nearth Frhancia	ai Systems	PERRY COUNTY H	USPLIAL	in Lie	U OT FORM CWS-2552-10
This report is	required by law (42 USC 1395)	g; 42 CFR 413.20(b)). Fai	lure to report can resu	It in all interim	FORM APPROVED
payments made	since the beginning of the cos	st reporting period being	deemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0050
. •					EXPIRES 05-31-2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX CO	OST REPORT CERTIFICATION	Provider CCN: 15-1322	Peri od:	Worksheet S
AND SETTLEMENT	SUMMARY			From 01/01/2017	
				To 12/31/2017	Date/Time Prepared:
					5/30/2018 10:03 am
PART I - COST	REPORT STATUS				
Provi der	1. [ X ] Electronically filed	cost report		Date: 5/30/20	18 Time: 10:03 am
use only	2. [ ] Manually submitted co	st report			
	3. [ 0 ] If this is an amended	report enter the number	of times the provider r	resubmitted this co	ost report
	4. [ F ] Medicare Utilization.	Enter "F" for full or "L	" for low.		•
Contractor	5. [ 1 ]Cost Report Status	6. Date Received:	10.	NPR Date:	
use only		7. Contractor No.		Contractor's Vendo	
)	(2) Settled without Audit	8. [ N ] Initial Report fo	or this Provider CCN 12.	[ 0 ] If line 5, co	lumn 1 is 4: Enter
	(3) Settled with Audit	9. N Final Report for	this Provider CCN		nes reopened = 0-9.
	(4) Deepened			ridiliber of trii	ies respensed = 0 7.

## PART II - CERTIFICATION

(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 the Balance Sheet and Statement of Revenue and Expenses prepared by PERRY COUNTY HOSPITAL ( 15-1322 ) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

> RYAN WHITE (Si gned) Officer or Administrator of Provider(s) CF0 Title

> > (Dated when report is electronically signed.) Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	298, 026	-133, 880	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	27, 367	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		40, 938		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-2, 394		0	10. 01
10.02	RURAL HEALTH CLINIC III	0		-2, 428		0	10. 02
10.03	RURAL HEALTH CLINIC IV	0		16, 639		0	10. 03
200.00	Total	0	325, 393	-81, 125	0	0	200. 00
9. 00 10. 00 10. 01 10. 02 10. 03 200. 00	HOME HEALTH AGENCY I RURAL HEALTH CLINIC I RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III RURAL HEALTH CLINIC IV	0 0 0 0 0 0		-2, 394 -2, 428 16, 639 -81, 125	0	0	9. 00 10. 00 10. 01 10. 02 10. 03

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

Health Financial Systems PERRY COUNTY HOSPITAL
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-1322
Period: From 01/01/2017 Part I

110311	THE AND HOST THE HEALTH GARE COMILEEN	I DENTITION TON DATA	110010	CI CON. I		From 01/01/ To 12/31/		Part I Date/Ti	me Pre	pared:
	1.00	0.00		0.00				5/29/20	18 5:5	5 pm
	1.00 Hospital and Hospital Health Care Co	2.00		3. 00		4	4. 00			
1. 00	Street: 8885 SR 237	PO Box: X								1.00
2.00	City: TELL CITY	State: IN	Zip Cod	e: 47586	Count	y: PERRY				2.00
		Component Name	CCN	CBSA	Provi der			nt Syst		
			Number	Number	Туре	Certified		0, or		
		1.00	2.00	2 00	4.00	F 00	V 00	7. 00	XIX	
	Hospital and Hospital-Based Componen	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7.00	8.00	
3. 00	Hospi tal	PERRY COUNTY HOSPITAL	151322	99915	1	07/01/2004	N	0	Р	3.00
4.00	Subprovi der - IPF									4. 00
5.00	Subprovi der - IRF									5.00
6.00	Subprovider - (Other)									6. 00
7. 00	Swing Beds - SNF	PERRY COUNTY HOSPITAL	15Z322	99915		07/01/2004	N	0	N	7. 00
8. 00	Swing Beds - NF	SWI NG								8. 00
9. 00	Hospi tal -Based SNF									9.00
10.00										10.00
11. 00	l '									11. 00
12. 00	Hospi tal -Based HHA	PERRY COUNTY HOSPITAL	157177	99915		06/13/1986	N	P	N	12. 00
12 00	Canamataly Cartified ACC	HHA								12.00
13. 00 14. 00	'									13. 00 14. 00
15. 00		TELL CITY CLINIC	158516	99915		05/18/2015	N	0	N	15.00
15. 01	, ·	PERRY CO FAMILY	158517	99915		05/19/2015		0	N	15. 01
	l I	PRACTI CE								
15. 02	Hospital-Based Health Clinic - RHC	TROY CLINIC	158518	99915		11/23/2015	N	0	N	15. 02
15. 03	Hospital-Based Health Clinic - RHC	CANNELTON CLINIC	158519	99915		05/06/2016	N	0	l N	15. 03
15. 03	IV	CANNELTON CLINIC	158519	99915		05/06/2016	l IN	0	I IN	15.03
16. 00	1									16. 00
17. 00	•									17. 00
18. 00										18. 00
19. 00	0ther									19. 00
						1.00		To		
20. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31		20. 00
21. 00						9				21.00
	Inpatient PPS Information									
22. 00						N		N		22. 00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil									
	amendment hospital?) In column 2, en			2. 100(C)	(Z) (FICKIE	7				
22. 01				s cost re	eporti ng	N		N		22. 01
	period? Enter in column 1, "Y" for y									
	reporting period occurring prior to									
	for no for the portion of the cost r (see instructions)	eporting period occurring	ng on or a	irter Octo	ober 1.					
22. 02	Is this a newly merged hospital that	requires final uncomper	nsated car	e pavmen	ts to be	N	ŀ	N		22. 02
	determined at cost report settlement									
	or "N" for no, for the portion of th									
	in column 2, "Y" for yes or "N" for	no, for the portion of 1	the cost r	eporti ng	peri od or	ו				
22. 03	or after October 1. Did this hospital receive a geograph	ic reclassification from	n urhan to	rural a	e a racult	. N	ŀ	N		22. 03
22. 03	of the OMB standards for delineating					·   N		11		22.03
	in column 1, "Y" for yes or "N" for									
	prior to October 1. Enter in column					9				
	cost reporting period occurring on o									
	hospital contain at least 100 but no			ın accor	dance with	ן י				
23. 00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me	dicaid days on lines 24	and/or 2F	below?	In column		2	N		23. 00
	1, enter 1 if date of admission, 2 i	9					-			
	method of identifying the days in th	is cost reporting period	d differer	it from t	he method					
	used in the prior cost reporting per	iod? In column 2, enter	Y" for	yes or "I	N" for no.	Out-of N	ladi - · ˈ	- A	ther	
		LD-ST2	ne + n-s	iale ()	111 - ()1	UULL-OT I N	indir (.91		LUCI	

	method of identifying the days in this cost reporting	g period dit	fferent fro	om the metho	od			
	used in the prior cost reporting period? In column 2	2, enter "Y	for yes c	or "N" for r	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital, enter the	0	0	0	0	C	0	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.							

	Financial Systems PERRY AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	COUNTY HOS	Provider CC	N: 15-1322	Peri od:	III L			CMS-2 et S-2	
						′31/201	7 Par 7 Dat 5/2	t I e/Tim 29/201	ne Pre 8 5:5	pared
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	НМО	cai d days	Medi da	ner cai d iys	
. 00	If this provider is an IRF, enter the in-state	1.00	2. 00	3. 00	4. 00	5.	00	6.	00	25. (
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	O O		/Rural		o of	Coogn	23.
						. 00	3 Dat	2.00		
7. 00	Enter your standard geographic classification (not wo cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wo reporting period. Enter in column 1, "1" for urban on enter the effective date of the geographic reclassifile this is a sole community hospital (SCH), enter the	rural. age) status "2" for r cation in	at the end ural. If ap column 2.	l of the cos pplicable,	t		2			26. 27. 35.
<i></i>	effect in the cost reporting period.	- Humber of	per rous oc							00.
						nni ng: . 00		Endi n 2. 00		
5. 00	Enter applicable beginning and ending dates of SCH s		cript line	36 for numb		. 00		2.00		36.
00	of periods in excess of one and enter subsequent date of this is a Medicare dependent hospital (MDH), enter		of period	ls MDH statu	s		0			37.
	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	ne MDH tran:	sitional pa	yment in		N				37.
. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number o	of MDH st	atus. If li	ne 37 is						38.
	enter subsequent dates.				,	//N		Y/N		
					1	. 00		2.00		
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii)? eage requi	Enter in co rements in	lumn 1 "Y" accordance		N		N		39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	oer 1. Ente	"Y" for y			N		N	VI V	40.
								. 00	XI X 3. 00	1
	Prospective Payment System (PPS)-Capital									
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	eption for	extraordi na	ıry circumst	ances		N N	N N	N N	45.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	ı. L, Pt. I	ı ana Wkst	. L-I, Pt.	ı through					
	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals						N N	N N	N N	47. 48.
. 00	Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	? Enter "Y	" for yes		N			56.
. 00	If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first monifor yes or "N" for no in column 2. If column 2 is "Y"	yes or "N" th of this of ", complete	' for no in cost report e Worksheet	column 1. ing period?	If column Enter "	Y"				57.
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. III If line 56 is yes, did this facility elect cost reiml defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	oursement fo complete W	or physicia kst. D-5.		s as					58.
. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N		sheet <i>F</i> ne #	Qua	ss-Thr Lific terior		59.
				1. 00	2	. 00		3.00	)	

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 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 5:55 pm Y/N IME Direct GME IME Direct GME 2.00 1.00 3.00 4.00 5.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 3.00 1.00 2.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.

	reaching hospitars that oralli kesi achts in Nonprovider settings				
3.00	Has your facility trained residents in nonprovider settings during this co	ost reporting p	eriod? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through	67. (see instru	ctions)		
		Unwei ghted	Unwei ghted	Ratio (col. 1/	
		FTEs	FTEs in	(col. 1 + col.	
		Nonprovi der	Hospi tal	2))	
		Si te	·		
		1. 00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost r	eporting	
	period that begins on or after July 1, 2009 and before June 30, 2010.	·	·		
4.00	Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0. 00	0. 000000	64.00
	in the base year period, the number of unweighted non-primary care				
	resident FTEs attributable to rotations occurring in all nonprovider				
	settings. Enter in column 2 the number of unweighted non-primary care				
	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

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 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 5:55 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) 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 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 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 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 N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 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)

ealth Financial Systems PERRY COUNTY OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-1322	Peri od: From 01/01/2017 To 12/31/2017	u of Form CMS Worksheet S Part I Date/Time P 5/29/2018 5	-2 repared:
				1.00	
Long Term Care Hospital PPS					
D.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes  1.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.			ng period? Enter	N N	80. 0 81. 0
TEFRA Providers  5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)  6.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ıl classified	under section	n	N	87. C
1880(d)(1)(b)(vi): Litter 1 101 yes 01 N 101 110.			V	XIX	
Title V and XIX Services			1. 00	2.00	
0.00 Does this facility have title V and/or XIX inpatient hospita	al services? E	nter "Y" for	N	Y	90.0
yes or "N" for no in the applicable column.  1.00   Is this hospital reimbursed for title V and/or XIX through t			N	N	91.0
full or in part? Enter "Y" for yes or "N" for no in the appl 2.00 Are title XIX NF patients occupying title XVIII SNF beds (du				N	92. 0
instructions) Enter "Y" for yes or "N" for no in the applica	able column.	, ,			
3.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	of title V an	d XIX? Enter	N	N	93.0
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94.0
5.00 $ \dot{f} $ line 94 is "Y", enter the reduction percentage in the app			0.00	0.00	95. 0
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for n	o in the	N	N	96. 0
7.00 $ \dot{f} $ line 96 is "Y", enter the reduction percentage in the app			0.00	0.00	97. (
B.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f			Y	Y	98. 0
column 1 for title V, and in column 2 for title XIX.  8.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti				Y	98. (
title XIX.  Boes title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of			Y	Y	98. 0
for title V, and in column 2 for title XIX.  3.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for years to be a service of the cost of the				N	98. (
for title V, and in column 2 for title XIX.  3.04 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 i	N	98. (
in column 2 for title XIX.  3.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98. (
column 2 for title XIX.  8.06  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. (
Rural Providers					
O5.00 Does this hospital qualify as a CAH? O6.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	nod of paymer	nt N		105. 0 106. 0
for outpatient services? (see instructions) 07.00 f this facility qualifies as a CAH, is it eligible for cost	rai mhursaman	t for I&P	N		107. 0
training programs? Enter "Y" for yes or "N" for no in column	n 1. (see inst	ructions) If			107.
yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	25 and the p	rogram is cos	st		
OB. OO 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	dul e? See 42	2 N		108. 0
CFR Section 9412.115(c). Enter 1 101 yes of N 101 no.	Physi cal	Occupati on	al Speech	Respi ratory	
09.00  f this hospital qualifies as a CAH or a cost provider, are	1. 00 Y	2.00 Y	3. 00 Y	4. 00 N	109. 0
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	· 	<u>'</u>	'	14	107.0
				1.00	
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter "				N	110. 0

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-		eriod: rom 01/01/2 o 12/31/2		Workshe Part I Date/Ti 5/29/20	me Pro	epared:
			1. 00		2. 0	0	1
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared for yes or "N" for no in column 1. If the response to contintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for action for tele-health services.	ost reporting period Dlumn 1 is Y, enter rticipating in colum	? Enter the n 2.	N				111. 0
				1. 00	2. 00	3. 00	
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2.  3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.  16.00 Is this facility classified as a referral center? Enter "Y"	If column 2 is "E" nt for long term car rs) based on the def for yes or "N" for	, enter i e (includ inition i no.	n column les n CMS	N N		0	115. 0
17.00 s this facility legally-required to carry malpractice insurno.		•		N			117. 0
18.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.			S	0			118. 0
	Pr	emiums	Losses	5	Insura	ance	
		1. 00	2.00		3. 0	0	-
18.01 List amounts of malpractice premiums and paid losses:		174, 560		0			0 118. 0
			1. 00 N		2. 0	0	
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments?	dule listing cost ce d Harmless provision n column 1, "Y" for ualifies for the Out	in ACA yes or patient	N		N		118. ( 119. ( 120. (
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla	antable devices char	ged to	Υ				121. (
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Y		5. 0	1	122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N" for n	o. If	N				125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2		on date					126. (
27.00   If this is a Medicare certified heart transplant center, ent   in column 1 and termination date, if applicable, in column 2	ter the certificatio 2.						127. (
28.00   f this is a Medicare certified liver transplant center, ent   in column 1 and termination date, if applicable, in column 2   29.00   f this is a Medicare certified lung transplant center, ente	2.						128.
column 1 and termination date, if applicable, in column 2.  80.00 If this is a Medicare certified pancreas transplant center,							129.
date in column 1 and termination date, if applicable, in col 11.00 If this is a Medicare certified intestinal transplant center	umn 2. r, enter the certifi						131.
date in column 1 and termination date, if applicable, in col 22.00 If this is a Medicare certified islet transplant center, ent	ter the certificatio	n date					132.
in column 1 and termination date, if applicable, in column 2 33.00 oll f this is a Medicare certified other transplant center, end	ter the certificatio	n date					133.
in column 1 and termination date, if applicable, in column 2 44.00 If this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2.		umn 1					134.
All Providers		15-1,	Y				140.

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 01/01/2017 Part I 12/31/2017 Date/Time Prepared: To 5/29/2018 5:55 pm 3.00 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? γ 144. 00 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 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? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If 146.00 Ν 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. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148. 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 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 Ν N 155. 00 Ν Ν 156.00 Subprovi der - IPF Ν Ν Ν Ν 156. 00 157.00 Subprovi der - IRF 157. 00 Ν Ν Ν Ν 158. 00 SUBPROVI DER 158. 00 159. 00 SNF Ν Ν Ν Ν 159. 00

160.00 HOME HEALTH AGENCY							
		N	N		N	N	160.00
161. 00 CMHC			N		N	N	161. 00
101.00 011110			.,			.,	101.00
						1.00	
Multicampus						1.00	
				66	CDCA-O	N	1/5 00
165.00 Is this hospital part of a Multica	ampus nospitai that na	s one or more campu	ses in ai	rrerent	CBSAS?	IN	165. 00
Enter "Y" for yes or "N" for no.	N.	0 1		7: 0	0004	ETE (O	_
	Name	County	State	Zip Coc		FTE/Campus	_
	0	1. 00	2. 00	3.00	4. 00	5.00	
166.00 If line 165 is yes, for each						0.0	00 166. 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 (HI	[] incentive in the Am	merican Recovery and	I Rei nves	tment Δc	+	1.00	
Heal th Information Technology (HI					t		167, 00
167.00 Is this provider a meaningful user	under §1886(n)? Ent	er "Y" for yes or "	N" for no	).		1.00 Y	
167.00 s this provider a meaningful user 168.00 f this provider is a CAH (line 10	under §1886(n)? Ent O5 is "Y") and is a me	er "Y" for yes or " aningful user (line	N" for no	).			
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru	er "Y" for yes or " aningful user (line ctions)	N" for no 167 is '	o. 'Y"), ent	er the		0168.00
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is r	under §1886(n)? Ent D5 is "Y") and is a me HT assets (see instru not a meaningful user,	er "Y" for yes or " aningful user (line ctions) does this provider	N" for no 167 is ' qualify	). 'Y"), ent for a ha	er the		0168.00
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is rexception under §413.70(a) (6) (ii)?	under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru not a meaningful user, P Enter "Y" for yes or	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i	N" for no 167 is ' qualify nstruction	o. 'Y"), ent for a ha ons)	er the ardship	Y	0 168. 00 168. 01
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) 7 169.00 If this provider is a meaningful to	under §1886(n)? Ent Us is "Y") and is a me HIT assets (see instru- not a meaningful user, PEnter "Y" for yes or user (line 167 is "Y")	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i	N" for no 167 is ' qualify nstruction	o. 'Y"), ent for a ha ons)	er the ardship	Y	167. 00 0168. 00 168. 01
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is rexception under §413.70(a) (6) (ii)?	under §1886(n)? Ent Us is "Y") and is a me HIT assets (see instru- not a meaningful user, PEnter "Y" for yes or user (line 167 is "Y")	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i	N" for no 167 is ' qualify nstruction	o. 'Y"), ent for a ha ons) is "N"),	er the ardship enter the	Y 0.4	0 168. 00 168. 01
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) 7 169.00 If this provider is a meaningful to	under §1886(n)? Ent Us is "Y") and is a me HIT assets (see instru- not a meaningful user, PEnter "Y" for yes or user (line 167 is "Y")	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i	N" for no 167 is ' qualify nstruction	o. 'Y"), ent for a ha ons) is "N"),	er the ardship	Y 0	0 168. 00 168. 01
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) 7 169.00 If this provider is a meaningful to	under §1886(n)? Ent Us is "Y") and is a me HIT assets (see instru- not a meaningful user, PEnter "Y" for yes or user (line 167 is "Y")	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i	N" for no 167 is ' qualify nstruction	o. 'Y"), ent for a ha ons) is "N"),	er the ardship enter the	Y 0.4	0 168. 00 168. 01
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) 7 169.00 If this provider is a meaningful to	under §1886(n)? Ent 5 is "Y") and is a me HIT assets (see instru not a meaningful user, P Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (	N" for no 167 is ' qualify nstruction line 105	o. 'Y"), ent for a ha ons) is "N"),	er the ardship enter the Beginning	Y 0	0168. 00 168. 01 00169. 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is rexception under §413.70(a) (6) (ii)? 169.00 If this provider is a meaningful utransition factor. (see instruction	under §1886(n)? Ent 5 is "Y") and is a me HIT assets (see instru not a meaningful user, P Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (	N" for no 167 is ' qualify nstruction line 105	o. 'Y"), ent for a ha ons) is "N"),	er the ardship enter the Beginning 1.00	0. Endi ng 2. 00	0168. 00 168. 01 00169. 00
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is rexception under §413.70(a) (6) (ii) 7 169.00 If this provider is a meaningful transition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR b	under §1886(n)? Ent 5 is "Y") and is a me HIT assets (see instru not a meaningful user, P Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (	N" for no 167 is ' qualify nstruction line 105	o. 'Y"), ent for a ha ons) is "N"),	er the ardship enter the Beginning 1.00	0. Endi ng 2. 00	0168. 00 168. 01 00169. 00
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is rexception under §413.70(a) (6) (ii) 7 169.00 If this provider is a meaningful utransition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR b	under §1886(n)? Ent 5 is "Y") and is a me HIT assets (see instru not a meaningful user, P Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (	N" for no 167 is ' qualify nstruction line 105	o. 'Y"), ent for a ha ons) is "N"),	er the ardship enter the Beginning 1.00	0. Endi ng 2. 00	0168. 00 168. 01 00169. 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful of the provider is a meaningful user the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a CAH and is reasonable to the provider is a meaningful of the provider is a me	runder §1886(n)? Ent 15 is "Y") and is a me HIT assets (see instru- not a meaningful user, P Enter "Y" for yes or user (line 167 is "Y") uns) peginning date and end	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (	N" for no 167 is ' qualify nstruction line 105	o. 'Y"), ent for a ha ons) is "N"),	er the ardship enter the Beginning 1.00	Property (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	0168. 00 168. 01 00169. 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the hexception under §413.70(a) (6) (ii)? 169.00 If this provider is a meaningful utransition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR hexperiod respectively (mm/dd/yyyy)	runder §1886(n)? Ent 15 is "Y") and is a me 15 is "Y") and is a me 11 T assets (see instrunct a meaningful user, 2 Enter "Y" for yes or 15 is "Y") ons)  Deginning date and end 17 is "Y" date and end 18 is "	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (	N" for no 167 is ' qualify nstruction line 105 porting	o. 'Y"), ent for a habons) is "N"),	er the ardship enter the Beginning 1.00 01/01/2017	Property (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	0168. 00 168. 01 00169. 00 170. 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is rexception under §413.70(a) (6) (ii)? 169.00 If this provider is a meaningful transition factor. (see instruction factor.)  170.00 Enter in columns 1 and 2 the EHR because in the period respectively (mm/dd/yyyy)  171.00 If line 167 is "Y", does this province in 1876 Medicare cost plans in the section 1876 Medicare cost plans in the section	r under §1886(n)? Ent 15 is "Y") and is a me 15 is "Y") and is a me 16 IT assets (see instrunct a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") uns)  Deginning date and end 20 ider have any days for reported on Wkst. S-3,	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (  ing date for the re rindividuals enrol Pt. I, line 2, col	N" for no 167 is ' qualify nstruction line 105 porting	o. 'Y"), ent for a habons) is "N"),	er the ardship enter the Beginning 1.00 01/01/2017	Property (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	0168. 00 168. 01 00169. 00 170. 00
167.00 s this provider a meaningful user 168.00 lf this provider is a CAH (line 10 reasonable cost incurred for the hexception under §413.70(a) (6) (ii)? 169.00 lf this provider is a meaningful utransition factor. (see instruction 170.00 lenter in columns 1 and 2 the EHR hexperiod respectively (mm/dd/yyyy)	runder §1886(n)? Ent 15 is "Y") and is a me HIT assets (see instru not a meaningful user, P Enter "Y" for yes or user (line 167 is "Y") ons)  Deginning date and end  wider have any days for reported on Wkst. S-3, umn 1. If column 1 is	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (  ing date for the re rindividuals enrol Pt. I, line 2, col	N" for no 167 is ' qualify nstruction line 105 porting	o. 'Y"), ent for a habons) is "N"),	er the ardship enter the Beginning 1.00 01/01/2017	Property (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	0168. 00 168. 01 00169. 00 170. 00

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1322	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Pro 5/29/2018 5:	epared:
				Y/N 1. 00	2. 00	+
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	esponses. Ente			
	Provider Organization and Operation					٠
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in t	Joi ullii 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.	nn 3, "V" for	N			2. 0
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providence of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	R		4.00
00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities				2.00	
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	S N		6.00
	the legal operator of the program?					
00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7.0
00	Were nursing school and/or allied health programs approved	and/or renewed	during the	N		8.00
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduate medic	al education	N		9. 0
00	program in the current cost report? If yes, see instruction		ai caacation	14		7.00
0. 00	Was an approved Intern and Resident GME program initiated of		he current	N		10.0
	cost reporting period? If yes, see instructions.					
1. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11.0
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	i ons.		Υ	12.0
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments.				N N	13. 0
	Bed Complement	onto narvour ri	<i>y</i> 000 1110			1
5. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	ructions.	N	15. 0
			rt A		t B	
		1. 00	2.00	Y/N 3. 00	Date 4. 00	
	PS&R Data	1.00	2.00	3.00	4.00	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16. 0
7. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2017	Y	12/31/2017	17. 0
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 0

alth Financial Systems SPITAL AND HOSPITAL HEALTI	PERRY COUNT  1 CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	N: 15-1322	Peri od:	wof Form CM Worksheet S	
				From 01/01/2017 To 12/31/2017	Part II Date/Time P	repare
		Descri	nti on	Y/N	5/29/2018 5 Y/N	: 55 pm
		0		1. 00	3. 00	
	res, were adjustments made to PS&R			N	N	20.
Report data for Other	? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
00 Was the cost report precords? If yes, see	repared only using the provider's instructions.	N		N		21
					1. 00	_
COMPLETED BY COST REI	MBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	SPI TALS)		1.00	
Capital Related Cost						
	fed for Medicare purposes? If yes, see				N	22
	l in the Medicare depreciation expense yes, see instructions.	due to appraisa	als made dur	ing the cost	N	23
00 Were new leases and/o	or amendments to existing leases entere ons	ed into during t	this cost re	porting period?	N	24
OO Have there been new of instructions.	apitalized leases entered into during	the cost report	ting period?	If yes, see	N	25
MI	o Sec. 2314 of DEFRA acquired during th	he cost reportir	ng period? I	f yes, see	N	26
	pitalization policy changed during the	e cost reportino	g period? If	yes, submit	N	27
Interest Expense  Were new Loans, morto	age agreements or letters of credit er	ntered into duri	ng the cost	reporti ng	N	28
period? If yes, see i 00 Did the provider have	nstructions. a funded depreciation account and/or	bond funds (Deb	ot Service R	eserve Fund)	N	29
	lepreciation account? If yes, see instr en replaced prior to its scheduled matu		debt? If yes	, see	N	30
instructions.  Has debt been recalled instructions.	d before scheduled maturity without is	ssuance of new o	debt? If yes	, see	N	31
Purchased Services						
arrangements with sup	greements occurred in patient care sem pliers of services? If yes, see instru	uctions.	-		N 	32
no, see instructions.	ere the requirements of Sec. 2135.2 app	plied pertaining	g to competi	tive bidding? If	N	33
Provider-Based Physic	ians d at the provider facility under an ar	rrangement with	nrovi der-ha	sed physicians?	Υ	34
If yes, see instructi		irangement with	provider-ba	seu physicians:		
	ere there new agreements or amended exi e cost reporting period? If yes, see in		ts with the	provi der-based	N	35
	The state of the s			Y/N	Date	
H 0.00' 0. 1				1. 00	2. 00	
Home Office Costs  Were home office cost	s claimed on the cost report?			N		36
	is a home office cost statement been pr	repared by the h	nome office?			37
If yes, see instructi						38
the provider? If yes,	enter in column 2 the fiscal year end d the provider render services to other	d of the home of	ffi ce.			39
J .	d the provider render services to the	home office? I	f yes, see	N		40
i nstructi ons.						
		1. (	00	2.	00	
	last name and the title/position	SHAWN		ADAMS		41
respecti vel y.	ort preparer in columns 1, 2, and 3,	ALLIANT MANAGE	MENT CERVICE	c		4.5
preparer.	mpany name of the cost report	ALLI ANT MANAGEN	MENT SERVICE			42
00 Enter the telephone r	number and email address of the cost	5029923500		SADAMS@BLUEAND	CO. COM	43

Health Financial Syst	ems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITA	L HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der (		Peri od:	Worksheet S-2	2
					From 01/01/2017 To 12/31/2017	Part II   Date/Time Pre	narod
					10 12/31/2017	5/29/2018 5:5	
			3	. 00			
Cost Report Pr	eparer Contact Information						
	st name, last name and the		REI MBURSEMENT	MANAGER			41. 00
	ost report preparer in colu	nns 1, 2, and 3,					
respecti vel y.							
42.00 Enter the empl	oyer/company name of the co	ost report					42. 00
preparer.							
	ephone number and email add						43. 00
report prepare	er in columns 1 and 2, respo	ecti vel y.	1				

 
 Heal th Financial
 Systems
 PERRY

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1322

				To	12/31/2017	Date/Time Prep 5/29/2018 5:55	
						I/P Days / 0/P	) piii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		7, 665	45, 144. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		21	7, 665	45, 144. 00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	4	1, 460	5, 112. 00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)					_	12. 00
13.00	NURSERY	43. 00		0.405	50 05/ 00	0	13.00
14.00	Total (see instructions)		25	9, 125	50, 256. 00	0	14.00
15. 00	CAH visits					0	15.00
16.00	SUBPROVIDER - I PF						16. 00 17. 00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER						17.00
19.00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	101.00				Ĭ	23. 00
24. 00	HOSPI CE	116. 00	0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00		Ĭ			24. 10
25. 00	CMHC - CMHC	00.00					25. 00
26. 00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 01	RURAL HEALTH CLINIC II	88. 01				ol	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02				ol	26. 02
26. 03	RURAL HEALTH CLINIC IV	88. 03				0	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		25				27.00
28. 00	Observation Bed Days					0	28.00
29. 00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01

Provider CCN: 15-1322

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2017	Part	
To 12/31/2017	Date/Time Prepared:	5/29/2018 5:55 pm

Title XVIII					'		5/29/2018 5:5	5 pm
No.			I/P Days	o / O/P Visits	/ Trips	Full Time I		
No.   Hospi tal Adul ts & Peds. (col umns 5, 6, 7 and 8 excl ude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   No.		Component	Title XVIII	Title XIX				
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   129   287   287   280   3.00   3.00   4.00   HMO and other (see instructions)   129   287   287   3.00   3.00   4.00   HMO IRF Subprovi der   0   0   0   0   3.00   3.00   4.00   HMO IRF Subprovi der   0   0   0   0   4.00   4.00   6.00   4.00   4.00   6.00   4.00   4.00   6.00   4.00   4.00   6.00   4.00   4.00   6.00   4.00   4.00   6.00   4.00   4.00   6.00   4.00   4.00   6.00   4.00   6.00   4.00   4.00   6.00   4.00   6.00   4.00   6.00			6.00	7 00				
B excl ude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room avail able beds)	1 00	Hospital Adults & Peds (columns 5 6 7 and					10.00	1 00
MNO   PF Subprovi der	1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	1,070	23	1, 001			1.00
MAD IRF Subprovider	2.00	HMO and other (see instructions)	129	287				2. 00
5.00   Hospital Adults & Peds. Swing Bed NF   984   0   984   6.00   7	3.00	HMO IPF Subprovider	o	o				3.00
10.00   Hospital Adults & Peds. Swing Bed NF   2.00   306   3.148	4.00	HMO IRF Subprovider	o	o				4. 00
Total Adults and Peds (exclude observation beds) (see instructions)   Description	5.00	Hospital Adults & Peds. Swing Bed SNF	984	o	984	l .		5. 00
Total Adults and Peds (exclude observation beds) (see instructions)   Description	6.00	Hospital Adults & Peds. Swing Bed NF		283	283	3		6.00
8.00   INTÉMSIVE CARE UNIT   126   0   213   8.00   9.00   10.	7. 00	Total Adults and Peds. (exclude observation	2, 080	306	3, 148	3		7. 00
9.00   CORONARY CARE UNIT   9.00   10.00   BURN INTENSIVE CARE UNIT   10.00   11.00	9 00	· · · · · · · · · · · · · · · · · · ·	124		212	,		0 00
10. 00   BURN INTENSIVE CARE UNIT   10. 00   SURGICAL INTENSIVE CARE UNIT   11. 00		· ·	120	٩	213			
11.00   SURGICAL INTENSIVE CARE UNIT		· ·						
12. 00   OTHER SPECIAL CARE (SPECIFY)   12   215   13. 00   13. 00   NURSERY   12   215   14. 00   13. 00   179. 19   14. 00   15. 00   16. 00   00   00   00   00   00   179. 19   14. 00   15. 00   00   00   00   00   00   00   00		1						
13. 00   NURSERY     12   215     13. 00   179. 19   14. 00   170. 11   14. 00   170. 11   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   14. 00   179. 19   15. 00   179. 19   14. 00   179. 19   15. 00   179. 19   14. 00   179. 19   15. 00   179. 19   14. 00   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   179. 19   15. 00   179. 19   17								
14. 00 Total (see instructions)				12	215			
15.00   CAH visits   CAH visi		1	2 204				170 10	1
16.00   SUBPROVI DER - I IPF			2, 200	310	3, 370	0.00	179.19	
17. 00   SUBPROVI DER - IRF   17. 00   18. 00   SUBPROVI DER   18. 00   19. 00   SUBLILED NURSI NG FACILITY   20. 00   19. 00   20. 00		y and the second	٥	٩	C	,		1
18. 00   SUBPROVI DER   18. 00   19. 00   SKI LLED NURSI NG FACI LI TY   20. 00   NURSI NG FACI LI TY   20. 00   NURSI NG FACI LI TY   20. 00   OTHER LONG TERM CARE   21. 00   21. 00   OTHER LONG TERM CARE   21. 00   22. 00   OHME HEALTH AGENCY   3. 403   0   6, 374   0. 00   6. 09   22. 00   23. 00   AMBULATORY SURGI CAL CENTER (D. P.)   23. 00   0   0   0   0   0   0   0   0   0		4						
19.00   20.00   NURSING FACILITY   20.00   NURSING FACILITY   21.00   20.00   20.00   20.00   20.00   21.00   22.00   HOME HEALTH AGENCY   3,403   0   6,374   0.00   6.09   22.00   23.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   24.00   HOSPICE   0   0   0   0   0   0   24.00   24.10   HOSPICE   0   0   0   0   0   0   24.10   25.00   26.00   RURAL HEALTH CLINIC   2,545   0   12,588   0.00   22.47   26.00   26.00   RURAL HEALTH CLINIC   11   159   0   2,167   0.00   3.50   26.01   26.02   RURAL HEALTH CLINIC III   159   0   2,167   0.00   3.52   26.02   26.23   RURAL HEALTH CLINIC IV   1,115   0   3,427   0.00   4.54   26.03   26.25   26.25   EDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   219.41   27.00   28.00   29.00   Ambulance Trips   922   0   20.00   20.00   31.00   20.00   31.00   Employee discount days - IRF   0   0   0   0   0   32.00   32.00   32.00   Total ancillary labor & delivery room   0   0   0   0   0   0   0   0   0								
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   22.00   22.00   40ME HEALTH AGENCY   3,403   0   6,374   0.00   6.09   22.00   23.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   24.00   40SPICE   0   0   0   0   0   0.00   0.00   24.00   24.10   40SPICE (non-distinct part)   0   0   0   0   0   0   0   0   0								
21.00   OTHER LONG TERM CARE								
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPI CE 24. 00 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC II 26. 01 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC IV 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 30. 00 30. 00 31. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 3, 403 0 6, 374 0. 00 0 0 0 0 0 0 0 0 0 0. 00 0		1						1
23.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   24.00   HOSPICE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	3 403	0	6 374	0.00	6.09	
24.00     HOSPICE     0     0     0     0.00     0.00     24.00       24.10     HOSPICE (non-distinct part)     0     0     0     0     0     24.00       25.00     CMHC - CMHC     25.00     0     0     0     0     24.00       26.01     RURAL HEALTH CLINIC II     129     0     12,588     0.00     3.60     26.00       26.02     RURAL HEALTH CLINIC III     159     0     2,167     0.00     3.52     26.02       26.03     RURAL HEALTH CLINIC IIV     1,115     0     3,427     0.00     4.54     26.03       26.25     FEDERALLY QUALIFIED HEALTH CENTER     0     0     0     0.00     0.00     26.25       27.00     Total (sum of lines 14-26)     0     0     346     28.00       28.00     Observation Bed Days     0     346     29.00       30.00     Employee di scount days (see instruction)     0     31.00       31.00     Employee di scount days (see instructions)     0     3     42       32.01     Total ancillary labor & delivery room outpatient days (see instructions)     0     32.01		1	0, 100	Ĭ	0, 07	0.00	0.07	
24. 10     HOSPICE (non-distinct part)     0     0     0     24. 10       25. 00     CMHC - CMHC     25. 00     25. 00     25. 00       26. 00     RURAL HEALTH CLINIC II     2, 545     0     12, 588     0. 00     22. 47     26. 00       26. 01     RURAL HEALTH CLINIC III     129     0     2, 262     0. 00     3. 60     26. 01       26. 02     RURAL HEALTH CLINIC III     159     0     2, 167     0. 00     3. 52     26. 02       26. 03     RURAL HEALTH CLINIC IV     1, 115     0     3, 427     0. 00     4. 54     26. 02       26. 03     FEDERALLY QUALIFIED HEALTH CENTER     0     0     0     0. 00     4. 54     26. 02       27. 00     Total (sum of lines 14-26)     0     0     0     0. 00     20. 00     26. 25       27. 00     Observation Bed Days     0     346     0     28. 00       28. 00     Observation Bed iscount days (see instruction)     0     30. 00       31. 00     Employee discount days (see instructions)     0     3     42       32. 01     Total ancillary labor & delivery room outpatient days (see instructions)     0     3     42			0	0	C	0.00	0.00	
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 1 26. 01 RURAL HEALTH CLINIC 1II 1 26. 02 RURAL HEALTH CLINIC III 1 26. 03 RURAL HEALTH CLINIC IV 1 26. 03 RURAL HEALTH CLINIC IV 1 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 0 27. 00 Observation Bed Days 0 28. 00 Observation Bed Days 0 29. 00 Ambul ance Tri ps 9 20. 00 Ambul ance Tri ps 9 21. 00 Employee di scount days (see instruction) 1 25. 00 Ambul ance Media (sum of lines 14-26) 0 27. 00 Imployee di scount days (see instruction) 1 28. 00 Ambul ance Tri ps 1 29. 00 Ambul ance Tri p			o	o	Ċ			
26. 00 RURAL HEALTH CLINIC 11 129 0 2, 262 0. 00 3. 60 26. 01 26. 01 RURAL HEALTH CLINIC 11 159 0 2, 167 0. 00 3. 52 26. 02 RURAL HEALTH CLINIC 1V 115 0 3, 427 0. 00 4. 54 26. 03 RURAL HEALTH CLINIC IV 1, 115 0 3, 427 0. 00 4. 54 26. 03 RURAL HEALTH CLINIC IV 1, 115 0 0 0. 00				٦				
26. 01 RURAL HEALTH CLINIC II 1 129 0 2, 262 0. 00 3. 60 26. 01 26. 02 RURAL HEALTH CLINIC III 159 0 2, 167 0. 00 3. 52 26. 02 26. 03 RURAL HEALTH CLINIC IV 1, 115 0 3, 427 0. 00 4. 54 26. 03 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 00 0. 00 0. 00 26. 25 27. 00 Observation Bed Days 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26, 00		2, 545	o	12, 588	0.00	22. 47	26, 00
26. 03 RURAL HEALTH CLINIC IV 1,115 0 3,427 0.00 4.54 26.03 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 28. 00 Observation Bed Days 0 0servation Bed Days 0 28. 00 Ambul ance Trips 922 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 0 32. 00 Labor & delivery days (see instructions) 0 3 42 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)		·	l	O				1
26. 03 RURAL HEALTH CLINIC IV 1,115 0 3,427 0.00 4.54 26.03 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 28. 00 Observation Bed Days 0 346 29. 00 Ambul ance Trips 922 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 0 32. 00 Labor & delivery days (see instructions) 0 3 42 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	26. 02		159	O	·		3. 52	26. 02
27.00       Total (sum of lines 14-26)       0.00       219.41       27.00         28.00       Observation Bed Days       0       346       28.00         29.00       Ambul ance Trips       922       29.00         30.00       Empl oyee di scount days (see instruction)       0       30.00         31.00       Empl oyee di scount days - IRF       0       31.00         32.00       Labor & delivery days (see instructions)       0       3       42       32.00         32.01       Total ancillary labor & delivery room outpatient days (see instructions)       0       32.01	26. 03	RURAL HEALTH CLINIC IV	1, 115	o			4. 54	26. 03
27.00       Total (sum of lines 14-26)       0.00       219.41       27.00         28.00       Observation Bed Days       0       346       28.00         29.00       Ambulance Trips       922       29.00         30.00       Employee discount days (see instruction)       0       30.00         31.00       Employee discount days - IRF       0       31.00         32.01       Total ancillary labor & delivery room outpatient days (see instructions)       0       3       42	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	o		0.00	0.00	26. 25
28.00   Observation Bed Days   0   346   28.00   29.00   Ambulance Trips   922   92.00   30.00   Employee discount days (see instruction)   0   30.00   31.00   Employee discount days - IRF   0   31.00   22.00   Labor & delivery days (see instructions)   0   3   42   32.00   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   0   32.01   32.01   33.00   33.00   34.00   33.0	27.00	Total (sum of lines 14-26)				0.00		
29.00 Ambulance Trips 922 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 29.00 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions)	28. 00			o	346			28. 00
30.00   Employee discount days (see instruction)   0   30.00   31.00   23.00   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   0   3   42   32.00   32.01   32.01   32.01   33.01	29. 00	1	922					29. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 a 31.00 32.00 a 32.01	30.00				C			30.00
32.00 Labor & delivery days (see instructions) 0 3 42 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01	31.00				C			31.00
outpatient days (see instructions)	32.00	1 . 3	o	3	42	2		32.00
outpatient days (see instructions)	32. 01				C			32. 01
33.00 LTCH non-covered days 0 33.00								
	33.00	LTCH non-covered days	0					33. 00
33.01 LTCH site neutral days and discharges 0 33.01	33. 01	LTCH site neutral days and discharges	0					33. 01

Health Financial Systems PERRY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time Prepared: | Provider CCN: 15-1322

Full Time   Equivalents   Full Time   Discharges   Full Time   Equivalents   Full Time   Equivalents   Full Time   Equivalents   Full Time   Full Ti					10	) 12/31/201/	Date/IIme Pre   5/29/2018 5:5	
Figurial and Interest			Full Time		Di sch	arges	0,2,,20.0 0.0	J
Note			Equi val ents					
1.00		Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
1.00			Workers				Pati ents	
S exclude Swing Bed, Observation Bed and Hospice days) (See instructions for col. 2 for the portion of LDP room available beds)   S			11. 00	12.00	13. 00	14.00	15. 00	
Hospice days) (see Instructions for col. 2   For the portion of LDP room available beds)	1.00			0	349	7	670	1. 00
For the portion of LIDP room available beds)   2.00   HMO and other (see Instructions)   35   58   2.00   3.00								
2.00   HMO and other (see instructions)   35   58   2.00   3.00   4.00   HMO IPF Subprovider   0   3.00   4.00   HMO IPF Subprovider   0   0   4.00   4.00   6.00   6.00   HMO IPF Subprovider   0   0   4.00   6.00   6.00   HMO IPF Subprovider   0   0   4.00   6.00   6.00   HMO IPF Subprovider   0   0   6.00   6.00   6.00   HMO IPF Subprovider   0   0   0   6.00   6								
3.00   HMO IPF Subprovider								
4. 00		,			35			
5.00		·				-		
6. 00   Hospital Adults & Peds. Swing Bed NF   Total Adults and Peds. (exclude observation beds) (see instructions)   7. 00   Total Adults and Peds. (exclude observation beds) (see instructions)   8. 00   INTERNITY CARE UNIT   9. 00   10. 00   BURN INTERSITY CARE UNIT   10. 00   Total (see instructions)   10. 00   BURN INTERSITY CARE UNIT   11. 00   10. 00   Total (see instructions)		·				U		
7.00   Total Adults and Peds (exclude observation								
BedS  (see instructions)   8		1 '						
8. 00   INTENSIVE CARE UNIT	7.00							7.00
9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 ONUSSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 ONUSSING FACILITY 19. 00 ONUSSING FACILITY 20. 00 ONUSSING FACILITY 20. 00 ONUSSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC II 26. 01 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC III 26. 04 RURAL HEALTH CLINIC III 27. 00 ONUS CHARL CONDUS CO	8 00							8 00
10. 00   BURN INTENSIVE CARE UNIT								l
11. 00   SURGICAL INTENSIVE CARE UNIT								
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMC - CMHC 26. 00 RURAL HEALTH CLINIC III 26. 00 RURAL HEALTH CLINIC III 26. 01 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC III 27. 00 OSSERVATION BED								•
13. 00 14. 00 16. 00 17. 00 18. 00 18. 00 18. 00 19		•						
14. 00 Total (see instructions) 15. 00 CAH visits 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 HOME HEALTH AGENCY 24. 00 HOSPICE 24. 00 HOSPICE 25. 00 CAMHOL - CAMHOL 26. 00 RURAL HEALTH CLINIC III 26. 00 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 27. 00 OD 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instructions) 31. 00 Employee discount days (see instructions) 33. 00 LTCH non-covered days 31. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days		` ′						
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 ONER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULLATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE 0.00 CMHC - CMHC 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC II 26. 01 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC III 26. 05 RURAL HEALTH CLINIC III 27. 00 Observation Bed Days 28. 00 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days		•	0.00	0	349	7	670	•
16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC II 26. 00 RURAL HEALTH CLINIC III 26. 00 RURAL HEALTH CLINIC III 26. 00 RURAL HEALTH CLINIC III 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Empl oyee di scount days (see instruction) 31. 00 Empl oyee di scount days (see instructions) 33. 00 LTOH non-covered days 33. 00 LTOH non-covered days			0.00	ŭ		•	0,70	
17. 00 SUBPROVI DER - IRF		4						1
18. 00   SUBPROVIDER   18. 00   19. 00   SKILLED NURSING FACILITY   20. 00   NURSING FACILITY   20. 00	17. 0	4						
20. 00		4						
21.00 OTHER LONG TERM CARE  22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.)  24.00 HOSPICE  40.00 HOSPICE (non-distinct part)  25.00 CMHC - CMHC  26.00 RURAL HEALTH CLINIC II  26.02 RURAL HEALTH CLINIC III  26.02 RURAL HEALTH CLINIC III  26.03 RURAL HEALTH CLINIC III  26.05 FEDERALLY QUALIFIED HEALTH CENTER  27.00 Total (sum of lines 14-26)  28.00 Observation Bed Days  29.00 Ambul ance Tri ps  30.00 Employee discount days (see instruction)  31.00 Employee discount days (see instructions)  32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  21.00  22.00  22.00  22.00  22.00  22.00  22.00  22.00  22.00  23.00  24.00  25.00  26.00  26.00  27.00  26.02  27.00  28.00  29.00  29.00  30.00  30.00  31.00  32.01  33.00  33.00  33.00	19. 0	SKILLED NURSING FACILITY						19. 00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC II 26. 01 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC IV 26. 03 RURAL HEALTH CLINIC IV 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days	20. 0	NURSING FACILITY						20.00
23.00 24.00  HOSPICE	21. 0	OTHER LONG TERM CARE						21. 00
24. 00 HOSPICE	22. 0	HOME HEALTH AGENCY	0.00					22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC   0. 00 26. 01 RURAL HEALTH CLINIC   11   0. 00 26. 02 RURAL HEALTH CLINIC   11   0. 00 26. 03 RURAL HEALTH CLINIC   1V   0. 00 26. 04 RURAL HEALTH CLINIC   1V   0. 00 26. 05 FEDERALLY QUALIFIED HEALTH CENTER   0. 00 27. 00 Observation Bed Days 29. 00 Observation Bed Days 29. 00 Ambul ance Trips 28. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  24. 10 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 0	23. 0	AMBULATORY SURGICAL CENTER (D.P.)						23. 00
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 1	24. 0	HOSPI CE	0.00					24. 00
26. 00 26. 01 RURAL HEALTH CLINIC II 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC IV 26. 03 RURAL HEALTH CLINIC IV 26. 03 RURAL HEALTH CLINIC IV 26. 03 Concept of Employer discount days (see instruction) Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  26. 00 0								
26. 01 26. 02 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 03 RURAL HEALTH CLINIC IV 26. 03 RURAL HEALTH CLINIC IV 26. 03 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Doservation Bed Days 28. 00 Doservation Bed Days 29. 00 Ambulance Trips 29. 00 Since the proper discount days (see instruction) Employee discount days (see instructions) 31. 00 Employee discount days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  26. 01 26. 02 26. 03 26. 03 26. 03 26. 03 26. 03 26. 03 26. 03 26. 03 26. 03 26. 03 26. 03 27. 00 28. 00 27. 00 28. 00 29. 00 31. 00 31. 00 Employee discount days (see instructions) 31. 00 32. 01 33. 00 LTCH non-covered days	25. 0	CMHC - CMHC						25. 00
26. 02 26. 03 RURAL HEALTH CLINIC III 0. 00 26. 03 RURAL HEALTH CLINIC IV 0. 00 26. 03 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Tri ps Employee discount days (see instruction) Employee discount days - IRF 29. 00 31. 00 Employee discount days (see instructions) 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days			l l					
26. 03 RURAL HEALTH CLINIC IV 0. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 Doservation Bed Days 28. 00 Ambul ance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days  26. 03 26. 25 0. 00 27. 00 28. 00 29. 00 29. 00 29. 00 30. 00 31. 00 31. 00 32. 01 32. 01 33. 00 33. 00			l l					
26. 25 27. 00 Total (sum of lines 14-26) 20. 00 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) Employee discount days - IRF 32. 00 32. 00 Total (sum of lines 14-26) 0. 00 28. 00 29. 00 29. 00 Employee discount days (see instruction) 31. 00 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & see instructions) 33. 00 LTCH non-covered days 0 0 26. 25 27. 00 28. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 01 33. 00			l l					ı
27.00 28.00   Observation Bed Days   Dobug			l l					
28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 TCH non-covered days 33. 00 UTCH non-covered days								
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  29.00 30.00 31.00 31.00 32.00 32.01			0. 00					
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  30.00 31.00 32.00 32.00 32.01								l
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  31.00 32.00 32.01		· ·						
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  32.00 32.01								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  32.01		13						
outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00		, , , , , , , , , , , , , , , , , , , ,						
33.00 LTCH non-covered days 0 33.00	32.0							32.01
	33 U							33 00
33. OF JETON 31 to heatr at days and disorial ges								
	55. 0	1   Elon of to heatral days and discharges	ı I		١	'		1 33.01

Heal th	Financial Systems	PERRY COUNTY	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA			CN: 15-1322	Peri od: From 01/01/2017	Worksheet S-4	
			Component	CCN: 15-7177	To 12/31/2017	Date/Time Pre	
					Home Health	5/29/2018 5: 5 PPS	o piii
					Agency I		
					1.	00	-
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4. 00	5. 00	
1 00	HOME HEALTH AGENCY STATISTICAL DATA		1 015	.l ar	1 525	2 001	1 00
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00	,		· ·		1. 00 2. 00
				Number of Em	ployees (Full Ti	me Equivalent)	
				01.00		<del></del>	
		Enter the numb		Staff	Contract	Total	
		, , , , , , , , , , , , , , , , , , , ,					
		(	)	1. 00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		40.00	0. 9			
5.00	Other Administrative Personnel			0.8			
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			2. 4			
8.00	Physical Therapy Service			0.0			
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0.0			
11. 00	Occupational Therapy Supervisor			0.0			
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.0			
14. 00	Medical Social Service			0.0			
15. 00	Medical Social Service Supervisor			0.0			
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			1.8			
18. 00	Other (specify)			0.0			1
19. 00	HOME HEALTH AGENCY CBSA CODES  Enter in column 1 the number of CBSAs where				1		19. 00
19.00	you provided services during the cost				'		19.00
20.00	reporting period.			99915			20.00
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			99915			20.00
	contains the first code).	Full Fe	.:				
		Full Ep Without	With Outliers	LUPA Epi sode	s PEP Only	Total (cols.	
		Outliers	2.00		Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2. 00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	647	215		24 4	890	
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	284, 545 943			32 1, 764 2 10		
24. 00	Physical Therapy Visit Charges	300, 052	114, 464	64		· ·	
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	465 129, 284	ł	1	2 2 58 558	767 213, 465	
27. 00	Speech Pathology Visits	77	l	1	1 0		
28. 00	Speech Pathology Visit Charges	24, 592	33, 280	32			
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	0			0 0	0	29. 00 30. 00
31.00	Home Health Aide Visits	95	l .		1 0	253	31. 00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	21, 959 2, 227	36, 424 1, 130		32 0 30 16		
	29, and 31)	2,221	1, 130				
34.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	740 422	262.253		0 0	1 140 520	34.00
35. 00	Total Charges (sum of Tines 22, 24, 26, 28, 30, 32, and 34)	760, 432	362, 353	12, 23	5, 522	1, 140, 539	35. 00
36. 00	Total Number of Episodes (standard/non	122		1	12 2	136	36. 00
37. 00	outlier) Total Number of Outlier Episodes		24		0	24	37. 00
	Total Non-Routine Medical Supply Charges	17, 699			29 227		38. 00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1322	Peri od:	Worksheet S-8	
			Component	CCN: 15-8516	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
					RHC I	Cost	ус рііі
	·						
	01:				1.	00	
1. 00	Clinic Address and Identification Street				109 I N-66		1.00
1.00	Sti ee t		Ci	tv	State	ZIP Code	1.00
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		TELL CITY		I N	47586	2. 00
						4.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for i	ırhan		1.00	3.00
3.00	HOSPITAL-BASED FUNCS UNLT. DESIGNATION - EITE	ei k ioi iuia	ai 0i 0 10i t		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4. 00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes						7. 00 8. 00
9. 00	OTHER (SPECIFY)						9. 00
	(5. 25)			1			,,,,,,,
		_			1. 00	2. 00	
10. 00	Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column	N	0	10.00
	Tiour 5. )	Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1) CLINIC			06: 30	17: 00	06: 30	11 00
11.00	I CELINI C			06: 30	17:00	06: 30	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. numbers below.	d in CMS Pub.' umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N	0	12. 00 13. 00
				Prov	ider name	CCN number	
					1.00	2. 00	
14. 00	RHC/FQHC name, CCN number	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		20/11/1	VIV	T 1 1 10 11	14. 00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	-
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)				4. 00	3. 00	15. 00
				unty			
2.00	City Ctata 7ID Code County			00			2.00
2.00	City, State, ZIP Code, County	Tuesday	PERRY	esday	Thur	sday	2.00
		to	from	to	from	to	
		6.00	7. 00	8.00	9. 00	10. 00	
	Facility hours of operations (1)						
11. 00	CLINIC	17: 00	06: 30	17: 00	06: 30	17: 00	11. 00

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Peri od:	Worksheet S-8	
				From 01/01/2017		
		Component	CCN: 15-8516	To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00   CLINIC	06: 30	16: 00				11. 00

Heal th	Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	eu of Form CMS	-2552-10
	FAL-BASED RHC/FQHC STATISTICAL DATA			CCN: 15-1322	Peri od:	Worksheet S-	
			Component	CCN: 15-8517	From 01/01/2017 To 12/31/2017		
					RHC II	Cost	
	Clinic Address and Identification					00	
1.00	Street				315 MAIN STREE	T	1.00
	1.5.5.5.5.5		С	i ty	State	ZIP Code	
	Tarre Carre			. 00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		TR0Y			47588	2. 00
						1. 00	
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for	urban			0 3.00
				Gra	nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	
4.00	Community Health Center (Section 330(d), PHS	Act)		Τ			4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5. 00
6.00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6. 00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes						7. 00 8. 00
9. 00	OTHER (SPECIFY)						9. 00
7.00	To men (or correspond						7.00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type or hours.)	ate number of o	ther operation	ns in column	N		0 10.00
	,	Sun	day	N	Monday	Tuesday	
		from	to	from	to	from	
	Facility house of energtions (1)	1.00	2. 00	3.00	4. 00	5. 00	
11 00	Facility hours of operations (1) CLINIC			08: 00	17: 00	08: 00	11.00
	100000000000000000000000000000000000000			100.00			
	To the second se				1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In numbers below.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapte enter in colu	r 9, section mn 2 the	N		0 13.00
				Prov	ider name	CCN number	
11.00	Taua (saua ann				1. 00	2. 00	11.00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14. 00
		1.00	2.00	3.00	4. 00	5. 00	'
15. 00	Have you provided all or substantially all 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)						15. 00
				unty			
2 00	City, State, ZIP Code, County		PERRY 4	. 00			2.00
2.00	jointy, State, ZIP code, county	Tuesday		nesday	Thui	sday	2.00
		to	from	to	from	to	
	Facility hours of operations (1)	6. 00	from 7.00	8. 00	9.00	to 10.00	

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	
				From 01/01/2017		
		Component	CCN: 15-8517	To 12/31/2017		
					5/29/2018 5:5	5 pm
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	12: 00				11. 00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1322	Peri od:	Worksheet S-8	
			Component	CCN: 15-8518	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
					RHC III	Cost	ээ рш
	[		-		1.	00	
1 00	Clinic Address and Identification				1040E OLD STAT	F DOAD 27	1 1 00
1.00	Street		Ci	ty	18485 OLD STAT State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		LEOPOLD			47551	2. 00
2.00	THOODITAL BACED FOUR ONLY D	11 D11 C	1 11111 6			1.00	2 00
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for L		nt Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds				1. 00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5. 00
6. 00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6. 00
7.00	Appal achi an Regional Commission						7.00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)						8. 00 9. 00
7.00	JOHNER (SI ECTIT)						7.00
					1. 00	2.00	
10. 00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column	N	C	10.00
	illoui s. )	Sur	nday	I	londav	Tuesday	
		from	to	from	to	from	
		1. 00	2.00	3.00	4.00	5. 00	
	Facility hours of operations (1)			I	1	I	
11. 00	CLI NI C			07: 00	16: 00	07: 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. numbers below.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N N	2.00	12. 00 13. 00
	Trumber 3 ber ow.			Prov	ider name	CCN number	
					1. 00	2.00	
14.00	RHC/FQHC name, CCN number						14. 00
		Y/N	V	XVIII	XIX	Total Visits	
1F 00	Have you provided all or substantially all	1. 00	2.00	3.00	4. 00	5. 00	15.00
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 column 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)						15. 00
				inty			
				00			
2.00	City, State, ZIP Code, County	T	PERRY				2. 00
		Tuesday to	from Wedn	esday to	from	sday to	
		6.00	7. 00	8. 00	9. 00	10.00	
	Facility hours of operations (1)	3.00	,. 55	3.00	,, 00	13.00	
11. 00	CLI NI C	16: 00	07: 00	11: 00	07: 00	16: 00	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 C	CN: 15-1322	Peri od:	Worksheet S-8	
		Component	CCN: 15-8518	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	15: 00				11. 00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	eu of Form CMS-	-2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1322	Peri od:	Worksheet S-8	
			Component	CCN: 15-8519	From 01/01/2017 To 12/31/2017		
					RHC I V	Cost	
					1.	00	
1. 00	Clinic Address and Identification Street				510 WASHI NGTON	CTDEET	1.00
1.00	Sti ee t		Ci	ty	State	ZIP Code	1.00
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		CANNELTON		IN	47520	2. 00
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "P" for rurs	al or "II" for i	ırhan		1.00	3.00
3.00	THOSE THE BASED TUTIES ONET. DESIGNATION - ETT	ei k ioi iuiz	1 01 0 101 0		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4. 00
5.00	Migrant Health Center (Section 329(d), PHS A						5. 00
6. 00 7. 00	Health Services for the Homeless (Section 34) Appalachian Regional Commission	U(d), PHS ACT)				-	6. 00 7. 00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9. 00
	I= :				1. 00	2. 00	
10. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operation	ns in column	N		10. 00
	induits.	Sun	ıday	l N	Monday	Tuesday	
		from	to	from	to	from	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Facility hours of operations (1) CLINIC	1	1	08: 30	17: 00	08: 30	11. 00
11.00	I CELINI C			06. 30	17.00	08. 30	11.00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. In numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N	(	12. 00 13. 00
-				Prov	ider name	CCN number	
					1. 00	2. 00	
14. 00	RHC/FQHC name, CCN number	N/ (N)	1 1	20/11/1	VI V	T 1 1 10 11	14. 00
		Y/N 1.00	V 2.00	3. 00	4. 00	Total Visits 5.00	
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)				4.00	3.00	15. 00
				inty			
2.00	City Ctate 7ID Code County			00			2.00
2.00	City, State, ZIP Code, County	Tuesday	PERRY Wedn	esday	Thur		2. 00
		to	from	to	from	to	
		6. 00	7. 00	8.00	9. 00	10.00	
	Facility hours of operations (1)	17: 00					11. 00
	I ==····· =	1	I .	1	T.	T.	, 50

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1322	Peri od:	Worksheet S-8	
		C	CON 15 0510	From 01/01/2017	D-+- /T: D	
		Component	CCN: 15-8519	To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
				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   CLINIC						11. 00

	Financial Systems PERRY COUNTY HOSP  L UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 15-1		Peri od:	Worksheet S-1	
				rom 01/01/2017	D 1 /T' D	
				o 12/31/2017	Date/Time Pre 5/29/2018 5:5	pared 5 pm
					1. 00	
l	Uncompensated and indigent care cost computation					
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 202	col umn	8)	0. 411187	1. (
	Medicaid (see instructions for each line)					
	Net revenue from Medicaid				3, 145, 113	1
	Did you receive DSH or supplemental payments from Medicaid?			10	Y	3.
	If line 3 is yes, does line 2 include all DSH and/or supplementa		Medi cai	ď?	N 1 202 527	4.0
	If line 4 is no, then enter DSH and/or supplemental payments fro Medicaid charges		1, 303, 536 12, 996, 333	1		
	Medicald charges Medicald cost (line 1 times line 6)				5, 343, 923	
- 1	Difference between net revenue and costs for Medicaid program (I	ine 7 minus sum	of line	es 2 and 5 if	895, 274	1
	< zero then enter zero)				2.2, 2.	
C	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
1	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)		0	11.		
	Difference between net revenue and costs for stand-alone CHIP (I enter zero)	ine II minus IIn	ie 9; i r	< zero tnen	0	12. (
	onter zero) Other state or local government indigent care program (see instr	ictions for each	line)			
	Net revenue from state or local indigent care program (Not inclu				0	13.
	Charges for patients covered under state or local indigent care				Ö	
	10)	· · · · · ·				
5. 00	State or local indigent care program cost (line 1 times line 14)				0	15.
	Difference between net revenue and costs for state or local indi	15 minus line	0	16.		
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	and atata/lacal	i ndi ac	n+ 0000 program	10.00	
	nstructions for each line)	and State/Tocal	i nai ge	ent care prograi	is (See	
	Private grants, donations, or endowment income restricted to fun				0	
	Government grants, appropriations or transfers for support of ho				0	
	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent care pr	ograms	(sum of lines	895, 274	19.
	0, 12 dila 10)	Uni n	sured	Insured	Total (col. 1	
		pati	ents	pati ents	+ col . 2)	
To To		1.	00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)		00/ 045	-	20/ 045	
	Charity care charges and uninsured discounts for the entire faci (see instructions)	iity	396, 945	0	396, 945	20.
1	Cost of patients approved for charity care and uninsured discoun	ts (see	163, 219	0	163, 219	21.
	instructions)	13 (300	100, 217		100, 217	
- 1	Payments received from patients for amounts previously written o	ff as	C	0	0	22.
	charity care					
3. 00	Cost of charity care (line 21 minus line 22)		163, 219	0	163, 219	23.
					1. 00	
. 00	Does the amount on line 20 column 2, include charges for patient	days heyond a l	enath o	of stay limit	1.00 N	24.
	imposed on patients covered by Medicaid or other indigent care p		engtir	n stay i i iii t	IN	24.
5. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit		rogram'	s length of	0	25.
	Total bad debt expense for the entire hospital complex (see inst	ructions)			3, 460, 374	26.
- 1	Medicare reimbursable bad debts for the entire hospital complex		ıs)		86, 329	1
- 1	Medicare allowable bad debts for the entire hospital complex (se	•	•		132, 814	1
	Non-Medicare bad debt expense (see instructions)	ŕ			3, 327, 560	28.
3. 00						1 20
9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (see instruc	tions)		1, 414, 734	1
9. 00 0. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus lin		tions)		1, 414, 734 1, 577, 953 2, 473, 227	30.

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	OF EXPENSES	Provi der Co		eri od:	Worksheet A	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/29/2018 5:5	pared: 5 pm
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
•	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 627, 206			2, 852, 568	1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	(	1, ,	1, 245, 466	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	158, 091	5, 034, 852			5, 192, 943	4.00
5. 01 5. 02	00540 ADMINISTRATIVE AND GENERAL 00590 OTHER ADMINISTRATIVE AND GENERAL	489, 647	2, 856, 217 1, 446, 731	3, 345, 864		3, 203, 504 2, 662, 962	5. 01
5. 02 7. 00	00700 OPERATION OF PLANT	1, 220, 186 252, 872	741, 770			2, 662, 962 992, 242	5. 02 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	989	86, 238			87, 227	8. 00
9. 00	00900 HOUSEKEEPING	242, 158	57, 874			300, 032	9. 00
10. 00	01000 DI ETARY	0	648, 673			212, 635	10.00
11. 00	01100 CAFETERI A	o	0			436, 038	11. 00
13.00	01300 NURSING ADMINISTRATION	365, 227	7, 505	372, 732		372, 732	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	190, 394	153, 032	343, 426	0	343, 426	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	1, 359, 947	365, 368			1, 718, 996	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	194, 383	132, 887	327, 270		327, 006	31. 00
43. 00	04300 NURSERY	85, 194	0	85, 194	0	85, 194	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	417 110	F07 140	1 014 077	F40 270	1 5/2 /2/	FO 00
50. 00 52. 00	O5000   OPERATING ROOM   O5200   DELIVERY ROOM & LABOR ROOM	417, 118 66, 602	597, 148 0			1, 562, 636	50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	854, 732	645, 628	66, 602 1, 500, 360		66, 602 1, 500, 120	54.00
60. 00	06000 LABORATORY	621, 786	1, 053, 584			1, 675, 370	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	10, 348	102, 971	113, 319		113, 319	62.00
65. 00	06500 RESPIRATORY THERAPY	455, 430	228, 099			670, 109	65. 00
66. 00	06600 PHYSI CAL THERAPY	24, 760	450, 377			475, 039	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	220, 387	220, 387		220, 387	67.00
68.00	06800 SPEECH PATHOLOGY	o	123, 675	123, 675	0	123, 675	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 372	694, 108	723, 480	-50, 124	673, 356	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	(	89, 838	89, 838	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	74, 607	2, 686, 894	2, 761, 501	-288, 347	2, 473, 154	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	1, 681, 580	584, 452			2, 268, 437	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	244, 073	159, 071	403, 144		403, 144	88. 01
88. 02 88. 03	O8803   RURAL HEALTH CLINIC III   O8802   RURAL HEALTH CLINIC IV	190, 888 527, 976	104, 789 111, 109			296, 686 639, 085	88. 02 88. 03
90. 00	09000 CLINIC	303, 290	47, 471	350, 761		596, 884	90.00
90. 01	09001 PAIN MANAGEMENT	113, 777	128, 110			241, 824	90. 01
90. 02	09002 WOUND CARE	161, 431	97, 330				90. 02
91. 00	09100 EMERGENCY	786, 276	982, 493			1, 765, 986	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			,	,	,	92.00
	OTHER REIMBURSABLE COST CENTERS	•					
	09500 AMBULANCE SERVI CES	762, 178	319, 126				
101.00	10100 HOME HEALTH AGENCY	329, 306	420, 378	749, 684	0	749, 684	101. 00
	SPECIAL PURPOSE COST CENTERS			-			
	11300 I NTEREST EXPENSE	_	1, 245, 466	1, 245, 466	-1, 245, 466		113. 00
	11600 H0SPI CE	0	0	(	0		116.00
118.00	, ,	12, 214, 618	25, 161, 019	37, 375, 637	664, 019	38, 039, 656	118.00
100.00	NONREI MBURSABLE COST CENTERS		^	_		0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  19200 PHYSICIANS' PRIVATE OFFICES	1, 219, 351	676, 591	1, 895, 942	-664, 019	1, 231, 923	
	19200 PHYSICIANS PRIVATE OFFICES	1, 217, 331	070, 391 A	1, 090, 942	-004, 019		192. 00
200.00		13, 433, 969	25, 837, 610	39, 271, 579			
200.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		_0,00.,010	0., 2, 0, .	١	0,,2,.,0,,	

Provider CCN: 15-1322

| Period: | Worksheet A | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/29/2018 5:55 pm

					5/29/2018 5: 5	55 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 & FIXT	-27, 356				1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-60, 057	1, 185, 409			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 192, 943			4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL	-909, 200	2, 294, 304			5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	0	2, 662, 962			5. 02
7.00	00700 OPERATION OF PLANT	0	992, 242			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	87, 227			8. 00
9.00	00900 HOUSEKEEPI NG	0	300, 032			9. 00
10.00	01000 DI ETARY	-476	212, 159			10.00
11. 00	01100 CAFETERI A	-105, 093	330, 945			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	372, 732			13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-6, 067	337, 359			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	-213, 100	1, 505, 896			30.00
31.00	03100 INTENSIVE CARE UNIT	0	327, 006			31. 00
43.00	04300 NURSERY	0	85, 194			43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	-1, 042, 163	520, 473			50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	66, 602			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-72, 152	1, 427, 968			54.00
60.00	06000 LABORATORY	0	1, 675, 370			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	113, 319			62. 00
65.00	06500 RESPI RATORY THERAPY	-142, 943	527, 166			65. 00
66.00	06600 PHYSI CAL THERAPY	0	475, 039			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	220, 387			67. 00
68.00	06800 SPEECH PATHOLOGY	0	123, 675			68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-14, 656	658, 700			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	89, 838			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-4, 043	2, 469, 111			73. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	-146, 907	2, 121, 530			88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	403, 144			88. 01
88. 02	08803 RURAL HEALTH CLINIC III	0	296, 686			88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0	639, 085			88. 03
90.00	09000 CLI NI C	0	596, 884			90. 00
90. 01	09001 PAIN MANAGEMENT	-10, 162	231, 662			90. 01
90. 02	09002 WOUND CARE	-137, 899	201, 292			90. 02
91.00	09100 EMERGENCY	0	1, 765, 986			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
	OTHER REIMBURSABLE COST CENTERS		,	<u>'</u>		
95.00	09500 AMBULANCE SERVICES	-6, 141	1, 056, 018			95. 00
101.00	10100 HOME HEALTH AGENCY	-454	749, 230			101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300   NTEREST EXPENSE	0	0			113. 00
116.00	11600 HOSPI CE	0	o			116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-2, 898, 869	35, 140, 787			118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 231, 923			192. 00
	19201 MARKETI NG	0	0			192. 01
200.00	TOTAL (SUM OF LINES 118 through 199)	-2, 898, 869	36, 372, 710			200. 00

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

Provider CCN: 15-1322 

				ate/IIme Prepare /29/2018 5:55 pm
	Increases			 
Cost Center	Li ne #	Sal ary	Other	
2.00	3. 00	4. 00	5. 00	
A - CAFETRIA COST	44.00	اه	101 000	
CAFETERI A	11.00	9	<u>436, 038</u>	1.
U LINTEDECT EVDENCE		U	436, 038	
B - INTEREST EXPENSE	2 00	ما	1 245 477	1
NEW CAP REL COSTS-MVBLE	2. 00	0	1, 245, 466	1.
EQUI P	+		1, 245, 466	
C - LEASE EXPENSE		U	1, 240, 400	
NEW CAP REL COSTS-BLDG &	1.00	0	89, 314	1
FIXT	1.00	o o	07, 314	'
	0.00	0	0	2
	0.00	0	0	3
	0.00	0	Ö	4
	0.00	0	0	5
	0.00	0	Ö	6
	0.00	0	o	7
, <u> </u>		<del>0</del>	89, 314	1 '
D - INSURANCE EXPENSE		9	07,011	
NEW CAP REL COSTS-BLDG &	1.00	0	50, 824	1
FIXT	1. 50	Ĭ	30, 32 1	[ '
	0.00	0	0	2
			50, 824	_
E - RECRUITING		91	00,021	
RURAL HEALTH CLINIC	88. 00	0	2, 405	1
RURAL HEALTH CLINIC III	88. 02	o	1, 009	2
TOTALS			$\frac{1}{3}, 414$	-
F - GAIN LOSS RECLASS		9	0, 111	
NEW CAP REL COSTS-BLDG &	1.00	0	85, 224	1
FLXT			00, 22 .	
TOTALS	+		85, 224	
G - DRUGS CHARGED		<u> </u>	00/ 22 1	
DRUGS CHARGED TO PATIENTS	73.00	0	22, 027	1
	0.00	o	0	2
	0.00	o	0	3
	0.00	o	0	4
			22, 027	
H - BILLABLE SUPPLIES				
MEDICAL SUPPLIES CHARGED TO	71.00	0	39, 714	1
PATI ENTS				
AMBULANCE SERVICES	95. 00	0	1, 086	2
	0.00	О	0	3
	0.00	o	0	4
	0.00	o	0	5
	0.00	o	0	6
	0.00	o	0	7
	0.00	o	0	8
	0.00	O	0	9
0			40, 800	
I - IMPLANTABLE DEVICE				
I MPL. DEV. CHARGED TO	72.00	0	89, 838	 1
PATI ENT				
0		0	89, 838	
J - WOUND CARE CENTER SALARIE				
WOUND CARE	90.02	105, 000	0	 1
0		105, 000	<u> </u>	
K - IV THERAPY				
CLINIC	90.00	0	246, 456	 1
TOTALS			246, 456	
L - SURGEON RECLASS	<u>'</u>			
OPERATING ROOM	50.00	O	559, 019	 1
TOTALS	+		559, 019	
TOTALS				

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1322

| Period: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/29/2018 5:55 pm

							5/29/2018 5:55 pm
		Decreases			_	1	
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETRIA COST					ı	
1.00	DI ETARY	10.00		43 <u>6, 0</u> 38	+		1. 00
	0		0	436, 038	3		
	B - INTEREST EXPENSE					Ī	
1. 00	INTEREST EXPENSE	113.00	0	1, 245, 466			1.00
	0		0	1, 245, 466			
	C - LEASE EXPENSE	5 00		0.055	.1	I	1.00
1. 00	OTHER ADMINISTRATIVE AND	5. 02	0	3, 955	9		1.00
2 00	GENERAL ON OF BLANT	7.00		2 400			2.00
2.00	OPERATION OF PLANT	7.00	0	2, 400		l .	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	3, 193		•	3.00
4.00	OPERATING ROOM	50.00	0	377			4.00
5.00	RESPIRATORY THERAPY	65.00	0	13, 395			5. 00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	63, 918		1	6.00
7. 00	AMBULANCE SERVICES	95.00		$ \frac{2,076}{20,316}$		1	7. 00
	D - INSURANCE EXPENSE		<u> </u>	89, 314	•		
1.00	ADMINISTRATIVE AND GENERAL	5. 01	0	50, 809	10		1.00
2.00	AMBULANCE SERVICES	95. 00	0				2. 00
2.00	AWBULANCE SERVICES	93.00		15 50, 824		1	2.00
	E - RECRUITING		<u> </u>	50, 624	i		
1.00	ADMINISTRATIVE AND GENERAL	5. 01	ol	3, 414	1 0		1. 00
2.00	ADMINISTRATIVE AND GENERAL	0.00	0	3, 414			2. 00
2.00	TOTALS — — — —			3, 414			2.00
	F - GAIN LOSS RECLASS		<u> </u>	5, 41-	•		
1. 00	ADMINISTRATIVE AND GENERAL	5. 01	0	85, 224	14		1.00
1.00	TOTALS		_ — — <del> </del>	85, 224		1	1. 66
	G - DRUGS CHARGED			00,22	•		
1.00	ADMINISTRATIVE AND GENERAL	5. 01	0	2, 913	3 0		1.00
2. 00	PAIN MANAGEMENT	90. 01	o	63		l .	2. 00
3. 00	WOUND CARE	90. 02	o	911			3. 00
4.00	AMBULANCE SERVICES	95. 00	o	18, 140	0		4. 00
				22, 027			
	H - BILLABLE SUPPLIES		<u>'</u>		<b>'</b>		
1.00	ADULTS & PEDIATRICS	30.00	0	3, 126	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	264	0		2. 00
3.00	OPERATING ROOM	50.00	0	10, 272	0		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	240	0		4. 00
5.00	RESPI RATORY THERAPY	65. 00	0	25	0		5. 00
6.00	PHYSI CAL THERAPY	66.00	0	98	0		6. 00
7.00	CLINIC	90.00	0	333	0		7. 00
8.00	WOUND CARE	90. 02	0	23, 659	0		8. 00
9.00	EMERGENCY	<u>91.</u> 00	0	<u>2, 7</u> 83	B 0		9. 00
	0		0	40, 800	)		
	I - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	89, 838	0		1. 00
	PATI ENTS						
	0		0	89, 838	3		
	J - WOUND CARE CENTER SALARIE					Т	
1. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	10 <u>5, 0</u> 00		<u> </u>		1. 00
	0		105, 000		)		
	K - IV THERAPY						
1. 00	DRUGS_CHARGED_TO_PATI_ENTS		0	24 <u>6, 4</u> 56		1	1.00
	TOTALS		0	246, 456	p	L	
4 00	L - SURGEON RECLASS	100 0-1	اء	F50 6:-	\		
1. 00	PHYSICIANS' PRIVATE OFFICES	192.00		559, 019		1	1.00
E00 00	TOTALS		105.000	559, 019		1	F00.00
500.00	Grand Total: Decreases		105, 000	2, 868, 420	ין	I	500.00

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

				1	To 12/31/2017	Date/Time Prep 5/29/2018 5:5	pared: 5 pm
				Acqui si ti ons		072772010 0.0.	<b>У</b>
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	2, 755, 753	1, 060, 000	(	1, 060, 000	0	1.00
2.00	Land Improvements	260, 652	0	(	0	189, 414	2.00
3.00	Buildings and Fixtures	3, 407, 771	40, 656, 977	(	40, 656, 977	157, 145	3. 00
4.00	Building Improvements	0	0	(	0	0	4. 00
5.00	Fi xed Equipment	8, 250, 651	0	(	0	5, 919, 934	5. 00
6.00	Movable Equipment	11, 572, 105	4, 245, 278	(	4, 245, 278	0	6. 00
7.00	HIT designated Assets	0	0	(	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	26, 246, 932	45, 962, 255	(	45, 962, 255	6, 266, 493	8. 00
9.00	Reconciling Items	0	0	(	0	0	9. 00
10.00	Total (line 8 minus line 9)	26, 246, 932	45, 962, 255	(	45, 962, 255	6, 266, 493	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	3, 815, 753	0				1. 00
2.00	Land Improvements	71, 238	0				2. 00
3.00	Buildings and Fixtures	43, 907, 603	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	2, 330, 717	0				5. 00
6.00	Movable Equipment	15, 817, 383	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	65, 942, 694	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	65, 942, 694	0				10. 00

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lieu of Form CMS-2552-1		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part II Date/Time Pre 5/29/2018 5:5	pared:
	SUMMARY OF CAPITAL					
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 WORK	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	2, 446, 370	0		0 177, 112	3, 724	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00 Total (sum of lines 1-2)	2, 446, 370	0		0 177, 112	3, 724	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
·	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14.00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
						1

0 0 0

2, 627, 206

2, 627, 206

1. 00 2. 00 3. 00

1.00 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E 3.00 Total (sum of lines 1-2)

NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part III Date/Time Pre 5/29/2018 5:5	pared:
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi talized	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FLXT	50, 125, 311					1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	15, 817, 383					2. 00
3.00	Total (sum of lines 1-2)	65, 942, 694		65, 942, 69			3. 00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONOLILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CENEW CAP REL COSTS-BLDG & FIXT	INTERS 0	1 0	1	0 2, 508, 328	50, 824	1. 00
2.00	NEW CAP REL COSTS-BLDG & FIXT	0	ľ		0 2, 506, 326	-60, 057	2.00
3.00	Total (sum of lines 1-2)	0			0 2, 508, 328		3.00
3.00	Total (Suil of Titles 1 2)		SI	JMMARY OF CAPI		7, 200	3.00
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	11.00	12. 00	13.00	14. 00	15. 00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	INTERS	177, 112	3, 72	4 85, 224	2, 825, 212	1. 00
2. 00	NEW CAP REL COSTS-BEBG & TTXT	1, 245, 466			0 0 0	1, 185, 409	2.00
3.00	Total (sum of lines 1-2)	1, 245, 466			٥		
			, , , , , ,				

| Period: | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | From 01/01/2017 | From Provider CCN: 15-1322

				Fr To	rom 01/01/2017 o 12/31/2017	Date/Time Pre	
				Expense Classification on	Worksheet A	5/29/2018 5: 5	5 pm
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	1. 00
	(chapter 2)						
2.00	Investment income - NEW CAP	В		NEW CAP REL COSTS-MVBLE	2. 00	10	2. 00
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUI P			
3.00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2)		0		0.00	0	4. 00
4.00	Trade, quantity, and time discounts (chapter 8)		U		0.00	U	4.00
5.00	Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
0.00	suppliers (chapter 8)		J		0.00		0.00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)						
8. 00	Tel evi si on and radi o servi ce		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physician	A-8-2	-1, 395, 157		0.00	0	10. 00
11 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11 00
11. 00	(chapter 23)		U		0. 00	U	11. 00
12.00	Related organization	A-8-1	1, 221			o	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-105, 093	CAFETERI A	11. 00	0	
15. 00	Rental of quarters to employee		0		0. 00	0	15. 00
16. 00	and others Sale of medical and surgical	В	-14, 656	MEDICAL SUPPLIES CHARGED TO	71. 00	0	16. 00
	supplies to other than			PATI ENTS			
17. 00	patients Sale of drugs to other than	В	-4 043	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
17.00	patients		4, 043	DROGS CHARGED TO FATTENTS	73.00		17.00
18. 00	Sale of medical records and abstracts	В	-6, 067	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00			0		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
20.00	therapy costs in excess of		J		55.55		20.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24 00
24. UU	therapy costs in excess of	N-0-3	U	IIII SI CAL III ERAPT	00.00		24. 00
05.00	limitation (chapter 14)		_	*** 0 0	44		25 22
25. 00	Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT		-	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26. 00
27. 00	Depreciation - NEW CAP REL			NEW CAP REL COSTS-MVBLE	2.00	0	27. 00
20 00	COSTS-MVBLE EQUIP			EQUIP	10.00		20 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	Ō	OCCUPATI ONAL THERAPY	67. 00	· ·	30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
24 00	instructions)	1 0 0					21 00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	O	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)						

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES	Provi der CCN: 15-1322	From 01/01/2017	Worksheet A-8 Date/Time Prep 5/29/2018 5:55	pared:
	Expense Classification To/From Which the Amount			, , , , , , , , , , , , , , , , , , ,

				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	C+ C+	D:- (01- (0)	A	Cook Cooker	1: "	WI+ A 7 D-6	
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
32.00	CAH HIT Adjustment for	A	-27, 356	NEW CAP REL COSTS-BLDG &	1. 00	9	32. 00
	Depreciation and Interest			FLXT			
33.00	ADMINISTRATION MISCELLANEOUS	В	-54, 982	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 00
	REVENUE						
33. 01	DIETARY MISC REVENUE	В	-476	DI ETARY	10.00	0	33. 01
33. 02	AMBULANCE MISC REVENUE	В	-6, 141	AMBULANCE SERVICES	95.00	0	33. 02
33. 03	RHC I MISC REVENUE	В	-146, 907	RURAL HEALTH CLINIC	88. 00	0	33. 03
33.04	HOME HEALTH MISC REVENUE	В	-454	HOME HEALTH AGENCY	101.00	0	33. 04
33.05	PAIN MANAGEMENT - ADVERTISING	A	-10, 162	PAIN MANAGEMENT	90. 01	0	33. 05
33.06	ADMI NI STRATI ON-CONTRI BUTI ONS	Α	-11, 999	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 06
33. 07	ADMI NI STRATI ON-NON-ALLOWABLE	A	-1, 222	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 07
33. 08	HAF FEES	В	-840, 997	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 08
33.09	ON CALL FEES	A	-213, 100	ADULTS & PEDIATRICS	30.00	0	33. 09
50.00	TOTAL (sum of lines 1 thru 49)		-2, 898, 869				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<sup>(1)</sup> 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	TY HOSPITAL	In Li€	2552-10	
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2017		
				To 12/31/2017		
					5/29/2018 5:5	5 pm
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	2. 00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	1, 221	0	1. 00
2.00	0.00			0	0	2. 00
2 00	0.00				0	2 00

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

0

1, 221

4.00

5.00

			Related Organization(s) and	or Home Office	1
			norated organization(e) and	0	
					1
					1
					1
0 1 1 (4)		l	N	In , c	
Symbol (1)	Name	Percentage of	Name	Percentage of	1
		Ownershi p		Ownershi p	
		Owner Sili p		Owner Sili p	
1. 00	2.00	3.00	4. 00	5.00	1
			11 00	0.00	
B INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:			1

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:

0.00

- 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.

4.00

5.00

Heal th	Financial Syste	ems		PERRY C	OUNTY H	OSPI TAL				In Lie	u of Form Cl	NS-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS AND	HOME	Provi der	CCN:	15-1322	Peri od		Worksheet	4-8-1
OFFICE	COSTS									1/01/2017	D-+- /T:	D
									To 1	2/31/2017	Date/Time 5/29/2018	
	Net	Wkst. A-7 Ref.				1					0,2,,2010	5. 00 p
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCURI	RED AND ADJUST	MENTS REC	QUIRED AS A RESULT	OF TRA	NSACTI ONS	WITH	RELATED C	DRGANI ZA	ATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	1, 221	10										1. 00
2.00	0	C										2. 00
3.00	0	C										3. 00
4.00	0	C										4. 00
5.00	1, 221											5. 00
* The	amounts on line	es 1-4 (and sub	scripts	as appropriate) a	re trans	sferred in	det	ail to Wor	ksheet	A. column	6. Lines as	

\* 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.

1100 1100	zoon postou to normanost m	cordinate transfer 2, the amount arrowable should be that eated the cordinate to this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
-	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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 12/31/201	5/29/2018 5:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
					'		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	50. 00	OPERATING ROOM	1, 042, 163	1, 042, 163	0	C	0	1. 00
2.00	54. 00	RADI OLOGY-DI AGNOSTI C	72, 152	72, 152	0	C	0	2. 00
3.00	60. 00	LABORATORY	18, 000	0	18, 000	[ c	0	3. 00
4.00	65. 00	RESPI RATORY THERAPY	142, 943	142, 943	0	l c	0	4. 00
5.00	90. 02	WOUND CARE	137, 899	137, 899	0	l c	ol o	5. 00
6.00	91.00	EMERGENCY	921, 660	0	921, 660	l c	ol o	6. 00
7.00	0.00		0	0	0		ol o	7. 00
8.00	0.00		0	0	0	1	ol o	8. 00
9. 00	0. 00		0	0	0	l c		9. 00
10.00	0. 00		0	0	0	1		10.00
200.00			2, 334, 817	1, 395, 157	939, 660		0	1
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identi fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	C	0	1. 00
2.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	C	0	2. 00
3.00	60. 00	LABORATORY	0	0	0	C	0	3. 00
4.00	65. 00	RESPI RATORY THERAPY	0	0	0	(	0	4. 00
5.00	90. 02	WOUND CARE	0	0	0	(	0	5. 00
6.00	91. 00	EMERGENCY	0	0	0	(	0	6. 00
7.00	0. 00		0	0	0	(	0	7. 00
8.00	0. 00		0	0	0	C	0	8. 00
9.00	0. 00		0	0	0	(	0	9. 00
10.00	0. 00		0	0	0	(	0	10.00
200.00			0	0	0	(	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		OPERATING ROOM	0	0	_	1,012,100		1. 00
2. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	72, 152	2	2. 00
3.00		LABORATORY	0	0	0	(		3. 00
4.00		RESPI RATORY THERAPY	0	0	0	142, 943		4. 00
5.00		WOUND CARE	0	0	0	137, 899	9	5. 00
6. 00		EMERGENCY	0	0	0	[ C		6. 00
7. 00	0. 00		0	0	_	[ C	)	7. 00
8.00	0. 00		0	0		C	)	8. 00
9.00	0. 00		0	0	_	[ C	)	9. 00
10. 00	0. 00		0	0	_	[ C	)	10. 00
200.00			0	0	0	1, 395, 157	7	200. 00

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES	PERRY COUNTY	HOSPITAL Provider CCN	l· 15_1222	In Lie	u of Form CMS-2 Worksheet A-8-	
	E SUPPLIERS	TORNI SILD BI	Frovider con	1. 13-1322	From 01/01/2017 To 12/31/2017	Parts I-VI Date/Time Prep 5/29/2018 5:55	pared:
					Physical Therapy		J PIII
	PART I - GENERAL INFORMATION					1. 00	
. 00	Total number of weeks worked (excluding aides	s) (see instruct	i ons)			52	1.0
. 00	Line 1 multiplied by 15 hours per week		ŕ			780	2.0
3. 00	Number of unduplicated days in which supervis					246	
. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see instr		n provider sit	e but neith	er supervisor	260	4.0
5. 00							
. 00	Number of unduplicated offsite visits - thera					0	6.0
	assistant and on which supervisor and/or ther	rapist was not p	resent during	the visit(s	)) (see		ł
7. 00	instructions) Standard travel expense rate					0.00	7. C
3. 00	Optional travel expense rate per mile					0.00	
		Supervi sors	Therapi sts	Assi stants		Trai nees	
9. 00	Total hours worked	1.00	2. 00 3, 594. 58	3. 00 7, 307.	4. 00 58 0. 00	5. 00	9.0
	AHSEA (see instructions)	0.00	81. 03	7, 307. 60.		0.00	
	Standard travel allowance (columns 1 and 2,	40. 52	40. 52	30.	39		11.0
	one-half of column 2, line 10; column 3,						
12. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	o		0		12.0
	Number of travel hours (offsite)	Ö	ő		0		12.0
	Number of miles driven (provider site)	0	0		0		13.0
13. 01	Number of miles driven (offsite)	0	0		0		13.0
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00						0	14.0
15. 00 16. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					291, 269 444, 155	•
17. 00	Subtotal allowance amount (sum of lines 14 ar		atory therapy	or lines 14	-16 for all	735, 424	
	others)	40)					
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	18. 0 19. 0
20. 00	Total allowance amount (sum of lines 17-19 fo		herapy or line	s 17 and 18	for all others)	735, 424	
	If the sum of columns 1 and 2 for respiratory	therapy or col	umns 1-3 for pl	hysical the	rapy, speech path	ol ogy or	
	occupational therapy, line 9, is greater than		entries on li	ines 21 and	22 and enter on	line 23	1
21. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by sum	of columns	1 and 2. line 9	0.00	21.0
	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)				
	Weighted allowance excluding aides and traine	ees (line 2 time	s line 21)			0	
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPU	TATION - PRO	OVIDER SLITE	735, 424	23.0
	Standard Travel Allowance	THE THE	EXI ENGE COM C	THE THE	OVIDER SITE		
24. 00	Therapists (line 3 times column 2, line 11)					9, 968	
25. 00	Assistants (line 4 times column 3, line 11)	oum of Lines 24	and OF for al	l othoro)		7, 901	
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	17, 869 0	26. C
	others)	. o oop a.o. y	:	000	o and i ioi an		
28. 00	Total standard travel allowance and standard	travel expense	at the provide	r site (sum	of lines 26 and	17, 869	28. 0
	27) Optional Travel Allowance and Optional Travel	Expense					1
9. 00	Therapists (column 2, line 10 times the sum of		2, line 12 )			0	29.0
30. 00	Assistants (column 3, line 10 times column 3,	,				0	30. C
31.00	Subtotal (line 29 for respiratory therapy or				as aum of	0	31.0
32. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s ranu z, rrne	is for respira	tory therap	y or Sulli of	0	32.0
3. 00	Standard travel allowance and standard travel	expense (line	28)			17, 869	33.0
	Optional travel allowance and standard travel	expense (sum o	flines 27 and			0	34.0
35. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				VICES OUTSIDE DO	0 NVIDED SITE	35. C
	Standard Travel Expense	NIVOE AIND TRAVEL	LAPENSE CUMPUI	MITUN - SER	VICES OUTSIDE PRO	VIDER SITE	
6. 00	Therapists (line 5 times column 2, line 11)					0	
	Assistants (line 6 times column 3, line 11)					0	37.0

31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31. 00					
32. 00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32. 00					
33. 00	Standard travel allowance and standard travel expense (line 28)	17, 869	33. 00					
	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00					
35. 00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	l ol	35. 00					
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PRO	OVI DER SITE						
	Standard Travel Expense							
36. 00	Therapists (line 5 times column 2, line 11)	0	36. 00					
37. 00	Assistants (line 6 times column 3, line 11)	0	37.00					
38. 00	Subtotal (sum of lines 36 and 37)	0	38. 00					
39. 00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39. 00					
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40. 00					
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00					
42.00	Subtotal (sum of lines 40 and 41)	0	42.00					
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00					
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line	es 44, 45,						
	or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44. 00					
	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	l ol	45. 00					

Hoal th	Financial Systems	PERRY COUNTY	HOSDI TAI		In Lie	eu of Form CMS-2	2552 10
REASON	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS		Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Parts I-VI	-3 pared:
					Physical Therapy	Cost	
						1. 00	
46. 00	Optional travel allowance and optional travel						46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4. 00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	0.00	0.00	O. C	0.00	0.00	47. 00
48. 00	column of line 56) Overtime rate (see instructions)	0. 00	0.00	0.0	0.00		48. 00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00				49. 00
50.00	CALCULATION OF LIMIT  Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	O. C	0.00	0.00	50. 00
51.00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	O. C	0.00	0.00	51.00
52. 00		81. 03	60. 78	0. C	0.00		52. 00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53. 00
54. 00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
55. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55. 00
56. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56. 00
		ND EVOES COST	AD IIIOTHELIT			1. 00	
F7 00	Part VI - COMPUTATION OF THERAPY LIMITATION A	IND EXCESS COST.	ADJUSTMENT			725 424	F7 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	Supplies (see instructions) Total allowance (sum of lines 57-62)	ces (from lines  n your records)	44, 45, or 46	)		7, 918 764, 999 431, 532	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
100.01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	17, 869 0 17, 869	100. 01
101.01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				mns 1-3, line		102. 00 102. 01
102. 02	13 for all others  Line 35 = sum of lines 31 and 32					0	102. 02

	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der CCN: 15-1322	Peri od: From 01/01/2017 To 12/31/2017		pared
				Occupati onal Therapy	Cost	o piii
					1. 00	
. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	c) (coo instruct	i one)		52	1.0
00	Line 1 multiplied by 15 hours per week	s) (see mstruct	1 0115)		780	2.
00	Number of unduplicated days in which supervis				257	3.
00	Number of unduplicated days in which therapy nor therapist was on provider site (see insti		n provider site but neit	ther supervisor	255	4.
00	Number of unduplicated offsite visits - super	rvisors or thera			0	5.
00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the				0	6.
	instructions)	rapisi was noi p	resent during the visit	(3)) (366		
. 00	Standard travel expense rate				0. 00 0. 00	7.
. 00	Optional travel expense rate per mile	Supervi sors	Therapists Assistant	ts Ai des	Trai nees	8.
		1.00	2.00 3.00	4. 00	5. 00	
. 00 0. 00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	3, 362. 12 76. 82 3, 430	0. 58 7. 62 0. 00		
1. 00	Standard travel allowance (columns 1 and 2,	38. 41	•	3. 81	0.00	11.
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)					
2. 00	Number of travel hours (provider site)	O	0	0		12.
2. 01	Number of travel hours (offsite)	0	0	0		12.
3. 00 3. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0	0		13. 13.
J. O I	Trainber of mires diriven (errsite)	<u> </u>	<u> </u>			10.
	Part II - SALARY EQUIVALENCY COMPUTATION				1.00	
1. 00		, line 10)			0	14.
5. 00	Therapists (column 2, line 9 times column 2,				258, 278	
5. 00 7. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 and 14 and 15 and 1		atory therapy or lines 1	4-16 for all	197, 670 455, 948	•
	others)	•				
8. 00 9. 00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li				0	18. 19.
0.00	Total allowance amount (sum of lines 17-19 for		herapy or lines 17 and 1	8 for all others)		
	If the sum of columns 1 and 2 for respiratory					
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		o entries on rines 21 ar	iu 22 anu enter on	TITIE 23	
1. 00	Weighted average rate excluding aides and tra	ainees (line 17		ns 1 and 2, line 9	0.00	21.
2. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained				0	22.
3. 00	Total salary equivalency (see instructions)		•		455, 948	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	NANCE AND TRAVEL	EXPENSE COMPUTATION - F	PROVI DER SITE		
4. 00	Therapists (line 3 times column 2, line 11)				9, 871	24.
5.00	Assistants (line 4 times column 3, line 11)	6.11	1.05.6		7, 347	1
6. 00 7. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3			3 and 4 for all	17, 218 0	26. 27.
	others)	, ,	13			
8. 00	Total standard travel allowance and standard 27)	travel expense	at the provider site (su	ım of lines 26 and	17, 218	28.
	Optional Travel Allowance and Optional Travel					
9. 00 0. 00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		2, line 12 )		0	29. 30.
1. 00	Subtotal (line 29 for respiratory therapy or		and 30 for all others)		0	31.
2. 00	Optional travel expense (line 8 times columns	s 1 and 2, line	13 for respiratory thera	apy or sum of	0	32.
	columns 1-3, line 13 for all others) Standard travel allowance and standard travel	l expense (line	28)		17, 218	33.
3. 00	Optional travel allowance and standard travel				0	34.
				DVICES OUTSIDE DD	OVIDED SITE	35.
4. 00		VNCE VND TDV//EL I	EXPENSE CONFUTATION - SE	KVICES OUTSIDE FR	OVIDER SITE	l I
4. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	ANCE AND TRAVEL				36.
4. 00 5. 00 6. 00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11)	ANCE AND TRAVEL			0	
4. 00 5. 00 6. 00 7. 00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	ANCE AND TRAVEL			0	37.
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	m of lines 5 and	6)			
4. 00 5. 00 6. 00 7. 00 3. 00 9. 00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel	m of lines 5 and Expense			0 0 0	37. 38. 39.
4. 00 5. 00 6. 00 7. 00 3. 00 9. 00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWAS tandard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	m of lines 5 and Expense O1 times column			0	37. 38. 39.
4. 00 5. 00 6. 00 7. 00 3. 00 9. 00 1. 00 2. 00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWAS tandard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	m of lines 5 and Expense 01 times column n 3, line 10)	2, line 10)		0 0 0	37. 38. 39. 40. 41. 42.
5. 00 6. 00 7. 00 8. 00 9. 00 1. 00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWAS tandard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times columns)	m of lines 5 and Expense 01 times column n 3, line 10) m of columns 1-3	2, line 10) , line 13.01)	N Lowing three Lin	0 0 0 0 0 0 0 0	37. 38. 39. 40. 41. 42.

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der C	CN: 15-1322	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Parts I-VI Date/Time Pre 5/29/2018 5:5	pared:
					Occupati onal Therapy	Cost	
						1. 00	
	Optional travel allowance and standard travel					0	45. 00
16. 00	Optional travel allowance and optional travel	expense (sum o	of lines 42 an Assistants	d 43 - see ir Aides	structions) Trainees	Total	46. 00
		1.00	2.00	3.00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION						
7. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.0	0.00	0.00	47. 00
	Overtime rate (see instructions)	0. 00	0.00				48. 00
9. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0. 00	0.0	0.00		49. 00
	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50. 00
1. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0. 00	0.0	0.00	0.00	51.00
2. 00	DETERMINATION OF OVERTIME ALLOWANCE  Adjusted hourly salary equivalency amount	76. 82	57. 62	0.0	0.00		52. 00
	(see instructions) Overtime cost limitation (line 51 times line	76. 82	07.62		0.00		53. 0
4. 00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54. 0
5. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56. 00
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	ND EXCESS COST	ADJUSTMENT			455, 948	57. 0
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	es (from lines your records)	44, 45, or 46	)		433, 946 17, 218 0 0 0 0 473, 166 220, 387	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
00. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	17, 218 0 17, 218	100. 0°
01. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
02. 00	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umps 1 2 lino		102. 0 102. 0

Health Financial Systems PERRY COUNTY HOSPITAL			In Lie	u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICOUTSIDE SUPPLIERS	CES FURNI SHED BY	Provider CCN: 15-1322	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8- Parts I-VI Date/Time Prep 5/29/2018 5:59	pared:
			Speech Pathology	Cost	
				1. 00	
PART I - GENERAL INFORMATION					
1.00 Total number of weeks worked (excluding a	ides) (see instruct	i ons)		52	1.00
2.00 Line 1 multiplied by 15 hours per week	2.00 Line 1 multiplied by 15 hours per week				
3.00 Number of unduplicated days in which supe	rvisor or therapist	was on provider site (se	ee instructions)	780	3.00
4.00 Number of unduplicated days in which ther	apy assistant was o	n provider site but neitl	her supervisor	214	4.00

0

6.00

Number of unduplicated offsite visits - supervisors or therapists (see instructions)

Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see

nor therapist was on provider site (see instructions)

5.00 6.00

instructions)

7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
		1. 00	2.00	3.00	4. 00	5. 00	
9.00	Total hours worked	0.00	2, 035. 53	0.00	0.00	0.00	9. 00
10.00	AHSEA (see instructions)	0.00	73. 84	0.00	0.00	0.00	10.00
11. 00	Standard travel allowance (columns 1 and 2,	36. 92	36. 92	0.00			11.00
	one-half of column 2, line 10; column 3,						
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0	0			12.00
12. 01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13. 01	Number of miles driven (offsite)	0	0	0			13. 01

3.01	Number of miles driven (offsite)	U	U]	0		13.
					1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION				•	
4.00	Supervisors (column 1, line 9 times column 1	line 10)			0	14.
5.00	Therapists (column 2, line 9 times column 2,	line 10)			150, 304	15.
6. 00	Assistants (column 3, line 9 times column 3,	line10)			0	16.
7. 00	Subtotal allowance amount (sum of lines 14 a	nd 15 for respiratory ther	apy or I	ines 14-16 for all	150, 304	17.
8. 00	others) Aides (column 4, line 9 times column 4, line	10)			0	18.
9. 00	Trainees (column 5, line 9 times column 5, li				0	1
). 00	Total allowance amount (sum of lines 17-19 for		lings 17	and 18 for all others)	150, 304	
	If the sum of columns 1 and 2 for respiratory					20.
	occupational therapy, line 9, is greater than	n line 2, make no entries				
	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		, cum of	columns 1 and 2 line 0	0.00	21
1. 00	for respiratory therapy or columns 1 thru 3,		Sulli 01	cordinins r and 2, rrine 9	0.00	21.
2. 00	Weighted allowance excluding aides and train				0	22.
3. 00	Total salary equivalency (see instructions)	ees (Title 2 tilles Title 21)			150, 304	1
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVEL EXPENSE C	OMDUTATI	ON _ DDOVIDED SITE	150, 304	23.
	Standard Travel Allowance	VANCE AND TRAVEL EXTENSE C	OWILDIAII	ON - TROVIDER SITE		1
. 00	Therapists (line 3 times column 2, line 11)				28, 798	24.
. 00	Assistants (line 4 times column 3, line 11)				20,770	
. 00	Subtotal (line 24 for respiratory therapy or	sum of lines 24 and 25 fo	r all ot	thers)	28, 798	
. 00	Standard travel expense (line 7 times line 3			· ·	20,770	1
. 00	others)	Tor respiratory therapy c	n Sum Oi	Tries 5 and 4 for all	Ĭ	27
. 00	Total standard travel allowance and standard	travel expense at the pro-	vider si	te (sum of lines 26 and	28, 798	28.
	27)			(		
	Optional Travel Allowance and Optional Travel	Expense				
. 00	Therapists (column 2, line 10 times the sum	of columns 1 and 2, line 1	2)		0	29.
. 00	Assistants (column 3, line 10 times column 3	line 12)			0	30.
. 00	Subtotal (line 29 for respiratory therapy or	sum of lines 29 and 30 fc	r all ot	thers)	0	31.
. 00	Optional travel expense (line 8 times columns	s 1 and 2, line 13 for res	pi ratory	therapy or sum of	0	32.
	columns 1-3, line 13 for all others)					
3. 00	Standard travel allowance and standard trave	expense (line 28)			28, 798	33.
. 00	Optional travel allowance and standard trave	expense (sum of lines 27	and 31)	1	0	34.
. 00	Optional travel allowance and optional trave				0	35.
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	ANCE AND TRAVEL EXPENSE CO	MPUTATI C	ON - SERVICES OUTSIDE PRO	OVI DER SITE	
	Standard Travel Expense					
	Therapists (line 5 times column 2, line 11)				0	
. 00	Assistants (line 6 times column 3, line 11)				0	37.
. 00	Subtotal (sum of lines 36 and 37)				0	
. 00	Standard travel expense (line 7 times the su				0	39.
	Optional Travel Allowance and Optional Travel					
. 00	Therapists (sum of columns 1 and 2, line 12.		))		0	
	Assistants (column 3, line 12.01 times column	n 3, line 10)			0	
. 00	Subtotal (sum of lines 40 and 41)				0	
3. 00	Optional travel expense (line 8 times the su				0	43.
	Total Travel Allowance and Travel Expense - ( or 46, as appropriate.	Offsite Services; Complete	one of	the following three line	es 44, 45,	
00	Standard travel allowance and standard trave	evnense (sum of lines 38	and 20	ooo inotrustions)	0	44.
i. 00	Standard traver arrowance and Standard trave	expense (sum of fines se	allu 39	- See Fristructions)	0	T - T - T -

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider CC		Peri od: From 01/01/2017 To 12/31/2017 Speech Pathol ogy	Worksheet A-8 Parts I-VI Date/Time Pre 5/29/2018 5:5	pare
					specen ratheregy	0031	
00		,	6.1.	1 40		1. 00	1.0
. 00	Optional travel allowance and optional travel						46.
		Therapi sts 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
	Overtime hours worked during reporting period (if column 5, line 47, is zero or	0. 00	0. 00	0.0	0.00	0.00	47.
	equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each						
	column of line 56)						
. 00	Overtime rate (see instructions)	0. 00	0. 00	0. 0			48.
. 00	Total overtime (including base and overtime	0. 00	0. 00	0. 0	0.00		49.
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
. 00	Percentage of overtime hours by category	0. 00	0.00	0.0	0.00	0.00	50
. 00	(divide the hours in each column on line 47	0.00	0.00	0.0	0.00	0.00	00.
	by the total overtime worked - column 5,						
	line 47)						
. 00	Allocation of provider's standard work year	0. 00	0. 00	0.0	0.00	0. 00	51.
	for one full-time employee times the						
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE  Adjusted hourly salary equivalency amount	73. 84	0.00	0.0	0.00		52
00	(see instructions)	70.01	0.00	0.0	0.00		02
00	Overtime cost limitation (line 51 times line	0	0		0 0		53
00	52)						١.,
00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54
00	Portion of overtime already included in	o	0		0		55.
	hourly computation at the AHSEA (multiply	٩	ŭ		٦		
	line 47 times line 52)						
00	Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56
	if negative enter zero) (Enter in column 5						
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			150, 204	١.,
	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 22	24 or 2E))			150, 304 28, 798	
	Travel allowance and expense - Offsite service			)		28, 748	1
00	Overtime allowance (from column 5, line 56)	.63 (110111 111163	77, 73, 01 70	)		Ö	
	Equipment cost (see instructions)					0	
00	Supplies (see instructions)					303	
	Total allowance (sum of lines 57-62)					179, 405	
	Total cost of outside supplier services (from	your records)				123, 371	
00	Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			0	65
	LINE 33 CALCULATION						
	Line 26 = line 24 for respiratory therapy or					28, 798	
1	Line 27 = line 7 times line 3 for respiratory	therapy or sum	of lines 3 a	nd 4 for all	others		100
). 02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					28, 798	1100
	Line 27 = line 7 times line 3 for respiratory	therany or sum	of lines 3 a	nd 4 for all	nthars	0	101
1 00	Line 31 = line 29 for respiratory therapy or				others		101
	Line of - Time 27 for respiratory therapy or	3um 01 111103 27	and 50 ron a	ii others			101
. 01	line $34 = \text{sum of lines } 27 \text{ and } 31$					U	1,0,
. 01	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						
. 01 . 02	LINE 35 CALCULATION	sum of lines 29	and 30 for a	II others		0	102
. 01					mns 1-3, line		102 102

Un Lieu of Form CMS-2552-10
Worksheet B
D1/2017 Part I
B1/2017 Date/Time Prepared:
5/29/2018 5:55 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS PERRY COUNTY HOSPITAL Peri od: From 01/01/2017 To 12/31/2017 Provider CCN: 15-1322 CAPITAL RELATED COSTS

	1. 00 2. 00 4. 00 5. 01 5. 02 7. 00
Col . 7)	2. 00 4. 00 5. 01 5. 02
0 1.00 2.00 4.00 4A    GENERAL SERVICE COST CENTERS	2. 00 4. 00 5. 01 5. 02
GENERAL SERVICE COST CENTERS   1.00   O0100   NEW CAP REL COSTS-BLDG & FIXT   2,825,212   2,825,212   1.	2. 00 4. 00 5. 01 5. 02
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 2, 825, 212 2, 825, 212 1.	2. 00 4. 00 5. 01 5. 02
	4. 00 5. 01 5. 02
2.00  00200 NEW CAP KEL COSTS-MVDLE EQUIP   1,105,409    1,105,409    2.	5. 01 5. 02
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5,192,943 13,329 5,592 5,211,864 4.	5. 02
	7. 00
	8. 00
	9. 00 10. 00
	11. 00
	13. 00
	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
	30.00
	31.00
	43.00
ANCI LLARY SERVI CE COST CENTERS	F0 00
	50.00
	52. 00 54. 00
	60.00
	62. 00
	65. 00
	66. 00
	67. 00
	68. 00
	71.00
72. 00   07200   I MPL. DEV. CHARGED TO PATIENT   89,838   0   0   0   89,838   72.	72.00
	73.00
OUTPATIENT SERVICE COST CENTERS	
	88. 00
	88. 01
	88. 02 88. 03
	90.00
	90. 00
	90. 02
	91. 00
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   92.	92.00
OTHER REIMBURSABLE COST CENTERS	
	95.00
101. 00 10100 HOME HEALTH AGENCY 749, 230 13, 559 5, 689 0 768, 478 101.	101. 00
SPECIAL PURPOSE COST CENTERS	
	113.00
116. 00   11600   HOSPI CE	
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   35, 140, 787  2, 793, 182  1, 171, 970  4, 735, 201  34, 618, 655   118. NONREI MBURSABLE COST CENTERS	10.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 32, 030 13, 439 0 45, 469 190.	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 231, 923 0 0 476, 663 1, 708, 586 192.	
192. 01 19201 MARKETI NG 0 0 0 0 192.	
200.00   Cross Foot Adjustments   0 200.	
201.00   Negative Cost Centers   0   0   0   201.	
202.00 TOTAL (sum lines 118 through 201) 36, 372, 710 2, 825, 212 1, 185, 409 5, 211, 864 36, 372, 710 202.	202.00

Provider CCN: 15-1322

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/29/2018 5:55 pm

						5/29/2018 5:5	5 pm
	Cost Center Description	ADMI NI STRATI VE	Subtotal	OTHER	OPERATION OF	LAUNDRY &	
		AND GENERAL		ADMI NI STRATI VE	PLANT	LINEN SERVICE	
				AND GENERAL			
		5. 01	5A. 01	5. 02	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 ADMINISTRATIVE AND GENERAL	2, 815, 815					5. 01
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL	287, 961	3, 719, 778	3, 719, 778			5. 02
7. 00	00700 OPERATION OF PLANT	156, 721	2, 024, 409				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	7, 904	102, 101		5, 573	120, 005	8. 00
9. 00	00900 HOUSEKEEPI NG	37, 563	485, 207				9. 00
10. 00	01000 DI ETARY	31, 817	410, 991		· ·	0	10.00
11. 00	01100 CAFETERI A	27, 770	358, 715		142, 100	0	11.00
					7 524		
13.00		45, 127	582, 922			0	13.00
16. 00		39, 263	507, 166	61, 249	41, 798	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.5 0.0	0.704 /40		407 470		
30.00		215, 343	2, 781, 642			40, 098	30.00
31. 00		43, 067	556, 303			1, 292	31.00
43.00		12, 201	157, 602	19, 033	20, 230	0	43. 00
	ANCI LLARY SERVI CE COST CENTERS			T.			
50. 00		94, 528	1, 221, 044		· ·	9, 576	50.00
52.00		16, 783	216, 791	26, 181	89, 308	0	52. 00
54.00		168, 665	2, 178, 689		· ·	12, 068	54.00
60.00		170, 406	2, 201, 176			422	60.00
62.00		9, 880	127, 625		0	0	62. 00
65.00		71, 867	928, 319		114, 470		65. 00
66.00	06600 PHYSI CAL THERAPY	46, 299	598, 054	72, 226	56, 288	2, 731	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	20, 902	269, 997	32, 607	24, 438	0	67.00
68.00	06800 SPEECH PATHOLOGY	11, 644	150, 410	18, 165	12, 846	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	56, 327	727, 591	87, 870	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	7, 538	97, 376	11, 760	0	0	72. 00
73.00		214, 005	2, 764, 361	333, 846		0	73. 00
	OUTPATIENT SERVICE COST CENTERS	.,	, , , , , ,		,		
88. 00		238, 379	3, 079, 204	371, 876	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	42, 589	550, 135				88. 01
88. 02		31, 747	410, 085				88. 02
88. 03		72, 578	937, 504			ő	88. 03
90. 00		73, 319	947, 080		125, 254	4, 967	90.00
90. 01	09001 PAIN MANAGEMENT	24, 932	322, 056			0	90. 01
90. 02		30, 800	397, 846		44, 083	0	90. 02
91. 00		195, 245	2, 522, 026			29, 736	91.00
92. 00		173, 243	2, 322, 020	304, 300	171, 071	27, 730	92.00
92.00	OTHER REIMBURSABLE COST CENTERS			1			72.00
05 00		100, 974	1, 304, 301	157, 518	125, 393	477	95. 00
95.00							101.00
101.0	0 10100 HOME HEALTH AGENCY	64, 485	832, 963	100, 595	16, 385	U	101.00
112 0	SPECIAL PURPOSE COST CENTERS			I			1112 00
	0 11300 I NTEREST EXPENSE						113.00
	0 11600 HOSPI CE	0	0	0	0		116.00
118. 0		2, 668, 629	34, 471, 469	3, 713, 826	2, 230, 188	120, 005	1118.00
400 -	NONREI MBURSABLE COST CENTERS			1		_	
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 815	49, 284	1			190. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	143, 371	1, 851, 957	0	0		192. 00
	1 19201 MARKETI NG	0	0	0 ا	0	0	192. 01
200. 0			0	1			200. 00
201. 0		0	0	0	0		201. 00
202. 0	0 TOTAL (sum lines 118 through 201)	2, 815, 815	36, 372, 710	3, 719, 778	2, 268, 893	120, 005	202. 00

Provider CCN: 15-1322

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/29/2018 5:55 pm

						5/29/2018 5:5	5 pm
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	
					ADMI NI STRATI ON	RECORDS &	
						LI BRARY	
		9. 00	10. 00	11. 00	13. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING	598, 382	1				9. 00
10.00	01000 DI ETARY	38, 220	641, 014				10.00
		30, 220	041, 014	402 024			ı
11. 00	01100 CAFETERI A	2 022	ĭ	402, 036			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 023	0	16, 886		(20, 214	13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	11, 237	0	17, 764	0	639, 214	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	109, 541	596, 302	101, 519		161, 801	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	23, 589	44, 712	10, 778	•	0	31. 00
43.00	04300 NURSERY	5, 439	0	0	0	7, 990	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	97, 856	0	26, 028	85, 572	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	24, 009	0	0	0	0	52. 00
54.00	05400   RADI OLOGY-DI AGNOSTI C	49, 531	0	52, 255	0	149, 816	54.00
60.00	06000 LABORATORY	20, 466	0	49, 900	0	115, 858	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	30, 773	o	29, 621	0	39, 951	65.00
66. 00	06600 PHYSI CAL THERAPY	15, 132	o	3, 154	0	15, 980	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	6, 570	o	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 453	ol	0	o	7, 990	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	0	O	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	o	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 289	o	6, 108	- 1	0	73. 00
70.00	OUTPATIENT SERVICE COST CENTERS	11,207		0, 100	<u>۷</u>		70.00
88. 00	08800 RURAL HEALTH CLINIC	0	O	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		0	0	0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC III		0	0		0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV		0	0	0	0	88. 03
90. 00	09000 CLINIC	33, 673	O O	17 2/5	57, 056	139, 828	90.00
			U	17, 365		•	1
90. 01	09001 PALN MANAGEMENT	3, 843	0	9, 341	0	0	90. 01
90. 02	09002 WOUND CARE	11, 851	0	10, 299		0	90. 02
91.00	09100 EMERGENCY	51, 367	0	51, 018	167, 799	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS			_			
	09500 AMBULANCE SERVICES	33, 710	0	0		0	95. 00
101.00	10100 HOME HEALTH AGENCY	4, 405	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	0	0	0		116. 00
118.00	122 2 2 (22 2 2 2 2 2 2 2 2 2 2 2 2 2 2	587, 977	641, 014	402, 036	679, 753	639, 214	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 405	0	0	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19201 MARKETI NG		o	0	O	0	192. 01
200.00	Cross Foot Adjustments		l				200. 00
201.00		0	ol	0	o	0	201. 00
202.00		598, 382	641, 014	402, 036	679, 753	639, 214	202. 00
			'		. '	-	•

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1322

COST CENTED DESCRIPTION   Subtotal   Intern & Total   S/29/2018 5: 55 pm						То	12/31/2017	Date/Time Pr	
STREAM SERVICE COST CENTERS		Cost Center Description	Subtotal	Intern &	Total			5/29/2018 5:	55 pm
Silve Stand		oost oontor boson peron			Total				
				& Post					
SINDERAL SERVICE COST CENTERS									
GINERAL SERVICE COST CENTERS									
1.00		CENEDAL CEDALCE COST CENTEDS	24. 00	25. 00	26. 00				
2.00	1 00					T			1 00
4.00									•
5.01   OSSAO ADMINISTRATIVE AND GENERAL     5.01   7.00   OSSAO OPTERA DMINISTRATIVE AND GENERAL     5.02   OSSAO OPTERA DMINISTRATIVE AND GENERAL     7.00   OSSAO OPTERA DMINISTRATION     7.00   OSSAO DELIVERY ROOM & LABOR ROOM   3.00   0.00   3.00   0.00		1 1							
7. 00   007000   DETART ON OF PLANT									•
8. 00	5.02	00590 OTHER ADMINISTRATIVE AND GENERAL							5. 02
9, 00 000000 HOUSEKEEPING		1							
10.00   01000   011ARY									1
11. 00   01100   CAPETERIA									1
13. 00   01300   MUSTRIN CADMINISTRATION   16.00   1000   MEDIOLA RECORDS & LIBRARY   16.00   1000   MEDIOLA RECORDS & LIBRARY   16.00   1000   MEDIOLA RECORDS & LIBRARY   17.00									1
16.00									1
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   31									1
31.00   03100   INTENSIVE CARE UNIT   827,095   0   827,095   31.00   A300   A300   A3600   A7500   CONTROL   CONT						_			
43.00   04300   NURSERY   210, 294   0   210, 294	30.00	03000 ADULTS & PEDI ATRI CS	4, 868, 142	0	4, 868, 1	42			30. 00
ANCILLARY SERVICE COST CENTERS   50.00				0					31. 00
50.00   050000   05000   05000   05000   050000   050000   050000   050000   050000   050000   0500000   05000000   0500000000	43. 00		210, 294	0	210, 2	94			43. 00
52.00   05.200   05	F0 00		4 054 540	ام	4 054 5	40			
54.00   05400   RADIOLOGY-DIAGNOSTIC   2, 889, 719   0   2, 889, 719   54.00   60.00   06000   LABORATORY   0   2, 729, 782   0   2, 729, 782   66.00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   143, 038   0   143, 038   62.00   65.00   06500   RESPI RATIORY THERAPY   1, 256, 784   0   1, 256, 784   65.00   66.00   06600   PHYSI CAL THERAPY   763, 565   0   763, 565   66.00   66.00   06600   PHYSI CAL THERAPY   333, 612   0   333, 612   67.00   67.00   06700   OCCUPATI ONAL THERAPY   333, 612   0   333, 612   67.00   68.00   06800   SPECEL PATHOLOGY   192, 864   0   192, 864   68.00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   815, 461   0   815, 461   71.00   72. 00   07300   DRUGS CHARGED TO PATIENTS   3, 157, 597   0   3, 157, 597   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   3, 157, 597   0   3, 157, 597   73.00   88.00   08800   RURAL HEALTH CLINIC   3, 451, 080   0   3, 451, 080   88.00   88.01   08801   RURAL HEALTH CLINIC   1   616, 574   0   616, 574   88.01   88.02   08803   RURAL HEALTH CLINIC   1   459, 610   0   459, 610   88.02   88.03   08803   RURAL HEALTH CLINIC   1   459, 610   0   459, 610   88.03   90.00   09000   CLINIC   1   459, 610   0   459, 610   90.00   90.01   09001   PAIN MANAGEMENT   388, 429   0   1, 439, 600   90.00   90.01   09000   CLINIC   2   4   4   4   4   4   4   4   4   4			l						
60.00   06000   LABORATORY   2,729,782   0   2,729,782   60.00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   143,038   0   143,038   62.00   65.00   06500   RESPIRATORY THERAPY   763,565   0   763,565   66.00   66.00   06600   PHYSI CAL THERAPY   763,565   0   763,565   66.00   66.00   06600   PHYSI CAL THERAPY   763,565   0   763,565   66.00   67.00   06700   OCCUPATI ONAL THERAPY   333,612   0   333,612   67.00   68.00   06800   SPECCH PATHOLOGY   192,864   0   192,864   68.00   67.00   07700   MEDICAL SUPPLIES CHARGED TO PATIENTS   815,461   0   815,461   71.00   77.00   07200   IMPL. DEV. CHARGED TO PATIENTS   3,157,597   0   3,157,597   72.00   77.00   07200   IMPL. DEV. CHARGED TO PATIENTS   3,157,597   0   3,157,597   72.00   77.00   07300   DRUGS CHARGED TO PATIENTS   3,157,597   0   3,157,597   72.00   88.01   08801   RURAL HEALTH CLINIC   3,451,080   0   3,451,080   88.00   88.01   08801   RURAL HEALTH CLINIC   1   459,610   0   459,610   88.02   88.02   08803   RURAL HEALTH CLINIC   1   459,610   0   459,610   88.03   88.02   08803   RURAL HEALTH CLINIC   1   505,724   0   1,050,724   88.03   88.02   08803   RURAL HEALTH CLINIC   1   459,610   0   459,610   88.02   88.03   08802   RURAL HEALTH CLINIC   1   505,724   0   1,050,724   88.03   89.00   09000   CLINIC   1   459,610   0   459,610   88.02   89.00   09000   CLINIC   5   5   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   99.00   09000   CLINIC   5   5   5   5   5   99.00   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   090			l						
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   1.43, 0.38   0   1.43, 0.38   0   65. 00   06500   RESPIRATORY THERAPY   1.256, 784   0   1.256, 784   65. 00   06600   PHYSI CAL THERAPY   7.63, 565   0   7.63, 565   66. 00   67. 00   06600   PHYSI CAL THERAPY   7.63, 565   0   7.63, 565   66. 00   68. 00   06600   SPECTH PATHOLOGY   192, 864   0   192, 864   68. 00   67. 00   07.00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   815, 461   0   815, 461   71. 00   72.00   10.00				-					
65. 00   06500   RESPIRATORY THERAPY   1, 256, 784   0   1, 256, 784   0   66. 00   066000   066000   066000   066000   066000   066000   066000   0660000   0660000   0660000				Ö					•
67. 00   06700   OCCUPATI ONAL THERAPY   333, 612   0   333, 612   0   68. 00   06800   OCCUPATI ONAL THERAPY   192, 864   0   192, 864   68. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   815, 461   0   815, 461   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   109, 136   0   109, 136   72. 00   07300   DRUGS CHARGED TO PATI ENT   109, 136   0   109, 136   72. 00   07300   DRUGS CHARGED TO PATI ENT   109, 136   0   109, 136   72. 00   07300   DRUGS CHARGED TO PATI ENT   109, 136   0   109, 136   72. 00   000TATI ENT   SERVI CE COST CENTERS   73. 00   000TATI ENT   SERVI CE COST CENTERS   88. 01   08801 RURAL HEALTH CLINI C   1   616, 574   0   616, 574   0   616, 574   88. 01   88. 02   88. 03   RURAL HEALTH CLINI C II   459, 610   0   459, 610   88. 02   88. 03   08802 RURAL HEALTH CLINI C IV   1, 050, 724   0   1, 050, 724   88. 03   08802 RURAL HEALTH CLINI C IV   1, 439, 600   0   1, 439, 600   90. 00   90000   CLINI C   1, 439, 600   0   1, 439, 600   90. 00   90000   CLINI C   1, 439, 600   0   388, 429   90. 01   90001 PAIN MANAGEMENT   388, 429   0   388, 429   90. 01   9001 PAIN MANAGEMENT   388, 429   0   388, 429   90. 01   9000   09100   EMERGENCY   3, 317, 597   0   3, 317, 597   91. 00   92. 00   09200   0SERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0			1	O					•
68.00   06800   SPECH PATHOLOGY   192,864   0   192,864   71.00   771.00	66.00	06600 PHYSI CAL THERAPY	763, 565	0	763, 5	65			66. 00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   815, 461   0   815, 461   72. 00   7			i i	0					
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   109, 136   0   109, 136   72. 00   73. 00   07300   DRIGS CHARGED TO PATIENTS   3, 157, 597   0   3, 157, 597				-					
73. 00   07300   DRUGS CHARGED TO PATIENTS   3, 157, 597   0   3, 157, 597   0   3, 157, 597   0   0   0   0   0   0   0   0   0				-					1
SECOND   SUBSTITUTE   SERVICE COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SERVICE   COST CENTERS   SUBSTITUTE   SERVICE   S			i i						1
88. 00	73.00		3, 137, 347	U	3, 137, 3	7/			73.00
88. 01 08801 RURAL HEALTH CLINIC III 616, 574 0 616, 574 88. 02 08803 RURAL HEALTH CLINIC III 459, 610 0 459, 610 88. 03 8803 RURAL HEALTH CLINIC III 459, 610 0 459, 610 88. 03 880. 09000 09000 CLINIC 1, 050, 724 0 1, 050, 724 88. 03 90. 00 09000 CLINIC 1, 439, 600 0 1, 439, 600 90. 00 90. 00 90. 01 09001 PAIN MANAGEMENT 388, 429 0 388, 429 90. 01 90. 01 90. 01 90. 00 90	88. 00		3, 451, 080	0	3, 451, 0	80			88. 00
88. 03		1	l	0					
90. 00   09000   CLINIC   1, 439, 600   0   1, 439, 600   90. 00	88. 02	08803 RURAL HEALTH CLINIC III	459, 610	0	459, 6	10			88. 02
90. 01				0					
90. 02		1		0					
91. 00		1	l	0					
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0				-					
OTHER REI MBURSABLE COST CENTERS   95.00   09500   AMBULANCE SERVI CES   1,621,399   0   1,621,399   95.00   101.00   HOME HEALTH AGENCY   954,348   0   954,348   0   954,348   101.00   SPECI AL PURPOSE COST CENTERS   113.00   INTEREST EXPENSE   113.00   11600   HOSPI CE   0   0   0   0   116.00   118.00   SUBTOTALS (SUM OF LI NES 1 through 117)   34,416,407   0   34,416,407   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   104,346   0   104,346   190.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   1,851,957   0   1,851,957   192.00   19201   MARKETI NG   0   0   0   192.01   200.00   Cross Foot Adj ustments   0   0   0   0   201.00   100.00   Negati ve Cost Centers   0   0   0   0   201.00   100.00			3, 317, 377	-	3, 317, 3	7 /			
95. 00	72.00			<u> </u>					72.00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	95. 00		1, 621, 399	0	1, 621, 3	99			95. 00
113. 00	101.00	10100 HOME HEALTH AGENCY	954, 348	0	954, 3	48			101. 00
116. 00		SPECIAL PURPOSE COST CENTERS							
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   34,416,407   0   34,416,407   0   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   104,346   0   104,346   190.00   192.00   19200   19200   19200   19201   19201   MARKETING   0   0   0   192.01   19201			_	_					
NONRET MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   104,346   0   104,346   190.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   1,851,957   0   1,851,957   192.00   192.01   19201   MARKETI NG   0   0   0   0   192.01   200.00   Cross Foot Adjustments   0   0   0   0   200.00   201.00   Negative Cost Centers   0   0   0   0   201.00			I - I						
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   104, 346   0   104, 346   190. 00   192. 00   19200   19200   19201	118.00		34, 416, 407	0	34, 416, 4	0/			118.00
192.00     19200     PHYSI CI ANS' PRI VATE OFFI CES     1,851,957     0     1,851,957     192.00       192.01     19201     MARKETI NG     0     0     0     192.01       200.00     Cross Foot Adjustments     0     0     0     200.00       201.00     Negative Cost Centers     0     0     0     201.00	190 00		104 346	n	104 3	46			190 00
192. 01     19201     MARKETI NG     0     0     0     192. 01       200. 00     Cross Foot Adjustments     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0		1 1	1	o					•
200.00       Cross Foot Adjustments       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0			O		, , -				
			o	o		0			200. 00
202.00   TOTAL (sum lines 118 through 201)   36,372,710  0  36,372,710   202.00			0			-			•
	202.00		36, 372, 710	0	36, 372, 7	10			J202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Prepa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322

				10	12/31/201/	5/29/2018 5:5	
			CAPI TAL REI	LATED COSTS		3/2//2010 3.3	J pill
			07.11 7.712 7.12.1	271728 00010			
(	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FLXT	EQUI P		BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2.00	2A	4. 00	
	L SERVICE COST CENTERS						
	NEW CAP REL COSTS-BLDG & FIXT						1. 00
	NEW CAP REL COSTS-MVBLE EQUIP	_					2. 00
	EMPLOYEE BENEFITS DEPARTMENT	0	13, 329		18, 921	18, 921	4. 00
	ADMINISTRATIVE AND GENERAL	0	219, 829		312, 065		5. 01
	OTHER ADMINISTRATIVE AND GENERAL	0	173, 940		246, 922		5. 02
	OPERATION OF PLANT	0	540, 495		767, 280		7. 00
	_AUNDRY & LINEN SERVICE	0	4, 612		6, 547	2	8. 00
	HOUSEKEEPI NG	0	31, 015		44, 029		9. 00
	DIETARY	0	117, 651		167, 015		10.00
	CAFETERI A	0	0	-	0	0	11.00
	NURSING ADMINISTRATION	0	6, 226		8, 838		13.00
	MEDICAL RECORDS & LIBRARY	0	34, 590	14, 513	49, 103	296	16. 00
	ENT ROUTINE SERVICE COST CENTERS		227 202	141, 484	470 (07	2 112	20.00
	ADULTS & PEDIATRICS NTENSIVE CARE UNIT	0	337, 203		478, 687	2, 112	30.00
1 1		0	72, 615		103, 083		31.00
		l U	16, 741	7, 024	23, 765	132	43. 00
	ARY SERVICE COST CENTERS DEFRATING ROOM	0	301, 230	126, 391	427, 621	648	50. 00
	DELIVERY ROOM & LABOR ROOM	0	73, 907		104, 917		52. 00
	RADI OLOGY-DI AGNOSTI C	0	152, 471		216, 445		54. 00
	_ABORATORY	0	62, 999		89, 432		60.00
	VHOLE BLOOD & PACKED RED BLOOD CELLS		02, 999		07, 432		62. 00
	RESPI RATORY THERAPY		94, 729	-	134, 476		65. 00
	PHYSI CAL THERAPY		46, 581		66, 125		66. 00
	OCCUPATI ONAL THERAPY		20, 223		28, 708	0	67. 00
	SPEECH PATHOLOGY		10, 631		15, 091	Ö	68. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0,001		0	_	71. 00
	MPL. DEV. CHARGED TO PATIENT	0	0	- 1	0	0	72. 00
	DRUGS CHARGED TO PATIENTS	0	34, 751	-	49, 332	116	73. 00
	IENT SERVICE COST CENTERS	-1		,	,		
	RURAL HEALTH CLINIC	0	0	0	0	2, 610	88. 00
	RURAL HEALTH CLINIC II	o	0	0	0	379	88. 01
	RURAL HEALTH CLINIC III	o	0	О	0	296	88. 02
	RURAL HEALTH CLINIC IV	o	0	0	0	820	88. 03
90.00 09000 0	CLI NI C	o	103, 654	43, 491	147, 145	471	90. 00
90. 01 09001 F	PAIN MANAGEMENT	o	11, 830	4, 964	16, 794	177	90. 01
90. 02 09002 V	VOUND CARE	o	36, 481	15, 307	51, 788	414	90. 02
91. 00 09100 E	EMERGENCY	o	158, 121	66, 345	224, 466	1, 221	91.00
92.00 09200 0	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER I	REIMBURSABLE COST CENTERS						
95. 00 09500 A	AMBULANCE SERVICES	0	103, 769	43, 540	147, 309		95. 00
	HOME HEALTH AGENCY	0	13, 559	5, 689	19, 248	0	101. 00
SPECI AI	L PURPOSE COST CENTERS						
1 1	NTEREST EXPENSE						113. 00
116. 00 11600 H		0	0	0	0		116. 00
	SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 793, 182	1, 171, 970	3, 965, 152	17, 190	118. 00
	MBURSABLE COST CENTERS	1		1			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32, 030	13, 439	45, 469		190. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
192. 01 19201 N		0	0	0	0		192. 01
	Cross Foot Adjustments				0		200. 00
	Negative Cost Centers	_	0 225 5:5	0	0		201. 00
202. 00	ΓΟΤΑL (sum lines 118 through 201)	0	2, 825, 212	1, 185, 409	4, 010, 621	18, 921	1202.00

| Peri od: | Worksheet B | From 01/01/2017 | Part | I | To 12/31/2017 | Date/Time Prepared: | From 01/01/2017 | Part | I | Prepared: | Pre Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322

				10	o 12/31/2017	Date/lime Pre 5/29/2018 5:5	
	Cost Center Description	ADMI NI STRATI VE	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	J pill
	out contain baseling than		ADMI NI STRATI VE		LINEN SERVICE	11000ENEEL 1110	
			AND GENERAL				
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00540 ADMINISTRATIVE AND GENERAL	312, 825					5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	32, 001	280, 818				5. 02
7.00	00700 OPERATION OF PLANT	17, 411	18, 457	803, 541			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	878	931	1, 974	10, 332		8. 00
9.00	00900 HOUSEKEEPI NG	4, 173	4, 424	13, 273	1, 472	67, 747	9. 00
10.00	01000 DI ETARY	3, 535	3, 747		0	4, 327	10.00
11. 00	01100  CAFETERI A	3, 085	3, 270	0	0		11. 00
13.00	01300 NURSING ADMINISTRATION	5, 013			0	229	
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 362	4, 624	14, 803	0	1, 272	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	23, 923			3, 453	12, 401	30. 00
31. 00	03100 INTENSIVE CARE UNIT	4, 784	5, 072		111	2, 671	31. 00
43. 00	04300 NURSERY	1, 355	1, 437	7, 165	0	616	43. 00
	ANCILLARY SERVICE COST CENTERS						1
50. 00	05000 OPERATING ROOM	10, 501	11, 132		824	11, 079	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 864	1, 976		0	2, 718	
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 737	19, 863		1, 039	· ·	
60.00	06000 LABORATORY	18, 931	20, 068		36	· ·	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 098	1		0		62. 00
65. 00	06500 RESPI RATORY THERAPY	7, 984	8, 463		133	· ·	
66. 00	06600 PHYSI CAL THERAPY	5, 143	5, 452		235	1, 713	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 322	2, 462		0		
68. 00	06800 SPEECH PATHOLOGY	1, 294			0		68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 258			-		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	837	888		-		
73. 00	07300 DRUGS CHARGED TO PATIENTS	23, 774	25, 203	14, 872	0	1, 278	73. 00
	OUTPATIENT SERVICE COST CENTERS	0, 100					
88. 00	08800 RURAL HEALTH CLINIC	26, 482	28, 080		-		
88. 01	08801 RURAL HEALTH CLINIC II	4, 731	5, 016		-		
88. 02	08803 RURAL HEALTH CLINIC III	3, 527	3, 739		_	-	
88. 03	08802 RURAL HEALTH CLINIC IV	8, 063	8, 547		0	0	
90.00	09000 CLINIC	8, 145			428		
90. 01	09001 PAIN MANAGEMENT	2, 770			0		
90. 02	09002 WOUND CARE	3, 422	3, 627		0	.,	
91. 00 92. 00	09100 EMERGENCY	21, 690	22, 993	67, 669	2, 560	5, 816	
92.00	O9200   OBSERVATI ON BEDS (NON-DI STINCT PART)   OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	11, 217	11, 891	44, 409	11	3, 817	95. 00
	10100 HOME HEALTH AGENCY						101. 00
101.00	SPECIAL PURPOSE COST CENTERS	7, 164	7, 594	5, 803	U	499	1101.00
112 00	11300 INTEREST EXPENSE						113. 00
	111600 HOSPI CE		0	0	0	0	116. 00
118.00		296, 474	-	_	10, 332		118. 00
110.00	NONREI MBURSABLE COST CENTERS	270,474	200, 309	707,034	10, 332	00, 309	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	424	449	13, 707	0	1 170	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15, 927	1 449		_		190.00
	19201 MARKETING	15, 927		_	0		192. 00
200.00			١	1	U		200. 00
200.00				_	0	_	200.00
201.00	1 13	312, 825	280, 818	803, 541	10, 332		201.00
202.00	TOTAL (Sum TITIES TTO CHILDUYH 201)	312,023	200,010	1 003, 341	10, 332	07,747	1202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Prepa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322

				10	12/31/2017	5/29/2018 5:5	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	
	·			ADMI NI STRATI ON	RECORDS &		
					LI BRARY		
		10.00	11. 00	13. 00	16. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00540 ADMINISTRATIVE AND GENERAL						5. 01
	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 02
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY	228, 974					10.00
	01100 CAFETERI A	0	6, 355	1			11. 00
	01300 NURSI NG ADMINI STRATI ON	0	267				13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	281	0	74, 741		16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	040.000	4 (05	44.040	40.040	005 040	
	03000 ADULTS & PEDIATRICS	213, 003	1, 605		18, 919	935, 013	
	03100 INTENSIVE CARE UNIT	15, 971	170		0	164, 435	
43. 00	04300 NURSERY	0	0	0	934	35, 404	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS		411	2 000	٥	F04 012	F0 00
	05000 OPERATING ROOM	0	411		0	594, 012	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		17 517	143, 207	1
	05400  RADI OLOGY-DI AGNOSTI C 06000  LABORATORY	0	826 789		17, 517	346, 613	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	789	1	13, 547 0	173, 047 2, 278	
	06500 RESPI RATORY THERAPY	0	468		4, 671	2, 278 200, 926	
	06600 PHYSI CAL THERAPY	0	50		1, 869	100, 560	
	06700 OCCUPATI ONAL THERAPY	0	0		1, 809	42, 891	67. 00
	06800 SPEECH PATHOLOGY		0		934	23, 630	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	12, 937	
	07200 IMPL. DEV. CHARGED TO PATIENT		0		o	1, 725	1
	07300 DRUGS CHARGED TO PATIENTS		97		o	114, 672	•
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	114,072	73.00
	08800 RURAL HEALTH CLINIC	0	0	0	0	57, 172	88. 00
	08801 RURAL HEALTH CLINIC II	ا	0	_	0	10, 126	1
	08803 RURAL HEALTH CLINIC III	o o	0	_	0	7, 562	
	08802 RURAL HEALTH CLINIC IV	o	0	o o	0	17, 430	
	09000 CLINI C	o	274	1, 922	16, 350	231, 541	90.00
	09001 PALN MANAGEMENT	o	148		0	28, 323	
	09002 WOUND CARE	o	163	1	0	76, 368	1
91. 00	09100 EMERGENCY	o	806		0	352, 872	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS				•		1
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	218, 684	95. 00
101.00	10100 HOME HEALTH AGENCY	o	0	0	0	40, 308	101.00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 I NTEREST EXPENSE						113. 00
116. 00	11600 HOSPI CE	0	0	0	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	228, 974	6, 355	22, 893	74, 741	3, 931, 736	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 00
	19201 MARKETI NG	0	0	0	0		192. 01
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)	228, 974	6, 355	22, 893	74, 741	4, 010, 621	202. 00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322 Peri od: Worksheet B From 01/01/2017 Part II 12/31/2017 Date/Time Prepared: 5/29/2018 5:55 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMINISTRATIVE AND GENERAL 5. 01 5.01 00590 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 935, 013 30.00 03100 INTENSIVE CARE UNIT 0 31.00 164, 435 31.00 04300 NURSERY 0 43.00 43 00 35, 404 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 594, 012 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000 143, 207 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54 00 346, 613 06000 LABORATORY 60.00 173, 047 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 278 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 200, 926 65.00 06600 PHYSI CAL THERAPY 100, 560 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 42, 891 67.00 06800 SPEECH PATHOLOGY 23, 630 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 12, 937 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 1, 725 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 114, 672 73.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 57, 172 88. 00 |08801|RURAL HEALTH CLINIC II 88. 01 10, 126 88 01 88.02 08803 RURAL HEALTH CLINIC III 000000 7, 562 88.02 08802 RURAL HEALTH CLINIC IV 88. 03 17, 430 88.03 09000 CLI NI C 90.00 231, 541 90.00 09001 PAIN MANAGEMENT 90.01 28, 323 90.01 90.02 09002 WOUND CARE 76, 368 90.02 91.00 09100 EMERGENCY 352, 872 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 218, 684 95.00 101.00 10100 HOME HEALTH AGENCY 101. 00 0 40, 308 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 Ω 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 931, 736 0 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 61, 227 00000

17, 658

4, 010, 621

Ω

0

192. 00

192, 01

200.00

201. 00 202. 00

192.00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

192. 01 19201 MARKETI NG

200.00

201.00

202.00

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1322 Period: Worksheet B-1

Provider CCN: 15-1322 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/29/2018 5:55 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE FIXT **FOULP** BENEFITS AND GENERAL (SQUARE (SOUARE DEPARTMENT (ACCUM. COST) FEET) FEET) (GROSS SALARI ES) 1.00 2.00 5A. 01 5. 01 4.00 GENERAL SERVICE COST CENTERS 122 517 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 122, 517 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 578 578 12, 184, 394 4.00 00540 ADMINISTRATIVE AND GENERAL 9. 533 5 01 9 533 489, 647 -2, 815, 815 33, 556, 895 5 01 5.02 00590 OTHER ADMINISTRATIVE AND GENERAL 7,543 7, 543 1, 220, 186 3, 431, 817 5.02 1, 867, 688 7.00 00700 OPERATION OF PLANT 23, 439 23, 439 252, 872 7.00 0 8.00 00800 LAUNDRY & LINEN SERVICE 200 200 989 94, 197 8.00 00900 HOUSEKEEPI NG 447, 644 9 00 242, 158 9 00 1.345 1.345 10.00 01000 DI ETARY 5, 102 5, 102 C 0 379, 174 10.00 01100 CAFETERI A 0 11.00 C 330, 945 11.00 01300 NURSING ADMINISTRATION 270 270 365, 227 0 537, 795 13.00 13.00 01600 MEDICAL RECORDS & LIBRARY 190, 394 467<u>,</u> 903 16.00 1,500 1,500 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 14,623 14, 623 1, 359, 947 2, 566, 299 30.00 03100 INTENSIVE CARE UNIT 3, 149 3, 149 513, 236 31.00 194, 383 0 31.00 43.00 04300 NURSERY 726 726 85, 194 0 145, 401 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13, 063 13, 063 417, 118 0 1, 126, 516 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 3.205 3, 205 200,008 52.00 66, 602 54.00 05400 RADI OLOGY-DI AGNOSTI C 6,612 6,612 854, 732 2, 010, 024 54 00 621, 786 06000 LABORATORY 2, 030, 770 60.00 2,732 2,732 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 10, 348 117, 745 62.00 06500 RESPIRATORY THERAPY 4 108 4.108 455, 430 856, 452 65.00 65.00 66.00 0 06600 PHYSI CAL THERAPY 2,020 2,020 24, 760 551, 755 66.00 06700 OCCUPATIONAL THERAPY 67.00 877 877 0 249, 095 67.00 68.00 06800 SPEECH PATHOLOGY 461 0 138, 766 68.00 461 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 C 29, 372 671, 264 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 89, 838 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,507 1, 507 74, 607 2, 550, 356 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 1, 681, 580 0 2, 840, 825 88.00 08801 RURAL HEALTH CLINIC II 0 244, 073 507, 546 88.01 0 0 88.01 08803 RURAL HEALTH CLINIC III 0 190, 888 378, 338 88.02 88.02 0 08802 RURAL HEALTH CLINIC IV 527, 976 864, 926 88.03 0 88 03 90.00 09000 CLI NI C 4, 495 4, 495 303, 290 0 873, 761 90.00 90.01 09001 PAIN MANAGEMENT 513 513 113, 777 0 297, 124 90.01 o 09002 WOUND CARE 90 02 1 582 1 582 266 431 367, 046 90 02 91.00 09100 EMERGENCY 6,857 6,857 786, 276 0 2, 326, 781 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 4, 500 1, 203, 327 95 00 09500 AMBULANCE SERVICES 4 500 0 95 00 0 101.00 10100 HOME HEALTH AGENCY 588 588 0 0 768, 478 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 121, 128 121, 128 11, 070, 043 -2, 815, 815 31, 802, 840 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 389 45, 469 190. 00 1. 389 1, 114, 351 1, 708, 586 192. 00 C 0 192. 01 19201 MARKETI NG 0 0 192. 01 200.00 Cross Foot Adjustments 200 00 201 00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 2, 825, 212 1, 185, 409 5, 211, 864 2, 815, 815 202. 00 Part I) 0. 427749 0. 083912 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 23. 059755 9.675465 Cost to be allocated (per Wkst. B, 204.00 18, 921 312, 825 204, 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001553 0.009322 205.00 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)

COST Content Description  Record Hallor  FEED 1/19/19/2017  COST Content Description  Record Hallor  FEED 1/19/19/2017  COST Content Description  FEED 1/19/19/2017  COST COST COST COST COST COST COST COST		LLOCATION - STATISTICAL BASIS	TERRIT GOORT	Provi der C	CN: 15-1322 P	eri od:	Worksheet B-1	
Cost Center Description					<del> </del>	rom 01/01/2017 o 12/31/2017	Date/Time Pre	pared:
ADMINISTRATIVE   MAD CARPED   SERVICE COST CENTERS   SA. 02   S. 0.2   S. 0.0		Cook Cooker December 1	D:   ! -+:	OTHER	ODEDATION OF		5/29/2018 5:5	
AND CENERAL   CROWNERS   FEET)   CAUMAND   FEET)   CAUMAND   FEET)   CAUMAND   CROWNERS   FEET)   CAUMAND   CAUMAND   CROWNERS   C		cost center bescription	Reconciliation					
No repr								
GAN BALL SLINVICE COST CENTERS   1.000   1.0					FEET)	LAUNDRY)		
SERIENAL SERVICE COST CENTERS   1.00   0.000			5Δ Ω2		7 00	8 00	9 00	
0.00   0.0100   NEW CAP PEL COSTS-BUD & FIXT		GENERAL SERVICE COST CENTERS	JA. 02	3.02	7.00	0.00	7.00	
4.00   0.0400   DIANOVER BRIFETTS DEPARTMENT   5.01   0.0540   0.0540   MINI STRATIVE AND GENERAL   -3,719,778   30,800,975   5.02   0.0540   DIANOVER & 1.0540   5.01   5.02		00100 NEW CAP REL COSTS-BLDG & FIXT						
5.01   0.0540  ADMINISTRATIVE AND GENERAL   -3,719,778   30,800,975     5.02   0.0550  OTERS ADMINISTRATIVE AND GENERAL   -3,719,778   2,024,407   81,424   1.000   13,009   16,000   10,000   1								
5.02   0.0590   OTHER ADMINISTRATIVE AND GENERAL   -2,719,778   30,800,975   7.00   0.0700   OPERATION OF PLANT   0.0000   0.0201   0.0101   0.0201   13,090   8.00   7.00   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000000   0.00000000								
0.00   0.0700   OPERATION OF PLANT   0   2,024,409   81,424   7,00   9,00   0.0000   0.000   0.000   0.000   0.0000   0.0000   0.0000   0.00			-3, 719, 778	30, 800, 975				
9.00   0.9900   MUSERKEPING   0   449, 207   1,345   1,866   79,879   9,00   11.00   0.1000   OETARY   0   410,991   5,102   0   0   0   11.00   0.1000   OETARY   0   388,715   0   0   0   11.00   13.00   13300   MESING ARMINISTRATION   0   582,792   270   0   270   13.00   13.00   0.00   0.000   OETARY   0   507,166   1.500   1.500   1.500   16.00   0.000   OETARY   0   0   0   0   0   0   0   11.00   0.000   OETARY   0   0   0   0   0   0   13.00   0.000   OETARY   0   0   0   0   0   0   13.00   0.000   OETARY   0   0   0   0   0   0   13.00   0.000   OETARY   0   0   0   0   0   0   13.00   0.000   OETARY   0   0   0   0   0   0   13.00   0.000   OETARY   0   0   0   0   0   0   13.00   0.000   OETARY   0   0   0   0   0   0   0   14.00   0.000   OETARY   0   0   0   0   0   0   15.00   OETARY   0   0   0   0   0   0   0   0   0   15.00   OETARY   0   0   0   0   0   0   0   0   0								
10.00   1000   DIETARY   0   4110, 991   5, 102   0   5, 102   10, 100   1			0	1	1			ł
11.00 0 1100 (DAFFTER) A 0 588,715 0 0 0 1 11.00 16.00 16.00 UNISING ADMINISTRATION 0 582,922 270 0 1.500 16.00 16.00 UNISING ADMINISTRATION 0 582,922 270 0 1.500 16.00 16.00 UNISING ADMINISTRATION 0 582,922 270 0 1.500 16.00 16.00 UNISING ADMINISTRATION 0 582,922 270 0 1.500 16.00 UNISING ADMINISTRATION 0 582,030 3.149 14.023 3.00 13.00 03100 UNISING ADMINISTRATION 0 582,030 3.149 14.023 3.00 0300 ADMINISTRATION 0 582,030 3.149 14.023 3.00 0300 ADMINISTRATION 0 582,030 3.149 14.03 1.00 3100 ADMINISTRATION 0 582,030 3.149 14.00 3.140 ADMINISTRATION 0 582,030 3.149 14.00 ADMINISTRATION 0 582,030 3.200 ADMINISTRATION 0 582,030 3.200 ADMINISTRATION O 582,030 3.200 ADMINISTRATION O 582,030 3.200 ADMINISTRATION O 582,030 ADMINIS			0					ł
13.00   01300   MURSING ADMINISTRATION   0   562,922   270   0   270   13.00			0					
0   0600   MEDICAL RECORDS & LIBRARY   0   507, 166   1,500   0   1,500   16,00			0					ı
0.000   0.0000   ADULTS & PEDIATRICS   0   2,781,642   14,623   4,376   14,623   30.00   30.00   0.100   INTENSIVE CARE INIT   0   556,305   3,149   141   3,149   31.00   30.00   0.4300   NURSERY   0   157,607   726   43.00   726   43.00   726   43.00   726   43.00   726   43.00   726   43.00   726   72								ı
31.00   03100   NITENSIVE CARE LIMIT   0   556, 302   3, 149   141   3, 149   31.00   AUGUSTERY   0   157, 602   776   0   776   43.00   AUGUSTERY   0   157, 602   776   0   776   43.00   AUGUSTERY   0   157, 604   13.003   1, 045   13.003   50.00   50.00   5000   OPERATI NG ROM   0   1, 221, 044   13.003   1, 045   13.003   50.00   50.00   5000   OPERATI NG ROM   0   216, 791   3.205   0   3.205   50.00   50.00   OSCORO DEFLATERY ROWS & LABOR ROWS   0   2, 178, 689   6, 612   1, 317   6, 617   54.00   0.0								
A3 DO   A3200 NURSERY   DI   T57, 602   726   DI   726   43, DO   NORTHERN   T50, DO   DECONO   PAPELLARY SERVICE COST CENTERS								1
ANCILLARY SERVICE COST CENTERS					· ·			
50,00   05000   0FEATI NG ROOM   0   1,221,044   13,063   1,045   13,063   50,00   54,00   0500   0ELIVERY ROOM & LABOR ROOM   0   21,718,689   6,612   1,317   6,612   54,00   62,00   05400   RADIOLOGY-DIAGNOSTI C   0   2,178,689   6,612   1,317   6,612   54,00   62,00   05400   RADIOLOGY-DIAGNOSTI C   0   2,178,689   6,612   1,377   6,612   54,00   62,00   05200   RADIOLOGY-DIAGNOSTI C   0   127,025   0   0   0   0,62,00   66,00   05200   RADIOLOGY-DIAGNOSTI C   0   127,025   0   0   0   0,62,00   66,00   05200   RADIOLOGY-DIAGNOSTI C   0   127,025   0   0   0   0   0,62,00   66,00   06600   PHYSICAL THERAPY   0   598,054   2,020   298   2,020   66,00   06600   PHYSICAL THERAPY   0   598,054   2,020   298   2,020   66,00   06600   PHYSICAL THERAPY   0   598,054   2,020   298   2,020   66,00   0   0   0   0   0   0   0   0   0	43.00			157,602	.] /20	l o	720	43.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   216, 791   3, 205   0   3, 205   52.00	50.00		0	1, 221, 044	13, 063	1, 045	13, 063	50.00
60 00   06000   LABDRATORY   0   2, 201, 176   2, 732   46   2, 732   60, 00   65 00   06500   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   127, 625   0   0   0   06, 62, 00   06500   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   127, 625   0   0   0   0, 62, 00   06500   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   127, 625   0   0   0   0   0, 62, 00   06500   WHOLE BLOOD & PATICAL THERAPY   0   288, 319   4, 108   168   4, 108   65, 00   06, 00   06000   PHYSICAL THERAPY   0   269, 997   877   0   877   67, 00   0710, 00   0710, 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   727, 591   0   0   0   0   0   0710, 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   2, 764, 361   1, 507   0   0   0   72, 500   07300   DRUGS CHARGED TO PATIENTS   0   2, 764, 361   1, 507   0   0   1, 507   73, 00   07300   DRUGS CHARGED TO PATIENTS   0   3, 079, 204   0   0   0   0   88, 00   08800   RUBAL HEALTH CLINIC   1   0   410, 695   0   0   0   88, 00   08800   RUBAL HEALTH CLINIC   1   0   410, 695   0   0   0   88, 02   08803   RUBAL HEALTH CLINIC   1   0   470, 695   0   0   0   88, 02   08803   RUBAL HEALTH CLINIC   1   0   470, 695   0   0   0   88, 02   08803   RUBAL HEALTH CLINIC   1   0   470, 695   0   0   0   88, 02   08803   RUBAL HEALTH CLINIC   1   0   470, 695   0   0   0   88, 02   08900   RUBAL HEALTH CLINIC   1   0   470, 695   0   0   0   0   88, 02   09000   DRINING MEMBERS   1   08900   1   09001   PAIN MANAGEMENT   0   322, 056   513   0   0   1, 589   90, 00   0   0   0   0   0   0   0   0			0			0	3, 205	52. 00
Color   Colo			0					
65 00   06500   RESPIRATORY THERAPY   0   928, 319   4, 108   168   4, 108   65. 00   66. 00   06600   PMYSICAL THERAPY   0   259, 997   877   0   877   67. 00   67. 00   06700   05700   0			0		1		•	1
66.00   06600   PHYSICAL THERAPY   0   598, 054   2,020   298   2,020   66.00   67.00   06700   0710			0		1		-	•
67 00   0670			0					
17.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   727, 591   0   0   0   0   0   0   0   0   0			0					1
17.00   OZDO   IMPL DEV. CHARGED TO PATIENT   0   97, 376   1,507   0   1,507   73.00			0					
173.00   O300   DRIUGS CHARGED TO PATIENTS   0   2,764,361   1,507   0   1,507   73.00			_		•		-	
OUTPATI ENT SERVICE COST CENTERS				1	1			1
88. 01   08801 RURAL HEALTH CLINIC II   0   550, 135   0   0   0   0   88. 01   88. 02   08802 RURAL HEALTH CLINIC II   0   410, 085   0   0   0   0   88. 02   88. 03   08802 RURAL HEALTH CLINIC IV   0   937, 504   0   0   0   0   88. 03   90. 00   09000 CLINIC   0   947, 080   4, 495   542   4, 495   90. 00   90. 01   09001 PAIN MANAGEMENT   0   322, 056   513   0   513   90. 01   90. 02   09002 WOUND CARE   0   397, 846   1, 582   0   1, 582   90. 02   91. 00   09100 EMERGENCY   0   2, 522, 026   6, 857   3, 245   6, 857   91. 00   92. 00   09200 DESERVATION BEDS (NON-DISTINCT PART)   92. 00   92. 00   09200 DESERVATION BEDS (NON-DISTINCT PART)   92. 00   93. 00   0900 AMBULANCE SERVI CES   0   1, 304, 301   4, 500   52   4, 500   95. 00   09500 AMBULANCE SERVI CES   0   832, 963   588   0   588   95. 00   09500 AMBULANCE SERVI CES   0   832, 963   588   0   588   95. 00   09500 AMBULANCE SERVI CES   0   16, 600   97. 00   1000   HORE HEALTH AGENCY   0   832, 963   588   0   588   95. 00   09500 AMBULANCE SERVI CES   0   0   0   0   0   97. 00   1000   HORE HEALTH AGENCY   0   832, 963   588   0   588   95. 00   00   0   0   0   0   0   97. 00   1000   HOSPIC CES   0   0   0   0   0   0   97. 00   1000   HOSPIC CES   0   0   0   0   0   98. 00   00   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   0   0   99. 00   1000   HOSPIC CES   0   0   0   0   0   0   0   99. 00   1000   1000   1000   1000   1000   1000   1000   1000   1000   1000   1	73.00			2,704,301	1, 307	<u> </u>	1, 507	73.00
88. 02 08803 RURAL HEALTH CLINIC III 0 410,085 0 0 0 88. 03 98.00 08002 RURAL HEALTH CLINIC IV 0 0 937,504 0 0 0 0 88. 03 90. 00 09000 CLINIC 0 0 947,080 4,495 542 4,495 90. 00 90. 01 09001 PAIN MANAGEMENT 0 322,056 513 0 513 90. 01 90. 02 09002 WOUND CARE 0 0 397,846 1,582 0 1,582 90. 02 91. 00 09100 EMERGENCY 0 2,522,026 6,857 3,245 6,857 91. 00 97. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 2,522,026 6,857 3,245 6,857 91. 00 97. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 2,522,026 6,857 3,245 6,857 91. 00 97. 00 09500 AMBULANCE SERVICES 0 1,304,301 4,500 52 4,500 95.00 97. 00 09500 AMBULANCE SERVICES 0 1,304,301 4,500 52 4,500 95.00 98. 00 09500 AMBULANCE SERVICES 0 832,963 588 0 588 10. 00 98. 00 09500 AMBULANCE SERVICES 0 832,963 588 0 588 10. 00 98. 00 09500 AMBULANCE SERVICES 0 1,304,301 4,500 52 4,500 95.00 99. 00 09500 AMBULANCE SERVICES 0 832,963 588 0 588 10. 00 99. 00 09500 AMBULANCE SERVICES 0 1,304,301 4,500 52 4,500 95.00 99. 00 09500 AMBULANCE SERVICES 0 832,963 588 0 588 10. 00 99. 00 09500 AMBULANCE SERVICES 0 1,304,301 4,500 52 4,500 95.00 99. 00 09500 AMBULANCE SERVICES 0 832,963 588 0 588 10. 00 99. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	3, 079, 204	. 0	0	0	88. 00
88.03   08802   RURAL HEALTH CLINIC IV   0   937, 504   0   0   0   88.03   90.00   09000   CLINIC   0   947, 080   4,495   542   4,495   90.00   90.01   09001   PAIN MANAGEMENT   0   322,056   513   0   513   90.01   90.02   09002   WOUND CARE   0   397, 846   1,582   0   1,582   90.02   91.00   09100   EMERGENCY   0   2,522,026   6,857   3,245   6,857   92.00   09200   08SERVATI ON BEDS (NON-DISTINCT PART)   92.00   95.00   09500   AMBURANCE SERVI CES   0   1,304,301   4,500   52   4,500   95.00   95.00   09500   AMBURANCE SERVI CES   0   832,963   588   0   588   101.00   95.00   09500   AMBURANCE SERVI CES   0   832,963   588   0   588   101.00   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   1,304,301   4,500   52   4,500   95.00   95.01   11300   INTEREST EXPENSE   0   0   0   0   0   0   95.02   11400   HOSPI CE   0   0   0   0   0   0   95.03   09500   AMBURANCE SERVI CES   0   1,304,301   4,500   52   4,500   95.00   95.04   09500   AMBURANCE SERVI CES   0   1,304,301   4,500   52   4,500   95.00   95.05   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   11300   INTEREST EXPENSE   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   95.00   09500   AMBURANCE SERVI CES   0   0   0   0   0   0   0   95.00   09500   0						_	-	
90.00   09000   CLINIC   0   0447,080   4,495   542   4,495   90.00   90.01			0			_	-	
90. 01   09001   PAI N MANAGEMENT   0   322,056   513   0   513   90. 01   90. 02   09002   09			0			-	-	
91. 00   09100   BERERGENCY   09200   DISERVATION BEDS (NON-DISTINCT PART)   92. 00   09500   DISERVATION BEDS (NON-DISTINCT PART)   92. 00   00   DISERVATION BEDS (NON-DISTINCT PART)   92. 00   00   DITHER REI MBURSABLE COST CENTERS   92. 00   00   00   00   00   00   00   00			0	1	1			ı
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   92. 00   0HER REIMBURSABLE COST CENTERS   0   1,304,301   4,500   52   4,500   95. 00     101. 00   10100   HOME HEALTH AGENCY   0   832,963   588   0   588   101. 00     SPECIAL PURPOSE COST CENTERS   113. 00   116.00     118. 00   118.00   NONREI MBURSABLE COST CENTERS   113.00   116.00     118. 00   118.00   NONREI MBURSABLE COST CENTERS   113. 00     119. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   49,284   1,389   0   1,389   190. 00     192. 00   192.00   192.00   192.00   192.00   192.00     192. 01   19201   MARKEI ING   0   0   0   0   0     201. 00   Negative Cost Centers   202. 00     202. 00   Cross Foot Adjustments   202. 00     203. 00   Unit cost multiplier (Wkst. B, Part I)   0.120768   27.865163   9.163485   7.491105   203. 00     204. 00   Cost to be allocated (per Wkst. B, Part II)   Unit cost multiplier (Wkst. B, Part III)   Unit cost multiplier (Wkst. D, Part III)   Unit cost multiplier (Wkst. D, Part III)   Unit cost multiplier (Wkst. D, Part IIII)   Uni	90. 02	09002 WOUND CARE	0			0	1, 582	90. 02
OTHER REIMBURSABLE COST CENTERS   0			0	2, 522, 026	6, 857	3, 245	6, 857	
95. 00   09500   AMBULANCE SERVICES   0   1, 304, 301   4, 500   52   4, 500   95. 00   101.00   10100   HOME HEALTH AGENCY   0   832, 963   588   0   588   101. 00   SPECIAL PURPOSE COST CENTERS  113. 00   11300   INTEREST EXPENSE   0   0   0   0   0   116. 00   116.00   SUBTOTALS (SUM OF LINES 1 through 117)   -3, 719, 778   30, 751, 691   80, 035   13, 096   78, 490   118. 00    NONREI MBURSABLE COST CENTERS  190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   49, 284   1, 389   0   1, 389   190. 00   192. 01   19201   09201   09200   094   094   094   094   094   094   192. 01   19201   MARKETI NG   0   0   0   0   0   192. 01   09201   09201   09202   094   094   094   094   094   192. 01   09201   09201   094   094   094   094   094   192. 01   09201   094   094   094   094   094   094   094   192. 01   09201   094   094   094   094   094   094   094   192. 01   09201   094   094   094   094   094   094   094   094   192. 01   09201   094	92.00							92.00
101.00	95 00		1 0	1 304 301	4 500	52	4 500	95 00
113.00   11300   INTEREST EXPENSE   116.00   11600   HOSPI CE   16.00   116.00   11600   HOSPI CE   118.00								1
116. 00		SPECIAL PURPOSE COST CENTERS						
18. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -3, 719, 778   30, 751, 691   80, 035   13, 096   78, 490   118. 00								•
NONRE   MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   49,284   1,389   0   1,389   190. 00   192. 00   19200			2 710 778	30 751 601	80 035	13 006		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 19200 PHYSICIANS' PRIVATE OFFICES 192.00 192.00 192.00 192.00 192.01 MARKETING 0 0 0 0 0 192.01 200.00 Cross Foot Adjustments 202.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 0.120768 27.865163 9.163485 7.491105 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.009117 9.868601 0.788943 0.848120 205.00 Unit cost multiplier (Wkst. B, Part II) 0.009117 9.868601 0.788943 0.848120 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	110.00		-3, /17, //0	30, 731, 041	80,033	13, 040	70, 490	1118.00
192. 01 19201 MARKETING 0 0 0 0 192. 01 200. 00 201. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 0. 120768 27. 865163 9. 163485 7. 491105 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 0. 0. 009117 9. 868601 0. 788943 0. 848120 205. 00 Unit cost multiplier (Wkst. B, Part II) 0. 0. 009117 9. 868601 0. 788943 0. 848120 205. 00 206. 00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207. 00	190.00		0	49, 284	1, 389	0	1, 389	190. 00
200. 00   Cross Foot Adjustments   200. 00   201. 00   Negative Cost Centers   202. 00   Cost to be allocated (per Wkst. B, Part I)   0. 120768   27. 865163   9. 163485   7. 491105 203. 00   204. 00   Cost to be allocated (per Wkst. B, Part II)   205. 00   Unit cost multiplier (Wkst. B, Part II)   205. 00   Unit cost multiplier (Wkst. B, Part II)   0. 009117   9. 868601   0. 788943   0. 848120 205. 00   NAHE adjustment amount to be allocated (per Wkst. B, Part II)   207. 00   NAHE unit cost multiplier (Wkst. D, Part II)   207. 00   NAHE unit cost multiplier (Wkst. D, Part II)   207. 00   NAHE unit cost multiplier (Wkst. D, Part III)   207. 00   NAHE unit cost multiplier (Wkst. D, Part III)   207. 00   NAHE unit cost multiplier (Wkst. D, Part III)   207. 00			-1, 851, 957	0	0	0		
201.00   Negative Cost Centers   201.00   Cost to be allocated (per Wkst. B, Part I)   0.120768   27.865163   9.163485   7.491105 203.00   204.00   Cost to be allocated (per Wkst. B, Part II)   205.00   Unit cost multiplier (Wkst. B, Part II)   0.009117   9.868601   0.788943   0.848120 205.00   206.00   NAHE adjustment amount to be allocated (per Wkst. B, Part II)   207.00   NAHE unit cost multiplier (Wkst. D, Part II)   207.00   NAHE unit cost multiplier (Wkst. D, Part II)   207.00			0	0	0	0	0	1
202.00   Cost to be allocated (per Wkst. B, Part I)   0.120768   27.865163   9.163485   7.491105   203.00   204.00   Cost to be allocated (per Wkst. B, Part II)   0.120768   27.865163   9.163485   7.491105   203.00   204.00   Part II)   205.00   Unit cost multiplier (Wkst. B, Part II)   0.009117   9.868601   0.788943   0.848120   205.00   206.00   NAHE adjustment amount to be allocated (per Wkst. B-2)   NAHE unit cost multiplier (Wkst. D, 207.00   2								
Part   1				3. 719. 778	2, 268, 893	120, 005	598. 382	
204.00   Cost to be allocated (per Wkst. B, Part II)   205.00   Unit cost multiplier (Wkst. B, Part II)   Unit cost multiplier (Wkst. B, Part II)   206.00   NAHE adjustment amount to be allocated (per Wkst. B-2)   NAHE unit cost multiplier (Wkst. D,   207.00   NAHE unit cost multiplier (Wkst. D,   207.00   2					] -,,	,	2.2,222	
Part II) Unit cost multiplier (Wkst. B, Part II) 205.00								•
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	204.00	51		280, 818	803, 541	10, 332	67, 747	204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	205 00			0 009117	9 868601	0 788943	0 848120	205 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	_00.00			0.307117	7. 500001	3. 700743	3. 340120	
207.00 NÄHE unit cost multiplier (Wkst. D, 207.00	206.00	NAHE adjustment amount to be allocated						206. 00
	207 00							207.00
	207.00							207.00
			1		•	. '		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1322 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/29/2018 5:55 pm Cost Center Description DI ETARY CAFETERI A NURSI NG MEDI CAL ADMI NI STRATI ON RECORDS & (MEALS (FTE'S) SERVED) LI BRARY (DI RECT (TIME NRSING HRS) SPENT) 10.00 11.00 13.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMINISTRATIVE AND GENERAL 5.01 5. 01 00590 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 12.057 10 00 10 00 01100 CAFETERI A 11.00 10,071 11.00 13.00 01300 NURSING ADMINISTRATION 0 423 107, 700 13.00 01600 MEDICAL RECORDS & LIBRARY 0 445 320 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 216 2,543 52, 893 81 30.00 03100 INTENSIVE CARE UNIT 31.00 841 270 5, 623 31.00 0 04300 NURSERY 43 00 0 43 00 4 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 13, 558 0 50.00 652 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 75 1, 309 54 00 54 00 60.00 06000 LABORATORY 1, 250 0 58 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 00000 742 0 20 65.00 06600 PHYSICAL THERAPY 79 0 8 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 C 0 0 67.00 06800 SPEECH PATHOLOGY 0 4 68.00 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 C 72.00 07300 DRUGS CHARGED TO PATIENTS 153 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 88.00 0 0 08801 RURAL HEALTH CLINIC II 0 88.01 C 0 88 01 08803 RURAL HEALTH CLINIC III 0 88.02 0 0 0 88.02 08802 RURAL HEALTH CLINIC IV 0 88.03 O 88.03 09000 CLINIC 70 90.00 435 9,040 90.00 09001 PAIN MANAGEMENT 90.01 234 C 0 90.01 90.02 09002 WOUND CARE 0 258 0 90.02 91.00 09100 EMERGENCY 1, 278 0 26.586 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES O 0 95.00 101.00 10100 HOME HEALTH AGENCY 101. 00 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 12, 057 10, 071 107, 700 320 118.00 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 C 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 0 0 192. 01 19201 MARKETI NG 0 0 0 192. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202 00 Cost to be allocated (per Wkst. B, 641, 014 402 036 679, 753 639 214 202 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 53. 165298 39. 920167 6. 311541 1.997.543750 203.00 228, 974 204.00 Cost to be allocated (per Wkst. B, 6, 355 22, 893 74, 741 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 18. 990960 0.631020 0.212563 233. 565625 205.00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems	PERRY COUNTY HOSPITAL	HOSPITAL In Lieu of Form CMS-25			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1322	Peri od: From 01/01/2017	Worksheet C Part I		

					From 01/01/201/ To 12/31/2017	Part I Date/Time Prep 5/29/2018 5:5	
			Title	XVIII	Hospi tal	Cost	5 piii
			11 110	XVIII	Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	5551 5511151 B5551 F11 611	(from Wkst. B,	Adj.	l rotal doors	Di sal I owance	10141 00010	
		Part I, col.					
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	•		•			
30.00	03000 ADULTS & PEDIATRICS	4, 868, 142		4, 868, 14	2 0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	827, 095		827, 09	5 0	0	31. 00
43.00	04300 NURSERY	210, 294		210, 29	4 0	0	43.00
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		<u> </u>			
50.00	05000 OPERATING ROOM	1, 951, 542		1, 951, 54	2 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	356, 289		356, 28	9 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 889, 719		2, 889, 71	9 0	0	54.00
60.00	06000 LABORATORY	2, 729, 782		2, 729, 78	2 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	143, 038		143, 03		0	62. 00
65.00	06500 RESPIRATORY THERAPY	1, 256, 784		1, 256, 78		0	65. 00
66.00	06600 PHYSI CAL THERAPY	763, 565		763, 56		0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	333, 612	0	333, 61	2 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	192, 864	0	192, 86		0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	815, 461		815, 46		0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	109, 136		109, 13	6 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 157, 597		3, 157, 59	7 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	3, 451, 080		3, 451, 08	0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	616, 574		616, 57	4 0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC III	459, 610		459, 61	0	0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	1, 050, 724		1, 050, 72	4 0	0	88. 03
90.00	09000 CLI NI C	1, 439, 600		1, 439, 60	0	0	90.00
90. 01	09001 PAIN MANAGEMENT	388, 429		388, 42	9 0	0	90. 01
90. 02	09002 WOUND CARE	512, 126		512, 12	6 0	0	90. 02
91.00	09100 EMERGENCY	3, 317, 597		3, 317, 59	7 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	519, 837		519, 83	7	0	92. 00
	OTHER REIMBURSABLE COST CENTERS			<u> </u>			
95.00	09500 AMBULANCE SERVI CES	1, 621, 399		1, 621, 39	9 0	0	95. 00
101.00	10100 HOME HEALTH AGENCY	954, 348		954, 34	8	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0			0	0	116. 00
200.00	Subtotal (see instructions)	34, 936, 244	0	34, 936, 24	4 0	0	200. 00
201.00		519, 837		519, 83		0	201. 00
202.00	1 1	34, 416, 407	0				202. 00
			•		'	'	•

					o 12/31/2017	Date/Time Pre 5/29/2018 5:5	
			Title	xVIII	Hospi tal	Cost	•
	·		Charges		·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	2, 364, 158		2, 364, 158		1	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	463, 011		463, 011		1	31. 00
43.00	04300 NURSERY	177, 160		177, 160			43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	522, 589	5, 050, 378	5, 572, 967		0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	445, 612	233, 474	679, 086	0. 524660	0.000000	52. 00
54.00	05400   RADI OLOGY-DI AGNOSTI C	1, 250, 688	16, 696, 124			0.000000	54. 00
60.00	06000 LABORATORY	1, 581, 624	10, 269, 101	11, 850, 725		0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	91, 962	373, 655	465, 617	0. 307201	0.000000	
65.00	06500 RESPI RATORY THERAPY	1, 358, 414	2, 225, 892	3, 584, 306	0. 350635	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	572, 387	2, 163, 395	2, 735, 782	0. 279103	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	415, 077	832, 933	1, 248, 010	0. 267315	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	105, 830	278, 653	384, 483	0. 501619	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 423, 034	2, 587, 872	4, 010, 906	0. 203311	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	867	178, 809	179, 676	0. 607404	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 471, 136	9, 334, 884	12, 806, 020	0. 246571	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	2, 200, 557	2, 200, 557		ı	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	433, 277	433, 277		ı	88. 01
88. 02	08803 RURAL HEALTH CLINIC III	0	424, 593	424, 593		ı	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0	676, 271	676, 271		ı	88. 03
90.00	09000 CLI NI C	253, 697	665, 357	919, 054	1. 566393	0.000000	
90. 01	09001 PAIN MANAGEMENT	0	281, 675	281, 675	1. 378997	0.000000	90. 01
90. 02	09002 WOUND CARE	0	1, 312, 660	1, 312, 660		0.000000	
91. 00	09100 EMERGENCY	200, 981	6, 569, 997	6, 770, 978	0. 489973	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	26, 235	426, 211	452, 446	1. 148948	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	3, 121, 240	3, 121, 240	0. 519473	0.000000	
101.00	10100 HOME HEALTH AGENCY	0	2, 638, 719	2, 638, 719			101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE					1	113. 00
	11600 H0SPI CE	0	0	0			116. 00
200.00	, ,	14, 724, 462	68, 975, 727	83, 700, 189			200. 00
201.00	1						201. 00
202.00	Total (see instructions)	14, 724, 462	68, 975, 727	83, 700, 189			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	Peri od: Worksheet C From 01/01/2017 To 12/31/2017 Date/Time Prepared:

				10 12/31/2017	5/29/2018 5:5	5 pm
			Title XVIII	Hospi tal	Cost	
Cos	st Center Description	PPS Inpatient				
	· ·	Ratio				
		11. 00				
I NPATI EN	T ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADL	JLTS & PEDIATRICS					30. 00
31.00 03100 I NT	TENSIVE CARE UNIT					31.00
43.00 04300 NUF	RSERY					43.00
ANCI LLAR	Y SERVICE COST CENTERS					
50. 00 05000 OPE	ERATING ROOM	0. 000000				50. 00
52. 00   05200 DEL	IVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00   05400 RAD	DI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LAE	BORATORY	0. 000000				60.00
62.00 06200 WHO	DLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RES	SPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHY	/SI CAL THERAPY	0. 000000				66.00
67. 00 06700 0C0	CUPATIONAL THERAPY	0. 000000				67.00
68. 00 06800 SPE	EECH PATHOLOGY	0. 000000				68. 00
71. 00 07100 MED	DICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
	PL. DEV. CHARGED TO PATIENT	0. 000000				72. 00
73. 00 07300 DRL	JGS CHARGED TO PATIENTS	0. 000000				73.00
	NT SERVICE COST CENTERS					
88. 00   08800 RUF	RAL HEALTH CLINIC					88. 00
88. 01   08801 RUF	RAL HEALTH CLINIC II					88. 01
88. 02   08803 RUF	RAL HEALTH CLINIC III					88. 02
88. 03   08802 RUF	RAL HEALTH CLINIC IV					88. 03
90. 00 09000 CLI	NI C	0. 000000				90.00
90. 01   09001 PAI	N MANAGEMENT	0. 000000				90. 01
90. 02   09002 WOL	JND CARE	0. 000000				90. 02
91.00 09100 EME	ERGENCY	0. 000000				91.00
92. 00 09200 OBS	SERVATION BEDS (NON-DISTINCT PART)	0. 000000				92. 00
	MBURSABLE COST CENTERS					
	BULANCE SERVICES	0. 000000				95. 00
	ME HEALTH AGENCY					101. 00
	PURPOSE COST CENTERS					
113. 00 11300 I NT						113. 00
116. 00 11600 HOS						116. 00
	ototal (see instructions)					200. 00
201. 00 Les	ss Observation Beds					201. 00
202. 00 Tot	tal (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	Peri od: Worksheet C
		From 01/01/2017   Part I
		T- 10/01/0017 D-+-/T: D

					To 12/31/2017	Date/Time Pre 5/29/2018 5:5	pared: 5 pm
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 030	00 ADULTS & PEDIATRICS	4, 868, 142		4, 868, 14	2 0	4, 868, 142	30.00
31.00 031	OO INTENSIVE CARE UNIT	827, 095		827, 09	5 0	827, 095	31.00
43.00 043	00 NURSERY	210, 294		210, 29	4 0	210, 294	43.00
ANC	ILLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	1, 951, 542		1, 951, 54	2 0	1, 951, 542	50. 00
52.00 052	OO DELIVERY ROOM & LABOR ROOM	356, 289		356, 28	9 0	356, 289	52. 00
54.00 054	OO RADI OLOGY-DI AGNOSTI C	2, 889, 719		2, 889, 71	9 0	2, 889, 719	54.00
60.00 060	00 LABORATORY	2, 729, 782		2, 729, 78	2 0	2, 729, 782	60.00
62. 00 062	OO WHOLE BLOOD & PACKED RED BLOOD CELLS	143, 038		143, 03	8 0	143, 038	62.00
65. 00 065	00 RESPI RATORY THERAPY	1, 256, 784	0	1, 256, 78	4 0	1, 256, 784	65. 00
66. 00 066	00 PHYSI CAL THERAPY	763, 565	0	763, 56	5 0	763, 565	66. 00
67. 00 067	OO OCCUPATIONAL THERAPY	333, 612	0	333, 61	2 0	333, 612	67. 00
68. 00 068	00 SPEECH PATHOLOGY	192, 864	0	192, 86	4 0	192, 864	68. 00
71. 00 071	OO MEDICAL SUPPLIES CHARGED TO PATIENTS	815, 461		815, 46	1 0	815, 461	71. 00
72. 00 072	OO IMPL. DEV. CHARGED TO PATIENT	109, 136		109, 13	6 0	109, 136	72. 00
73. 00 073	OO DRUGS CHARGED TO PATIENTS	3, 157, 597		3, 157, 59	7 0	3, 157, 597	73. 00
OUT	PATIENT SERVICE COST CENTERS						1
88. 00 088	OO RURAL HEALTH CLINIC	3, 451, 080		3, 451, 08	0 0	3, 451, 080	88. 00
88. 01 088	01 RURAL HEALTH CLINIC II	616, 574		616, 57	4 0	616, 574	88. 01
88. 02 088	03 RURAL HEALTH CLINIC III	459, 610		459, 61	o o	459, 610	88. 02
88. 03 088	02 RURAL HEALTH CLINIC IV	1, 050, 724		1, 050, 72	4 0	1, 050, 724	88. 03
90.00 090	OO CLI NI C	1, 439, 600		1, 439, 60	o o	1, 439, 600	90.00
90. 01 090	O1 PALN MANAGEMENT	388, 429		388, 42	9 0	388, 429	90. 01
90. 02 090	02 WOUND CARE	512, 126		512, 12	6 0	512, 126	90. 02
91.00 091	OO EMERGENCY	3, 317, 597		3, 317, 59	7 0	3, 317, 597	91.00
92. 00 092	OO OBSERVATION BEDS (NON-DISTINCT PART)	519, 837		519, 83	7	519, 837	92.00
OTH	ER REIMBURSABLE COST CENTERS						1
95. 00 095	00 AMBULANCE SERVICES	1, 621, 399		1, 621, 39	9 0	1, 621, 399	95. 00
101.00 101	OO HOME HEALTH AGENCY	954, 348		954, 34	8	954, 348	101.00
SPE	CLAL PURPOSE COST CENTERS						1
	00 I NTEREST EXPENSE						113. 00
116. 00 116	00 HOSPI CE	0			0	0	116. 00
200.00	Subtotal (see instructions)	34, 936, 244	0	34, 936, 24	4 0	34, 936, 244	200.00
201. 00	Less Observation Beds	519, 837		519, 83	7	519, 837	201.00
202. 00	Total (see instructions)	34, 416, 407	0	34, 416, 40	7 0	34, 416, 407	202. 00

				From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/29/2018 5:5	
			e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6		TEFRA	
			+ col. 7)	Ratio	I npati ent	
	/ 00	7.00	0.00	0.00	Ratio	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7. 00	8. 00	9. 00	10. 00	
30. 00 03000 ADULTS & PEDIATRICS	2, 364, 158		2, 364, 158			30.00
31. 00   03100   NTENSIVE CARE UNIT	463, 011		463, 01			31.00
43. 00   04300   NURSERY	177, 160		177, 160			43.00
ANCI LLARY SERVI CE COST CENTERS	177, 160		177, 100	الــــــــــــــــــــــــــــــــــــ		43.00
50. 00 05000 OPERATING ROOM	522, 589	5, 050, 378	5, 572, 96	0. 350180	0. 000000	50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	445, 612	233, 474			0. 000000	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 250, 688	16, 696, 124			0.000000	
60. 00   06000   LABORATORY	1, 581, 624	10, 269, 124			0. 000000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	91, 962	373, 655			0. 000000	
65. 00 06500 RESPI RATORY THERAPY	1, 358, 414	2, 225, 892			0. 000000	
66. 00   06600   PHYSI CAL THERAPY	572, 387	2, 163, 395			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	415, 077	832, 933			0. 000000	
68. 00 06800 SPEECH PATHOLOGY	105, 830	278, 653			0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 423, 034	2, 587, 872			0. 000000	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	867	178, 809			0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 471, 136	9, 334, 884			0. 000000	
OUTPATIENT SERVICE COST CENTERS	0, 171, 100	7,001,001	12,000,020	0.210071	0.00000	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	2, 200, 557	2, 200, 55	1. 568276	0. 000000	88. 00
88. 01   08801 RURAL HEALTH CLINIC II	o	433, 277			0. 000000	
88. 02   08803 RURAL HEALTH CLINIC III	o	424, 593			0. 000000	
88. 03   08802 RURAL HEALTH CLINIC IV	o	676, 271			0.000000	
90. 00 09000 CLI NI C	253, 697	665, 357			0.000000	
90. 01 09001 PALN MANAGEMENT	o	281, 675			0.000000	90. 01
90. 02 09002 WOUND CARE	o	1, 312, 660	1, 312, 660	0. 390144	0.000000	90. 02
91. 00 09100 EMERGENCY	200, 981	6, 569, 997	6, 770, 978	0. 489973	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	26, 235	426, 211	452, 446	1. 148948	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0	3, 121, 240	3, 121, 240	0. 519473	0.000000	95. 00
101.00 10100 HOME HEALTH AGENCY	o	2, 638, 719	2, 638, 719			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	O	0				116. 00
200.00 Subtotal (see instructions)	14, 724, 462	68, 975, 727	83, 700, 189	9		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	14, 724, 462	68, 975, 727	83, 700, 189	9		202. 00

Health Financial Syste	ems	PERRY COUNTY H	OSPI TAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO	OF COSTS TO CHARGES		Provi der CC	N: 15-1322	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared:

				10 12/31/2017	5/29/2018 5: 5	55 pm
			Title XIX	Hospi tal	PPS	
Co	ost Center Description	PPS Inpatient		<u>'                                    </u>		
	· ·	Ratio				
		11. 00				
I NPATI EN	NT ROUTINE SERVICE COST CENTERS					
30. 00 03000 AD	DULTS & PEDIATRICS					30.00
31.00 03100 I N	NTENSIVE CARE UNIT					31.00
43. 00   04300 NL	JRSERY					43.00
ANCI LLAF	RY SERVICE COST CENTERS					
50. 00 05000 OF	PERATING ROOM	0. 350180				50. 00
52. 00   05200 DE	ELIVERY ROOM & LABOR ROOM	0. 524660				52. 00
54.00 05400 RA	ADI OLOGY-DI AGNOSTI C	0. 161016				54.00
60.00 06000 LA	ABORATORY	0. 230347				60.00
62.00 06200 WH	HOLE BLOOD & PACKED RED BLOOD CELLS	0. 307201				62. 00
65. 00 06500 RE	ESPI RATORY THERAPY	0. 350635				65.00
66. 00 06600 PH	HYSI CAL THERAPY	0. 279103				66. 00
67.00 06700 00	CCUPATIONAL THERAPY	0. 267315				67. 00
68. 00 06800 SF	PEECH PATHOLOGY	0. 501619				68. 00
71. 00 07100 ME	EDICAL SUPPLIES CHARGED TO PATIENTS	0. 203311				71. 00
	MPL. DEV. CHARGED TO PATIENT	0. 607404				72. 00
73.00 07300 DF	RUGS CHARGED TO PATIENTS	0. 246571				73. 00
	ENT SERVICE COST CENTERS					
	JRAL HEALTH CLINIC	1. 568276				88. 00
	JRAL HEALTH CLINIC II	1. 423048				88. 01
	JRAL HEALTH CLINIC III	1. 082472				88. 02
	JRAL HEALTH CLINIC IV	1. 553703				88. 03
90. 00   09000   CL		1. 566393				90.00
90. 01   09001   PA		1. 378997				90. 01
90. 02   09002 WC		0. 390144				90. 02
91.00 09100 EN		0. 489973				91. 00
	SSERVATION BEDS (NON-DISTINCT PART)	1. 148948				92. 00
	EIMBURSABLE COST CENTERS					
	MBULANCE SERVICES	0. 519473				95. 00
	DME HEALTH AGENCY					101. 00
	PURPOSE COST CENTERS					
	NTEREST EXPENSE					113. 00
116. 00 11600 HC						116. 00
	ubtotal (see instructions)					200. 00
	ess Observation Beds					201. 00
202. 00 To	otal (see instructions)					202. 00

Health Financial Systems	PERRY COUNTY HO	OSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE REDUCTIONS FOR MEDICALD ONLY	COST TO CHARGE RATIOS NET OF	Provider CCN: 15-1322	From 01/01/2017	Worksheet C Part II Date/Time Prepared:

				Ic	12/31/2017	Date/lime Pre 5/29/2018 5:5	
			Titl	e XIX	Hospi tal	PPS	o piii
Co	ost Center Description	Total Cost	Capital Cost	Operating Cost		Operating Cost	
	·	(Wkst. B, Part)	Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
		·		col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	RY SERVICE COST CENTERS						
	PERATING ROOM	1, 951, 542	594, 012	1, 357, 530	0	0	50.00
52. 00   05200 DE	ELIVERY ROOM & LABOR ROOM	356, 289	143, 207	213, 082	0	0	52. 00
54. 00   05400 RA	ADI OLOGY-DI AGNOSTI C	2, 889, 719	346, 613	2, 543, 106	0	0	54. 00
60. 00   06000 LA	ABORATORY	2, 729, 782	173, 047	2, 556, 735	0	0	60.00
62.00 06200 WH	HOLE BLOOD & PACKED RED BLOOD CELLS	143, 038	2, 278	140, 760	0	0	62.00
65. 00 06500 RE	SPI RATORY THERAPY	1, 256, 784	200, 926	1, 055, 858	0	0	65.00
66. 00 06600 PH	IYSI CAL THERAPY	763, 565	100, 560	663, 005	0	0	66.00
67. 00 06700 0C	CCUPATIONAL THERAPY	333, 612	42, 891	290, 721	0	0	67.00
68. 00 06800 SP	PEECH PATHOLOGY	192, 864	23, 630	169, 234	0	0	68. 00
71.00 07100 ME	EDICAL SUPPLIES CHARGED TO PATIENTS	815, 461	12, 937	802, 524	0	0	71.00
72.00 07200 I M	MPL. DEV. CHARGED TO PATLENT	109, 136	1, 725	107, 411	0	0	72. 00
73.00 07300 DR	RUGS CHARGED TO PATIENTS	3, 157, 597	114, 672	3, 042, 925	0	0	73.00
OUTPATI E	ENT SERVICE COST CENTERS						
88. 00 08800 RU	JRAL HEALTH CLINIC	3, 451, 080	57, 172	3, 393, 908	0	0	88. 00
88. 01   08801 RU	JRAL HEALTH CLINIC II	616, 574	10, 126	606, 448	0	0	88. 01
88. 02   08803 RU	JRAL HEALTH CLINIC III	459, 610	7, 562	452, 048	0	0	88. 02
88. 03   08802 RU	JRAL HEALTH CLINIC IV	1, 050, 724	17, 430	1, 033, 294	0	0	88. 03
90. 00 09000 CL	LI NI C	1, 439, 600	231, 541	1, 208, 059	0	0	90.00
90. 01   09001 PA	ALN MANAGEMENT	388, 429	28, 323	360, 106	0	0	90. 01
90. 02 09002 W0	OUND CARE	512, 126	76, 368	435, 758	0	0	90. 02
91.00 09100 EM	MERGENCY	3, 317, 597	352, 872	2, 964, 725	0	0	91.00
92. 00 09200 OB	SSERVATION BEDS (NON-DISTINCT PART)	519, 837	99, 844	419, 993	0	0	92.00
OTHER RE	EIMBURSABLE COST CENTERS						
95.00 09500 AM	MBULANCE SERVICES	1, 621, 399	218, 684	1, 402, 715	0	0	95. 00
101.00 10100 H0	DME HEALTH AGENCY	954, 348	40, 308	914, 040	0	0	101.00
SPECI AL	PURPOSE COST CENTERS						
113. 00 11300 I N	ITEREST EXPENSE						113. 00
116.00 11600 HO	OSPI CE	O	0	0	0	0	116. 00
200. 00 Su	ubtotal (sum of lines 50 thru 199)	29, 030, 713	2, 896, 728	26, 133, 985	0	0	200. 00
201.00 Le	ess Observation Beds	519, 837	99, 844	419, 993	0	0	201. 00
202. 00 To	otal (line 200 minus line 201)	28, 510, 876	2, 796, 884	25, 713, 992	0	0	202. 00

Heal th Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY POR MEDICALD ONLY POR MEDICALD ONLY In Lieu of Form CMS-2552-10
Provider CCN: 15-1322
From 01/01/2017
To 12/31/2017
Date/Time Prepared:

					0 12/31/201/	5/29/2018 5:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Total Charges	Outpati ent			
				Cost to Charge			
		Operating Cost F					
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 951, 542	5, 572, 967				50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	356, 289	679, 086				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 889, 719	17, 946, 812	0. 161016			54.00
60.00	06000 LABORATORY	2, 729, 782	11, 850, 725	0. 230347	'		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	143, 038	465, 617				62.00
65.00	06500 RESPI RATORY THERAPY	1, 256, 784	3, 584, 306	0. 350635	5		65. 00
66.00	06600 PHYSI CAL THERAPY	763, 565	2, 735, 782	0. 279103	3		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	333, 612	1, 248, 010	0. 267315	5		67. 00
68.00	06800 SPEECH PATHOLOGY	192, 864	384, 483	0. 501619			68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	815, 461	4, 010, 906	0. 203311			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	109, 136	179, 676	0. 607404			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 157, 597	12, 806, 020	0. 246571			73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	3, 451, 080	2, 200, 557	1. 56827 <i>6</i>			88. 00
88. 01	08801 RURAL HEALTH CLINIC II	616, 574	433, 277	1. 423048	3		88. 01
88. 02	08803 RURAL HEALTH CLINIC III	459, 610	424, 593	1. 082472	2		88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	1, 050, 724	676, 271	1. 553703	3		88. 03
90.00	09000 CLI NI C	1, 439, 600	919, 054	1. 566393	3		90. 00
90. 01	09001 PAIN MANAGEMENT	388, 429	281, 675	1. 378997	,		90. 01
90. 02	09002 WOUND CARE	512, 126	1, 312, 660	0. 390144			90. 02
91.00	09100 EMERGENCY	3, 317, 597	6, 770, 978	0. 489973	3		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	519, 837	452, 446	1. 148948	3		92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 621, 399	3, 121, 240	0. 519473	3		95. 00
101.00	10100 HOME HEALTH AGENCY	954, 348	2, 638, 719	0. 361671			101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0	0	0. 000000			116. 00
200.00	Subtotal (sum of lines 50 thru 199)	29, 030, 713	80, 695, 860				200. 00
201.00	Less Observation Beds	519, 837	0				201. 00
202.00	Total (line 200 minus line 201)	28, 510, 876	80, 695, 860				202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL			u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provider CCN: 15-1322	Peri od:	Worksheet D

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/29/2018 5:5	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges			Capi tal Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
		Part II, col. 26)	8)	2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	594, 012	5, 572, 967	0. 10658	8 34, 843	3, 714	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	143, 207	679, 086	0. 21088	2 0	0	52.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	346, 613				11, 601	54. 00
60.00	06000 LABORATORY	173, 047	11, 850, 725			10, 509	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 278				232	62. 00
65.00	06500 RESPI RATORY THERAPY	200, 926	3, 584, 306	0. 05605	7 645, 690	36, 195	65. 00
66. 00	06600 PHYSI CAL THERAPY	100, 560				5, 174	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	42, 891	1, 248, 010	0. 03436	8 51, 778	1, 780	67. 00
68. 00	06800 SPEECH PATHOLOGY	23, 630	384, 483	0. 06145	9 25, 765	1, 583	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 937				1, 652	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 725	179, 676	0.00960	1 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	114, 672	12, 806, 020	0. 00895	5 1, 660, 113	14, 866	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	57, 172				0	00.00
88. 01	08801 RURAL HEALTH CLINIC II	10, 126				0	88. 01
88. 02	08803 RURAL HEALTH CLINIC III	7, 562				0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	17, 430				0	88. 03
90.00	09000 CLI NI C	231, 541				28, 397	90. 00
90. 01	09001 PAI N MANAGEMENT	28, 323		•		0	90. 01
90. 02	09002 WOUND CARE	76, 368		•		0	90. 02
91. 00	09100 EMERGENCY	352, 872		•		632	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	99, 844	452, 446	0. 22067	6 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	T	1	ı			
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	2, 637, 736	74, 935, 901	I	4, 563, 851	116, 335	200. 00

Health Financial Systems	PERRY COUNTY H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1322	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2017	Part IV

					lo 12/31/2017	Date/lime Pre 5/29/2018 5:5	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	)	0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60.00	06000 LABORATORY	0	0		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	)	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	)	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	)	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	)	0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC III	0	0	)	0	0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0	0	)	0	0	88. 03
90.00	09000 CLI NI C	0	0	)	0	0	90.00
90. 01	09001 PAIN MANAGEMENT	0	0	)	0	0	90. 01
90. 02	09002 WOUND CARE	0	0	)	0	0	90. 02
91.00	09100 EMERGENCY	0	0	)	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(	O	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0	)  (	0	0	200. 00

Health Financial Systems	Health Financial Systems PERRY COUNTY HOS			u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIE	NT ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1322	Peri od:	Worksheet D
TUDOUGU COCTO			From 01/01/2017	Dart IV

	HONMENT OF INPATTENT/OUTPATTENT ANCILLARY SE GH COSTS	RVICE OTHER PAS	S Provider C	F	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/29/2018 5:5	
			Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of	Part I, col.		
			4)	col. 2, 3 and	8)	7)	
				4)			
	T	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	_	I -	_			
	05000 OPERATI NG ROOM	0	0		5, 572, 967	0. 000000	1
		0	0		679, 086		
	05400 RADI OLOGY-DI AGNOSTI C	0	0		17, 946, 812	0. 000000	
60.00	06000 LABORATORY	0	0	)	11, 850, 725	0. 000000	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	) (	465, 617	0. 000000	62.00
65.00	06500 RESPI RATORY THERAPY	0	0	) (	3, 584, 306	0. 000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	) (	2, 735, 782	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	) (	1, 248, 010	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	) (	384, 483	0.000000	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		4, 010, 906	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	) (	179, 676	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	) (	12, 806, 020	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	O	)	2, 200, 557	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	) (	433, 277	0. 000000	88. 01
88. 02	08803 RURAL HEALTH CLINIC III	0	0	) (	424, 593	0.000000	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0		) (	676, 271	0.000000	88. 03
90.00	09000 CLI NI C	0	0	) (	919, 054	0. 000000	90.00
90. 01	09001 PAIN MANAGEMENT	0	0	) (	281, 675	0. 000000	90. 01
90. 02	09002 WOUND CARE	0	l 0	ol c	1, 312, 660	0. 000000	90. 02
91.00	09100 EMERGENCY	0	l o	ol c	6, 770, 978	0.000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			452, 446		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00		0	o	) (	74, 935, 901		200.00

Heal th	Financial Systems	PERRY COUNTY	ΗΟ ΣΡΙΤΔΙ		In lie	u of Form CMS-	2552_10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		Provi der CC		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/29/2018 5:5	pared:
				XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col . 12)	
	ANOLULARY OFRICASE COOT OFFITTED	9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS		0.4.0.4.0	ı			
50. 00	05000 OPERATI NG ROOM	0. 000000	34, 843		0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	600, 699		0	0	54.00
60.00	06000 LABORATORY	0. 000000	719, 672		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	47, 388		0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	645, 690		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	140, 755		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	51, 778		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	25, 765		0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	512, 306		0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 660, 113		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC III	0. 000000	0		0	0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0. 000000	0		0	0	88. 03
90.00	09000 CLINIC	0. 000000	112, 715		0	0	90.00
90. 01	09001 PAIN MANAGEMENT	0. 000000	0		0	0	90. 01
90. 02	09002 WOUND CARE	0. 000000	10 107		0	0	90. 02
91.00	09100 EMERGENCY	0. 000000	12, 127		0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		U  0	0	92. 00

4, 563, 851

0

0

0 92.00 95.00

0 200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part V | To 12/31/2017 | Date/Time Prepared:

					10 12/31/2017	5/29/2018 5:5	pared: 5 pm
			Titl∈	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge P			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	LARY SERVICE COST CENTERS	0.050400		1 4 15 1 5			
	OPERATI NG ROOM	0. 350180	Ü	1, 656, 50		0	
	DELIVERY ROOM & LABOR ROOM	0. 524660	0	١ ـ	0	0	52.00
	RADI OLOGY-DI AGNOSTI C	0. 161016	0	5, 439, 64		0	54.00
	LABORATORY	0. 230347	0	3, 499, 63		0	60.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 307201	0	153, 17		0	62. 00
	RESPI RATORY THERAPY	0. 350635	0	1, 245, 75		0	65. 00
	PHYSI CAL THERAPY	0. 279103	0	765, 50		0	66. 00
	OCCUPATI ONAL THERAPY	0. 267315	0	230, 13		0	67. 00
	SPEECH PATHOLOGY	0. 501619	0	27, 17		0	68. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 203311	0	753, 24		0	71. 00
	IMPL. DEV. CHARGED TO PATIENT	0. 607404	0	117, 34		0	72. 00
	DRUGS CHARGED TO PATIENTS	0. 246571	0	3, 504, 77	3 8, 546	0	73. 00
	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0. 000000				0	88. 00
	RURAL HEALTH CLINIC II	0. 000000				0	88. 01
	RURAL HEALTH CLINIC III	0. 000000				0	88. 02
	RURAL HEALTH CLINIC IV	0. 000000				0	88. 03
	CLI NI C	1. 566393	0	394, 30		0	90. 00
	PAIN MANAGEMENT	1. 378997	0	217, 45		0	90. 01
	WOUND CARE	0. 390144	0	222, 47		0	90. 02
	EMERGENCY	0. 489973	0	1, 700, 48		0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	1. 148948	0	182, 08	3 0	0	92.00
	REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	0. 519473			0		95. 00
200. 00	Subtotal (see instructions)		0	20, 109, 70	7 9, 312	0	200. 00
201. 00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		0	20, 109, 70	7 9, 312	0	202. 00

Health Financial Syst	tems		PERRY	COUNTY H	OSPI TAL		In Lieu	of Form CMS-2552-10
APPORTI ONMENT OF MED	I CAL, OTHER	HEALTH SERVICES	AND VACCINE	COST	Provider CC	N: 15-1322	Peri od: From 01/01/2017	Worksheet D Part V
							To 12/21/2017	Data/Time Dropared

Costs	
Cost Center Description Cost Cost	
Rei mbursed   Rei mbursed	
Services 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 OPERATI NG ROOM 580, 074 0	50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0	52.00
54. 00   05400   RADI 0LOGY-DI AGNOSTI C 875, 870 0	54.00
60. 00   06000   LABORATORY   806, 131   0	60.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   47,057   0	62. 00
65. 00 06500 RESPI RATORY THERAPY 436, 806 0	65. 00
66. 00   06600   PHYSI CAL THERAPY 213, 656 0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 61, 518 0	67. 00
68. 00   06800   SPEECH PATHOLOGY   13, 630   0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 153,144 0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 71,278 0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 864, 175 2, 107	73. 00
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 0 0	88. 00
88. 01   08801   RURAL HEALTH CLINIC II 0 0 0	88. 01
88. 02   08803   RURAL HEALTH CLINIC III 0 0 0	88. 02
88. 03   08802   RURAL HEALTH CLINIC IV 0 0	88. 03
90. 00   09000   CLI NI C   617, 630   1, 200	90.00
90. 01   09001   PAI N MANAGEMENT 299, 868 0	90. 01
90. 02   09002   WOUND CARE   86, 798   0	90. 02
91. 00   09100   EMERGENCY   833, 193   0	91.00
92. 00   09200   0BSERVATI 0N   BEDS (NON-DI STINCT PART)   209, 204   0	92. 00
OTHER REIMBURSABLE COST CENTERS	
95. 00   09500   AMBULANCE   SERVI CES   0	95. 00
200.00 Subtotal (see instructions) 6,170,032 3,307	200. 00
201.00 Less PBP Clinic Lab. Services-Program 0	201. 00
Only Charges	
202.00   Net Charges (line 200 - line 201)   6,170,032   3,307	202. 00

Health Financial Systems		PERRY COUNTY H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provi der CCN: 15-1322	Peri od: From 01/01/2017	Worksheet D Part V

		Component		o 12/31/2017		
		Title	XVIII S	wing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 350180	0	C	0	0	
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 524660		C	0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 161016	0	C	0	0	54.00
60. 00   06000   LABORATORY	0. 230347	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 307201	0	C	0	0	62. 00
65. 00   06500   RESPI RATORY THERAPY	0. 350635	0	C	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 279103	0	C	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 267315	0	C	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 501619	0	C	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 203311	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 607404	0	C	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 246571	0	C	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88. 01
88. 02   08803 RURAL HEALTH CLINIC III	0. 000000				0	88. 02
88.03 08802 RURAL HEALTH CLINIC IV	0. 000000				0	88. 03
90. 00   09000   CLI NI C	1. 566393	0	C	0	0	90.00
90. 01   09001   PAIN MANAGEMENT	1. 378997	0	C	0	0	90. 01
90. 02   09002   WOUND CARE	0. 390144	0	C	0	0	90. 02
91. 00   09100   EMERGENCY	0. 489973	0	C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 148948	0	C	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 519473		C			95. 00
200.00 Subtotal (see instructions)		0	C	0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program			[ c	o		201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)		0	l c	0	0	202. 00

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider Component (	CN: 15-1322 CCN: 15-Z322	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 5:5	pared: 5 pm
		Title	XVIII	Swing Beds - SNF	Cost	
	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded & Coins	Ded & Coins				

			11 11 0	2 AVIII OWING Dods	5111	
			sts			
	Cost Center Description	Cost	Cost			
		Rei mbursed	Rei mbursed			
		Servi ces	Services Not			
		Subject To	Subject To			
		Ded. & Coi ns.	Ded. & Coins.			
		(see inst.)	(see inst.)			
	ANOLLI ARV CERVI OF COCT CENTERS	6. 00	7. 00			
F0 00	ANCILLARY SERVICE COST CENTERS			J		4
50.00	05000 OPERATING ROOM					50.00
	05200 DELIVERY ROOM & LABOR ROOM					52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C					54.00
60.00	06000 LABORATORY					60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			)		62. 00
65. 00	06500 RESPI RATORY THERAPY		0			65. 00
66. 00	06600 PHYSI CAL THERAPY	C	0	)		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C	0	)		67. 00
	06800 SPEECH PATHOLOGY	C	0	)		68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	)		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	C	0	)		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	C	) 0	)		73. 00
	OUTPATIENT SERVICE COST CENTERS					4
	08800 RURAL HEALTH CLINIC	C	0	)		88. 00
	08801 RURAL HEALTH CLINIC II	C	0	)		88. 01
	08803 RURAL HEALTH CLINIC III	C	0	)		88. 02
	08802 RURAL HEALTH CLINIC IV	C	0	)		88. 03
	09000 CLI NI C	C	0	)		90. 00
	09001 PAIN MANAGEMENT	C	0	)		90. 01
	09002 WOUND CARE	C	0	)		90. 02
	09100 EMERGENCY	C	) 0	)		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0	)		92. 00
	OTHER REIMBURSABLE COST CENTERS					4
	09500 AMBULANCE SERVICES	C	)			95. 00
200.00		C	0			200. 00
201. 00		0	)			201. 00
	Only Charges					
202. 00	Net Charges (line 200 - line 201)		)  0	0		202. 00

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2017 To 12/31/2017		
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	935, 013	292, 376	642, 63	7 2, 227	288. 57	30. 00
31.00 INTENSIVE CARE UNIT	164, 435		164, 43	5 213	772.00	31.00
43. 00 NURSERY	35, 404		35, 40	4 215	164. 67	43.00
200.00 Total (lines 30 through 199)	1, 134, 852		842, 47	6 2, 655		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 & PEDI ATRI CS	23	6, 637				30. 00
31.00 INTENSIVE CARE UNIT	0	0				31.00
43. 00 NURSERY	12	1, 976	,			43.00
200.00 Total (lines 30 through 199)	35	8, 613				200. 00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
					From 01/01/2017 To 12/31/2017		narod:
					10 12/31/2017	5/29/2018 5:5	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost			Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		T	T	-1		
	05000 OPERATI NG ROOM	594, 012					1
	05200 DELIVERY ROOM & LABOR ROOM	143, 207					
	05400 RADI OLOGY-DI AGNOSTI C	346, 613		1		<b>l</b>	54. 00
	06000 LABORATORY	173, 047					
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 278		1			62. 00
	06500 RESPI RATORY THERAPY	200, 926					65. 00
	06600 PHYSI CAL THERAPY	100, 560				•	66. 00
	06700 OCCUPATI ONAL THERAPY	42, 891				l	67. 00
	06800 SPEECH PATHOLOGY	23, 630		1			68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 937				279	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 725					72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	114, 672	12, 806, 020	0. 00895	5 148, 401	1, 329	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	57, 172				0	
	08801 RURAL HEALTH CLINIC II	10, 126				0	88. 01
	08803 RURAL HEALTH CLINIC III	7, 562				0	88. 02
	08802 RURAL HEALTH CLINIC IV	17, 430		1		0	88. 03
	09000 CLI NI C	231, 541				9	90.00
	09001 PAIN MANAGEMENT	28, 323	281, 675	0. 10055	2 0	0	90. 01
	09002 WOUND CARE	76, 368	1, 312, 660			0	90. 02
91. 00	09100 EMERGENCY	352, 872	6, 770, 978	0. 05211	57, 280	2, 985	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	99, 844	452, 446	0. 22067	6 3, 508	774	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	2, 637, 736	74, 935, 901		659, 734	33, 806	200. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COSTS	Provider Co		Period: From 01/01/2017	Worksheet D	
Cost Center Description				To 12/31/2017	Part III Date/Time Pre 5/29/2018 5:5	
Cost Center Description		Ti tl	e XIX	Hospi tal	PPS	
oust contain besettight on	Nursing School Nu Post-Stepdown Adjustments	ursing School	Allied Health Post-Stepdown Adjustments 2A		All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		11.00		2.00	0.00	
30. 00	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	30. 00 31. 00 43. 00 200. 00
Cost Center Description	Adjustment ( Amount (see instructions) m	Total Costs sum of cols. 1 through 3, ninus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 43. 00   04300   NURSERY 200. 00   Total (Lines 30 through 199)	0	0 0 0	2, 22 21 21 2, 65	3 0.00 5 0.00	0 12	30. 00 31. 00 43. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	v	2,00	<u></u>	30	233.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 43. 00   04300   NURSERY 200. 00   Total (Lines 30 through 199)	0 0					30. 00 31. 00 43. 00 200. 00

Health Financial Systems	PERRY COUNTY H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1322	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared:

					o 12/31/2017	Date/lime Pre   5/29/2018 5:5	
			Ti tI	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C	C	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	) c	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	ol c	0	0	54.00
60.00	06000 LABORATORY	0	0	ol c	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	ol c	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	0	ol c	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	ol c	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	ol c	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	ol c	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	ol c	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	ol c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	ol c	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	ol c	0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC III	0	0	) c	0	0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0	0	) c	0	0	88. 03
90.00	09000 CLI NI C	0	0	ol c	0	0	90.00
90. 01	09001 PAIN MANAGEMENT	0	0	ıl c	0	0	90. 01
90. 02	09002 WOUND CARE	0	0	ıl c	0	0	90. 02
91.00	09100 EMERGENCY	0	0	ol c	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		c		0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	C	) c	0	0	200. 00

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

From 01/01/2017 Part IV To 12/31/2017 Date/Time Prepared: THROUGH COSTS 5/29/2018 5:55 pm Title XIX Hospi tal All Other Total Cost Ratio of Cost Cost Center Description Total Total Charges to Charges Medi cal (sum of col 1 Outpati ent (from Wkst. C, Education Cost through col. Cost (sum of Part I, col.  $(col. 5 \div col$ col. 2, 3 and 8) 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 5, 572, 967 50.00 05000 OPERATING ROOM 0.000000 50.00 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 679, 086 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 17, 946, 812 0.000000 54.00 54.00 60.00 06000 LABORATORY 0 0 11, 850, 725 0.000000 60.00 OI 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 465, 617 0.000000 62.00 0 65.00 06500 RESPIRATORY THERAPY 0 3, 584, 306 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 2, 735, 782 0.000000 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 0.000000 67.00 1, 248, 010 06800 SPEECH PATHOLOGY 0 0 384, 483 0.000000 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 4, 010, 906 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0.000000 72.00 0 179, 676 72.00 07300 DRUGS CHARGED TO PATIENTS O 12, 806, 020 0.000000 73 00 73.00 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 2, 200, 557 0.000000 88.00 88.00 0 0 0 0 0 0 0 08801 RURAL HEALTH CLINIC II 0 0 433, 277 0.000000 88. 01 88 01 08803 RURAL HEALTH CLINIC III 0 88.02 0 424, 593 0.000000 88.02 88. 03 08802 RURAL HEALTH CLINIC IV 0 0 676, 271 0.000000 88.03 09000 CLI NI C 919, 054 90.00 0 0 0.000000 90.00 09001 PAIN MANAGEMENT 0 0 0.000000 90 01 281, 675 90 01 09002 WOUND CARE 0 90.02 0 1, 312, 660 0.000000 90.02 91.00 09100 EMERGENCY 6, 770, 978 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 0 0 452, 446 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50 through 199) 0 0 0 74, 935, 901 200.00

Hoal th	Financial Systems	PERRY COUNTY	HUSDI TVI		Inlie	eu of Form CMS-:	2552_10
APPORT	TITIBLICAL SYSTEMS  LONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER  H COSTS		Provi der Co		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV	pared:
			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		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	1	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 000000	102, 694		0	0	00.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	58, 038		0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	50, 318		0	0	54.00
	06000 LABORATORY	0. 000000	99, 447		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	2, 292	(	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	48, 460	(	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 481		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 130	(	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	(	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	86, 649	(	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0	(	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	148, 401	(	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS				_		
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	(	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0	(	0	0	88. 01
88. 02	08803 RURAL HEALTH CLINIC III	0. 000000	0	(	0	0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0. 000000	0	(	0	0	88. 03
90.00	09000 CLI NI C	0. 000000	36	(	0	0	90. 00
90. 01	09001 PAIN MANAGEMENT	0. 000000	0	(	0	0	90. 01
	09002 WOUND CARE	0. 000000	0		0	0	90. 02
91.00	09100 EMERGENCY	0. 000000	57, 280		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	3, 508	(	0	0	92.00

0

0

659, 734

0 92.00 95.00

0 200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part V | To 12/31/2017 | Date/Time Prepared:

Cost Center Description					10 12/31/2017	Date/lime Pre 5/29/2018 5:5	
Cost Center Description			Ti tl	e XIX	Hospi tal		
Ratio From   Services (see   Reimbursed   Services Not   Services Not   Services Not   Services Not   Services Not   Services Not   Subject To   Ded. & Coins.				Charges		Costs	
Norksheet C, Part I, col. 9   Inst.)   Services   Services Not   Subject To   Ded. & Colns.   (see Inst.)	Cost Center Description	Cost to Charge PI	PS Reimbursed	Cost	Cost	PPS Services	
Part I, col. 9   Subject To Ded. & Coins.   Subject To Ded. & Coins.   Subject To Ded. & Coins.   See Inst.		Ratio From S	Services (see	Reimbursed	Rei mbursed	(see inst.)	
NOTE		Worksheet C,	inst.)	Servi ces	Services Not		
Note		Part I, col. 9		Subject To	Subject To		
ANCILLARY SERVICE COST CENTERS				Ded. & Coins.			
ANCI LLARY SERVICE COST CENTERS							
50.00		1.00	2. 00	3. 00	4. 00	5. 00	
52.00   05200   DELI VERY ROOM & LABOR ROOM   0.524660   0   0   0   0.52.00					_		
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 161016   0   1, 860, 683   0   0   54. 00			0	600, 350	0	_	
60. 00   06000   LABORATORY   0. 230347   0   1, 206, 431   0   0   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0. 307201   0   10, 104   0   0   62. 00   65. 00   06500   RESPI RATORY THERAPY   0. 250635   0   343, 342   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 279103   0   269, 062   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 267315   0   57, 443   0   0   67. 00   68. 00   08600   SPEECH PATHOLOGY   0. 501619   0   1, 749   0   0   68. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 203311   0   304, 187   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0. 607404   0   3, 953   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 246571   0   534, 658   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 246571   0   534, 658   0   0   73. 00   0017PATIENT SERVICE COST CENTERS  88. 00   08800   RURAL HEALTH CLINIC   1   1   1. 082472   88. 03   88. 02   08803   RURAL HEALTH CLINIC   1   1   1. 082472   88. 03   89. 00   09000   CLINIC   0   1. 566393   0   5, 736   0   90. 00   90. 01   09001   PAIN MANAGEMENT   1. 378997   0   49, 625   0   0   90. 01   90. 02   09002   WOUND CARE   0. 390144   0   53, 487   0   0   90. 02   90. 02   09002   WOUND CARE   0. 390144   0   53, 487   0   0   90. 02   91. 00   09100   DESERVATION BEDS (NON-DISTINCT PART)   1. 148948   0   37, 878   0   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   1. 148948   0   37, 878   0   0   92. 00   07000   OSCONDON   OSCONDON			0	1	-		
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0. 307201   0   10, 104   0   0   62. 00   65. 00   06500   RESPIRATORY THERAPY   0. 350635   0   343, 342   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 267315   0   57, 443   0   0   67. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0. 267315   0   57, 443   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 501619   0   1, 749   0   0   68. 00   67. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 203311   0   304, 187   0   0   71. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 203311   0   304, 187   0   0   72. 00   73. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 203311   0   339, 53   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 246571   0   534, 658   0   0   73. 00   88. 01   08801   RURAL HEALTH CLINIC   1   1   1, 423048   8   0   88. 01   08801   RURAL HEALTH CLINIC   1   1   1, 423048   8   0   88. 02   08803   RURAL HEALTH CLINIC   1   1   1, 568276   8   0   88. 03   08802   RURAL HEALTH CLINIC   1   1   1, 563703   0   90. 00   09000   CLINIC   1, 566393   0   5, 736   0   0   90. 00   90. 01   09001   PAIN MANAGEMENT   1, 378997   0   49, 625   0   0   90. 01   90. 02   09002   WOUND CARE   0, 390144   0   53, 487   0   0   90. 01   90. 04   09000   DEMERGENCY   0. 489973   0   1, 014, 970   0   91. 00   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   1, 148948   0   37, 878   0   0   90. 02   92. 00   09500   AMBULANCE SERVICES   0. 519473   0   6,535,320   0   0   200,000   201. 00   Only Charges   0   0,51467   0   0   0,000   201. 00   Only Charges   0   0,51467   0   0   0,000   201. 00   Only Charges   0   0,51467   0   0   0,000   201. 00   0,001   0,000   0,000   0,000   201. 00   0,000   0,000   0,000   0,000   201. 00   0,000   0,000   0,000   0,000   0,000   201. 00   0,000   0,000   0,000   0,000   0,000   201. 00   0,000   0,000   0,000   0,000   0,000   201. 00   0,000   0,000   0,000   0,000   0,000   201. 00   0,000   0,000   0,000   0,000   0,000			0			0	
65. 00			0			0	
66.00   06600   PHYSICAL THERAPY   0.279103   0   269,062   0   0   66.00	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 307201	0	10, 10	1 0	0	62.00
67. 00 06700 OCCUPATIONAL THERAPY 0. 267315 0 57, 443 0 0 67. 00 68. 00 9FEECH PATHOLOGY 0. 501619 0 1,749 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 203311 0 304, 187 0 0 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 607404 0 3,953 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 246571 0 534, 658 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 246571 0 534, 658 0 0 0 0 00 0000 DRUGS CHARGED TO PATIENTS 0. 246571 0 534, 658 0 0 0 73. 00 0000 DRUGS CHARGED TO PATIENTS 0. 246571 0 534, 658 0 0 0 0 73. 00 0000 DRUGS CHARGED TO PATIENTS 0. 246571 0 534, 658 0 0 0 0 0 0000 DRUGS CHARGED TO PATIENTS 0. 246571 0 534, 658 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	0. 350635	0	343, 342	2 0	0	65. 00
68.00 06800 SPEECH PATHOLOGY 0. 501619 0 1,749 0 0 68.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 203311 0 304, 187 0 0 71.00 72.00 1MPL. DEV. CHARGED TO PATIENT 0. 607404 0 3,953 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 246571 0 534,658 0 0 73.00 00 00 00 00 00 00 00 00 00 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	0. 279103	0	269, 062	2 0	0	66. 00
71.00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 267315	0	57, 443	3 0	0	67. 00
72. 00	68. 00 06800 SPEECH PATHOLOGY	0. 501619	0	1, 749	9 0	0	68. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 246571   0   534, 658   0   0   73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 203311	0	304, 18	7 0	0	71. 00
SECTION   SERVICE COST CENTERS   SERVICES COST CENTERS COST CEN	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 607404	0	3, 953	3 0	0	72.00
88. 00		0. 246571	0	534, 658	3 0	0	73. 00
88. 01							
88. 02	88.00 08800 RURAL HEALTH CLINIC	1. 568276				0	88. 00
88. 03	88.01   08801   RURAL HEALTH CLINIC II	1. 423048				0	88. 01
90. 00	88.02 08803 RURAL HEALTH CLINIC III	1. 082472				0	88. 02
90. 01	88.03   08802   RURAL HEALTH CLINIC IV	1. 553703				0	88. 03
90. 02	90. 00  09000 CLI NI C	1. 566393	0	5, 730	5 0	0	90. 00
91. 00	90. 01   09001   PAI N MANAGEMENT	1. 378997	0	49, 62	5 0	0	90. 01
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1. 148948   0   37,878   0   0   92. 00	90. 02   09002   WOUND CARE	0. 390144	0	53, 48	7 0	0	90. 02
OTHER REIMBURSABLE COST CENTERS   O5. 00   O500   AMBULANCE SERVICES   O. 519473   O   181, 662   95. 00   O200. 00   O   O100	91. 00   09100   EMERGENCY	0. 489973	0	1, 014, 970	0	0	91.00
95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 148948	0	37, 878	3 0	0	92.00
200.00   Subtotal (see instructions)	OTHER REIMBURSABLE COST CENTERS						
201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00 Only Charges	95. 00 09500 AMBULANCE SERVICES	0. 519473	0	181, 662	2		95. 00
Only Charges	200.00 Subtotal (see instructions)		0	6, 535, 320	0	0	200. 00
	201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
202.00   Net Charges (line 200 - line 201)   0 6,535,320 0 0 202.00	Only Charges						
	202.00   Net Charges (line 200 - line 201)		0	6, 535, 320	0	0	202. 00

Health Financial Systems		PERRY COL	UNTY HOSPITAL		In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COS	ST Provi der	CCN: 15-1322	From 01/01/2017	Worksheet D Part V Date/Time Prepared

					To 12/31/2017	Date/Time Pro	
			Ti tl	e XIX	Hospi tal	PPS	
		Cos	sts		•		
	Cost Center Description	Cost	Cost				
	·	Rei mbursed	Rei mbursed				
		Servi ces	Servi ces 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	210, 231	•				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	1				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	299, 600					54. 00
60.00	06000 LABORATORY	277, 898					60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 104					62. 00
65.00	06500 RESPI RATORY THERAPY	120, 388					65. 00
66. 00	06600 PHYSI CAL THERAPY	75, 096					66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	15, 355					67. 00
68. 00	06800 SPEECH PATHOLOGY	877					68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61, 845					71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	2, 401					72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	131, 831	0				73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0				88. 01
	08803 RURAL HEALTH CLINIC III	0	0				88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0	0				88. 03
90. 00	09000 CLI NI C	8, 985					90. 00
	09001 PAI N MANAGEMENT	68, 433					90. 01
	09002 WOUND CARE	20, 868					90. 02
	09100 EMERGENCY	497, 308					91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	43, 520	0				92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	94, 369	l e				95. 00
200.00	, ,	1, 932, 109	0				200. 00
201.00		0					201. 00
	Only Charges		_				
202.00	Net Charges (line 200 - line 201)	1, 932, 109	0				202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1322	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-1  Date/Time Prepared: 5/29/2018 5:55 pm
·	Title XVIII	Hospi tal	Cost

Cost Center Description  ART 1 - ALL PROVIDES COMPONENTS    MRATTER DAYS   1.00					5/29/2018 5:5	5 pm
NAME			Title XVIII	Hospi tal	Cost	
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description			1 00	
INPACTEMENT DAYS		DADT I _ ALL DROVENED COMPONENTS			1.00	
Impatient days (including private room days and saing-bed days, excluding newborn)   3.494   1.00						
Impatient days (including private room days, excluding swing-bed and newborn days)   1.7 you have only private room days.   0.3.00	1.00		s, excluding newborn)		3, 494	1. 00
do not complete this line.  4. 05 Semi-private room days (excluding swing-bed and observation bed days)  7. 00 Total swing-bod SMF type inpatient days (including private room days) after December 31 of the cost period (if callendar year, enter 0 on this line)  7. 00 Total swing-bod SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  7. 00 Total sing-bod MF type inpatient days (including private room days) after December 31 of the cost period (if callendar year, enter 0 on this line)  8. 00 Total sing-bod MF type inpatient days (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including December 31 of the cost reporting	2.00				2, 227	2. 00
Semi-private room days (excluding swing-bed and observation bed days) through December 31 of the cost reporting period reporting period of reporting period of the cost reporting period of reporting period reporting period of reporting period of reporting period reporting period of reporting period reportin	3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period. Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		· ·				
reporting period (if calendar year, enter 0 on this line) 7.00 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost applicable to SNF type services after December 31 of the cost reporting period (line S X into 17) 12.00 Swing-bed cost applicable to SNF type services						
Total swing-Ded SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if ceil endary year, enter 0 on this line)	5.00		om days) through Decembe	r 31 of the cost	984	5.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total sing-good Nf type inpatient days (including private room days) strongin December 31 of the cost reporting period 8.00 Total sing-good type inpatient days (including private room days) after December 31 of the cost 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 9.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (including private room days) 9.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (including private room days) 9.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.01 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.01 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.01 Swing-bed SNF type inpatient days applicable to titles V or XX only (including private room days) 9.02 Swing-bed SNF type inpatient days applicable to titles V or XX only (including private room days) 9.03 Swing-bed SNF type synchroom days applicable to titles V or XX only (including private room days) 9.04 Swing-bed SNF type synchroom days applicable to titles V or XX only (including private room days) 9.05 Swing-bed SNF type synchroom days applicable to services through December 31 of the cost reporting period (including private room days) 9.07 SWING-BRD ADUSTNERY 9.00 Swing-bed cost applicable SNF services applicable to services through December 31 of the cost reporting period (including SWING-BRD ADUSTNERY 9.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line S x iine 12) 9.00 Swing-bed cost ap	4 00		om days) after December	21 of the cost	0	4 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   283   7.00	6.00		oni days) arter becember	31 OF THE COST	U	6.00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SMHs 73 of the cost reporting period (see instructions)  9. 01 Total inpatient days applicable to title XVIII only (including private room days)  9. 02 Swing-bed SMHs 73 of the cost reporting period (see instructions)  9. 03 Swing-bed SMHs 73 of the cost reporting period (see instructions)  9. 04 Including private room days)  9. 05 Swing-bed SMHs 73 of the cost reporting period (see instructions)  9. 05 Swing-bed SMHs 73 of the cost reporting period (see instructions)  9. 06 Swing-bed SMHs 73 of the cost reporting period (see instructions)  10. 07 Swing-bed SMHs 73 of the cost reporting period (see instructions)  10. 08 Swing-bed SMHs 74 of the cost reporting period (see instructions)  10. 08 Swing-bed SMHs 74 of the cost reporting period (see instructions)  10. 09 Swing-bed SMHs 74 of the cost reporting period (see instructions)  10. 00 Indically necessary private room days applicable to titles V or XIX only (including private room days)  10. 00 Indically necessary private room days applicable to services through December 31 of the cost reporting period  10. 00 Indical rorse for swing-bed SMF services applicable to services through December 31 of the cost reporting period  10. 00 Indical orate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (line s x iine 17)  10. 00 Indical orate for swing-bed SMF services through December 31 of the cost reporting period (line s x iine 17)  10. 00 Indical orate for swing-bed SMF services structions)  10. 00 Indical orate for swing-bed SMF services structions  10. 00 Indical orate for swing-bed SMF services structions  10. 00 Indical orate for swing-bed SMF services structions  10. 00 Indical orate for swing-bed SM	7. 00		n davs) through December	31 of the cost	283	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (on this line) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (on this line) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding private room days) 15.00 Intrace nursery days (title V or XIX only) 16.00 Intrace nursery days (title V or XIX only) 17.00 SWING-BED ADUSTMENT 17.00 SWING-BED ADUSTMENT 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (eader rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (load drate for swing-bed NF services applicable to services after December 31 of the cost swing-bed SNF services applicable to services after December 31 of the cost swing-bed SNF services applicable to services after December 31 of the cost swing-bed SNF services applicable to services after December 31 of the cost swing-bed SNF services applicable to services after December 31 of the cost swing-bed SNF services applicable to services after December 31 of the cost swing-bed SNF services swing-bed SNF services swing-bed SNF services after December 31 of the cost reporting period (line 6 SNF sympheticable to SNF type services through December 31 of the cost reporting period (line 6 SNF sympheticable to SNF type services th						
1.00   One   1.0	8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
newborn days						
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 984 10.00 through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 14.00 Nersory days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 16.00 SWIN & BED ADUSTWENT  17.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 17.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost 155.02 20.00 Nedicade rate for swing-bed NF services applicable to services through December 31 of the cost 155.02 20.00 Nedicade rate for swing-bed NF services applicable to services after December 31 of the cost 155.02 20.00 Nedicade rate for swing-bed NF services applicable to services after December 31 of the cost 155.02 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost 155.02 20.00 Nedical d rate for swing-bed NF services after December 31 of the cost reporting period (line 8 x Line 18) 10.00 Nedical drate for swing-bed to SNF type services after December 31 of the cost reporting period (line 8 x Line 18) 10.00 Nedical drate for swing-bed to SNF type services after December 31 of the cost reporting period (line 8 x Line 18) 10.00 Nedical drate for swing-bed cost applicable to SNF type services after December 31 of the co	9. 00		o the Program (excluding	swing-bed and	1, 096	9. 00
through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medical rip necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  15.00 Total nursery days (title V or XIX only)  16.00 Nersery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  20.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total days applicable to services after December 31 of the cost reporting period  22.00 Swing-days (title V or XIX only)  23.00 Swing-days (title V or XIX only)  24.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (10 NP of the cost applicable to SNF type services after December 31 of the cost reporting period (10 NP of the cost applicable to SNF type services after December 31 of the cost reporting period (10 NP of the cost applicable to SNF type services after December 31 of the cost reporting period (10 NP of the cost applicable to SNF type services after December 31 of the cost reporting period (10 NP of the cost applicable to SNF type services after December 31 of the cost	10.00				004	10.00
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x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 43, 871 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 1, 522, 252 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3, 345, 890 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room per diem charge (line 27 + line 28) 0.00 31.00 Semi-private room per diem charge (line 30 + line 3) 0.00 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00 Semi-private room cost differential diem private room cost differential (line 3 x line 31) 0.00 Semi-private room cost differential (line 3 x line 31) 0.00 Semi-private room cost differential diem service cost per diem (see instructions) 1, 502.42 38.00 37.00 Program general inpatient routine service cost per diem (see instructions) 1, 646, 652 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	00.00	· · · · · · · · · · · · · · · · · · ·	04 6 11			00.00
24. 00  25. 00  25. 00  25. 00  25. 00  25. 00  25. 00  26. 00  26. 00  27. 1 ine 19)  26. 00  27. 1 ine 20)  28. 00  29. 00  29. 00  20. 00	23.00		31 of the cost reportin	g period (line 6	0	23.00
7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average private room per diem charge (line 29 + line 3)  32. 00 Average semi-private room per diem charge (line 29 + line 3)  33. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  38. 00 Average and inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24 00	1	31 of the cost reporti	na period (line	43 871	24 00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 32 minus line 33) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21.00		or or the cost reporti	ing period (inte	10, 071	21.00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  38.00 Ajusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00	· · · · · · · · · · · · · · · · · · ·	31 of the cost reporting	period (line 8	0	25. 00
27. 00    Concernation particular routine service cost net of swing-bed cost (line 21 minus line 26)   3, 345, 890   27. 00     PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28. 00     Private room charges (excluding swing-bed charges)   0   29. 00     30. 00   Semi-private room charges (excluding swing-bed charges)   0   30. 00     31. 00   General inpatient routine service cost/charge ratio (line 27 ± line 28)   0. 000000   31. 00     32. 00   Average private room per diem charge (line 29 ± line 3)   0. 00   32. 00     33. 00   Average semi-private room per diem charge (line 30 ± line 4)   0. 00   32. 00     34. 00   Average per diem private room charge differential (line 32 minus line 33) (see instructions)   0. 00   34. 00     35. 00   Average per diem private room cost differential (line 34 x line 31)   0. 00   35. 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 differential (line 37 minus line 36)   27 minus line 36)   PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   1,502. 42   38. 00     39. 00   Program general inpatient routine service cost per diem (see instructions)   1,502. 42   38. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0   40. 00						
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 29.00 30.00 Pri vate room charges (excluding swing-bed and observation bed charges) 0 29.00 30.00 Semi-pri vate room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charges ratio (line 27 ÷ line 28) 0 .0000000 31.00 Average private room per diem charge (line 29 ÷ line 3) 0 .00 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0 .00 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0 .00 34.00 Average per diem private room cost differential (line 34 x line 31) 0 .00 35.00 Average per diem private room cost differential (line 3 x line 35) 0 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) 1, 646, 652 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 29.00 29.00 29.00 20		, ,				
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 Part II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00  29.00 29.00  30.00  30.00  30.00  30.00  30.00  31.00  32.00  32.00  32.00  32.00  33.00  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  0.00 34.00  35.00  36.00  37.00 General inpatient routine service cost and private room cost differential (line 3, 345, 890)  37.00 FORM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  1,646,652 39.00  40.00	27. 00		(line 21 minus line 26)		3, 345, 890	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00	28 00		d and observation had ab	arnes)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00			a and observation bed cir	ai yes)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 0.00 32.00  32.00  32.00 32.00  3						
32.00 Average private room per diem charge (line 29 ÷ line 3)  34.00 Average semi-private room per diem charge (line 30 ÷ line 4)  35.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  36.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 32.00  32.00 33.00  32.00 34.00  34.00  35.00 40.00			- line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  35.00 35.00  37.00 27 minus line 36)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  1, 646, 652 39.00  40.00	32.00	Average private room per diem charge (line 29 ÷ line 3)	ŕ		0.00	32. 00
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 35.00 36.00 37.00 36.00 37.00 3						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 345, 890 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 36.00 37.00				tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00						
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,502.42 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  1,646,652 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,502.42 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  1,646,652 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00	,	and private room cost di	rrentral (IINe	3, 345, 890	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,502.42 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,502.42 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,646,652 39.00 40.00			ISTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,646,652 39.00 40.00	38. 00				1, 502. 42	38. 00
	39. 00	, , , , , , , , , , , , , , , , , , , ,	•		1, 646, 652	
41.00   Iotal Program general inpatient routine service cost (line 39 + line 40)   1,646,652   41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)		1, 646, 652	41.00

Heal th	Financial Systems PERRY COUNTY HOSPITAL In Li	eu of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST Provider CCN: 15-1322 Period: From 01/01/201	Worksheet D-1	
	To 12/31/201		
	Title XVIII Hospital	Cost	<u>Б рііі</u>
	Cost Center Description   Total   Total   Average Per   Program Days  Inpatient Cost Inpatient Days Diem (col. 1 ÷	Program Cost (col. 3 x col.	
	col. 2)	4)	
42. 00	1. 00 2. 00 3. 00 4. 00 NURSERY (title V & XIX only) 0 0 0. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units	100.040	40.00
43. 00 44. 00	INTENSIVE CARE UNIT   827, 095   213   3, 883. 08   12   CORONARY CARE UNIT	489, 268	43. 00 44. 00
45.00			45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		46. 00 47. 00
	Cost Center Description	1.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1. 00 1, 277, 698	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3, 413, 618	
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51. 00
31.00	and IV)		
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	52. 00 53. 00
33. 00	medical education costs (line 49 minus line 52)		33. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54. 00
55. 00	Target amount per discharge	0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	0	61. 00
(2.00	amount (line 56), otherwise enter zero (see instructions)		(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions)	0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	1, 478, 381	64. 00
04.00	instructions)(title XVIII only)	1, 476, 361	04.00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	1, 478, 381	66. 00
67. 00	CAH (see instructions) Title V or XLX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
<b>40.00</b>	(line 12 x line 19)		40.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
	26, line 45)		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2)   Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79. 00 80. 00
81. 00 82. 00	Inpatient routine service cost per diem limitation		81. 00 82. 00
82.00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82. 00 83. 00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	346	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1, 502. 42	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see instructions)	519, 837	89. 00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017		
				To 12/31/2017	Date/Time Prep 5/29/2018 5:5!	
		Title	XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	935, 013	4, 868, 142	0. 19206	8 519, 837	99, 844	90.00
91.00 Nursing School cost	0	4, 868, 142	0.00000	519, 837	0	91.00
92.00 Allied health cost	0	4, 868, 142	0.00000	0 519, 837	0	92.00
93.00 All other Medical Education	0	4, 868, 142	0.00000	0 519, 837	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	Peri od: From 01/01/2017		
		To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
	Title XIX	Hospi tal	PPS	

		Title XIX	Hospi tal	5/29/2018 5: 5 PPS	5 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			3, 494 2, 227	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.		ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 881	4. 00
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	984	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	283	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	23	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private r	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	283	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			215 12	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			12	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18. 00
19. 00					19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	155. 02	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		4, 868, 142	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reporti	ng period (line	43, 871	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			1, 522, 252	
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		3, 345, 890	27. 00
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34. 00
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 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 a 27 minus line 36)	and private room cost di	fferential (line	3, 345, 890	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTAIN TO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 500 10	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 502. 42	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	-		34, 556 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	•		34, 556	
	•	•			

44.00   ORROMARY CARE UNIT	Heal th	Financial Systems PERRY COUNTY HOSPITAL In Lie	u of Form CMS-2	2552-10
Cost Center Description	COMPUT		Worksheet D-1	
Title XIX				
Inpatient Cost Inpatient Dosphipmen (cbit. 1 -   col. 2)			PPS	<u> </u>
1.00   2.00   3.00   4.00   5.00   5.00   4.00   6.00				
10.00   NURSERY (LITLY V. & XIX only)			4)	
Intensive Care Type Inpatient Mospital Units  807,095 213 3,883.08 0 0 0 4  40 00 DROMARY CARE UNIT 4 0 0 0 4  40 00 Busel STRENEY CARE UNIT 4 0 0 0 4  40 00 Busel STRENEY CARE UNIT 4 0 0 0 4  40 00 Busel STRENEY CARE UNIT 4 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42. 00			42. 00
CORDINARY CARE UNIT		Intensive Care Type Inpatient Hospital Units		
4.00   SURGIAL HITMSHY CARE (NAT   4.00   OTHER SPECIAL CARE (SPECIFY)   4.00   OTHER SPECIAL CARE (SPECIFY)   4.00   OTHER SPECIAL CARE (SPECIFY)   4.00   Total Program inpatient cost (suce of ines 41 through 48) (see instructions)   20.2.193   20.2.193   20.2.193   20.2.193   20.0.193   20.2.193   20.2.193   20.0.193   20.2.193   20.0.193   20.2.193   20.0.193   20.2.193   20.0.193   20.0.193   20.2.193   20.0.193   20.0.193   20.2.193   20.0.193   20.0.193   20.2.193   20.0.			U	43. 00 44. 00
1.00   OHER SPECIAL CARE (SPECIFY)   4   0.00   Cost Center Description   1.00   1.0	45.00			45. 00
Cost Center Description  48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)  202, 192  203, 192  204, 485 4  205 POSS TREQUENT COST ADDUSTRETS  50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and 6,613 5  51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 6,613 5  51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 6,613 5  51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and 7,614 5  51.00 Pass through costs applicable to program inpatient ancillary services (from Wkst. D. sum of Parts II and 7,614 5  51.00 Pass Through costs applicable to program inpatient ancillary services (from Wkst. D. sum of Parts II and 7,614 5  52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 7,614 5  52.00 Pass Table Program inpatient poperating cost excluding capital related, non-physician anesthetist, and 7,614 5  52.00 Pass Table Program inpatient poperating cost and target amount (line 5 of minus line 5)  53.00 Pass Table Program inpatient poperating cost and target amount (line 5 of minus line 5)  54.00 Pass Table Program inpatient and target amount (line 5 of minus line 5)  55.00 Difference between adjusted inpatient operating cost and target amount (line 5 of minus line 5)  56.00 Difference between adjusted inpatient operating cost and target amount (line 5 of minus line 5)  57.00 Difference between adjusted inpatient operating cost and target amount (line 5 of minus line 5)  58.00 Difference between adjusted inpatient operating cost and target amount (line 5 of minus line 5)  59.00 Lesser of lines 53/34 or 55 from the cost reporting period ending 1996, updated by the market basket  60.00 Difference between adjusted inpatient part operating costs (line 5 of operating costs (line 5 of operating costs (line 5 of operating co				46. 00 47. 00
Response   Program inpatient ancillary service cost (West. D-3, col. 3, line 200)   202, 192   49, 00   Total Program inpatient costs (com of lines 41 through 48) (see instructions)   246, 485   50.00   Pass through costs applicable to Program inpatient routine services (from West. D, sum of Parts I and III)   100   Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III)   100   Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III)   100   Program excludable cost (sum of lines 50 and 51)   22, 419   53.00   Total Program excludable cost (sum of lines 50 and 51)   22, 419   53.00   Total Program excludable cost (sum of lines 50 and 51)   20, 606   5   MacGet MoMDT AND (Unit COMPUTATION)   200, 600			1.00	
1970   Total Program Inpatient costs (sum of Fines 41 through 48) (see instructions)   248, 485   48	48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48. 00
50.00 Pass through costs applicable to Program Inpatient routine services (From Wkst. D., sum of Parts I and III) 51.00 Pass through costs applicable to Program Inpatient ancillary services (From Wkst. D., sum of Parts II 33,806 S and IV) 52.00 Total Program inpatient cost (sum of lines 50 and 51) 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 20,606 S seed call education costs (line 49 minus line 52) 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 20,606 S seed call education costs (line 49 minus line 52) 53.00 Total Program inpatient perating cost excluding capital related, non-physician anesthetist, and 20,606 S seed call education costs (line 54 minus line 52) 54.00 Total program dischage (see instructions) 55.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Response payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the analysis and the seed to be seen of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the analysis and the seen of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		
51.00 Pass through costs applicable to Program inpatient anciliary services (from Wist. D. sum of Parts II all 80, and IV)  Total Program excludable cost (sum of lines 50 and 51)  Total Program excludable cost (sum of lines 50 and 51)  Total Program any patient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARKET AMOUNT AND LIMIT COMPUTATION  Program discharges  O.05  TOTAL TOT	50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	8, 613	50. 00
52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) TARCE AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges  55.00 Target amount per discharge  56.00 Target amount per discharge  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Bonus payment (see instructions)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket and see of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket and see of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket and see of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket and see of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket and see of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket and see of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket and see of lines 53/54 or 55 from the cost reporting period (50 or 16 in 1997) and 1998 and 1998 and 1998 and 1999	51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	33, 806	51. 00
medical education costs (line 49 minus line 52)  54.00 Program discharges  55.00 Target amount per discharge  56.00 Target amount per discharge  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Bonus payment (see instructions)  59.00 Loses of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  60.00 Loses of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Loses of lines 53/54 or 55 from the cost report, updated by the market basket  60.00 Loses of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Loses of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Loses of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Loses of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Loses of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Loses of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Loses of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Loses of lines 53/54 or 55 from prior year cost report of the cost reporting period (see line from prior year cost year year year year year year year year	52. 00		42, 419	52. 00
TARGET AMOUNT AND LIMIT COMPUTATION  55.00 Target amount per discharges 0.00 5  55.00 Target amount per discharges 0.00 5  55.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.5  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.5  58.00 Bous payment (see instructions) 0.5  59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated by the market basket 0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 6  60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.0  60.00 Relief payment (see instructions) 0.0  61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.0  61.00 Relief payment (see instructions) 0.0  62.00 Relief payment (see instructions) 0.0  63.00 Allowable inpatient cost plus incentive payment (see instructions) 0.0  64.00 Modicare swing-bed SNF impatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only) 1.0  65.00 Modicare swing-bed SNF impatient routine costs through December 31 of the cost reporting period 0.0  66.00 Total Medicare swing-bed SNF impatient routine costs (line 64 plus line 65) (title XVIII only). For 0.0  67.00 Total Medicare swing-bed SNF impatient routine costs (line 67 + line 68) 43,871 6  68.00 Total title V or XIX swing-bed NF impatient routine service costs (line 67 + line 68) 43,871 6  69.00 Total title V or XIX swing-	53. 00		206, 066	53. 00
55.00 Target amount pir discharge 56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Rell ef payment (see instructions) 60.00 Rell ef payment		TARGET AMOUNT AND LIMIT COMPUTATION		
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Losser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Losser of lines 53/54 or 55 from the cost report, updated by the market basket 61.00 Lift lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 63.00 Allowable inpatient cost plus incentive payment (see instructions) 64.00 Medicare swin-peed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swin-peed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 66.00 Total Medicare swin-peed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 7 + line 2) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 2) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 97 + line 73) 60 Medically necessary private room cost applicable to Program (line 14 x line 35) 60 Capital -related cost (line 98 x line 76) 61 Inpatient routi				54. 00 55. 00
S8.00 Bonus payment (see instructions)  59.00 Losser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  60.00 Losser of lines 53/54 or 55 from prior year cost report, updated by the market basket  61.00 If lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SWE inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XWIII only)  65.00 Medicare swing-bed SWE inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XWIII only)  66.00 Total Medicare swing-bed SWE inpatient routine costs (line 64 plus line 65) (title XWIII only). For CAH (see instructions) (title XWIII only) of CAH (see instructions) (title VXVIII only) of CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 72 + line 73)  60.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 73 + line 2)  70.00 Skilled nursing facility/other nursing facility/ICP/IID routine service cost (line 73 + line 2)  71.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  72.00 Program routine service cost (line 75 + line 2)  73.00 Adjusted general inpatient	56. 00	Target amount (line 54 x line 55)	0	56. 00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 71 lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see Instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 77 + line 2)  70.00 Skilled nursing facility/other nursing facility/lCF/IID routine service c				57. 00 58. 00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.02 Adjusted general inpatient routine service cost (line 67 + line 68) 60.03 Adjusted general inpatient routine service cost (line 70 + line 2) 61.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 62.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 63.00 Total Program proutine service cost (line 75 + line 2) 64.00 Total Program general inpatient routine service costs (from provider records) 65.00 Total Program routine service cost (line 75 + line 2) 66.00 Total Program inpatient routine service costs (see instructions) 66.0		Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the		
61.00 If line \$3/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Allowable Inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)  Allowable Inpatient routine costs (line 64 plus line 65) (title XVIII only).  Allowable Inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Bayon Intel V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  Allowable Inpatient routine costs (line 67 + line 68)  Allowable Inpatient routine service costs (line 67 + line 68)  Allowable Inpatient routine service cost (line 37)  Allowable Inpatient routine service cost peridient (line 70 + line 2)  Allowable Inpatient routine service costs (line 72 + line 73)  Allowable Inpatient routine service costs (line 72 + line 73)  Allowable Inpatient routine service costs (line 75 + line 2)  Allowable Inpatient routine service costs (line 77)  Allowable Inpatient routine service costs (line 77)  Allowable Inpatient routine service costs (line 77)  Allowable Inpatient routine service costs (line 78 minus line 79)  Allowable Inpatient routine service costs (line 11 minus line 77)  Allowable Inpatient routine service costs (see instructions)  Allowable Inpatient rou	60. 00		0. 00	60. 00
amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.02 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.02 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/IOF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related costs (line 9 x line 76)  76.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program inpatient ancillary services (see instructions)  81.00 Inpatient	61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0	61. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Ocatal Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Ocatal Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Ocatal Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  68.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.01 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.02 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.03 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 9 x line 76)  77.00 Program capital-related costs (line 9 x line 77)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program inpatient routine service costs (see instructions)  80.00 Total Program inpatien				
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0 6  67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0 6  68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 20)  70.00 Total program routine service cost (line 70 + line 70 + line 20)  71.00 Agregate charges routine service cost (line 70 + line 70)  72.00 Program capital-related cost (line 75 + line 2)  73.00 Program capital-related cost (line 75 + line 2)  74.00 Total Program routine service cost (line 77 + line 76)  75.00 Agregate charges to beneficiaries for excess costs (from provider records)  76.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost limitation (line 9 x l				
instructions)(title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.01 PART III - SKILLED NURSING FACILITY. OTHER NURSING FACILITY, AND ICF/IID ONLY  70.02 SKIIIed nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  82.00 Inpatient routine service cost for somparison to the cost limitation (line 78 minus line 79)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)	03.00	PROGRAM INPATIENT ROUTINE SWING BED COST		
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 (Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 * line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 * line 2)  77.00 Program capital related costs (line 75 * line 2)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost (see instructions)  83.00 Reasonable inpatient routine service (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	64. 00		0	64. 00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 67.10 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 68.10 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.01 Total visit of title V or XIX swing-bed NF inpatient routine service cost (line 37) 69.02 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY 69.03 Skilled nursing facility/other nursing facility/ICE/IID routine service cost (line 37) 69.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 60.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 60.00 Total Program general inpatient routine service costs (line 72 + line 73) 60.01 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 60.00 Per diem capital-related costs (line 75 + line 2) 60.00 Total Program routine service cost (line 76) 60.00 Total Program routine service costs (from provider records) 60.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 60.01 Inpatient routine service cost (see instructions) 60.00 Medically necessary inpatient ancillary services (see instructions) 60.00 Total Program inpatient accillary services (see instructions) 60.00 Total Program inpatient operating costs (sum of lines 83 through 85)	65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICE/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.10 Inpatient routine service cost limitation (line 9 x line 81) 70.11 Reasonable inpatient ancillary services (see instructions) 70.12 Reasonable inpatient ancillary services (see instructions) 71.01 Aggregam inpatient ancillary services (see instructions) 72.03 Reasonable inpatient operating costs (sum of lines 83 through 85)	66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital related costs (line 75 + line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.01 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	43, 871	67. 00
Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital -related costs (line 75 ÷ line 2)  77.00 Program capital -related costs (line 9 x line 76)  1 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  70.01 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Inpatient routine service cost (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  7 Total Program inpatient operating costs (sum of lines 83 through 85)	68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 1 Inpatient routine service cost per diem limitation 2 Inpatient routine service cost limitation (line 9 x line 81) 8 Reasonable inpatient routine services (see instructions) 8 Program inpatient ancillary services (see instructions) 8 Utilization review - physician compensation (see instructions) 8 Utilization review - physician compensation (see instructions) 8 Total Program inpatient operating costs (sum of lines 83 through 85)	69. 00		43, 871	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital—related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital—related costs (line 75 ÷ line 2) 77.00 Program capital—related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	70 00			70. 00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	71. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71. 00
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				72. 00 73. 00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74. 00
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	75. 00	26. line 45)		75. 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)		· · · · · · · · · · · · · · · · · · ·		76. 00 77. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				79. 00 80. 00
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	81. 00	Inpatient routine service cost per diem limitation		81. 00
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)		· · · · · · · · · · · · · · · · · · ·		82. 00 83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	84. 00	Program inpatient ancillary services (see instructions)		84. 00
				85. 00 86. 00
		PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	_	
87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  1,502.42 8				
89.00 Observation bed cost (line 87 x line 88) (see instructions)	89. 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 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	935, 013	4, 868, 142	0. 19206	8 519, 837	99, 844	90.00
91.00 Nursing School cost	0	4, 868, 142	0.00000	0 519, 837	0	91.00
92.00 Allied health cost	0	4, 868, 142	0.00000	0 519, 837	0	92.00
93.00 All other Medical Education	0	4, 868, 142	0. 00000	0 519, 837	0	93. 00

	Financial Systems PERRY ENT ANCILLARY SERVICE COST APPORTIONMENT	COUNTY HOSPITAL Provider C	CN: 15-1322	Peri od:	u of Form CMS-2 Worksheet D-3	
1 101 7411	ENT ANOTEEART SERVICE COST ALTORITONIMENT	Trovider 6	014. 15 1522	From 01/01/2017	WOI KSHEEL D 5	
				To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
		Ti tl e	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INDATIENT DOUTINE CEDVICE COCT CENTEDO		1.00	2. 00	3. 00	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS		I	1, 170, 875		30.00
31. 00	03100   NTENSI VE CARE UNI T			271, 782		31.00
	04300 NURSERY			2/1, /02		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS		l			45.00
50. 00	05000 OPERATI NG ROOM		0. 35018	34, 843	12, 201	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 52466		0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1610 <sup>-</sup>	16 600, 699	96, 722	54.00
60.00	06000 LABORATORY		0. 23034	47 719, 672	165, 774	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 30720	01 47, 388	14, 558	62. 00
65.00	06500 RESPI RATORY THERAPY		0. 35063		226, 402	
66.00	06600 PHYSI CAL THERAPY		0. 27910			
	06700 OCCUPATI ONAL THERAPY		0. 2673		•	
	06800 SPEECH PATHOLOGY		0. 5016			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2033	•	104, 157	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 60740		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0. 2465	71 1, 660, 113	409, 336	73. 00
88. 00	08800 RURAL HEALTH CLINIC		0.0000	20	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC		0.00000		0	88. 01
88. 02	08803 RURAL HEALTH CLINIC III		0.00000		0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV		0.00000		0	88. 03
90.00	09000 CLI NI C		1. 56639		_	
	09001 PALN MANAGEMENT		1. 37899		0	90. 01
90. 02	09002 WOUND CARE		0. 39014	44 0	0	90. 02
	09100 EMERGENCY		0. 4899		5, 942	
02 00	00000 ODCEDVATION DEDC (NON DICTINCT DADT)		1 1 1 1 1 0 0	40	0	00 00

4, 563, 851

0 4, 563, 851 92. 0095. 00

201. 00 202. 00

1, 277, 698 200. 00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

200.00

201. 00 202. 00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

	Financial Systems	PERRY COUNTY HOSPITAL			u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od: From 01/01/2017	Worksheet D-3	
		Component		To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
		Title	XVIII	Swing Beds - SNF		<u>o p</u>
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		1	
	03000 ADULTS & PEDIATRICS			0		30.00
	03100   NTENSIVE CARE UNIT			0		31.00
43. 00	04300 NURSERY					43. 00
F0 00	ANCILLARY SERVICE COST CENTERS		0.05046	200	0.40	F0 00
50.00	05000 OPERATING ROOM		0. 35018			
	05200 DELIVERY ROOM & LABOR ROOM		0. 52466			52.00
54. 00	05400   RADI OLOGY-DI AGNOSTI C   06000   LABORATORY		0. 16101			
60. 00 62. 00			0. 23034			
65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY		0. 30720 0. 35063		<b>l</b>	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 33003			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 26731			
	06800 SPEECH PATHOLOGY		0. 50161			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 20331			
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 60740		l	72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 24657			
70.00	OUTPATIENT SERVICE COST CENTERS		0.21007	1 100, 170	111,017	70.00
88. 00	08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
	08801 RURAL HEALTH CLINIC II		0.00000		0	88. 01
	08803 RURAL HEALTH CLINIC III		0.00000		0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV		0.00000		l o	88. 03
90. 00	09000 CLI NI C		1. 56639		20, 062	
90. 01	09001 PAIN MANAGEMENT		1. 37899		0	1
90. 02	09002 WOUND CARE		0. 39014		0	90. 02
91.00	09100 EMERGENCY		0. 48997	73 0	0	91.00
	OOGOO ORCEDVATION REDC (NON DISTINCT DART)		1 1 1 1 1 0 0 1		۱ .	00 00

470, 170 200. 00 201. 00 202. 00

92.00 95.00

1. 148948

1, 682, 139

1, 682, 139

200.00

201.00 202.00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

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

	Financial Systems	PERRY COUNTY HOSPITAL			u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1322	Peri od: From 01/01/2017	Worksheet D-3	
				To 12/31/2017		
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30.00	03000 ADULTS & PEDIATRICS			90, 919		30.00
31.00	03100 INTENSIVE CARE UNIT			28, 990		31.00
43.00	04300 NURSERY			9, 888		43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 35018			
	05200 DELIVERY ROOM & LABOR ROOM		0. 52466			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 16101			
60.00	06000 LABORATORY		0. 23034			60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 30720		<b>l</b>	62. 00
65. 00	06500 RESPI RATORY THERAPY		0. 35063			65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 27910			
	06700 OCCUPATI ONAL THERAPY		0. 26731		l	67. 00
	06800 SPEECH PATHOLOGY		0. 5016			68. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 20331			71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS		0. 60740 0. 24657			72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS		0. 2465	148, 401	36, 591	73.00
88. 00	08800 RURAL HEALTH CLINIC		1. 56827	76 0	0	88. 00
	08801 RURAL HEALTH CLINIC II		1. 42304		0	88. 01
88. 02	08803 RURAL HEALTH CLINIC III		1. 08247		0	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV		1. 55370		0	88. 03
90.00	09000 CLINIC		1. 56639		56	90.00
90. 01	09001 PALN MANAGEMENT		1. 37899			90. 01
90. 02	09002 WOUND CARE		0. 39014		Ö	90. 02
	09100 EMERGENCY		0. 48997		28, 066	
	OOGOO ODCEDVATION DEDC (NON DICTINCT DADT)		1 1400			00 00

3, 508

659, 734

659, 734

1. 148948

4, 031

202, 192 200. 00 201. 00 202. 00

92.00 95.00

200.00 201.00 202.00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

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

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1322	Peri od: Worksheet E From 01/01/2017 Part B Date/Time Prepared: 5/29/2018 5.55 pm

			10 12/31/2017	5/29/2018 5:5	
		Title XVIII	Hospi tal	Cost	Орш
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6, 173, 339	
2. 00	Medical and other services reimbursed under OPPS (see instructions)	ti ons)		0	
3. 00	OPPS payments			0	
4.00	Outlier payment (see instructions)			0	
4. 01	Outlier reconciliation amount (see instructions)	-+:>		0	
5.00	Enter the hospital specific payment to cost ratio (see instruction 2 times line 5	ctions)		0.000	1
6. 00 7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV col 13 line 200		0	
10. 00	Organ acquisitions	14, 661. 16, 11116 266		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 173, 339	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				1
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 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			0	
16. 00	Amounts that would have been realized from patients liable for	1 3	n a c <b>n</b> argebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(a Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17. 00
	Total customary charges (see instructions)			0.00000	l .
19. 00	Excess of customary charges over reasonable cost (complete onl	lv if line 18 exceeds lin	ne 11) (see	0	l
17.00	instructions)	Ty TT TTHE TO EXCEEDED TT	(300	Ĭ	17.00
20.00	Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			6, 235, 072	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			// 101	1 25 00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	r CAU soo instructions)		66, 121 3, 306, 717	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		and 231 (see	2, 862, 234	
27.00	instructions)	prus the sum of fries 22	ana 25] (300	2,002,254	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)		0	28. 00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	·		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2, 862, 234	30.00
31.00	Primary payer payments			1, 479	31.00
32.00	Subtotal (line 30 minus line 31)			2, 860, 755	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CES)		·	
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			127, 754	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	munti ana)		83, 040	
	Subtotal (see instructions)	ructions)		0 2, 943, 795	
	MSP-LCC reconciliation amount from PS&R			2, 943, 793	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	e)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration	~ <i>,</i>		0	l
39. 98	Partial or full credits received from manufacturers for replacements	ced devices (see instruc	tions)		39. 98
	RECOVERY OF ACCELERATED DEPRECIATION	actions (See Thatiac	5115)		1
40. 00	Subtotal (see instructions)			2, 943, 795	
40. 01	Sequestration adjustment (see instructions)			58, 876	1
40. 02	Demonstration payment adjustment amount after sequestration			0	
41.00	Interim payments			3, 018, 799	41.00
42.00	Tentative settlement (for contractors use only)			0	1
43.00	Balance due provider/program (see instructions)			-133, 880	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, (	chapter 1,	0	44.00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			_	00.00
	Original outlier amount (see instructions)			0	l
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
92.00	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94.00
, 1. 00	1.000. (00 01 111100 /1 4114 /0)			, ,	, , , , , ,

Health Financial Systems PE
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1322

Title XVIII Hospital  Inpatient Part A Part B  mm/dd/yyyy Amount mm/dd/yyyy Am  1.00 Z.00 3.00 4  1.00 Total interim payments paid to provider 2,744,980 3  2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero  3.00 List separately each retroactive lump sum adjustment	2018 5:55 Cost	
mm/dd/yyyy Amount mm/dd/yyyy Am  1.00 2.00 3.00 4  1.00 2.744,980 3  2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero  3.00 List separately each retroactive lump sum adjustment		
1.00 2.00 3.00 4  1.00 Total interim payments paid to provider 2,744,980 3  2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero  3.00 List separately each retroactive lump sum adjustment		
1.00 2.00 3.00 4  1.00 Total interim payments paid to provider 2,744,980 3  2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero  3.00 List separately each retroactive lump sum adjustment	ount	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero  3.00 List separately each retroactive lump sum adjustment	. 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	, 018, 799	1. 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	ol	2.00
write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment		
3.00 List separately each retroactive lump sum adjustment		
		3.00
amount based on subsequent revision of the interim rate		
for the cost reporting period. Also show date of each		
payment. If none, write "NONE" or enter a zero. (1)		
Program to Provider		
3.01 ADJUSTMENTS TO PROVIDER 0	0	3. 01
3.02	0	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	0	3. 50
3.51	0	3. 51
3.52	0	3. 52
3.53	0	3. 53
3.54	0	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0	0	3. 99
3. 50-3. 98)	040 700	
	, 018, 799	4. 00
(transfer to Wkst. E or Wkst. E-3, line and column as		
appropriate) TO BE COMPLETED BY CONTRACTOR		
5.00 List separately each tentative settlement payment after		5. 00
desk review. Also show date of each payment. If none,		5.00
write "NONE" or enter a zero. (1)		
Program to Provider		
5.01 Tentative to provider	0	5. 01
5.02	0	5. 02
5.03	0	5. 03
Provider to Program	<u> </u>	0.00
5.50 TENTATI VE TO PROGRAM O	0	5. 50
5.51	ol	5. 51
5. 52	ol	5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0	ol	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 298,026	0	6. 01
6.02 SETTLEMENT TO PROGRAM 0	133, 880	6. 02
7.00 Total Medicare program Liability (see instructions) 3,043,006 2	, 884, 919	7. 00
	Date	
	ay/Yr)	
	. 00	
8.00   Name of Contractor		8. 00

Health Financial Systems PE
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED 

		Component	CCN. 13-2322   1	0 12/31/201/	5/29/2018 5: 5	
		Title	XVIII S	wing Beds - SNF		•
		I npati en	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 888, 896	1	0	1.00
2.00	Interim payments payable on individual bills, either		( c	)	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		1		_	
3. 01	ADJUSTMENTS TO PROVIDER		C		0	
3. 02			C		0	
3. 03			C		0	
3.04			C		0	
3. 05			C		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		1 0		0	2 50
3. 50	ADJUSTMENTS TO PROGRAM				0	
3. 52					0	
3. 52					0	1 0.02
3. 54					0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	
3. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 888, 896		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as		", ", ", ", ", ", ", ", ", ", ", ", ",			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	•				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		( C		0	
5. 02			C		0	
5. 03			<u> </u>		0	5. 03
F F0	Provi der to Program		1	ı	1 0	
5. 50	TENTATI VE TO PROGRAM		C		0	
5. 51			C		0	0.0.
5. 52 5. 99	Subtatal (sum of lines E 01 E 40 minus sum of lines				0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		27, 367	,	0	6, 01
6. 02	SETTLEMENT TO PROGRAM		27,507		0	
7. 00	Total Medicare program liability (see instructions)		1, 916, 263		0	
	The second of th		1,7.3,200	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	0	1. 00	2.00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems PERRY COUNTY H	IOSPI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1322 Period: White Provider CCN: White Provider CCN: 15-1322 Period: Whit					
	From 01/01/2017   P To 12/31/2017   D 5					
		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 line	· 14		1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00	
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			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 l	ine 20			6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
8. 00	line 168				8. 00	
	9.00 Sequestration adjustment amount (see instructions)					
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10. 00	
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				30.00	
	Initial/interim HIT payment adjustment (see instructions)				30.00	
	11.00 Other Adjustment (specify)				31.00	

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	PERRY COUNTY H	PERRY COUNTY HOSPITAL		
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1322	Peri od:	Worksheet E-2
			From 01/01/2017	
		Component CCN: 15-Z322	To 12/31/2017	Date/Time Prepared:
				5/20/2018 5:55 nm

		Component Con. 13-2322	10 12/31/2017	5/29/2018 5:5	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 493, 165	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		474, 872	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4. 00
	instructions)				
5.00	Program days		984	0	
6.00	Interns and residents not in approved teaching program (see in			0	
7.00	Utilization review - physician compensation - SNF optional me	thod only	1 0/0 027	0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 968, 037	0	
9. 00 10. 00	Primary payer payments (see instructions)		1 0/0 027	0	
	Subtotal (line 8 minus line 9)	and a to physician	1, 968, 037	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	U	0	11. 00
12. 00	professional services) Subtotal (line 10 minus line 11)		1 040 027	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records)	\ (aveluda cai neuranca	1, 968, 037 12, 667	0	13.00
13.00	for physician professional services)	(exclude collisulance	12,007	U	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	1, 955, 370	0	1
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	1, 700, 070	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)	٩	· ·	16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr		0		16. 55
.0.00	adjustment (see instructions)	atton, paymont	٩		10.00
16. 99	Demonstration payment adjustment amount before sequestration		ol	0	16. 99
	Allowable bad debts (see instructions)		o	0	1
	Adjusted reimbursable bad debts (see instructions)		o	0	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	o	0	18.00
19.00	Total (see instructions)		1, 955, 370	0	19.00
19. 01	Sequestration adjustment (see instructions)		39, 107	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		o	0	19. 02
20.00	Interim payments		1, 888, 896	0	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	27, 367	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement	Miss D 1 Dt II I issue			201 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from N	WKST. D-1, Pt. II, IIne			201. 00
202.00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst D 2 col 2 lin			202. 00
202.00	200 (title XVIII swing-bed SNF))	II WKSt. D-3, COI. 3, IIII	e		202.00
303 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204. 00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demonst	ration	1204.00
	period)	Trist year or the earle	iit 5 year demonstr	i a ti on	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				1
207.00	Program reimbursement under the §410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	-	1		208.00
	and 3)				
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
	Reserved for future use	•			210. 00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1322	From 01/01/2017	Worksheet E-3 Part V Date/Time Prepared: 5/29/2018 5:55 pm
	Title XVIII	Hospi tal	Cost

				5/29/2018 5:5	5 pm
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			3, 413, 618	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
3.00	Organ acquisition	•		o	3. 00
4.00	Subtotal (sum of lines 1 through 3)			3, 413, 618	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 447, 754	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 117, 701	0.00
	Reasonable charges				
7.00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			o	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
10.00	Customary charges			0	10.00
11. 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge hasis	0	11. 00
12.00	Amounts that would have been realized from patients liable for			0	12. 00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)		ii a charge basis	O	12.00
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)			0.000000	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	v if line 14 exceeds li	na 6) (saa	0	15. 00
13.00	instructions)	Ty II IIIIe 14 exceeds II	(3ee	U	13.00
16. 00	Excess of reasonable cost over customary charges (complete only	vifline 6 exceeds lin	e 14) (see	0	16. 00
10.00	instructions)	Ty IT TIME O EXCEEDS ITH	C 11) (300	J	10.00
17. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		o	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	4011 0113)		U	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-	1 line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	1, 11116 17)		3, 447, 754	
20. 00	Deductibles (exclude professional component)			345, 935	
21. 00	Excess reasonable cost (from line 16)			0 10, 700	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 101, 819	22. 00
23. 00	Coi nsurance			3, 101, 017	23. 00
24. 00	Subtotal (line 22 minus line 23)			3, 101, 819	
25. 00	Allowable bad debts (exclude bad debts for professional service	cas) (saa instructions)		5, 060	
26. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see mistructions)		3, 289	
27. 00	Allowable bad debts for dual eligible beneficiaries (see insti	suctions)		3, 207	27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	detrons)		3, 105, 108	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			3, 103, 108	29. 00
29. 50	, , , , ,	-)		0	29. 50
29. 30	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	5)		0	29. 30
	, , , , , , , , , , , , , , , , , , , ,			-	
30. 00 30. 01	Subtotal (see instructions)			3, 105, 108 62, 102	
	Sequestration adjustment (see instructions)			· ·	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			2 744 000	
31.00	Interim payments			2, 744, 980	
32.00	Tentative settlement (for contractor use only)	2 21 22)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0)		abanton 1	298, 026	33.00
34. 00	Protested amounts (nonallowable cost report items) in accordance in acco	ice with CMS Pub. 15-2,	chapter I,	0	34. 00
	§115. 2				l

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

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

Worksheet G
7
Date/Time Prepared:

5/29/2018 5:55 pm Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 Cash on hand in banks 2, 308, 221 0 0 0 1.00 Temporary investments 2, 982, 255 0 0 2.00 0 2.00 0 3.00 Notes receivable 0 0 3.00 11, 086, 872 0 4 00 4 00 Accounts receivable 0 0 5.00 Other receivable 728, 184 0 0 5.00 6.00 Allowances for uncollectible notes and accounts receivable -7, 156, 832 6.00 0 7.00 Inventory 634, 989 0 0 7.00 0 8.00 Prepaid expenses 419, 030 0 8.00 0 9.00 Other current assets 0 9.00 10 00 Due from other funds 0 0 0 10 00 Total current assets (sum of lines 1-10) 11, 002, 719 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 3, 815, 753 0 0 0 12.00 Land improvements 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 -5, 066, 667 οĺ Accumulated depreciation 14.00 -14, 782 0 14.00 15.00 Bui I di ngs 43, 907, 603 0 0 15.00 16.00 Accumulated depreciation -2, 334, 348 0 16.00 0 17.00 Leasehold improvements 17.00 0 C 0 18 00 Accumulated depreciation 0 18 00 Fi xed equipment 2, 330, 717 19.00 19.00 0 0 20.00 Accumulated depreciation -162, 801 0 20.00 0 21.00 Automobiles and trucks 477, 834 0 21.00 22.00 Accumulated depreciation -129, 398 Ω 22.00 23.00 Major movable equipment 15, 339, 549 0 0 23.00 Accumulated depreciation -8, 252, 964 24.00 0 24.00 0 25.00 Mi nor equi pment depreci able C Ω 25, 00 26.00 Accumulated depreciation 0 0 26.00 C 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 28.00 Accumulated depreciation 0 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 49, 910, 496 0 30.00 OTHER ASSETS 31 00 Investments O 0 0 31 00 0 0 32.00 Deposits on Leases C 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 1, 975, 000 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 1, 975, 000 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 62, 888, 215 0 0 0 36.00 CURRENT LIABILITIES 37 00 1, 515, 154 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 0 38.00 0 Payroll taxes payable 802, 175 0 39.00 39.00 0 40.00 Notes and Loans payable (short term) 38, 613, 217 0 40.00 0 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 1, 675, 926 0 0 44.00 0 44.00 Total current liabilities (sum of lines 37 thru 44) 42, 606, 472 0 0 45.00 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 46.00 0 0 47.00 Notes payable 0 0 47.00 48 00 Unsecured Loans C 0 0 0 48 00 Other long term liabilities 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 42, 606, 472 51.00 0 0 0 51.00 CAPITAL ACCOUNTS General fund balance 20, 281, 743 52.00 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 0 57.00 58.00 0 58.00 replacement, and expansion Total fund balances (sum of lines 52 thru 58) 20, 281, 743 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 62, 888, 215 0 0 0 60.00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-1322

					10 12/31/2017	5/29/2018 5:5	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		21, 887, 514		(		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1, 605, 771				2. 00
3.00	Total (sum of line 1 and line 2)		20, 281, 743		(		3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		0		(	P	10.00
11. 00	Subtotal (line 3 plus line 10)		20, 281, 743		(		11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16.00		0			0	0	16.00
17. 00	Total deductions (sum of Lines 12 17)	0	0		0	0	17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		20, 281, 743				18. 00 19. 00
19.00	sheet (line 11 minus line 18)		20, 281, 743				19.00
	Sheet (Title II illinus IIIIe 10)	Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9.00		_	0				9. 00
	Total additions (sum of line 4-9)	I OI			0		10.00
10.00		-	ı				
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
11. 00 12. 00		-	0				11. 00 12. 00
11. 00 12. 00 13. 00	Subtotal (line 3 plus line 10)	-	0				11. 00 12. 00 13. 00
11. 00 12. 00 13. 00 14. 00	Subtotal (line 3 plus line 10)	-	0 0				11. 00 12. 00 13. 00 14. 00
11. 00 12. 00 13. 00 14. 00 15. 00	Subtotal (line 3 plus line 10)	-	0 0 0				11. 00 12. 00 13. 00 14. 00 15. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Subtotal (line 3 plus line 10)	-	0 0 0 0				11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	o	0 0 0 0 0		0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17)	-	0 0 0 0 0				11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	o	0 0 0 0 0		0		11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00

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

			To 12/31/2017	Date/Time Prep 5/29/2018 5:5	
	Cost Center Description	Inpatient	Outpati ent	Total	o piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	2, 467, 19	5	2, 467, 195	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	2, 467, 19	5	2, 467, 195	10. 00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	493, 83	0	493, 830	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)	400.00		400.000	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	493, 83	0	493, 830	16. 00
17. 00	11-15)   Total inpatient routine care services (sum of lines 10 and 16)	2, 961, 02	_	2, 961, 025	17. 00
18. 00	Ancillary services	11, 736, 71		72, 411, 105	
19. 00	Outpatient services	1	0 00, 074, 389	72, 411, 103	19.00
20. 00	RURAL HEALTH CLINIC	I	0 2, 200, 557	2, 200, 557	20.00
20. 00	RURAL HEALTH CLINIC II	•	0 433, 277	433, 277	
20. 01	RURAL HEALTH CLINIC III		0 424, 593	424, 593	20. 01
20. 02	RURAL HEALTH CLINIC IV		0 676, 271	676, 271	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0,0,2,1	0,0,2,1	21.00
22. 00	HOME HEALTH AGENCY		2, 638, 719	2, 638, 719	22. 00
23. 00	AMBULANCE SERVICES		0 3, 121, 240	3, 121, 240	
24. 00	CMHC		0, 121, 210	0/ 121/210	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE		o	0	26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	14, 697, 74	1 70, 169, 046	84, 866, 787	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		39, 271, 579		29. 00
30.00	ADD (SPECIFY)		0		30. 00
31.00			0		31. 00
32.00			0		32. 00
33.00			0		33. 00
34.00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0		40.00
41. 00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	ster	39, 271, 579		43. 00
	to Wkst. G-3, line 4)	1		l	I

Heal th	Financial Systems PERRY C	COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1322	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	nared:
			10 12/31/201/	5/29/2018 5: 5	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column			84, 866, 787	1. 00
2.00	Less contractual allowances and discounts on patients'	accounts		49, 280, 574	
3.00	Net patient revenues (line 1 minus line 2)			35, 586, 213	
4.00	Less total operating expenses (from Wkst. G-2, Part II			39, 271, 579	
5.00	Net income from service to patients (line 3 minus line	4)		-3, 685, 366	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			628, 457	1
7. 00	Income from investments			384, 082	1
8.00	Revenues from telephone and other miscellaneous commun	ication services		0	
9. 00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			14, 656	
12.00	Parking lot receipts			0	
13. 00	Revenue from Laundry and Linen service			0	1
14.00	Revenue from meals sold to employees and guests			105, 093	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to	other than patients		0	16. 00
	Revenue from sale of drugs to other than patients				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			30, 216	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUE			917, 091	24.00
25.00	Total other income (sum of lines 6-24)			2, 079, 595	25. 00
26.00	Total (line 5 plus line 25)			-1, 605, 771	26. 00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 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 lin	e 28)		-1, 605, 771	29 00

749, 684

-454

749, 230

24.00

24.00 Total (sum of lines 1-23)

Heal th	Financial Systems		PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST			CN: 15-1322	Period: From 01/01/2017	Worksheet H-1 Part I	
				HHA CCN:	15-7177	To 12/31/2017	Date/Time Pre	pared:
						Home Health	5/29/2018 5:5 PPS	5 pm
			Canital Dala	atad Casta		Agency I		
			Capital Rela	ated Costs				
		Net Expenses	Bl dgs & Fi xtures	Movable	Plant	Transportati on		
		for Cost Allocation	Fixtures	Equi pment	Operation & Maintenance		(cols. 0-4)	
		(from Wkst. H,						
		col . 10) 0	1. 00	2. 00	3.00	4. 00	4A. 00	
1 00	GENERAL SERVICE COST CENTERS		0		I		0	1 00
1. 00	Capital Related - Bldg. & Fixtures		٩				0	1. 00
2. 00	Capital Related - Movable	0		0			0	2. 00
3.00	Equipment Plant Operation & Maintenance	О	o	O		0	0	3. 00
4.00	Transportation	0	o	0	ł	0 0	000 000	4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	299, 280	0	0		0 0	299, 280	5. 00
6.00	Skilled Nursing Care	173, 484	0	O	1	0 0	173, 484	
7. 00 8. 00	Physical Therapy Occupational Therapy	117, 528 60, 023	0	0	l .	0 0	117, 528 60, 023	•
9. 00	Speech Pathology	33, 600	ő	0		0 0	33, 600	•
10. 00 11. 00	Medical Social Services Home Health Aide	210 59, 000	0	0		0 0	210 59, 000	•
12. 00	Supplies (see instructions)	4, 535	o	0		0 0	4, 535	•
13.00	Drugs	404	O	0	1	0	404	•
14. 00	DME HHA NONREI MBURSABLE SERVI CES	1, 166	0	0		0 0	1, 166	14. 00
15.00	Home Dialysis Aide Services	0	0	0		0 0	-	
16. 00 17. 00	Respiratory Therapy Private Duty Nursing		0	0	1	0 0	0	16. 00 17. 00
18. 00	Clinic	Ō	ō	O		0 0	0	18. 00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0	1	0 0	0	19. 00 20. 00
21. 00	, ,	Ö	Ö	0	1	0 0	Ö	21. 00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22. 00 23. 00
23. 50	Tel emedi ci ne		Ö	0		0 0	0	
24. 00	Total (sum of lines 1-23)	749, 230 Admi ni strati ve	O Total (col.s	0		0 0	749, 230	24. 00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5.00	6. 00					
1. 00	Capital Related - Bldg. &							1. 00
2 00	Fixtures Capital Related - Movable							2. 00
2. 00	Equipment							2.00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	299, 280						5. 00
4 00	HHA REIMBURSABLE SERVICES	115, 390	288, 874					4 00
6. 00 7. 00	Skilled Nursing Care Physical Therapy	78, 173	195, 701					6. 00 7. 00
8.00	Occupational Therapy	39, 924	99, 947					8. 00
9. 00 10. 00	Speech Pathology Medical Social Services	22, 349 140	55, 949 350					9. 00 10. 00
11. 00	Home Health Aide	39, 243	98, 243					11. 00
12. 00 13. 00	Supplies (see instructions) Drugs	3, 016 269	7, 551 673					12. 00 13. 00
14. 00	DME	776	1, 942					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	l ol	O					15. 00
16. 00	Respi ratory Therapy		О					16. 00
17. 00 18. 00	Private Duty Nursing Clinic	0	0					17. 00 18. 00
19.00	Health Promotion Activities		0					19.00
20.00	Day Care Program	0	0					20. 00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0					21. 00 22. 00
23. 00	All Others (specify)	0	0					23. 00
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	0	0 749, 230					23. 50 24. 00
			. , 5 0					

Heal th	Financial Systems		PERRY COUNTY	/ HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	LLOCATION - HHA STATISTICAL BAS	SIS		Provi der Co	CN: 15-1322	Peri od:	Worksheet H-1	
				HHA CCN:	15-7177	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/29/2018 5:5	
						Home Health Agency I	PPS	<del></del>
		Capital Rel	ated Costs			, rigorio y		
		BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportati (MI LEAGE)	onReconciliation	Administrative & General (ACCUM. COST)	
		1.00	2. 00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1. 00 2. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable	0	0			0		1. 00 2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0		3. 00
4. 00	Transportation (see instructions)	0	0	0		0		4. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	0		0 -299, 280	449, 950	5. 00
6. 00	Skilled Nursing Care	0	0	0		0 0	173, 484	6.00
7. 00	Physical Therapy		0	0		0 0	117, 528	
8.00	Occupational Therapy	0	0	0		0 0	60, 023	1
9. 00	Speech Pathology	0	0	0		0 0	33, 600	
10.00	Medical Social Services	l o	0	Ö		0 0	210	
11. 00	Home Health Aide	0	0	0		0 0	59,000	
12. 00	Supplies (see instructions)	0	0	0		0 0	4, 535	
13.00	Drugs	l 0	0	0		0	404	13.00
14.00	DME	0	0	0		0 0	1, 166	14. 00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16.00	Respi ratory Therapy	0	0	0		0 0	0	16. 00
17.00	Private Duty Nursing	0	0	0		0 0	0	17. 00
18.00	Clinic	0	0	0		0 0	0	18. 00
19.00	Health Promotion Activities	0	0	0		0 0	0	19. 00
20.00	Day Care Program	0	0	0		0 0	0	20. 00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21. 00
22.00	Homemaker Service	0	0	0		0 0	0	22. 00
23.00	All Others (specify)	0	0	0		0 0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0		0 0	0	23. 50
24.00	Total (sum of lines 1-23)	0	0	0		0 -299, 280	449, 950	
25. 00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0		0	299, 280	25. 00
26, 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 665141	26. 00

Worksheet H-2 Part I Date/Time Prepared: 5/29/2018 5:55 pm From 01/01/2017 To 12/31/2017 HHA CCN: 15-7177

		5/29/2018 5: 5!	5 pm
Н	Home Health Agency I	PPS	
CAPITAL RELATED COSTS	Agency i		
Cost Center Description   HHA Trial   NEW BLDG & NEW MVBLE   EMPLOYEE	Subtotal	ADMI NI STRATI VE	
Balance (1) FIXT EQUIP BENEFITS DEPARTMENT		AND GENERAL	
0 1.00 2.00 4.00	4A	5. 01	
1.00 Administrative and General 0 13,559 5,689 0	19, 248		1. 00
2.00 Skilled Nursing Care 288,874 0 0 0	288, 874	24, 240	2. 00
3.00 Physical Therapy 195, 701 0 0 0	195, 701	16, 422	3. 00
4.00 Occupational Therapy 99,947 0 0 0	99, 947		4. 00
5.00 Speech Pathology 55,949 0 0	55, 949		
6.00 Medical Social Services 350 0 0	350		
7.00   Home Health Aide   98,243   0   0   0   8.00   Supplies (see instructions)   7,551   0   0   0	98, 243 7, 551		7. 00 8. 00
8.00   Supplies (see instructions)   7,551   0   0   0   0   9.00   Drugs   673   0   0   0	673		9. 00
10. 00 DME 1, 942 0 0 0	1, 942		
11.00 Home Dialysis Aide Services 0 0 0	0	0	11. 00
12.00 Respiratory Therapy 0 0 0	0	О	12. 00
13.00 Private Duty Nursing 0 0 0 0	0	0	13.00
14.00   Clinic   0 0 0 0	0	0	14.00
15.00   Health Promotion Activities 0 0 0 0	0	0	15. 00
16.00 Day Care Program 0 0 0	0	0	16.00
17.00         Home Delivered Meals Program         0         0         0         0           18.00         Homemaker Service         0         0         0         0	0	0	17. 00
18.00   Homemaker Service	0	0	18. 00 19. 00
19. 50   Tel emedi ci ne	0	0	19. 50
20.00 Total (sum of lines 1-19) (2) 749,230 13,559 5,689 0	768, 478	64, 485	
21.00 Unit Cost Multiplier: column	0. 000000		21. 00
26, line 1 divided by the sum			
of column 26, line 20 minus			
column 26, line 1, rounded to			
6 decimal places.   Cost Center Description   Subtotal OTHER OPERATION OF LAUNDRY & H	HOUSEKEEPI NG	DI ETARY	
ADMI NI STRATI VE PLANT LI NEN SERVI CE	1000EREET THO	DI EI/III	
AND GENERAL			
54.01 5.02 7.00 8.00	9. 00	10.00	
1.00 Administrative and General 20,863 2,520 16,385 0	4, 405		1. 00
2.00   Skilled Nursing Care   313,114   37,814   0   0	0	-	2.00
3.00   Physical Therapy   212,123   25,618   0   0   4.00   Occupational Therapy   108.334   13.083   0   0	0	0	3.00
4.00   Occupational Therapy   108, 334   13, 083   0   0   0   5.00   Speech Pathology   60, 644   7, 324   0   0	0	0	4. 00 5. 00
6. 00   Medical Social Services   379   46   0	0	o	6. 00
7. 00 Home Heal th Ai de 106, 487 12, 860 0	0	o	7. 00
8.00 Supplies (see instructions) 8,185 988 0 0	0	o	8. 00
9.00 Drugs 729 88 0 0	0	0	9. 00
10. 00   DME   2, 105   254   0   0	0	0	10.00
11.00   Home Dialysis Aide Services   0  0  0	^	l Ol	11. 00
	0		
12.00 Respiratory Therapy 0 0 0 0	0	0	12. 00
12.00     Respiratory Therapy     0     0     0       13.00     Private Duty Nursing     0     0     0	0	0	12. 00 13. 00
12.00     Respiratory Therapy     0     0     0       13.00     Private Duty Nursing     0     0     0       14.00     Clinic     0     0     0	0	0	12. 00 13. 00 14. 00
12.00     Respiratory Therapy     0     0     0       13.00     Private Duty Nursing     0     0     0       14.00     Clinic     0     0     0       15.00     Health Promotion Activities     0     0     0	-	0 0 0	12. 00 13. 00 14. 00 15. 00
12.00     Respiratory Therapy     0     0     0       13.00     Private Duty Nursing     0     0     0       14.00     Clinic     0     0     0       15.00     Health Promotion Activities     0     0     0       16.00     Day Care Program     0     0     0	-	0	12. 00 13. 00 14. 00 15. 00 16. 00
12.00     Respiratory Therapy     0     0     0       13.00     Private Duty Nursing     0     0     0       14.00     Clinic     0     0     0       15.00     Health Promotion Activities     0     0     0       16.00     Day Care Program     0     0     0	-	0 0 0	12. 00 13. 00 14. 00 15. 00
12.00 Respiratory Therapy 0 0 0 0 0 0 0 13.00 Private Duty Nursing 0 0 0 0 0 0 0 0 14.00 Clinic 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-	0 0 0	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
12.00     Respiratory Therapy     0     0     0       13.00     Private Duty Nursing     0     0     0       14.00     Clinic     0     0     0       15.00     Health Promotion Activities     0     0     0       16.00     Day Care Program     0     0     0       17.00     Home Delivered Meals Program     0     0     0       18.00     Homemaker Service     0     0     0       19.00     All Others (specify)     0     0     0       19.50     Tel emedicine     0     0     0	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
12.00 Respiratory Therapy 0 0 0 0 0 0 0 13.00 Private Duty Nursing 0 0 0 0 0 0 0 0 14.00 Clinic 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

6 decimal places.

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

0

954, 348

19.50

20.00

21.00

0

44, 173

0.048532

19.50

20.00

21.00

Tel emedi ci ne

6 decimal places.

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

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

Unit Cost Multiplier: column

<sup>(1)</sup> Column 0, line 20 must agree with Wkst. A, column 7, line 101.

<sup>(2)</sup> Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO H BASIS	HA COST CENTERS STATISTICAL Provider CCN: 15-1322	Period: Worksheet H-2 From 01/01/2017 Part II
BAST 5	HHA CCN: 15-7177	To 12/31/2017 Date/Time Prepared:

5/29/2018 5:55 pm

Home Health **PPS** Agency I CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE Reconciliation Cost Center Description FIXT FOUL P **BENEFITS** AND GENERAL (SQUARE (SQUARE **DEPARTMENT** (ACCUM. COST) FEET) FEET) (GROSS SALARI ES) 1.00 2.00 5A. 01 5. 01 5A. 02 4.00 588 588 1.00 Administrative and General 0 19, 248 1.00 0 2.00 Skilled Nursing Care 288, 874 2.00 3.00 Physical Therapy 0 0 0 195, 701 3.00 000000000000 Occupational Therapy 0 0 99, 947 4.00 0 0 4.00 0 0 55, 949 5.00 Speech Pathology 5.00 6.00 Medical Social Services 0 0 0 350 6.00 0 0 7.00 Home Health Aide 0 98, 243 7.00 0 0 Supplies (see instructions) 0 7, 551 8.00 8.00 0 9.00 Drugs 0 0 673 9.00 10.00 DMF 0 1, 942 10.00 0 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 0 12.00 12.00 Respiratory Therapy 0 0 0 13.00 Private Duty Nursing 0 13.00 0 00000 0 14.00 Clinic 0 0 0 14.00 0 0 15.00 Health Promotion Activities 0 15.00 16.00 Day Care Program 0 16.00 17.00 Home Delivered Meals Program 0 0 17.00 0 0 0 Homemaker Service 18.00 18.00 0 0 0 19.00 All Others (specify) 19.00 19.50 Tel emedi ci ne 0 0 0 0 0 19.50 Total (sum of lines 1-19) 20.00 588 588 768, 478 20.00 21.00 Total cost to be allocated 13, 559 5. 689 64.485 21.00 2<u>3. 059524</u> 9. <u>675170</u> 0.000000 0.083913 22.00 Unit cost multiplier 22.00 Cost Center Description OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A ADMI NI STRATI VE PLANT LINEN SERVICE (SQUARE (MEALS (FTE'S) AND GENERAL (SQUARE (POUNDS OF FEET) SERVED) (ACCUM. COST LAUNDRY) FEET) NO PBP) 8.00 5.02 7.00 9.00 10.00 11.00 1.00 Administrative and General 20, 863 588 588 1. 00 2.00 Skilled Nursing Care 313, 114 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 2.00 0 0 0 C 0 0 3 00 Physical Therapy 212, 123 O 3 00 4.00 Occupational Therapy 108, 334 0 0 4.00 5.00 Speech Pathology 0 0 5.00 60,644 0 6.00 Medical Social Services 379 00000000000 0 O 6 00 0 7.00 Home Heal th Aide 106, 487 0 7.00 8.00 Supplies (see instructions) 8, 185 0 0 8.00 Drugs 0 9.00 729 0 9.00 0 10 00 10.00 DMF 2, 105 Ω 11.00 Home Dialysis Aide Services 0 0 11.00 Respiratory Therapy 0 0 0 12.00 12.00 13.00 Private Duty Nursing 0 0 0 13.00 0 0 14.00 0 14.00 Clinic 0 0 15.00 Health Promotion Activities 0 15.00 Day Care Program 16.00 16.00 0 0 Home Delivered Meals Program 0 0 17.00 17.00 0 0 18.00 Homemaker Service C 18.00 0 19.00 All Others (specify) 0 0 0 0 19.00 19.50 Tel emedi ci ne 0 0 C 0 0 19.50 Total (sum of lines 1-19) 832.963 20.00 20.00 588 588 0 C 21.00 Total cost to be allocated 100.595 16.385 4 405 21.00 27. 865646 22.00 Unit cost multiplier 0. 120768 0.000000 7. 491497 0.000000 0.000000 22.00

Heal th	Financial Systems		PERRY COUNTY H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS	TO HHA COST CENT	ERS STATISTICAL	Provi der	CCN: 15-1322	Peri od:	Worksheet H-2	
BASIS				HHA CCN:	15-7177	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/29/2018 5:5	
						Home Health	PPS	
					,	Agency I		
	Cost Center Description	NURSI NG	MEDI CAL					
		ADMI NI STRATI ON	RECORDS &					
		(5) 5507	LI BRARY					
		(DI RECT	(TIME					
		NRSI NG HRS)	SPENT) 16.00			-		-
1. 00	Administrative and General	13. 00	16.00					1.00
2. 00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4. 00	Occupati onal Therapy	0	O O					4.00
5. 00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7. 00	Home Heal th Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9. 00	Drugs	0	0					9.00
10. 00	DME	0	0					10.00
11. 00	Home Dialysis Aide Services		0					11.00
12. 00	Respiratory Therapy	0	0					12.00
13. 00	Private Duty Nursing	0	0					13.00
14. 00	Clinic	0	0					14. 00
15. 00	Health Promotion Activities	0	o					15. 00
16. 00	Day Care Program	0	o					16.00
17. 00	Home Delivered Meals Program	O	o					17. 00
18. 00	Homemaker Service	O	o					18.00
19. 00	All Others (specify)		ol					19.00
19. 50	Tel emedi ci ne		o					19. 50
20. 00	Total (sum of lines 1-19)	0	o					20.00
21.00	Total cost to be allocated	O	o					21.00
22. 00	Unit cost multiplier	0. 000000	0. 000000					22. 00

Heal th	Financial Systems		PERRY COUNTY	/ HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
	TONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-1322	Period: From 01/01/2017	Worksheet H-3 Part I	
				HHA CCN:	15-7177	To 12/31/2017		pared: 5 pm
				Ti tl e	e XVIII	Home Health Agency I	PPS	•
	Cost Center Description		Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
1 00	Cost Per Visit Computation	2.00	2/7 050		2/7.05	1 040	100 11	1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	2. 00 3. 00		0	367, 95 249, 27			1. 00 2. 00
3.00	Occupational Therapy	4. 00		0	1			3.00
4. 00	Speech Pathology	5. 00		0	71, 26			1
5. 00	Medical Social Services	6. 00		_	44			1
6.00	Home Health Aide	7. 00	125, 139		125, 13	1, 118	111. 93	6.00
7.00	Total (sum of lines 1-6)		941, 400	0				7. 00
			1		Program Visit			
	0 1 0 1 5 11		ODCA N (4)	D 1 4		art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to Deductibles			
					Coi nsurance			
		0	1.00	2. 00	3. 00	4. 00	5. 00	
	Limitation Cost Computation				1			
8.00	Skilled Nursing Care		99915	C				8. 00
9.00	Physical Therapy		99915	0	1 ., -			9. 00
10.00	Occupational Therapy		99915	0	76			10.00
11.00	Speech Pathology		99915 99915	0	18	0		11. 00 12. 00
12. 00 13. 00	Medical Social Services Home Health Aide		99915	0	25			13.00
14. 00	1		77713	0	•			14. 00
11.00		From Wkst. H-2	Facility Costs	Shared	Total HHA		Ratio (col. 3	11.00
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
				Part II)				
	Supplies and Drugs Cost Computa	0	1.00	2. 00	3. 00	4. 00	5. 00	
15. 00	Cost of Medical Supplies	8. 00	9, 618	0	9, 61	8 0	0. 000000	15. 00
	Cost of Drugs	9. 00		0				l
	1		Program Visits		Cost of		0.00000	
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles & Coinsurance	Coi nsurance		Deductibles & Coinsurance	Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10, 00	11. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
<b>.</b> -:	Cost Per Visit Computation				1			
1.00	Skilled Nursing Care	0				0 177, 208		1.00
2.00	Physical Therapy	0			1	0 163, 482 0 83, 457		2. 00 3. 00
3. 00 4. 00	Occupational Therapy Speech Pathology		180			0 83, 457 0 54, 356		4.00
5.00	Medical Social Services		1			0 54, 350		5.00
6.00	Home Health Aide	Ö	1		1	0 28, 318		6. 00
7.00	Total (sum of lines 1-6)	0	1			0 506, 821		7. 00
	Cost Center Description							
	limitation Coot Com	6. 00	7.00	8. 00	9. 00	10.00	11. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care	T T						8. 00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology				1			11.00
12. 00	Medical Social Services							12. 00
13.00	Home Health Aide							13. 00
14. 00	Total (sum of lines 8-13)				I			14. 00

	Financial Systems		PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552- <u></u> 10
APPORT	TONMENT OF PATIENT SERVICE COST	S		Provider CO	CN: 15-1322 15-7177	Peri od: From 01/01/2017 To 12/31/2017		pared:
				Title	: XVIII	Home Health	5/29/2018 5: 5 PPS	5 pm
				11 (16	XVIII	Agency I	113	
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Not Subject to	Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8.00	9.00	10.00	11. 00	
	Supplies and Drugs Cost Computa		7.00	0.00	7.00	10.00	11.00	
15. 00	Cost of Medical Supplies	0	0	0		0 0	0	15.00
16.00	Cost of Drugs		265	0		0	0	16.00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	AGGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	?	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	177, 208						1.00
2.00	Physi cal Therapy	163, 482						2.00
3. 00 4. 00	Occupational Therapy Speech Pathology	83, 457						3.00
5.00	Medical Social Services	54, 356 0						5.00
6.00	Home Health Aide	28, 318						6.00
7. 00	Total (sum of lines 1-6)	506, 821						7.00
7.00	Cost Center Description	000,021						7.00
		12. 00						1
	Limitation Cost Computation	•						
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11. 0
12.00	Medical Social Services							12.00
13.00	Home Heal th Aide							13. 0
14.00	Total (sum of lines 8-13)							14.00

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CM						u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	Provi der C		Peri od:	Worksheet H-3			
			HHA CCN:	15-7177	From 01/01/2017 To 12/31/2017	Part II	narad.
			HHA CCN:	15-/1//	10 12/31/2017	Date/Time Pre 5/29/2018 5:5	
			Title	XVIII	Home Health	PPS	
Agency							
Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2. 00	3. 00	4. 00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66. 00	0. 279103	0		0 col. 2, line 2	. 00	1. 00
2.00 Occupational Therapy	67. 00	0. 267315	0	)	0 col. 2, line 3	. 00	2. 00
3.00 Speech Pathology	68. 00	0. 501619	0	)	0 col. 2, line 4	. 00	3. 00
4.00 Cost of Medical Supplies	71. 00	0. 203311	0	)	0 col. 2, line 1	5. 00	4. 00
5.00 Cost of Drugs	73. 00	0. 246571	0	)	0 col. 2, line 1	6. 00	5. 00

II THE FINANCIAL SYSTEMS  LOULATION OF HHA REIMBURSEMENT SETTLEMENT	Y COUNTY HOSPITAL			eu of Form CMS-2552	
CULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1322		Worksheet H-4 Part I-II	
	HHA CCN:	15-7177	To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
	Title	XVIII	Home Health	PPS	о рі
			Agency I		
		Part A	Not Subject to	t B Subject to	
		Tart A	Deductibles &		
			Coi nsurance	Coi nsurance	
DADT I COMPUTATION OF THE LECCED OF DEACONABLE COC	T OD CHCTOMADY CHARCE	1.00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COS Reasonable Cost of Part A & Part B Services	OF CUSTOMARY CHARGE	5			1
Reasonable cost of services (see instructions)			0 0	0	1
70 Total charges			0 265	0	2
Customary Charges				0	١,
On a charge basis (from your records)	payment for services		0 0	0	3
On Amount that would have been realized from patients I	iable for payment		0 0	0	4
for services on a charge basis had such payment been	n made in accordance				
with 42 CFR §413.13(b)  Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 00000	0. 000000	5
Total customary charges (see instructions)		0.0000	0.00000	0.000000	1
00 Excess of total customary charges over total reasona	able cost (complete		0 265	0	
only if line 6 exceeds line 1)				_	
00 Excess of reasonable cost over customary charges (co 1 exceeds line 6)	omplete only if line		0 0	0	8
OPrimary payer amounts			0 0	0	9
			Part A	Part B	
			Servi ces	Servi ces	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMEN	IT		1. 00	2. 00	$\vdash$
00 Total reasonable cost (see instructions)	•		0	0	10
00 Total PPS Reimbursement - Full Episodes without Outl			0	406, 408	
00 Total PPS Reimbursement - Full Episodes with Outlier 00 Total PPS Reimbursement - LUPA Episodes	-S		0	117, 221 3, 861	
00 Total PPS Reimbursement - PEP Episodes			0	1, 025	
00 Total PPS Outlier Reimbursement - Full Episodes with	o Outliers		0	21, 745	
00 Total PPS Outlier Reimbursement - PEP Episodes			0	0	
00 Total Other Payments 00 DME Payments			0	0	1
00 Oxygen Payments			0	0	1
00 Prosthetic and Orthotic Payments			0	0	1
00 Part B deductibles billed to Medicare patients (excl	ude coinsurance)			0	
00   Subtotal (sum of lines 10 thru 20 minus line 21) 00   Excess reasonable cost (from line 8)			0	550, 260	1
00 Subtotal (line 22 minus line 23)				0 550, 260	
OD Coinsurance billed to program patients (from your re	ecords)			0	١
00 Net cost (line 24 minus line 25)			0	550, 260	
OO Reimbursable bad debts (from your records)	os (soo instructions)				27
00 Reimbursable bad debts for dual eligible beneficiari 00 Total costs - current cost reporting period (line 26			0	550, 260	28
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, p. 43 11110 21)		0	0	
50 Pioneer ACO demonstration payment adjustment (see in	-		0	0	30
99 Demonstration payment adjustment amount before seque	estration		0	0	
00   Subtotal (see instructions) 01   Sequestration adjustment (see instructions)			0	550, 260 11, 005	
02 Demonstration payment adjustment amount after seques	strati on			0	
00 Interim payments (see instructions)			0	539, 255	
			0	0	33
OO Tentative settlement (for contractor use only)					I -
00 Tentative settlement (for contractor use only) 00 Balance due provider/program (line 31 minus lines 31 00 Protested amounts (nonallowable cost report items) i		Dub 15 2	0	0	

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

Health Financial Systems PERRY COUNTY
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES Peri od: Worksnee: ...
From 01/01/2017
To 12/31/2017 Date/Ti me Prepared: 5/29/2018 5:55 pm
PPS Provider CCN: 15-1322 HHA CCN: 15-7177

Total interim payments paid to provider					Home Health Agency I	PPS	
1.00   Total Interim payments paid to provider   1.00   2.00   3.00   4.00   539,255   1.00   1.00   1.00   1.00   539,255   1.00   1			Inpatient Part A				
1.00   Total Interim payments paid to provider   1.00   2.00   3.00   4.00   539,255   1.00   1.00   1.00   1.00   539,255   1.00   1			mm/dd/yyyyy	Amount	mm/dd/yyyyy	Amount	
Interim payments payable on individual bilis, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero							
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1.00	Total interim payments paid to provider			0	539, 255	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero   3.00   1.5	2.00				0	0	2.00
write "NONE" or enter a zero  NOL is separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  NOL is a separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O							
List separately each retroactive lump sum adjustment amount based on Subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   0							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3.01 3.02 3.03 3.04 3.05 8.00 9.00 3.05 8.00 9.00 3.05 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	3.00						3.00
Program to Provider							
3.01							
3.02   0		Program to Provider					
3. 03 3. 04 3. 05 Provider to Program	3. 01						
3.04   0				•			
3.05							
Provider to Program							
3.50   0   0   3.50   3.50   3.51   0   0   0   3.51   3.52   0   0   0   3.51   3.53   0   0   0   3.53   3.53   0   0   0   3.53   3.53   0   0   0   3.53   3.53   3.54   0   0   0   3.53   3.53   3.54   0   0   0   3.53   3.53   3.54   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   0   3.59   3.50-3.98   0   0   0   0   0   0   0   0   0	3. 03	Provider to Program			<u> </u>		3. 03
3.52   3.53   3.54   3.50	3.50				0	0	3. 50
3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.54   3.54   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   3.59   3.50-3.98   0   0   0   5.39,255   4.00   0   0   0   0   0   0   0   0   0	3. 51				0		3. 51
3.54   3.99   3.50-3.98   0   0   3.54   3.99   3.50-3.98   0   0   0   3.54   3.99   3.50-3.98   0   0   0   3.54   3.99   3.50-3.98   0   0   0   3.54   3.99   0   0   0   0   0   0   0   0   0	3. 52						
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   0   3.59-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   0   539,255   4.00   (transfer to Wkst. H-4, Part II, column as appropriate, line 32)   TOBE COMPLETED BY CONTRACTOR							
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total interim payments (sum of lines 1, 2, and 3.99)   Total Medicare program liability (see instructions)		Cubtatal (a.m. of lines 2 01 2 40 minus arm of lines			~		
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)   TO BE COMPLETED BY CONTRACTOR	3. 99				U	ا	3. 99
Contractor   Con	4 00				0	539 255	4 00
TO BE COMPLETED BY CONTRACTOR   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	1.00					007, 200	1. 00
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider		line 32)					
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
write "NONE" or enter a zero. (1)   Program to Provider	5.00						5. 00
Program to Provider							
0							
Provider to Program	5. 01	11 ogram to 11 ovrder			o	0	5. 01
Provider to Program	5.02				o	0	5. 02
0	5.03				0	0	5. 03
5.51   5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   5.50-5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   0   0   6.01   6.02   SETTLEMENT TO PROGRAM   0   0   6.02   7.00   Total Medicare program liability (see instructions)   0   Say, 255   7.00   Total Medicare program liability (see instructions)   0   Contractor NPR Date (Mo/Day/Yr)   0   NPR Date (Mo/Day/Yr)   1.00   2.00   1.00   2.00   1.00   2.00   1.0		Provider to Program	Г	1		_	
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52							
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVI DER 0 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00					-		
5. 50-5. 98)  Determined net settlement amount (balance due) based on the cost report. (1)  6. 01 SETTLEMENT TO PROVI DER  6. 02 SETTLEMENT TO PROGRAM  7. 00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2. 00		Subtotal (sum of lines 5 01-5 49 minus sum of lines			-		
the cost report. (1) SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	0. , ,					Ĭ	0. 77
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00	Determined net settlement amount (balance due) based on					6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
7.00 Total Medicare program liability (see instructions) 0 539,255 7.00  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00	6. 01			l .	-		
Contractor NPR Date (Mo/Day/Yr)           0         1.00         2.00						1 - 1	
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Trotal medicale program frability (see instructions)			-		7.00
0 1.00 2.00							
0.00 News of Contractor			(	0			
8.00 Name or contractor     8.00	8.00	Name of Contractor					8. 00

	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	PERRY COUNTY	Provider C	CN: 15-1322	In Lie Period:	wof Form CMS-: Worksheet M-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
					RHC I	5/29/2018 5:5 Cost	5 piii
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
				,		(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0		0 636, 478	636, 478	1.00
2.00	Physician Assistant	0	0		0 0	0	2. 00
3.00	Nurse Practitioner	0	0		0 211, 543	211, 543	3. 00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	0	0		0 255, 432	255, 432	5. 00
6.00	Clinical Psychologist	0	0		0 0	0	6. 00
7.00	Clinical Social Worker	0	0		0 0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0 96, 691	96, 691	9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	0		0 1, 200, 144	1, 200, 144	10. 00
11. 00	Physician Services Under Agreement	0	0		0 0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12. 00
13.00	Other Costs Under Agreement	0	0		0 0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14. 00
15. 00	Medi cal Supplies	0	503	50	3 0	503	15. 00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16. 00
17. 00	Depreciation-Medical Equipment	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	19. 00
20.00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	503	50	3 0	503	21. 00
22. 00	Total Cost of Health Care Services (sum of	0	503	50	3 1, 200, 144	1, 200, 647	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES				_		1
23. 00		0	50, 609	50, 60			1
24. 00	Dental	0	0		0	0	
25. 00	Optometry	0	0		0	0	20.00
25. 01	Tel eheal th	0	0		0	0	
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	50, 609	50, 60	9 0	50, 609	28. 00
	through 27)						1
00.05	FACILITY OVERHEAD				al -		
29. 00	1	0	0	0.044.00	0	0	
	Administrative Costs	1, 681, 580	533, 340				
3 I. UU	Total Facility Overhead (sum of lines 29 and	1, 681, 580	533, 340	2, 214, 92	0 -1, 197, 739	1, 017, 181	31.00

1, 681, 580

1, 681, 580

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

533, 340

584, 452

2, 214, 920

2, 266, 032

31.00

32.00

1, 017, 181 1, 017, 181

2, 268, 437

-1, 197, 739 -1, 197, 739

2, 405

31.00

32.00

and 31)

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: Worksheet M-1 From 01/01/2017
	Component CCN: 15-8516	To 12/31/2017 Date/Time Prepared: 5/29/2018 5:55 pm

			Component CC	N: 13-8516	10 12/31/20	5/29/2018 5:	
					RHC I	Cost	оо рііі
		Adjustments	Net Expenses		100 1	0031	
			or Allocation				
			col. 5 + col.				
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	636, 478				1.00
2.00	Physician Assistant	0	0				2. 00
3.00	Nurse Practitioner	0	211, 543				3. 00
4.00	Visiting Nurse	o	0				4. 00
5. 00	Other Nurse	0	255, 432				5. 00
6.00	Clinical Psychologist	0	0				6. 00
7. 00	Clinical Social Worker	o	o				7. 00
8.00	Laboratory Techni ci an	o	0				8.00
9. 00	Other Facility Health Care Staff Costs	Ö	96, 691				9.00
10.00	Subtotal (sum of lines 1 through 9)	Ö	1, 200, 144				10.00
11. 00	Physician Services Under Agreement		1, 200, 144				11. 00
12. 00	Physician Supervision Under Agreement		0				12. 00
13. 00	Other Costs Under Agreement	0	o				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	o				14. 00
15. 00	Medical Supplies	0	503				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	٩	ď				20.00
21. 00	1		503				21. 00
22. 00	Subtotal (sum of lines 15 through 20) Total Cost of Health Care Services (sum of	0	1, 200, 647				22. 00
22.00	lines 10, 14, and 21)	۷	1, 200, 647				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	٥	50, 609				23. 00
24. 00	Dental	0	50, 609				24. 00
25. 00	Optometry	0	0				25. 00
25. 00	Tel eheal th	0	0				25. 00
25. 01	1	0	0				25. 01
26. 00	Chronic Care Management All other nonreimbursable costs	0	0				26. 00
	1	۷	۷				27. 00
27. 00	Nonallowable GME costs		E0 (00				
28. 00	Total Nonreimbursable Costs (sum of lines 23	۷	50, 609				28. 00
	through 27)						
29. 00	FACILITY OVERHEAD Facility Costs	0	0				29. 00
	1	-146, 907	870, 274				
30.00	Administrative Costs						30.00
31. 00	Total Facility Overhead (sum of lines 29 and 30)	-146, 907	870, 274				31.00
32. 00	Total facility costs (sum of lines 22, 28	-146, 907	2 121 520				32. 00
32.00	and 31)	- 140, 907	2, 121, 530				32.00
	juna 51)	1	ı				1

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-1	
			Component	CCN: 15-8517	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 5:5	pared: 5 pm
					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
	EAGLILEY WENT THE CARE OTHER COOTS	1.00	2. 00	3.00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS			,			1 00
1.00	Physi ci an	0	C	1	0 0	0	
2.00	Physician Assistant	0	C	1	0 0	0	2.00
3.00	Nurse Practitioner	0	C		0 114, 885	114, 885	
4.00	Visiting Nurse	0	C		0 44 707	44 707	4.00
5.00	Other Nurse	0	C		0 44, 787	44, 787	5. 00
6. 00 7. 00	Clinical Psychologist	0	C		0	0	6. 00 7. 00
7. 00 8. 00	Clinical Social Worker	0			0 0	0	8.00
9. 00	Laboratory Technician Other Facility Health Care Staff Costs	0			0 52, 598		
10.00	Subtotal (sum of lines 1 through 9)	0			0 212, 270		
11. 00	Physician Services Under Agreement	0			0 212, 270	212, 270	
12. 00	Physician Supervision Under Agreement	0			0 0		12.00
13. 00		0				0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0			0 0	0	14.00
15. 00	Medical Supplies	0				0	
16. 00	Transportation (Health Care Staff)	0			0 0	0	
	Depreciation-Medical Equipment	0				0	
18. 00	1 '	0				0	18. 00
	Other Health Care Costs	0	Č	ó	0 0	0	1
20. 00	Allowable GME Costs	J.	_	1			20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	C		0 0	0	1
22. 00	Total Cost of Health Care Services (sum of	0	Ċ		0 212, 270	212, 270	
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES				<u>.</u>		
23.00		0	6, 528	6, 5	28 0	6, 528	23. 00
24.00	Dental	0	C		0 0	0	24. 00
25.00	Optometry	0	C		0 0	0	25. 00
25. 01	Tel eheal th	0	C		0 0	0	25. 01
25. 02	Chronic Care Management	0	C		0 0	0	25. 02
26. 00	All other nonreimbursable costs	0	C		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	6, 528	6, 5	28 0	6, 528	28. 00
	through 27)						
20.00	FACILITY OVERHEAD	ما		\[ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0 0	_	20.00
29. 00 30. 00	Facility Costs Administrative Costs	244, 073	152, 543	396, 6	0 16 -212, 270	0 184, 346	
	Total Facility Overhead (sum of lines 29 and	244, 073	152, 543				
	Trotal rucifity overhead (Sull Of Filles 27 allu)	244, 0/3		,, 370,0			

244, 073

244, 073

Total Facility Overhead (sum of lines 29 and

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

152, 543

159, 071

396, 616

403, 144

-212, 270

31.00

32.00

184, 346

403, 144

31.00

32.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1322	Peri od: Worksheet M-1 From 01/01/2017
		To 12/31/2017 Date/Time Prepared:

			Component	CCN: 15-8517	10	12/31/201/	Date/IIME Pre	
						RHC II	Cost	oo piii
		Adjustments	Net Expenses			MIO II	0031	
			for Allocation					
			(col. 5 + col.					
			6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	0					1.00
2.00	Physician Assistant	0	0	1				2. 00
3.00	Nurse Practitioner	0	114, 885					3. 00
4. 00	Visiting Nurse	0	0	,				4. 00
5. 00	Other Nurse	0	44, 787					5. 00
6. 00	Clinical Psychologist	0	0	1				6.00
7. 00	Clinical Social Worker	0	0	,				7. 00
8.00	Laboratory Techni ci an	0	0	1				8.00
9. 00	Other Facility Health Care Staff Costs	0	52, 598					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	212, 270					10.00
11. 00	Physician Services Under Agreement	0	0					11.00
12. 00	Physician Supervision Under Agreement	0	0	,				12.00
13. 00		0	0	,				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	,				14.00
15. 00	Medical Supplies	0	0	,				15. 00
16. 00	Transportation (Health Care Staff)	0	0	1				16.00
17. 00		o	0	,				17. 00
18. 00		o	0	)				18. 00
19. 00		o	0	)				19.00
20.00								20.00
21. 00	Subtotal (sum of lines 15 through 20)	o	0	,				21.00
22. 00	Total Cost of Health Care Services (sum of	0	212, 270	,				22. 00
	lines 10, 14, and 21)		,					
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	6, 528					23. 00
24.00	Dental	0	0					24. 00
25.00	Optometry	0	0					25. 00
25. 01	Tel eheal th	0	0					25. 01
25. 02	Chronic Care Management	0	0					25. 02
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	6, 528					28. 00
	through 27)							
	FACILITY OVERHEAD							
29. 00	Facility Costs	0	0					29. 00
30.00	Administrative Costs	0	184, 346	,				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	184, 346	,				31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	0	403, 144					32. 00
	and 31)			I				

Heal th	Financial Systems	PERRY COUNTY	' HOSPITAL		In Li∈	eu of Form CMS-:	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-1	
			Component	CCN: 15-8518	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
					RHC III	Cost	
		Compensation	Other Costs		1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2.00	2.00	4.00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2. 00	3.00	4. 00	5.00	
1. 00	Physician	ol	(		0 0	0	1.00
2.00	Physician Assistant		(	1	0 0	0	
3.00	Nurse Practitioner		(	1	0 122, 455	122, 455	
4. 00	Visiting Nurse		(	á	0 122, 100	0	1
5. 00	Other Nurse	o o	(		0 22,009	22, 009	
6.00	Clinical Psychologist	o	(		0 0	0	6. 00
7. 00	Clinical Social Worker	l ol	C		0 0	l o	
8.00	Laboratory Techni ci an	o	C		0 0	0	
9.00	Other Facility Health Care Staff Costs	o	C		0 0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	o	C		0 144, 464	144, 464	10.00
11.00	Physician Services Under Agreement	o	C		0 0	0	11. 00
12.00	Physician Supervision Under Agreement	0	C		0 0	0	12. 00
13.00	Other Costs Under Agreement	0	C		0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	C	1	0	0	14. 00
15. 00	Medical Supplies	0	290	2	90 0	290	
16. 00	Transportation (Health Care Staff)	0	C	1	0	0	
17. 00		0	C	1	0	0	
18. 00	Professional Liability Insurance	0	C	1	0 0	0	
19. 00		0	C	)	0	0	
20.00	Allowable GME Costs		000		20		20.00
21. 00 22. 00	Subtotal (sum of lines 15 through 20)	0	290 290		90 0 90 144, 464	290	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	٩	290	۷ ۲	90 144, 464	144, 754	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			-
23. 00	Pharmacy	O	9, 104	9, 1	04 0	9, 104	23. 00
24. 00	Dental	l ol	(	1	0 0	0	
25. 00	Optometry	o	C		0 0	0	1
25. 01	Tel eheal th	o	C		0 0	0	25. 01
25. 02	Chronic Care Management	o	C		0 0	0	25. 02
26.00	All other nonreimbursable costs	o	C		0 0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	9, 104	9, 1	04	9, 104	28. 00
	through 27)						
	FACILITY OVERHEAD	T			_1	T	
29. 00		0	05	)	0 0	0	
30.00	Administrative Costs	190, 888	95, 395			142, 828	
31. 00	Total Facility Overhead (sum of lines 29 and	190, 888	95, 395	286, 2	-143, 455	142, 828	31. 00
	(30)	1		1	1	I	I

190, 888

104, 789

295, 677

32.00

296, 686

1,009

32.00

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

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1322	Peri od: Worksheet M-1 From 01/01/2017
	Component CCN: 15-8518	To 12/31/2017 Date/Time Prepared:

			Component	CN: 15-8518	10 12/31/20	5/29/2018 5:	
					RHC III	Cost	55 piii
		Adjustments	Net Expenses		I KIIO III	0031	
			for Allocation				
			(col. 5 + col.				
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0				1.00
2.00	Physician Assistant	o	o				2. 00
3.00	Nurse Practitioner	o	122, 455				3.00
4.00	Visiting Nurse	o	0				4. 00
5.00	Other Nurse	o	22, 009				5. 00
6.00	Clinical Psychologist	o	0				6. 00
7.00	Clinical Social Worker	o	o				7. 00
8.00	Laboratory Techni ci an	o	o				8. 00
9.00	Other Facility Health Care Staff Costs	o	o				9, 00
10.00	Subtotal (sum of lines 1 through 9)	o	144, 464				10.00
11. 00	Physician Services Under Agreement	o	0				11. 00
12. 00	Physician Supervision Under Agreement	o	o				12. 00
13.00	Other Costs Under Agreement	o	o				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	ol				14. 00
15.00	Medical Supplies	0	290				15. 00
16.00	Transportation (Health Care Staff)	o	o				16. 00
17.00	Depreciation-Medical Equipment	0	o				17. 00
18.00	Professional Liability Insurance	0	o				18. 00
19.00	Other Health Care Costs	0	o				19. 00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	o	290				21. 00
22. 00	Total Cost of Health Care Services (sum of	o	144, 754				22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	9, 104				23. 00
24.00	Dental	0	0				24. 00
25.00	Optometry	0	0				25. 00
25. 01	Tel eheal th	0	0				25. 01
25. 02	Chronic Care Management	0	0				25. 02
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	9, 104				28. 00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	0				29. 00
30. 00	Administrative Costs	0	142, 828				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	142, 828				31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	0	296, 686				32. 00
	and 31)	I	I				1

	Financial Systems	PERRY COUNTY				eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1322		Period: From 01/01/2017	Worksheet M-1	
			Component (		To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
					RHC IV	Cost	
	·	Compensation	Other Costs	Total (col. 1	Recl assi fi cati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		4.00				4)	
	FACILITY HEALTH CADE STAFF COSTS	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	FACILITY HEALTH CARE STAFF COSTS  Physi ci an	0	0		0 300, 471	300, 471	1. 00
2. 00	Physician Assistant	0	0		0 300,471	300, 471	2.00
3. 00	Nurse Practitioner	0	0		0 105, 701	105, 701	3.00
4. 00	Visiting Nurse	0	0		0 103, 701	0	
5. 00	Other Nurse	0	0		0 47, 993	47, 993	1
6. 00	Clinical Psychologist	0	0		0 .,,,,	0	6.00
7. 00	Clinical Social Worker	0	0		0 0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	0		0 454, 165	454, 165	10.00
11. 00	Physician Services Under Agreement	0	0		0	0	11. 00
12. 00	Physician Supervision Under Agreement	0	0		0	0	
13. 00	Other Costs Under Agreement	0	0		0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	0	
15. 00	Medical Supplies	0	126	12		126	•
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17. 00 18. 00	Depreciation-Medical Equipment	0	0			0	17. 00 18. 00
19. 00	Professional Liability Insurance Other Health Care Costs	0	0		0 0	0	19.00
20. 00	Allowable GME Costs	O	O		0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	126	12	6	126	
22. 00	Total Cost of Health Care Services (sum of	0	126	12			22. 00
22.00	lines 10, 14, and 21)	Ü	.20		1017100	101,271	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	12, 406	12, 40	6 0	12, 406	23. 00
24. 00	Dental	0	0		0	0	24. 00
25. 00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs		40.407	40.40	,	40.40/	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	12, 406	12, 40	6 0	12, 406	28. 00
	through 27) FACILITY OVERHEAD					I	
29. 00	Facility Costs	0	0		0 0	0	29. 00
30. 00	Administrative Costs	527, 976	98, 577	626, 55	-		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	527, 976	98, 577	626, 55			
	30)					, , , , ,	

527, 976

111, 109

639, 085

32.00

639, 085

32.00

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

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1322	Period: Worksheet M-1 From 01/01/2017
	Component CCN: 15-8519	To 12/31/2017 Date/Time Prepared: 5/29/2018 5:55 pm

			Component	CON.	13 0317	10	12/31/201/	5/29/2018 5:	
							RHC IV	Cost	
	·	Adjustments	Net Expenses						
		•	for Allocatio	n					
			(col. 5 + col	.					
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	300, 47	1					1. 00
2.00	Physici an Assistant	0	l .	0					2. 00
3.00	Nurse Practitioner	0	105, 70	1					3. 00
4.00	Visiting Nurse	0	l	0					4. 00
5.00	Other Nurse	0	47, 99	3					5. 00
6.00	Clinical Psychologist	0		0					6. 00
7.00	Clinical Social Worker	0		0					7. 00
8.00	Laboratory Techni ci an	0		0					8. 00
9.00	Other Facility Health Care Staff Costs	0		0					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	454, 16	5					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	12	6					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	12	6					21. 00
22.00	Total Cost of Health Care Services (sum of	0	454, 29	1					22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								
23.00	Pharmacy	0	12, 40	6					23. 00
24.00	Dental	0		0					24. 00
25. 00	Optometry	0		0					25. 00
25. 01	Tel eheal th	0		0					25. 01
25. 02	Chronic Care Management	0		0					25. 02
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	12, 40	6					28. 00
	through 27)								
	FACILITY OVERHEAD								
29. 00	Facility Costs	0	l	0					29. 00
30. 00	Administrative Costs	0	172, 38	1					30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	172, 38	8					31. 00
	30)								
32. 00	Total facility costs (sum of lines 22, 28	0	639, 08	5					32. 00
	and 31)								1

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2017 To 12/31/2017		nared·
			- Component	30.11 10 0010		5/29/2018 5:5	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	2.00	2.00	3)	4 5. 00	
	VISITS AND PRODUCTIVITY	1.00	2. 00	3.00	4. 00	5.00	
	Posi ti ons						
1.00	Physi ci an	1. 60	6, 159	4, 20	0 6, 720		1.00
2.00	Physician Assistant	0.00		1			2.00
3.00	Nurse Practitioner	2. 94					3. 00
4.00	Subtotal (sum of lines 1 through 3)	4. 54			12, 894		4. 00
5. 00	Visiting Nurse	0. 00		1	,	0	5. 00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00	o c			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	4. 54	12, 588			12, 894	8. 00
0.00	through 7)						0.00
9.00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE 1	O HOSPITAL-BASE	ED RHC/EOHC SER	VICES		1.00	
10.00	Total costs of health care services (from W					1, 200, 647	10.00
11. 00	1					50, 609	
12.00	Cost of all services (excluding overhead) (s					1, 251, 256	
13.00	Ratio of hospital-based RHC/FQHC services (					0. 959553	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fi	om Worksheet. N	/l−1, col. 7, li	ne 31)		870, 274	14. 00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			1, 329, 550	15. 00
16.00	Total overhead (sum of lines 14 and 15)					2, 199, 824	16. 00
17. 00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					2, 199, 824	
	Overhead applicable to hospital-based RHC/FG					2, 110, 848	
20.00	Total allowable cost of hospital-based RHC/I	-UHC services (s	sum of lines 10	and 19)		3, 311, 495	20.00

	Financial Systems	PERRY COUNT					eu of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi de	er CC		Peri od:	Worksheet M-2	
			Compone	nt C		From 01/01/2017 To 12/31/2017	Date/Time Pre	nared:
			Comporte	) I C	JON: 13 0317	10 12/31/2017	5/29/2018 5:5	5 pm
						RHC II	Cost	
		Number of FTE	Total Visi	its		Minimum Visits		
		Personnel			Standard (1)	(col. 1 x col.		
						3)	4	
	hu ou to take propulativi ti	1.00	2.00		3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							
4 00	Posi ti ons	0.00			4 00			4 00
1.00	Physician	0.00		0	4, 20		l	1.00
2.00	Physician Assistant Nurse Practitioner	0.00		0	2, 10		1	2. 00 3. 00
4.00		1.00		, 262 , 262	2, 10	0 2, 100 2, 100		4.00
5.00	Subtotal (sum of lines 1 through 3) Visiting Nurse	1. 00 0. 00		, 262		2, 100	2, 262 0	5.00
6. 00	Clinical Psychologist	0.00	1	0			0	6.00
7. 00	Clinical Social Worker	0.00	1	0			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .	0			0	7.00
7. 02	Diabetes Self Management Training (FQHC	0.00	l .	0			0	7.02
7.02	only)	0.00		Ĭ			Ĭ	7.02
8.00	Total FTEs and Visits (sum of lines 4	1.00	2.	262			2, 262	8.00
	through 7)						·	
9.00	Physician Services Under Agreements			0			0	9.00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			SER\	VI CES			
	Total costs of health care services (from Wk						212, 270	
	Total nonreimbursable costs (from Wkst. M-1,						6, 528	
12.00	Cost of all services (excluding overhead) (s			_			218, 798	
13.00	Ratio of hospital -based RHC/FQHC services (I						0. 970164	
14.00	Total hospital-based RHC/FQHC overhead - (fr			, lii	ne 31)		184, 346	
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)				213, 430	
16.00	Total overhead (sum of lines 14 and 15)						397, 776	
17.00	Allowable GME overhead (see instructions) Enter the amount from line 16						0	17. 00 18. 00
		UC convices (1:	no 12 v III	no 10	0)		397, 776	
	Overhead applicable to hospital-based RHC/FQ Total allowable cost of hospital-based RHC/FQ						385, 908 598, 178	
∠∪. ∪∪	Tiotal allowable cost of hospital-based RHC/F	unc services (S	sum Of TTHE	5 10	and 19)		J 370, 178	<sub>1</sub> 20.00

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	PERRY COUNTY SERVICES	Provi der C		Peri od:	u of Form CMS-2 Worksheet M-2	
			Component (		From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 5:5	
					RHC III	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0.00	0	4, 20	0 0		1. 00
2.00	Physician Assistant	0.00	0	2, 10	0 0		2. 00
3.00	Nurse Practitioner	1.00	2, 167	2, 10	0 2, 100		3. 00
4.00	Subtotal (sum of lines 1 through 3)	1.00	2, 167		2, 100	2, 167	4. 00
5.00	Visiting Nurse	0.00	0			0	5. 00
6.00	Clinical Psychologist	0.00	0			0	6. 00
7.00	Clinical Social Worker	0.00	0			0	7. 00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4	1. 00	2, 167			2, 167	8. 00
9. 00	through 7)		0			0	0 00
9.00	Physician Services Under Agreements		0			U	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			144, 754	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			9, 104	11. 00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			153, 858	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 940829	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. M	1-1, col. 7, li	ne 31)		142, 828	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			162, 924	
16.00	Total overhead (sum of lines 14 and 15)					305, 752	16. 00
17. 00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					305, 752	
	Overhead applicable to hospital-based RHC/FQ					287, 660	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		432, 414	20.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Period: From 01/01/2017	Worksheet M-2	
			Component		To 12/31/2017	Date/Time Pre 5/29/2018 5:5	
					RHC IV	Cost	э рш
		Number of FTE	Total Visits	Producti vi tv	Minimum Visits		
		Personnel	10141 110110		(col. 1 x col.		
					3)	4	
		1.00	2.00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 72			·		1.00
2. 00	Physici an Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 90			·		3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 62			4, 914		4.00
5. 00	Visiting Nurse	0.00	1			0	5.00
5. 00	Clinical Psychologist	0.00	1			0	6.00
7. 00	Clinical Social Worker	0.00	l control of the cont			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l control of the cont			0	7.01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)	4.0	0 407				
8. 00	Total FTEs and Visits (sum of lines 4	1. 62	3, 427			4, 914	8.00
9. 00	through 7)		0			0	9.00
9.00	Physician Services Under Agreements					U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL-BASE	ED RHC/EOHC SER	VLCES		1.00	
10. 00						454, 291	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-					12, 406	
12. 00	Cost of all services (excluding overhead)					466, 697	
13. 00	Ratio of hospital -based RHC/FQHC services					0. 973417	13.00
14.00	Total hospital-based RHC/FQHC overhead - (			ne 31)		172, 388	14.00
15. 00	Parent provider overhead allocated to faci			•		411, 639	15.00
16. 00	Total overhead (sum of lines 14 and 15)	•	•			584, 027	16.00
17. 00	Allowable GME overhead (see instructions)					0	17.00
18. 00	Enter the amount from line 16					584, 027	18.00
19. 00	Overhead applicable to hospital-based RHC/	FQHC services (li	ine 13 x line 1	8)		568, 502	19.00
20 00	Total allowable cost of hospital-based RHC	/FQHC services (s	sum of lines 10	and 19)		1, 022, 793	20.00

Health Financial Systems PERRY COUNTY H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1322	Peri od:	Worksheet M-3	
SERVI CES	Component CCN: 15-8516	From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 5:5	
	Title XVIII	RHC I	Cost	
			1 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1. 00	
1.00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2. Line 20)		3, 311, 495	1.00
2.00 Cost of vaccines and their administration (from Wkst. M-4, li			0	2. 00
3.00 Total allowable cost excluding vaccine (line 1 minus line 2)			3, 311, 495	3. 00
4.00 Total Visits (from Wkst. M-2, column 5, line 8)			12, 894	4. 00
5.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		12.004	5.00
6.00 Total adjusted visits (line 4 plus line 5) 7.00 Adjusted cost per visit (line 3 divided by line 6)			12, 894 256. 82	6. 00 7. 00
7.00   Adjusted cost per visit (Title 3 divided by Title 6)		Cal cul ati on		7.00
		our cur a tron	01 21 1111 2 (1)	
		Prior to Jan.	On or After	
		1 (Rate Period		
		1)	Peri od 2) 2.00	
8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	82. 30	8. 00
9.00 Rate for Program covered visits (see instructions)		256. 82	256. 82	ı
CALCULATION OF SETTLEMENT				
10.00 Program covered visits excluding mental health services (from		0	2, 545	
11.00 Program cost excluding costs for mental health services (line	•	0	653, 607	11.00
12.00 Program covered visits for mental health services (from control 13.00 Program covered cost from mental health services (line 9 x li		0	0	12.00
14.00 Limit adjustment for mental health services (see instructions	,	0	0	13. 00 14. 00
15.00 Graduate Medical Education Pass Through Cost (see instruction	•		O .	15. 00
16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	653, 607	•
16.01 Total program charges (see instructions)(from contractor's re	cords)		364, 715	16. 01
16.02 Total program preventive charges (see instructions)(from prov			33, 828	1
16.03 Total program preventive costs ((line 16.02/line 16.01) times	-		60, 623	1
16.04 Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		434, 822	16. 04
16.05 Total program cost (see instructions)		0	495, 445	16. 05
17.00 Primary payer amounts			0	17. 00
18.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		49, 457	18. 00
records)			5, aa,	40.00
19.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		56, 286	19. 00
20.00 Net Medicare cost excluding vaccines (see instructions)			495, 445	20.00
21.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	21. 00
22.00 Total reimbursable Program cost (line 20 plus line 21)			495, 445	22. 00
23.00 Allowable bad debts (see instructions)			0	23. 00
23. 01 Adjusted reimbursable bad debts (see instructions)			0	1
24.00   Allowable bad debts for dual eligible beneficiaries (see inst 25.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	24. 00 25. 00
25.50 Pioneer ACO demonstration payment adjustment (see instruction	5)		0	25. 50
25. 99 Demonstration payment adjustment amount before sequestration	/		0	
26.00 Net reimbursable amount (see instructions)			495, 445	26. 00
26.01 Sequestration adjustment (see instructions)			9, 909	ł
26.02 Demonstration payment adjustment amount after sequestration			0	
27.00 Interim payments			444, 598 0	ı
28.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.01)	02 27 and 28)		40, 938	
30.00 Protested amounts (nonallowable cost report items) in accorda			40, 730	1
	•	1	-	1

Heal th	Financial Systems PERRY COUNTY F	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1322	Peri od:	Worksheet M-3	
SERVI (	CES	Component CCN: 15-8517	From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 5:5	
		Title XVIII	RHC II	Cost	<u> </u>
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M-2 line 20)		598, 178	1. 00
2. 00	Cost of vaccines and their administration (from Wkst. M-4, li			0	2. 00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			598, 178	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2, 262	4.00
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	line 9)		0 2, 262	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			264. 45	7. 00
	,		Cal cul ati on		
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2)	
0.00	Don visit normant limit (from CMC Dub. 100 04 shorter 0, 620	( or your contractor)	1.00	2. 00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	. 6 or your contractor)	0. 00 264. 45	82. 30 264. 45	8. 00 9. 00
7. 00	CALCULATION OF SETTLEMENT		204. 43	204. 43	7.00
10.00	Program covered visits excluding mental health services (from	contractor records)	0	129	10. 00
11. 00	Program cost excluding costs for mental health services (line	•	0	34, 114	1
12.00	Program covered visits for mental health services (from contr		0	0	12.00
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions	,	0	0	13. 00 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	34, 114	•
16. 01	Total program charges (see instructions)(from contractor's re	•		20, 309	1
16. 02	Total program preventive charges (see instructions) (from prov			3, 767	16. 02
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0)	*		6, 328 19, 883	1
10.04	(Titles V and XIX see instructions.)	and roy trilles . 60)		17, 003	10.04
16. 05	Total program cost (see instructions)		0	26, 211	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		2, 932	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		2, 722	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			26, 211	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			26, 211	1
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	23. 01 24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	ıs)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26. 00	Net reimbursable amount (see instructions)			26, 211	1
26. 01	Sequestration adjustment (see instructions)			524	1
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 28, 081	26. 02 27. 00
28. 00	1			20,001	1
29. 00	1	02, 27, and 28)		-2, 394	
30. 00		nce with CMS Pub. 15-II,		0	
	chapter I, §115.2				l

	Financial Systems PERRY COUNTY H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1322	Peri od:	Worksheet M-3	
SERVI C	ES	Component CCN: 15-8518	From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 5:5	
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			432, 414	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		0	2. 00
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			432, 414 2, 167	3. 00 4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		2, 107	5.00
6.00	Total adjusted visits (line 4 plus line 5)	,		2, 167	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			199. 54	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	.6 or your contractor)	0.00	82. 30	8. 00
9.00	Rate for Program covered visits (see instructions)		199. 54	199. 54	9. 00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	•	0	159	•
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contra	•	0	31, 727 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x lines)		0	0	13. 00
14. 00	Limit adjustment for mental health services (see instructions)	•	0	Ö	14. 00
15.00	Graduate Medical Education Pass Through Cost (see instructions	s)			15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	31, 727	
16. 01	Total program charges (see instructions)(from contractor's red	•		25, 652	
16. 02 16. 03	Total program preventive charges (see instructions)(from provi Total program preventive costs ((line 16.02/line 16.01) times			2, 393 2, 960	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0)	•		19, 605	1
	(Titles V and XIX see instructions.)	, , , , , , , , , , , , , , , , , , , ,		,	
16. 05	Total program cost (see instructions)		0	22, 565	
17. 00	Primary payer amounts	(from contractor		4 2/1	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Troill contractor		4, 261	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		3, 800	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			22, 565	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			22, 565	•
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	23. 01 24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructi ons)		Ö	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	1
26. 00	Net reimbursable amount (see instructions)			22, 565	1
26. 01 26. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			451 0	ı
	Interim payments			24, 542	
28. 00	1			24, 342	1
	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		-2, 428	29. 00
29. 00					30.00

CAL CITI	Financial Systems PERRY COUNTY H ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (		Component CCN: 15-8519	From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 5:5	pared:
		Title XVIII	RHC IV	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 (from	m Wkst. M-2, line 20)		1, 022, 793	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		0	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 022, 793	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, l	Lino (1)		4, 914 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	1111e 9)		4, 914	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			208. 14	
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate Period	Jan. 1 (Rate	
			1)	Peri od 2)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	1.00	2. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)	o or your contractor)	208. 14	208. 14	l
7. 00	CALCULATION OF SETTLEMENT		200111	200.11	7.00
10.00	Program covered visits excluding mental health services (from	contractor records)	0	1, 115	10.00
11.00	Program cost excluding costs for mental health services (line	•	0	232, 076	
12.00	Program covered visits for mental health services (from contra		0	0	
13. 00 14. 00	Program covered cost from mental health services (line 9 x line) Limit adjustment for mental health services (see instructions)		0	0	13. 00 14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instructions			O	15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	232, 076	
16. 01	Total program charges (see instructions)(from contractor's red	•		163, 669	
16. 02	Total program preventive charges (see instructions)(from provi	•		2, 847	
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0)			4, 037 166, 056	
10. 04	(Titles V and XIX see instructions.)	3 and 16) times .60)		100, 030	10.04
16. 05	Total program cost (see instructions)		0	170, 093	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		20, 469	18.00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		28, 071	19. 00
20.00	records)			170 000	20.00
20. 00 21. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		170, 093 0	1
22. 00	Total reimbursable Program cost (line 20 plus line 21)	W 4, 1111C 10)		170, 093	
23. 00	Allowable bad debts (see instructions)			0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	24.00
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	c)		0	25. 00 25. 50
25. 99	Demonstration payment adjustment amount before sequestration	<i>a)</i>		0	l l
26. 00	Net reimbursable amount (see instructions)			170, 093	
26. 01	Sequestration adjustment (see instructions)			3, 402	26. 01
26. 02	Demonstration payment adjustment amount after sequestration			0	
27. 00	Interim payments			150, 052	1
28. 00 29. 00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.0	ກາງ 27 and 28)		0 16, 639	28. 00 29. 00
30.00	Protested amounts (nonallowable cost report items) in accordan			10, 039	1
	chapter I, §115.2			ŭ	

Health Financial Systems	PERRY COUNTY H	OSPI TAL				In Lie	u of Form CMS	-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC	PROVIDER FOR	Provi der	CCN:	15-1322	Perio		Worksheet M-	5
SERVICES RENDERED TO PROGRAM BENEFICIARIES						01/01/2017		
		Component	CCN:	15-8516	To	12/31/2017	Date/Time Pr	epared:
		,					5/29/2018 5:	55 pm

		Component CCN: 15-8516	10 12/31/2017	5/29/2018 5:55	
			RHC I	Cost	
	· · · · · · · · · · · · · · · · · · ·		Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			444, 598	1. 0
. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2. 0
. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3. 0
01	Program to Provider			0	3. 0
. 01					3.0
. 02				0	3.0
. 03 . 04					3. (
. 04 . 05					3. (
. 03	Provider to Program			U	٥.١
. 50	Frovider to Frogram			0	3. !
51				0	3. !
52					3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)			444, 598	4. (
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	k review. Also show date o	f		5. (
	each payment. If none, write "NONE" or enter a zero. (1)				
0.4	Program to Provider			0	_
. 01				0	5. (
. 02				0	5. (
03	Dravi dan ta Dragnam			0	5.
50	Provider to Program			0	5. !
51				0	5.
51 52					5. 5.
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	00)		0	5. 5.
				ا	
00 01	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER	cost report. (1)		40, 938	6. 6.
	SETTLEMENT TO PROVIDER			40, 938	6. 6.
02	Total Medicare program liability (see instructions)			485, 536	6. 7.
. 00	Total Medicale program Trability (see Instructions)		Contractor	NPR Date	7.
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	

Health Financial Systems	PERRY COUNTY H	OSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-1322 Component CCN: 15-8517	From 01/01/2017	Worksheet M-5 Date/Time Prepared: 5/29/2018 5:55 pm

		Component CCN: 15-8517	10 12/31/2017	5/29/2018 5:55	
			RHC II	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			28, 081	1.
00	Interim payments payable on individual bills, either submitt the contractor for services rendered in the cost reporting p "NONE" or enter a zero			0	2.
0	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3
	Program to Provider				
)1				0	-
)2				0	3
)3				0	3
)4				0	3
15				0	3
	Provider to Program				
0				0	
1				0	3
2				0	3
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		28, 081	4
	27)				ļ
_	TO BE COMPLETED BY CONTRACTOR				
0	List separately each tentative settlement payment after desk each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5
	Program to Provider				_
)1				0	5
12 13				0	5
3	Provider to Program				5
0	Provider to Program			0	5
1					5
				0	
2 9		20)		0	5
9	Determined net settlement amount (balance due) based on the			١	6
	SETTLEMENT TO PROVIDER	cost report. (1)		0	6
1	SETTLEMENT TO PROGRAM			2, 394	6
12	Total Medicare program liability (see instructions)			2, 394 25, 687	
0	TIOTAL MEDICALE DIODIAM FLADILLIV (SEE INSTRUCTIONS)			25, 687	7
00	Total medical program readily		Contract	NDD Doto	
00	Total mode of program traditity (coo thetractions)		Contractor	NPR Date	
00	Total mode od o program readinity (coo mot dottone)	0	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	

Health Financial Systems	PERRY COUNTY HOSPITAL		In Lieu of Form CMS-25	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-1322 Component CCN: 15-8518	Peri od: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/29/2018 5:55 pm

		Component CCN: 15-8518	10 12/31/2017	5/29/2018 5:55	
			RHC III	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			24, 542	1. 00
2.00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting   "NONE" or enter a zero			0	2. 00
3.00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3. 00
	Program to Provider				
3. 01				0	3. 0
3. 02				0	3. 02
3. 03				0	3. 03
3. 04				0	3. 04
3. 05	Provider to Program			U	3. 0
3. 50	Provider to Program			0	3. 5
3. 51				0	3. 5
3. 52				Ö	3. 5
3. 53				ő	3. 5
3.54				ol	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		o	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans: 27)	fer to Worksheet M-3, line		24, 542	4. 0
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desleach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. 0
	Program to Provider				
5. 01				0	5. 0
5. 02				0	5.0
5. 03				0	5.0
F F0	Provider to Program				
5.50				0	5. 5
5. 51 5. 52				0	5. 5 5. 5
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	00)		0	5. 9
6. 00	Determined net settlement amount (balance due) based on the				6.0
6. 01	SETTLEMENT TO PROVIDER	cost report. (1)		0	6. 0
6. 02	SETTLEMENT TO PROGRAM			2, 428	6. 0
7.00	Total Medicare program liability (see instructions)			22, 114	7. C
	in the second se		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR Provider CCN: 15-1322 Period: Workshee	CMS-2552-10
Component CCN: 15-8519   To   12/31/2017   Date/Tim	

mm/dd/y  1.00  Total interim payments paid to hospital-based RHC/FQHC  2.00  Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write	Part B yyy Amount 2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC 2.00 Interim payments payable on individual bills, either submitted or to be submitted to	yyy Amount 2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC 2.00 Interim payments payable on individual bills, either submitted or to be submitted to	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC 2.00 Interim payments payable on individual bills, either submitted or to be submitted to		
2.00 Interim payments payable on individual bills, either submitted or to be submitted to		
	150, 052	1. 0
"NONE" or enter a zero	0	2. 0
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider		3. 0
3.01	0	3. 0
3.02		3. 0
3.03		3. 0
3.04	l ol	3. 0
3.05		3. 0
Provider to Program	1	
3.50	0	3. 5
. 51	o	3. !
. 52	0	3. !
. 53	0	3. 5
5.54	0	3. 5
s. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	0	3. 9
1.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)	150, 052	4. 0
TO BE COMPLETED BY CONTRACTOR		
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		5. (
Program to Provider		
.01	0	5.0
5. 02	0	5. C
Provider to Program	0	5. (
. 50	0	5. 5
551		5. 5
52		5. 5
.02   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		5. 9
.00 Determined net settlement amount (balance due) based on the cost report. (1)		6. (
. 01 SETTLEMENT TO PROVIDER	16, 639	6. 0
0.02 SETTLEMENT TO PROGRAM	0	6. 0
7.00 Total Medicare program Liability (see instructions)	166, 691	7. 0
Contrac	tor NPR Date	
Numbe		
0 1.00	2.00	
3.00  Name of Contractor		8. 0