This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1322 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/23/2023 1:34 pm] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PERRY COUNTY HOSPITAL (15-1322) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Randall Russell		ı	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Randall Russell			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1. 00 HOSPI TAL	0	328, 451	-268, 738	0	0	1.00
2. 00 SUBPROVI DER - I PF	0	0	0		0	2.00
3. 00 SUBPROVI DER - I RF	0	0	0		0	3.00
5. 00 SWING BED - SNF	0	303, 746	0		0	5. 00
6.00 SWING BED - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC - TCC I	0		17, 415		0	10.00
10.01 RURAL HEALTH CLINIC II - PCFP	0		3, 061		0	10. 01
10.02 RURAL HEALTH CLINIC III - 13TH	0		2, 535		0	10.02
10.03 RURAL HEALTH CLINIC IV - SPENCER	0		23, 887		0	10. 03
200. 00 TOTAL	0	632, 197	-221, 840	0	0	200.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1322 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 1:34 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 8885 SR 237 PO Box: X 1.00 Zi p Code: 47586 2.00 City: TELL CITY State: IN County: PERRY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal PERRY COUNTY HOSPITAL 151322 99915 07/01/2004 Ν 0 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF PERRY COUNTY HOSPITAL 15Z322 99915 07/01/2004 N 0 N 7.00 SWI NG 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital -Based Health Clinic - RHC TELL CITY CLINIC 158516 99915 15 00 05/18/2015 N Λ N 15 00 Hospital-Based Health Clinic - RHC PERRY CO FAMILY 158517 99915 05/19/2015 Ν 15.01 15.01 0 PRACTI CE Hospital -Based Health Clinic - RHC PERRY CO SURG - 13TH ST 158560 99915 0 N 15.02 15.02 03/24/2021 N 1111 15.03 Hospital -Based Health Clinic - RHC SPENCER CO CLINIC 158562 99915 03/24/2021 Ν 0 Ν 15.03 ١V Hospital -Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 9 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for Ν 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Heal th	Financial Systems PERRY C	COUNTY HOS	PI TAL			In Lieu	of For	m CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	A F	Provi der CC	CN: 15-1322	Period: From 01/0 To 12/3	01/2022 81/2022	Part I	eet S-2 ime Pre	
					10 127	,1,2022		023 1: 3	
23. 00	Which method is used to determine Medicaid days on lin	uos 24 and	/or 25	1.00	2.	00	3.	00	23.00
23.00	which method is used to determine medical days on the below? In column 1, enter 1 if date of admission, 2 if if date of discharge. Is the method of identifying the reporting period different from the method used in the reporting period? In column 2, enter "Y" for yes or "	census de days in e prior co	ays, or 3 this cost st		2 1	N			23.00
	N	n-State Medicaid aid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Me	ther di cai d days	
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
	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state	0	0		0		0		25. 00
	Medicaid paid days in column 1, the in-state Medicaid paid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	J	· ·	O					
					1.	Rural S 00	Date of 2.		
26. 00	Enter your standard geographic classification (not wag cost reporting period. Enter "1" for urban or "2" for		at the be	ginning of	the	2			26. 00
27. 00	Enter your standard geographic classification (not wag reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassific	e) status "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.			CH status i	n Begi n	0 ni na:	Endi	na:	35.00
24 00	5.1			24 6	1.		2.		24.00
	Enter applicable beginning and ending dates of SCH sta of periods in excess of one and enter subsequent dates If this is a Medicare dependent hospital (MDH), enter	i.	•			0			36. 00 37. 00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for								37. 01
38. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
	enter subsequent dates.				Υ,		Υ/		
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 th accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii	(ii), or ne mileage	(iii)? En requireme	ter in colu nts in	mn		2. N		39.00
40. 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobe no in column 2, for discharges on or after October 1.	er 1. Ente	r "Y" for			ı	١	I	40.00
		(See Thist	r uctrons)			V 1. 00	XVIII 2. 00		
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment	for disp	roporti ona	te share in	accordance	e N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excep pursuant to 42 CFR §412.348(f)? If yes, complete Wkst.					N	N	N	46.00
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS ca Is the facility electing full federal capital payment?	•		•		N N	N N	N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in a	pproved G	ME program	s? For cost	reporting	N			56.00
	periods beginning prior to December 27, 2020, enter "Y cost reporting periods beginning on or after December the instructions. For column 2, if the response to colinvolved in training residents in approved GME program and are you are impacted by CR 11642 (or applicable CR "Y" for yes; otherwise, enter "N" for no in column 2.	for yes 27, 2020, umn 1 is as in the	or "N" fo under 42 "Y", or if prior year	r no in col CFR 413.78(this hospi or penulti	umn 1. For b)(2), see tal was mate year,				

		HOSPI TAL	ON 45 4000		eu of Form CMS-	
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA 	Provi der CC		Peri od: From 01/01/202: To 12/31/202:	Date/Time Pre 5/23/2023 1:3	epared
				1. (+
For cost reporting periods beginning prior to Decemb is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not compl 15 line 56 is yes, did this facility elect cost reim	reside n column cost re e Works applica R 413.7 on dut ete col	nts in approve n 1. If column porting period heet E-4. If c able. For cost 7(e)(1)(iv) a y, if the resp umn 2, and com	ed GME program 1 1 is "Y", di 1? Enter "Y" column 2 is "! reporting per ind (v), regal conse to line aplete Workshe	is yes, as trained d for yes or "", eriods dless of 56 is "Y" eet E-4.		57.
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 9.00 Are costs claimed on line 100 of Worksheet A? If ye	comple	te Wkst. D-5.		N		59.
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
	Z212:		1.00	2.00	3. 00	
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent adjustment? Enter "Y" for yes or "N" for no in colu	.85? (: lumn 1. CR) NAH	see If column 1	N			60.
judjustilient: Enter 1 for yes of 14 for 16 fill enter	Y/N	I ME	Direct GME	I ME	Direct GME	
1 00 Did complemental	1.00	2. 00	3. 00	4. 00	5. 00] , .
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care	N			0.0	0.00	61.
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 1.02 Enter the current year total unweighted primary care						61.
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) .03 Enter the base line FTE count for primary care						61.
and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) .04 Enter the number of unweighted primary care/or						61.
surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61.
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
care or general surgery. (see mistructions)	Pro	ogram Name	Program Cod	IME FTE Coun	FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1. 00	2.00	3.00	4.00	61.
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. 1. 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, the direct GME FTE unweighted count.				0.0		0 61.

lealth Financial Systems		COUNTY HOSPITAL	ON 45 4055		u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE CO	MPLEX IDENIIFICATION DA	AIA Provider C	CN: 15-1322	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/23/2023 1:3	pared:
					1.00	
ACA Provisions Affecting the 2.00 Enter the number of FTE reside				oriod for which		62.0
your hospital received HRSA Po	CRE funding (see instru	ctions)				
2.01 Enter the number of FTE reside during in this cost reporting				to your hospital	0.00	62.0
Teaching Hospitals that Claim	Residents in Nonprovid	er Settings		iIQ Ft	N	63.0
3.00 Has your facility trained resi "Y" for yes or "N" for no in o			67. (see ins	tructions)	N	63.0
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der		col . 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base				_		
period that begins on or afte 4.00 Enter in column 1, if line 63			0.	0. 00	0. 000000	64. (
in the base year period, the resident FTEs attributable to						
settings. Enter in column 2	he number of unweighte	d non-primary care				
resident FTEs that trained in of (column 1 divided by (column						
	Program Name	Program Code	Unwei ghted		Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1.00	0.00	Si te		5.00	
5.00 Enter in column 1, if line 6	1. 00	2. 00	3. 00	4. 00 00 0. 00	5. 00 0. 000000	65.
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter icolumn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted		Ratio (col.	
			FTEs Nonprovi der Si te	FTES in Hospital	1/ (col. 1 + col. 2))	
Section 5504 of the ACA Curre	nt Year FTE Residents i	n Nonprovider Settin	1.00 gsEffecti ve	2.00 for cost report	3.00 ing periods	
beginning on or after July 1, 5.00 Enter in column 1 the number of	2010	•	0.			66 1
FTEs that trained in your hos (column 1 divided by (column	s occurring in all nonpo of unweighted non-prima oital. Enter in column :	rovider settings. ry care resident 3 the ratio of	0.	0.00	0. 000000	00. (
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	1

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1322 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 1:34 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTES FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4. 00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0. 00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 N 68.00 68.00 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no. Ν 75 00 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80 00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 'Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85 00 N 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Permanent Adjustment (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target 0 88.00 amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.

Health Financial Systems PERRY COUNTY			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Pro 5/23/2023 1:3	epared:
		Wkst. A Line No.	Date	Approved Permanent Adjustment Amount Per Discharge	
00 00 Caluma 1, I.G. Lina 00, asluma 1 is V, antara the Wardishast A I	:	1.00	2. 00	3. 00	00.00
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA taper discharge. Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	based. period rget amount	0. (V	XIX	0 89.00
			1.00	2.00	1
Title V and XIX Services	l		NI NI		00.00
 90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the second column. 			N N	Y N	90.00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	al certificat			N	92.00
93.00 linstructions) Enter "Y" for yes or "N" for no in the applical Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appl 98.00 Does title V or XIX follow Medicare (title XVIII) for the in- stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo column 1 for title V, and in column 2 for title XIX.	terns and res	idents post	0. 00 Y	0. 00 Y	97. 00 98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the report of the property of the				Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			Y	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for year				N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add backwist. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col.				Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH?			Y		105.00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive met	hod of paymer	4		106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instruction	1. (see ins you train I&R F and/or IRF	tructions) s in an	N		107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche				108. 00
	Physi cal	Occupati ona	-	Respiratory	4
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1. 00 N	2. 00 N	3. 00 N	4. 00 N	109.00

		TIT LICE	of Form CMS	, 2002 1
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider		eriod: rom 01/01/2022	Worksheet S- Part I	-2
		o 12/31/2022	Date/Time Pr	
			5/23/2023 1:	:34 pm
			1.00	110.0
110.00 Did this hospital participate in the Rural Community Hospital Demonstr Demonstration) for the current cost reporting period? Enter "Y" for yes complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2 applicable.	or "N" for no. I	f yes,	N	110. 0
		1.00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Frontie Health Integration Project (FCHIP) demonstration for this cost reporti "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participating Enter all that apply: "A" for Ambulance services; "B" for additional b for tele-health services.	ng period? Enter Y, enter the in column 2.	N N	2.00	111.00
	1.00	2. 00	3. 00	\dashv
112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in t demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost	N he			112.00
reporting period? Enter "Y" for yes or "N" for no.				
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for n in column 1. If column 1 is yes, enter the method used (A, B, or E onl in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based o	y)			0115.00
the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or	N			116. 0
"N" for no.				
17.00 Is this facility legally-required to carry malpractice insurance? Ente "Y" for yes or "N" for no.				117. 0
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.0
	Premi ums	Losses	Insurance	
	1. 00	2. 00	3. 00	
18.01 List amounts of malpractice premiums and paid losses:	1.00		3. 00	0118.0
18.01 List amounts of malpractice premiums and paid losses:		0		0118.0
	284,69° er than the		2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies fo Hold Harmless provision in ACA §3121 and applicable amendments? (see i	er than the g cost centers provision in ACA "Y" for yes or the Outpatient	1.00		118.0
 18.02 Are mal practice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies fo Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev 	er than the g cost centers provision in ACA "Y" for yes or the Outpatient instructions)	7 O	2.00	118. C
18.02 Are mal practice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies fo Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e	er than the g cost centers provision in ACA "Y" for yes or r the Outpatient nstructions) ices charged to 903(w)(3) of the	7 O	2.00	118. (119. (120. (
18.02 Are mal practice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies fo Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase prof services, e.g., legal, accounting, tax preparation, bookkeeping, payro management/consulting services, from an unrelated organization? In col for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater t professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, ente "N" for no.	er than the g cost centers provision in ACA "Y" for yes or r the Outpatient nstructions) ices charged to 903(w)(3) of the nter in column 2 essional II, and/or umn 1, enter "Y" than 50% of total organizations	7 O 1.00 N N	2. 00 N	118. C 119. C 120. C
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 18.02 Are malpractice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies fo Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase prof services, e.g., legal, accounting, tax preparation, bookkeeping, payro management/consulting services, from an unrelated organization? In col for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater t professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, ente "N" for no. Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant center? Ent and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below 	er than the g cost centers provision in ACA "Y" for yes or r the Outpatient nstructions) ices charged to 903(w)(3) of the nter in column 2 essional II, and/or umn 1, enter "Y" han 50% of total organizations r "Y" for yes or	7 O 1.00 N N Y Y Y	2. 00 N	118. 0 119. 0 120. 0 121. 0 122. 0 123. 0
18.02 Are mal practice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies fo Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase prof services, e.g., legal, accounting, tax preparation, bookkeeping, payro management/consulting services, from an unrelated organization? In col for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater t professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, ente "N" for no. Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant center? Ent and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below in column 1 and termination date, if applicable, in column 2.	er than the g cost centers provision in ACA "Y" for yes or r the Outpatient nstructions) ices charged to 903(w)(3) of the nter in column 2 essional II, and/or umn 1, enter "Y" than 50% of total organizations r "Y" for yes or	7 O 1.00 N N Y Y Y	2. 00 N	118. 0 119. 0 120. 0 121. 0 122. 0 123. 0
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies fo Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal thcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase prof services, e.g., legal, accounting, tax preparation, bookkeeping, payro management/consulting services, from an unrelated organization? In col for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater t professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, ente "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Ent and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below 126.00 If this is a Medicare-certified kidney transplant program, enter the column 2 is "Supposed to the standard program, enter the column 2 is "Supposed to the standard program, enter the column 2 is "Supposed to the standard program, enter the column 2 is "Supposed to the standard program, enter the column 2 is and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below 126.00 If this is a Medicare-certified kidney transplant program, enter the column 2 is 125.00 In the supposed to the suppose	er than the g cost centers provision in ACA "Y" for yes or r the Outpatient nstructions) ices charged to 903(w)(3) of the nter in column 2 essional II, and/or umn 1, enter "Y" han 50% of total organizations r "Y" for yes or er "Y" for yes or ertification date	7 O 1.00 N N Y Y Y	2. 00 N	0 118. 0 118. 0 119. 0 120. 0 121. 0 122. 0 123. 0 125. 0 126. 0 127. 0

In Lieu of Form CMS-2552-10 Health Financial Systems PERRY COUNTY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1322 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 1:34 pm 1. 00 2.00 129.00 If this is a Medicare-certified lung transplant program, enter the certification date 129.00 in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00|If this is a Medicare-certified islet transplant program, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 134.00 If this is a hospital-based organ procurement organization (0P0), enter the 0P0 number 134.00 in column 1 and termination date, if applicable, in column 2 All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. ٧ 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 3.00 1.00 2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: Contractor's Name: Contractor's Number: 141.00 142.00 Street: PO Box 142.00 143.00 Ci ty: State: Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 1. 00 2.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. Ν 148.00 for yes or "N" for no 149.00 Was there a change to the simplified cost finding method? Enter "Y" N 149. 00 Part A Part B Title XIX Title V 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N 155.00 Ν Ν Ν 156.00 Subprovi der - IPF Ν Ν Ν Ν 156. 00 157.00 Subprovi der - IRF N Ν N N 157.00 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY Ν Ν 160.00 Ν Ν 161.00 CMHC N N Ν 161.00 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. N 165.00 FTE/Campus CBSA Name County State Zi p Code 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4. FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.
168.00 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the Υ 167 00 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions)

Health Financial Systems PERRY COUNTY HOSPITAL				u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	Peri od:	Worksheet S-2			
			From 01/01/2022 To 12/31/2022	Part Date/Time Pre	narod:
			10 12/31/2022	5/23/2023 1: 3	
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beging period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider			N	0	171. 00
section 1876 Medicare cost plans repor "Y" for yes and "N" for no in column 1. 1876 Medicare days in column 2. (see in	If column 1 is yes, er		on		

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1322 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/23/2023 1:34 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 R 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Ν N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 03/30/2023 17.00 Υ 03/30/2023 Υ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems PERRY COUNTY		ON 45 4000		u of Form CM	
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-1322	Peri od: From 01/01/2022 To 12/31/2022		repared:
			i pti on	Y/N	Y/N	
20.00	If line 14 on 17 is yes were adjustments made to DCOD		0	1. 00 N	3.00	20.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	N	20.00
	nobolit data for other. Bescribe the other day astmorts.	Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS	HOSPLTALS)		1.00	
	Capital Related Cost	OIN EDITEIRO	11001 1 11120)			
	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense			ring the cost	N N	22. 00 23. 00
	reporting period? If yes, see instructions.			5		
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions				N	24.00
25. 00	Have there been new capitalized leases entered into during instructions.	·	.		N	25. 00
	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	•	0.		N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	f yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into du	ıring the cos	t reporting	N	28.00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)					29. 00
30. 00						30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If ye	s, see	N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care ser		ed through c	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	N	33.00
	Provi der-Based Physi ci ans					
4. 00	Were services furnished at the provider facility under an a	arrangement wi	th provider-	based physicians?	Υ	34.00
	If yes, see instructions.	Ü	·	. 3		
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ents with the	·	N	35. 0
				Y/N	Date	
	Home Office Costs			1.00	2. 00	
	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been pr	repared by the	home office			37. 00
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off					38.00
	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	d of the home	offi ce.			39.00
	see instructions.	•	,			40.00
. 3. 30	instructions.					10.00
	1.00 2.					
	Cost Report Preparer Contact Information					
1. 00	held by the cost report preparer in columns 1, 2, and 3,	CLINT		BRI LL		41.00
	respectively. Enter the employer/company name of the cost report	BLUE & CO., LI	_C			42.00
2.00	preparer.					

Heal th	Financial Systems F	PERRY COUNTY	HOSPI TAL		In Lieu	of Form CMS-2	2552-10
HOSPI 7	FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	ONNAI RE	Provider CCN		Period: From 01/01/2022 To 12/31/2022		pared:
			3. 00	<u> </u>	_		
	Cost Report Preparer Contact Information		3.00	<u> </u>			
41. 00			MANAGER				41. 00
42. 00	Enter the employer/company name of the cost repo	ort					42.00
43. 00	preparer. Enter the telephone number and email address of report preparer in columns 1 and 2, respectively						43.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: Heal th Fi nancialSystemsPERRYHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1322

5/23/20	23 1: 34	oared:
1/P Da		T DIII
O/P Vis		
Tri		
Component Worksheet A No. of Beds Bed Days CAH Hours Title	e V	
Line No. Available		
1.00 2.00 3.00 4.00 5.0	0	
PART I - STATISTICAL DATA		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 25 9,125 44,424.00	0	1. 00
8 exclude Swing Bed, Observation Bed and		
Hospice days)(see instructions for col. 2		
for the portion of LDP room available beds)		2 00
2.00 HMO and other (see instructions)		2.00
3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider		3. 00 4. 00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	4. 00 5. 00
6.00 Hospital Adults & Peds. Swing Bed NF	0	6. 00
7. 00 Total Adults and Peds. (exclude observation 25 9, 125 44, 424. 00	0	7. 00
beds) (see instructions)	٠	7.00
8. 00 INTENSIVE CARE UNIT 31. 00 0 0. 00	0	8. 00
9. 00 CORONARY CARE UNIT	ŭ	9. 00
10. 00 BURN I NTENSI VE CARE UNI T		10.00
11. 00 SURGICAL INTENSIVE CARE UNIT		11. 00
12.00 OTHER SPECIAL CARE (SPECIFY)		12.00
13. 00 NURSERY 43. 00	o	13.00
14.00 Total (see instructions) 25 9,125 44,424.00	0	14.00
15. 00 CAH vi si ts	0	15.00
16. 00 SUBPROVI DER - I PF		16.00
17. 00 SUBPROVI DER - I RF		17.00
18. 00 SUBPROVI DER		18.00
19.00 SKILLED NURSING FACILITY		19.00
20.00 NURSING FACILITY		20.00
21.00 OTHER LONG TERM CARE		21.00
22.00 HOME HEALTH AGENCY		22.00
23.00 AMBULATORY SURGICAL CENTER (D. P.)		23.00
24. 00 HOSPI CE 116. 00 0 0		24.00
24.10 HOSPICE (non-distinct part) 30.00		24. 10
25. 00 CMHC - CMHC		25.00
26.00 RURAL HEALTH CLINIC - TCC 88.00	0	26.00
26.01 RURAL HEALTH CLINIC II - PCFP 88.01	0	26. 01
26. 02 RURAL HEALTH CLINIC III - 13TH 88. 02	2	26. 02
26. 03 RURAL HEALTH CLINIC IV - SPENCER 88. 03	0	26. 03
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00	0	26. 25
27.00 Total (sum of lines 14-26)		27.00
28.00 Observation Bed Days 29.00 Ambulance Trips	0	28. 00 29. 00
		29. 00 30. 00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF		30.00
32.00 Labor & delivery days (see instructions)		32.00
32.01 Total ancillary labor & delivery room		32. 00
outpatient days (see instructions)		JZ. U I
33. 00 LTCH non-covered days		33.00
33.01 LTCH site neutral days and discharges		33. 01
34.00 Temporary Expansion COVID-19 PHE Acute Care 30.00 0	0	

 Heal th
 Fi nancial
 Systems
 PERRY

 HOSPITAL
 AND
 HOSPITAL
 HEALTH
 CARE
 COMPLEX
 STATISTICAL
 DATA
 Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/23/2023 1:34 pm Provider CCN: 15-1322

				-		5/23/2023 1: 3	4 pm
	·	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
						•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	974	21	1, 851			1.00
	8 exclude Swing Bed, Observation Bed and			,			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	286	198				2.00
3. 00	HMO IPF Subprovider	0	0				3. 00
4. 00	HMO IRF Subprovider	l ol	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	824	0	824			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	021	0	204			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 798	21	2, 879			7.00
7.00	beds) (see instructions)	1, 770	21	2,017			7.00
8. 00	INTENSIVE CARE UNIT	o	0	0			8.00
9. 00	CORONARY CARE UNIT	l	O				9.00
10. 00	BURN INTENSIVE CARE UNIT	1					10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	119			13.00
		1, 798	21	2, 998		211. 91	
14. 00 15. 00	Total (see instructions)	1, 798	21	2, 998 1	0.00	211.91	
	CAH visits	l o	U	U			15.00
16.00	SUBPROVIDER - I PF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)			_			23. 00
24. 00	HOSPI CE	0	0	0		0.00	1
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC - TCC	2, 331	0	8, 875		22. 23	1
26. 01	RURAL HEALTH CLINIC II - PCFP	147	0	2, 507		6. 37	
26. 02	RURAL HEALTH CLINIC III - 13TH	511	0	5, 356		2. 68	
26. 03	RURAL HEALTH CLINIC IV - SPENCER	976	0	4, 414		7. 30	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	250. 49	27. 00
28.00	Observation Bed Days		6	476			28. 00
29.00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	l ol	1	34			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)]			
33.00	LTCH non-covered days	l					33.00
	LTCH site neutral days and discharges	l ol					33. 01
	Temporary Expansion COVID-19 PHE Acute Care	1	0	О			34.00
2 30	1 - 1 - 1 J - I - J - I - I - I - I - I - I - I -	١	٥	'	1	1	

Provider CCN: 15-1322

				10	12/31/2022	5/23/2023 1:3	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Ti tle V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	13.00	14. 00	Pati ents 15.00	
	PART I - STATISTICAL DATA	11.00	12.00	13.00	14.00	13.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	237	6	517	1.00
	8 exclude Swing Bed, Observation Bed and			[Ĭ	0.7	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			67	53		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNI T						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT						11. 00 12. 00
13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						13.00
14. 00	Total (see instructions)	0.00	C	237	6	517	14.00
15. 00	CAH visits	0.00	C	237	o _l	317	15.00
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC - TCC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II - PCFP	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III - 13TH	0.00					26.02
26. 03	RURAL HEALTH CLINIC IV - SPENCER	0.00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00 28. 00	Total (sum of lines 14-26)	0.00					27. 00 28. 00
29. 00	Observation Bed Days Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Fristruction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
52.01	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days	1		0			33. 00
33. 01	LTCH site neutral days and discharges]		0			33. 01
	Temporary Expansion COVID-19 PHE Acute Care						34.00
		·		'			

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1322	Peri od: From 01/01/2022	Worksheet S-8	3
			Component	CCN: 15-8516	To 12/31/2022	Date/Time Pro 5/23/2023 1:3	
					RHC I	Cost	
					1.	00	-
	Clinic Address and Identification				1.	00	
1. 00	Street				109 I N-66		1.00
				ty	State	ZIP Code	
2. 00	City, State, ZIP Code, County		TELL CITY	00	2. 00 I N	3. 00 47586	2.00
2.00	for the order 211 south souther		1.222 0.11			1,7000	2.00
	Turana					1. 00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		nt Award	O Date	3.00
					1. 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 Health Services for the Homeless (Section 34						5. 00
7. 00	Appal achi an Regional Commission	O(u), FIIS ACL)					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	ospi tal -based	RHC or FQHC? E	nter "Y" for			10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o	f other operat	ion(s) and the	operati ng			
	hours.)	Cur	 nday	Ι	Monday	Tuesday	
		from	to	from	to	from	
		1. 00	2.00	3.00	4.00	5. 00	
	Facility hours of operations (1)				1		
11.00	CLINIC			07: 00	20: 00	07: 00	11.00
					1. 00	2. 00	
12. 00	Have you received an approval for an excepti	on to the prod	luctivity stand	ard?	N		12.00
13.00					N	0	13.00
	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.						
	numbers below.	LIST THE Halle	s of all provi	uers and			
				Prov	ider name	CCN	
14.00	DU0 (50H0				1. 00	2. 00	11.00
14.00	RHC/FOHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14.00
		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						
	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)						
	(See HISTI UCTI OHS)		Cou	I inty			
			4.	00			
2.00	City, State, ZIP Code, County		PERRY		_		2.00
		Tuesday		esday T +a	Thur		
		6. 00	7.00	8. 00	from 9.00	to 10. 00	
	Facility hours of operations (1)	0.00	7.00	3.00			
11.00	CLINIC	20: 00	07: 00	20: 00	07: 00	20: 00	T 11. 00

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1322	Peri od:	Worksheet S-8	3
		Component	CCN, 1E 0E14	From 01/01/2022 To 12/31/2022		norod.
		Component	CCN: 15-8516	10 12/31/2022	5/23/2023 1: 3	
				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 CLI NI C	07: 00	20: 00				11. 00

	n Financial Systems TAL-BASED RHC/FQHC STATISTICAL DATA	PERRY COUNT		CCN: 15-1322	Peri od:	eu of Form CMS Worksheet S-	
				CCN: 15-8517	From 01/01/2022 To 12/31/2022	2 Date/Time Pr	epare
					RHC II	5/23/2023 1: Cost	34 pili
					INTO TT	0031	
					1	. 00	
	Clinic Address and Identification						
00	Street		1		18485 STATE R		1.
				i ty . 00	State 2.00	ZIP Code 3.00	
00	City, State, ZIP Code, County		LEOPOLD	. 00		147551	2.
	10.13, 0.000, 2.1. 0.000, 0.000.						
						1. 00	
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for				0 3.
					nt Award 1.00	Date	
	Source of Federal Funds				1.00	2. 00	
00	Community Health Center (Section 330(d), PHS	Act)					4.
00	Migrant Health Center (Section 329(d), PHS A						5.
00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6.
00	Appalachian Regional Commission Look-Alikes						7.
00	OTHER (SPECIFY)						8.
00	TOTTLER (SI EGITT)						7.
					1. 00	2. 00	
. 00	Does this facility operate as other than a h				N		0 10.
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o	r other operat	non(s) and the	e operating			
	hours.)	Sur	nday	I M	onday	Tuesday	
		from	to	from	to	from	
		1. 00	2.00	3.00	4. 00	5. 00	
	Facility hours of operations (1)			lo-7 .00	1	lo 00	
1.00	CLINIC			07: 00	16: 00	07: 00	11.
					1. 00	2.00	
2. 00	Have you received an approval for an excepti	on to the prod	luctivity stand	lard?	N N	2.00	12.
3. 00					N		0 13.
	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	
					1. 00	2. 00	
1. 00	RHC/FQHC name, CCN						14.
		Y/N	V	XVIII	XIX	Total Visits	
- 00	Hove you provided all as substantially	1. 00	2.00	3. 00	4. 00	5. 00	15
o. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.
	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)						
			Cor	unty			
	(See Tristructrons)			. 00			
	(See Histiactions)		4.				1 0
00	Ci ty, State, ZIP Code, County		PERRY				2.
00		Tuesday	PERRY Wedr	esday		rsday .	2.
. 00		to	PERRY Wedr	to	from	to	2.
00			PERRY Wedr				2.

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1322	Peri od:	Worksheet S-8	1
		Component	CCN: 15-8517	From 01/01/2022 To 12/31/2022		
				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 CLI NI C	07: 00	16: 00				11. 00

	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	eu of Form CM	S-2!	552-10
HOSPI T	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1322	Peri od:	Worksheet S	8-8	
			Component	CCN: 15-8560	From 01/01/2022 To 12/31/2022			
					RHC III	Cos1		РШ
			-					
					1	. 00		
	Clinic Address and Identification				4.0 4.0711 0705			
1.00	Street		Ci	ty	148 13TH STREE	ZIP Code	_	1. 00
				00	State 2.00	3. 00	\dashv	
2. 00	City, State, ZIP Code, County		TELL CITY	00		N 47586		2.00
	1		<u> </u>					
						1. 00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for				0	3.00
					nt Award	Date		
	Source of Federal Funds				1. 00	2. 00	_	
4. 00	Community Health Center (Section 330(d), PHS	Act)				1		4.00
5. 00	Migrant Health Center (Section 329(d), PHS A							5. 00
6.00	Health Services for the Homeless (Section 34						ı	6.00
7.00	Appal achi an Regi onal Commi ssi on							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 -hasad	PHC 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	IV.			10.0
	hours.)	•						
			nday		onday	Tuesday	_	
		from 1.00	2. 00	from 3.00	4. 00	from 5.00	+	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	-	
11. 00	CLINIC			08: 00	16: 00	08: 00		11.00
			•					
					1. 00	2. 00		
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N			12. 00 13. 00
	numbers below.							
					der name	CCN	_	
					1. 00	2. 00	_	14 00
11 00	IDUC/FOUC name CCN							14.00
14.00	RHC/FQHC name, CCN	V/N	V	Y\/	YIY	Total Visit		
14. 00	RHC/FQHC name, CCN	Y/N 1 00	V 2 00	XVIII 3.00	XI X 4 00	Total Visit		
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1. 00	V 2.00	XVIII 3. 00	XI X 4. 00	Total Visit 5.00	S	15. 00
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	1. 00					S	15.00
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1. 00	2. 00 Cou	3.00			S	15. 0
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1. 00	2. 00 Cou	3.00			S	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2. 00 Cou 4. PERRY	3.00 inty 00	4.00	5.00	S	2. 00
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Cou 4. PERRY Wedn	3.00 unty 00 esday	4. 00	5.00	S	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	Cou 4. PERRY Wedn	3.00 inty 00 esday to	4.00 Thu	5.00	S	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Cou 4. PERRY Wedn	3.00 unty 00 esday	4. 00	5.00	S	

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1322	Peri od:	Worksheet S-8	}
		Component	CCN: 15-8560	From 01/01/2022 To 12/31/2022		norod.
		Component	CCN: 15-8560	10 12/31/2022	5/23/2023 1: 3	
				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 CLI NI C	08: 00	16: 00				11.00

	AL-BASED RHC/FQHC STATISTICAL DATA	PERRY COUNT	Provi der C	CN: 15-1322	Peri od:	Worksheet S-	-2552- ·8
					From 01/01/2022 To 12/31/2022	Date/Time Pr	epared
					RHC IV	5/23/2023 1: Cost	34 pm
					10011	0031	
					1.	00	
	Clinic Address and Identification				1		
00	Street		C:	+	105 2ND STREET		1.
				00	State 2.00	ZIP Code 3.00	
00	City, State, ZIP Code, County		ROCKPORT	00		47635	2.
	LIGORI TAL DACED FOLIO ONLY Destruction Full	II DII C				1.00	0 0
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		t Award	Date	0 3.
					1. 00	2. 00	
	Source of Federal Funds					2.00	
00	Community Health Center (Section 330(d), PHS						4.
00	Migrant Health Center (Section 329(d), PHS A						5.
00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	u(d), PHS Act)					6. 7.
00	Look-Alikes						8.
00	OTHER (SPECIFY)						9.
				•			
	T				1. 00	2. 00	
. 00	Does this facility operate as other than a h				N		0 10.
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o						
	hours.)	other operat	ron(3) and the	operating			
		Sur	iday	Mc	onday	Tuesday	
		from	to	from	to	from	
	Facility have of appeting (1)	1. 00	2. 00	3. 00	4.00	5. 00	
. 00	Facility hours of operations (1)			3. 00	4. 00	5. 00	11
. 00	Facility hours of operations (1)				4. 00		11.
. 00				3. 00	4. 00	5. 00	11.
2. 00	CLINIC Have you received an approval for an excepti	1.00	2.00	3.00 07:30 ard?	4. 00 17: 00 1. 00	5. 00 07: 30 2. 00	12.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define	1.00 on to the prod d in CMS Pub.	2.00 uctivity stand 100-04, chapte	3.00 07:30 ard? r 9, section	4. 00	5. 00 07: 30 2. 00	12.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	on to the prod d in CMS Pub. umn 1. If yes,	2.00 uctivity stand 100-04, chapte enter in colu	3.00 07:30 ard? r 9, section mn 2 the	4. 00 17: 00 1. 00	5. 00 07: 30 2. 00	12.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	on to the prod d in CMS Pub. umn 1. If yes,	2.00 uctivity stand 100-04, chapte enter in colu	3.00 07:30 ard? r 9, section mn 2 the	4. 00 17: 00 1. 00	5. 00 07: 30 2. 00	12.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	on to the prod d in CMS Pub. umn 1. If yes,	2.00 uctivity stand 100-04, chapte enter in colu	3.00 07:30 ard? r 9, section mn 2 the ders and	4. 00 17: 00 1. 00	5. 00 07: 30 2. 00	12.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	on to the prod d in CMS Pub. umn 1. If yes,	2.00 uctivity stand 100-04, chapte enter in colu	3.00 07:30 ard? r 9, section mn 2 the ders and Provi	4. 00 17: 00 1. 00 N	5. 00 07: 30 2. 00	12.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	3.00 07:30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name	5. 00 07: 30 2. 00 CCN 2. 00	12. 0 13.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi	3.00 or: 30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name 1.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits	12. 0 13.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	3.00 07:30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name	5. 00 07: 30 2. 00 CCN 2. 00	12. 0 13.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi	3.00 or: 30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name 1.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits	12.0 13.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi	3.00 07:30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name 1.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits	12.0 13.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi	3.00 07:30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name 1.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits	12. 0 13.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi	3.00 07:30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name 1.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits	12. 0 13.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 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	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi	3.00 07:30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name 1.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits	12. 0 13.
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi	3.00 07:30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name 1.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits	12. 0 13.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	3.00 07:30 ard? r 9, section mn 2 the ders and Provi	4.00 17:00 1.00 N der name 1.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits	12. 0 13.
2. 00 3. 00 4. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in col umns 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)	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi V 2.00	3.00 or: 30 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	4.00 17:00 1.00 N der name 1.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits	12. 0 13.
2. 00 3. 00 4. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi V 2.00 Cou 4. SPENCER	3.00 or: 30 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	4.00 17:00 1.00 N der name 1.00 XIX 4.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits 5. 00	12. 0 13.
22. 00 33. 00 44. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in col umns 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)	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	2.00 uctivity stand 100-04, chapte enter in colu s of all provi V 2.00 Cou 4. SPENCER Wedn	3.00 or: 30 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	4.00 17:00 1.00 N der name 1.00 XIX 4.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits 5. 00	12.0 13.
2. 00 3. 00 4. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in col umns 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)	on to the prod d in CMS Pub. umn 1. If yes, List the name	2.00 uctivity stand 100-04, chapte enter in colu s of all provi V 2.00 Cou 4. SPENCER	3.00 or: 30 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	4.00 17:00 1.00 N der name 1.00 XIX 4.00	5. 00 07: 30 2. 00 CCN 2. 00 Total Visits 5. 00	14.

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1322	Peri od:	Worksheet S-8	1
		Component	CCN: 15_8562	From 01/01/2022 To 12/31/2022		nared:
		Component	CCN. 13-0302	10 12/31/2022	5/23/2023 1: 3	
				RHC I V	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLI NI C	07: 30	17: 00				11. 00

	TAL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet S-1	
	THE UNCOME ENSATED AND THUTGENT CARE DATA	JON. 13-1322	From 01/01/2022		U
			To 12/31/2022	Date/Time Pre 5/23/2023 1:3	pared 4 pm
				1.00	
	Uncompensated and indigent care cost computation			1.00	
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	ine 202 colu	mn 8)	0. 352841	1.0
. 00	Medicaid (see instructions for each line)	1110 202 001 0	0)	0.002011	1
. 00	Net revenue from Medicaid			3, 992, 437	2.0
. 00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payme		cai d?	Y	4.0
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medic	ai d		0	5.0
. 00	Medi cai d charges			16, 654, 630	
. 00 . 00	Medicaid cost (line 1 times line 6)	nus sum of l	inco 2 and E. if	5, 876, 436	
. 00	Difference between net revenue and costs for Medicaid program (line 7 m < zero then enter zero)	nus sum or r	rnes z anu s; i i	1, 883, 999	8.0
	Children's Health Insurance Program (CHIP) (see instructions for each I	ne)		L	
. 00	Net revenue from stand-alone CHIP	•		0	9.0
	Stand-alone CHIP charges			0	1
1. 00	,		0	11. (
2. 00	· ·	minus line 9;	if < zero then	0	12. (
	enter zero) Other state or local government indigent care program (see instructions	for each line	2)		ŀ
3. 00	Other state or local government indigent care program (see instructions Net revenue from state or local indigent care program (Not included on			0	13.0
	Charges for patients covered under state or local indigent care program			0	
00	10)	(1.01 11.01 440			
5. 00				0	15.
5. 00	Difference between net revenue and costs for state or local indigent ca	re program (li	ine 15 minus line	0	16.
	13; if < zero then enter zero)			<u> </u>	ļ
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and strinstructions for each line)	ate/Local indi	gent care progra	ams (see	
7. 00	Private grants, donations, or endowment income restricted to funding ch				
		aritv care		0	17. (
8. 00	Government grants, appropriations or transfers for support of hospital			0	
	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen	operati ons	ns (sum of lines		18.0
	Government grants, appropriations or transfers for support of hospital	operati ons	ms (sum of lines	0	18.0
	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen	Uni nsured pati ents	I nsured pati ents	0 1,883,999 Total (col. 1 + col. 2)	18.0
	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen 8, 12 and 16)	operations t care progra	Insured	0 1, 883, 999 Total (col. 1	18.0
9. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line)	Uni nsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	18. (19. (
9. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	Uni nsured pati ents	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	18. (19. (
0. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions)	Uni nsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	18. (19. (20. (
9. 00 0. 00 1. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions)	Uni nsured patients 1.00	Insured patients 2.00 68 0 68 0	Total (col. 1 + col. 2) 3.00 524, 268 184, 983	18. (19. (20. (21. (
9. 00 0. 00 1. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	Uni nsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00 524, 268 184, 983	18. (19. (20. (21. (
9. 00 0. 00 1. 00 2. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	Uni nsured pati ents 1.00 524, 2 184, 9	Insured patients 2.00	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983	20. (21. (22. (
9. 00 0. 00 1. 00 2. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	Uni nsured patients 1.00	Insured patients 2.00	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983	20. (21. (22. (
9. 00 0. 00 1. 00 2. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	Uni nsured pati ents 1.00 524, 2 184, 9	Insured patients 2.00	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983	20. (21. (22. (
9. 00 0. 00 1. 00 2. 00 3. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	Uni nsured patients 1.00 524, 2 184, 9	Insured patients 2.00	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983 0 184, 983	20. (21. (23. (
9. 00 0. 00 1. 00 2. 00 3. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days b imposed on patients covered by Medicaid or other indigent care program?	Uni nsured pati ents 1.00 524, 2 184, 9	Insured patients 2.00	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983 0 184, 983	20. (21. (23. (24. (
9. 00 0. 00 1. 00 2. 00 3. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days b imposed on patients covered by Medicaid or other indigent care program?	Uni nsured pati ents 1.00 524, 2 184, 9	Insured patients 2.00	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983 0 184, 983	20. (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit	Uni nsured patients 1.00 524, 2 184, 9 184, 9	Insured patients 2.00	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983 0 184, 983 1. 00 N	20. (21. (23. (24. (25. (26. (
99. 00 00. 00 11. 00 22. 00 44. 00 55. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days b imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in	Uni nsured pati ents 1.00 524, 2 184, 9 184, 9 eyond a length of care programs s) structions)	Insured patients 2.00	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983 0 184, 983 1. 00 N 0 2, 188, 758 301, 992	20. (C 21. (C 23. (C 25. (C 26. (C 27. (C)
9.00 0.00 1.00 2.00 3.00 4.00 6.00 7.00 7.01	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see instruction Medicare allowable bad debts for the entire hospital complex (see instruction	Uni nsured pati ents 1.00 524, 2 184, 9 184, 9 eyond a length of care programs s) structions)	Insured patients 2.00	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983 0 184, 983 1. 00 N 0 2, 188, 758 301, 992 464, 604	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 27. 0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 7. 01 8. 00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see instruction Medicare allowable bad debts for the entire hospital complex (see instruction Medicare bad debt expense (see instructions)	Uninsured patients 1.00 524, 2 184, 9 184, 9 eyond a length at care programs structions)	Insured patients 2.00 68 0 83 0 0 0 83 0 n of stay limit am's length of	0 1, 883, 999 Total (col. 1 + col. 2) 3.00 524, 268 184, 983 0 1.00 N 0 2, 188, 758 301, 992 464, 604 1, 724, 154	20. (21. (22. (23. (25. (26. (27. (27. (28. (
9.00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in Medicare allowable bad debts for the entire hospital complex (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see	Uninsured patients 1.00 524, 2 184, 9 184, 9 eyond a length at care programs structions)	Insured patients 2.00 68 0 83 0 0 0 83 0 n of stay limit am's length of	0 1, 883, 999 Total (col. 1 + col. 2) 3. 00 524, 268 184, 983 0 184, 983 1. 00 N 0 2, 188, 758 301, 992 464, 604	20. (21. (22. (23. (25. (26. (27. (27. (29. (29. (

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	pared.
						5/23/2023 1: 3	4 pm
	Cost Center Description	Sal ari es	0ther		Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
		1. 00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 477, 424	2, 477, 42	4 111, 311	2, 588, 735	1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 109, 914			1, 109, 914	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	154, 902	419, 867			574, 376	4.00
5. 01	00540 ADMINISTRATIVE AND GENERAL	1, 319, 049	1, 072, 119			2, 364, 836	5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	1, 141, 433	4, 682, 730	5, 824, 16	3 -30, 769	5, 793, 394	5. 02
7.00	00700 OPERATION OF PLANT	274, 236	1, 933, 763	2, 207, 99	9 -3, 925	2, 204, 074	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	72, 626	72, 62	6 0	72, 626	8. 00
9.00	00900 HOUSEKEEPI NG	316, 895	207, 933			524, 828	9. 00
10.00	01000 DI ETARY	0	664, 896	1		261, 615	1
11. 00	01100 CAFETERI A	0	0		0 402, 888		11. 00
13.00	01300 NURSING ADMINISTRATION	419, 432	60, 319			479, 751	13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	194, 210	150, 671	344, 88	1 -1, 525	343, 356	16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0 (40 0(0	0.007.140	F 000 44	2 010 010	F (70 440	00.00
30.00	03000 ADULTS & PEDIATRICS	2, 612, 268	3, 286, 149				30.00
31.00	03100 NTENSIVE CARE UNIT	0	0		0 0	0	31.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	Ŋ	0		0	0	43.00
50. 00	05000 OPERATING ROOM	718, 046	1, 403, 969	2, 122, 01	5 -199, 786	1, 922, 229	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	718, 040	1, 403, 707			147, 175	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	931, 514	499, 448			1, 429, 525	54.00
60.00	06000 LABORATORY	763, 666	1, 482, 662			2, 245, 284	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	372	112, 111			112, 483	62.00
65. 00	06500 RESPIRATORY THERAPY	465, 635	1, 056, 851			1, 461, 879	65.00
66.00	06600 PHYSI CAL THERAPY	520, 369	127, 790			647, 672	66.00
67.00	06700 OCCUPATI ONAL THERAPY	177, 605	28, 715	206, 32	o o	206, 320	67.00
68.00	06800 SPEECH PATHOLOGY	105, 522	17, 697	123, 21	9 0	123, 219	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	372, 507	372, 50	7 352, 009	724, 516	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 113, 166	113, 166	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	66, 448	3, 605, 956	3, 672, 40	4 -7, 291	3, 665, 113	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC	1, 871, 432	1, 223, 518			3, 047, 334	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	588, 032	496, 838				88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	1, 634, 745	672, 887				88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	615, 930	294, 441			974, 963	1
90.00	09000 CLINIC	376, 032	205, 840			595, 595	•
90. 01	09001 PAI N MANAGEMENT 09002 WOUND CARE	100 025	205 404		0 04 700	400 430	90. 01
90. 02 90. 03	09002 WOUND CARE	198, 935 77, 406	205, 694 27, 416		· ·	489, 428 100, 324	90. 02 90. 03
91.00	09100 EMERGENCY	727, 603	1, 677, 555				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	121,003	1,077,555	2,403,13	-3,090	2, 402, 002	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95 00	09500 AMBULANCE SERVICES	707, 473	435, 751	1, 143, 22	4 -21, 795	1, 121, 429	95 00
	10200 OPI OI D TREATMENT PROGRAM	0	0		0 2.,,,,		102.00
0	SPECIAL PURPOSE COST CENTERS	<u> </u>		•			1
113.00	11300 NTEREST EXPENSE		0		0 0	0	113.00
116.00	11600 HOSPI CE	0	0		0 0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	16, 979, 190	30, 233, 232	47, 212, 42	2 0	47, 212, 422	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	60	195, 834				
200.00	TOTAL (SUM OF LINES 118 through 199)	16, 979, 250	30, 429, 066	47, 408, 31	6 0	47, 408, 316	200.00

Provider CCN: 15-1322

Period: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm

				5/23/2023 1: 3	34 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	0	2, 588, 735		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	260, 501	1, 370, 415		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	,		4.00
5. 01	00540 ADMINISTRATIVE AND GENERAL	-291, 872	2, 072, 964		5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	-893, 347	4, 900, 047		5. 02
7.00	00700 OPERATION OF PLANT	-1, 088	2, 202, 986		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	72, 626		8. 00
9.00	00900 HOUSEKEEPI NG	0	524, 828		9. 00
10.00	01000 DI ETARY	-13, 928	247, 687		10.00
11. 00	01100 CAFETERI A	-65, 036	337, 852		11.00
13.00	01300 NURSING ADMINISTRATION	0	479, 751		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-4, 896	338, 460		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-85, 750	5, 592, 699		30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		31.00
43.00	04300 NURSERY	0	0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-888, 006	1, 034, 223		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-147, 175			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 429, 525		54.00
60.00	06000 LABORATORY	0	2, 245, 284		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			62.00
65.00	06500 RESPI RATORY THERAPY	-465, 227			65.00
66.00	06600 PHYSI CAL THERAPY	0			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	206, 320		67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0			72.00
73.00		-2, 260	3, 662, 853		73.00
	OUTPATIENT SERVICE COST CENTERS	,			
88.00	08800 RURAL HEALTH CLINIC - TCC	0	3, 047, 334		88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0			88. 01
88. 02		-259			88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0			88. 03
90.00	09000 CLI NI C	-25, 050			90.00
90. 01	09001 PALN MANAGEMENT	0	0		90. 01
90. 02	09002 WOUND CARE	-134, 671	354, 757		90. 02
90. 03	09003 ORTHOPEDIC CLINIC	0	100, 324		90.03
91. 00	09100 EMERGENCY	0			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	_	_,,		92.00
	OTHER REIMBURSABLE COST CENTERS				1
95.00	09500 AMBULANCE SERVICES	-1, 770	1, 119, 659		95.00
	10200 OPIOID TREATMENT PROGRAM	0			102.00
	SPECIAL PURPOSE COST CENTERS				1
113. 00	11300 I NTEREST EXPENSE	0	0		113.00
	11600 HOSPI CE	0	1	l .	116.00
118. 00		-2, 759, 834	1		118.00
	NONREI MBURSABLE COST CENTERS	2,707,001	1.7.027000		1
190 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		l .	192.00
200.00		-2, 759, 834			200.00
_50.0	1.51.12 (55 51 E. NEO 116 till 64911 177)	2,707,004	1, 0 10, 702	I	

Health Financial Systems RECLASSIFICATIONS PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10

Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm Provider CCN: 15-1322

					10 12/31/2	5/23/2023 1: 34 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
1 00	A - CAFETERIA COST	11 00	٥	402 000		1.00
1. 00	CAFETERI A		0	40 <u>2, 8</u> 88 402, 888		1.00
	C - LEASE EXPENSE		UU	402, 000		
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	73, 773		1.00
1.00	FIXT	1.00		70,770		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0. 00	0	0		4.00
5.00		0. 00	0	0		5. 00
6. 00		0. 00	0	0		6.00
7. 00		0. 00	0	0		7. 00
8.00		0.00	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13. 00		0.00	0	Ö		13.00
14. 00		0. 00	o	O		14.00
15.00		0.00	O	0		15. 00
16.00		0. 00	0	0		16.00
17.00		0. 00	0_	O		17. 00
	0		0	73, 773		
	D - INSURANCE EXPENSE					
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	37, 538		1.00
2 00	FIXT	0.00				2.00
2. 00		0.00		<u> 0</u> 37,538		2.00
	E - DRUGS CHARGED		<u> </u>	37, 538		
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	o	7, 814		1.00
2. 00	DROGS CHARGED TO FATTENTS	0.00	0	7, 014		2.00
3. 00		0.00	o	O		3.00
				7, 814		
	F - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	465, 175		1.00
	PATI ENTS					
2.00		0. 00	0	0		2.00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	0	0		6.00
7. 00		0.00	0	Ö		7.00
7.00				465, 175		7.00
	G - IMPLANTABLE DEVICE	,	-1			
1.00	IMPL. DEV. CHARGED TO	72. 00	0	113, 166		1.00
	PATI ENT					
	0		0	113, 166		
	H - WOUND CARE RECLASS					
1.00	WOUND CARE	90. 02	108, 622	0		1.00
2. 00		0.00	00 108, 622	<u>0</u>		2.00
	I - RHC RECRUITING EXPENSE REC	21 455	100, 022			
1. 00	RURAL HEALTH CLINIC - TCC	88. 00	0	4, 218		1.00
2. 00	RURAL HEALTH CLINIC III -	88. 02	o	12, 742		2.00
	13TH		1	,		
				16, 960		
	J - IV THERAPY					
1.00	CLI NI C	90.00	0	<u>14, 7</u> 12		1.00
	0		0	14, 712		
	L - TELL CITY RECLASS					
1. 00	RURAL HEALTH CLINIC IV -	88. 03	64, 592	0		1.00
2 00	SPENCER	0.00				2.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
5.00			64, 592	— — <u> </u>		3.00
500 00	Grand Total: Increases		173, 214	1, 132, 026		500.00
555.00	Jo. d., d. 10 tal. 17101 00303	ı	175,214	1, 102, 020		1 300.00

	Financial Systems SIFICATIONS		PERRY COUNTY		CCN: 15-1322	In Lieu Period:	u of Form CMS-2552-10 Worksheet A-6
KLULAS	STITCATIONS			Flovidei		From 01/01/2022	
						To 12/31/2022	Date/Time Prepared: 5/23/2023 1:34 pm
	Coot Conton	Decreases	Colomy	Othon	Wko+ A 7 Dof	I	
	Cost Center 6.00	Li ne #	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	-	
	A - CAFETERIA COST	7.00	0.00	7. 00	10.00		
1.00	DI ETARY	10.00	0	402, 888	C		1.00
	0			402, 888			
	C - LEASE EXPENSE				1		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	393		1	1.00
2.00	ADMINISTRATIVE AND GENERAL	5. 01	0	7, 199		l .	2.00
3. 00	ADMINISTRATIVE AND GENERAL - OTHER	5. 02	0	9, 121	C)	3.00
4. 00	OPERATION OF PLANT	7. 00	o	3, 925	C		4.00
5. 00	DI ETARY	10. 00	o	393			5. 00
6. 00	MEDICAL RECORDS & LIBRARY	16. 00	ō	1, 525			6.00
7.00	ADULTS & PEDIATRICS	30.00	o	3, 991			7.00
8.00	OPERATING ROOM	50. 00	O	10, 093	C		8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 437	C)	9.00
10.00	LABORATORY	60. 00	0	1, 044)	10.00
11. 00	RESPI RATORY THERAPY	65. 00	0	24, 933)	11.00
12.00	PHYSI CAL THERAPY	66.00	0	393)	12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	393			13.00
14. 00 15. 00	CLINIC WOUND CARE	90. 00 90. 02	0	956 393			14. 00 15. 00
16. 00	EMERGENCY	91. 00	0	1, 679			16.00
17. 00	AMBULANCE SERVICES	95. 00	Ö	5, 905			17. 00
.,, 00	0	— / / / -		$\frac{3,73}{73,773}$		1	
	D - INSURANCE EXPENSE	· · · · · · · · · · · · · · · · · · ·				'	
1.00	ADMINISTRATIVE AND GENERAL -	5. 02	0	21, 648	12	2	1.00
	OTHER						
2. 00	AMBULANCE SERVICES	9500	•	1 <u>5, 8</u> 90		<u> </u>	2.00
	0 DDUCC CHARCED		0	37, 538			
1. 00	E - DRUGS CHARGED ADMINISTRATIVE AND GENERAL	5. 01	0	2, 173			1.00
2. 00	WOUND CARE	90. 02	0	1, 143		1	2.00
3. 00	ORTHOPEDIC CLINIC	90. 03	Ö	<u>4, 4</u> 98		1	3.00
	0			7, 814			
	F - BILLABLE SUPPLIES						
1.00	ADULTS & PEDIATRICS	30. 00	0	215, 977			1.00
2. 00	OPERATING ROOM	50. 00	0	189, 693			2.00
3.00	RESPIRATORY THERAPY	65. 00	0	35, 674)	3.00
4.00	PHYSI CAL THERAPY	66.00	0	94			4.00
5. 00 6. 00	CLINIC WOUND CARE	90. 00 90. 02	0	33 22, 287			5. 00 6. 00
7. 00	EMERGENCY	91. 00	0	1, 417			7.00
7.00	0		- - 	465, 175		<u>/</u>	7.00
	G - IMPLANTABLE DEVICE	,	- '			1	
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	113, 166	C)	1.00
	PATI ENTS						
	0		0	113, 166			
1 00	H - WOUND CARE RECLASS RURAL HEALTH CLINIC - TCC	00.00	25, 979			\[\tag{\tag{\tag{\tag{\tag{\tag{\tag{	1 00
1. 00 2. 00	RURAL HEALTH CLINIC - ICC	88. 00 88. 02	82, 643	0	-		1.00
2.00	13TH	00.02	02, 043	0		'	2.00
	0	+	108, 622	_		†	
	I - RHC RECRUITING EXPENSE REC	CLASS	· · ·			'	
1.00	ADMINISTRATIVE AND GENERAL	5. 01	0	16, 960	C		1.00
2.00		0.00	0_	0			2.00
	0		0	16, 960			
4 00	J - IV THERAPY	70.00		44.740	1	\ \	1.00
1. 00	DRUGS CHARGED TO PATIENTS		0	$ \frac{14,712}{14,712}$		<u> </u>	1.00
	L - TELL CITY RECLASS		U	14, 712			
1. 00	RURAL HEALTH CLINIC - TCC	88. 00	25, 855	0	0		1.00
2. 00	RURAL HEALTH CLINIC II -	88. 01	388	0	0	6	2.00
2. 50	PCFP	55. 51	550	O			2.00
3.00	RURAL HEALTH CLINIC III -	88. 02	38, 349	0	C		3.00
	13TH				L	1	
F00 -	0		64, 592	0		1	
500.00	Grand Total: Decreases		173, 214	1, 132, 026	1		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS PERRY COUNTY HOSPITAL Provider CCN: 15-1322

| Period: | Worksheet A-7 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				To	12/31/2022	Date/Time Prep 5/23/2023 1:34	
				Acqui si ti ons		3/23/2023 1. 3	4 pili
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances	. u. onasos	5011411 011	.ota.	Retirements	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES	•				
1.00	Land	3, 805, 753	0	0	0	112, 375	1.00
2.00	Land Improvements	272, 277	0	0	0	226, 619	2.00
3.00	Buildings and Fixtures	43, 981, 242	54, 991	0	54, 991	0	3.00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	2, 606, 705	0	0	0	0	5.00
6.00	Movable Equipment	18, 486, 521	1, 296, 403	0	1, 296, 403	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8. 00	Subtotal (sum of lines 1-7)	69, 152, 498	1, 351, 394	0	1, 351, 394	338, 994	8.00
9.00	Reconciling Items	0	0	0	0	[0	9. 00
10.00	Total (line 8 minus line 9)	69, 152, 498	1, 351, 394	0	1, 351, 394	338, 994	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		al				
1.00	Land	3, 693, 378	0				1.00
2.00	Land Improvements	45, 658	0				2.00
3.00	Buildings and Fixtures	44, 036, 233	0				3.00
4.00	Building Improvements	0 (0) 705	0				4.00
5.00	Fi xed Equi pment	2, 606, 705	0				5.00
6.00	Movable Equipment	19, 782, 924	0				6.00
7.00	HIT designated Assets	70 1/4 000	U				7.00
8. 00 9. 00	Subtotal (sum of lines 1-7)	70, 164, 898	0				8. 00 9. 00
	Reconciling Items	70 144 000	0				
10.00	Total (line 8 minus line 9)	70, 164, 898	0			l	10.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-1322	Peri od: From 01/01/2022 To 12/31/2022		pared:
			SL	JMMARY OF CAP	I TAL	372372023 1.3	4 pili
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 470, 773	0		0 0	6, 651	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	1, 109, 9 ⁻	14 0	0	2.00
3.00	Total (sum of lines 1-2)	2, 470, 773	0	1, 109, 9 ⁻	14 0	6, 651	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
	·	Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	,				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 477, 424				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1, 109, 914				2.00
3. 00	Total (sum of lines 1-2)	0	3, 587, 338				3. 00

Heal th	n Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2022 To 12/31/2022		pared:
		COM	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 -			
		1. 00	2.00	col. 2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	3.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	50, 381, 974	0	50, 381, 97	4 0. 718051	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	19, 782, 924	0	19, 782, 92	0. 281949	0	2.00
3.00	Total (sum of lines 1-2)	70, 164, 898		70, 164, 89			3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
	DART III DECONCILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1		0 2, 470, 773	73, 773	1.00
2.00	NEW CAP REL COSTS-BEDG & TTAT	0			0 2,470,773	260, 501	2.00
3.00	Total (sum of lines 1-2)	0	ĺ		0 2, 470, 773	•	3.00
			Sl	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)			9 through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12. 00	13.00	14. 00	15. 00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0	37, 538	6, 65	1 0	2, 588, 735	1.00
2. 00	NEW CAP REL COSTS-DEDG & TTXT	1, 109, 914			0		2.00
3.00	Total (sum of lines 1-2)	1, 109, 914		1	J	1	
					1		•

Cost Center Description Basis/Code Amount Cost Center Line # Wkst. A-7 Ref.	
Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	ared:
Cost Center Description	pm
C2	
1.00 2.00 3.00 4.00 5.00	
REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other (chapter 2) 4.00 Trade, quantity, and time discounts (chapter 8) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 2) A 195, 152 NEW CAP REL COSTS-MVBLE 2.00 10 EQUIP 0.00 0 0.0	1 00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other (chapter 2) 4.00 Trade, quantity, and time discounts (chapter 8) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 7.00 Tel ephone services (pay stations excluded) (chapter 2) A 195, 152 NEW CAP REL COSTS-MVBLE 2.00 10 EQUIP 0.00 0 0.00	1. 00
3.00 Investment income - other (chapter 2) 4.00 Trade, quantity, and time discounts (chapter 8) 8.00 Refunds and rebates of expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 7.00 Tel ephone services (pay stations excluded) (chapter 21) 0.00 0 0.00	2. 00
4.00 Trade, quantity, and time discounts (chapter 8) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 21) 0.00 0.00 0 0.	3. 00
discounts (chapter 8) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 21) discounts (chapter 8) 0 0.00 0.00 0.00 0 0.00 0 0 0 0 0 0 0	4. 00
expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 7.00 Tel ephone services (pay stations excluded) (chapter 21) O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
6.00 Rental of provider space by suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 21) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00
7.00 Telephone services (pay stations excluded) (chapter 21) A -5, 261 ADMINISTRATIVE AND GENERAL - 5.02 0 OTHER	6.00
stations excluded) (chapter 21) OTHER	7. 00
	7.00
8.00 Television and radio service A -1,088 OPERATION OF PLANT 7.00 0 (chapter 21)	8.00
9.00 Parking Lot (chapter 21) 0 0.00 0	9. 00
10. 00 Provi der-based physi ci an A-8-2 -1, 744, 307 0 adj ustment	10. 00
	11. 00
	12. 00
13.00 Laundry and Linen service 0 0.00 0.00	13.00
	14. 00 15. 00
and others	
supplies to other than	16. 00
	17. 00
	18. 00
abstracts 19.00 Nursing and allied health 0 0.00 0	19. 00
education (tuition, fees,	
books, etc.) 20.00 Vending machines B -13,928 DI ETARY 10.00 0	20. 00
	21. 00
interest, finance or penalty charges (chapter 21)	
22.00 Interest expense on Medicare 0 0.00 0 overpayments and borrowings to	22. 00
repay Medicare overpayments	22.00
23. 00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65. 00 therapy costs in excess of	23. 00
limitation (chapter 14)	04.00
24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 therapy costs in excess of	24. 00
limitation (chapter 14)	05.00
25. 00 Utilization review - 0 *** Cost Center Deleted *** 114. 00 physicians' compensation	25. 00
(chapter 21)	26. 00
COSTS-BLDG & FIXT	
27. 00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 2. 00 O EQUIP	27. 00
28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00	28. 00
	29. 00 30. 00
therapy costs in excess of limitation (chapter 14)	
30. 99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30. 00	30. 99
instructions)	

Heal th	Financial Systems		PERRY COUNTY	Y HOSPITAL	In Lie	u of Form CMS-2	2552-10
	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	narad:
					10 12/31/2022	5/23/2023 1: 3	
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4.00	Ref. 5.00	
31. 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00	5.00	31.00
01.00	pathology costs in excess of	7, 0, 0	J	SI 22311 1741102301	00.00		01.00
	limitation (chapter 14)						
32.00			0		0. 00	0	32.00
	Depreciation and Interest	_		 		_	
33. 00	ADMINISTRATION MISCELLANEOUS REVENUE	В	-211, 136	ADMINISTRATIVE AND GENERAL	5. 01	0	33.00
33. 01	NONPATIENT SERVICES-CPR/EDU	В	-1 770	AMBULANCE SERVICES	95. 00	0	33. 01
00.01	CLASSES-		1,770	7 MIBOLI WOL SERVI SES	70.00		00.01
33. 02	ADMINISTRATION-MISC EXPENSES	Α	-47, 089	ADMINISTRATIVE AND GENERAL	5. 02	0	33. 02
				OTHER			
33. 03	MISCELLANEOUS RENTAL INCOME -	В	-52, 718	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 03
33. 04	A&G OTHER CLINIC REVENUE	В	1 050	CLI NI C	90.00	0	33. 04
33. 05	WOUND CENTER-ADVERTISING	A A		WOUND CARE	90.00	0	1
33. 06	ADMINI STRATI ON-MI SC EXPENSES	Ä		ADMINISTRATIVE AND GENERAL	5. 01	0	33.06
33. 07	HAF FEES	В		ADMINISTRATIVE AND GENERAL	5. 02	Ō	33. 07
				OTHER			
33. 08	LOBBYING DUES	Α		ADMINISTRATIVE AND GENERAL	5. 01	0	00.00
33. 09	RHC III-MISC EXPENSES	A	-259	RURAL HEALTH CLINIC III -	88. 02	0	33. 09
33 10	OTHER ADJUSTMENTS (SPECIFY)		0	13TH	0.00	0	33. 10
33. 10	(3)				0.00		33. 10
50.00	1 ` '		-2, 759, 834				50.00
	/T C I . W I . I I A						I

(Transfer to Worksheet A,

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	PERRY COUNT	ΓΥ HOSPITAL	In Lie	u of Form CMS-	2552-10
STATEME OFFICE	NT OF COSTS OF SERVICES FROM	RELATED ORGANI ZATIONS AND HO		Period: From 01/01/2022	Worksheet A-8	3-1
OTTTOL	00313			To 12/31/2022	Date/Time Pro 5/23/2023 1:3	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	2. 00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	65, 349	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			o	0	4.00
5. 00	TOTALS (sum of lines 1-4).			65, 349	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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
 1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	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.
- 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Heal th	Financial Syste	ems	PERRY COUNT	Y HOSPITAL	In Lie	u of Form CMS-	2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1322	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2022	D-+- /T: D	
					To 12/31/2022	Date/Time Pro 5/23/2023 1:3	
	Net	Wkst. A-7 Ref.			•	,	
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1.00	65, 349	10					1.00
2.00	0	0					2.00
3.00	0	0					3.00
4.00	0	0					4.00
5.00	65, 349						5.00
* The	amounts on line	es 1-4 (and sub	bscripts as appropriate) are t	ransferred in detail to Wo	rksheet A. column	6. lines as	
			se cost and negative amounts o				t which
			columns 1 and/or 2, the amour				
	Related Orga	ani zati on(s)		·			
	and/or Ho	me Office					
	Type of	Busi ness					

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	100.00

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

6. 00

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

Provider CCN: 15-1322

						10 12/31/2022	5/23/2023 1:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	928, 283			0	0	1
2.00		OPERATING ROOM	888, 006	888, 00	6 0	0	0	2.00
3.00	52. 00	DELIVERY ROOM & LABOR ROOM	147, 175	147, 17		0	0	3.00
4.00		LABORATORY	18, 000		0 18,000	0	0	4.00
5.00		RESPIRATORY THERAPY	465, 227			0	C	5.00
6.00		CLINIC	24, 000	24, 00	0 0	0	C	6.00
7. 00	90. 02	WOUND CARE	134, 149	134, 14	9 0	0	0	7.00
8. 00	91. 00	EMERGENCY	1, 377, 126		0 1, 377, 126	0	0	8.00
9. 00	0.00		0		o c	0	0	9.00
10. 00	0.00		0		o c	0	0	10.00
200.00			3, 981, 966	1, 744, 30	7 2, 237, 659			200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RC	E Memberships &	Component	of Mal practice	:
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12.00	13. 00	14. 00	
1.00		ADULTS & PEDIATRICS	0		0 0	0	C	1
2.00	50.00	OPERATING ROOM	0		0 0	0	0	2.00
3.00	52. 00	DELIVERY ROOM & LABOR ROOM	0		0 0	0	0	3.00
4.00	60. 00	LABORATORY	0		0 0	0	0	4.00
5. 00	65. 00	RESPI RATORY THERAPY	0		o c	0	0	5.00
6. 00	90. 00	CLINIC	0		o c	0	0	6.00
7. 00	90. 02	WOUND CARE	0		o c	0		7.00
8. 00	91. 00	EMERGENCY	0		ol c	0		8.00
9. 00	0.00		0		ol c	0		9.00
10.00	0.00		0		o c	0		10.00
200.00			0		o c	0		200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0		0 0	85, 750		1.00
2.00	50. 00	OPERATING ROOM	0		0 0	888, 006		2.00
3.00		DELIVERY ROOM & LABOR ROOM	0		0 0	147, 175		3.00
4.00		LABORATORY	0		0 0	0		4.00
5.00		RESPI RATORY THERAPY	0		0 0	465, 227		5.00
6. 00		CLINIC	0		0 0	24, 000		6.00
7. 00	90. 02	WOUND CARE	0		0 0	134, 149		7.00
8. 00	91. 00	EMERGENCY	0		o c	0		8.00
9. 00	0.00		0		o c	0		9.00
10.00	0.00		0		o c	0		10.00
200.00			0		o c	1, 744, 307		200.00
						t and the second	·	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-1322

				To	12/31/2022	Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/23/2023 1: 3	4 piii
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		for Cost Allocation	FLXT	EQUI P	BENEFITS DEPARTMENT		
		(from Wkst A			DEPARTMENT		
		col . 7)					
		0	1.00	2.00	4. 00	4A	
1 00	GENERAL SERVI CE COST CENTERS	0 500 705	0 500 705				4 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	2, 588, 735	2, 588, 735				1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 370, 415 574, 376	12, 324	1, 370, 415 6, 524	593, 224		4.00
5. 01	00540 ADMINISTRATIVE AND GENERAL	2, 072, 964	199, 353		46, 510	2, 424, 360	5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL - OTHER	4, 900, 047	164, 728		40, 247	5, 192, 225	5. 02
7.00	00700 OPERATION OF PLANT	2, 202, 986	499, 748	264, 555	9, 670	2, 976, 959	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	72, 626	4, 264		0	79, 147	8.00
9. 00	00900 HOUSEKEEPI NG	524, 828	28, 677		11, 174	579, 860	9. 00
10.00	01000 DI ETARY	247, 687	108, 781	57, 586	0	414, 054	10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	337, 852 479, 751	0 5, 757	0 3, 047	0 14, 789	337, 852 503, 344	11. 00 13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	338, 460	31, 982	· ·	6, 848	394, 220	16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	330, 400	31, 702	10, 730	0, 0+0	374, 220	10.00
30.00	03000 ADULTS & PEDIATRICS	5, 592, 699	378, 920	200, 591	92, 108	6, 264, 318	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	_	0	0	31.00
43.00	04300 NURSERY	0	15, 479	8, 194	0	23, 673	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 034, 223	278, 519	147, 441	25, 318	1, 485, 501	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1,034,223	68, 334		25, 316	1, 465, 501	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 429, 525	140, 976		32, 845	1, 677, 975	54.00
60.00	06000 LABORATORY	2, 245, 284	58, 250		26, 927	2, 361, 297	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	112, 483	0		13	112, 496	62.00
65.00	06500 RESPI RATORY THERAPY	996, 652	87, 587	46, 367	16, 418	1, 147, 024	65.00
66. 00	06600 PHYSI CAL THERAPY	647, 672	43, 069		18, 348	731, 889	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	206, 320	18, 699		6, 262	241, 180	67.00
68.00	06800 SPEECH PATHOLOGY	123, 219	9, 829		3, 721	141, 972	68.00
71.00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O7200 MPL. DEV. CHARGED TO PATIENT	724, 516	0	0	0	724, 516	71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	113, 166 3, 662, 853	32, 131	17, 009	0 2, 343	113, 166 3, 714, 336	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	3, 002, 033	32, 131	17,007	2, 545	3, 714, 330	73.00
88. 00	08800 RURAL HEALTH CLINIC - TCC	3, 047, 334	0	0	64, 159	3, 111, 493	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	1, 084, 482	0	0	20, 720	1, 105, 202	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	2, 199, 123	0	=	53, 375	2, 252, 498	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	974, 963	0	_	23, 995	998, 958	88. 03
90.00	09000 CLINIC	570, 545	95, 839		13, 259	730, 378	90.00
90. 01 90. 02	09001 PAIN MANAGEMENT 09002 WOUND CARE	354, 757	33, 730	0 17, 856	0 10, 844	0 417, 187	90. 01 90. 02
90. 02	09003 ORTHOPEDIC CLINIC	100, 324	33, 730 N	17, 636	2, 729	103, 053	90.02
91. 00	09100 EMERGENCY	2, 402, 062	146, 199	77, 395	25, 655	2, 651, 311	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 102, 002	110, 177	77,070	20,000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	1, 119, 659	95, 945	50, 791	24, 945	1, 291, 340	
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	0	o		116. 00
118.00	1 1	44, 452, 588	2, 559, 120	1, 354, 737	593, 222	44, 407, 293	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29, 615		0	45, 293	
	19200 PHYSI CI ANS' PRI VATE OFFI CES	195, 894	0	0	2	195, 896	
200.00			0				200.00
201. 00 202. 00		44, 648, 482	0 2, 588, 735	1, 370, 415	0 593, 224	44, 648, 482	201. 00
202.00	I TOTAL (Sum TITIES TTO LINGUIGHT 201)	44, 040, 482	2, 300, 135	1,370,415	090, 224	44, 040, 482	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1322

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared:

	5/23/2023 1: 34	
Cost Center Description ADMINISTRATIV Subtotal ADMINISTRATIV OPERATION OF	LAUNDRY &	+ piii
	LINEN SERVICE	
- OTHER		
5. 01 5A. 01 5. 02 7. 00	8. 00	
GENERAL SERVICE COST CENTERS		4 00
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT		1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P		2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 ADMINISTRATIVE AND GENERAL 2, 424, 360		4. 00 5. 01
5. 02 00590 ADMINISTRATIVE AND GENERAL 2, 424, 300 5. 02 00590 ADMINISTRATIVE AND GENERAL 298, 117 5, 490, 342 5, 490, 342		5. 02
7. 00 00700 OPERATION OF PLANT 170, 925 3, 147, 884 443, 710 3, 591, 594		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE 4,544 83,691 11,797 8,943	104, 431	8. 00
9. 00 00900 HOUSEKEEPI NG 33, 293 613, 153 86, 427 60, 141	14, 207	9. 00
10. 00 01000 DI ETARY 23, 773 437, 827 61, 714 228, 133	0	10.00
11. 00 01100 CAFETERI A 19, 398 357, 250 50, 356 0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 28, 900 532, 244 75, 022 12, 073	0	13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 22, 635 416, 855 58, 758 67, 072	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 03000 ADULTS & PEDIATRICS 359, 692 6, 624, 010 933, 691 794, 661	33, 652	30.00
31.00 03100 INTENSIVE CARE UNIT 0 0 0 0	0	31.00
43. 00 04300 NURSERY 1, 359 25, 032 3, 528 32, 463	0	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 85, 292 1, 570, 793 221, 411 584, 104	6.047	EO 00
50. 00 05000 OPERATI NG ROOM 85, 292 1, 570, 793 221, 411 584, 104 52. 00 05200 DELI VERY ROOM & LABOR ROOM 6, 000 110, 509 15, 577 143, 310	6, 047 0	50. 00 52. 00
52. 00 05200 DELI VERT ROUM & LABOR ROUM 0,000 110,309 15,377 143,310 54. 00 05400 RADI OLOGY-DI AGNOSTI C 96,343 1,774,318 250,099 295,652	12, 593	54. 00
60. 00 06000 LABORATORY 135, 576 2, 496, 873 351, 947 122, 160	436	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 6, 459 118, 955 16, 767 0	0	62.00
65. 858 1, 212, 882 170, 962 183, 687	2, 716	65.00
66. 00 06600 PHYSI CAL THERAPY 42, 022 773, 911 109, 087 90, 323	1, 870	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 13, 848 255, 028 35, 947 39, 215	0	67.00
68. 00 06800 SPEECH PATHOLOGY 8, 151 150, 123 21, 161 20, 613	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 41,599 766,115 107,988 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 6, 498 119, 664 16, 867 0	0	72.00
73. 00 O O O O O O O O O O O O O O O O O O	0	73.00
OUTPATIENT SERVICE COST CENTERS		
88. 00 08800 RURAL HEALTH CLINI C - TCC 178, 649 3, 290, 142 463, 762 0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II - PCFP 63, 456 1, 168, 658 164, 728 0 88. 02 08802 RURAL HEALTH CLINIC III - 13TH 129, 329 2, 381, 827 335, 730 0	0	88. 01 88. 02
88. 02 08802 RURAL HEALTH CLINI C 11 13TH 129, 329 2, 381, 827 335, 730 0 88. 03 08803 RURAL HEALTH CLINI C 1 V - SPENCER 57, 356 1, 056, 314 148, 893 0	0	88. 02 88. 03
90. 00 09000 CLI NI C 41, 935 772, 313 108, 861 200, 991	3, 254	90.00
90. 01 09001 PAI N MANAGEMENT	0	90. 01
90. 02 09002 WOUND CARE 23, 953 441, 140 62, 181 70, 738	o l	90. 02
90. 03 09003 0RTHOPEDI C CLINI C 5, 917 108, 970 15, 360 0	o l	90. 03
91. 00 09100 EMERGENCY 152, 228 2, 803, 539 395, 173 306, 607	29, 477	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 0		92.00
OTHER REIMBURSABLE COST CENTERS		
95. 00 09500 AMBULANCE SERVI CES 74, 144 1, 365, 484 192, 472 201, 215	179	95.00
102.00 10200 OPI 0I D TREATMENT PROGRAM O O O	0	102.00
SPECIAL PURPOSE COST CENTERS		
113. 00 11300 INTEREST EXPENSE		113.00
116. 00 11600 HOSPI CE 0 0 0 0 0 0 110 00 110 00 0 0 0 0 0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2,410,511 44,393,444 5,483,591 3,529,486 NONREIMBURSABLE COST CENTERS	104, 431	118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 2, 601 47, 894 6, 751 62, 108	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES		190.00
200.00 Cross Foot Adjustments 0		200.00
201.00 Negative Cost Centers 0 0 0		201.00
202.00 TOTAL (sum lines 118 through 201) 2,424,360 44,648,482 5,490,342 3,591,594	104, 431	202. 00

Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

				T	o 12/31/2022		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	5/23/2023 1: 3 MEDI CAL	4 piii
	cost center bescription	11003EREET TWO	DILIMI	ONIETEKTA	ADMI NI STRATI O	RECORDS &	
					N	LI BRARY	
		9. 00	10. 00	11. 00	13.00	16.00	
	NERAL SERVICE COST CENTERS						
	100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	540 ADMINISTRATIVE AND GENERAL						5. 01
	590 ADMINISTRATIVE AND GENERAL - OTHER						5. 02
	700 OPERATION OF PLANT						7.00
	800 LAUNDRY & LINEN SERVICE	770 000					8.00
	900 HOUSEKEEPI NG	773, 928					9.00
	000 DI ETARY	50, 123	777, 797	407 (0)			10.00
	100 CAFETERI A	0	0	407, 606			11.00
	300 NURSING ADMINISTRATION	2, 653	0	13, 069		F70 000	13.00
	600 MEDI CAL RECORDS & LI BRARY	14, 736	0	14, 881	0	572, 302	16. 00
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	174, 594	777, 797	119, 402	373, 415	165, 860	30.00
	100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
	300 NURSERY	7, 132	0	0	0	0	43.00
	CILLARY SERVICE COST CENTERS		_1				
	OOO OPERATING ROOM	128, 333	0	28, 565	89, 388	7, 290	50.00
	200 DELIVERY ROOM & LABOR ROOM	31, 486	0	0	0	0	52.00
	400 RADI OLOGY-DI AGNOSTI C	64, 957	0	46, 486	0	21, 871	54.00
	000 LABORATORY	26, 840	0	48, 945	0	27, 339	60.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
	500 RESPI RATORY THERAPY	40, 358	0	25, 330	0	25, 517	65.00
	600 PHYSI CAL THERAPY	19, 845	0	22, 839	0	7, 290	66.00
	700 OCCUPATI ONAL THERAPY	8, 616	0	7, 796	0	0	67.00
	800 SPEECH PATHOLOGY	4, 529	0	3, 947	0	7, 290	68. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
	300 DRUGS CHARGED TO PATIENTS	14, 805	0	4, 626	0	0	73. 00
	TPATIENT SERVICE COST CENTERS						
	800 RURAL HEALTH CLINIC - TCC	0	0	0	0	0	88. 00
	801 RURAL HEALTH CLINIC II - PCFP	0	0	0	0	0	88. 01
	802 RURAL HEALTH CLINIC III - 13TH	0	0	0	0	0	88. 02
	803 RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	0	88. 03
	000 CLINIC	44, 160	0	17, 631	55, 162	145, 809	90.00
	001 PAIN MANAGEMENT	0	0	0	0	0	90. 01
	002 WOUND CARE	15, 542	0	11, 258	0	0	90. 02
	003 ORTHOPEDIC CLINIC	0	0	5, 402	0	0	90. 03
	100 EMERGENCY	67, 364	0	37, 429	117, 096	164, 036	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	HER REIMBURSABLE COST CENTERS		. 1		. 1		
	500 AMBULANCE SERVICES	44, 209	0	0		0	95.00
	200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	ECIAL PURPOSE COST CENTERS				1		
	300 INTEREST EXPENSE						113. 00
	600 HOSPI CE	0	0	0	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	760, 282	777, 797	407, 606	635, 061	572, 302	118. 00
	NREI MBURSABLE COST CENTERS	,			,		
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 646	0	0	0		190. 00
	200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	773, 928	777, 797	407, 606	635, 061	572, 302	202. 00

In Lieu of Form CMS-2552-10 PERRY COUNTY HOSPITAL

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1322

					5/23/2023 1::	34 pm
	Cost Center Description	Subtotal	Intern &	Total		
	·		Resi dents			
			Cost & Post			
			Stepdown			
			Adjustments			
		24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01	00540 ADMINISTRATIVE AND GENERAL					5. 01
5. 02	00590 ADMINISTRATIVE 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					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON					13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY					16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	9, 997, 082	0	9, 997, 082		30.00
	03100 INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300 NURSERY	68, 155	0	68, 155		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	2, 635, 931	0	2, 635, 931		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	300, 882	0	300, 882		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 465, 976	0	2, 465, 976		54.00
60.00	06000 LABORATORY	3, 074, 540	0	3, 074, 540		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	135, 722	o	135, 722		62.00
65.00	06500 RESPI RATORY THERAPY	1, 661, 452	o	1, 661, 452		65.00
66.00	06600 PHYSI CAL THERAPY	1, 025, 165	o	1, 025, 165		66.00
67.00	06700 OCCUPATI ONAL THERAPY	346, 602	o	346, 602		67.00
68.00	06800 SPEECH PATHOLOGY	207, 663	o	207, 663		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	874, 103	o	874, 103		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	136, 531	o	136, 531		72.00
	07300 DRUGS CHARGED TO PATIENTS	4, 568, 029	o	4, 568, 029		73. 00
	OUTPATIENT SERVICE COST CENTERS		- 1			
88. 00	08800 RURAL HEALTH CLINIC - TCC	3, 753, 904	0	3, 753, 904		88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	1, 333, 386	o	1, 333, 386		88. 01
	08802 RURAL HEALTH CLINIC III - 13TH	2, 717, 557	0	2, 717, 557		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	1, 205, 207	0	1, 205, 207		88. 03
90.00	09000 CLINIC	1, 348, 181	0	1, 348, 181		90.00
90. 01	09001 PAIN MANAGEMENT	1, 340, 101	0	0		90.01
90. 02	09002 WOUND CARE	600, 859	0	600, 859		90. 02
	09003 ORTHOPEDIC CLINIC	129, 732	0	129, 732		90.02
91.00	09100 EMERGENCY	3, 920, 721	0	3, 920, 721		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 920, 721	_	3, 920, 721		1
92. 00			0			92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	4 000 550	ما	4 000 550		
	09500 AMBULANCE SERVICES	1, 803, 559	0	1, 803, 559		95.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0		102. 00
440.00	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113.00
	11600 HOSPI CE	0	0	0		116.00
118.00		44, 310, 939	0	44, 310, 939		118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	130, 399		130, 399		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	207, 144	0	207, 144		192. 00
200.00	, ,	0	0	0		200. 00
201.00		0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	44, 648, 482	0	44, 648, 482		202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Provider CCN: 15-1322

				То	12/31/2022	Date/Time Pre 5/23/2023 1:3	
			CAPI TAL REI	ATED COSTS		3/23/2023 1.3	4 piii
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FLXT	EQUI P		BENEFITS DEPARTMENT	
		Capi tal Rel ated Costs				DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 324		18, 848	18, 848	4.00
5. 01 5. 02	00540 ADMI NI STRATI VE AND GENERAL 00590 ADMI NI STRATI VE AND GENERAL - OTHER	0	199, 353 164, 728		304, 886 251, 931	1, 477 1, 278	5. 01 5. 02
7. 00	00700 OPERATION OF PLANT		499, 748		764, 303	307	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	l o	4, 264		6, 521	0	8. 00
9. 00	00900 HOUSEKEEPI NG	0	28, 677		43, 858	355	9. 00
10.00	01000 DI ETARY	0	108, 781	57, 586	166, 367	0	10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11.00
	01300 NURSI NG ADMI NI STRATI ON	0	5, 757		8, 804	470	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	31, 982	16, 930	48, 912	218	16. 00
30. 00	03000 ADULTS & PEDIATRICS	l ol	378, 920	200, 591	579, 511	2, 933	30. 00
	03100 INTENSIVE CARE UNIT		370, 720		0	2, 733	31. 00
	04300 NURSERY	0	15, 479		23, 673	0	43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	278, 519		425, 960	804	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	68, 334		104, 509	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	140, 976		215, 605	1, 043	
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58, 250 0		89, 086 0	855 0	60. 00 62. 00
65. 00	06500 RESPIRATORY THERAPY		87, 587	I -	133, 954	522	65. 00
66. 00	06600 PHYSI CAL THERAPY	l o	43, 069		65, 869	583	66. 00
	06700 OCCUPATI ONAL THERAPY	O	18, 699		28, 598	199	67.00
68. 00	06800 SPEECH PATHOLOGY	0	9, 829	5, 203	15, 032	118	68. 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 OUTPATIENT SERVICE COST CENTERS] 0	32, 131	17, 009	49, 140	74	73. 00
88. 00	08800 RURAL HEALTH CLINIC - TCC	O	0	0	ol	2, 038	88. 00
	08801 RURAL HEALTH CLINIC II - PCFP	0	0		0	658	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	Ö	0		Ö	1, 695	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	762	88. 03
90.00	09000 CLI NI C	0	95, 839	50, 735	146, 574	421	90.00
	09001 PAIN MANAGEMENT	0	0	0	0	0	90. 01
90. 02 90. 03	O9002 WOUND CARE O9003 ORTHOPEDIC CLINIC	0	33, 730	17, 856	51, 586	344 87	90. 02 90. 03
	09100 EMERGENCY		146, 199	77, 395	223, 594	815	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		140, 177	77, 373	223, 374	013	92.00
	OTHER REIMBURSABLE COST CENTERS				- 1		
	09500 AMBULANCE SERVI CES	0	95, 945	50, 791	146, 736		95.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
440.00	SPECIAL PURPOSE COST CENTERS	1 1		ı			440.00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0		0		113. 00 116. 00
118.00			2, 559, 120	1, 354, 737	3, 913, 857	18, 848	
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	2, 337, 120	1, 354, 757	3, 713, 037	10, 040	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	29, 615	15, 678	45, 293	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00					0		200. 00
201.00		_	0	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	0	2, 588, 735	1, 370, 415	3, 959, 150	18, 848	202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322

				''	0 12/31/2022	5/23/2023 1: 3	
	Cost Center Description	ADMI NI STRATI V	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	·	E AND GENERAL	E AND GENERAL	PLANT	LINEN SERVICE		
			- OTHER				
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 ADMINISTRATIVE AND GENERAL	306, 363					5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL - OTHER	37, 675	290, 884				5. 02
7. 00	00700 OPERATION OF PLANT	21, 601	23, 508				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	574	625		9, 736	•	8. 00
9. 00	00900 HOUSEKEEPI NG	4, 207	4, 579		1, 324	67, 882	9. 00
10.00	01000 DI ETARY	3, 004	3, 270		0	.,	
11. 00	01100 CAFETERI A	2, 451	2, 668		0	· -	
13.00	01300 NURSING ADMINISTRATION	3, 652	3, 975		0		1
16.00	01600 MEDI CAL RECORDS & LI BRARY	2, 860	3, 113	15, 121	0	1, 293	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	45, 441	49, 464		3, 138	15, 312	1
31.00	03100 INTENSIVE CARE UNIT	0	0				31.00
43.00	04300 NURSERY	172	187	7, 319	0	626	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	10, 779	11, 731	131, 685	564	11, 256	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	758			0	2, 762	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 175	13, 251	66, 654	1, 174		1
60.00	06000 LABORATORY	17, 134	18, 647		41	2, 354	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	816	888		0	· -	62.00
65. 00	06500 RESPI RATORY THERAPY	8, 323	9, 058		253		
66. 00	06600 PHYSI CAL THERAPY	5, 311	5, 780		174	1, 741	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 750	1, 905		0		
68. 00	06800 SPEECH PATHOLOGY	1, 030	1		0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 257	5, 721	0	0		
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	821	894		0		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	26, 951	29, 331	15, 192	0	1, 299	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	00 577	04 574				00.00
88. 00	08800 RURAL HEALTH CLINIC - TCC	22, 577	24, 571		_	· -	1
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	8, 019	8, 728		-	1	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	16, 344	17, 787		0	1	
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	7, 248	7, 889		0	0	88. 03
90. 00 90. 01	09000 CLINIC 09001 PALN MANAGEMENT	5, 300	5, 768		303 0	3, 873 0	90. 00 90. 01
90.01	09001 PATN MANAGEMENT	2 027			-	1	
90. 02	09003 ORTHOPEDI C CLI NI C	3, 027 748	3, 294 814		0	1, 363 0	90.02
	1				· ·		
91.00	09100 EMERGENCY	19, 238	20, 937	69, 124	2, 748	5, 909	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS	0.270	10 107	45 274	17	2.070	05.00
	09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM	9, 370	10, 197 0		0		95.00
102.00	SPECIAL PURPOSE COST CENTERS	0	0	0	U	0	102. 00
112 00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0	0	0	_	116.00
118.00	1	304, 613	290, 526		9, 736		118.00
110.00	NONREI MBURSABLE COST CENTERS	304,013	270, 320	175,717	7, 730	1 00,000	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	329	358	14, 002	0	1 107	190. 00
	19000 BIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 421	330		-	.,	190.00
200.00		1, 421			U		200.00
200.00	,	0	_	0	0	_	200.00
202.00	1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	306, 363	290, 884		J		202.00
_52.00	1 1.5 (5am 1.1.55 116 till bagil 201)	1 333, 303	2,0,004	1 337,717	,,,,,	0,,002	1-02.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322

				To	12/31/2022	Date/Time Pro 5/23/2023 1:3	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	Subtotal	уч ріп
		10. 00	11. 00	13.00	16. 00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00590 ADMINISTRATIVE 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						9. 00
10.00	01000 DI ETARY	228, 469					10.00
11.00	01100 CAFETERI A	0	5, 119				11.00
13. 00 16. 00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	0	164 187		71, 704		13. 00 16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	U _I	107] 0	71, 704		10.00
30.00	03000 ADULTS & PEDI ATRI CS	228, 469	1, 499	11, 772	20, 782	1, 137, 476	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		0	.,,	31.00
43.00	04300 NURSERY	0	0	0	0	31, 977	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	359		913	596, 869	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	- 1	0	141, 163	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	584 615		2, 740 3, 425	318, 923 159, 698	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	013		3, 423	1, 704	1
65. 00	06500 RESPIRATORY THERAPY	Ö	318		3, 197	200, 577	
66. 00	06600 PHYSI CAL THERAPY	O	287		913	101, 021	1
67.00	06700 OCCUPATI ONAL THERAPY	0	98	0	o	42, 147	67.00
68.00	06800 SPEECH PATHOLOGY	0	50		913	23, 308	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	- 1	0	10, 978	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	1, 715	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	58	0	0	122, 045	73. 00
88. 00	08800 RURAL HEALTH CLINIC - TCC	0	0	O	ol	49, 186	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	Ö	0		ő	17, 105	
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	O	0	- 1	Ö	35, 826	
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	0	0	o	15, 899	88. 03
90.00	09000 CLI NI C	0	221	1, 739	18, 269	227, 781	1
90. 01	09001 PAIN MANAGEMENT	0	0	-	0	C	
90. 02	09002 WOUND CARE	0	141		0	75, 703	1
90. 03 91. 00	09003 ORTHOPEDIC CLINIC 09100 EMERGENCY	0	68 470		0 20, 552	1, 717 367, 078	1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	U	470	3,091	20, 552	307, 076	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	216, 354	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	О		102.00
	SPECIAL PURPOSE COST CENTERS						1
	11300 NTEREST EXPENSE		_	_	_	_	113.00
	11600 HOSPI CE	0	O 5 110		71 704		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	228, 469	5, 119	20, 020	71, 704	3, 896, 550	J 18.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	ol	ol	61 170	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	- 1	ol		192.00
200.00	1 1		· ·		Ĭ		200.00
201.00		o	0	0	o	C	201. 00
202. 00	TOTAL (sum lines 118 through 201)	228, 469	5, 119	20, 020	71, 704	3, 959, 150	202.00

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322 Period: From 01/01/2022 Part II

12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 1.00 1.00 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 ADMINISTRATIVE AND GENERAL 5.01 5.01 00590 ADMINISTRATIVE AND GENERAL - OTHER 5.02 5.02 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1, 137, 476 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 04300 NURSERY 43.00 31, 977 43.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 596, 869 05200 DELIVERY ROOM & LABOR ROOM 0000000000 52.00 52.00 141, 163 05400 RADI OLOGY-DI AGNOSTI C 54.00 318, 923 54.00 60.00 06000 LABORATORY 159, 698 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 1, 704 62.00 06500 RESPIRATORY THERAPY 65 00 200.577 65.00 06600 PHYSI CAL THERAPY 66.00 101, 021 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 42, 147 67.00 06800 SPEECH PATHOLOGY 68.00 23, 308 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 10, 978 71 00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 1, 715 72.00 07300 DRUGS CHARGED TO PATIENTS 0 122, 045 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 88 00 0 49, 186 88.01 08801 RURAL HEALTH CLINIC II - PCFP 00000000 17, 405 88.01 08802 RURAL HEALTH CLINIC III - 13TH 88.02 35, 826 88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER 15, 899 88. 03 09000 CLI NI C 227, 781 90 00 90 00 90.01 09001 PAIN MANAGEMENT 90.01 90 02 09002 WOUND CARE 75, 703 90.02 09003 ORTHOPEDIC CLINIC 90.03 90.03 1.717 09100 EMERGENCY 91.00 367,078 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95. 00 09500 AMBULANCE SERVICES 0 216, 354 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 0 116. 00 11600 HOSPI CE 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 896, 550 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 00 61.179 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 1, 421 192.00 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 201.00 0 3, 959, 150 202.00 TOTAL (sum lines 118 through 201) 202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1322 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description **FOULP** BENEFITS E AND GENERAL FLXT n (SQUARE (ACCUM. COST) (SQUARE DEPARTMENT FEET) (GROSS FEET) SALARIES) 1. 00 2.00 4.00 5A. 01 5. 01 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 121, 416 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 121, 416 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 578 16, 824, 348 4.00 578 4.00 00540 ADMINISTRATIVE AND GENERAL 9, 350 1, 319, 049 5.01 9, 350 -2, 424, 360 42, 224, 122 5.01 5.02 00590 ADMINISTRATIVE AND GENERAL - OTHER 7,726 7,726 1, 141, 433 5, 192, 225 5.02 7.00 00700 OPERATION OF PLANT 23, 439 23, 439 274, 236 0 2, 976, 959 7.00 79, 147 00800 LAUNDRY & LINEN SERVICE 200 0 8.00 8 00 200 0 0 579, 860 9.00 00900 HOUSEKEEPI NG 1, 345 1, 345 316, 895 9.00 10.00 01000 DI ETARY 5, 102 5, 102 0 0 414, 054 10.00 0 11.00 01100 CAFETERI A 0 C 0 337, 852 11.00 01300 NURSING ADMINISTRATION 270 270 419, 432 o 13 00 503.344 13 00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,500 1,500 194, 210 394, 220 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 6, 264, 318 30.00 03000 ADULTS & PEDIATRICS 30.00 17,772 17,772 2, 612, 268 0 03100 INTENSIVE CARE UNIT 31 00 0 0 0 31 00 43.00 04300 NURSERY 726 726 0 0 23, 673 43.00 ANCILLARY SERVICE COST CENTERS 50 00 718, 046 0 1, 485, 501 50.00 05000 OPERATING ROOM 13 063 13,063 05200 DELIVERY ROOM & LABOR ROOM 52.00 3, 205 3, 205 0 104, 509 52.00 05400 RADI OLOGY-DI AGNOSTI C 931, 514 0 1, 677, 975 54.00 6,612 6, 612 54.00 0 2, 361, 297 60.00 06000 LABORATORY 2,732 2,732 763, 666 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 112, 496 62 00 0 372 62 00 0 65.00 06500 RESPIRATORY THERAPY 4, 108 4, 108 465, 635 1, 147, 024 65.00 06600 PHYSI CAL THERAPY 520, 369 0 66.00 2.020 2,020 731, 889 66.00 0 06700 OCCUPATI ONAL THERAPY 241, 180 67.00 877 877 177.605 67.00 06800 SPEECH PATHOLOGY 141, 972 68.00 461 461 105, 522 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 724, 516 71.00 71.00 0 0 07200 I MPL. DEV. CHARGED TO PATIENT 0 72 00 113, 166 72 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 73.00 1, 507 1, 507 66, 448 3, 714, 336 73.00 08800 RURAL HEALTH CLINIC - TCC 88.00 1, 819, 598 0 3, 111, 493 88.00 o 88.01 08801 RURAL HEALTH CLINIC II - PCFP 0 C 587, 644 1, 105, 202 88.01 08802 RURAL HEALTH CLINIC III - 13TH 0 2, 252, 498 0 1, 513, 753 88.02 88. 02 0 08803 RURAL HEALTH CLINIC IV - SPENCER 0 88.03 0 680, 522 998, 958 88.03 90.00 09000 CLI NI C 4.495 4, 495 376, 032 0 730, 378 90.00 09001 PAIN MANAGEMENT 0 90.01 90.01 09002 WOUND CARE 307, 557 0 417, 187 90 02 90 02 1,582 1, 582 90.03 09003 ORTHOPEDIC CLINIC 77, 406 0 103, 053 90.03 91.00 09100 EMERGENCY 6,857 6,857 727,603 2, 651, 311 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 4,500 4,500 707, 473 1, 291, 340 95.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 102.00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116,00 SUBTOTALS (SUM OF LINES 1 through 117) -2, 424, 360 120, 027 120,027 16, 824, 288 41, 982, 933 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 389 1, 389 0 0 45, 293 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 60 0 195, 896 192. 00 200.00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 588, 735 1, 370, 415 593, 224 2, 424, 360 202. 00 Part I) 203.00 0. 057416 203. 00 Unit cost multiplier (Wkst. B, Part I) 21. 321201 11, 286939 0.035260 204.00 Cost to be allocated (per Wkst. B, 18.848 306, 363 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 0.001120 0.007256 205.00 205.00 II) NAHE adjustment amount to be allocated 206.00 206 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1322 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm Cost Center Description Reconciliatio ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG PLANT LINEN SERVICE (SQUARE E AND GENERAL n - OTHER (SQUARE (POUNDS OF FEET) (ACCUM. COST I AUNDRY) FEET) NO PBP) 5A. 02 5.02 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 ADMINISTRATIVE AND GENERAL 5.01 5.01 00590 ADMINISTRATIVE AND GENERAL - OTHER 38, 950, 996 -5, 490, 342 5.02 5.02 00700 OPERATION OF PLANT 7.00 3, 147, 884 80, 323 7.00 83, 691 8.00 00800 LAUNDRY & LINEN SERVICE 0 200 8.152 8.00 9.00 00900 HOUSEKEEPI NG 0 613, 153 1, 345 1, 109 78, 778 9.00 0 5, 102 01000 DI ETARY 437, 827 5, 102 10.00 10.00 0 11.00 01100 CAFETERI A 0 357, 250 0 0 O 11.00 13.00 01300 NURSING ADMINISTRATION 0 532, 244 270 0 270 13.00 416, 855 01600 MEDICAL RECORDS & LIBRARY 16.00 1,500 0 1,500 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 6, 624, 010 17, 772 2,627 17, 772 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 0 0 04300 NURSERY 25,032 43.00 0 726 0 726 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1, 570, 793 13, 063 472 13, 063 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 3, 205 52.00 110, 509 3. 205 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 774, 318 6,612 983 6, 612 54.00 0 60.00 06000 LABORATORY 2, 496, 873 2,732 34 2,732 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 118, 955 0 0 62.00 65 00 06500 RESPIRATORY THERAPY 1, 212, 882 4. 108 212 4.108 65 00 06600 PHYSI CAL THERAPY 66.00 773, 911 2,020 146 2,020 66.00 06700 OCCUPATIONAL THERAPY 255, 028 877 877 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 150, 123 461 ol 461 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 766, 115 0 71 00 0 Ω 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 119, 664 C 0 0 72.00 1, 507 07300 DRUGS CHARGED TO PATIENTS 3, 927, 598 1, 507 73.00 73.00 0 OUTPATIENT SERVICE COST CENTERS 88 00 88 00 08800 RURAL HEALTH CLINIC - TCC 0 3, 290, 142 0 0 0 88.01 08801 RURAL HEALTH CLINIC II - PCFP 1, 168, 658 0 0 0 88.01 08802 RURAL HEALTH CLINIC III - 13TH 0 2, 381, 827 0 88.02 0 0 88.02 0 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 1, 056, 314 0 0 0 88.03 4, 495 90 00 772, 313 09000 CLI NI C 4.495 254 90 00 0 90.01 09001 PAIN MANAGEMENT 0 90.01 90 02 09002 WOUND CARE 0 441, 140 1,582 0 1,582 90 02 09003 ORTHOPEDIC CLINIC 0 90.03 90.03 108.970 0 0 09100 EMERGENCY 2, 301 91.00 2,803,539 6,857 6,857 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95. 00 09500 AMBULANCE SERVICES 0 1, 365, 484 4,500 14 4.500 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE \cap 0 0 116,00 SUBTOTALS (SUM OF LINES 1 through 117) -5, 490, 342 38, 903, 102 78, 934 8, 152 77, 389 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 389 190. 00 47, 894 1,389 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES -207, 144 0 0 192.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 773, 928 202. 00 202.00 Cost to be allocated (per Wkst. B, 5, 490, 342 3, 591, 594 104, 431 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.140955 44.714391 12.810476 9. 824164 203. 00 204.00 Cost to be allocated (per Wkst. B, 809, 719 67, 882 204. 00 290, 884 9,736 Part II) 0.007468 10.080786 1. 194308 0. 861687 205. 00 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207. 00 207 00 Parts III and IV)

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm Cost Center Description DI ETARY CAFETERI A NURSI NG MEDI CAL ADMI NI STRATI O RECORDS & (MEALS (FTE'S) SERVED) LI BRARY Ν (DI RECT (TIME NRSING HRS) SPENT) 10.00 11.00 13.00 16.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 ADMINISTRATIVE AND GENERAL 5.01 5.01 00590 ADMINISTRATIVE AND GENERAL - OTHER 5.02 5.02 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 9, 932 10.00 11.00 01100 CAFETERI A 0 12,600 11.00 13.00 01300 NURSING ADMINISTRATION 0 404 130, 553 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 460 314 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 932 3, 691 76, 765 91 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 0 0 04300 NURSERY 43.00 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 883 18, 376 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 1, 437 54.00 0 12 54.00 0 60.00 06000 LABORATORY 1,513 0 15 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 000000 0 0 62.00 65 00 06500 RESPIRATORY THERAPY 783 0 14 65 00 06600 PHYSI CAL THERAPY 0 66.00 706 4 66.00 67.00 06700 OCCUPATI ONAL THERAPY 241 0 0 67.00 06800 SPEECH PATHOLOGY 4 68.00 122 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71 00 71 00 C 07200 I MPL. DEV. CHARGED TO PATIENT 0 72.00 C 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 143 0 OUTPATIENT SERVICE COST CENTERS 88. 00 88 00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.01 08801 RURAL HEALTH CLINIC II - PCFP 0 0 0 88.01 08802 RURAL HEALTH CLINIC III - 13TH 0 88.02 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0 0 0 88.03 0 90 00 09000 CLI NI C 80 545 11, 340 90 00 90.01 09001 PAIN MANAGEMENT 0 90.01 90 02 09002 WOUND CARE 0 348 0 0 90.02 09003 ORTHOPEDIC CLINIC 0 90.03 90.03 0 167 0 09100 EMERGENCY 91.00 0 1, 157 24.072 90 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0 Ω 0 0 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE Λ 0 Λ 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 9, 932 130, 553 118.00 118.00 12,600 314 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 777, 797 407, 606 635, 061 572, 302 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 78. 312223 32. 349683 4.864392 1, 822. 617834 203.00 204.00 Cost to be allocated (per Wkst. B, 20,020 204.00 228, 469 5, 119 71, 704 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 23.003323 0.406270 0.153348 228. 356688 205.00 11) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207. 00 207 00 Parts III and IV)

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1322	Period: Worksheet C From 01/01/2022 Part I
		To 12/31/2022 Date/Time Prepared

					To 12/31/2022	Date/Time Pre 5/23/2023 1:3	pared: 4 pm
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description		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	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	9, 997, 082		9, 997, 082		0	
	03100 INTENSIVE CARE UNIT	0		(·	0	31.00
	04300 NURSERY	68, 155		68, 155	0	0	43.00
	ANCILLARY SERVICE COST CENTERS				.1		
	05000 OPERATING ROOM	2, 635, 931		2, 635, 93		0	
	05200 DELIVERY ROOM & LABOR ROOM	300, 882		300, 882		0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 465, 976		2, 465, 976		0	54.00
	06000 LABORATORY	3, 074, 540		3, 074, 540		0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	135, 722	_	135, 722		0	62.00
	06500 RESPI RATORY THERAPY	1, 661, 452	0	1, 661, 452		0	65.00
	06600 PHYSI CAL THERAPY	1, 025, 165	0	1, 025, 165		0	66.00
	06700 OCCUPATI ONAL THERAPY	346, 602	0	346, 602		0	67.00
	06800 SPEECH PATHOLOGY	207, 663	0	207, 663		0	68.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	874, 103		874, 103		0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	136, 531		136, 53		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	4, 568, 029		4, 568, 029	9 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	0.750.004		0.750.00	ıl al		00.00
	08800 RURAL HEALTH CLINIC - TCC	3, 753, 904		3, 753, 904		0	88.00
	08801 RURAL HEALTH CLINIC II - PCFP	1, 333, 386		1, 333, 386		0	
	08802 RURAL HEALTH CLINIC III - 13TH	2, 717, 557		2, 717, 557		0	88. 02
	08803 RURAL HEALTH CLINIC IV - SPENCER	1, 205, 207		1, 205, 207		0	88. 03
	09000 CLINIC	1, 348, 181		1, 348, 18		0	90.00
	09001 PAIN MANAGEMENT	(00.050		(00.05		0	90. 01 90. 02
	09002 WOUND CARE	600, 859		600, 859		0	
	09003 ORTHOPEDIC CLINIC	129, 732		129, 732		0	90.03
	09100 EMERGENCY	3, 920, 721		3, 920, 72		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 502, 470		1, 502, 470	الــــــــــال	0	92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1 002 550		1 002 FF	ol ol	0	95.00
	10200 OPI OI D TREATMENT PROGRAM	1, 803, 559		1, 803, 559		0	102.00
	SPECIAL PURPOSE COST CENTERS	0		(/	0	102.00
	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE			,		0	116.00
200.00		45, 813, 409	0	45, 813, 409	را ال		200.00
200.00	,	1, 502, 470	0	1, 502, 470			200.00
201.00	l l	44, 310, 939	0				201.00
202.00	Total (See Histiactions)	1 44, 510, 737	U	1 44,010,70	'ı	0	1202.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1322	Peri od: Worksheet C
		From 01/01/2022 Part I
		To 12/31/2022 Data/Time Prepared

					To 12/31/2022	Date/Time Pre 5/23/2023 1:3	pared: 4 pm
			Title	: XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	5, 374, 008		5, 374, 00	8		30.00
31.00	03100 INTENSIVE CARE UNIT	0			0		31.00
43.00	04300 NURSERY	120, 720		120, 72	0		43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	975, 904	8, 237, 177			0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	529, 008	122, 023			0. 000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	907, 377	17, 084, 485			0. 000000	54.00
60.00	06000 LABORATORY	1, 613, 747	18, 905, 252			0. 000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	54, 878	378, 844			0. 000000	62.00
65.00	06500 RESPI RATORY THERAPY	1, 150, 591	3, 842, 252			0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	654, 276	2, 361, 787	3, 016, 06		0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	556, 907	764, 240	1, 321, 14		0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	163, 228	507, 730			0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 542, 013	3, 092, 577	4, 634, 59		0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 312	206, 913			0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 684, 135	17, 571, 937	20, 256, 07	2 0. 225514	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC	0	5, 567, 354				88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	2, 151, 240				88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0	2, 872, 301	2, 872, 30	1		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	1, 488, 978				88. 03
90.00	09000 CLI NI C	30, 710	904, 220	934, 93			90.00
90. 01	09001 PAI N MANAGEMENT	0	0	1	0. 000000	0. 000000	90. 01
90. 02	09002 WOUND CARE	16, 194	1, 505, 917			0. 000000	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	0	782, 478			0. 000000	90. 03
91.00	09100 EMERGENCY	513, 236	14, 939, 653			0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	32, 125	865, 720	897, 84	5 1. 673418	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	4, 509, 939			0. 000000	
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0		102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0		0		116.00
200.00		16, 920, 369	108, 663, 017	125, 583, 38	6		200. 00
201.00	1						201. 00
202.00	Total (see instructions)	16, 920, 369	108, 663, 017	125, 583, 38	6		202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1322	Period: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm		

			10 12/31/2022	5/23/2023 1: 34 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient		<u> </u>	
,	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. 000000			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 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. 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 - TCC				88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP				88. 01
88.02 08802 RURAL HEALTH CLINIC III - 13TH				88. 02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER				88. 03
90. 00 09000 CLI NI C	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 ORTHOPEDI C CLI NI C	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				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
102.00 10200 OPIOLD TREATMENT PROGRAM				102. 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				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1322	Period: Worksheet C From 01/01/2022 Part I
		To 12/31/2022 Date/Time Prepared:

			j	To 12/31/2022	Date/Time Pre 5/23/2023 1:3	pared: 4 pm
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
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	
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00 03000 ADULTS & PEDI ATRI CS	9, 997, 082		9, 997, 082	2 0	9, 997, 082	30.00
31.00 03100 INTENSIVE CARE UNIT	0		('l "I	0	31.00
43. 00 04300 NURSERY	68, 155		68, 155	5 0	68, 155	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 635, 931		2, 635, 931		2, 635, 931	
52.00 05200 DELIVERY ROOM & LABOR ROOM	300, 882		300, 882		300, 882	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 465, 976		2, 465, 976		2, 465, 976	
60. 00 06000 LABORATORY	3, 074, 540		3, 074, 540	이	3, 074, 540	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	135, 722		135, 722		135, 722	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 661, 452		1, 661, 452		1, 661, 452	
66. 00 06600 PHYSI CAL THERAPY	1, 025, 165		1, 025, 165		1, 025, 165	
67. 00 06700 OCCUPATI ONAL THERAPY	346, 602		346, 602		346, 602	67.00
68. 00 06800 SPEECH PATHOLOGY	207, 663		207, 663		207, 663	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	874, 103		874, 103		874, 103	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	136, 531		136, 531		136, 531	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 568, 029		4, 568, 029	9 0	4, 568, 029	73.00
OUTPATIENT SERVICE COST CENTERS		T				
88.00 08800 RURAL HEALTH CLINIC - TCC	3, 753, 904		3, 753, 904		3, 753, 904	88. 00
88. 01 08801 RURAL HEALTH CLINIC II - PCFP	1, 333, 386		1, 333, 386		1, 333, 386	
88. 02 08802 RURAL HEALTH CLINIC III - 13TH	2, 717, 557		2, 717, 557		2, 717, 557	
88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER	1, 205, 207		1, 205, 207		1, 205, 207	88. 03
90. 00 09000 CLI NI C	1, 348, 181		1, 348, 181		1, 348, 181	
90. 01 09001 PAI N MANAGEMENT	0		(´	0	90. 01
90. 02 09002 WOUND CARE	600, 859		600, 859		600, 859	90. 02
90. 03 09003 ORTHOPEDIC CLINIC	129, 732		129, 732		129, 732	
91. 00 09100 EMERGENCY	3, 920, 721		3, 920, 721		3, 920, 721	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 502, 470		1, 502, 470)	1, 502, 470	92.00
OTHER REIMBURSABLE COST CENTERS		ı				
95. 00 09500 AMBULANCE SERVI CES	1, 803, 559		1, 803, 559		1, 803, 559	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0		()	0	102.00
SPECIAL PURPOSE COST CENTERS		1	ı	1		
113. 00 11300 INTEREST EXPENSE	_				_	113.00
116. 00 11600 HOSPI CE	0	_	(] .		116.00
200.00 Subtotal (see instructions)	45, 813, 409		10,010,10		45, 813, 409	
201.00 Less Observation Beds	1, 502, 470		1, 502, 470		1, 502, 470	
202.00 Total (see instructions)	44, 310, 939	0	44, 310, 939	위 이	44, 310, 939	J202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1322	Period: Worksheet C From 01/01/2022 Part I
		To 12/31/2022 Date/Time Prepared

				1	o 12/31/2022	Date/Time Pre 5/23/2023 1:3	
			Ti tl	e XIX	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	·	+ col. 7)	Rati o	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 374, 008		5, 374, 008	3		30.00
31.00	03100 INTENSIVE CARE UNIT	0		(31.00
43.00	04300 NURSERY	120, 720		120, 720			43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	975, 904	8, 237, 177	9, 213, 08	0. 286107	0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	529, 008	122, 023	651, 031	0. 462162	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	907, 377	17, 084, 485	17, 991, 862	0. 137061	0.000000	54.00
60.00	06000 LABORATORY	1, 613, 747	18, 905, 252	20, 518, 999	0. 149839	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	54, 878	378, 844	433, 722	0. 312924	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	1, 150, 591	3, 842, 252	4, 992, 843	0. 332767	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	654, 276	2, 361, 787	3, 016, 063	0. 339902	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	556, 907	764, 240	1, 321, 147	0. 262349	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	163, 228	507, 730	670, 958	0. 309502	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 542, 013	3, 092, 577	4, 634, 590	0. 188604	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 312	206, 913	208, 225	0. 655690	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 684, 135	17, 571, 937	20, 256, 072	0. 225514	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC	0	5, 567, 354	5, 567, 354	0. 674271	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	2, 151, 240		0. 619822	0.000000	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0	2, 872, 301	2, 872, 301	0. 946125	0.000000	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	1, 488, 978	1, 488, 978	0. 809419	0.000000	88. 03
90.00	09000 CLI NI C	30, 710	904, 220	934, 930	1. 442013	0.000000	
90. 01	09001 PAIN MANAGEMENT	0	0	(0. 000000	0.000000	90. 01
90.02	09002 WOUND CARE	16, 194	1, 505, 917	1, 522, 111	0. 394754	0.000000	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	0	782, 478	782, 478	0. 165796	0.000000	90. 03
91.00	09100 EMERGENCY	513, 236	14, 939, 653	15, 452, 889	0. 253721	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	32, 125	865, 720	897, 845	1. 673418	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0	4, 509, 939	4, 509, 939	0. 399908	0. 000000	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	()		102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
	11600 H0SPI CE	0	0	(116. 00
200.00	Subtotal (see instructions)	16, 920, 369	108, 663, 017	125, 583, 386	b		200. 00
201.00							201. 00
202.00	Total (see instructions)	16, 920, 369	108, 663, 017	125, 583, 386)		202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1322
Form 01/01/2022
To 12/31/2022
Date/Time Prepared:
F(22/2023 1: 24 pm

			10 12/31/2022	5/23/2023 1: 34	
		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. 286107				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 462162				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 137061				54.00
60. 00 06000 LABORATORY	0. 149839				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 312924				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 332767				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 339902				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 262349				67.00
68.00 06800 SPEECH PATHOLOGY	0. 309502				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 188604				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 655690				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 225514				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC - TCC	0. 674271				88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP	0. 619822				88. 01
88.02 08802 RURAL HEALTH CLINIC III - 13TH	0. 946125				88. 02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0. 809419				88. 03
90. 00 09000 CLI NI C	1. 442013				90.00
90. 01 09001 PAI N MANAGEMENT	0. 000000				90. 01
90. 02 09002 WOUND CARE	0. 394754				90.02
90. 03 09003 ORTHOPEDI C CLI NI C	0. 165796				90. 03
91. 00 09100 EMERGENCY	0. 253721				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 673418				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 399908				95.00
102.00 10200 OPI OI D TREATMENT PROGRAM					102.00
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					201.00
202.00 Total (see instructions)				2	202.00

Health Financial Systems	PERRY COUNTY H	OSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE CORREDUCTIONS FOR MEDICALD ONLY	ST TO CHARGE RATIOS NET OF	Provider CCN: 15-1322	From 01/01/2022	Worksheet C Part II Date/Time Prepared

			To	12/31/2022	Date/Time Pre 5/23/2023 1:3	pared:
		Ti +I	e XIX	Hospi tal	PPS	4 piii
Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
COST CONTENT DESCRIPTION	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
	Part I, col.	Part II col.	Capital Cost	Reduction	Reduction	
	26)	26)	(col . 1 -		Amount	
	20)	20)	col . 2)		Amount	
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 635, 931	596, 869	2, 039, 062	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	300, 882	141, 163	159, 719	ol	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 465, 976	318, 923	2, 147, 053	o	0	54.00
60. 00 06000 LABORATORY	3, 074, 540	159, 698	2, 914, 842	o	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	135, 722	1, 704	134, 018	o	0	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 661, 452	200, 577	1, 460, 875	o	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 025, 165	101, 021	924, 144	o	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	346, 602	42, 147	304, 455	o	0	67.00
68. 00 06800 SPEECH PATHOLOGY	207, 663	23, 308	184, 355	o	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	874, 103	10, 978	863, 125	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	136, 531	1, 715	134, 816	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 568, 029	122, 045	4, 445, 984	o	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC	3, 753, 904	49, 186	3, 704, 718	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II - PCFP	1, 333, 386	17, 405	1, 315, 981	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III - 13TH	2, 717, 557	35, 826	2, 681, 731	0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	1, 205, 207	15, 899	1, 189, 308	0	0	88. 03
90. 00 09000 CLI NI C	1, 348, 181	227, 781	1, 120, 400	0	0	90.00
90. 01 09001 PAIN MANAGEMENT	0	0	0	0	0	90. 01
90. 02 09002 WOUND CARE	600, 859	75, 703	525, 156	0	0	
90. 03 09003 ORTHOPEDIC CLINIC	129, 732	1, 717	128, 015	0	0	90. 03
91. 00 09100 EMERGENCY	3, 920, 721	367, 078	3, 553, 643	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 502, 470	170, 953	1, 331, 517	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	1, 803, 559	216, 354	1, 587, 205	0	0	
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	1	0		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	35, 748, 172			0		200. 00
201.00 Less Observation Beds	1, 502, 470			0		201. 00
202.00 Total (line 200 minus line 201)	34, 245, 702	2, 727, 097	31, 518, 605	0	0	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems PERRY COUNTY HOSPITAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: 15-1322 Peri od: Worksheet C From 01/01/2022 To 12/31/2022 REDUCTIONS FOR MEDICALD ONLY Part II

Date/Time Prepared:

202.00

5/23/2023 1:34 pm Title XIX Hospi tal PPS Total Charges Outpati ent Cost Center Description Cost Net of Capital and (Worksheet C, Cost to Operating Part I Charge Ratio Cost column 8) (col. 6 / Reducti on col. 7) 7. 00 8.00 6.00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 2, 635, 931 0. 286107 50 00 9, 213, 081 52.00 | 05200 | DELIVERY ROOM & LABOR ROOM 300, 882 651, 031 0.462162 52.00 05400 RADI OLOGY-DI AGNOSTI C 17, 991, 862 0. 137061 54.00 2, 465, 976 54.00 06000 LABORATORY 3, 074, 540 20, 518, 999 0.149839 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 135, 722 433, 722 0.312924 62.00 65.00 06500 RESPIRATORY THERAPY 1, 661, 452 4, 992, 843 0.332767 65.00 66.00 06600 PHYSI CAL THERAPY 1, 025, 165 3, 016, 063 0. 339902 66.00 06700 OCCUPATIONAL THERAPY 346, 602 67.00 1, 321, 147 0.262349 67.00 68.00 06800 SPEECH PATHOLOGY 207, 663 670, 958 0.309502 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 874, 103 4, 634, 590 0.188604 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 208, 225 0.655690 72.00 136, 531 07300 DRUGS CHARGED TO PATIENTS 20, 256, 072 0. 225514 73.00 4, 568, 029 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - TCC 08801 RURAL HEALTH CLINIC II - PCFP 88.00 3, 753, 904 5, 567, 354 0.674271 88.00 2, 151, 240 88.01 1, 333, 386 0.619822 88.01 88. 02 08802 RURAL HEALTH CLINIC III - 13TH 2, 717, 557 2, 872, 301 0.946125 88.02 08803 RURAL HEALTH CLINIC IV - SPENCER 1, 205, 207 1, 488, 978 0.809419 88. 03 90.00 09000 CLI NI C 1, 348, 181 934, 930 1.442013 90.00 09001 PAIN MANAGEMENT 90.01 C 0.000000 90.01 90.02 09002 WOUND CARE 600, 859 1, 522, 111 0.394754 90.02 09003 ORTHOPEDIC CLINIC 90.03 129, 732 782, 478 0.165796 90.03 3, 920, 721 91 00 09100 EMERGENCY 15, 452, 889 0.253721 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1,502,470 897, 845 1.673418 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 803, 559 4, 509, 939 0.399908 95.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0.000000 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0.000000 116.00 200.00 Subtotal (sum of lines 50 thru 199) 35, 748, 172 120, 088, 658 200.00 201.00 Less Observation Beds 1, 502, 470 201.00

34, 245, 702

120, 088, 658

202.00

Total (line 200 minus line 201)

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS Provider CCN: 1	15-1322 Period: Worksheet D

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			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)	0.00	0.00			
ANOULL ARV. CERVILOE, COCT, CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 O5000 OPERATING ROOM	F0/ 0/0	0 212 001	0.0(476	257 407	1/ /17	
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	596, 869		0. 06478 0. 21683		16, 617	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	141, 163	651, 031 17, 991, 862			7 700	
60. 00 06000 LABORATORY	318, 923 159, 698				7, 709 5, 194	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1.704				5, 194	62.00
65. 00 06500 RESPIRATORY THERAPY	200, 577	4, 992, 843			17, 684	
66. 00 06600 PHYSI CAL THERAPY	101, 021	3, 016, 063			6, 477	
67. 00 06700 OCCUPATI ONAL THERAPY	42, 147	1, 321, 147			4, 734	
68. 00 06800 SPEECH PATHOLOGY	23, 308				1, 747	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 978	•			1, 265	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 715				1, 203	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	122, 045	•	0. 00602		6, 153	73.00
OUTPATIENT SERVICE COST CENTERS	122,010	20, 200, 072	0.00002	1,021,170	0, 100	70.00
88. 00 08800 RURAL HEALTH CLINIC - TCC	49, 186	5, 567, 354	0. 00883	35 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II - PCFP	17, 405				0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III - 13TH	35, 826		0. 01247		0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	15, 899				0	88. 03
90. 00 09000 CLI NI C	227, 781	934, 930	0. 24363	11, 435	2, 786	90.00
90. 01 09001 PALN MANAGEMENT	0	0	0. 00000	0 0	0	90. 01
90. 02 09002 WOUND CARE	75, 703	1, 522, 111	0. 04973	12, 706	632	90. 02
90. 03 09003 ORTHOPEDIC CLINIC	1, 717	782, 478	0. 00219	04	0	90. 03
91. 00 09100 EMERGENCY	367, 078	15, 452, 889	0. 02375	35, 982	855	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	170, 953	897, 845	0. 19040	3, 026	576	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 681, 696	115, 578, 719		3, 826, 553	72, 496	200. 00

Health Financial Systems	PERRY COUNTY H	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1322	Peri od:	Worksheet D

From 01/01/2022 Part IV
To 12/31/2022 Date/Time Prepared: THROUGH COSTS 5/23/2023 1:34 pm Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Program Post-Stepdown Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 54.00 06000 LABORATORY 0 0 60.00 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 62.00 0 06500 RESPIRATORY THERAPY 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 Ω 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 0 0 0 73.00 0 0 73.00 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 88.00 0 0 0 0 0 0 0 08801 RURAL HEALTH CLINIC II - PCFP 08802 RURAL HEALTH CLINIC III - 13TH 0 0 0 88. 01 0 0 0 0 0 88.01 0 88.02 0 0 88.02 08803 RURAL HEALTH CLINIC IV - SPENCER 88. 03 0 0 88.03 90.00 09000 CLI NI C 0 0 0 90.00 09001 PAIN MANAGEMENT 0 0 90.01 0 90.01 09002 WOUND CARE 0 90.02 90.02 0 0 09003 ORTHOPEDIC CLINIC 0 90.03 0 0 0 90.03 09100 EMERGENCY 0 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 0 92.00 0 0 92.00 95. 00 09500 AMBULANCE SERVICES 95.00 0 200.00

o

0

o

200.00

Total (lines 50 through 199)

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1322	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2022 Part IV

THROUGH COSTS				o 12/31/2022	Date/Time Pre 5/23/2023 1:3	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	1	9, 213, 081	0.000000	
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0	(651, 031	0.000000	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(17, 991, 862		
60. 00 06000 LABORATORY	0	0	(20, 518, 999		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(433, 722		
65. 00 06500 RESPI RATORY THERAPY	0	0	(4, 992, 843		
66. 00 06600 PHYSI CAL THERAPY	0	0	(3, 016, 063	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(1, 321, 147		
68.00 06800 SPEECH PATHOLOGY	0	0	(670, 958		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(4, 634, 590	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(208, 225	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(20, 256, 072	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC	0	0	(5, 567, 354	0.000000	88. 00
88.01 08801 RURAL HEALTH CLINIC II - PCFP	0	0	(2, 151, 240		
88.02 08802 RURAL HEALTH CLINIC III - 13TH	0	0	(2, 872, 301		
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0	0	(1, 488, 978	0.000000	88. 03
90. 00 09000 CLI NI C	0	0	(934, 930	0.000000	90.00
90. 01 09001 PAI N MANAGEMENT	0	0	(0	0.000000	90. 01
90. 02 09002 WOUND CARE	0	0	(1, 522, 111	0.000000	90. 02
90. 03 09003 ORTHOPEDIC CLINIC	0	0	(782, 478	0.000000	90. 03
91. 00 09100 EMERGENCY	0	0	(15, 452, 889	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(897, 845	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	0	(115, 578, 719		200. 00

Health Financial Systems	PERRY COUNTY I	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	NCILLARY SERVICE OTHER PASS	Provi der Co		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/23/2023 1:3	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient	Inpatient	I npati ent	Outpati ent	Outpati ent	

			10) 12/31/2022	5/23/2023 1: 3	
		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	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	256, 496	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	434, 921	0	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	667, 340		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	17, 079	0	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	440, 204	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	193, 392	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	148, 405	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	50, 280	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	534, 092	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, 021, 195	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC	0. 000000	0	0	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II - PCFP	0. 000000	0	0	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III - 13TH	0. 000000	0	0	0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0. 000000	0	0	0	0	88. 03
90. 00 09000 CLI NI C	0. 000000	11, 435	0	0	0	90.00
90. 01 09001 PAI N MANAGEMENT	0. 000000	0	0	0	0	90. 01
90. 02 09002 WOUND CARE	0. 000000	12, 706	0	0	0	90. 02
90. 03 09003 ORTHOPEDI C CLI NI C	0. 000000	0	0	0	0	90. 03
91. 00 09100 EMERGENCY	0. 000000	35, 982	0	o	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	3, 026	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS	· '		'			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		3, 826, 553	O	o	0	200. 00

Health Financial Systems	PERRY COUNTY H	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1322	Peri od:	Worksheet D

To 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm Title XVIII Hospi tal Cost Charges Costs PPS Services PPS Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 4. 00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 575, 326 50.00 0. 286107 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.462162 0 0 0 0 0 52.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 0. 137061 0 4, 888, 552 54.00 0 54.00 60.00 06000 LABORATORY 0.149839 2, 818, 555 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 312924 154, 637 62.00 06500 RESPIRATORY THERAPY 871, 906 65.00 0.332767 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.339902 608, 117 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 262349 137, 922 0 0 67.00 45, 327 o 68.00 06800 SPEECH PATHOLOGY 0.309502 0 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.188604 0 0 71.00 71.00 718, 118 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.655690 0 65, 680 0 72.00 07300 DRUGS CHARGED TO PATIENTS 8, 504, 920 0 73.00 73.00 0. 225514 4, 829 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 88.00 88. 01 08801 RURAL HEALTH CLINIC II - PCFP 88.01 08802 RURAL HEALTH CLINIC III - 13TH 88.02 88.02 08803 RURAL HEALTH CLINIC IV - SPENCER 88. 03 88 03 09000 CLI NI C 90.00 1.442013 0 186, 078 9, 343 0 90.00 90.01 09001 PAIN MANAGEMENT 0.000000 0 90.01 09002 WOUND CARE 90.02 0.394754 0 800, 546 0 0 90.02 09003 ORTHOPEDIC CLINIC 90 03 0. 165796 0 0 90.03 0 91.00 09100 EMERGENCY 0. 253721 0 3, 191, 017 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.673418 319, 168 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0.399908 200.00 Subtotal (see instructions) 0 24, 885, 869 14, 172 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 - line 201) 0 202.00 202.00 0 24, 885, 869 14, 172

Health Financial Systems	PERRY COUNTY HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTI	THER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1322	From 01/01/2022	Worksheet D Part V Date/Time Prepared: 5/23/2023 1: 34 pm

					10 12/31/2022	Date/lime Pr 5/23/2023 1:	
			Title	e XVIII	Hospi tal	Cost	
		Cos	its				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	450, 712	(50.00
	5200 DELIVERY ROOM & LABOR ROOM	0	()			52.00
	5400 RADI OLOGY-DI AGNOSTI C	670, 030	()			54.00
	6000 LABORATORY	422, 329	()			60.00
62.00 06	5200 WHOLE BLOOD & PACKED RED BLOOD CELLS	48, 390	(62.00
	5500 RESPIRATORY THERAPY	290, 142	(65.00
66.00 06	6600 PHYSI CAL THERAPY	206, 700	(66.00
67.00 06	5700 OCCUPATIONAL THERAPY	36, 184	(67.00
68. 00 06	5800 SPEECH PATHOLOGY	14, 029	(68. 00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	135, 440	(71.00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENT	43, 066	(72.00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	1, 917, 979	1, 089	9			73.00
OL	JTPATIENT SERVICE COST CENTERS						
88. 00 08	B800 RURAL HEALTH CLINIC - TCC						88. 00
88. 01 08	3801 RURAL HEALTH CLINIC II - PCFP						88. 01
88. 02 08	3802 RURAL HEALTH CLINIC III - 13TH						88. 02
	3803 RURAL HEALTH CLINIC IV - SPENCER						88. 03
90.00 09	9000 CLI NI C	268, 327	13, 473	3			90.00
90. 01 09	POO1 PAIN MANAGEMENT	0	(90. 01
90. 02 09	9002 WOUND CARE	316, 019	(90. 02
90. 03 09	9003 ORTHOPEDIC CLINIC	0	(90. 03
91.00 09	9100 EMERGENCY	809, 628	(91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	534, 101	(92.00
TO	THER REIMBURSABLE COST CENTERS						
95.00 09	9500 AMBULANCE SERVICES	0					95. 00
200.00	Subtotal (see instructions)	6, 163, 076	14, 562	2			200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	6, 163, 076	14, 562	2			202.00
		•		-			•

Health Financial Systems	PERRY COUNTY	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der CO		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		narad.
				Го 12/31/2022	5/23/2023 1: 3	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 137, 476	301, 748	835, 72	3 2, 327	359. 14	30.00
31.00 INTENSIVE CARE UNIT	0		(0	0.00	31.00
43. 00 NURSERY	31, 977		31, 97	7 119	268. 71	43.00
200.00 Total (lines 30 through 199)	1, 169, 453		867, 70	5 2, 446	I	200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	21	7, 542				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	21	7, 542				200.00

Health Financial Systems	PERRY COUNTY HOSPITAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	PLTAL COSTS	Provi der CCN: 15-1322	Peri od:	Worksheet D

Heal th	Financial Systems	PERRY COUNT	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der CO		Peri od:	Worksheet D	
					From 01/01/2022	Part II	
					To 12/31/2022	Date/Time Pre 5/23/2023 1:3	pared:
			Ti +I	e XIX	Hospi tal	PPS	4 piii
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	2001 201121 20001 1 21 011	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)	3	,	
		col. 26)	Í	Í			
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	596, 869	9, 213, 081	0. 06478	5 162, 196	10, 508	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	141, 163	651, 031	0. 21683	0 200, 804	43, 540	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	318, 923	17, 991, 862	0. 01772	6 40, 381	716	54.00
60.00	06000 LABORATORY	159, 698	20, 518, 999	0. 00778	3 100, 902	785	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 704	433, 722	0. 00392	9 1, 358	5	62.00
65.00	06500 RESPI RATORY THERAPY	200, 577	4, 992, 843	0. 04017	9, 386	377	65.00
66.00	06600 PHYSI CAL THERAPY	101, 021	3, 016, 063	0. 03349	4 3, 147	105	66.00
67.00	06700 OCCUPATI ONAL THERAPY	42, 147	1, 321, 147	0. 03190	2, 839	91	67.00
68. 00	06800 SPEECH PATHOLOGY	23, 308	670, 958	0. 03473	8 5, 032	175	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 978	4, 634, 590	0. 00236	9 124, 752	296	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 715	208, 225	0.00823	6 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	122, 045	20, 256, 072	0. 00602	5 100, 297	604	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC - TCC	49, 186	5, 567, 354	0. 00883	5 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	17, 405	2, 151, 240	0.00809	1 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	35, 826	2, 872, 301	0. 01247	3 0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	15, 899	1, 488, 978	0. 01067	8 0	0	88. 03
90.00	09000 CLI NI C	227, 781	934, 930	0. 24363	4 3, 087	752	90.00
90. 01	09001 PAIN MANAGEMENT	0	0	0.00000	0	0	90. 01
	09002 WOUND CARE	75, 703	1, 522, 111	0. 04973	6 242	12	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	1, 717	782, 478	0. 00219	4 0	0	90. 03
91.00	09100 EMERGENCY	367, 078	15, 452, 889	0. 02375	5 89, 223	2, 119	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	170, 953	897, 845	0. 19040	4 3, 738	712	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	2, 681, 696	115, 578, 719		847, 384	60, 797	200.00

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C	1	Period: From 01/01/2022 Fo 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education	
	Adjustments		,		Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0	(0	0	43.00
200.00 Total (lines 30 through 199)	0	0	(0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient		I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	2, 32			30.00
31. 00 03100 INTENSIVE CARE UNIT		0	(0.00		
43. 00 04300 NURSERY		0	119			
200. 00 Total (lines 30 through 199)		0	2, 446	0		200.00
Cost Center Description	Inpatient Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9, 00					
INPATIENT ROUTINE SERVICE COST CENTERS	7. 00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNIT	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-1					

Health Financial Systems	PERRY COUNTY HOSPITAL		In Lieu of Form	
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1322	Peri od:	Worksheet D

From 01/01/2022 Part IV
To 12/31/2022 Date/Time Prepared: THROUGH COSTS 5/23/2023 1:34 pm Title XIX Hospi tal PPS Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 06000 LABORATORY 0 0 60.00 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 62.00 0 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 Ω 68.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 0 0 73.00 0 0 73.00 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 88.00 0 0 0 0 0 0 0 08801 RURAL HEALTH CLINIC II - PCFP 08802 RURAL HEALTH CLINIC III - 13TH 0 0 0 88. 01 0 0 0 0 0 88.01 0 88.02 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0 0 88.03 90.00 09000 CLI NI C 0 0 0 90.00 09001 PAIN MANAGEMENT 0 0 90.01 0 90.01 09002 WOUND CARE 0 90.02 90.02 0 0 09003 ORTHOPEDIC CLINIC 90.03 0 0 0 90.03 09100 EMERGENCY 0 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 0 92.00 0 0 92.00 95. 00 09500 AMBULANCE SERVICES 95.00

o

0

o

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1322	Period: Worksheet D
THROUGH COSTS		From 01/01/2022 Part IV

111100011 00010			Т	o 12/31/2022	Date/Time Pre 5/23/2023 1:3	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	0	9, 213, 081	0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	651, 031	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	17, 991, 862		
60. 00 06000 LABORATORY	0	0	0	20, 518, 999		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	433, 722		
65. 00 06500 RESPI RATORY THERAPY	0	0	0	4, 992, 843		
66. 00 06600 PHYSI CAL THERAPY	0	0	0	3, 016, 063		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 321, 147		
68. 00 06800 SPEECH PATHOLOGY	0	0	0	670, 958		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4, 634, 590		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	20, 256, 072	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS			,			
88.00 08800 RURAL HEALTH CLINIC - TCC	0	•		-,,		
88.01 08801 RURAL HEALTH CLINIC II - PCFP	0	0	0	2, 151, 240		
88.02 08802 RURAL HEALTH CLINIC III - 13TH	0	0	0	2, 872, 301		
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0	0	0	1, 488, 978		
90. 00 09000 CLI NI C	0	0	0	934, 930		
90. 01 09001 PAI N MANAGEMENT	0	0	0	0	0.000000	
90. 02 09002 WOUND CARE	0	0	0	1, 522, 111	0.000000	
90. 03 09003 ORTHOPEDIC CLINIC	0	0	0	782, 478		
91. 00 09100 EMERGENCY	0	0	1	.0, .02, 00,		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	897, 845	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	0	0	115, 578, 719	1	200. 00

Health Financial Systems	PERRY COUNTY	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1322	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/23/2023 1:34 pm
		Title XIX	Hospi tal	PPS

THICOC	311 00313				To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	'	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	ŭ	Costs (col. 8	3	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	162, 196		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	200, 804		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	40, 381		0	0	54.00
60.00	06000 LABORATORY	0. 000000	100, 902		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1, 358		0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	9, 386		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	3, 147		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	2, 839		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	5, 032		0 0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	124, 752		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	100, 297		0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC - TCC	0. 000000	0		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0. 000000	0		0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0. 000000	0		0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0. 000000	0		0	0	88. 03
90.00	09000 CLI NI C	0. 000000	3, 087		0	0	90.00
90. 01	09001 PAIN MANAGEMENT	0. 000000	0		0	0	90. 01
90.02	09002 WOUND CARE	0. 000000	242		0	0	90. 02
90.03	09003 ORTHOPEDIC CLINIC	0. 000000	0		0	0	90. 03
91.00	09100 EMERGENCY	0. 000000	89, 223		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	3, 738		0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		847, 384		0 0	0	200. 00

Health Financial Systems	PERRY COUNTY HOS	SPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1322	Peri od: From 01/01/2022	Worksheet D

To 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm Title XIX Hospi tal PPS Costs Charges PPS Services PPS Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 4.00 1.00 2.00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 012, 310 50.00 0. 286107 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.462162 0 0 0 0 0 0 0 0 0 52.00 0 37, 826 0 05400 RADI OLOGY-DI AGNOSTI C 0 1, 925, 678 54.00 0. 137061 0 54.00 60.00 06000 LABORATORY 0.149839 2, 206, 381 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 312924 3, 395 62.00 06500 RESPIRATORY THERAPY 413, 306 65.00 0.332767 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.339902 0 221, 809 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 262349 101,073 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.309502 0 90, 685 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 188604 0 71.00 71.00 417, 328 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.655690 0 3, 334 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 0. 225514 2, 306, 914 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 88.00 88. 01 08801 RURAL HEALTH CLINIC II - PCFP 88.01 08802 RURAL HEALTH CLINIC III - 13TH 88.02 88.02 08803 RURAL HEALTH CLINIC IV - SPENCER 88. 03 88 03 09000 CLI NI C 90.00 1.442013 0 59, 978 0 90.00 90.01 09001 PAIN MANAGEMENT 0.000000 0 0 90.01 09002 WOUND CARE 90.02 0.394754 0 142, 698 0 0 0 90.02 09003 ORTHOPEDIC CLINIC 90 03 0. 165796 0 90.03 0 91.00 09100 EMERGENCY 0. 253721 0 2, 438, 078 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.673418 0 92.00 76, 764 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0.399908 200.00 Subtotal (see instructions) 0 11, 457, 557 0 0 200.00 Less PBP Clinic Lab. Services-Program o 201.00 201.00 Only Charges 0 202.00 202.00 Net Charges (line 200 - line 201) 0 11, 457, 557 0

Health Financial Systems	PERRY COUNTY H	OSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1322	From 01/01/2022	Worksheet D Part V Date/Time Prepared:

				10 12/31/2022	5/23/2023 1:3	apareu: 34 pm
		Ti tl e	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	289, 629					50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	17, 482					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	263, 935					54.00
60. 00 06000 LABORATORY	330, 602					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 062					62.00
65. 00 06500 RESPI RATORY THERAPY	137, 535					65.00
66. 00 06600 PHYSI CAL THERAPY	75, 393					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	26, 516	0				67.00
68. 00 06800 SPEECH PATHOLOGY	28, 067	0				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	78, 710					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 186					72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	520, 241	0				73.00
OUTPATIENT SERVICE COST CENTERS	_					
88.00 08800 RURAL HEALTH CLINIC - TCC						88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP						88. 01
88.02 08802 RURAL HEALTH CLINIC III - 13TH						88. 02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER						88. 03
90. 00 09000 CLI NI C	86, 489	0				90.00
90. 01 09001 PAIN MANAGEMENT	0	0				90. 01
90. 02 09002 WOUND CARE	56, 331	0				90. 02
90. 03 09003 ORTHOPEDIC CLINIC	0	0				90. 03
91. 00 09100 EMERGENCY	618, 592					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	128, 458	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	2, 661, 228	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	2, 661, 228	0				202.00

Health Financial Systems	PERRY COUNTY HOSPITAL	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1322	Peri od: From 01/01/2022	Worksheet D-1	
			Date/Time Pre 5/23/2023 1:3	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				

		Title XVIII	Hospi tal	Cost	piii
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		3, 355	1.00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		2, 327	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
4 00	do not complete this line.	ad daya)		1 051	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	1, 851 824	4. 00 5. 00
0.00	reporting period	om days) trii odgir becembe	01 01 110 0031	021	0.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line)	and the second second	24 . 6 . 11	204	7.00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through becember	31 of the cost	204	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 /			
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	974	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	noom days)	824	10.00
10.00	through December 31 of the cost reporting period (see instruc		oon days)	024	10.00
11. 00			oom days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, e				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X onlv (including privat	e room davs)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			U	16. 00
17. 00		es through December 31 c	of the cost		17.00
	reporting period	9			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	250. 44	10 00
17.00	reporting period	3 thi dagii becember 31 or	the cost	230. 44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	250. 44	20.00
04 00	reporting period			0 007 000	04 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	9, 997, 082 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost report	ing period (inte	U	22.00
23.00		31 of the cost reportin	g period (line 6	0	23.00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through Decembe $17 \times 11 = 19$	r 31 of the cost reporti	ng period (line	51, 090	24.00
25. 00		31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	,			
26. 00	,	(11 04 11 04)		2, 652, 013	
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		7, 345, 069	27. 00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)		,	0	
30. 00				0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x li			0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 345, 069	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			3, 156. 46	38. 00
39. 00		•		3, 074, 392	•
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 30)			0 3, 074, 392	
41.00	Total Program general inpatient routine service cost (line 39	+ ITTIE 40 <i>)</i>		3, 0/4, 392	41.00

COMPUTATI	nancial Systems ON OF INPATIENT OPERATING COST	PERRY COUNTY		CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2022 To 12/31/2022		
			Title	e XVIII	Hospi tal	5/23/2023 1:3 Cost	4 рш
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpati ent	Di em (col. + col. 2)		(col. 3 x col. 4)	
		1. 00	Days 2.00	3.00	4. 00	5. 00	
	RSERY (title V & XIX only)	0	(42.00
	tensive Care Type Inpatient Hospital Units	ما			20		40.00
	TENSIVE CARE UNIT	0	(0.0	00 0	0	43.00
	RN INTENSIVE CARE UNIT						45. 00
	RGICAL INTENSIVE CARE UNIT						46.00
47. 00 OT	HER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00 Pr	ogram inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			871, 773	48. 00
	ogram inpatient cellular therapy acquisiti				, column 1)	0	
	tal Program inpatient costs (sum of lines SS THROUGH COST ADJUSTMENTS	41 through 48.(01)(see instru	icti ons)		3, 946, 165	49.00
	ss through costs applicable to Program inp	atient routine	services (fro	om Wkst D su	m of Parts I and	0	50.00
11		arrone routino	30. 7. 333 (01 141 10 1 4110		00.00
	ss through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00
1	d IV) tal Program excludable cost (sum of lines	50 and 51)				0	52.00
	tal Program inpatient operating cost exclu		elated, non-ph	ysician anest	hetist, and	0	
me	dical education costs (line 49 minus line						
	RGET AMOUNT AND LIMIT COMPUTATION Ogram discharges					0] 54.00
	rget amount per discharge					0.00	
	rmanent adjustment amount per discharge					0. 00	1
1 '	justment amount per discharge (contractor	J ,				0. 00	1
1	rget amount (line 54 x sum of lines 55, 55 fference between adjusted inpatient operat			lino E4 minus	lino E2)	0	
1	nus payment (see instructions)	ing cost and ta	arget amount (Title 50 IIITlus	111le 53)	0	58.00
59.00 Tr	ended costs (lesser of line 53 ÷ line 54,	or line 55 from	m the cost rep	orting period	endi ng 1996,	0. 00	1
	dated and compounded by the market basket)					0.00	,,,,,,,
	pected costs (lesser of line 53 ÷ line 54, rket basket)	or line 55 Tro	om prior year	cost report,	updated by the	0. 00	60.00
1	ntinuous improvement bonus payment (if lin	e 53 ÷ line 54	is less than	the lowest of	lines 55 plus	0	61.00
	.01, or line 59, or line 60, enter the les						
) are less than expected costs (lines 54 x ter zero. (see instructions)	60), or 1 % of	the target a	imount (line 5	6), otherwise		
	lief payment (see instructions)					0	62.00
	lowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00
	OGRAM INPATIENT ROUTINE SWING BED COST dicare swing-bed SNF inpatient routine cos	ts through Doc	ombor 21 of th	o cost roport	ing ported (Soc	2, 600, 923	44 00
	structions)(title XVIII only)	ts through bece	siliber 31 of tr	ie cost report	ing perrou (see	2,000,423	04.00
	dicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the	cost reportin	g period (See	0	65.00
	structions)(title XVIII only) tal Medicare swing-bed SNF inpatient routi	no costs (lino	44 plus lins	4E) (+; +1 o V)//	II only): for	2, 600, 923	66.00
	H, see instructions	ne costs (Title	04 prus rine	os)(title xvi	ii diiy), idi	2,000,423	00.00
	tle V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost r	eporting period	0	67.00
	ine 12 x line 19)	o occto often [Dagambar 21 of	the east man	orting ported	0	40.00
	tle V or XIX swing-bed NF inpatient routinine 13 x line 20)	e costs after t	veceninei 31 OT	the cost rep	orting period	0	68. 00
69. 00 To	tal title V or XIX swing-bed NF inpatient					0	69.00
	RT III - SKILLED NURSING FACILITY, OTHER NI				`		70.00
	illed nursing facility/other nursing facil justed general inpatient routine service c)		70.00
	ogram routine service cost (line 9 x line		70 711110)			72.00
	dically necessary private room cost applic						73.00
	tal Program general inpatient routine serv	•		•	Dart II column		74.00
	pital-related cost allocated to inpatient, line 45)	TOUTTHE SELVICE	CUSIS (IIUIII	MOLKSHEEL D.	rart II, COTUIIII		75. 00
76.00 Pe	r diem capital-related costs (line 75 ÷ li						76. 00
	ogram capital-related costs (line 9 x line						77.00
	patient routine service cost (line 74 minu gregate charges to beneficiaries for exces		provi den inecon	ds)			78. 00 79. 00
5	tal Program routine service costs for comp				nus line 79)		80.00
1	patient routine service cost per diem limi						81.00
1	patient routine service cost limitation (I		* .				82.00
1	asonable inpatient routine service costs (ogram inpatient ancillary services (see in		13)				84.00
1	ilization review - physician compensation	,	ons)				85.00
	tal Program inpatient operating costs (sum		nrough 85)				86.00
IPAI	RT IV - COMPUTATION OF OBSERVATION BED PASS						4
	tal observation bed days (see instructions)				476	87.00

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 502, 470	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 137, 476	9, 997, 082	0. 11378	1, 502, 470	170, 953	90.00
91.00 Nursing Program cost	0	9, 997, 082	0.00000	0 1, 502, 470	0	91.00
92.00 Allied health cost	0	9, 997, 082	0.00000	0 1, 502, 470	0	92.00
93.00 All other Medical Education	0	9, 997, 082	0.00000	0 1, 502, 470	0	93.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1322		Worksheet D-1	
		From 01/01/2022		
		To 12/31/2022	Date/Time Pre	pared:
			5/23/2023 1: 3	4 pm
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
DART I _ ALL PROVIDER COMPONENTS				

		Title XIX	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 355	1.00
2.00	Inpatient days (including private room days, excluding swing-			2, 327	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). It you have only pr	ivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ned days)		1, 851	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	824	•
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om dave) through Docombor	21 of the cost	204	7. 00
7.00	reporting period	olii days) tili odgir becelliber	31 Of the cost	204	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	swi ng-bed and	21	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		days)	G	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
10.00	after December 31 of the cost reporting period (if calendar y			G	10.00
14.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)			119	ł
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	ces through December 31 o	f the cost		17. 00
17.00	reporting period	ces through becember 31 o	the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost		18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	250. 44	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	250. 44	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instruction			9, 997, 082	1
22. 00	Swing-bed cost applicable to SNF type services through December 173	per 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportin	a period (line A	0	23.00
23.00	x line 18)	or the cost reportin	g perroa (rriie d	O	25.00
24.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	51, 090	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00				2, 652, 013	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 345, 069	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	-	28.00
	Pri vate room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0. 00	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	1
34.00	Average per diem private room charge differential (line 32 mi		tions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7 345 069	36. 00 37. 00
37.00	27 minus line 36)	and private 100m COSt Of	ricicittai (IINe	7, 345, 069	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			3, 156. 45	ł
39.00	Program general inpatient routine service cost (line 9 x line	•		66, 285	1
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 66, 285	40.00
11.00	1.044 Sgram general impationt routine service cost (fille 3:			00, 200	1 00

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		I
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	3, 156. 45	38.0
39.00	Program general inpatient routine service cost (line 9 x line 38)	66, 285	39.0
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	ol	40. C
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	66, 285	41.0

	Financial Systems ATION OF INPATIENT OPERATING COST	PERRY COUNTY	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	epare
			Ti +1	e XIX	Hospi tal	5/23/2023 1: 3 PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	·	I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		Cost 1.00	Days	÷ col. 2) 3.00	4.00	col . 4)	
2. 00	NURSERY (title V & XIX only)	68, 155	2. 00 119		4.00	5. 00	42.
	Intensive Care Type Inpatient Hospital Units	337 .33		J	-		1
3. 00	INTENSIVE CARE UNIT	0	0	0.0	0	0	
4. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
5. 00	SURGICAL INTENSIVE CARE UNIT						46.
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
3. 00	Program inpatient ancillary service cost (Wk	st D_3 col 3	line 200)			1. 00 246, 370	48
3. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	eet D-6, Part	III, line 10	, column 1)	240, 370	1
9. 00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instru	ctions)	,	312, 655	49.
	PASS THROUGH COST ADJUSTMENTS						١
0. 00	Pass through costs applicable to Program inp	atient routine	services (fro	n Wkst. D, sui	m of Parts I and	7, 542	50.
1. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	60, 797	51.
	and IV)						
2.00	Total Program excludable cost (sum of lines		ال حجم المعامل	vol al ar	botiot	68, 339	
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-pn	ysician anesti	netist, and	244, 316	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
1. 00	Program di scharges						54
00	Target amount per discharge					0.00	
6. 01 6. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	
. 00	Target amount (line 54 x sum of lines 55, 55					0.00	1
. 00	Difference between adjusted inpatient operat	ing cost and ta	irget amount (line 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)					0	
0. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 trom	the cost rep	orting period	ending 1996,	0. 00	59
0. 00						0. 00	60
	market basket)						
1. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by	which operati	ng costs (line	0	61.
2. 00	Relief payment (see instructions)					0	62.
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	icti ons)			0	63.
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	umber 31 of the	e cost report	ing period (See	0	64.
r. 00	instructions)(title XVIII only)	ts through bece	illiber 31 of th	s cost report	ing period (see	0	04
6. 00	J	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65
5. 00	instructions)(title XVIII only)	no costs (lino	44 plus lino	4E) (+; + 0 V)/	II only). for	0	66
3. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (Title	o4 prus rine	35)(title XVI	ii oniy), ioi	U	00
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67
	(line 12 x line 19)						1,,
3. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after L	ecemper 31 of	ine cost rep	orting period	0	68
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + Line	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY			ļ
. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70
. 00	Program routine service cost (line 9 x line		ine /o - iine	۷)			72
. 00	Medically necessary private room cost applic		(line 14 x l	ine 35)			73
. 00	Total Program general inpatient routine serv				David III		74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	worksheet B,	Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital-related costs (line 9 x line	76)					77
00	Inpatient routine service cost (line 74 minu		والمراجعة المراجعة	do)			78
. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 70)		79 80
.00	Inpatient routine service costs for comp		ost rimitatio	. (11/16 /0 1111)	1110 /7)		81
. 00	Inpatient routine service cost limitation ()				82
. 00	Reasonable inpatient routine service costs (ıs)				83
. 00	Program inpatient ancillary services (see in		ine)				84
i. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PASS						1
	Total observation bed days (see instructions					476	

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 4 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			1, 502, 470	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 137, 476	9, 997, 082	0. 11378	1 1, 502, 470	170, 953	90.00
91.00 Nursing Program cost	0	9, 997, 082	0.00000	0 1, 502, 470	0	91.00
92.00 Allied health cost	0	9, 997, 082	0.00000	0 1, 502, 470	0	92.00
93.00 All other Medical Education	0	9, 997, 082	0.00000	0 1, 502, 470	0	93. 00

	Figure 1 1 Control	DDV COUNTY HOCDITAL		111	C. F OMC. (0550 40
	Financial Systems PER ENT ANCILLARY SERVICE COST APPORTIONMENT	RRY COUNTY HOSPITAL Provider C	CN: 15 1222	Period:	u of Form CMS-2 Worksheet D-3	
TINIATI	ENT ANGIELANT SERVICE COST ALTONITONIMENT	Trovider c	ON. 13-1322	From 01/01/2022 To 12/31/2022		pared:
-		Title	: XVIII	Hospi tal	Cost	тт рііі
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			1, 660, 008		30.00
31.00	03100 I NTENSI VE CARE UNI T			0		31.00
43.00	04300 NURSERY					43.00
50.00	ANCILLARY SERVICE COST CENTERS			25/ 40/	70.005	
50.00	05000 OPERATING ROOM		0. 28610		73, 385	1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 46216 0. 13706		0 F0 (11	
60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY		0. 1370		59, 611 99, 994	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1490.		5, 344	1
65. 00	06500 RESPIRATORY THERAPY		0. 31242		146, 485	
66. 00	06600 PHYSI CAL THERAPY		0. 33270		65, 734	
67. 00	06700 OCCUPATI ONAL THERAPY		0. 26234		38, 934	1
68. 00	06800 SPEECH PATHOLOGY		0. 30950			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18860		100, 732	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 65569		0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 2255		230, 294	73.00
	OUTPATIENT SERVICE COST CENTERS					1
88. 00	08800 RURAL HEALTH CLINIC - TCC		0.00000	00	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP		0.00000		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH		0. 00000		0	
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER		0. 00000		0	
90.00	09000 CLI NI C		1. 44201			1
90. 01	09001 PAIN MANAGEMENT		0. 00000		0	
90. 02	09002 WOUND CARE		0. 3947		5, 016	1
90. 03	09003 ORTHOPEDIC CLINIC		0. 16579		0	90. 03
91.00	09100 EMERGENCY		0. 25372		9, 129	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 6734	18 3, 026	5, 064	92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES					95.00
200.00		cough 09)		3, 826, 553	871, 773	
200.00				3, 020, 353 N	0/1,//3	200.00
201.00	1 1	only charges (Title 01)		3, 826, 553		202.00
202.00	The charges (True 200 millios True 201)		ı	5, 020, 333	l	1202.00

	RRY COUNTY HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od: From 01/01/2022	Worksheet D-3	3
	Component		To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2. 00	col . 2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 NTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		'	'		
50. 00 05000 OPERATING ROOM		0. 28610	2, 573	736	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 46216	0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13706		812	
60. 00 06000 LABORATORY		0. 14983		17, 559	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 31292		0	
65. 00 06500 RESPI RATORY THERAPY		0. 33276		52, 126	
66. 00 06600 PHYSI CAL THERAPY		0. 33990		109, 677	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26234		· ·	
68. 00 06800 SPEECH PATHOLOGY		0. 30950		22, 501	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 18860		31, 331	
72. 00 O7200 IMPL. DEV. CHARGED TO PATIENT 73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 65569 0. 22551		0 54, 257	
OUTPATIENT SERVICE COST CENTERS		0. 22331	240, 392	34, 237	73.00
88. 00 08800 RURAL HEALTH CLINIC - TCC		0.00000	10	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II - PCFP		0. 00000		ő	
88. 02 08802 RURAL HEALTH CLINIC III - 13TH		0. 00000		0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER		0. 00000		0	
90. 00 09000 CLINIC		1. 44201	3 798	1, 151	90.00
90. 01 09001 PAI N MANAGEMENT		0. 00000	00	0	90. 01
90. 02 09002 WOUND CARE		0. 39475		86	
90. 03 09003 ORTHOPEDIC CLINIC		0. 16579		0	
91. 00 09100 EMERGENCY		0. 25372		69	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 67341	8 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES			1 202 227	2/0 5/4	95.00
200.00 Total (sum of lines 50 through 94 and 96 thr			1, 383, 987	368, 561	1
201.00 Less PBP Clinic Laboratory Services-Program 202.00 Net charges (line 200 minus line 201)	only charges (Tine 61)		1, 383, 987		201. 00 202. 00
202.00 Thet charges (Title 200 IIII has Title 201)		I	1, 303, 907	l	1202.00

Health Financial Systems	PERRY COUNTY HOSPITAL		In Lio	u of Form CMS-:	2552 10
I NPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT		CN: 15-1322	Peri od:	Worksheet D-3	
THE ATTENT AND LEARN SERVICE COST ATTORITONIMENT	Trovider o	014. 10 1022	From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
	Ti tl	e XIX	Hospi tal	PPS	ри ри
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
INDATIONE DOUTING CODY OF COCE CONTEDC		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			140 544		
30. 00 03000 ADULTS & PEDI ATRI CS			149, 544		30.00
31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY			10, 060		31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			10,060		43.00
50. 00 05000 OPERATING ROOM		0. 28610	07 162, 196	46, 405	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 4621	· ·	92, 804	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1370		5, 535	
60. 00 06000 LABORATORY		0. 1498	· ·	15, 119	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 3129		425	1
65. 00 06500 RESPIRATORY THERAPY		0. 3327		3, 123	
66. 00 06600 PHYSI CAL THERAPY		0. 33990		1, 070	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2623	49 2, 839	745	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 30950	5, 032	1, 557	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18860		23, 529	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 6556		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2255	14 100, 297	22, 618	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC - TCC		0. 6742		0	
88. 01 08801 RURAL HEALTH CLINIC II - PCFP		0. 61983		0	
88. 02 08802 RURAL HEALTH CLINIC III - 13TH 88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER		0. 94612 0. 8094		0	
90. 00 09000 CLINIC V - SPENCER		1. 4420		4, 451	90.00
90. 01 09001 PALN MANAGEMENT		0. 00000		0	1
90. 02 09002 WOUND CARE		0. 3947!		96	
90. 03 09003 0RTHOPEDI C CLI NI C		0. 16579		0	1
91. 00 09100 EMERGENCY		0. 2537		_	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 6734			
OTHER REIMBURSABLE COST CENTERS			., ., .,	., ====	1
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50 through 94 and 9			847, 384	246, 370	200.00
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			847, 384		202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1322	Peri od:

	Title William			5/23/2023 1: 3	4 pm
	Title XVII	l	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			11.00	
1.00	Medical and other services (see instructions)			6, 177, 638	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
3.00	OPPS payments			0	3.00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5. 00
6. 00	Line 2 times line 5			0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line	e 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 177, 638	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for payment for servi			0	15.00
16. 00	Amounts that would have been realized from patients liable for payment for se	rvi ces o	n a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17 00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 excess)	ceeds li	ne 11) (see	0	19.00
17.00	instructions)	cccus iii	110 11) (300	0	17.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exc	ceeds li	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			6, 239, 414	21.00
22. 00	Interns and residents (see instructions)			0	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			61, 949	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, so	ee instr	uctions)	4, 353, 141	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 25 and 26)			1, 824, 324	
	instructions)		- ,		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			1, 824, 324	30.00
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			597 1, 823, 727	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			1, 023, 727	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			429, 422	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			279, 124	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			294, 585	36.00
37. 00 38. 00	Subtotal (see instructions)			2, 102, 851	
39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			· ·	39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see	instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			2, 102, 851	40.00
40. 01	Sequestration adjustment (see instructions)			26, 496	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs			0	40. 02 40. 03
41. 00	Interim payments			2, 345, 093	41.00
41. 01	Interim payments-PARHM or CHART			_, _, _,	41. 01
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)				42.01
43.00	Balance due provider/program (see instructions)			-268, 738	43.00
43. 01	Balance due provider/program-PARHM (see instructions)	4			43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub.	. 15-2,	chapter 1,	150, 298	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			Ö	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	93. 00
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Worksheet E	
		From 01/01/2022		
		To 12/31/2022	Date/IIme Pr	eparea:
			5/23/2023 1:	34 pm
	Title XVIII	Hospi tal	Cost	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			(200.00

Peri od: Worksheet E-1 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm Provider CCN: 15-1322

					5/23/2023 1: 34	4 pm
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		3, 185, 270	D	2, 345, 093	1. 00
2.00	Interim payments payable on individual bills, either		(0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	10/18/2022	166, 700		0	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	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51					0	3. 51
3. 52					0	3. 52
3.53					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)		166, 700		١	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 351, 970		2, 345, 093	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as				_, _, , , , , , ,	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			_		
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider				0	F 01
5. 01 5. 02	TENTATI VE TO PROVI DER					5. 01 5. 02
5. 02					0	5. 02
5.05	Provider to Program			21	0	5.05
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		328, 45		0	6. 01
6. 02	SETTLEMENT TO PROGRAM				268, 738	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 680, 42		2, 076, 355	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 00	name of contractor			1	ı	0.00

Health Financial Systems PER ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED PERRY COUNTY HOSPITAL

					5/23/2023 1: 3	4 pm
		Titl∈	XVIII	Swing Beds - SNF		
		Inpatier	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3.00	4. 00	
1.00	Total interim payments paid to provider		2, 542, 01	4	0	1.00
2.00	Interim payments payable on individual bills, either			o	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	10/18/2022	113, 90	0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05				0	0	3.05
	Provider to Program					
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				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		113, 90	0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 655, 91	4	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T			
5. 00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider				0	- 01
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01 5. 02
5. 02				0	0	
5. 03	Provider to Program			<u>U</u>	0	5.03
5. 50	TENTATIVE TO PROGRAM			ol	0	5. 5C
5. 51	TENTATIVE TO PROGRAM			0	0	5. 50
5. 52				0	0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
5. 99	5. 50-5. 98)		'	U .	0	3.99
6. 00	Determined net settlement amount (balance due) based on					6.00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		303, 74	6	0	6. 01
6. 02	SETTLEMENT TO PROVIDER		1	0	0	6.02
7. 00	Total Medicare program liability (see instructions)		2, 959, 66	9	0	7.00
7.00	Tiotal medicale program traditity (see Histractions)		2,757,00	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor					8.00
		1		1		

Heal th	Financial Systems PERRY COUNTY I	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1322 Period: W				
			From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	narodi
			10 12/31/2022	5/23/2023 1: 3	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2. 00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				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		7. 00
	line 168				
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
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & 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 instructio	ns)		32.00
		, ,	. '		•

Health Financial Systems	PERRY COUNTY H	OSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 15-1322	Peri od: From 01/01/2022	Worksheet E-2
		Component CCN: 15-Z322		Date/Time Prepared: 5/23/2023 1:34 pm

		Component CCN: 15-Z322	To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPLITATION OF NET COCT OF COVERED CERVICES		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		2, 626, 932	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		2, 020, 732	O	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	372, 247	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi		·		
	instructions)				
3. 01	Nursing and allied health payment-PARHM or CHART (see instruc	*		0.00	3. 01
4. 00	Per diem cost for interns and residents not in approved teach instructions)	ing program (see		0. 00	4. 00
5. 00	Program days		824	0	5. 00
6. 00	Interns and residents not in approved teaching program (see i	nstructions)		0	6. 00
7.00	Utilization review - physician compensation - SNF optional me	thod only	0		7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2, 999, 179	0	8. 00
9.00	Primary payer payments (see instructions)		0 000 170	0	9.00
10. 00 11. 00	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applied	cablo to physician	2, 999, 179	0	10. 00 11. 00
11.00	professional services)	cable to physician		Ü	11.00
12.00	Subtotal (line 10 minus line 11)		2, 999, 179	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	1, 751	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)		2 007 420	0	14.00
15. 00 16. 00	Subtotal (see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		2, 997, 428	0	15. 00 16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instruction:	5)		O	16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	•	0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17. 01 18. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	17. 01 18. 00
19. 00	Total (see instructions)	1 40 (1 0113)	2, 997, 428	0	19.00
19. 01	Seguestration adjustment (see instructions)		37, 768	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM or CHART pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20. 00 20. 01	Interim payments Interim payments-PARHM or CHART		2, 655, 914	0	20. 00 20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01	Tentative settlement-PARHM or CHART (for contractor use only)			Ü	21. 01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.0.	2, 19.25, 20, and 21)	303, 746	0	22. 00
22. 01	Balance due provider/program-PARHM or CHART (see instructions				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstr	cation) Adjustment			
200.00	Is this the first year of the current 5-year demonstration pe				200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201. 00
202.00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst D_3 col 3 line			202. 00
202.00	200 (title XVIII swing-bed SNF))	III WAST. D-3, COL. 3, TITIE			202.00
203.00	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the currer	nt 5-year demons	trati on	
205 00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206.00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				200.00
207.00	Program reimbursement under the §410A Demonstration (see inst				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines 1			208. 00
200 5	and 3)	-+!>			200 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	CTI ONS)			209.00
∠ 10. UC	Reserved for future use Comparision of PPS versus Cost Reimbursement				210. 00
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line :	209 plus line 210) (see			215. 00
	instructions)	,			

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1322	From 01/01/2022	Worksheet E-3 Part V Date/Time Prepared: 5/23/2023 1:34 pm
	Title XVIII	Hosni tal	Cost

				5/23/2023 1:3	4 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR V	ART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpatient services			3, 946, 165	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	s)		0	2.00
3.00	Organ acquisition			0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			3, 946, 165	4. 00
5. 00	Primary payer payments			10, 437	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 975, 190	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 773, 170	0.00
	Reasonable charges				
7. 00	Routi ne servi ce charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00				0	9.00
	Organ acquisition charges, net of revenue				
10. 00	Total reasonable charges			0	10. 00
11 00	Customary charges			0	11 00
11.00	Aggregate amount actually collected from patients liable for pa			0	11.00
12. 00	Amounts that would have been realized from patients liable for	payment for services o	n a cnarge basis	0	12.00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	40.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			3, 975, 190	
20. 00	Deductibles (exclude professional component)			267, 560	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)			3, 707, 630	22.00
23.00	Coi nsurance			3, 112	23.00
24.00	Subtotal (line 22 minus line 23)			3, 704, 518	24.00
25.00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		35, 182	25. 00
26. 00	Adjusted reimbursable bad debts (see instructions)	, (, , , , , , , , , , , , , , , , , ,		22, 868	26.00
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		17, 790	27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	011 0113)		3, 727, 386	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			3, 727, 300	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29.50
29. 30	,			0	
	Recovery of accelerated depreciation.				29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			3, 727, 386	30.00
30. 01	Sequestration adjustment (see instructions)			46, 965	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM or CHART				30. 03
31.00	Interim payments			3, 351, 970	
31. 01	Interim payments-PARHM or CHART				31. 01
32.00	Tentative settlement (for contractor use only)			0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02,	31, and 32)		328, 451	33.00
33. 01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, an		3, 31.01, and		33. 01
	32.01)		•		
34.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	12, 314	34.00
	§115. 2		•		
	•			•	

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

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

Provi der CCN: 15-1322 | Peri od: | W | From 01/01/2022 | To 12/31/2022 | D

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/23/2023 1:34 pm

OH y)					5/23/2023 1: 3	4 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund	Fund	4.00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1. 00	Cash on hand in banks	14, 978, 506	0	0	0	1.00
2. 00	Temporary investments	3, 711, 019		Ö	0	2.00
3. 00	Notes recei vabl e	0		Ö	Ö	3.00
4. 00	Accounts recei vable	14, 628, 710	0	0	0	4.00
5.00	Other recei vable	957, 930	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8, 958, 643	0	0	0	6. 00
7.00	Inventory	756, 012	0	0	0	7. 00
8.00	Prepai d expenses	302, 790		0	0	8. 00
9. 00	Other current assets	0	١	0	0	9. 00
10.00	Due from other funds	1, 820, 000		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	28, 196, 324	0	0	0	11. 00
12 00	FIXED ASSETS Land	2 402 270	0	0	0	12. 00
12. 00 13. 00	Land improvements	3, 693, 378 45, 658		0	0	13.00
14. 00	Accumulated depreciation	-15, 463, 195		0	0	14.00
15. 00	Bui I di ngs	44, 036, 233		0	Ö	15.00
16. 00	Accumul ated depreciation	-2, 817, 288		0	0	16.00
17. 00	Leasehold improvements	0		Ö	Ö	17. 00
18. 00	Accumulated depreciation	0	0	O	0	18.00
19.00	Fi xed equipment	2, 606, 705	0	0	0	19.00
20.00	Accumulated depreciation	-187, 015		0	0	20.00
21.00	Automobiles and trucks	477, 834	0	0	0	21.00
22.00	Accumulated depreciation	-477, 834	0	0	0	22.00
23.00	Major movable equipment	19, 305, 090	0	0	0	23.00
24.00	Accumulated depreciation	-10, 324, 062	0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26. 00
	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	40, 895, 504	0	0	0	30.00
21 00	OTHER ASSETS			ما		21 00
31.00	Investments	0		0	0	31.00
32. 00 33. 00	Deposits on leases Due from owners/officers	0	0	0	0	32. 00 33. 00
34. 00	Other assets		0	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)		0	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	69, 091, 828		ő	0	36.00
00.00	CURRENT LIABILITIES	07/07/1/020	<u> </u>		5	00.00
37.00	Accounts payable	1, 644, 732	0	0	0	37. 00
38.00	Salaries, wages, and fees payable	0	0	0	0	38. 00
39.00	Payrol I taxes payable	705, 520	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	1, 116, 429	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
	Other current liabilities	2, 909, 158		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 375, 839	0	0	0	45. 00
47.00	LONG TERM LIABILITIES					47.00
46. 00	Mortgage payable	0		0	0	
47. 00	Notes payable	34, 635, 000		0	0	
48. 00	Unsecured Loans		0	0	0	48. 00 49. 00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	34, 635, 000		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	41, 010, 839		0	0	51.00
31.00	CAPITAL ACCOUNTS	41,010,037		<u> </u>	0	31.00
52.00	General fund balance	28, 080, 989				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			ol	 	54.00
55.00	Donor created - endowment fund balance - unrestricted			o		55.00
56.00	Governing body created - endowment fund balance			o	 	56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion				 	
59.00	Total fund balances (sum of lines 52 thru 58)	28, 080, 989		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	69, 091, 828	0	0	0	60.00
	[59]	I	ı İ	l	ļ	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-1322

					То	12/31/2022	Date/Time Pre 5/23/2023 1:3	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	·
		1. 00	2. 00	3, 00		4. 00	5. 00	
1. 00 2. 00 3. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	1.00	28, 823, 648 -396, 065 28, 427, 583			0	3.00	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	FREESTANDING HOME HEALTH	-346, 594 0 0	20, 127, 000		0 0 0		0 0 0	4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	Tabel additions (our of line 4.0)	0 0 0	244 504		0 0 0		0 0 0	7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	-346, 594 28, 080, 989		0	0	0	10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00		0 0			0 0 0		0 0	14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	Ů	0 28, 080, 989			0 0		18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) FREESTANDING HOME HEALTH	0	0		0			1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00			0 0 0 0					5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	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	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	O		0			17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1322

			То	12/31/2022	Date/Time Pre 5/23/2023 1:3	
	Cost Center Description	Inpat	ent	Outpati ent	Total	+ piii
	Social Boson per on	1. 0		2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	5, 5	94, 833		5, 594, 833	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7. 00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9. 00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	5, 5	94, 833		5, 594, 833	10.00
	Intensive Care Type Inpatient Hospital Services			T		
11.00	INTENSIVE CARE UNIT		0		0	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14. 00 15. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)					14. 00 15. 00
16.00	Total intensive care type inpatient hospital services (sum of I	inos	0		0	16. 00
10.00	111-15)	THES	U		U	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	5.5	94, 833		5, 594, 833	17. 00
18. 00	Ancillary services		01, 336	92, 467, 504	103, 768, 840	18.00
19. 00	Outpatient services	11,0	0	0	0	19. 00
20. 00	RURAL HEALTH CLINIC - TCC		0	5, 567, 354	5, 567, 354	20.00
20. 01	RURAL HEALTH CLINIC II - PCFP		Ō	2, 151, 240	2, 151, 240	
20. 02	RURAL HEALTH CLINIC III - 13TH		0	2, 872, 301	2, 872, 301	20. 02
20. 03	RURAL HEALTH CLINIC IV - SPENCER		0	1, 488, 978	1, 488, 978	20. 03
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES		0	4, 509, 939	4, 509, 939	23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE		0	0	0	26.00
27. 00	OTHER (SPECIFY)		0	0	0	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	to Wkst. 16,8	96, 169	109, 057, 316	125, 953, 485	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES			47 400 04/		
29.00	Operating expenses (per Wkst. A, column 3, line 200)		0	47, 408, 316		29.00
30.00	ADD (SPECIFY)		0			30.00
31. 00 32. 00			0			31. 00 32. 00
32.00			0			32.00
34.00			0			34. 00
35.00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		J	0		36.00
37. 00	DEDUCT (SPECIFY)		0	Ĭ		37. 00
38. 00	525501 (6. 25111)		Ö			38.00
39. 00			Ö			39. 00
40.00			Ō			40.00
41. 00			0			41.00
42.00	Total deductions (sum of lines 37-41)			o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		47, 408, 316		43.00
	to Wkst. G-3, line 4)					

Hool +h	Financial Systems PERRY COUNTY	HOSDITAL	In Lie	u of Form CMS-2	DEE2 10
	FINANCIAL SYSTEMS MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1322	Peri od:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I			125, 953, 485	
2.00	Less contractual allowances and discounts on patients' acco	ounts		83, 010, 802	
3.00	Net patient revenues (line 1 minus line 2)			42, 942, 683	
4.00	Less total operating expenses (from Wkst. G-2, Part II, Iir	ie 43)		47, 408, 316	
5.00	Net income from service to patients (line 3 minus line 4)			-4, 465, 633	5. 00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			296, 026	
7. 00	Income from investments			-144, 261	
8.00	Revenues from telephone and other miscellaneous communicati	on services		0	
9. 00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			161, 709	
12.00	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			65, 036	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			54, 954	22.00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING INCOME			2, 643, 468	24.00
24.50	COVI D-19 PHE Fundi ng			992, 636	24.50
25.00	Total other income (sum of lines 6-24)			4, 069, 568	25.00
26.00	Total (line 5 plus line 25)			-396, 065	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-396, 065	29. 00
			· ·		-

Heal th	Financial Systems	PERRY COUNTY	′ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-1322	Peri od:	Worksheet M-1	
			Component	CCN: 15-8516	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	EAGULETY HEALTH CARE OTAES COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	1, 093, 029	0	1, 093, 0	·	1, 045, 413	1.00
2.00	Physician Assistant	0	0	0.40 4	0 0	0	
3. 00 4. 00	Nurse Practitioner	240, 123	0	240, 12	23 0	240, 123	3.00
4. 00 5. 00	Visiting Nurse Other Nurse	151 (07	0	151 //	0		1
6. 00	Clinical Psychologist	151, 607 0	0	151, 60	0	151, 607 0	1
7. 00	Clinical Social Worker	0	0				
8. 00	Laboratory Techni ci an	0	0			0	
9. 00	Other Facility Health Care Staff Costs	189, 895	0	189, 89	95 0	189, 895	
10.00	Subtotal (sum of lines 1 through 9)	1, 674, 654	0	1, 674, 6!			1
11. 00	Physician Services Under Agreement	1, 074, 034	0	1,074,0	0 -47,010	1,027,030	11.00
12. 00	Physician Supervision Under Agreement	0	0			0	12.00
13. 00	Other Costs Under Agreement	0	0		0 0	o o	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15. 00	Medical Supplies	o	143, 109	143, 10	09	143, 109	
16.00	Transportation (Health Care Staff)	0	0	,	0 0	0	1
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	143, 109	143, 10	09	143, 109	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 674, 654	143, 109	1, 817, 7	-47, 616	1, 770, 147	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES		45.005		·=l	45.005	
23. 00	Pharmacy	0	45, 035	45, 0	35 0	45, 035	
24.00	Dental	0	0		0	0	24.00
25. 00 25. 01	Optometry Tel eheal th	0	0		0	0	25. 00 25. 01
25. 01		0	0		0 0		
26. 00	Chronic Care Management All other nonreimbursable costs	0	0			0	1
27. 00	Nonallowable GME costs	U	U			0	27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	45, 035	45, 0	35 0	45, 035	1
20.00	through 27)	J	45, 055	45, 0.	55	45, 055	20.00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	0		0 0	0	29. 00
30.00	Administrative Costs	196, 778	1, 035, 374	1, 232, 1!	52 0	1, 232, 152	30.00
31.00	Total Facility Overhead (sum of lines 29 and	196, 778	1, 035, 374			1, 232, 152	31.00
	30)			·			

3, 094, 950

-47, 616

1, 223, 518

1, 871, 432

32.00

3, 047, 334

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1322	Peri od:	Worksheet M-1	
				From 01/01/2022		
		Component	CCN: 15-8516	To 12/31/2022		
					5/23/2023 1: 3	4 pm
				RHC I	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				

					RHC I	Cost
		Adjustments	Net Expenses			
			for			
			Allocation			
			(col. 5 +			
			col. 6)			
		6. 00	7. 00			
	FACILITY HEALTH CARE STAFF COSTS		T			
1. 00	Physi ci an	0	1, ,	1		1.00
2.00	Physician Assistant	0	1	1		2.00
3. 00	Nurse Practitioner	0	240, 123			3.00
4. 00	Visiting Nurse	0	0			4.00
5. 00	Other Nurse	0	151, 607			5.00
6.00	Clinical Psychologist	0	0			6.00
7.00	Clinical Social Worker	0	0			7.00
8.00	Laboratory Techni ci an	0	0			8.00
9.00	Other Facility Health Care Staff Costs	0	189, 895			9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 627, 038	1		10.00
11.00	Physician Services Under Agreement	0	0			11.00
12.00	1 3 1	0	0			12.00
13.00	9	0	0	1		13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0	1		14.00
15.00	Medical Supplies	0	143, 109	1		15. 00
16.00	Transportation (Health Care Staff)	0	0	•		16.00
17.00		0	0	ł		17. 00
	Professional Liability Insurance	0	0	1		18.00
	Other Health Care Costs	0	0			19.00
20.00		•	440 400			20.00
21. 00		0	143, 109	1		21.00
22. 00	Total Cost of Health Care Services (sum of	0	1, 770, 147			22. 00
	lines 10, 14, and 21)					
22 00	COSTS OTHER THAN RHC/FQHC SERVICES	0	45.025	1		23.00
	Pharmacy	0	45, 035			23.00
24. 00 25. 00	Dental	0		1		25. 00
25. 00	Optometry Tel eheal th	0				25.00
25. 01	Chronic Care Management	0				25. 01
26. 00	1	0				26. 00
27.00	1	Ü	·			27.00
	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23	0	45 025			
28. 00	through 27)	Ü	45, 035			28. 00
	FACILITY OVERHEAD					
20 00	Facility Overhead Facility Costs	0				29.00
30.00	Administrative Costs	0	1	1		30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	1, 232, 152	1		31.00
31.00	30)	Ü	1, 232, 132			31.00
32. 00	Total facility costs (sum of lines 22, 28	0	3, 047, 334			32.00
32.00	and 31)	0	3,047,334			32.00
	[and 01)		ı	I		1

Heal th	Financial Systems	PERRY COUNTY	′ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	GIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-1322	Peri od:	Worksheet M-1	
			Component (CCN: 15-8517	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS	404 070		404.0	70 444 777	200 000	1 00
1.00	Physi ci an	404, 070	0	404, 0		292, 293	1.00
2.00	Physician Assistant	0	0		0 0	111 200	2.00
3. 00 4. 00	Nurse Practitioner	O O	0		0 111, 389	111, 389 0	1
5. 00	Visiting Nurse Other Nurse	2, 690	0	2, 6	0	2, 690	
6. 00	Clinical Psychologist	2, 090	0	2,0	0 0	2,090	
7. 00	Clinical Social Worker	0	0			0	
8. 00	Laboratory Techni ci an	0	0			0	
9. 00	Other Facility Health Care Staff Costs	131, 134	0	131, 1;	34 0	131, 134	1
10. 00	Subtotal (sum of lines 1 through 9)	537, 894	0	537, 89		537, 506	1
11. 00	Physician Services Under Agreement	0	0	1	0 0	0	11.00
12.00	Physician Supervision Under Agreement	o	0		0 0	0	12.00
13.00	Other Costs Under Agreement	o	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	o	0		0 0	0	14.00
15.00	Medical Supplies	0	38, 028	38, 0	28 0	38, 028	15. 00
16. 00	Transportation (Health Care Staff)	0	0		0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0		0	0	
18. 00	Professional Liability Insurance	0	0		0	0	
19. 00		0	0		0	0	1 . ,
20. 00	Allowable GME Costs	_			_		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38, 028			38, 028	
22. 00	Total Cost of Health Care Services (sum of	537, 894	38, 028	575, 9:	-388	575, 534	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23. 00	Pharmacy	ol	118, 683	118, 68	33 0	118, 683	23.00
24. 00	Dental	0	110,003	110,00	0	0	24.00
25. 00	Optometry	Ö	0		0	Ö	25.00
25. 01	Tel eheal th	ol	0		0 0	Ö	
25. 02	Chronic Care Management	ol	0		0 0	0	
26. 00	All other nonreimbursable costs	o	0		0 0	0	1
27. 00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	o	118, 683	118, 68	33 0	118, 683	28. 00
	through 27)						
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	0		0 0	0	
30.00	Administrative Costs	50, 138	340, 127	390, 20		390, 265	
31. 00	Total Facility Overhead (sum of lines 29 and	50, 138	340, 127	390, 20	65 0	390, 265	31.00
	30)			1	1	l .	i .

588, 032

496, 838

-388

1, 084, 482

32.00

1, 084, 870

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der 0	CCN: 15-1322	Peri od: From 01/01/2022	Worksheet M-1	
		Component	CCN: 15-8517	To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
				RHC II	Cost	
	Adiustmonts	Not Expanses				

RHC I I	Cost
Adjustments Net Expenses	
for	
Allocation	
(col. 5 +	
col . 6)	
6.00 7.00	
FACILITY HEALTH CARE STAFF COSTS	
1.00 Physician 0 292, 293	1.00
2.00 Physician Assistant 0 0	2.00
3.00 Nurse Practitioner 0 111, 389	3.00
4.00 Visiting Nurse 0 0	4.00
5.00 Other Nurse 0 2,690	5.00
6. 00 Clinical Psychologist 0 0	6.00
7. 00 Clinical Social Worker 0	7.00
8. 00 Laboratory Technician 0 0	8.00
9.00 Other Facility Health Care Staff Costs 0 131,134	9.00
10.00 Subtotal (sum of lines 1 through 9) 0 537,506	10.00
11.00 Physician Services Under Agreement 0 0	11.00
12.00 Physician Supervision Under Agreement 0 0	12.00
13.00 Other Costs Under Agreement 0 0	13. 00
14.00 Subtotal (sum of lines 11 through 13) 0 0	14.00
15.00 Medical Supplies 0 38,028	15. 00
16.00 Transportation (Health Care Staff) 0 0	16.00
17.00 Depreciation-Medical Equipment 0 0	17. 00
18.00 Professional Liability Insurance 0 0	18. 00
19.00 Other Health Care Costs 0 0	19.00
20.00 Allowable GME Costs	20.00
21.00 Subtotal (sum of Lines 15 through 20) 0 38,028	21.00
22.00 Total Cost of Health Care Services (sum of 0 575,534	22. 00
lines 10, 14, and 21)	22.00
COSTS OTHER THAN RHC/FOHC SERVICES	
23. 00 Pharmacy 0 118, 683	23.00
24.00 Dental 0 0	24.00
25. 00 Optometry 0 0	25. 00
25. 01 Tel eheal th	25. 01
25. 02 Chroni c Care Management	25. 02
	26.00
25. Co M. F. Ctilor Holli Chimar Capt C Cocto	•
27.00 Nonallowable GME costs	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 0 118,683	28. 00
through 27)	
FACILITY OVERHEAD	
29. 00 Facility Costs 0 0	29.00
30. 00 Administrative Costs 0 390, 265	30.00
31.00 Total Facility Overhead (sum of lines 29 and 0 390,265	31.00
30)	
32.00 Total facility costs (sum of lines 22, 28 0 1,084,482	32.00
and 31)	I

ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1322	Peri od:	Worksheet M-1	
			Component	CCN: 15-8560	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
				_	RHC III	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	0.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Physician	1, 363, 497	0	1, 363, 49	-170, 521	1, 192, 976	1.00
2. 00	Physician Assistant	1, 303, 497	0		0 -170, 521	1, 192, 970	1
3. 00	Nurse Practitioner	0	0		0 62, 271	62, 271	3.00
4. 00	Vi si ti ng Nurse	0	0		02,2/1	02, 271	
5. 00	Other Nurse	123, 284	0	123, 28	24	123, 284	
5. 00	Clinical Psychologist	123, 204	0	125, 20	0 0	123, 204	
7. 00	Clinical Social Worker	o O	0			0	
3. 00	Laboratory Techni ci an	ol	0		0	0	
9. 00	Other Facility Health Care Staff Costs	95, 084	0	95, 08	34 0	95, 084	
10.00	Subtotal (sum of lines 1 through 9)	1, 581, 865	0	1, 581, 86		1, 473, 615	
11.00	Physician Services Under Agreement	0	0	1, 22., 22	0 0	0	1
12.00	Physician Supervision Under Agreement	ol	0		0 0	0	
13. 00	Other Costs Under Agreement	o	0		0 0	0	13.0
14.00	Subtotal (sum of lines 11 through 13)	o	0		0 0	0	14.00
15. 00	Medical Supplies	o	48, 839	48, 83	0	48, 839	15.00
16. 00	Transportation (Health Care Staff)	o	0		0	0	16.0
17.00	Depreciation-Medical Equipment	o	0		0	0	17.0
18.00	Professional Liability Insurance	0	0		0	0	18.0
19. 00	Other Health Care Costs	0	0		0 0	0	19.0
20. 00	Allowable GME Costs						20.0
21. 00	Subtotal (sum of lines 15 through 20)	0	48, 839			48, 839	ı
22. 00	Total Cost of Health Care Services (sum of	1, 581, 865	48, 839	1, 630, 70	-108, 250	1, 522, 454	22. 0
	lines 10, 14, and 21)						
20.00	COSTS OTHER THAN RHC/FQHC SERVICES	ما	0.4.054	04.05		04.054	
23. 00	Pharmacy	0	84, 251	84, 25		84, 251	23. 0
24. 00 25. 00	Dental	O O	0		0 0	0	
25. 00 25. 01	Optometry Tel eheal th	O O	0			0	1
25. 01	· I	0	0		0 0	0	
26. 00	All other nonreimbursable costs	0	0		0 0	0	
27. 00	Nonallowable GME costs	٩	0			U	27.0
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	84, 251	84, 25	61 0	84, 251	28.0
20.00	through 27)	ď	04, 231	04, 20		04, 231	20.00
	FACILITY OVERHEAD						İ
29. 00	Facility Costs	0	0		0 0	0	29.0
30.00	Administrative Costs	52, 880	539, 797	592, 67	7 0	592, 677	
31. 00	Total Facility Overhead (sum of lines 29 and		539, 797			592, 677	31.00
	30)		•	, ,		•	
32. 00	Total facility costs (sum of lines 22, 28	1, 634, 745	672, 887	2, 307, 63	-108, 250	2, 199, 382	32.0
	and 31)			I			1

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 01/01/2022	Worksheet M-1
	Component CCN: 15-8560	To 12/31/2022	Date/Time Prepared: 5/23/2023 1:34 pm
		RHC III	Cost

					5/23/2023 1: 3	34 pm
				RHC III	Cost	
		Adjustments	Net Expenses			
		,	for			
			Allocation			
			(col. 5 +			
			col. 6)			
		6. 00	7.00			
	FACILITY HEALTH CARE STAFF COSTS	0.00	71.00			
1.00	Physi ci an	0	1, 192, 976			1.00
2. 00	Physician Assistant	0	1, 172, 770			2.00
3. 00	Nurse Practitioner	0	62, 271			3.00
4. 00	Vi si ti ng Nurse	0	02, 271			4.00
5. 00		0	123, 284			5.00
	Other Nurse	0				1
6.00	Clinical Psychologist	0	0			6.00
7.00	Clinical Social Worker	0	0			7.00
8. 00	Laboratory Techni ci an	0	0			8. 00
9. 00	Other Facility Health Care Staff Costs	0	95, 084			9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 473, 615			10.00
11. 00	Physician Services Under Agreement	0	0			11. 00
12.00	Physician Supervision Under Agreement	0	0			12.00
13.00	Other Costs Under Agreement	0	0			13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0			14.00
15.00	Medical Supplies	0	48, 839			15.00
16.00	Transportation (Health Care Staff)	0	0			16.00
17.00	Depreciation-Medical Equipment	0	0			17.00
18.00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	0	0			18.00
19.00	Other Health Care Costs	0	0			19.00
20.00	Allowable GME Costs	-	_			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	48, 839			21.00
22. 00	Total Cost of Health Care Services (sum of	Ö	1, 522, 454			22.00
22.00	lines 10, 14, and 21)	٩	1, 522, 454			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES					
22 00	Pharmacy	ol	84, 251			23.00
24. 00	Dental	0	04, 231			24.00
25.00	1	0	0			25.00
	Optometry	0	0			25.00
25. 01	Tel eheal th	0	0			
25. 02	Chronic Care Management	U	0			25. 02
26.00	All other nonreimbursable costs	U	U			26.00
27. 00	Nonallowable GME costs	_				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	84, 251			28. 00
	through 27)					
	FACILITY OVERHEAD					
	Facility Costs	0	0			29.00
30.00	Administrative Costs	-259	592, 418			30.00
31.00	Total Facility Overhead (sum of lines 29 and	-259	592, 418			31.00
	30)					
32.00	Total facility costs (sum of lines 22, 28	-259	2, 199, 123			32.00
	and 31)					

Heal th	Financial Systems	PERRY COUNTY	΄ ΗΛΩΡΙΤΔΙ		In lie	u of Form CMS-:	2552_10
	SIS OF HOSPITAL-BASED RHC/FOHC COSTS	TERRY COUNTY		CN: 15-1322	Peri od:	Worksheet M-1	
				CCN: 15-8562	From 01/01/2022 To 12/31/2022		pared:
					RHC IV	Cost	тт рііі
		Compensation	Other Costs	Total (col.	1 Reclassificat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
				Í		(col. 3 +	
						col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	401, 412	0		12, 215	413, 627	1.00
2.00	Physician Assistant	0	0		0	0	2.00
3. 00	Nurse Practitioner	0	0	1	0 52, 377	52, 377	3. 00
4.00	Visiting Nurse	0	0		0 0	0	1
5. 00	Other Nurse	125, 376	0	125, 3		125, 376	1
6.00	Clinical Psychologist	0	0		0	0	
7.00	Clinical Social Worker	0	0	1	0 0	0	
8.00	Laboratory Technician	20.0(4	0	20.0	54	0	
9.00	Other Facility Health Care Staff Costs	29, 064	0	27,0		29, 064	1
10. 00 11. 00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	555, 852 0	0	1 000, 0	52 64, 592 0 0	620, 444 0	
12.00	Physician Supervision Under Agreement	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	14.00
15. 00	Medical Supplies	0	6, 647		-	6, 647	
16. 00	Transportation (Health Care Staff)	0	0, 047	0, 0	0 0	0,047	1
17. 00	Depreciation-Medical Equipment	0	0		0 0	l o	1
18. 00	Professional Liability Insurance	o	0	,	0 0	l o	
19.00	Other Health Care Costs	0	0		0 0	0	1
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6, 647	6, 6	47 0	6, 647	21.00
22.00	Total Cost of Health Care Services (sum of	555, 852	6, 647	562, 4	99 64, 592	627, 091	22.00
	lines 10, 14, and 21)]
	COSTS OTHER THAN RHC/FQHC SERVICES			,			
23. 00	Pharmacy	0	26, 519	26, 5		26, 519	
24. 00	Dental	0	0	1	0 0	0	24.00
25. 00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	
25. 02	Chronic Care Management	0	0	1	0 0	0	
26.00	All other nonreimbursable costs	U	Ü	1	0	0	
27. 00 28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23	0	24 E10	24 5	19 0	0/ E10	27. 00
28.00	through 27)	٩	26, 519	26, 5	19 0	26, 519	28. 00
	FACILITY OVERHEAD			1			1
29. 00	Facility Costs	o	0		0 0	0	29. 00
30.00	Administrative Costs	60, 078	261, 275	1			1
31. 00	Total Facility Overhead (sum of lines 29 and	60, 078	261, 275				1
	30)	, -, -	,]]	

615, 930

294, 441

910, 371

64, 592

974, 963

32.00

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 01/01/2022	Worksheet M-1
	Component CCN: 15-8562	To 12/31/2022	Date/Time Prepared: 5/23/2023 1:34 pm
		RHC IV	Cost

					5/23/2023 1:34 pm
				RHC IV	Cost
		Adjustments	Net Expenses		
		•	for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7.00		
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00		
1. 00	Physi ci an	0	413, 627		1, 00
		0	I I		
2.00	Physician Assistant	0	0		2.00
3. 00	Nurse Practitioner	0	52, 377		3. 00
4. 00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	125, 376		5.00
6.00	Clinical Psychologist	0	0		6. 00
7.00	Clinical Social Worker	0	0		7. 00
8.00	Laboratory Techni ci an	0	l ol		8.00
9.00	Other Facility Health Care Staff Costs	0	29, 064		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	620, 444		10.00
11. 00	Physician Services Under Agreement	0	0		11.00
12. 00		0	Ö		12.00
	Other Costs Under Agreement	0	l ö		13.00
		0	- 1		I
14.00	Subtotal (sum of lines 11 through 13)	0	0		14. 00
15. 00	Medical Supplies	0	6, 647		15. 00
16. 00		0	0		16.00
17. 00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6, 647		21.00
22.00	Total Cost of Health Care Services (sum of	0	627, 091		22.00
	lines 10, 14, and 21)		, , , , ,		
	COSTS OTHER THAN RHC/FQHC SERVICES		'		
23. 00		0	26, 519		23.00
24. 00	Dental	0	0		24.00
25. 00	Optometry	0	0		25.00
25. 00	Tel eheal th	0	0		25. 01
	1	0	0		25. 02
25. 02	Chronic Care Management	0	0		
26. 00	All other nonreimbursable costs	0	0		26. 00
27. 00	Nonallowable GME costs				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	26, 519		28. 00
	through 27)				
	FACILITY OVERHEAD				
29. 00	Facility Costs	0	0		29. 00
30.00	Administrative Costs	0	321, 353		30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	321, 353		31.00
	30)				
32.00	Total facility costs (sum of lines 22, 28	0	974, 963		32.00
	and 31)				1
					•

	Financial Systems	PERRY COUNT				u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
					RHC I	Cost	•
	·	Number of FTE	Total Visits		Mi ni mum	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. 68					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	1. 68					3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 36			6, 384	8, 875	
5.00	Visiting Nurse	0.00		1		0	5.00
6.00	Clinical Psychologist	0.00		1		0	6.00
7.00	Clinical Social Worker	0.00		1		0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		1		0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0	1		0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	2. 36	8, 875			8, 875	8.00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0	1		0	9. 00
						1.00	
	DETERMINATION OF ALLOWARIE COOT ARRULOARIE T	O HOCDITAL DAG	ED DUO (EQUID CE	DVII OFC		1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES		1 770 147	10.00
11. 00	Total costs of health care services (from Wk					1, 770, 147	
	Total nonreimbursable costs (from Wkst. M-1,					45, 035	
12.00	Cost of all services (excluding overhead) (s					1, 815, 182	
13.00	Ratio of hospital -based RHC/FQHC services (I			: 21)		0. 975190	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		1, 232, 152	
15.00	Parent provider overhead allocated to facili	ty (see Instru	Ctions)			706, 570	
16.00	Total overhead (sum of lines 14 and 15)					1, 938, 722	
17.00	Allowable GME overhead (see instructions)					1 020 722	
	Enter the amount from line 16	NIC comit cos (1)	l no 10 v 11	10)		1, 938, 722	
	Overhead applicable to hospital based RHC/FC					1, 890, 622 3, 660, 769	
∠∪. ∪∪	Total allowable cost of hospital-based RHC/F	unc services (Sum of Fines I	o and 19)	l	3,000,769	I 20.00

	Financial Systems	PERRY COUNT				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
					RHC II	Cost	
		Number of FTE	Total Visits			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. 67					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 70					3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 37			4, 284	4, 284	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			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	1. 37	2, 507			4, 284	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			RVI CES			
	Total costs of health care services (from Wk					575, 534	
	Total nonreimbursable costs (from Wkst. M-1,					118, 683	l
12.00	Cost of all services (excluding overhead) (s					694, 217	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 829040	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		390, 265 248, 904	
15.00							
16.00	Total overhead (sum of lines 14 and 15)					639, 169	
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					639, 169	
	Overhead applicable to hospital-based RHC/FQ					529, 897	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (:	sum of lines 1	o and 19)		1, 105, 431	20.00

	Financial Systems	PERRY COUNT				u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
			Component	0014: 10 0000	10 12/01/2022	5/23/2023 1: 3	
					RHC III	Cost	
		Number of FTE	Total Visits			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	10.00(
1.00	Physi ci an	2. 43					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 25				10 701	3.00
4. 00 5. 00	Subtotal (sum of lines 1 through 3)	2. 68 0. 00		1	10, 731	10, 731	4. 00 5. 00
6. 00	Visiting Nurse Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7.00
7. 01	Diabetes Self Management Training (FQHC	0.00	l .			0	7.01
7.02	only)	0.00	0			U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	2. 68	5, 356			10, 731	8.00
0.00	through 7)	2.00	0,000			10, 701	0.00
9.00	Physician Services Under Agreements		0			0	9.00
	J	·					
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			1, 522, 454	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			84, 251	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			1, 606, 705	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 947563	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		592, 418	14.00
15.00	5.00 Parent provider overhead allocated to facility (see instructions)						
16.00	Total overhead (sum of lines 14 and 15)					1, 110, 852	
17.00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					1, 110, 852	
	Overhead applicable to hospital-based RHC/FC					1, 052, 602	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		2, 575, 056	20.00

	Financial Systems	PERRY COUNT				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
					RHC IV	Cost	
		Number of FTE	Total Visits			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					
1. 00	Physi ci an	1. 36					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 03		•			3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 39			5, 775	5, 775	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			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	1. 39	4, 414			5, 775	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					627, 091	
	Total nonreimbursable costs (from Wkst. M-1,					26, 519	l
12.00	Cost of all services (excluding overhead) (s					653, 610	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 959427	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		321, 353 230, 244	
15.00	5.00 Parent provider overhead allocated to facility (see instructions)						
16.00	b.00 Total overhead (sum of lines 14 and 15)						
17.00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					551, 597	
	Overhead applicable to hospital-based RHC/FQ					529, 217	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		1, 156, 308	20.00

	Financial Systems PERRY COUNTY H			u of Form CMS-2	
CALCUL SERVI (ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1322	Peri od: From 01/01/2022	Worksheet M-3	
JLKVI	,L3	Component CCN: 15-8516	To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			3, 660, 769	1.00
2.00	Cost of injections/infusions and their administration (from W			58, 569	2.00
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	inus iine 2)		3, 602, 200 8, 875	3. 00 4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0, 675	5.00
6. 00	Total adjusted visits (line 4 plus line 5)			8, 875	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			405. 88	7. 00
			Cal cul ati on	of Limit (1)	
				Rate Period 1	
			N/A	(01/01/2022	
				through 12/31/2022)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	225. 59	8. 00
9. 00	Rate for Program covered visits (see instructions)		0.00	225. 59	9.00
	CALCULATION OF SETTLEMENT				
10. 00 11. 00	Program covered visits excluding mental health services (from	•	0	2, 331 525, 850	1
12. 00	Program cost excluding costs for mental health services (line 9 x line 10) Program covered visits for mental health services (from contractor records)				ı
13. 00	Program covered cost from mental health services (line 9 x li		o	0	13.00
14.00	Limit adjustment for mental health services (see instructions)				14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	525, 850	•
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov			614, 594 98, 121	16. 01 16. 02
16. 02	Total program preventive charges (see Histractions) (From prov Total program preventive costs ((line 16.02/line 16.01) times	•		83, 953	ı
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	•		319, 575	
	(Titles V and XIX see instructions.)				
16.05	Total program cost (see instructions)		0	403, 528	16. 05 17. 00
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 42, 428	ı
10.00	records)	(110m contractor		12, 120	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		94, 810	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			403, 528	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		15, 054	
22. 00	, , ,			418, 582	
23. 00	Allowable bad debts (see instructions)			0	23.00
23. 01 24. 00	` ` '	ructions)		0	23. 01 24. 00
25. 00		ructions)		0	25.00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	ı
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions)			418, 582	1
26. 01	Sequestration adjustment (see instructions)			5, 274	1
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 395, 893	
	Tentative settlement (for contractor use only)			343, 643	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		17, 415	
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-II		0	30.00

	Financial Systems PERRY COUNTY H			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1322	Peri od: From 01/01/2022	Worksheet M-3	
SERVI CE	<u>-</u> S	Component CCN: 15-8517	To 12/31/2022	Date/Time Pre	pared:
		·		5/23/2023 1: 3	
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		1, 105, 431	1.00
1	Cost of injections/infusions and their administration (from W			173, 178	2.00
	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		932, 253	
1	Total Visits (from Wkst. M-2, column 5, line 8)	line O		4, 284	4.00
1	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	Time 9)		0 4, 284	5. 00 6. 00
1	Adjusted cost per visit (line 3 divided by line 6)			217. 61	7.00
7.00	rajusted dost per visit (Time o di vided by Time o)		Cal cul ati on		7.00
				Rate Period 1	
			N/A	(01/01/2022	
				through 12/31/2022)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	162. 77	8. 00
9.00	Rate for Program covered visits (see instructions)		0.00	162. 77	9.00
	CALCULATION OF SETTLEMENT				
	Program covered visits excluding mental health services (from		0	147	10.00
1	Program cost excluding costs for mental health services (line	•	0	23, 927	11. 00 12. 00
	Program covered visits for mental health services (from contr Program covered cost from mental health services (line 9 x li		0	0	13.00
	Limit adjustment for mental health services (see instructions	•	o	0	14.00
	Graduate Medical Education Pass Through Cost (see instructions)			_	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	23, 927	16.00
	Total program charges (see instructions)(from contractor's re			41, 882	
1	Total program preventive charges (see instructions) (from prov	•		15, 649	
	Total Program preventive costs ((line 16.02/line 16.01) times			8, 940	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		9, 632	16.04
16. 05	Total program cost (see instructions)		0	18, 572	16. 05
1	Primary payer amounts			0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		2, 947	18.00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		4, 657	19.00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			18, 572	20.00
	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		2, 565	
1	Total reimbursable Program cost (line 20 plus line 21)	,		21, 137	
	Allowable bad debts (see instructions)			0	23.00
1	Adjusted reimbursable bad debts (see instructions)			0	23. 01
	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	24.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	6)		0	25.00
	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	5)		0	
	Net reimbursable amount (see instructions)			21, 137	
	Sequestration adjustment (see instructions)		266	1	
	Demonstration payment adjustment amount after sequestration			0	
1	Interim payments			17, 810	
1	Tentative settlement (for contractor use only)	00 07 1		0	28.00
	Balance due component/program (line 26 minus lines 26.01, 26.			3, 061	
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-11		0	30.00

	Financial Systems PERRY COUNTY H			u of Form CMS-2	
CALCUL SERVI (ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1322	Peri od: From 01/01/2022	Worksheet M-3	
SERVI (ies.	Component CCN: 15-8560	To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			2, 575, 056	1.00
2.00	Cost of injections/infusions and their administration (from W			134, 602	
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		2, 440, 454	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	lino ()		10, 731 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	11116 9)		10, 731	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			227. 42	7.00
			Cal cul ati on		
				Rate Period 1	
			N/A	(01/01/2022 through	
				12/31/2022)	
			1. 00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	113. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)		0.00	113. 00	9.00
10 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	0	511	10.00
10. 00 11. 00	Program cost excluding costs for mental health services (line		0	57, 743	
12. 00	Program covered visits for mental health services (from contr	,	0	0	1
13.00	Program covered cost from mental health services (line 9 x li	,	O	0	
14.00	Limit adjustment for mental health services (see instructions)				14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction				15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	57, 743	1
16. 01	Total program charges (see instructions)(from contractor's re			123, 027 3, 799	
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	•		3, 799 1, 783	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	•		36, 586	1
	(Titles V and XIX see instructions.)	· · · · · · · · · · · · · · · · · · ·			
16.05	Total program cost (see instructions)		0	38, 369	1
17. 00	Primary payer amounts			178	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		10, 228	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FOHC services (see instruction	ns) (from contractor		21, 800	19.00
. ,	records)	(2.,000	.,
20.00	Net Medicare cost excluding vaccines (see instructions)			38, 191	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		1, 714	
22. 00	, , ,			39, 905	1
23. 00 23. 01	Allowable bad debts (see instructions)			0	23.00
24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00		r de tr ons)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	
26.00	Net reimbursable amount (see instructions)			39, 905	1
26. 01	Sequestration adjustment (see instructions)			503	
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 36, 867	
	Tentative settlement (for contractor use only)			30, 807	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		2, 535	
30.00			.	0	
00.00	chapter I, §115.2		1		1

	Financial Systems PERRY COUNTY H			u of Form CMS-2	
CALCUL SERVI (ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1322	Peri od: From 01/01/2022	Worksheet M-3	
JLKVI	.L.S	Component CCN: 15-8562	To 12/31/2022	Date/Time Pre 5/23/2023 1:3	
		Title XVIII	RHC I V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			11 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	· · · · · · · · · · · · · · · · · · ·		1, 156, 308	•
2.00	Cost of injections/infusions and their administration (from W			85, 669	2.00
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	inus iine 2)		1, 070, 639 5, 775	3.00 4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		5, 775	5.00
6. 00	Total adjusted visits (line 4 plus line 5)			5, 775	6.00
7.00					7. 00
			Cal cul ati on	of Limit (1)	
				Rate Period 1	
			N/A	(01/01/2022	
				through 12/31/2022)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	113. 00	8. 00
9. 00	Rate for Program covered visits (see instructions) 0.				9. 00
10.00	CALCULATION OF SETTLEMENT			07/	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	976 110, 288	
12. 00	Program covered visits for mental health services (from contractor records)				12.00
13.00	Program covered cost from mental health services (line 9 x li	,	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions	•	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction			110 200	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re		0	110, 288 236, 331	16. 00 16. 01
16. 02	Total program preventive charges (see instructions) (from prov			6, 181	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		2, 884	16.03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		58, 261	16.04
1/ 05	(Titles V and XIX see instructions.)			/1 145	1/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	61, 145 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		34, 578	
	records)	•		·	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		39, 115	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			61, 145	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		20, 954	
22.00	, , ,			82, 099	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
25. 00	,	. 451. 51.5)		0	25.00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			82, 099 1, 034	
26. 01 26. 02	, ,			1, 034	26. 01 26. 02
27. 00	Interim payments			57, 178	
	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			23, 887	
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II	, [0	30.00

COMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od: From 01/01/2022	Worksheet M-4	
		Component (To 12/31/2022		
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 627, 038 0. 001256				1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	2, 044	10, 77	3 0	0	3.0
1. 00	Injections/infusions and related medical supplies costs (from your records)	7, 704	7, 80	0 0	0	4.0
5. 00 5. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	9, 748 1, 770, 147			0 1, 770, 147	5. 0 6. 0
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 890, 622 0. 005507	1, 890, 62 0. 01049			7. 0 8. 0
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10, 412 20, 160			0	9. 0 10. 0
1.00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	37 544. 86	19 196. 9			11. 0 12. 0
3. 00	Number of injection/infusion administered to Program beneficiaries	11	4	6 0	0	13.0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5, 993	9, 06	1 0	0	14.0
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		58, 569	15. 0
6.00	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou		s (sum of		15, 054	16. C

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 15-1322	Peri od: From 01/01/2022	Worksheet M-4	
		Component C	CCN: 15-8517	To 12/31/2022	Date/Time Prep 5/23/2023 1:3	
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	537, 506	537, 50	06 537, 506	537, 506	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 015380	0. 0173	0. 000000	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	8, 267	9, 30	04 0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	60, 753	11, 84	4O O	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	69, 020	21, 14	44 0	ol	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	575, 534	575, 53	575, 534	575, 534	6.0
7. 00	Total overhead (from Wkst. M-2, line 19)	529, 897	529, 89	97 529, 897	529, 897	7.0
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 119923	0. 03673	0. 000000	0. 000000	8.0
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	63, 547	19, 40	67 0	0	9.0
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	132, 567	40, 6	11 0	0	10.0
11.00	Total number of injections/infusions (from your records)	263	29	96 0	0	11.0
2.00	Cost per injection/infusion (line 10/line 11)	504.06	137. 2	20 0.00	0. 00	12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	4		4 0	0	13.0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2, 016	54	49 0	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND ADMINISTRATIO	
					N N	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administratio	•	col umns 1,	1.00	173, 178	15.0
4 00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		(cum of		2 5/5	14 0
o. UU	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				2, 565	10.0

OMPUTATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der CO		Peri od: From 01/01/2022	Worksheet M-4	
	'	CCN: 15-8560	To 12/31/2022	Date/Time Prep 5/23/2023 1:34	
		XVIII	RHC III	Cost	
	PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
	1.00	2. 00	2. 01	2. 02	
OD Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 473, 615 0. 008133	1, 473, 67 0. 00367		1, 473, 615 0. 000000	1. C 2. C
00 Injection/infusion health care staff cost (line 1 x line 2)	11, 985	5, 42	20 0	0	3. 0
00 Injections/infusions and related medical supplies costs (from your records)	57, 256	4, 92	0	0	4. C
OD Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from	69, 241 1, 522, 454	10, 3 ⁴ 1, 522, 45		0 1, 522, 454	5. C 6. C
Worksheet M-1, col. 7, line 22) Total overhead (from Wkst. M-2, line 19)	1, 052, 602	1, 052, 60			7. 0
On Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 045480	0. 00679			8. (
00 Overhead cost - injection/infusion (line 7 x line 8) 0.00 Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	47, 872 117, 113	7, 14 17, 48		0	9. (10. (
1.00 Total number of injections/infusions (from your records) 2.00 Cost per injection/infusion (line 10/line 11)	272 430. 56	12 142.			11. (
3.00 Number of injection/infusion administered to Program beneficiaries	2	142.	6 0	0.00	13. (
3.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. (
4.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	861	85	53 0	0	14. (
				COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO	
			1.00	N 2. 00	
5.00 Total cost of injections/infusions and their administratio		f columns 1,	1.00	134, 602	15. (
2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. 5.00 Total Program cost of injections/infusions and their admin		s (sum of		1, 714	16.
columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou	nt to Wkst. M-3	3, line 21)			

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	N: 15-1322	Peri od:	Worksheet M-4	
		Component C	CN: 15-8562	From 01/01/2022 To 12/31/2022		
		Title	XVIII	RHC IV	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	620, 444 0. 004670	620, 44 0. 01890		620, 444 0. 000000	
. 00	Injection/infusion health care staff cost (line 1 x line 2)	2, 897	11, 7	32 0	0	3. (
. 00	Injections/infusions and related medical supplies costs (from your records)	18, 711	13, 12	20 0	0	4. (
00	Direct cost of injections/infusions (line 3 plus line 4)	21, 608	24, 85	52 0	0	5.
00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	627, 091	627, 09	·	627, 091	6.
00	Total overhead (from Wkst. M-2, line 19)	529, 217	529, 2		529, 217	7.
00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 034458	0. 03963			
00	Overhead cost - injection/infusion (line 7 x line 8)	18, 236	20, 9		0	
). 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	39, 844	45, 82		0	
1.00	Total number of injections/infusions (from your records)	81	32		0	
2. 00	Cost per injection/infusion (line 10/line 11)	491. 90	139.		0.00	
3. 00	Number of injection/infusion administered to Program beneficiaries	23	(59 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	11 214	0 (0	0	
1. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	11, 314	9, 64	0	0	14.
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
				1.00	N	
00	Total and Children Colors and the Children			1. 00	2. 00	4.5
	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			85, 669	
. 00	Total Program cost of injections/infusions and their admin	istration costs	(sum of , line 21)		20, 954	16.

Health Financial Systems	PERRY COUNTY H	OSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR			CCN: 15-1322 CCN: 15-8516	From 01/01/2022	Date/Time Prepared:
					5/23/2023 1:34 pm
				RHC I	Cost

		component con. 13-8316	10 12/31/2022	5/23/2023 1: 34	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2, 00	
00	Total interim payments paid to hospital-based RHC/FQHC			395, 893	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		o	2.
	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 amount	based on subsequent			3
	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				
)1				0	3
)2				0	3
)3				0	3
04				0	3
05				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line	:	395, 893	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date d	T .		5
	each payment. If none, write "NONE" or enter a zero. (1)				
01	Program to Provider			0	5
)2					5
)3				0	5
	Provider to Program			0	,
50	1 Tovi dei 10 1 Togi alli			0	5
51				o o	5
52				l ől	5
9	 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
0	Determined net settlement amount (balance due) based on the				è
1	SETTLEMENT TO PROVIDER			17, 415	
)2	SETTLEMENT TO PROGRAM			0	
00	Total Medicare program liability (see instructions)			413, 308	
_	(300 1101 431 310)		Contractor	NPR Date	Ĺ
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	PERRY COUNTY H	OSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-1322 Component CCN: 15-8517	From 01/01/2022	
			DUC 11	C+

		Component Con. 13-6317	10 12/31/2022	5/23/2023 1: 34	
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			17, 810	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	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 amount	based on subsequent			3.
	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				
21				0	3
02				0	3
)3				0	3
04				0	3
25				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		17, 810	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				_
00	List separately each tentative settlement payment after des	k review. Also show date o	OT		5
	each payment. If none, write "NONE" or enter a zero. (1)				
01	Program to Provider			0	5
02				0	5
03				0	5
	Provider to Program			0	
50	Tovider to Trogram			0	5
51				0	5
52				l ől	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		٥	5
00	Determined net settlement amount (balance due) based on the				6
)1	SETTLEMENT TO PROVIDER	. 3331 . opor c. (1)		3, 061	6
)2	SETTLEMENT TO PROGRAM			3,001	6
00	Total Medicare program liability (see instructions)			20, 871	7
-	Total mod. od. o program readility (300 restractions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	

Health Financial Systems	PERRY COUNTY H	IOSPI TAL		In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR			CCN: 15-1322 CCN: 15-8560	From 01/01/2022	Worksheet M-5 Date/Time Prepared:
		'			5/23/2023 1:34 pm
				RHC III	Cost

		Component CCN: 15-8560	10 12/31/2022	5/23/2023 1: 34	
			RHC III	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			36, 867	1.00
2.00	Interim payments payable on individual bills, either submit			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3. 00
	revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)	Also snow date of each			
	Program to Provider				
3. 01	1 Togram to 11 ovider			0	3. 01
3. 02				ő	3. 02
3. 03				l ol	3. 03
3. 04				Ö	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				0	3. 53
3. 54		00)		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. Total interim payments (sum of lines 1, 2, and 3.99) (trans			0	3. 99 4. 00
4. 00	27)	ster to worksheet M-3, Titl	e	36, 867	4.00
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	k 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. 02
5. 03	Describing to Describe			0	5. 03
5. 50	Provider to Program			0	5. 50
5. 50				0	5. 51
5. 52					5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		٥	5. 99
6. 00	Determined net settlement amount (balance due) based on the				6. 00
6. 01	SETTLEMENT TO PROVIDER			2, 535	6. 01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7. 00	Total Medicare program liability (see instructions)			39, 402	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
0.00	Name of Contractor	0	1.00	2. 00	0.00
8. 00	Name of Contractor		I		8. 00

Health Financial Systems	PERRY COUNTY H	OSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI			CCN: 15-1322	From 01/01/2022	Worksheet M-5 Date/Time Prepared:
		Component	. CCN. 15-6502		5/23/2023 1: 34 pm
				RHC IV	Cost

		component con. 13-6362	10 12/31/2022	5/23/2023 1: 34	
			RHC IV	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
00	Total interim payments paid to hospital-based RHC/FQHC			57, 178	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		o	2.
	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 amount	based on subsequent			3
	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				0	3
)2				0	3
03				0	3
04				0	3
05				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line	9	57, 178	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		.e		_
00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	ak review. Also snow date c	OT		5
	Program to Provider				
01	Flogram to Flovider			0	5
02				Ö	5
03				Ö	5
	Provider to Program				
50				0	5
51				l ol	5
52				l ol	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
00	Determined net settlement amount (balance due) based on the				6
01	SETTLEMENT TO PROVIDER	, , ,		23, 887	6
)2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			81, 065	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
00	Name of Contractor				8