 RURAL HEALTH CLINIC IV 0 0 0 0 0 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0 0.000000 88.02 90.00 09000 CLNIC 0<		0	0				
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 4, 437, 340 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 182, 336 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 182, 336 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 16, 706, 566 0.000000 88.00 88.00 08800 RURAL HEALTH CLINIC II 0 0 0 1, 143, 331 0.000000 88.01 88.01 08801 RURAL HEALTH CLINIC III 0 0 0 537, 405 0.000000 88.02 88.02 08803 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.03 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.03 90.01 09001 PAIN MANAGEMENT 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02		0	0				
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 182,336 0.00000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 16,706,566 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 3,532,703 0.000000 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 1,143,331 0.000000 88.01 88.01 08803 RURAL HEALTH CLINIC III 0 0 0 537,405 0.000000 88.01 88.02 08802 RURAL HEALTH CLINIC III 0 0 0 0.000000 88.01 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 80.30 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.03 90.00 09000 CLINIC 0 0 0 0.000000 90.00 90.00		0	0		0 500, 492		
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 16, 706, 566 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS		0	0		0 4, 437, 340	0.000000	
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 3, 532, 703 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 1, 143, 331 0.000000 88.01 88.02 08803 RURAL HEALTH CLINIC III 0 0 0 537, 405 0.000000 88.01 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 90.00 09000 CLINIC 0 0 0 0 0.000000 90.00 90.02 09002 WOUND CARE 0 0 0 0 0.000000 90.02 90.03 <	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 182, 336	0. 000000	72.00
88.00 08800 RURAL HEALTH CLINIC 0 0 3, 532, 703 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 1, 143, 331 0.000000 88.01 88.02 08803 RURAL HEALTH CLINIC III 0 0 0 537, 405 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.03 90.00 09000 CLINIC 0 0 0 0 0.000000 90.00 90.01 09001 PAI N MANAGEMENT 0 0 0 0.000000 90.02 90.02 09002 WUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDI C LINIC 0 0 0 7.781,741 0.000000 90.02 91.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 16, 706, 566	0.000000	73.00
88.01 08801 RURAL HEALTH CLINICII 0 0 1, 143, 331 0.000000 88.01 88.02 08803 RURAL HEALTH CLINICIII 0 0 0 537, 405 0.000000 88.02 88.03 08802 RURAL HEALTH CLINICIV 0 0 0 0.000000 88.03 90.00 09000 CLINIC 0 0 0 0.000000 90.00 90.01 09001 PAI N MANAGEMENT 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 711,767 0.000000 92.00 00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	OUTPATIENT SERVICE COST CENTERS						
88.02 08803 RURAL HEALTH CLINICIII 0 0 537,405 0.000000 88.02 88.03 08802 RURAL HEALTH CLINICIV 0 0 0 0.000000 88.03 90.00 09000 CLINIC 0 0 0 0.000000 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 0.000000 90.02 91.00 OP100 DESERVATION 0 0 0 7.781,741 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 7.11,767 0.000000 92.00 92.00 09500 AMBULANCE SERVICES 95.00 95.00		0	0		0 3, 532, 703	0. 000000	88.00
88.03 08802 RURAL HEALTH CLINICIV 0 0 0 0.00000 88.03 90.00 09000 CLINIC 0 0 0 1,369,575 0.00000 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 475,009 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 711,767 0.000000 92.00 92.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	88.01 08801 RURAL HEALTH CLINIC II	0	0		0 1, 143, 331	0. 000000	88.01
90.00 09000 CLINIC 0 0 1,369,575 0.00000 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 0.00000 90.01 90.02 09002 WOUND CARE 0 0 0 0 0.00000 90.01 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 475,009 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 711,767 0.000000 92.00 07HER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00 <td>88.02 08803 RURAL HEALTH CLINIC III</td> <td>0</td> <td>0</td> <td></td> <td>0 537, 405</td> <td>0. 000000</td> <td>88.02</td>	88.02 08803 RURAL HEALTH CLINIC III	0	0		0 537, 405	0. 000000	88.02
90.01 09001 PAIN MANAGEMENT 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDI C CLINIC 0 0 0 475,009 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 711,767 0.000000 92.00 07HER REI MBURSABLE COST CENTERS 95.00		0	0		0 0	0. 000000	88.03
90.02 09002 WOUND CARE 0 0 2,008,660 0.00000 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 475,009 0.00000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.00000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 711,767 0.000000 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00		0	0		0 1, 369, 575	0. 000000	90.00
90.03 09003 ORTHOPEDIC CLINIC 0 0 475,009 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 711,767 0.000000 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	90. 01 09001 PALN MANAGEMENT	0	0		0 0	0. 000000	90.01
91.00 09100 EMERGENCY 0 0 7,781,741 0.00000 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 711,767 0.000000 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90. 02 09002 WOUND CARE	0	0		0 2,008,660	0. 000000	90.02
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 711,767 0.000000 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90. 03 09003 ORTHOPEDIC CLINIC	0	0		0 475,009	0.000000	90.03
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	91.00 09100 EMERGENCY	0	0		0 7, 781, 741	0.000000	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 711, 767	0.000000	92.00
200.00 Total (lines 50 through 199) 0 0 0 93, 428, 715 200.00							95.00
	200.00 Total (lines 50 through 199)	0	0		0 93, 428, 715		200.00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 6/8/2020 8:34	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	167, 498		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	477, 114		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	549, 212		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	12, 241		0 0	0	62.00
65.00 06500 RESPI RATORY THERAPY	0. 000000	412, 542		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	135, 878		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	99, 195		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	41, 469		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	441, 070		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 157, 664		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
88.02 08803 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88.02
88.03 08802 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	0	88.03
90. 00 09000 CLINIC	0. 000000	97, 719		0 0	0	90.00
90. 01 09001 PALN MANAGEMENT	0. 000000	0		0 0	0	90.01
90. 02 09002 WOUND CARE	0. 000000	8, 028		0 0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	0. 000000	0		0 0	0	90.03
91.00 09100 EMERGENCY	0. 000000	33, 439		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	4, 410		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS]
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		3, 637, 479		0 0	0	200.00

Health Financial Systems	PERRY COUNT				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Title	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
'	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-				
50.00 O5000 OPERATING ROOM	0. 276643	0	1, 955, 02	2 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 643870	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 104215	0	6, 740, 98	5 0	0	54.00
60. 00 06000 LABORATORY	0. 169006	0	3, 232, 34	9 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 284259	0	118, 82	1 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 336691	0	865, 12	6 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 352462	0	918, 19	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 298692	0	205, 31	3 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 389523	0	42,63	9 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 185271	0	904, 59	4 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 980306	0	115, 81		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 220181	0	7, 751, 60		0	73.00
OUTPATIENT SERVICE COST CENTERS		•				1
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88.01
88.02 08803 RURAL HEALTH CLINIC III	0. 000000				0	88.02
88.03 08802 RURAL HEALTH CLINIC IV	0. 000000				0	88.03
90. 00 09000 CLINIC	0. 901354		458, 55	1 0	0	•
90. 01 09001 PALN MANAGEMENT	0. 000000			0 0	0	•
90. 02 09002 WOUND CARE	0. 268431	0	1, 214, 86	5 0	0	•
90. 03 09003 ORTHOPEDIC CLINIC	0. 263715	0		0 0	0	•
91. 00 09100 EMERGENCY	0. 438617		2, 050, 40	5 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 828020		284, 08		0	
OTHER REIMBURSABLE COST CENTERS				<u> </u>		
95.00 09500 AMBULANCE SERVICES	0. 418829			0		95.00
200.00 Subtotal (see instructions)		0	26, 858, 36	4 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges					1	
202.00 Net Charges (line 200 - line 201)		0	26, 858, 36	4 0	0	202.00

	-inancial Systems	PERRY COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
APPORTI (ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1322	Period: From 01/01/2019	Worksheet D Part V		
					To 12/31/2019	Date/Time Pre	epared:	
						6/8/2020 8:34		
				XVIII	Hospi tal	Cost		
			sts	-				
	Cost Center Description	Cost	Cost					
		Reimbursed	Reimbursed					
		Servi ces	Services Not					
		Subject To Ded. & Coins.	Subject To Ded. & Coins.					
			(see inst.)					
		(see inst.) 6.00	(see inst.) 7.00	-				
	NCILLARY SERVICE COST CENTERS	0.00	7.00					
	05000 OPERATING ROOM	540, 843	С				50.00	
	5200 DELIVERY ROOM & LABOR ROOM	0		•			52.00	
	05400 RADI OLOGY-DI AGNOSTI C	702, 512					54.00	
	6000 LABORATORY	546, 286					60.00	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	33, 776					62.00	
	6500 RESPIRATORY THERAPY	291, 280					65.00	
	6600 PHYSI CAL THERAPY	323, 627					66.00	
	6700 OCCUPATI ONAL THERAPY	61, 325					67.00	
	6800 SPEECH PATHOLOGY	16, 609					68.00	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	167, 595					71.00	
	7200 IMPL. DEV. CHARGED TO PATIENT	113, 537					72.00	
	07300 DRUGS CHARGED TO PATIENTS	1, 706, 755					73.00	
	UTPATIENT SERVICE COST CENTERS	.,	-	1				
	08800 RURAL HEALTH CLINIC	0	C)			88.00	
88.01 0	8801 RURAL HEALTH CLINIC II	0	l c				88.01	
	8803 RURAL HEALTH CLINIC III	0	l c				88.02	
	8802 RURAL HEALTH CLINIC IV	0	l c				88.03	
90.00 0	99000 CLINIC	413, 317	c c				90.00	
90.01 0	99001 PALN MANAGEMENT	0	C C				90.01	
90.02 0	99002 WOUND CARE	326, 107	C C				90.02	
90.03 0	99003 ORTHOPEDIC CLINIC	0	C C				90.03	
91.00 0	09100 EMERGENCY	899, 342	C C				91.00	
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)	519, 311	C C				92.00	
0	THER REIMBURSABLE COST CENTERS						1	
95.00 0	9500 AMBULANCE SERVICES	0					95.00	
200.00	Subtotal (see instructions)	6, 662, 222	C				200.00	
201.00	Less PBP Clinic Lab. Services-Program	0					201.00	
	Only Charges							
202.00	Net Charges (line 200 - line 201)	6, 662, 222	C	P			202.00	

Health Financial Systems	PERRY COUNT	Y HOSPI TAL			u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period:	Worksheet D	
		Component		From 01/01/2019		norod
		Component	CCN: 15-Z322	To 12/31/2019	Date/Time Pre 6/8/2020 8:34	epared: am
		Title	XVIII S	Swing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		_				
50.00 05000 OPERATING ROOM	0. 276643	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 643870	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 104215	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 169006	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 284259	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 336691	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 352462	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 298692	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 389523	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 185271			0 0	0	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 980306			0 0	0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 220181			0 0	0	
OUTPATIENT SERVICE COST CENTERS		-				
88.00 08800 RURAL HEALTH CLINIC	0.00000				0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02 08803 RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03 08802 RURAL HEALTH CLINIC IV	0,000000				0	88.03
90. 00 09000 CLINIC	0. 901354			0 0	0	
90. 01 09001 PALN MANAGEMENT	0. 000000			0 0	0	1
90. 02 09002 WOUND CARE	0. 268431			0 0	0	
90. 03 09003 ORTHOPEDIC CLINIC	0. 263715			0 0	0	
91. 00 09100 EMERGENCY	0. 438617				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 828020			0 0	-	
OTHER REI MBURSABLE COST CENTERS	1. 020020	, <u> </u>	1	0 0		/2.00
95. 00 09500 AMBULANCE SERVICES	0. 418829			0		95.00
200.00 Subtotal (see instructions)	0. 110027	0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ			Ŭ	201.00
Only Charges				0	l	201.00
202.00 Net Charges (line 200 - line 201)		0		o o	0	202.00
	I		1	-1 0	, O	

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-1322	Peri od:	Worksheet D		
		Component	CCN: 15-Z322	From 01/01/2019 To 12/31/2019	Part V Date/Time Pre	nared	
				10 12/01/2017	6/8/2020 8: 34	am	
			XVIII	Swing Beds - SNF	Cost		
	Cos		-				
Cost Center Description	Cost	Cost					
	Reimbursed	Reimbursed Services Not					
	Services Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins.					
	(see inst.)	(see inst.)					
	6,00	7.00					
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	1	· · · · ·			
50. 00 05000 OPERATI NG ROOM	0	0)			50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00	
60. 00 06000 LABORATORY	0	0				60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00	
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00	
68.00 06800 SPEECH PATHOLOGY	0	0				68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)			73.00	
OUTPATIENT SERVICE COST CENTERS	1		1				
88.00 08800 RURAL HEALTH CLINIC	0	0	1			88.00	
88.01 08801 RURAL HEALTH CLINIC II	0	0				88.01	
88.02 08803 RURAL HEALTH CLINIC III	0	0				88.02	
88.03 08802 RURAL HEALTH CLINIC IV	0	0				88.03	
90. 00 09000 CLINIC	0	0				90.00	
90. 01 09001 PALN MANAGEMENT	0	0				90.01	
90. 02 09002 WOUND CARE	0	0				90.02	
90. 03 09003 ORTHOPEDIC CLINIC 91. 00 09100 EMERGENCY	0	0				90.03 91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				91.00	
OTHER REIMBURSABLE COST CENTERS	0	0	1			92.00	
95. 00 09500 AMBULANCE SERVICES	0					95.00	
200.00 Subtotal (see instructions)	0	0				200.00	
201.00 Less PBP Clinic Lab. Services-Program		0				201.00	
Only Charges							
202.00 Net Charges (line 200 - line 201)	0	0				202.00	

Health Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE C	APITAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/8/2020 8:34	epared:
		Ti +I	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	Aujustillent	Related Cost		col. 4)	
	B, Part II,		(col. 1 -		COI. 4)	
	col. 26)		col. 2)			
	1.00	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	1, 045, 848	258, 921	786, 92	7 2, 177	361.47	30.00
31. 00 I NTENSI VE CARE UNI T	1, 043, 040	200, 721	700,72		0.00	•
43. 00 NURSERY	30, 623		30, 62	3 99	309.32	•
200.00 Total (lines 30 through 199)	1, 076, 471		817, 55			200.00
Cost Center Description	Inpati ent	Inpati ent	017, 33	2,270		200.00
cost center bescription	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6,00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	60	21, 688				30.00
31.00 I NTENSI VE CARE UNI T	0	0				31.00
43. 00 NURSERY	8	2, 475				43.00
200.00 Total (lines 30 through 199)	68					200.00
	1 00					

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	-		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	r		1	- 1		
50.00 05000 OPERATI NG ROOM	557, 150					
52.00 05200 DELIVERY ROOM & LABOR ROOM	132, 892	471, 671			37, 578	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	302, 413	21, 544, 905			1, 578	54.00
60. 00 06000 LABORATORY	154, 054	16, 611, 877			1, 386	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 148					62.00
65. 00 06500 RESPI RATORY THERAPY	187, 064				2, 425	65.00
66. 00 06600 PHYSI CAL THERAPY	96, 195	2, 700, 440	0. 03562	22 5, 285	188	66.00
67.00 06700 OCCUPATI ONAL THERAPY	40, 447	1, 177, 339	0. 03435	2, 094	72	67.00
68.00 06800 SPEECH PATHOLOGY	22, 167	500, 492	0. 04429	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 862	4, 437, 340	0.00267	214, 831	574	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 579	182, 336	0. 01414	4 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	113, 589	16, 706, 566	0.00679	218, 763	1, 487	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	60, 358				0	88.00
88.01 08801 RURAL HEALTH CLINIC II	12, 273				0	88.01
88.02 08803 RURAL HEALTH CLINIC III	8, 347	537, 405	0. 01553	32 0	0	88.02
88.03 08802 RURAL HEALTH CLINIC IV	0	0	0.0000		0	88.03
90. 00 09000 CLINIC	237, 675	1, 369, 575			6, 351	90.00
90. 01 09001 PALN MANAGEMENT	0	0	0.0000	0 0	0	90.01
90. 02 09002 WOUND CARE	71, 594	2, 008, 660	0. 03564	3 8, 549	305	90.02
90. 03 09003 ORTHOPEDIC CLINIC	1, 916	475, 009	0.00403	34 0	0	90.03
91.00 09100 EMERGENCY	345, 296	7, 781, 741	0.04437	3 65, 489	2, 906	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	191, 580	711, 767	0. 26916	19, 066	5, 132	92.00
OTHER REIMBURSABLE COST CENTERS	1		1			
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 550, 599	93, 428, 715	l	1, 294, 516	80, 508	200.00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVIC	CE OTHER PASS THROUGH COS			Period: From 01/01/2019 Fo 12/31/2019	Date/Time Pre 6/8/2020 8:34	epared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	School	School	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CEN	TERS					
30. 00 03000 ADULTS & PEDIATRICS	0	C		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	31.00
43. 00 04300 NURSERY	0	C		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	C		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
p	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)		0011 0)		
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CEN		0.00	0.00	1100	0100	
30.00 03000 ADULTS & PEDIATRICS	0	C	2, 17	7 0.00	60	30.00
31.00 03100 INTENSIVE CARE UNIT		C		0.00	0	31.00
43. 00 04300 NURSERY		- -	9		8	
200.00 Total (lines 30 through 199)		C	2,27			200.00
Cost Center Description	Inpatient		· ·	-		
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CEN						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	I O					1200.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		١n	Lieu of Form CMS	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-1322	Period: From 01/01/2 To 12/31/2	019 Date/Time Pr 6/8/2020 8:3	repared: 34 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Heal	th Allied Healt	n 🛛
	Anesthetist	School	School	Post-Stepdo		
	Cost	Post-Stepdown		Adj ustment	s	
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0	0	0 50.00
52.00 05200 DELIVERY ROOM & 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 PHYSI CAL THERAPY	0	0		0	0	0 66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1	0	0	0 68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	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	0	0		0	0	0 88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	1	0	0	0 88.01
88.02 08803 RURAL HEALTH CLINIC III	0	0		0	0	0 88.02
88.03 08802 RURAL HEALTH CLINIC IV	0	0		0	0	0 88.03
90. 00 09000 CLINIC	0	0		0	0	0 90.00
90. 01 09001 PALN MANAGEMENT	0	0		0	0	0 90.01
90. 02 09002 WOUND CARE	0	0		0	0	0 90.02
90. 03 09003 ORTHOPEDIC CLINIC	0	0		0	0	0 90.03
91.00 09100 EMERGENCY	0	0		0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0 92.00
OTHER REIMBURSABLE COST CENTERS	<u>.</u>	·				
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0	0	0 200. 00
	•	•	-			

APPORT IONNENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CON: 15-1322 Period: Find 12/31/2019 Period: For 12/31/2019 Worksheet D Part IV Cate/Jine Cost Center Description All Other Medical Cost Total Cost (sum of cols: 4) Total Cost (sum of cols: 4) Total Cost (col: S. 2, 3) (col. S) Norksheet D Part IV Cate/Jine Worksheet D Part IV Cate/Jine ANCILLARY SERVICE COST CENTERS Total Cost (col: S. 2, 3) (col. S) Total Cost (col: S, 2, 3) (col. S) Total Cost (col: S, 2, 3) (col. S) Total Cost (col. S, 2, 7) (col. S, 2, 7) Total Cost (col. S, 2, 7)	Health Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-	2552-10
Cost Center Description All Other Medical Education Cost Total (sum of cols. 4) Total (sum of cols. 1, 2, 3, and 4) Total Outpatient (sum of cost, 2, 3, and 4) Total Outpatient (sum of cost, 2, 3, and 4) Total Cost (col. 5, 2, 3, and 4) Total Cost (col. 5, 2, 3, and 4) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 DELIVERY ROOM & LABOR ROOM 00 0 0 7, 644, 424 0.000000 50.00 50.00 05200 RADIOLOCY-DI AGNOSTI C 0 0 0 27, 68, 60, 00 50.00 50.00 60.00 Cast Center Description 0 0 0 27, 68, 60, 00 50.00 50.00 52.00 D5400 RADIOLOCON & ALABOR ROOM 0 0 0 279, 383, 0.000000 50.00 50.00 50.00 50.00 66.00 66.00 66.00 66.00 67.00 0 0 1,17,33 0.000000 66.00 66.00 66.00 66.00 66.00 66.00 67.00 0 1,17,33 0.000000 67.00 0 1,17,33 0.000000 <td></td> <td>RVICE OTHER PAS</td> <td>S Provider C</td> <td>CN: 15-1322</td> <td>From 01/01/2019</td> <td>Part IV Date/Time Pre</td> <td></td>		RVICE OTHER PAS	S Provider C	CN: 15-1322	From 01/01/2019	Part IV Date/Time Pre	
Medical Education Ost Sum of cols. (sum of cols. 4) Outpatient (sum of cols. 4) Outpatient (sum of cols. and 4) (from Wksi. col. 7) (from Wksi. col. 7) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 (PERATING ROOM 52.00 0 0 0 7.644,424 0.000000 50.00 52.00 05200 (DELIVERY ROOM & LABOR ROOM 60.00 0 0 7.644,424 0.000000 52.00 64.00 0 0 0 1.54.905 0.000000 52.00 65.00 06000 (LABORATORY 0 0 0 16.611.877 0.000000 66.00 65.00 06000 RESPIRATORY THERAPY 0 0 0 3.611.751 0.000000 66.00 66.00 0 0.501.004.00 0.000000 67.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.			Ti tl	e XIX	Hospi tal	PPS	
Education Cost 1, 2, 3, and 4) Cost (sum of col s. 2, 3, and 4) ANCI LLARY SERVICE COST CENTERS 0 6.00 7.00 8.00 50.00 05000 DELIVERY ROM & LABOR ROOM 0 0 7.644.424 0.000000 52.00 50.00 05400 RADI LOGY-DI AGNOSTI C 0 0 0 7.644.424 0.000000 52.00 60.00 06000 LABORATORY 0 0 0 16.611.877 0.000000 66.00 60.00 06000 PLYSI CAL THERAPY 0 0 0 2.700.440 0.000000 66.00 60.00 06000 PLYSI CAL THERAPY 0 0 0 2.700.440 0.000000 66.00 61.00 06000 PLYSI CAL THERAPY 0 0 0 1.77.339 0.000000 66.00 66:00 06600 PLYSI CARCED TO PATI ENTS 0 0 1.437.331 0.000000 72.00 70:00 0 1.437.331 0.0000000 73	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
Cost 4) col s. 2, 3, and 4) col . 8) col . 7) ANCI LLARY SERVICE COST CENTERS		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 0PERATING ROOM 0 0 7.644,424 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 7.644,424 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 16.611,877 0.000000 54.00 60.00 06500 RESPI RATORY THERAPY 0 0 0 2,70,444 0.000000 65.00 65.00 06600 CAGOW HOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 2,700,440 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 1,773,339 0.000000 65.00 66.00 06700 PCUPATI IONAL THERAPY 0 0 0 1,773,339 0.000000 67.00 68.00 PHYSI CAL THERAPY 0 0 0 1,873,340 0.000000 71.00		Educati on	1, 2, 3, and		C, Part I,		
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ANCI LLARY SERVICE COST CENTERS 0 0 7.644,424 0.00000 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 471,671 0.00000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 21,544,905 0.000000 54.00 60.00 06600 LABORATORY 0 0 0 16,611,877 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 311,751 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 1,177,339 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 1,177,339 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 1,233,40 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 1,2		Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
ANCI LLARY SERVICE COST CENTERS Image: Control of the co							
50.00 05000 DPERATING ROOM 0 0 7, 644, 424 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 471, 671 0.000000 52.00 64.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 21, 544, 905 0.000000 54.00 65.00 06000 LABORATORY 0 0 0 16, 611, 877 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 3, 611, 751 0.000000 66.00 66.00 06400 PHYSI CAL THERAPY 0 0 0 1, 177, 339 0.000000 66.00 67.00 06400 PHYSI CAL THERAPY 0 0 0 1, 177, 339 0.000000 66.00 68.00 06400 SPECH PATHOLOGY 0 0 0 50.04, 92 0.000000 67.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 16, 706, 566 0.0000000 71.00 72.00 072001 MURLALHEALTH CLINIC 0 0		4.00	5.00	6.00	7.00	8.00	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 471, 671 0.000000 52.00 54.00 RADI OLGGY-DI AGNOSTI C 0 0 0 21, 544, 905 0.0000000 60.00 AGOOD LABORATORY 0 0 0 16, 611, 877 0.000000 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 279, 383 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 2, 700, 440 0.000000 66.00 66.00 OC4700 SPEECH PATHOLOGY 0 0 0 1, 177, 339 0.000000 67.00 67.00 OG700 OC4LAL SUPPLIES CHARGED TO PATI ENTS 0 0 4, 437, 340 0.000000 71.00 71.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 182, 336 0.000000 72.00 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 18, 7334 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENT 0 0 16, 706						-	
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 21, 544, 905 0.000000 54.00 60.00 06000 LABORATORY 0 0 16, 611, 877 0.000000 62.00 62.00 06500 RESPI RATORY 0 0 0 3, 611, 751 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 3, 611, 751 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 1, 177, 339 0.000000 67.00 67.00 0C0PATI TONAL THERAPY 0 0 0 1, 177, 339 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 4, 437, 340 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 182, 336 0.000000 72.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0 0 182, 336 0.000000 73.00 00 07300 DRUGS CHARGED TO PATI ENTS 0 0		0	0				
60.00 06000 LABORATORY 0 0 16, 611, 877 0.00000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 279, 383 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 3, 611, 751 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 2, 700, 440 0.000000 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 1, 177, 339 0.000000 67.00 68.00 OSE00 SPEECH PATHOLOGY 0 0 0 500, 492 0.000000 71.00 07100 MEDI LS CHARGED TO PATI ENTS 0 0 4, 437, 340 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 16, 706, 566 0.000000 73.00 08800 RURAL HEALTH CLINIC III 0 0 0 1, 143, 331 0.000000 88.01 88.00 08803 RURAL HEALTH CLINIC III 0 0 0 0.		0	0				
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 279,383 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 0 0 3,611,751 0.000000 65.00 66.00 06500 RESPIRATORY THERAPY 0 0 0 2,700,440 0.000000 66.00 67.00 0CUPATI ONAL THERAPY 0 0 0 1,177,339 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 500,492 0.000000 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 182,336 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 182,336 0.000000 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 14,437,340 0.000000 88.00 88.01 08800 RURAL HEALTH CLINIC C 0 0 11,43,331 0.000000 88.01 88.01 08803 RURAL HEALTH CLINIC III 0 0 0 0.000000 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
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66.00 06600 PHYSI CAL THERAPY 0 0 0 2,700,440 0.00000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 1,177,339 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 500,492 0.000000 68.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 4,437,340 0.000000 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 0 0 182,336 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 16,706,566 0.000000 73.00 0 0 0 3,532,703 0.000000 88.00 90.00 0 0.000000 <td>62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS</td> <td>0</td> <td>0</td> <td></td> <td>0 279, 383</td> <td>0. 000000</td> <td></td>	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 279, 383	0. 000000	
67.00 06700 0CCUPATIONAL THERAPY 0 0 1,177,339 0.00000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 500,492 0.000000 68.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 4,437,340 0.000000 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 0 0 182,336 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 16,706,566 0.000000 73.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 1,143,331 0.000000 73.00 78.00 08801 RURAL HEALTH CLINIC 0 0 1,143,331 0.000000 88.01 88.01 08802 RURAL HEALTH CLINIC III 0 0 0 0.000000 88.02 88.03 08902 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.03 90.01 09001 PAI MANAGEMENT 0 0 0 0.000000 90.01		0	0				
68.00 06800 SPEECH PATHOLOGY 0 0 500, 492 0.000000 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 4, 437, 340 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 182, 336 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 16, 706, 566 0.000000 73.00 0 0 08800 RURAL HEALTH CLINIC 0 0 3, 532, 703 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 0 537, 405 0.000000 88.02 88.02 08802 RURAL HEALTH CLINIC IV 0 0 0 0 0 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0 0.000000 88.02 90.00 09000 CLNIC 0<		0	0				
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 4, 437, 340 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 182, 336 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 182, 336 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 16, 706, 566 0.000000 88.00 88.00 08800 RURAL HEALTH CLINIC II 0 0 0 1, 143, 331 0.000000 88.01 88.01 08801 RURAL HEALTH CLINIC III 0 0 0 537, 405 0.000000 88.02 88.02 08803 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.03 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.03 90.01 09001 PAIN MANAGEMENT 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02		0	0				
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73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 16, 706, 566 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 4, 437, 340	0. 000000	71.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 3, 532, 703 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 1, 143, 331 0.000000 88.01 88.02 08803 RURAL HEALTH CLINIC III 0 0 0 537, 405 0.000000 88.01 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 90.00 09000 CLINIC 0 0 0 0 0.000000 90.00 90.02 09002 WOUND CARE 0 0 0 0 0.000000 90.02 90.03 <	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 182, 336	0. 000000	72.00
88.00 08800 RURAL HEALTH CLINIC 0 0 3, 532, 703 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 1, 143, 331 0.000000 88.01 88.02 08803 RURAL HEALTH CLINIC III 0 0 0 537, 405 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.02 88.03 08802 RURAL HEALTH CLINIC IV 0 0 0 0.000000 88.03 90.00 09000 CLINIC 0 0 0 0 0.000000 90.00 90.01 09001 PAI N MANAGEMENT 0 0 0 0.000000 90.02 90.02 09002 WUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDI C LINIC 0 0 0 7.781,741 0.000000 90.02 91.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 16, 706, 566	0. 000000	73.00
88.01 08801 RURAL HEALTH CLINICII 0 0 1, 143, 331 0.000000 88.01 88.02 08803 RURAL HEALTH CLINICIII 0 0 0 537, 405 0.000000 88.02 88.03 08802 RURAL HEALTH CLINICIV 0 0 0 0.000000 88.03 90.00 09000 CLINIC 0 0 0 0 0.000000 90.00 90.01 09001 PAI N MANAGEMENT 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDI C CLINIC 0 0 0 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 711,767 0.000000 92.00 01HER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	OUTPATIENT SERVICE COST CENTERS			_			
88.02 08803 RURAL HEALTH CLINICIII 0 0 537,405 0.00000 88.02 88.03 08802 RURAL HEALTH CLINICIV 0 0 0 0.000000 88.03 90.00 09000 CLINIC 0 0 0 0.000000 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 0.000000 90.02 91.00 09100 EMEGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 05260/08567510N 0 0 7,781,741 0.000000 92.00 92.00 05200/085674110N BEDS (NON-DI STINCT PART) 0 0 711,767 0.000000 92.00 0 09500 AMBULANCE SERVICES 95.00 95.00 95.00 <td>88.00 08800 RURAL HEALTH CLINIC</td> <td>0</td> <td>0</td> <td></td> <td>0 3, 532, 703</td> <td>0. 000000</td> <td>88.00</td>	88.00 08800 RURAL HEALTH CLINIC	0	0		0 3, 532, 703	0. 000000	88.00
88.03 08802 RURAL HEALTH CLINICIV 0 0 0 0.00000 88.03 90.00 09000 CLINIC 0 0 0 1,369,575 0.00000 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 475,009 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 711,767 0.000000 92.00 92.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	88.01 08801 RURAL HEALTH CLINIC II	0	0		0 1, 143, 331	0. 000000	88.01
90.00 09000 CLINIC 0 0 1,369,575 0.00000 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 0.00000 90.01 90.02 09002 WOUND CARE 0 0 0 0 0.00000 90.01 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 475,009 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 711,767 0.000000 92.00 07HER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00 <td>88.02 08803 RURAL HEALTH CLINIC III</td> <td>0</td> <td>0</td> <td></td> <td>0 537, 405</td> <td>0. 000000</td> <td>88.02</td>	88.02 08803 RURAL HEALTH CLINIC III	0	0		0 537, 405	0. 000000	88.02
90.01 09001 PAIN MANAGEMENT 0 0 0 0.000000 90.01 90.02 09002 WOUND CARE 0 0 0 0.000000 90.02 90.03 09003 ORTHOPEDI C CLINIC 0 0 0 475,009 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 711,767 0.000000 92.00 07HER REI MBURSABLE COST CENTERS 95.00		0	0		0 0	0. 000000	88.03
90.02 09002 WOUND CARE 0 0 2,008,660 0.00000 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 475,009 0.00000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.00000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 711,767 0.000000 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90. 00 09000 CLINIC	0	0		0 1, 369, 575	0. 000000	90.00
90.03 09003 ORTHOPEDIC CLINIC 0 0 475,009 0.000000 90.03 91.00 09100 EMERGENCY 0 0 0 7,781,741 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 711,767 0.000000 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	90.01 09001 PALN MANAGEMENT	0	0		0 0	0. 000000	90.01
91.00 09100 EMERGENCY 0 0 7,781,741 0.00000 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 711,767 0.000000 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90. 02 09002 WOUND CARE	0	0		0 2,008,660	0. 000000	90.02
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 711,767 0.000000 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90. 03 09003 ORTHOPEDIC CLINIC	0	0		0 475,009	0. 000000	90.03
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	91.00 09100 EMERGENCY	0	0		0 7, 781, 741	0. 000000	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 711, 767	0. 000000	92.00
200.00 Total (lines 50 through 199) 0 0 93, 428, 715 200.00							95.00
	200.00 Total (lines 50 through 199)	0	0		0 93, 428, 715		200.00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 6/8/2020 8:34	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	281, 610		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	133, 376		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	112, 428		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	149, 473		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	125		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	46, 828		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	5, 285		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 094		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	214, 831		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	218, 763		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
88.02 08803 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88.02
88.03 08802 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	0	88.03
90. 00 09000 CLINIC	0. 000000	36, 599		0 0	0	90.00
90. 01 09001 PALN MANAGEMENT	0. 000000	0		0 0	0	90.01
90. 02 09002 WOUND CARE	0. 000000	8, 549		0 0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	0. 000000	0		0 0	0	90.03
91.00 09100 EMERGENCY	0. 000000	65, 489		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	19, 066		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		1, 294, 516	l	0 0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACOINE COST Provider CCN: 15-1322 Period: From 01/01/2019 Period: From 01/01/2019 Worksheet D pate/TI w Date/Time Prepared: (56/2020 b) 534 am TI LI & XIX Hospital Provider CCN: 15-1322 Period: From 01/01/2019 Period: From 01/01	Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANCILLARY SERVICE COST CENTERS Cost Control Cost Control Cost Control Cost Control Cost Control Cost Cost Cost PPS Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C				
ANCILLARY SERVICE COST CENTERS Cost (see inst.) Cost (see inst.) Cost (see inst.) Cost (see inst.) Subject To Ded. & Cost (see inst.) 4NCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 DELIVERY NOM & LABOR ROOM 0.276643 0 815,278 0 0 50.00 50.00 05000 DELIVERY NOM & LABOR ROOM 0.243870 21,167 0 50.00 50.00 50.00 64.00 50.00 52.00 50.00 50.00 64.00 66.01 66.01 52.00 50.00 52.00 50.00 52.00 50.00 50.00 66.00 66.00 67.07 0 52.00 50.00 52.00 50.00							pared:
Cost Center Description Cost to Charge Ratio Prom Worksheet C, Part I, col. Cost to Charge Ratio Prom Worksheet C, Part I, col. Cost Scrices Reimbursed Subject To Ded. & Coins. Cost scienst. 4NCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (DeFRATING ROOM 0.276643 0 815,278 0 0 50.00 05000 (DeFRATING ROOM 0.643870 0 21,167 0 0 52.00 50.00 05000 (DEDUTCRY ROOM & LABOR ROOM 0.643870 0 21,167 0 0 52.00 650.00 (DEDUTCRY ROOM & LABOR ROOM 0.643870 0 21,67 0 0 52.00 650.00 (DEDUTCRY ROOM & LABOR ROOM 0.643870 0 21,67 0 0 60.00 600 (DAGOR RESPI RATORY 0.336691 0 21,8,96 0 0 66.00 700 (COUPATIONAL THERAPY 0.3356491 0 215,896 0 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 <t< td=""><td></td><td></td><td></td><td></td><td>10 12/01/2017</td><td></td><td></td></t<>					10 12/01/2017		
Cost Center Description Cost of Charge Ratio Worksheet C, Part I, col. PP Reimbursed Services inst.) Cost Reimbursed Services Subject To Ded. & Coins. PS Services Subject To Ded. & Coins. PS Services Subject To Ded. & Coins. 0 1.00 2.00 3.00 4.00 5.00 05000 (PERATING ROOM 52:00 (DSD00 RADILOGY-DIAGNOSTIC 0.276643 0 815,278 0 0 50.00 052:00 (DSD00 RADILOGY-DIAGNOSTIC 0.104215 0 2.91,076 0 52.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 68.00			Titl		Hospi tal		
ANCI LLARY SERVICE COST CENTERS Charge Ratio Prom Worksheet C, Part I, col. Reimbursed Services (see inst.) Reimbursed Subject To Ded. & Colns. Reimbursed Subject To Ded. & Colns. (see inst.) 50.00 05000 (PERATI NC ROOM 0.276643 0 815,278 0 0 50.00 50.00 05000 (PERATI NC ROOM 0.276643 0 815,278 0 0 50.00 52.00 05000 (PERATI NC ROOM 0.643870 0 21,167 0 55.00 54.00 05000 (PERATI NC ROOM 0.643870 0 21,167 0 0 54.00 60.00 06000 (PABDRATORY 0.104215 0 2.291,076 0 62.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
Image: Services (see inst.) 0 0 0 2.00 3.00 4.00 5.00 50.00 05000 (PERATING ROOM 0.276643 0 815.278 0 0 52.00 50.00 05000 (PERATING ROOM 0.276643 0 2.1 167 0 0 52.00 50.00 05000 (PERATING ROOM 0.104215 0 2.91,076 0 0 52.00 60.00 06000 (ABDOLGOZ VALED RED BLOOD CELLS 0.164215 0 2.91,076 0 0 66.00 61.00 06000 (PHATING ROOM 0.164215 0 2.91,076 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00	Cost Center Description						
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Part I, col. Ded. & Coins. Case inst.) Case inst.) Case inst.) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 Scool OS200 DELIVERY ROM & LABOR ROM 0.276643 0 815.278 0 0 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0.443870 0 21,167 0 52.00 64.00 06000 LABORATORY 0 1.04215 0.291,076 0 60.00 60.00 65.00 06500 RESPI RATORY THERAPY 0.352462 0 18,675 0 65.00 66.00 66.00 06600 CARDI CHARTORY THERAPY 0.352462 0 198,309 0 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 721.00 721.09 73.00 721.09 73.00 721.493 0 721.00 721.09 73.00 721.493 0 721.493 0 721.09		-					
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68.00 06800 SPECH PATHOLOGY 0.389523 0 46,858 0 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.185271 0 437,696 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.980306 0 5,302 0 0 73.00 007300 DRUGS CHARGED TO PATIENTS 0.220181 0 721.493 0 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 88.01 80.01 88.01 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>1</td>						-	1
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72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.980306 0 5,302 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.220181 0 721,493 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 71.00 73.00 0 0 73.00 0 0 73.00 88.00 08800 RURAL HEALTH CLINIC 1.133805 0 0 88.01 0 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.02 88.01 88.02 88.01 88.02 88.01 88.02 88.01 88.02 88.01 88.02 88.03 88.02 88.03 88.02 88.03 88.03 88.02 88.03 88.03 88.03 88.03 88.03 80.03 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td>						0	
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OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1.133805 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0.715348 0 88.01 88.02 08803 RURAL HEALTH CLINIC III 0.715348 0 88.01 80.02 08802 RURAL HEALTH CLINIC III 1.048291 0 88.02 80.30 08002 RURAL HEALTH CLINIC I V 0.000000 0 0 88.03 90.00 09000 CLINIC 0.901354 0 112,469 0 90.00 90.01 09001 PAI N MANAGEMENT 0.000000 0 0 90.01 90.02 09002 WOUND CARE 0.268431 0 122,857 0 0 90.02 90.02 90.02 90.02 90.02 90.02 0 90.02 90.02 90.02 90.02 0 0 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02						-	
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88.01 08801 RURAL HEALTH CLINICII 0.715348 0 0 88.01 88.02 08803 RURAL HEALTH CLINICIII 1.048291 0 88.02 88.03 08802 RURAL HEALTH CLINICIV 0.000000 0 0 88.03 90.00 09000 CLINIC 0.901354 0 112,469 0 90.00 90.01 09001 PAIN MANAGEMENT 0.000000 0 0 0 90.01 90.02 09002 WOND CARE 0.268431 0 122,857 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0.263715 0 0 90.03 90.03 91.00 09100 EMERGENCY 0.438617 1.135,843 0 0 91.00 92.00 OSERVATION BEDS (NON-DISTINCT PART) 1.828020 0 80,000 0 92.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.828020 0 80,036,415 0 0 200.00 200.00 Subtotal (see instructions) 0 8,036,415 0			1	1			
88.02 08803 RURAL HEALTH CLINICIII 1.048291 0 0 88.02 88.03 08802 RURAL HEALTH CLINICIV 0.000000 0 0 88.03 90.00 09000 CLINIC 0.901354 0 112,469 0 90.00 90.01 09001 PAIN MANAGEMENT 0.000000 0 0 0 90.01 90.02 WOUND CARE 0.268431 0 122,857 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0.263715 0 0 90.03 90.03 91.00 09100 EMERGENCY 0.438617 1.135,843 0 0 91.00 92.00 OS200 OBSERVATION BEDS (NON-DISTINCT PART) 1.828020 0 80,000 0 92.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.828020 0 81,448 95.00 92.00 0 09200 MBULANCE SERVICES 0.418829 0 8,036,415 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program <t< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>						-	
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90. 02 09002 WOUND CARE 0. 268431 0 122,857 0 0 90. 02 90. 03 09003 ORTHOPEDIC CLINIC 0. 263715 0 0 0 90. 03 91. 00 09100 EMERGENCY 0. 438617 0 1, 135, 843 0 0 91. 00 92. 00 09520 0BSERVATI ON BEDS (NON-DI STINCT PART) 1. 828020 0 80, 000 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 0 0 418829 0 81, 448 95. 00 95.00 0 00 200. 00 200. 00 200. 00 200. 00 201. 00 0 201. 00 0 0 201. 00 201. 00 0 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 0 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00				112, 46	9 0	-	
90. 03 09003 ORTHOPEDIC CLINIC 0. 263715 0 0 0 0 90. 03 91. 00 09100 EMERGENCY 0. 438617 0 1, 135, 843 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 1. 828020 0 80, 000 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0. 418829 0 81, 448 95. 00 200. 00 Subtotal (see instructions) 0 0 8, 036, 415 0 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201. 00 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 201. 00 201. 00 0 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00					0 0	-	
91.00 09100 EMERGENCY 0.438617 0 1,135,843 0 0 91.00 92.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 1.828020 0 80,000 0 92.00 92.00 0THER REIMBURSABLE COST CENTERS 0 0 81,448 95.00 95.00 Subtotal (see instructions) 0 8,036,415 0 0 200.00 201.00 201.00 0 91.00 201.00 201.00 0 0 201.00 0 201.00 0 0 201.00 0 0 201.00 0 201.00 0 201.00 0 0 201.00 0 201.00 0 201.00 0 0 201.00 0 201.00 2						-	
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.828020 0 80,000 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 80,000 0 92.00 92.00 95.00 OP500 AMBULANCE SERVICES 0.418829 0 81,448 95.00 92.00 200.00 Subtotal (see instructions) 0 8,036,415 0 0 200.00 201.00 201.00 201.00 201.00 0 201.00 0 201.00 0 201.00 201.00 0 201.00 0 201.00 0 201.00 201						-	
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 0. 418829 0 81, 448 95. 00 200.00 Subtotal (see i nstructions) 0 8, 036, 415 0 0 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201. 00						-	
95. 00 09500 AMBULANCE SERVICES 0. 418829 0 81, 448 95. 00 200. 00 Subtotal (see instructions) 0 8, 036, 415 0 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 201. 00		1. 828020	0	80,00	0 0	0	92.00
200.00 Subtotal (see instructions) 0 8,036,415 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00		0 410000		01.44			
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 0 0 201.00		0.418829				0	
Only Charges							
					0		201.00
	202.00 Net Charges (line 200 - line 201)		0	8, 036, 41	5 0	0	202.00

Heal th	Financial Systems	PERRY COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/8/2020 8:34	epared: 4 am	
			Titl	e XIX	Hospi tal	PPS		
		Cos	sts		· · · · · · · · · · · · · · · · · · ·			
	Cost Center Description	Cost	Cost					
		Reimbursed	Reimbursed					
		Servi ces	Services Not					
		Subject To	Subject To					
		Ded. & Coins.	Ded. & Coins.					
		(see inst.)	(see inst.)					
		6.00	7.00					
	ANCI LLARY SERVI CE COST CENTERS	1					_	
	05000 OPERATING ROOM	225, 541	0				50.00	
	05200 DELIVERY ROOM & LABOR ROOM	13, 629	0				52.00	
	05400 RADI OLOGY-DI AGNOSTI C	238, 764	0				54.00	
	06000 LABORATORY	276, 524	0				60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	5, 309	0				62.00	
65.00	06500 RESPI RATORY THERAPY	72, 690	0				65.00	
66.00	06600 PHYSI CAL THERAPY	69, 896	0				66.00	
	06700 OCCUPATI ONAL THERAPY	28, 635					67.00	
	06800 SPEECH PATHOLOGY	18, 252	0				68.00	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	81, 092	0				71.00	
	07200 IMPL. DEV. CHARGED TO PATIENT	5, 198					72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	158, 859	0				73.00	
	OUTPATIENT SERVICE COST CENTERS							
	08800 RURAL HEALTH CLINIC	0	0				88.00	
88.01	08801 RURAL HEALTH CLINIC II	0	0				88.01	
	08803 RURAL HEALTH CLINIC III	0	0				88.02	
	08802 RURAL HEALTH CLINIC IV	0	0				88.03	
	09000 CLINIC	101, 374	0				90.00	
90.01	09001 PALN MANAGEMENT	0	0				90.01	
	09002 WOUND CARE	32, 979	0				90.02	
	09003 ORTHOPEDIC CLINIC	0	0				90.03	
	09100 EMERGENCY	498, 200					91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	146, 242	0				92.00	
	OTHER REIMBURSABLE COST CENTERS	-		1				
	09500 AMBULANCE SERVI CES	34, 113					95.00	
200.00		2,007,297	0				200.00	
201.00		0					201.00	
	Only Charges							
202.00	Net Charges (line 200 - line 201)	2,007,297	0	1			202.00	

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Hospi tal	6/8/2020 8:34 Cost	am
	Cost Center Description		- nospi tai	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	-
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	avs. excluding newborn)		3, 046	1 1.
00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed of	g-bed and newborn days)	vrivate room davs	2, 177	2.
00	do not complete this line.	ays). If you have only p	n i vate i ooni days,	0	3.
00 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	1, 647 706	4. 5.
00	reporting period	<i>.</i>		, 00	0.
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	163	7
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excludir	ig swing-bed and	932	9.
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	706	10.
	through December 31 of the cost reporting period (see instru	uctions)	5 /		
1.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) after	0	11.
2.00	Swing-bed NF type inpatient days applicable to titles V or > through December 31 of the cost reporting period	(IX only (including priva	ite room days)	0	12
3.00	Swing-bed NF type inpatient days applicable to titles V or >			0	13
. 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
7.00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31	of the cost		17
3. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	ces through December 31 c	of the cost	155. 02	19
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	ces after December 31 of	the cost	155. 02	20
1 00	reporting period Total general inpatient routine service cost (see instruction	ne)		7, 102, 898	21
	Swing-bed cost applicable to SNF type services through Decen		ting period (line		
3.00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reporti	ng period (line 6	0	23
	x line 18) Swing-bed cost applicable to NF type services through Decemb			25, 268	24
	7 x line 19)		0 1 1		
5.00	Swing-bed cost applicable to NF type services after December x line 20)	⁻ 31 of the cost reportir	ng period (line 8	0	25
	Total swing-bed cost (see instructions)	t (line 21 minus line 24)		1, 758, 463	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		I	5, 344, 435	21
	General inpatient routine service charges (excluding swing-b	ped and observation bed o	harges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4))		0.00	
. 00	Average per diem private room charge differential (line 32 m	ninus line 33)(see instru	ictions)	0.00	34
	Average per diem private room cost differential (line 34 x l			0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	t and private room cost c	lifferential (line	5, 344, 435	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		I		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AL Adjusted general inpatient routine service cost per diem (se		1	2, 454. 95	38
	That as to a general inpatrent routille service cost per uren (St				
		ne 38)		2 288 013	30
9.00	Program general inpatient routine service cost (line 9 x lir Medically necessary private room cost applicable to the Proc	-		2, 288, 013 0	

	Financial Systems	PERRY COUNTY		CN: 15-1322	Period:	u of Form CMS-: Worksheet D-1	
50MI 01	ATTON OF THE ATTENT OF ERATTING COST			UNI. 13 1322	From 01/01/2019 To 12/31/2019		
						6/8/2020 8:34	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient	I npati ent	Diem (col.		(col. 3 x	
		<u>Cost</u> 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	
42.00	NURSERY (title V & XIX only)	0	2.00			<u> </u>	42.00
	Intensive Care Type Inpatient Hospital Units			T			1
13.00 14.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	C	0.0	0 0	0	43.00
15.00							45.0
46.00							46.0
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
	cost center bescription					1.00	
18.00	Program inpatient ancillary service cost (W					874, 508	
19.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	ee instructi	ons)		3, 162, 521	49.0
50.00	Pass through costs applicable to Program ing	atient routine s	ervices (fro	m Wkst. D, su	m of Parts I and	0	50.0
51.00	Pass through costs applicable to Program inp and IV)	batient ancillary	services (f	rom Wkst. D,	sum of Parts II	0	51.0
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.0
53.00	Total Program inpatient operating cost exclu		ated, non-ph	ysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.0
5.00	5.000 1000 1000 1000 1000					0.00	
6.00 7.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	aet amount (line 56 minus	line 53)	0	
8.00	Bonus payment (see instructions)	ing boot and tar	got amount (0	
9.00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	ndi ng 1996,	updated and c	ompounded by the	0.00	59.0
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. upo	ated by the	market basket		0.00	60.0
51.00	If line 53/54 is less than the lower of line					0	
	which operating costs (line 53) are less that		(lines 54 x	60), or 1% o	f the target		
52.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62.0
53.00		nent (see instruc	tions)			0	
4 00	PROGRAM INPATIENT ROUTINE SWING BED COST	ta thursuch Decem	h		ing and (Coo	1, 733, 195	
54.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through becen		e cost report	ing period (see	1, 733, 195	64.0
65.00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the	cost reportin	g period (See	0	65.0
56.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no coste (lino 6	1 plus lino	65) (+i +l o VVI	LL only() For	1, 733, 195	66 0
00.00	CAH (see instructions)	ne costs (inne c	4 prus rine	05)(11110 XVI	TT OILY). TO	1,733,173	00.0
67.00		ne costs through	December 31	of the cost r	eporting period	0	67.0
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after De	cember 31 of	the cost ren	orting period	0	68.0
00.00	(line 13 x line 20)			the cost rep	or tring period	0	00.0
69.00	Total title V or XIX swing-bed NF inpatient					0	69.0
70.00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70.0
1.00	Adjusted general inpatient routine service of				,		71.0
2.00	Program routine service cost (line 9 x line						72.0
'3.00 '4.00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.0
5.00	Capital -related cost allocated to inpatient			·	Part II, column		75.0
14 00	26, line 45)	no ()					74 0
'6.00 '7.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.0
8.00	Inpatient routine service cost (line 74 minu						78.0
9.00	Aggregate charges to beneficiaries for exces	• •					79.0
0.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ist i i illi tati o	n (ine /ơ Mi	nus IThe /9)		80.0
2.00	Inpatient routine service cost limitation (I						82.0
3.00	Reasonable inpatient routine service costs (•	.)				83.0
34.00 35.00	Program inpatient ancillary services (see in Utilization review - physician compensation		e)				84.0 85.0
35.00 36.00							85.0
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	<u> </u>				
	Total observation bed days (see instructions					530	
87.00 88.00	Adjusted general inpatient routine cost per	diem (line 27 ·	line 2)			2, 454. 95	

Health Financial Systems	PERRY COUNTY	(HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 045, 848	7, 102, 898	0. 14724	2 1, 301, 124	191, 580	90.00
91.00 Nursing School cost	0	7, 102, 898	0.00000	0 1, 301, 124	0	91.00
92.00 Allied health cost	0	7, 102, 898	0.00000	0 1, 301, 124	0	92.00
93.00 All other Medical Education	0	7, 102, 898	0.00000	0 1, 301, 124	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1322	Period: From 01/01/2019	Worksheet D-1	
			To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00 00	Inpatient days (including private room days and swing-bed day			3,046	1
00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs.	2, 177 0	
	do not complete this line.	5, 5, 5, 5,			
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	1, 647 706	4
00	reporting period	Join days) through becenic		700	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om davs) through Decembe	r 31 of the cost	163	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excludir	g swing-bed and	60	9
~ ~	newborn days)			70/	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	706	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days) after	0	11
2. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room days)	163	12
. 00	through December 31 of the cost reporting period	x only (including priva	ite room days)	105	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	5 (51	<i>,</i>	0	13
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
. 00		am (exer during swring bee	uuys)	99	15
. 00	Nursery days (title V or XIX only)			8	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost		17
	reporting period	5			
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	of the cost	155.02	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	155.02	20
	reporting period			7 400 000	
. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	7, 102, 898 0	21
. 00	5 x line 17)	the cost repor	tring period (rine	0	
8.00	Swing-bed cost applicable to SNF type services after December x line 18)	⁻ 31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	25, 268	24
	7 x line 19)				
6. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	ig period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			1, 758, 463	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		5, 344, 435	27
8. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed o	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	30
	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
. 00			ICTI ONS)	0.00 0.00	
. 00				0.00	36
. 00		and private room cost c	lifferential (line	5, 344, 435	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				1
8.00		-		2, 454. 95	
9.00).00				147, 297 0	39 40
-	Total Program general inpatient routine service cost (line 39	, ,		147, 297	

	Financial Systems	PERRY COUNTY				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider (CCN: 15-1322	Period: From 01/01/2019		
					To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
			Tit	le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	5	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	102, 800	9	9 1,038.3	38 8	8, 307	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.0	0 00	0	43.00
	CORONARY CARE UNI T	Ű					44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00
47.00	Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		405, 883 561, 487	
	PASS THROUGH COST ADJUSTMENTS	41 through 48)(0115)			49.00
	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, su	m of Parts I and	d 24, 163	50.00
F1 00	<pre>()) Deconstruction of the program into </pre>	ationt anaillan		From Witcot D	our of Dorto II	00 500	E1 00
51.00	Pass through costs applicable to Program inp and IV)		y services (i	TOIII WKSL. D,	Sum of Parts II	80, 508	51.00
	Total Program excludable cost (sum of lines					104, 671	
53.00	Total Program inpatient operating cost exclu		lated, non-pl	iysi ci an anest	hetist, and	456, 816	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	J∠)				1	-
54.00	Program di scharges					0	
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (line 56 minus	Line 53)	0	
	Bonus payment (see instructions)		rget anount i	inne so minus	The 55)	0	1
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport up	dated by the	markat baskat		0.00	60.00
	If line 53/54 is less than the lower of line					0.00	1
	which operating costs (line 53) are less that	n expected cost				-	
62.00	amount (line 56), otherwise enter zero (see	instructions)				0	62.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST					-	1
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	ne cost report	ing period (See	1, 733, 195	64.00
65.00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the	cost reportir	a period (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	ll only). For	1, 733, 195	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	25, 268	67.00
	(line 12 x line 19)				-p		
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lir	ne 68)		25, 268	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY			
	Skilled nursing facility/other nursing facil)		70.00
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /0 ÷ line	: 2)			71.00
	Medically necessary private room cost applic		(line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv						74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B,	Part II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital-related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovidor roca	-de)			78.00
80.00	Total Program routine service costs for comp	• •			nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi			、 - · - ····	· · · · · · · · · · · · · · · · · · ·		81.00
82.00	Inpatient routine service cost limitation (I		· .				82.00
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83.00
	Utilization review - physician compensation		ns)				85.00
86.00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS						07 00
87.00	Total observation bed days (see instructions					530	
	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			2, 454. 95	88.00

Health Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 6/8/2020 8:34	pared: am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 045, 848	7, 102, 898	0. 14724	2 1, 301, 124	191, 580	90.00
91.00 Nursing School cost	0	7, 102, 898	0.00000	0 1, 301, 124	0	91.00
92.00 Allied health cost	0	7, 102, 898	0.00000	0 1, 301, 124	0	92.00
93.00 All other Medical Education	0	7, 102, 898	0.00000	0 1, 301, 124	0	93.00

Health Financial Systems PERRY COUNTY HOS INPATIENT ANCILLARY SERVICE COST APPORTIONMENT F		CN: 15-1322	Peri od:	u of Form CMS- Worksheet D-3	
		011. 10 1022	From 01/01/2019	WOLKSHEET D	,
			To 12/31/2019		
	T : 11			6/8/2020 8: 34	1 am
Cont Contae Departing	litle	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
		To charges	Charges	(col. 1 x	
			charges	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			1, 279, 733		30.00
31.00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		1			1
50. 00 05000 OPERATI NG ROOM		0. 2766	43 167, 498	46, 337	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.6438			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1042		49, 722	54.00
60. 00 06000 LABORATORY		0. 1690			60.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2842	59 12, 241	3, 480	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 3366	91 412, 542	138, 899	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3524	62 135, 878	47, 892	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 2986	92 99, 195	29, 629	67.00
68.00 06800 SPEECH PATHOLOGY		0. 3895	23 41, 469	16, 153	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1852	71 441, 070	81, 717	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 9803	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2201	81 1, 157, 664	254, 896	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
88.01 08801 RURAL HEALTH CLINIC II		0.0000		0	00.0
38.02 08803 RURAL HEALTH CLINIC III		0.0000		0	
38. 03 08802 RURAL HEALTH CLINIC IV		0.0000		0	
90. 00 09000 CLINIC		0. 9013			
90. 01 09001 PALN MANAGEMENT		0.0000		0	
90. 02 09002 WOUND CARE		0. 2684		2, 155	
90. 03 09003 ORTHOPEDIC CLINIC		0. 2637		-	
91. 00 09100 EMERGENCY		0. 4386			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.8280	20 4, 410	8, 062	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 637, 479	874, 508	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			3, 637, 479		202.00

Health Financial Systems PERRY COUNTY HOS	PITAL		In Lie	eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT P	rovider CO	CN: 15-1322	Peri od:	Worksheet D-3	3
	omponent (CCN: 15-Z322	From 01/01/2019 To 12/31/2019		anarod.
	onponent	JUN. 15-2522		6/8/2020 8: 34	1 am
	Title	XVIII	Swing Beds - SN	F Cost	
Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1	
30. 00 03000 ADULTS & PEDI ATRI CS				2	30.00
31. 00 03100 I NTENSI VE CARE UNI T			(31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS				-	
50. 00 05000 OPERATING ROOM		0. 2766			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 6438		-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1042			
60. 00 06000 LABORATORY		0. 1690			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2842			
65. 00 06500 RESPI RATORY THERAPY		0. 3366			
66. 00 06600 PHYSI CAL THERAPY		0. 3524			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2986			
68. 00 06800 SPEECH PATHOLOGY		0. 3895			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1852			
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 9803		-	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 2201	81 276, 042	2 60, 779	73.00
OUTPATIENT SERVICE COST CENTERS		0.0000	00		
88. 00 08800 RURAL HEALTH CLINIC		0.0000		C	
88. 01 08801 RURAL HEALTH CLINIC II		0.0000		C	00.0
88. 02 08803 RURAL HEALTH CLINIC III		0.0000		C	
88. 03 08802 RURAL HEALTH CLINIC IV		0.0000			
90. 00 09000 CLINIC		0.9013			
90. 01 09001 PALN MANAGEMENT		0.0000			
90. 02 09002 WOUND CARE		0.2684			
90. 03 09003 ORTHOPEDIC CLINIC		0. 2637			
91. 00 09100 EMERGENCY		0. 4386			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.8280	20 (D C	92.00
OTHER REI MBURSABLE COST CENTERS					05 01
95. 00 09500 AMBULANCE SERVICES			1 170 //		95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 178, 66	7 316, 047	
201.00 Less PBP Clinic Laboratory Services-Program only charges ((II ne 61)		(1 170 / /		201.00
202.00 Net charges (line 200 minus line 201)			1, 178, 66	/	202.00

Health Financial Systems PERRY COUNTY HOS INPATIENT ANCILLARY SERVICE COST APPORTIONMENT I	Provider CC	N 15-1322	Peri od:	u of Form CMS- Worksheet D-3	
			From 01/01/2019		
			To 12/31/2019		
				6/8/2020 8: 34	1 am
Cast Castas Description		e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col. 2)	
	ŀ	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			192, 134		1 30. 00
31.00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY			7,088		43.00
ANCI LLARY SERVICE COST CENTERS			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
50. 00 05000 OPERATI NG ROOM		0. 27664	43 281, 610	77, 905	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.6438	70 133, 376	85, 877	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1042			54.00
60. 00 06000 LABORATORY		0.16900			
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2842	59 125	36	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 33669	46, 828	15, 767	65.00
66. 00 06600 PHYSI CAL THERAPY		0.35240	52 5, 285	1, 863	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 2986	2, 094	625	67.00
68.00 06800 SPEECH PATHOLOGY		0. 38952	23 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1852	214, 831	39, 802	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 98030	06 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 22018	218, 763	48, 167	73.0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		1.13380	05 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II		0. 71534		0	88.0
38.02 08803 RURAL HEALTH CLINIC III		1.04829	91 0	0	
38. 03 08802 RURAL HEALTH CLINIC IV		0.0000		0	
90. 00 09000 CLINIC		0. 9013	54 36, 599	32, 989	90.00
90. 01 09001 PALN MANAGEMENT		0.0000	0 00	0	
90.02 09002 WOUND CARE		0. 26843	8, 549	2, 295	90.02
90. 03 09003 ORTHOPEDIC CLINIC		0. 2637	15 0	0	90.0
91. 00 09100 EMERGENCY		0. 4386	17 65, 489	28, 725	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.82802	20 19, 066	34, 853	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 294, 516	405, 883	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			1, 294, 516		202.00

	Financial Systems PERRY COUNTY H ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-1322	In Lie Period: From 01/01/2019 To 12/31/2019		pared:
		Title XVIII	Hospi tal	Cost	
				1.00	
1. 00 2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct OPPS payments Outlier payment (see instructions) Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions) Enter the hospital specific payment to cost ratio (see instructions) Enter the hospital specific payment to cost ratio (see instructions) Enter the hospital specific payment (see instructions) Enter the s 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	uctions)		6, 662, 222 0 0 0 0 0 0.000 0 0 0 0 0 0 0 0 0 0	6.00 7.00 8.00 9.00 10.00
13.00	Reasonable charges Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	line 69)		0 0 0	12.00 13.00 14.00
15. 00 16. 00	Customary charges Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.130	or payment for services	U U	0	15.00 16.00
17.00 18.00 19.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or instructions)	nlyifline 18 exceeds l	ine 11) (see	0. 000000 0 0	17.00 18.00 19.00
20.00	Excess of reasonable cost over customary charges (complete or instructions)	nly if line 11 exceeds l	ine 18) (see	0	20.00
22.00 23.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructions)		6, 728, 844 0 0 0	21.00 22.00 23.00 24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	ns)		45, 414	25.00
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	ne 24 (for CAH, see inst		4, 684, 493 1, 998, 937	
29.00 30.00 31.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31)			0 0 1, 998, 937 751 1, 998, 186	28.00 29.00 30.00 31.00 32.00
33. 00 34. 00 35. 00 36. 00 37. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2	tructions) ns) aced devices (see instru		0 1, 018, 257 661, 867 442, 695 2, 660, 053 0 0 2, 660, 053 53, 201 0 3, 023, 937 0 -417, 085 0	33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00
91.00 92.00 93.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	91.00 92.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2019 To 12/31/2019		pared:
		Title		Hospi tal	Cost	
		Inpatient	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		2, 291, 26	9	3, 023, 937	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)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3.02
3.03 3.04				0	0	3.03 3.04
3.04				0	0	3.02
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53				0	0	3.53
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.54 3.99
3.99	3. 50-3. 98)			0	0	3.95
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		2, 291, 26	9	3, 023, 937	4.00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
0100	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0.00
5. 01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03				0	Ő	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.51
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.52 5.99
5.99	5. 50-5. 98)			0	0	5.95
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		597,60	2	0	6. 0 ²
6. 02	SETTLEMENT TO PROGRAM			0	417, 085	6.02
7.00	Total Medicare program liability (see instructions)		2, 888, 87		2, 606, 852	7.00
				Contractor	NPR Date	
		0		Number 1.00	(Mo/Day/Yr) 2.00	
8.00	Name of Contractor	0		1.00	2.00	8.00

IALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Period: From 01/01/2019		
		component	CCN: 15-Z322	To 12/31/2019	9 Date/Time Pre 6/8/2020 8:34	
		Title	XVIII	Swing Beds - SN		
		Inpati en	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		1, 376, 68	31	0	1. (
00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.0
	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					
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02	Absolution to thous bet			0	0	
03				0	0	
04				0	0	3.
05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		1, 376, 68	51	0	4.
00	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 370, 00		0	4.
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	
02				0	0	
03	Drovidor to Drogrom			0	0	5.
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51				0	0	
52				0	0	
99 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
	5. 50-5. 98)			-		
00	Determined net settlement amount (balance due) based on					6.
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		651, 65	58	0	
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		2,028,33		0	7.
				Contractor	NPR Date	
		()	Number	(Mo/Day/Yr)	
		()	1.00	2.00	8.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1322 Period: Workshee From 01/01/2019 Part II To 12/31/2019 Date/Tir	ne Prepared:
	7 o. 34 alli
	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 Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2	3.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00 Calculation of the HIT incentive payment (see instructions)	8.00
9.00 Sequestration adjustment amount (see instructions)	9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

ALCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1322	Peri od: From 01/01/2019	Worksheet E-2	
		Component CCN: 15-Z322	To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
		Title XVIII	Swing Beds - SNF		
			Part A 1.00	<u>Part B</u> 2.00	
0	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	Inpatient routine services - swing bed-SNF (see instructions)		1, 750, 527	0	1.00
	Inpatient routine services - swing bed-NF (see instructions)				2.00
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		, 319, 207	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins	-		0.00	1 00
	Per diem cost for interns and residents not in approved teachi instructions)	ng program (see		0.00	4.00
	Program days		706	0	5.00
. 00	Interns and residents not in approved teaching program (see ir	istructions)		0	6.00
	Utilization review - physician compensation - SNF optional met	hod only	0		7.00
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2, 069, 734	0	8.00
	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		2, 069, 734	0	9.00 10.00
	Deductibles billed to program patients (exclude amounts applic	able to physician	2,007,734	0	11.00
	professional services)				
	Subtotal (line 10 minus line 11)		2, 069, 734	0	12.00
	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0	0	13.00
	for physician professional services) 80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	2, 069, 734	0	15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	.,	2,007,701	0	16.00
	Pioneer ACO demonstration payment adjustment (see instructions	5)			16.50
	Rural community hospital demonstration project (§410A Demonstr	ation) payment	0		16.55
	adjustment (see instructions)			0	1.000
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	16.99 17.00
	Adjusted reimbursable bad debts (see instructions)		0	0	17.00
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18.00
9.00	Total (see instructions)	-	2, 069, 734	0	19.00
	Sequestration adjustment (see instructions)		41, 395	0	19.01
	Demonstration payment adjustment amount after sequestration)		0	0	19.02
	Interim payments Tentative settlement (for contractor use only)		1, 376, 681	0	20.00
	Balance due provider/program (line 19 minus lines 19.01, 20, a	ind 21)	651, 658	0	22.00
	Protested amounts (nonallowable cost report items) in accordar		0	0	23.00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr				
	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	lod under the 21st			200.00
	Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from W	/kst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, li	ne		202.00
	200 (title XVIII swing-bed SNF)) Tatal (sum of lines 201 and 202)				203.00
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				203.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curr	ent 5-year demons	tration	201.00
	period)	J	, , , , , , , , , , , , , , , , , , ,		
	Medicare swing-bed SNF target amount				205.00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs Program reimbursement under the §410A Demonstration (see instr				207.00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	-	1		207.00
	and 3)				200100
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209.00
	Reserved for future use				210.00
15 00	Comparision of PPS versus Cost Reimbursement	00 plup lin- 210) (
15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2 instructions)	tov prus rine 210) (see			215.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Pre 6/8/2020 8:34	pare
		Title XVIII	Hospi tal	Cost	
			-		
				1.00	
~~	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	RE PART A SERVICES - COS	I REIMBURSEMENT	0.4/0.504	
00	Inpatient services			3, 162, 521	
00	Nursing and Allied Health Managed Care payment (see instruct	lions)		0	2
00	Organ acquisition			0	3
00	Subtotal (sum of lines 1 through 3)			3, 162, 521	4
00 00	Primary payer payments Total cost (line 4 less line 5). For CAH (see instructions)			0 3, 194, 146	
00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 194, 140	0
	Reasonable charges				-
00	Routi ne servi ce charges			0	1 7
00	Ancillary service charges			0	8
00	Organ acquisition charges, net of revenue			0	9
0.00	Total reasonable charges			0	
. 00	Customary charges			0	
. 00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	111
. 00	Amounts that would have been realized from patients liable f	1 5	5	0	12
	had such payment been made in accordance with 42 CFR 413.13(g		
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13
. 00	Total customary charges (see instructions)			0	14
. 00	Excess of customary charges over reasonable cost (complete c	only if line 14 exceeds l	ine 6) (see	0	15
	instructions)	5	, ,		
b. 00	Excess of reasonable cost over customary charges (complete c	only if line 6 exceeds li	ne 14) (see	0	16
	instructions)				
7.00		structions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Direct graduate medical education payments (from Worksheet E	E-4, line 49)		0	
. 00	Cost of covered services (sum of lines 6, 17 and 18)			3, 194, 146	
	Deductibles (exclude professional component)			305, 536	
. 00	Excess reasonable cost (from line 16)			0	
. 00	Subtotal (line 19 minus line 20 and 21)			2, 888, 610	
. 00				0	23
. 00	Subtotal (line 22 minus line 23)			2, 888, 610	
. 00	Allowable bad debts (exclude bad debts for professional serv	/ices) (see instructions)		91, 104	
. 00	Adjusted reimbursable bad debts (see instructions)	· · · · · · · · · · · · · · · · · · ·		59, 218	
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		10, 576	
. 00	Subtotal (sum of lines 24 and 25, or line 26)			2, 947, 828	
. 00 . 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
	Pioneer ACO demonstration payment adjustment (see instruction			0	29
. 99	Demonstration payment adjustment amount before sequestration	1		-	
. 00 . 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 947, 828 58, 957	
	Demonstration payment adjustment amount after sequestration			58, 957	30
. 02				2, 291, 269	
. 00	Tentative settlement (for contractor use only)			2, 291, 209	
. 00	Balance due provider/program (line 30 minus lines 30.01, 30.	02 31 and 32)		597,602	
. 00	Protested amounts (nonallowable cost report items) in accord		chanter 1	597, 602	34
. 00	§115. 2	ance with GWS PUD. 15-2,	chapter I,	0	^د ا

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider CO	F	eriod: rom 01/01/2019 o 12/31/2019	Worksheet G Date/Time Pre 6/8/2020 8:34	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	5, 949, 639	0	0	0	1.00
2.00	Temporary investments	3, 893, 530			0	2.00
3.00	Notes receivable	12 000 212	0	0	0	3.00
4.00 5.00	Accounts receivable Other receivable	12, 980, 212 705, 366	0	0	0	4.00 5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8, 246, 687	0	0	0	6.00
7.00	Inventory	899, 185	0	0	0	7.00
8.00	Prepaid expenses	465, 064	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
	Due from other funds Total current assets (sum of lines 1–10)	1, 820, 000 18, 466, 309	0	0	0	10.00 11.00
11.00	FIXED ASSETS	10, 400, 309	0	<u> </u>	0	111.00
12.00	Land	3, 815, 753	0	0	0	12.00
13.00	Land improvements	66, 330	0	0	0	13.00
	Accumulated depreciation	-9, 226, 705	0	0	0	14.00
	Buildings	44,023,461	0		0	15.00
	Accumulated depreciation Leasehold improvements	-2, 599, 994 0	0	0	0	16.00 17.00
	Accumulated depreciation	0	0	0	0	18.00
	Fixed equipment	2, 330, 717	0	0	0	19.00
	Accumulated depreciation	-166, 739	0	0	0	20.00
	Automobiles and trucks	477, 834	0	0	0	21.00
	Accumulated depreciation Major movable equipment	-310, 122 16, 244, 053	0	0	0	22.00 23.00
	Accumulated depreciation	-9, 064, 914		Ű	0	23.00
	Minor equipment depreciable	0	0	0	0	25.00
	Accumulated depreciation	0	0	0	0	26.00
	HIT designated Assets	0	0	0	0	27.00
	Accumulated depreciation	0	0	0	0	28.00
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	0 45, 589, 674	0	0	0	29.00 30.00
30.00	OTHER ASSETS	43, 307, 074		<u> </u>	0	30.00
31.00	Investments	0	0	0	0	31.00
	Deposits on Leases	0	0		0	32.00
	Due from owners/officers	0	0	0	0	33.00
34.00 35.00	Other assets Total other assets (sum of lines 31-34)	0	0	0	0	34.00 35.00
	Total assets (sum of lines 11, 30, and 35)	64,055,983	-	-	0	36.00
	CURRENT LI ABI LI TI ES			1		
	Accounts payable	1, 232, 473			0	37.00
	Salaries, wages, and fees payable	0	0		0	38.00 39.00
	Payroll taxes payable Notes and Loans payable (short term)	404, 436 641, 000	0	0	0	40.00
	Deferred income	0 11, 000	0	0	0	41.00
42.00	Accelerated payments	0				42.00
	Due to other funds	0	0	0	0	
	Other current liabilities	2, 451, 736			0	
45.00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	4, 729, 645	0	0	0	45.00
46.00	Mortgage payable	0	0	0	0	46.00
	Notes payable	36, 693, 000	0		0	47.00
	Unsecured Loans	0	0	0	0	48.00
	Other long term liabilities	0	0	0	0	49.00
	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	36, 693, 000		0	0	50.00 51.00
51.00	CAPITAL ACCOUNTS	41, 422, 645	0	<u> </u>	0	51.00
52.00	General fund balance	22, 633, 338				52.00
	Specific purpose fund		0			53.00
	Donor created - endowment fund balance - restricted			0		54.00
	Donor created - endowment fund balance - unrestricted			0		55.00
	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56.00 57.00
	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	22, 633, 338			0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	64, 055, 983	0	0		60.00

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet G- Date/Time Pre 6/8/2020 8:34	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		21, 036, 395 1, 596, 943 22, 633, 338 0 22, 633, 338 0 22, 633, 338				5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund	_		
1.00	Fund halances at basisming of agrical	6.00	7.00	8.00			1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

EMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der C	CN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet G-2 Parts I & II Date/Time Pre 6/8/2020 8:34	epare
Cost Center Description		I npati ent	Outpati ent	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					-
General Inpatient Routine Services					
Hospi tal		2, 342, 48	35	2, 342, 485	
SUBPROVIDER - IPF					2.
SUBPROVIDER - IRF					3.
SUBPROVIDER					4.
Swing bed - SNF			0	0	
Swing bed - NF			0	0	
SKILLED NURSING FACILITY					7.
NURSING FACILITY					8.
OTHER LONG TERM CARE	1 0)	0.040.44		0 040 405	9.
0 Total general inpatient care services (sum of lines	1-9)	2, 342, 48	35	2, 342, 485	10.
Intensive Care Type Inpatient Hospital Services		246.20		246-260	1 1 1
0 INTENSIVE CARE UNIT		246, 26	50	246, 260	
O CORONARY CARE UNIT					12.
0 BURN INTENSIVE CARE UNIT					13.
0 SURGI CAL I NTENSI VE CARE UNI T					14.
0 OTHER SPECIAL CARE (SPECIFY)	o (our of lines	246.20		246 260	15.
0 Total intensive care type inpatient hospital service	es (sum of fines	246, 26	50	246, 260	16.
11-15)	10 and 1()	2 500 7	IF.	2 500 745	17
0 Total inpatient routine care services (sum of lines 0 Ancillary services	10 and 16)	2, 588, 74 9, 890, 56		2, 588, 745	
0 Ancillary services 0 Outpatient services		9, 890, 50		89, 794, 096 0	
0 RURAL HEALTH CLINIC			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		
1 RURAL HEALTH CLINIC II				3, 532, 703	
2 RURAL HEALTH CLINIC III			0 1, 143, 331 0 537, 405	1, 143, 331 537, 405	
			0 -116 0 0	-116 0	
0 FEDERALLY QUALIFIED HEALTH CENTER 0 HOME HEALTH AGENCY			3, 005, 345	3,005,345	
0 AMBULANCE SERVICES			0 3, 858, 719	3, 858, 719	
0 CMHC			0 3,030,719	3, 030, 717	24.
O AMBULATORY SURGICAL CENTER (D. P.)					25.
0 HOSPICE			0 0	0	
0 OTHER (SPECIFY)			0 0	0	
0 Total patient revenues (sum of lines 17-27)(transfer	column 3 to Wkst	12, 479, 30	°	104, 460, 228	
G-3, line 1)	cordinit 5 to wrst.	12, 477, 30	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	104, 400, 220	20.
PART II - OPERATING EXPENSES		1			
0 Operating expenses (per Wkst. A, column 3, line 200)			40, 075, 912		29
0 ADD (SPECIFY)			0		30
0			0		31
0			0		32
0			0		33
0			0		34
0			0		35
0 Total additions (sum of lines 30-35)			0		36
0 DEDUCT (SPECIFY)			0		37.
0			0		38
0			0		39
0			0		40
0			0		41
0 Total deductions (sum of lines 37-41)			0		42.
0 Total operating expenses (sum of lines 29 and 36 min	nus line 42)(transfer		40, 075, 912		43.
to Wkst. G-3, line 4)					

	Financial Systems	PERRY COUNTY HOSPITAL		u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1322	Period:	Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	pared [.]
			10 12/01/2017	6/8/2020 8: 34	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part			104, 460, 228	1.00
2.00	Less contractual allowances and discounts on	patients' accounts		66, 295, 416	
3.00	Net patient revenues (line 1 minus line 2)			38, 164, 812	
4.00	Less total operating expenses (from Wkst. G-2			40, 075, 912	
5.00	Net income from service to patients (line 3 r	minus line 4)		-1, 911, 100	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			306, 883	6.00
7.00	Income from investments			101, 885	7.00
8.00	Revenues from telephone and other miscellaned	ous communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			55, 155	
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and gues	sts		104, 718	
	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical sup	oplies to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than pati	ents		0	17.00
18.00	Revenue from sale of medical records and abs	tracts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e	etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, an	nd canteen		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			89, 559	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING INCOME			2, 849, 843	24.00
25.00	Total other income (sum of lines 6-24)			3, 508, 043	25.00
26.00	Total (line 5 plus line 25)			1, 596, 943	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subs	scripts)		0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)		1, 596, 943	29.00

	Financial Systems		PERRY COUNTY			In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS			F	Period: From 01/01/2019	Worksheet H	
				HHA CCN:	15-7177 1	To 12/31/2019	6/8/2020 8:34	
						Home Health Agency I	PPS	
		Sal ari es	Empl oyee		Contracted/Pu		Total (sum of	
			Benefits	n (see instructions)	rchased Servi ces		cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &			0		0	0	1.00
2.00	Fixtures Capital Related - Movable			0		0	0	2.00
	Equipment					0	0	
3.00 4.00	Plant Operation & Maintenance Transportation	0	0		-		0	
5.00	Administrative and General	106, 631	81, 373			-	-	
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	214, 804	0	C		0	214, 804	6.00
7.00	Physi cal Therapy	0	0	0) (0 0	0	7.00
8.00 9.00	Occupational Therapy Speech Pathology	0	0			-	0	8.00 9.00
10.00	Medical Social Services	251, 426		0		-	251, 426	
11.00 12.00	Home Health Aide Supplies (see instructions)	56, 719 0			-	-	56, 719 12, 232	
13.00	Drugs	0	-	0		265	265	13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0) (2, 201	2, 201	14.00
15.00	Home Dialysis Aide Services	0	-			-	0	
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0	0			0	
18.00	Clinic	0	0	0	-	-	0	
19.00 20.00	Health Promotion Activities Day Care Program	0	0			-	0	19.00 20.00
21.00	Home Delivered Meals Program	0	0	0		0	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0				0	
23.50	Telemedicine Total (sum of lines 1–23)	0 629, 580	0 81, 373	0	-	-	0 824, 871	
24.00	Total (sum of Tries 1-23)	Recl assi fi cat	Recl assi fi ed	Adjustments	Net Expenses	100,718	024,071	24.00
		i on	Trial Balance (col. 6 +		for Allocation			
			col . 7)		(col. 8 +			
		7.00	8.00	9.00	col. 9) 10.00	-		-
1 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0	0				1.00
1.00	Fixtures	0	0	U				1.00
2.00	Capital Related - Movable Equipment	0	0	O				2.00
3.00	Plant Operation & Maintenance	0	0	C				3.00
4.00 5.00	Transportation Administrative and General	0 -31, 373	0 255, 851	0				4.00 5.00
	HHA REIMBURSABLE SERVICES					1		
6.00 7.00	Skilled Nursing Care Physical Therapy	0 161, 586						6.00 7.00
8.00	Occupational Therapy	104, 303	104, 303	0	104, 303	3		8.00
9.00 10.00	Speech Pathology Medical Social Services	16, 628 -251, 144						9.00 10.00
11.00	Home Health Aide	0	56, 719	0	56, 719	2		11.00
12.00 13.00	Supplies (see instructions) Drugs	0	12, 232 265					12.00 13.00
14.00	DME	0	2, 201	0	2, 201	1		14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0				15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0				16.00 17.00
18.00	Clinic	0	0	0				18.00
19.00 20.00	Health Promotion Activities Day Care Program	0	0	0				19.00 20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00 23.00	Homemaker Service All Others (specify)	0	0					22.00 23.00
23.50	Tel emedi ci ne	0	-	0)			23.50
24.00	Total (sum of lines 1-23)	0	824, 871	0	824, 871	l]		24.00

Heal th	Financial Systems		PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	E COST		Provi der C	CN: 15-1322	Period: From 01/01/2019	Worksheet H-1	
				HHA CCN:	15-7177	To 12/31/2019	Date/Time Pre 6/8/2020 8:34	pared:
						Home Health	PPS	
			Capital Rela	ated Costs		Agency I		
		Net Expenses	BIdgs &	Movabl e	Plant	Transportati o	Subtotal	
		for Cost Allocation	Fixtures	Equi pment	Operation &	n	(col s. 0-4)	
		(from Wkst.			Maintenance			
		H, col. 10) 0	1.00	2.00	3.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS			2.00	0.00	1.00		
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	О	0		0	0	3.00
4.00 5.00	Transportation Administrative and General	0 255, 851	0	0		0 0	255, 851	4.00 5.00
	HHA REIMBURSABLE SERVICES		-		1			
6.00 7.00	Skilled Nursing Care Physical Therapy	214, 804 161, 586	0	0 0		0 0 0 0	214, 804 161, 586	
8.00	Occupational Therapy	104, 303	0	0		0 0	104, 303	
9. 00 10. 00	Speech Pathology Medical Social Services	16, 628 282	0	0 0		0 0 0 0	16, 628 282	
11.00 12.00	Home Health Aide Supplies (see instructions)	56, 719 12, 232	0	0		0 0	56, 719 12, 232	
13.00	Drugs	265	0	0		0	265	13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	2, 201	0	0		0 0	2, 201	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0 0	0 0		0 0 0 0	0	16.00 17.00
18.00 19.00	Clinic Health Promotion Activities	0	0	0		0 0 0 0	0	18.00 19.00
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	21.00 22.00
23.00	All Others (specify)	0	0	0		0 0	0	23.00
23.50 24.00	Telemedicine Total (sum of lines 1-23)	0 824, 871	0	0 0		0 0 0 0	0 824, 871	23.50 24.00
		Administrativ e & General	Total (cols. 4A + 5)					
		5.00	6.00					
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
	Fixtures							
2.00	Capital Related - Movable Equipment							2.00
3.00 4.00	Plant Operation & Maintenance Transportation							3.00 4.00
5.00	Administrative and General	255, 851						5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	96, 582	311, 386					6.00
7.00	Physical Therapy	72, 655	234, 241					7.00
8.00 9.00	Occupational Therapy Speech Pathology	46, 898 7, 477	151, 201 24, 105					8.00 9.00
10. 00 11. 00	Medical Social Services Home Health Aide	127 25, 503	409 82, 222					10.00 11.00
12.00	Supplies (see instructions)	5, 500	17, 732					12.00
13.00 14.00	Drugs DME	119 990	384 3, 191					13.00 14.00
	HHA NONREI MBURSABLE SERVI CES	1						
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0 0					15.00 16.00
17.00 18.00	5 5	0	0					17.00 18.00
19.00	Health Promotion Activities	0	0					19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	O O					20.00 21.00
22.00	Homemaker Service	0	0					22.00
23.00 23.50	All Others (specify) Telemedicine	0	0 0					23.00 23.50
24.00	Total (sum of lines 1-23)	I	824, 871					24.00

Heal th	Financial Systems		PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	SI S		Provider C	CN: 15-1322	Period: From 01/01/2019	Worksheet H-1 Part II	
				HHA CCN:	15-7177	To 12/31/2019	Date/Time Pre 6/8/2020 8:34	pared:
						Home Health	PPS	an
						Agency I		
		Capital Rel	ated Costs					
		BIdgs &	Movabl e	PI ant	Transportati	o Reconciliatio	Administrativ	1
		Fixtures	Equipment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	588				0		1.00
	Fixtures							
2.00	Capital Related - Movable Equipment		588			0		2.00
3.00	Plant Operation & Maintenance	0	0	588		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	instructions)	Ŭ	Ū	0				
5.00	Administrative and General	588	588	588		0 -255, 851	569, 020	5.00
	HHA REIMBURSABLE SERVICES				I			
6.00	Skilled Nursing Care	0	0	0		0 0	214, 804	6.00
7.00	Physical Therapy	0	0	0		0 0	161, 586	7.00
8.00	Occupational Therapy	0	0	0		0 0	104, 303	8.00
9.00	Speech Pathology	0	0	0		0 0	16, 628	9.00
10.00	Medical Social Services	0	0	0		0 0	282	10.00
11.00	Home Health Aide	0	0	0		0 0	56, 719	11.00
12.00	Supplies (see instructions)	0	0	0		0 0	12, 232	12.00
13.00	Drugs	0	0	0		0	265	13.00
14.00	DME	0	0	0		0 0	2, 201	14.00
	HHA NONREI MBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0			0 0	0	
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify)	0	0	0		0 0	0	
23.50	Tel emedi ci ne	0	0	0		0 0	0	
24.00	Total (sum of lines 1-23)	588	588			0 -255, 851	569, 020	
25.00	Cost To Be Allocated (per	0	0	0		U	255, 851	25.00
26 00	Worksheet H-1, Part I) Unit Cost Multiplier	0, 000000	0. 000000	0. 000000	0.00000	20	0. 449634	26 00
26.00	junit cost multiplier	0.000000	0. 000000	0.000000	0.00000		0. 449034	20.00

	Financial Systems		PERRY COUNTY				In Lie	u of Form CMS-2	
ALLOC.	ATION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	IIERS	Provider CO HHA CCN:	UN: 15-1322 15-7177		/01/2019 /31/2019		pared:
							Heal th	PPS	
			CAPI TAL REL	ATED COSTS		Ager	ncy I		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT		total	ADMI NI STRATI V E AND GENERAL	
		0	1.00	2.00	4.00		4A	5. 01	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine 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	0 311, 386 234, 241 151, 201 24, 105 409 82, 222 17, 732 384 3, 191 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	5, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			17, 986 311, 386 234, 241 151, 201 24, 105 409 82, 222 17, 732 384 3, 191 0 0 0 0 0 0 0 0 0 0 0 0 0	20, 255 13, 075 2, 084 35 7, 110	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$
	6 decimal places. Cost Center Description	Subtotal	ADMI NI STRATI V E AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVIC		KEEPI NG	DI ETARY	
		5A. 01	5. 02	7.00	8.00		. 00	10.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	$\begin{array}{c} 19,541\\ 338,313\\ 254,496\\ 164,276\\ 26,189\\ 444\\ 89,332\\ 19,265\\ 417\\ 3,467\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	32, 540 21, 004 3, 348 57 11, 422 2, 463 53 443 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21, 132 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			4, 733 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		14. 00 15. 00 16. 00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	ITERS	Provider C HHA CCN:		5-1322 15-7177	Period: From 01/01/2019 To 12/31/2019 Home Health		pared:
						Agency I	115	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	Sı	ubtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
	11.00	13.00	16.00		24.00	25.00	26.00	
 Administrative and General Administrative and General Skilled Nursing Care O Skilled Nursing Care O Ccupational Therapy O Ccupational Therapy Speech Pathology Medical Social Services Medical Social Services O Home Health Aide Supplies (see instructions) O Drugs O DME Meme Dialysis Aide Services O Respiratory Therapy O Private Duty Nursing O Day Care Program O Home Delivered Meals Program 					100, 7 21, 7	71 0 36 0 80 0 37 0 54 0 28 0 70 0 0 0	381, 571 287, 036 185, 280 29, 537 501 100, 754 21, 728 470 3, 910 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$
Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs						
1.00 Administrative and Canaral	27.00	28.00						1.00
 Administrative and General Administrative and General Skilled Nursing Care O Skilled Nursing Care O Ccupational Therapy O Ccupational Therapy Speech Pathology Medical Social Services Medical Social Services O Home Health Aide Supplies (see instructions) O Drugs O DME Meme Dialysis Aide Services O Respiratory Therapy O Private Duty Nursing O Day Care Program O Home Delivered Meals Program Meme Dail view Grup O Home Delivered Meals Program O Home Delivered Meals Program O Home Delivered Meals Program O Home Johres (specify) So Telemedicine O Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 	18, 084 13, 603 8, 781 1, 400 24 4, 775 1, 030 22 185 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	300, 639 194, 061 30, 937 525 105, 529 22, 758 492 4, 095 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTICA	L Provider C	CN: 15-1322	Period:	Worksheet H-2	
BASI S			HHA CCN:	15-7177	From 01/01/2019 To 12/31/2019	Part II Date/Time Pre 6/8/2020 8:34	pared: am
					Home Health Agency I	PPS	
	CAPI TAL REL	ATED COSTS	I		Agency		
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliati n	o ADMI NI STRATI V E AND GENERAL (ACCUM. COST)	Reconciliatio n	-
	1.00	2.00	SALARI ES) 4.00	5A. 01	5. 01	5A. 02	
1.00Administrative and General2.00Skilled Nursing Care3.00Physical Therapy4.00Occupational Therapy5.00Speech Pathology6.00Medical Social Services7.00Home Health Aide8.00Supplies (see instructions)9.00Drugs11.00Home Dialysis Aide Services12.00Respiratory Therapy13.00Private Duty Nursing14.00Clinic15.00Health Promotion Activities16.00Day Care Program17.00Home Belivered Meals Program18.00Hothers (specify)19.50Telemedicine20.00Total (sum of lines 1-19)	588 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	588 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			$ \begin{smallmatrix} 0 & 17, 986 \\ 0 & 311, 386 \\ 0 & 234, 241 \\ 0 & 151, 201 \\ 0 & 24, 105 \\ 0 & 409 \\ 0 & 82, 222 \\ 0 & 17, 732 \\ 0 & 384 \\ 0 & 3, 191 \\ 0 & 0 \\ 0 &$		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
21.00 Total cost to be allocated	12, 538	5, 448	0		72, 883		21.00
22.00 Unit cost multiplier Cost Center Description	21. 323129 ADMI NI STRATI V E AND GENERAL - OTHER (ACCUM. COST NO PBP)	(SQUARE FEET)	0.000000 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI N (SQUARE FEET)	(MEALS SERVED)	CAFETERI A (FTE' S)	22.00
1 00 Administrative and Conoral	5.02	7.00	8.00	9.00	10.00	11.00	1.00
 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 Home Are Program 17.00 Home Meal th Promotion Activities 16.00 Day Care Program 17.00 Home Dialysis (specify) 19.00 All Others (specify) 19.00 Total (sum of lines 1-19) 21.00 Total cost multiplier 	19, 541 338, 313 254, 496 164, 276 26, 189 444 89, 332 19, 265 417 3, 467 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	588 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		5	88 0 0 0 3 0		2.00 3.00 4.005.00 6.00 7.008.00 9.00 10.008.00 11.00 12.00 13.000 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00

Heal th	Financial Systems		PERRY COUNTY H	OSPI TAL		In Lieu	u of Form CMS-2	2552-10
ALLOCA BASI S	ATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTICAL	Provider CCN HHA CCN:	N: 15-1322 15-7177	Period: From 01/01/2019 To 12/31/2019	Worksheet H-2 Part II Date/Time Pre	
					10 / 17 /	10 12/01/2017	6/8/2020 8: 34	am
						Home Health	PPS	
						Agency I		
	Cost Center Description	NURSI NG	MEDI CAL					
		ADMI NI STRATI O	RECORDS &					
		N	LI BRARY					
		(DI RECT	(TIME					
		NRSING HRS)	SPENT)			-		
1.00		13.00	16.00					1.00
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical 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	Respiratory 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
17.00	Home Delivered Meals Program	0	0					
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Tel emedi ci ne	0	0					19.50
20.00	Total (sum of lines 1-19)	0	0					20.00
21.00		0	0					21.00
22.00	Unit cost multiplier	0. 000000	0. 000000					22.00

Heal th	Financial Systems		PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	FIONMENT OF PATIENT SERVICE COST	ГS		Provider C		Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2019 To 12/31/2019		pared: am
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)			col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TI	HE PROGRAM LIN	MITATION COST, O	OR BENEFICIARY	
	COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	399, 655		399, 65	5 2, 118	188.69	1.00
2.00	Physical Therapy	3.00	300, 639	0	300, 63	9 2,031	148.03	2.00
3.00	Occupational Therapy	4.00	194, 061	0	194,06			
4.00	Speech Pathology	5.00		0				
5.00	Medical Social Services	6.00		0	52			
6.00	Home Heal th Ai de	7.00			105, 52			
		7.00		0				
7.00	Total (sum of lines 1-6)		1, 031, 346	0				7.00
					Program Visit	S		
					De			
			0000 11 (1)			rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
					to	Deducti bl es		
					Deductibles &	λ.		
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation	1				. [
8.00	Skilled Nursing Care		99915	0				8.00
9.00	Physical Therapy		99915	0				9.00
10.00	Occupational Therapy		99915	0	98	2		10.00
11.00	Speech Pathology		99915	0	17	6		11.00
12.00	Medical Social Services		99915	0		5		12.00
13.00	Home Health Aide		99915	0	21	8		13.00
	Total (sum of lines 8-13)			0	1			14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	
	oust conter bescription	H-2 Part I,	Costs (from	Ancillary	Costs (col s.	(from HHA	÷ col . 4)	
		col. 28, line		Costs (from	1 + 2)	Records)		
		20, 11110	Part I)	Part II)	1 + 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput	-	1.00	2.00	3.00	4.00	5.00	
15.00	Cost of Medical Supplies	8.00	22, 758	0	22, 75	8 0	0. 000000	15 00
16.00		9.00		0				
10.00	COST OF DEGGS	9.00	Program Visits		Cost of	2 0	0.000000	10.00
					Services			
			Par	+ D	361 11 663	Part B		
	Cost Contor Decerintion	Dort A			Dort A		Subject to	
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
		(Coi nsurance	0.00	0.00	Coi nsurance	11.00	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LIN	MITATION COST, (DR BENEFICIARY	
	COST LIMITATION							
	Cost Per Visit Computation		1			-		
1.00	Skilled Nursing Care	0			1	0 196, 426		1.00
2.00	Physical Therapy	0				0 216, 272		2.00
3.00	Occupational Therapy	0				0 145, 365		3.00
5.00	Caraala Dathalami	l c	176			0 26, 052		4.00
4.00	Speech Pathology		170			20,032		
	Medical Social Services					0 656		5.00
4.00 5.00		0	5			0 656		5.00
4.00	Medical Social Services		5 218					

	n Financial Systems		PERRY COUNTY				u of Form CMS-	
APPOR	TIONMENT OF PATIENT SERVICE COS	15		Provider CO	15-7177	Period: From 01/01/2019 To 12/31/2019	Worksheet H-3 Part I Date/Time Pre 6/8/2020 8:34	epared
			1	Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description	(00	7.00	0.00	0.00	10.00	11.00	
		6.00	7.00	8.00	9.00	10.00	11.00	-
3. 00	Limitation Cost Computation Skilled Nursing Care							8.0
9.00	Physical Therapy							9.0
10.00								10.0
11.00								11. (
2.00								12.0
13.00								13.0
14.00	Total (sum of lines 8-13)							14.0
		Prog	ram Covered Cha	rges	Cost of			
					Servi ces			
			Daved	L D		Davet D		
	Cost Contor Description	Dort A	Part		Dorst A	Part B	Subject to	
	Cost Center Description	Part A	Not Subject	Subject to Deductibles &	Part A	Not Subject	Subject to Deductibles &	
			to Deductibles &	Coi nsurance		to Deductibles &	Coi nsurance	
			Coi nsurance	corrisul ance		Coi nsurance	corrisul ance	
		6.00	7.00	8.00	9,00	10.00	11.00	
	Supplies and Drugs Cost Comput		7.00	0.00	7.00	10.00	11.00	
15.00		0	12, 232	0		0 0	(J 15. 0
16.00			265	0		0		16.0
	Cost Center Description	Total Program				-		
		Cost (sum of						
		col s. 9-10)						
		12.00			-			
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM L	IMITATION COST, O	R BENEFICIARY	
	Cost Per Visit Computation	1						
1.00	Skilled Nursing Care	196, 426						1.0
. 00	Physical Therapy	216, 272						2.
. 00	Occupational Therapy	145, 365						3.
. 00	Speech Pathology	26, 052						4.
6.00	Medical Social Services	656						5.
5.00	Home Health Aide	26, 596						6.
. 00	Total (sum of lines 1-6)	611, 367						7.0
	Cost Center Description	10.00						_
		12.00						-
	Limitation Cost Computation	1						
00	Skilled Nursing Care							8.
	Dhugi gol Thomas	1						9. 10.
. 00	Physical Therapy							1 10
0. 00 0. 00	Occupational Therapy							
9.00 10.00 11.00	Occupational Therapy Speech Pathology							11.
8.00 9.00 10.00 11.00 12.00	Occupational Therapy Speech Pathology Medical Social Services							11. (12. (
9.00 10.00 11.00 12.00 13.00	Occupational Therapy Speech Pathology Medical Social Services							11.

Health Financial Systems		PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	Provider CCN: 15-1322		Worksheet H-3	
			HHA CCN:	15-7177	From 01/01/2019 To 12/31/2019		pared: am
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge 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 OF COS	T OF HHA SERVI	CES FURNI SHED	BY SHARED HOSP	ITAL DEPARTME	INTS		
1.00 Physical Therapy	66.00	0. 352462	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 298692	0		Ocol. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 389523	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 185271	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 220181	0		0 col. 2, line 1	6.00	5.00

	Financial Systems PERRY COUNTY ATION OF HHA REIMBURSEMENT SETTLEMENT PERRY COUNTY	Provider C	CN: 15-1322	Peri od:	Worksheet H-4	
		HHA CCN:	15-7177	From 01/01/2019 To 12/31/2019		
		Title	× XVIII	Home Health	PPS	
				Agency I Par	rt B	
			Part A	Not Subject to Deductibles &	Subject to Deductibles &	
				Coi nsurance	corrisul ance	
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CU Reasonable Cost of Part A & Part B Services	STOMARY CHARGE	ES			-
00	Reasonable cost of services (see instructions)			0 0	0	1
00	Total charges			0 0		
	Customary Charges					
00	Amount actually collected from patients liable for payment	for services		0 0	0	3
00	on a charge basis (from your records) Amount that would have been realized from patients liable fo	or navment		0 0	0	
00	for services on a charge basis had such payment been made in with 42 CFR §413.13(b)			0		
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000			
00 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cos only if line 6 exceeds line 1)	t (complete		0 0 0 0	-	
00	Excess of reasonable cost over customary charges (complete 1 exceeds line 6)	only if line		0 0	0	8
00	Primary payer amounts			0 0		
				Part A	Part B	
				Services 1.00	Services 2.00	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)			0	-	
00	Total PPS Reimbursement - Full Episodes without Outliers			0		
00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			0		
. 00	Total PPS Reimbursement - PEP Episodes			0		
00	Total PPS Outlier Reimbursement - Full Episodes with Outlie	rs		0		
00	Total PPS Outlier Reimbursement - PEP Episodes	15		0	0	
. 00	Total Other Payments			0	0	
. 00	DME Payments			0	0	
00	Oxygen Payments			0	0	1
~ ~	Prosthetic and Orthotic Payments			0	0	20
. 00	Part B deductibles billed to Medicare patients (exclude coin	nsurance)			0	2
				0	689, 217	
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)					23
00 00 00	Excess reasonable cost (from line 8)			0		
. 00 . 00 . 00 . 00	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0		24
. 00 . 00 . 00 . 00 . 00	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)			0	689, 217 0	24
. 00 . 00 . 00 . 00 . 00 . 00	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)			-	689, 217 0	24 25 26
00 00 00 00 00 00 00	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)		,	0	689, 217 0	24 25 20 20
. 00 . 00 . 00 . 00 . 00 . 00 . 00	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)	0	689, 217 0 689, 217	24 25 26 27 28
00 00 00 00 00 00 00 00 00	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 Total costs - current cost reporting period (line 26 plus l)	0	689, 217 0 689, 217 689, 217	24 25 26 27 28 29
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ine 27))	0 0 0 0	689, 217 0 689, 217 689, 217 0	24 25 26 27 28 28 29 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Total costs - current cost reporting period (line 26 plus I OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ine 27) ons))		689, 217 0 689, 217 689, 217 0 0 0	24 25 26 27 28 29 30 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Total costs - current cost reporting period (line 26 plus I OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	ine 27) ons))		689, 217 0 689, 217 689, 217 0 0 0 0 0	24 25 26 27 28 29 30 30 30 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Total costs - current cost reporting period (line 26 plus I OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment before sequestration Subtotal (see instructions)	ine 27) ons))		689, 217 0 689, 217 689, 217 0 0 0 0 689, 217	24 25 26 27 28 29 30 30 30 30 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Total costs - current cost reporting period (line 26 plus I OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions)	i ne 27) ons) n)		689, 217 0 689, 217 689, 217 0 0 0 689, 217 13, 784	24 25 26 26 26 26 30 30 30 30 30 31 31 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	i ne 27) ons) n)		689, 217 0 689, 217 689, 217 0 0 0 689, 217 13, 784 0	24 25 26 27 28 29 30 30 30 30 31 31 31
. 00 2. 00 3. 00 4. 00 5. 00 5. 00 6. 00 7. 00 3. 00 9. 00 0. 01 0. 02 0. 00	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 Total costs - current cost reporting period (line 26 plus I OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions)	i ne 27) ons) n)		689, 217 0 689, 217 689, 217 0 0 0 689, 217 13, 784 0 675, 433	24 25 26 27 28 29 30 30 30 30 30 31 31 31 31
	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 Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions)	i ne 27) ons) n)		689, 217 0 689, 217 0 689, 217 0 0 0 689, 217 13, 784 0 675, 433 0	22 26 27 28 29 30 30 30 31 31 31 31 32 33

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-1322		eriod:	Worksheet H-5	
) PR	DGRAM BENEFI CI ARI ES	HHA CCN:	15-7177		rom 01/01/2019 o 12/31/2019	Date/Time Prep 6/8/2020 8:34	
					Home Health Agency I	PPS	
		I npati en	it Part A		Par	t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
20	Total interim payments paid to provider	1.00	2.00	0	3.00	4.00	1
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		675, 433 0	1 2
0	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
4	Program to Provider			0		0	_
)1)2				0		0	3
)3				0		0	3
)4				0		0	3
)5	Provider to Program			0		0	3
0				0		0	3
1				0		0	;
52				0		0	3
53 54				0		0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	
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		675, 433	4
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1				Ę
10	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						ć
1	Program to Provider			0		0	Ę
)2				0		0	5
)3				0		0	Ę
0	Provider to Program		1	0		0	-
0 1				0		0	5
2				0		0	Ę
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	Ę
)0)1	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			0		0	e
)2	SETTLEMENT TO PROVIDER			0		0	6
00	Total Medicare program liability (see instructions)			0		675, 433	7
					Contractor Number	NPR Date (Mo/Day/Yr)	
00	Name of Contractor	(0		1.00	2.00	6

Heal th	Financial Systems	PERRY COUNTY	(HOSPI TAL			In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1322		ri od:	Worksheet M-1	
			Component	CCN: 15-8516	Fr To	com 01/01/2019 12/31/2019	Date/Time Pre 6/8/2020 8:34	
						RHC I	Cost	cim
		Compensation	Other Costs	Total (col.	1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
							col. 4)	
		1.00	2.00	3.00		4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	1, 069, 934	0			5, 529		1.00
2.00	Physician Assistant	0	0		0	0	0	2.00
3.00	Nurse Practitioner	207, 163	0		63	0	207, 163	3.00
4.00	Visiting Nurse	0	0		0	0	0	4.00
5.00	Other Nurse	266, 725	0			0	266, 725	5.00
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	169, 292	0			0	169, 292	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 713, 114	0			5, 529	1, 718, 643	10.00
11.00	Physician Services Under Agreement	0	0		0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		-	0	0	14.00
15.00	Medical Supplies	0	7,068 0		80 0	0	7,068	
16.00 17.00	Transportation (Health Care Staff) Depreciation-Medical Equipment	0	0		0	0	0	16.00 17.00
17.00	Professional Liability Insurance	0	0		0	0	0	17.00
18.00	Other Health Care Costs	0	0		0	0	0	18.00
20.00	Allowable GME Costs	0	0		U	0	0	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	7, 068	7,0	68	0	7,068	20.00
22.00	Total Cost of Health Care Services (sum of	1, 713, 114	7,068			5, 529		22.00
22.00	lines 10, 14, and 21)	1,713,114	7,000	1,720,1	02	5, 527	1,725,711	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	53, 913	53, 9	13	0	53, 913	23.00
24.00	Dental	0	0		0	0	0	24.00
25.00	Optometry	0	0		0	0	0	25.00
25.01	Tel eheal th	0	0)	0	0	0	25.01
25.02	Chronic Care Management	0	0		0	0	0	25.02
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs							27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	53, 913	53, 9	13	0	53, 913	
	through 27)							
	FACILITY OVERHEAD							
29.00	Facility Costs	0	0		0	0	0	29.00
30.00	Administrative Costs	152, 444	942, 609	1, 095, 0	53	5, 769	1, 100, 822	30.00
31.00	Total Facility Overhead (sum of lines 29 and	152, 444	942, 609	1, 095, 0	53	5, 769	1, 100, 822	31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	1, 865, 558	1, 003, 590	2, 869, 1	48	11, 298	2, 880, 446	32.00
	and 31)							

ANALYSIS	S OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der (CCN: 15-1322	Peri od:	Worksheet M-	1
			Component	CCN: 15-8516	From 01/01/2019 To 12/31/2019	Date/Time Pro	
					DUC	6/8/2020 8: 3	4 am
					RHC I	Cost	
		Adjustments	Net Expenses for				
			Allocation				
			(col. 5 +				
			col. 6)				
	-	6.00	7.00	-			
F/	ACILITY HEALTH CARE STAFF COSTS			1			
	Physi ci an	0	1,075,46	3			1.00
2.00 P	hysician Assistant	0		o			2.00
3.00 N	lurse Practitioner	0	207, 16	3			3.00
4.00 V	'isiting Nurse	0					4.00
5.00 0)ther Nurse	0	266, 72	5			5.00
6.00 C	linical Psychologist	0		D			6.00
7.00 C	Clinical Social Worker	0		D			7.00
8.00 L	aboratory Techni ci an	0		D			8.00
	Other Facility Health Care Staff Costs	0	169, 29	2			9.00
	Subtotal (sum of lines 1 through 9)	0	1, 718, 64	3			10.00
	Physician Services Under Agreement	0		O			11.00
	Physician Supervision Under Agreement	0					12.00
	other Costs Under Agreement	0		o			13.00
	Subtotal (sum of lines 11 through 13)	0					14.00
	ledi cal Supplies	0	7,06	1			15.00
	ransportation (Health Care Staff)	0		D			16.00
	Depreciation-Medical Equipment	0		D			17.00
	Professional Liability Insurance	0		D			18.00
	ther Health Care Costs	0		D			19.00
	llowable GME Costs		7.0/				20.00
	Subtotal (sum of lines 15 through 20)	0	7,06				21.00
	otal Cost of Health Care Services (sum of	0	1, 725, 71	1			22.00
	i nes 10, 14, and 21) OSTS OTHER THAN RHC/FQHC SERVICES						-
	Pharmacy	0	53, 91	2			23.00
	pental	0		0			23.00
	ptometry	0					24.00
	el eheal th	0					25.00
	Chronic Care Management	0		0			25.02
	I other nonreimbursable costs	0					26.00
	Ional I owable GME costs	0					27.00
	otal Nonreimbursable Costs (sum of lines 23	0	53, 91	3			28.00
	hrough 27)	0	00, 71				20.00
	ACILITY OVERHEAD						1
	acility Costs	0		0			29.00
	dministrative Costs	-10, 369	1, 090, 45	3			30.00
	otal Facility Overhead (sum of lines 29 and	-10, 369	1, 090, 45	1			31.00
	0)						
32. 00 T	otal facility costs (sum of lines 22, 28	-10, 369	2, 870, 07	7			32.00
a	ind 31)						

Heal th	Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-1	
			Component	CCN: 15-8517	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
					RHC II	Cost	
		Compensati on	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00		2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physician	258, 578	0	258, 5	78 -75, 603	182, 975	1.00
2.00	Physi ci an Assi stant	230, 370	0		0 0		2.00
3.00	Nurse Practi ti oner	40, 914	0		0	-	3.00
4.00	Visiting Nurse	40, 714	0			40, 714	4.00
4.00 5.00	Other Nurse	1, 434	0		24 0	1, 434	
6.00	Clinical Psychologist	1, 434	0		0 0		•
	Clinical Social Worker	0	0		0 0	-	
7.00		0	0				7.00
8.00	Laboratory Technician	0	0		0	-	8.00
9.00	Other Facility Health Care Staff Costs	80, 107	0	, .			
10.00	Subtotal (sum of lines 1 through 9)	381, 033	0				•
11.00	Physician Services Under Agreement	0	0		0 0	-	•
12.00	Physician Supervision Under Agreement	0	0		0 0	-	
13.00	Other Costs Under Agreement	0	0		0 0	-	13.00
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	0	0		0 0	0	
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		0 0	0	
22.00	Total Cost of Health Care Services (sum of	381, 033	0	381, 0	33 -75, 603	305, 430	22.00
	lines 10, 14, and 21)						
23.00	COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy	0	87, 568	87, 5	68 0	87, 568	23.00
23.00	Dental	0	٥٦, 500 ۵				23.00
24.00		0	0			-	
25.00 25.01	Optometry Telehealth	0	0				
		0	0			0	
25.02	Chronic Care Management	0	0		-	-	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs		07 5/0	07.5	()	07 5/0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	87, 568	87, 5	68 0	87, 568	28.00
	through 27) FACILITY OVERHEAD						-
20.00		0	0	1	0 0		29.00
29.00	Facility Costs		0				•
30.00	Administrative Costs	48, 789	152, 339				•
31.00	Total Facility Overhead (sum of lines 29 and	48, 789	152, 339	201, 1	28 0	201, 128	31.00
22 00	30) Total facility costs (sum of lines 22, 28	429, 822	239, 907	440 7		E0/ 10/	22 00
32.00	and 31)	429, 822	239,907	669, 7	-75, 603	594, 126	32.00
		I		I	T	I	1

	Financial Systems	PERRY COUNT				u of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Period: From 01/01/2019	Worksheet M-	1
			Component	CCN: 15-8517	To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
					RHC II	Cost	_
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 + col. 6)				
		6.00	7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00	1			
1.00	Physi ci an	0	182, 975				1.00
2.00	Physician Assistant	0		1			2.00
3.00	Nurse Practitioner	0	40, 914				3.00
4.00	Visiting Nurse	0	C				4.00
5.00	Other Nurse	0	1, 434				5.00
6.00	Clinical Psychologist	0	-	1			6.00
7.00	Clinical Social Worker	0	-				7.00
8.00	Laboratory Techni ci an	0					8.00
9.00	Other Facility Health Care Staff Costs	0					9.00
10.00	Subtotal (sum of lines 1 through 9)	0					10.00
11.00	Physician Services Under Agreement	0	-				11.00
12.00 13.00	Physician Supervision Under Agreement Other Costs Under Agreement	0	-				12.00
14.00	Subtotal (sum of lines 11 through 13)	0					14.00
15.00	Medical Supplies	0	-				15.00
16.00	Transportation (Health Care Staff)	0	-				16.00
17.00	Depreciation-Medical Equipment	0	-				17.00
	Professional Liability Insurance	0					18.00
19.00	Other Heal th Care Costs	0	-				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	c c				21.00
22.00	Total Cost of Health Care Services (sum of	0	305, 430				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23.00	Pharmacy	0		1			23.00
24.00	Dental	0	-	1			24.00
25.00 25.01	Optometry Toleboolth	0	-	•			25.00 25.0
25.01	Telehealth Chronic Care Management	0	, °				25.0
26.02	All other nonreimbursable costs	0	-				25.02
27.00	Nonallowable GME costs	0					27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	87, 568				28.00
20.00	through 27)	0	0,,000				20.00
	FACILITY OVERHEAD		•				1
29.00	Facility Costs	0	C				29.00
30.00	Administrative Costs	0	201, 128				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	201, 128				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	594, 126	1			32.00
	and 31)						

Heal th	Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-1	
			Component	CCN: 15-8518	From 01/01/2019 To 12/31/2019		
					RHC III	Cost	
		Compensation	Other Costs	Total (col.	1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	195, 181	195, 18	81 0	195, 181	1.00
2.00	Physician Assistant	0	0		0 0		2.00
3.00	Nurse Practitioner	99, 187	0	99, 1	87 –1, 937	97, 250	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	2, 312	0	2, 3	12 0	2, 312	5.00
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	C)	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)	101, 499	195, 181	296, 6	-1, 937	294, 743	10.00
11.00	Physician Services Under Agreement	0	0		0 0		1
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15.00	Medical Supplies	0	211		11 0	211	
16.00	Transportation (Health Care Staff)	0	211		0 0		1
17.00	Depreciation-Medical Equipment	0	0		0 0	-	
18.00	Professional Liability Insurance	0	0		0 0	-	18.00
19.00	Other Heal th Care Costs	0			0 0	0	
20.00	Allowable GME Costs	0	0		0	0	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	211	2	11 0	211	1
21.00	Total Cost of Health Care Services (sum of	101, 499					
22.00	lines 10, 14, and 21)	101, 499	175, 372	290,0	-1, -1, -1, -1, -1, -1, -1, -1, -1, -1,	294, 934	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23.00	Pharmacy	0	5, 936	5, 9	36 0	5, 936	23.00
24.00	Dental	0	3, 730				1
25.00	Optometry	0	0		0 0	, s	
25.00	Tel eheal th	0	0		0 0		
25.01	Chronic Care Management	0	0		0	0	25.01
26.02	All other nonreimbursable costs	0	0		0 0	0	•
28.00	Nonallowable GME costs	0	U		0 0	0	27.00
27.00	Total Nonreimbursable Costs (sum of lines 23	0	5, 936	5, 9	36 0	5, 936	
26.00	through 27)	0	5, 950	5, 9.	50 0	5, 930	20.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0		0 0	0	29.00
29.00 30.00	Administrative Costs	62, 132					
30.00	Total Facility Overhead (sum of lines 29 and						
31.00	30)	02, 132	02, 739	124,8		124, 0/1	31.00
32.00	Total facility costs (sum of lines 22, 28	163, 631	264, 067	427, 6	-1, 937	425, 761	32.00
52.00	and 31)	100,001	204,007	427,0	1, 757	725,701	52.00
		I I		1	I	1	1

	Financial Systems	PERRY COUNT				u of Form CMS-	
NALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der	CCN: 15-1322	Period: From 01/01/2019	Worksheet M-	1
			Componen	t CCN: 15-8518	To 12/31/2019	Date/Time Pr 6/8/2020 8:3	
					RHC III	Cost	_
		Adjustments	Net Expense	s			
			for				
			Allocation				
			(col. 5 +				
		6. 00	col. 6) 7.00	_			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
. 00	Physi ci an	0	195, 1	81			1.0
2.00	Physician Assistant	0		0			2.0
3.00	Nurse Practitioner	0					3.0
1.00	Visiting Nurse	0		0			4.0
5.00	Other Nurse	0	2,3	12			5.0
6.00	Clinical Psychologist	0		0			6.0
. 00	Clinical Social Worker	0		0			7.0
8.00	Laboratory Techni ci an	0		0			8.0
. 00	Other Facility Health Care Staff Costs	0		0			9.0
0.00	Subtotal (sum of lines 1 through 9)	0	294, 7	43			10.0
1.00	Physician Services Under Agreement	0		0			11. (
2.00	Physician Supervision Under Agreement	0		0			12.
	Other Costs Under Agreement	0		0			13. (
4.00	Subtotal (sum of lines 11 through 13)	0		0			14. (
5.00	Medical Supplies	0	2	11			15.0
	Transportation (Health Care Staff)	0		0			16. (
7.00	Depreciation-Medical Equipment	0		0			17.0
	Professional Liability Insurance	0		0			18.0
	Other Health Care Costs	0		0			19.0
	Allowable GME Costs	0		11			20.0
1.00 2.00	Subtotal (sum of lines 15 through 20) Total Cost of Health Care Services (sum of	0		11			21.0
2.00	lines 10, 14, and 21)	0	294, 9	34			22.0
	COSTS OTHER THAN RHC/FQHC SERVICES						
3.00	Pharmacy	0	5,9	36			23.0
4.00	Dental	0		0			24.0
5.00	Optometry	0		0			25.0
5. 01	Tel eheal th	0		0			25.
5.02	Chronic Care Management	0		0			25.0
6.00	All other nonreimbursable costs	0		0			26.0
7.00	Nonallowable GME costs						27.0
8.00	Total Nonreimbursable Costs (sum of lines 23	0	5,9	36			28.0
	through 27)						
	FACILITY OVERHEAD			-			-
	Facility Costs	0		0			29.0
0.00	Administrative Costs	0					30.0
1.00	Total Facility Overhead (sum of lines 29 and	0	124, 8	/1			31.0
32.00	30) Total facility costs (sum of lines 22, 28	0	425, 7	(1			32.0
		0					

2.00 Physician Assistant 0.00 0 2,100 0 2.00 3.00 3.00 Nurse Practitioner 1.68 6,351 2,100 3,528 3.00 4.00 Subtotal (sum of lines 1 through 3) 3.00 15,211 9,072 15,211 4.00 5.00 Visiting Nurse 0.00 0 0 0 5.00 6.00 Clinical Psychologist 0.00 0 0 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7.02 0 abetee Self Management Training (FQHC 0.00 0 7.02 0.10 Tati FTEs and Visits (sum of lines 4 3.00 15,211 15,211 8.00 9.00 9.00 Physician Services Under Agreements 0 0 9.00 9.00 1.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,725,711 10.00 10.00 1.00 Total costs of health care services (from Wkst. M-1, col. 7, line 23) 1,779,624 12.00	Heal th	Financial Systems	PERRY COUNT	Y HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
Component CCN: 15-8516 To 12/31/2019 Date/Time Prepared: 6/8/2020 8: 34 am Number of FTE Personnel Number of FTE Personnel Total Visits Productivity Minimum Visits (col. 1 x col. 3) Col. Col. 4 1.00 2.00 3.00 4.00 5.00 Positions 1.00 2.00 3.00 4.00 5.00 0.00 Physician Assistant 0.00 0 2.100 0 2.00 3.00 Nurse Practitioner 1.68 6.351 2.100 3.528 3.00 0.00 Visiting Nurse 0.00 0 2.00 0 5.00 0.00 Uisiting Nurse 0.00 0 2.100 3.528 3.00 0.00 0 0.00 0 0.00 0 7.00 1.01 Deterself Management Training (FOHC only) 0.00 0 7.00 0.7.00 1.00 Position 0 0 0 7.00 1.5,211 15,211 0.00 0 0 <t< td=""><td>ALLOCA</td><td>TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC</td><td>SERVI CES</td><td>F</td><td>Provider C</td><td></td><td></td><td>Worksheet M-2</td><td></td></t<>	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	F	Provider C			Worksheet M-2	
Number of FTE Personnel Total Visits Productivity Minimum Visits (col. 1 x col. 3) Greater of col. 2 or col. 4 VISITS AND PRODUCTIVITY Positions 1.00 2.00 3.00 4.00 5.00 1.00 Physician Assistant 1.32 8,860 4,200 5,544 1.00 2.00 Nurse Practitioner 1.68 6,351 2,100 3,528 3.00 3.00 Visiting Nurse 0.00 0 2,100 3,528 3.00 0.00 Colinical Social Worker 0.00 0 0 0.00 0 5.00 0.00 Colinical Social Worker 0.00 0 0 0.00 0 0.00 0 7.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 <td< td=""><td></td><td></td><td></td><td>C</td><td>Component (</td><td></td><td></td><td></td><td></td></td<>				C	Component (
Personnel Standard (1) Visits (col. 1 x col. 3) col. 4 (col. 4) 1.00 2.00 3.00 4.00 5.00 Positions 1.00 2.00 3.00 4.00 5.00 Positions 1.32 8.860 4.200 5.544 1.00 2.00 Physician Assistant 0.00 0 2.100 3.528 3.00 3.00 Nurse Practitioner 1.68 6.351 2.100 3.528 3.00 0.00 Vulsiting Nurse 0.00 0 0 0 5.00 0.01 Subtotal (sum of lines 1 through 3) 3.00 15,211 9.072 15,211 4.00 0.00 0 0 0 0 0 0 5.00 0.01 Iciaal Social Worker 0.00 0 0 0 0 0 0 0 0 7.02 0.01 Jabetes Sel f Management Training (FOHC 0.00 0 0 0 0 0 0							RHC I	Cost	
Image: Note of the second se			Number of FTE	Tota	al Visits	Producti vi ty	Minimum		
I.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Positions 1.00 2.00 3.00 4.00 5.00 Physician Assistant 0.00 0 2.00 5.544 1.00 2.00 Physician Assistant 0.00 0 2.100 3.528 3.00 3.00 Nurse Practitioner 1.68 6.351 2.100 3.528 3.00 0.00 Subtotal (sum of lines 1 through 3) 3.00 15.211 9.072 15.211 4.00 0.00 Clinical Social Worker 0.00 0 0 6.00 6.00 6.00 7.02 Diabetes Self Management Training (FOHC 0.00 0 0 7.02 0 7.02 0 9.00 7.02 0 7.02 0 9.00 9.00 9.00 7.02 0 Dettermination of Lowable Cost of Lowable Cost AppLi CABLE TO HOSPI TAL-BASED RHC/FOHC SERVICES 1.00 1.00 10.00 10.00 10.00 10.00 1.00 1			Personnel			Standard (1)			
VISITS AND PRODUCTIVITY Visit solutions 1.00 Physician 1.32 8.860 4.200 5.544 1.00 2.00 Physician Assistant 0.00 0 2.100 0 2.00 3.00 Nurse Practitioner 1.68 6.351 2.100 3.528 3.00 5.00 Visiting Nurse 0.00 0 0 9.072 15.211 4.00 5.00 Visiting Nurse 0.00 0 0 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00									
Positions Positions 1.00 Physician Assistant 1.32 8,860 4,200 5,544 1.00 2.00 Physician Assistant 0.00 0 2,100 0 2.00 3.00 Nurse Practitioner 1.68 6,351 2,100 3,528 3.00 4.00 Subtotal (sum of lines 1 through 3) 3.00 15,211 9,072 15,211 4.00 5.00 Visiting Nurse 0.00 0 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 0 0 5.00 0 0 5.00 0			1.00		2.00	3.00	4.00	5.00	
1.00 Physician 1.32 8,860 4,200 5,544 1.00 2.00 Physician Assistant 0.00 0 2,100 0 2.00 3.00 Nurse Practitioner 1.68 6,351 2,100 3,528 3.00 4.00 Subtotal (sum of lines 1 through 3) 3.00 15,211 9,072 15,211 4.00 5.00 Visiting Nurse 0.00 0 0 0 6.00 0 6.00 0 6.00 0 6.00 0 0 6.00 0 0 0 6.00 0									
2.00 Physician Assistant 0.00 0 2,100 0 2.00 3.00 Nurse Practitioner 1.68 6,351 2,100 3,528 3.00 4.00 Subtotal (sum of lines 1 through 3) 3.00 15,211 9,072 15,211 4.00 5.00 Visiting Nurse 0.00 0							- T		
3.00 Nurse Practitioner 1.68 6,351 2,100 3,528 3.00 4.00 Subtotal (sum of lines 1 through 3) 3.00 15,211 9,072 15,211 4.00 5.00 Visiting Nurse 0.00 0 0 6.00 0 6.00 0 0 6.00 0 0 6.00 0 0 6.00 0 0 0 0 6.00 0					8, 860				1.00
4.00 Subtotal (sum of lines 1 through 3) 3.00 15,211 9,072 15,211 4.00 5.00 Visiting Nurse 0.00 0 0 5.00 6.00 Clinical Psychologist 0.00 0 0 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7.01 0 7.02 0 blaetes Sel f Management Training (FOHC 0.00 0 0 0 7.02 8.00 Total FTEs and Visits (sum of lines 4 3.00 15,211 15,211 8.00 9.00 Physician Services Under Agreements 0 0 9.00 9.00 9.00 Physician Services Under Agreements 0 10.00 10.00 10.00 Total costs of heal th care services (from Wkst. M-1, col. 7, line 22) 1,725,711 10.00 53,913 11.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 1,779,624 12.00 53,913 11.00 12.00 Cost of all services (excluding overhead) (sum of lines	2.00				•				2.00
5.00 Visiting Nurse 0.00 0 0 5.00 6.00 Clinical Psychologist 0.00 0 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 7.00 0 7.00 0 7.00 0 7.01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 7.01 0 7.01 0 7.01 0 7.01 0 7.01 0 7.01 0 7.01 0 7.01 0	3.00	Nurse Practitioner	1.68	3	6, 351	2, 10			3.00
6.00 Clinical Psychologist 0.00 0 0 0 6.00 0 0 0 0 0 0 0 0 0 0 7.00 0 9.00 0 9.00 0 9.00 0	4.00				15, 211		9, 072	15, 211	4.00
7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7.01 7.02 Diabetes Self Management Training (FOHC only) 0.00 0 0 7.02 8.00 Total FTEs and Visits (sum of lines 4 through 7) 3.00 15,211 15,211 8.00 9.00 Physician Services Under Agreements 0 0 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of heal th care services (from Wkst. M-1, col. 7, line 22) 1,725,711 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 53,913 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,725,711 10.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0.969705 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 1,090,453 14.00 15.00 Parent provider overhead (sum of lines 14 and 15) 2,225,774 15.00 17.00 Allowable GME overhead (s	5.00				0			0	5.00
7.01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 7.01 7.02 Diabetes Sel f Management Training (FQHC only) 0.00 0 0 0 7.02 8.00 Total FTEs and Visits (sum of lines 4 3.00 15,211 15,211 15,211 8.00 9.00 Physician Services Under Agreements 0 0 0 9.00 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1, 725, 711 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 53, 913 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1, 779, 624 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0, 969705 13.00 14.00 Total overhead allocated to facility (see instructions) 1, 135, 321 15.00 16.00 Total overhead (sum of lines 14 and 15) 2, 225, 774 16.00 17.01 Kib ei instructions) 0 0, 70.00 17.00 18.00 Enter the amou	6.00	Clinical Psychologist	0.00)	0			0	6.00
7. 02 Diabetes Self Management Training (F0HC 0.00 0 0 0 7.02 8. 00 Total FTEs and Visits (sum of lines 4 3.00 15,211 15,211 15,211 8.00 9. 00 Physician Services Under Agreements 0 0 9.00 9.00 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 1.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 1,779,624 12.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,779,624 12.00 13.00 Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12) 0.969705 13.00	7.00	Clinical Social Worker	0.00	D	0			0	7.00
onlyy Total FTEs and Visits (sum of lines 4 through 7) 3.00 15,211 15,211 8.00 9.00 Physician Services Under Agreements 0 0 9.00 9.00 Physician Services Under Agreements 0 0 9.00 9.00 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 0 9.00 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,725,711 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 53,913 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,779,624 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0.969705 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 1,135,321 15.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,135,321 15.00 16.00 Total overhead (sum of lines 14 and 15) 2,225,774 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16	7.01		0.00	D	0			0	7.01
8.00 Total FTEs and Visits (sum of lines 4 through 7) 3.00 15,211 15,211 8.00 9.00 Physician Services Under Agreements 0 0 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,725,711 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 53,913 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,779,624 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0.969705 13.00 14.00 Total overhead allocated to facility (see instructions) 1,135,321 15.00 15.00 Parent provider overhead (sum of lines 14 and 15) 2,225,774 16.00 17.00 Allowable GME overhead (see instructions) 0 0 0 18.00 Enter the amount from line 16 2,225,774 18.00	7.02	Diabetes Self Management Training (FQHC	0.00	D	0			0	7.02
9.00 Physician Services Under Agreements 0 0 9.00 9.00 Physician Services Under Agreements 0 0 9.00 9.00 9.00 Determination Determination 0 0 9.00 9.00 Determination Determination 0 0 9.00 Determination Determination 0 9.00 Determination Determination 1.00 0 Dotal costs of health care services (from Wkst. M-1, col. 7, line 22) 1,725,711 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 53,913 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,779,624 12.00 13.00 Ratio of hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 0.969705 13.00 14.00 Total overhead (sum of lines 14 and 15) 1,135,321 15.00 15.00 Parent provider overhead (see instructions) 0 17.00 16.00 Total overhead (see instructions) 0 17.00 18									
9.00 Physician Services Under Agreements 0 0 9.00 9.00 Determination of Allowable Cost Applicable To Hospital-Based RHC/FOHC SERVICES 1.00 1.725,711 10.00 1.00 1.00 1.775,624 12.00 1.00 1.779,624 12.00 1.00 1.00 1.00 1.00,90,453 14.00 1.00 1.135,321 15.00 1.135,321 15.00 1.135,321 15.00 1.135,321 15.00 1.135,321 15.00 1.135,321 15.00<	8.00	Total FTEs and Visits (sum of lines 4	3.00	D	15, 211			15, 211	8.00
Image: Colspan="2">Image: Colspan="2" Image: Colspan="2" Imag									
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES10.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)1,725,71110.0011.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)53,91311.0012.00Cost of all services (excluding overhead) (sum of lines 10 and 11)1,779,62412.0013.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)0.96970513.0014.00Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)1,090,45314.0015.00Parent provider overhead (sum of lines 14 and 15)2,225,77416.0017.00Allowable GME overhead (see instructions)017.0018.00Enter the amount from line 162,225,77418.00	9.00	Physician Services Under Agreements			0			0	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES10.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)1,725,71110.0011.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)53,91311.0012.00Cost of all services (excluding overhead) (sum of lines 10 and 11)1,779,62412.0013.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)0.96970513.0014.00Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)1,090,45314.0015.00Parent provider overhead (sum of lines 14 and 15)2,225,77416.0017.00Allowable GME overhead (see instructions)017.0018.00Enter the amount from line 162,225,77418.00								1 00	
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11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 53,913 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,779,624 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 0.969705 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 1,090,453 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,135,321 15.00 16.00 Total overhead (sum of lines 14 and 15) 2,225,774 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 2,225,774 18.00	10.00							1, 725, 711	10.00
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,779,624 12.00 13.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 0.969705 13.00 14.00 Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 1,090,453 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,135,321 15.00 16.00 Total overhead (sum of lines 14 and 15) 2,225,774 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 2,225,774 18.00									
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14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 1,090,453 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,135,321 15.00 16.00 Total overhead (sum of lines 14 and 15) 2,225,774 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 2,225,774 18.00									
15.00 Parent provider overhead allocated to facility (see instructions) 1,135,321 15.00 16.00 Total overhead (sum of lines 14 and 15) 2,225,774 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 2,225,774 18.00						ne 31)			
16.00 Total overhead (sum of lines 14 and 15) 2,225,774 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 2,225,774 18.00									
17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 2,225,774 18.00			-, (000 1.10tru						
18.00 Enter the amount from line 16 2,225,774 18.00									
			MC services (1	ine 1	3 x line	18)			

 19.00
 Overhead applicable to hospital-based RhC/Func services (time is x time is)
 2, 100, 344
 17.00

 20.00
 Total allowable cost of hospital-based RHC/FUNC services (sum of lines 10 and 19)
 3, 884, 055
 20.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPIT	AL		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Prov	vider C		Period: From 01/01/2019	Worksheet M-2	
			Comp	onent		To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
						RHC II	Cost	
		Number of FTE	Total '	Visits	Producti vi ty		Greater of	
		Personnel			Standard (1)	Visits (col.	col. 2 or	
						1 x col. 3)	col. 4	
		1.00	2.	00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY							
	Posi ti ons	-	-			-		
1.00	Physi ci an	0. 25		1, 518				1.00
2.00	Physician Assistant	0.00	1	0	2, 10			2.00
3.00	Nurse Practitioner	0.46	1	1, 911	2, 10			3.00
4.00	Subtotal (sum of lines 1 through 3)	0.71		3, 429		2, 016	3, 429	4.00
5.00	Visiting Nurse	0.00	1	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. 71		3, 429			3, 429	8.00
	through 7)							
9.00	Physician Services Under Agreements			0			0	9.00
							1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BAS	ED RHC/F	OHC SEI	RVICES		1.00	
10.00	Total costs of health care services (from W	kst. M-1, col.	7, line	22)			305, 430	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1	, col. 7, line .	28)	,			87, 568	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10	and 11))			392, 998	12.00
13.00	Ratio of hospital-based RHC/FQHC services (0. 777180	
14.00	Total hospital-based RHC/FQHC overhead - (f				ine 31)		201, 128	
15.00	Parent provider overhead allocated to facil				,		223, 753	
16.00	Total overhead (sum of lines 14 and 15)	5	- /				424, 881	
							0	
18.00	Enter the amount from line 16						424, 881	
	Overhead applicable to hospital-based RHC/F	QHC services (1	ine 13 >	k line '	18)		330, 209	

20. 00 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)

Heal th	Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provider C		Period: From 01/01/2019	Worksheet M-2	
			Component		To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
					RHC III	Cost	an
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions			1			
1.00	Physi ci an	0.09					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	0.60					3.00
4.00	Subtotal (sum of lines 1 through 3)	0.69			1, 638		4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00				0	7.02
8.00	only) Total FTEs and Visits (sum of lines 4	0.69	2, 734			2, 734	8.00
0.00	through 7)	0.09	2,734	r -		2,734	0.00
9.00	Physician Services Under Agreements					0	9.00
7.00	Thysteran services under Agreements			/		0	7.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SE	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			294, 954	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					5, 936	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			300, 890	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 980272	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. I	M-1, col. 7, I	ine 31)		124, 871	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			137, 596	15.00
16.00	Total overhead (sum of lines 14 and 15)					262, 467	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					262, 467	18.00
19.00	Overhead applicable to hospital-based RHC/FC	DHC services (I	ine 13 x line	18)		257, 289	19.00

 19.00
 Overhead applicable to hospital-based RhC/FQHC services (sum of lines 10 and 19)
 207, 207, 17.00

 20.00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 552, 243

			3
Component CCN: 15-8516	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 8:34	
Title XVIII	RHC I	Cost	
		1.00	
m Wkot M 2 Line 20)		2 004 055	1 1
ne is)			
line 9)			
		-	
		247.08	
	Cal cul ati on	of Limit (1)	
	Prior to Jan.	On or After	
	1 (Rate	Jan. 1 (Rate	
	Period 1)	Period 2)	
	1.00	2.00	
.6 or your contractor)			
	247.08	247.08	9.
contractor records)	0	2 402	1 10
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	-	-	
		0	15.
·	0	840, 566	
cords)		908, 121	16.
ider's records)		81, 769	16.
line 16)		75, 686	16.
3 and 18) times .80)		556, 052	16.
		(a	
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(from contractor		-	
		07,015	10.
ns) (from contractor		151 302	19.
		,	
		631, 738	20.
M-4, line 16)		56, 156	21.
		687, 894	
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ructions)		-	
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02, 27, and 28)		-135, 322	
nce with CMS Pub. 15-II	,	0	30.
	Title XVIII Title XVIII m Wkst. M-2, line 20) ne 15) line 9) .6 or your contractor) contractor records) 9 x line 10) actor records) ne 12)) s) and 3) * cords) ider's records) line 16) 3 and 18) times .80) (from contractor ns) (from contractor M-4, line 16) ructions) s) 02, 27, and 28)	Title XVIIIRHC Im Wkst. M-2, line 20) ne 15)Cal cul ation of Prior to Jan. 1 (Rate Period 1)line 9)Cal cul ation of Prior to Jan. 1 (Rate Period 1)6 or your contractor)83.45 247.08contractor records) 9 x line 10) actor records) ne 12) 0) s) and 3) * cords) ider's records) line 16) 3 and 18) times .80)0 o 0 0 0(from contractor ms) (from contractor0 0 0M-4, line 16) s)0xuctions) s)0	Title XVIII RHC I Cost 1.00 1.00 m Wkst. M-2, line 20) 3,884,055 ne 15) 3,758,320 11ine 9) 15,211 Cal culation of Limit (1) Pri or to Jan. 1 (Rate Period 1) On or After Jan. 1 (Rate Period 2) Contractor records) 0 9 x line 10) 0 actor records) 0 0) 0 sand 3) * 0 cords) 0 ider's records) 0 1ine 16) 556,052 0 631,738 0 631,738 0 631,738 0 631,738 0 631,738 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

	Financial Systems PERRY COUNTY H ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CE			From 01/01/2019	WULKSHEEL W-3)
		Component CCN: 15-8517	To 12/31/2019		
		Title XVIII	RHC II	6/8/2020 8: 34	am
			KIIC II	Cost	
				1.00	<u> </u>
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
. 00 [Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		635, 639	1
1	Cost of vaccines and their administration (from Wkst. M-4, Ii	ne 15)		16, 355	
	Total allowable cost excluding vaccine (line 1 minus line 2)			619, 284	
	Total Visits (from Wkst. M-2, column 5, line 8)			3, 429	
	Physicians visits under agreement (from Wkst. M-2, column 5, Tatal adjusted visits (line 4 plus line 5)	line 9)		0	
	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			3, 429 180. 60	
00	Augusted cost per visit (The 5 divided by The 0)		Cal cul ati on		
				01 <u>2</u> 1 m t (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	
00	Der visit navmant limit (from CNS Dub 100.04 sharter 0.520	A or your contractor	1.00	2.00 84.70	0
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	. o or your contractor)	83.45 180.60	180.60	
	CALCULATION OF SETTLEMENT		100.00	100.00	1 1
	Program covered visits excluding mental health services (from	contractor records)	0	167	1 10
	Program cost excluding costs for mental health services (line		0	30, 160	
2.00	Program covered visits for mental health services (from contr	actor records)	0	0	
3.00	Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13
	Limit adjustment for mental health services (see instructions	·	0	0	
	Graduate Medical Education Pass Through Cost (see instruction				15
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	30, 160	
	Total program charges (see instructions) (from contractor's re			42, 388	
	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times			3, 589 2, 554	
	Total Program non-preventive costs ((line 16 minus lines 16.0	-		18, 109	
	(Titles V and XIX see instructions.)			,	
6. 05	Total program cost (see instructions)		0	20, 663	16
	Primary payer amounts			0	
8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		4, 970	18
0 00	records)			/ 7//	10
	Beneficiary coinsurance for RHC/FQHC services (see instructio records)	ons) (from contractor		6, 766	19
	Net Medicare cost excluding vaccines (see instructions)			20, 663	20
	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		1, 404	
2.00	Total reimbursable Program cost (line 20 plus line 21)	. ,		22, 067	
3.00	Allowable bad debts (see instructions)			0	23
1	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	IS)		0	
5.50	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 22, 067	
5.50 5.99				441	
5.50 5.99 6.00					
5.50 5.99 6.00 6.01	Sequestration adjustment (see instructions)			0	26
5.50 5.99 6.00 6.01 6.02					
5.50 5.99 6.00 6.01 6.02 7.00	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	27
5.50 5.99 6.00 6.01 6.02 7.00 8.00	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments	02, 27, and 28)		0 29, 891	27 28

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	OSPITAL Provider CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVICES		From 01/01/2019	WOLKSHEET M S	
	Component CCN: 15-8518	To 12/31/2019		
	Title XVIII	RHC III	6/8/2020 8:34 Cost	am
	II the Aviii		0031	
		-	1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		552, 243	1.
.00 Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		66, 177	2.
.00 Total allowable cost excluding vaccine (line 1 minus line 2)			486, 066	
.00 Total Visits (from Wkst. M-2, column 5, line 8)			2, 734	
.00 Physicians visits under agreement (from Wkst. M-2, column 5, .00 Total adjusted visits (line 4 plus line 5)	Tine 9)		0 2, 734	5. 6.
.00 Total adjusted visits (line 4 plus line 5) .00 Adjusted cost per visit (line 3 divided by line 6)			177.79	
		Cal cul ati on		/.
		our our attron		
		Prior to Jan.	On or After	
		1 (Rate	Jan. 1 (Rate	
		Period 1)	Period 2)	
00 Des visit severent limit (from CNC Dub 100 04 starter 0 500		1.00	2.00	0
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 .00 Rate for Program covered visits (see instructions)	. 6 or your contractor)	83. 45 177. 79	84. 70 177. 79	
CALCULATION OF SETTLEMENT		1//./7	177.77	7.
0.00 Program covered visits excluding mental health services (from	contractor records)	0	515	10.
1.00 Program cost excluding costs for mental health services (line		0	91, 562	
2.00 Program covered visits for mental health services (from contr	,	0	0	
3.00 Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.
4.00 Limit adjustment for mental health services (see instructions		0	0	
5.00 Graduate Medical Education Pass Through Cost (see instruction	-			15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	91, 562	
6.01 Total program charges (see instructions)(from contractor's re			94, 447	
6.02 Total program preventive charges (see instructions)(from prov 6.03 Total program preventive costs ((line 16.02/line 16.01) times			2, 040 1, 978	
6.04 Total Program non-preventive costs ((The 10.02711) 10.07) thies			63, 343	
(Titles V and XIX see instructions.)			00,010	10.
6.05 Total program cost (see instructions)		0	65, 321	16.
7.00 Primary payer amounts			0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		10, 405	18.
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		16, 401	19.
records) 0.00 Net Medicare cost excluding vaccines (see instructions)			65, 321	20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		50, 567	20.
2.00 Total reimbursable Program cost (line 20 plus line 21)			115, 888	
3.00 Allowable bad debts (see instructions)			0	23
3.01 Adjusted reimbursable bad debts (see instructions)			0	23
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50 Pioneer ACO demonstration payment adjustment (see instruction	IS)		0	
5.99 Demonstration payment adjustment amount before sequestration			0 115 000	
6.00 Net reimbursable amount (see instructions)6.01 Sequestration adjustment (see instructions)			115, 888 2, 318	
6.02 Demonstration payment adjustment amount after sequestration			2, 310	
7.00 Interim payments			66, 638	
8.00 Tentative settlement (for contractor use only)			00,000	
9.00 Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		46, 932	
0.00 Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-II	,	0	30.
chapter I, §115.2				1

Heal th	Financial Systems PERRY COUNTY H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1322	Peri od:	Worksheet M-4	
VACCIN	E COST	Component CCN: 15-8516	From 01/01/2019 To 12/31/2019		
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 718, 643		
2.00	Ratio of pneumococcal and influenza vaccine staff time to to				
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	1, 469	29, 057	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (1	rom your records)	6, 982	18, 357	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	us line 4)	8, 451	47, 414	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	neet M-1, col. 7, line 22) 1, 725, 711	1, 725, 711	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2, 158, 344	2, 158, 344	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	otal direct cost (line 5	0. 004897	0. 027475	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	10, 569	59, 301	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	19, 020	106, 715	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	s (from your records)	32	633	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line	10/line 11)	594.38	168.59	12.00
13.00	Number of pneumococcal and influenza vaccine injections admir beneficiaries	nistered to Program	23	252	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (1 (line 12 x line 13)	their) administration	13, 671	42, 485	14.00
15.00				125, 735	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this	its (their)		56, 156	16.00
	line 21)		1		

Health Financial Systems PER	RRY COUNTY H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND	I NFLUENZA	Provider CCN: 15-1322	Period:	Worksheet M-4	
VACCI NE COST		Component CCN: 15-8517	From 01/01/2019 To 12/31/2019		
		Title XVIII	RHC II	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00 Health care staff cost (from Wkst. M-1, col. 7, li	,		305, 430		
2.00 Ratio of pneumococcal and influenza vaccine staff					
3.00 Pneumococcal and influenza vaccine health care sta	•	,	2, 688		3.00
4.00 Medical supplies cost - pneumococcal and influenza	•	5	2, 061		
5.00 Direct cost of pneumococcal and influenza vaccine	· ·	,	4, 749		
6.00 Total direct cost of the hospital-based RHC/FQHC ((from Worksh	eet M-1, col. 7, line 22			
7.00 Total overhead (from Wkst. M-2, line 19)			330, 209		
8.00 Ratio of pneumococcal and influenza vaccine direct divided by line 6)	t cost to to	tal direct cost (line 5	0. 015549	0. 010182	8.00
9.00 Overhead cost - pneumococcal and influenza vaccine	e (line 7 x	line 8)	5, 134	3, 362	9.00
10.00 Total pneumococcal and influenza vaccine cost and lines 5 and 9)	its (their)	administration (sum of	9, 883	6, 472	10.00
11.00 Total number of pneumococcal and influenza vaccine	e injections	(from your records)	78	49	11.00
12.00 Cost per pneumococcal and influenza vaccine inject	tion (line 1	0/line 11)	126. 71	132.08	12.00
13.00 Number of pneumococcal and influenza vaccine inject beneficiaries	ctions admin	istered to Program	9	2	13.00
14.00 Program cost of pneumococcal and influenza vaccine (line 12 x line 13)	e and its (t	heir) administration	1, 140	264	14.00
15.00 Total cost of pneumococcal and influenza vaccine a of cols. 1 and 2, line 10) (transfer this amount t				16, 355	15.00
16.00 Total Program cost of pneumococcal and influenza v administration (sum of cols. 1 and 2, line 14) (tr line 21)	vacci ne and	its (their)		1, 404	16.00

Health Financial Systems PERRY C	OUNTY HOSPITAL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFL	JENZA Provider CCN: 15-1322	Peri od:	Worksheet M-4	
VACCINE COST	Component CCN: 15-8518			
	Title XVIII	RHC III	Cost	
		Pneumococcal	I nfl uenza	
		1.00	2.00	
1.00 Health care staff cost (from Wkst. M-1, col. 7, line 1		294, 743		
2.00 Ratio of pneumococcal and influenza vaccine staff time				
3.00 Pneumococcal and influenza vaccine health care staff of	cost (line 1 x line 2)	3, 800	3, 286	3.00
4.00 Medical supplies cost - pneumococcal and influenza vac	cine (from your records)	25, 641	2, 618	4.00
5.00 Direct cost of pneumococcal and influenza vaccine (lir	e 3 plus line 4)	29, 441	5, 904	5.00
6.00 Total direct cost of the hospital-based RHC/FQHC (from	Worksheet M-1, col. 7, line	22) 294, 954	294, 954	6.00
7.00 Total overhead (from Wkst. M-2, line 19)		257, 289	257, 289	7.00
8.00 Ratio of pneumococcal and influenza vaccine direct cos divided by line 6)	t to total direct cost (line	5 0.099816	0. 020017	8.00
9.00 Overhead cost - pneumococcal and influenza vaccine (li	ne 7 x line 8)	25, 682	5, 150	9.00
10.00 Total pneumococcal and influenza vaccine cost and its lines 5 and 9)	(their) administration (sum o	of 55, 123	11, 054	10.00
11.00 Total number of pneumococcal and influenza vaccine inj	ections (from your records)	111	96	11.00
12.00 Cost per pneumococcal and influenza vaccine injection	(line 10/line 11)	496.60	115.15	12.00
13.00 Number of pneumococcal and influenza vaccine injection beneficiaries	s administered to Program	90	51	13.00
14.00 Program cost of pneumococcal and influenza vaccine and (line 12 x line 13)	lits (their) administration	44, 694	5, 873	14.00
15.00 Total cost of pneumococcal and influenza vaccine and i of cols. 1 and 2, line 10) (transfer this amount to W		IM	66, 177	15.00
16.00 Total Program cost of pneumococcal and influenza vacci administration (sum of cols. 1 and 2, line 14) (transf line 21)	ne and its (their)		50, 567	16.00

Hoal th	Financial Systems PERRY COUNTY		Inlie	u of Form CMS-2	552-10
	SIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provi der CCN: 15-1322	Peri od:	Worksheet M-5	332 10
	CES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2019		
OLIVIT		Component CCN: 15-8516	To 12/31/2019		
			500	6/8/2020 8: 34	am
			RHC I	Cost	
				t B	
				Amount	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1.00	2.00 691,758	1.00
2.00	Interim payments payable on individual bills, either submit	tod or to be submitted to		091,758	2.00
2.00	the contractor for services rendered in the cost reporting			0	2.00
	"NONE" or enter a zero	period. In none, write			
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01			08/29/2019	117, 700	3.01
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	3.51
3.52				0	3.52
3. 53 3. 54				0	3.53 3.54
3. 94 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	08)		117, 700	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		_	809, 458	4.00
4.00	27)			007,400	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	k review. Also show date o	of		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		÷		
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program			-	
5.50				0	5.50
5.51				0	5.51
5.52 5.99	Subtatel (sum of lines E 01 E 40 minus sum of lines E 50 E	00)		0	5.52 5.99
5.99 6.00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the			0	5.99 6.00
6.00 6.01	SETTLEMENT TO PROVIDER			0	6.00 6.01
6.02	SETTLEMENT TO PROGRAM			135, 322	6.02
7.00	Total Medicare program liability (see instructions)			674, 136	7.00
7.00			Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

Health Financial Systems PERRY COU	NTY HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1322	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2019		
	Component CCN: 15-8517	To 12/31/2019		
			6/8/2020 8:34	am
		RHC I I	Cost	
			rt B	
		mm/dd/yyyy	Amount	
		1.00	2.00	1 00
1.00 Total interim payments paid to hospital-based RHC/FQHC			29, 891	1.00
2.00 Interim payments payable on individual bills, either sub		D	0	2.00
the contractor for services rendered in the cost reporti	ng period. It none, write			
"NONE" or enter a zero				
3.00 List separately each retroactive lump sum adjustment amo				3.00
revision of the interim rate for the cost reporting peri	od. Also show date of each			
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider			-	
3. 01			0	
3. 02			0	
3. 03			0	
3. 04			0	
3. 05			0	3.05
Provider to Program				
3. 50			0	3.50
3. 51			0	
3. 52			0	3.52
3. 53			0	
3. 54			0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50	-3.98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (tr	ansfer to Worksheet M-3, lir	ne	29, 891	4.00
27)				
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after	desk review. Also show date	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
5. 01			0	5.01
5. 02			0	
5. 03			0	5.03
Provider to Program				
5. 50			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 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	• • • •		0	6.01
6.02 SETTLEMENT TO PROGRAM			8, 265	6.02
7.00 Total Medicare program liability (see instructions)			21, 626	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	
				8.00

Health Fir	nancial Systems PERRY COUNT	Y HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
		Provider CCN: 15-1322	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES			From 01/01/2019 To 12/31/2019	Date/Time Prepared:	
			RHC III	6/8/2020 8: 34 Cost	am
				rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00 Tot	tal interim payments paid to hospital-based RHC/FQHC		1.00	66, 638	1.00
2.00 Int the	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	2.00
3.00 Lis rev	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
	gram to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	ovider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54 3.99 Sub	statel (sum of lines 2.01.2.40 minus sum of lines 2.50.3	2 08)		0	3.54 3.99
				66, 638	3.99 4.00
4.00 101		ISTEL LO WOLKSHEEL M-3, TITLE		00, 030	4.00
	BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Pro	gram to Provider				
5.01				0	5.01
5.02				0	5.02
5.03	· · · · -			0	5.03
	vider to Program				
5.50				0	5.50
5. 51 5. 52				0	5.51 5.52
	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	5.5∠ 5.99
	Determined net settlement amount (balance due) based on the cost report. (1)				5.99 6.00
	SETTLEMENT TO PROVIDER			46, 932	6.00
	ITLEMENT TO PROGRAM			40, 752	6.02
	tal Medicare program liability (see instructions)			113, 570	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8.00 Nam	ne of Contractor				8.00