Health Financial Systems	PERRY COUNTY				eu of Form CMS-2552-10			
This report is required by law (42 USC 1395g; 42 CF payments made since the beginning of the cost repor					FORM APPROVED OMB NO. 0938-0050			
	ting period bei	ng deelled over	payments (42	03C 13759).	EXPIRES 03-31-2022			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	RT CERTIFICATIO	N Provider CO		Period: From 01/01/2020	Worksheet S Parts I-III			
AND SETTLEMENT SUMMART				To 12/31/2020	Date/Time Prepared:			
PART I – COST REPORT STATUS					6/11/2021 11:56 am			
Provider 1. [X] Electronically prepared cost				Date: 6/11/20	021 Time: 11:56 am			
use only 2. []Manually prepared cost report 3. [0]If this is an amended report enter the number of times the provider resubmitted this cost report								
4. [F] Medicare Utilization. Enter "	F" for full or							
Contractor use only5. [1] Cost Report Status (1) As Submitted6. Date Received: 7. Contractor No. (2) Settled without Audit10. NPR Date: 11. Contractor's Vendor Code: 12. [0] If line 5, column 1 is 4: number of times reopened =								
(4) Reopened(5) Amended								
PART II – CERTIFICATION								
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI								
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O								
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA								
CERTIFICATION BY CHIEF FINANCIAL OFFICER OF	ADMI NI STRATOR	OF PROVIDER(S))					
I HEREBY CERTIFY that I have read the above					1 5 5			
electronically filed or manually submitted Expenses prepared by PERRY COUNTY HOSPITAL								
ending 12/31/2020 and to the best of my kno	wledge and beli	ef, this repor	rt and stateme	ent are true, co	rrect,			
complete and prepared from the books and re except as noted. I further certify that I								
health care services, and that the services								
laws and regulations.								
 I have read and agree with the above of signature on this certification statem 								
	(Si gn	0 9	g equivarent e	or my orriginal 3	inghature.			
	(Si gii		er or Adminis	trator of Provid	der(s)			
		Title						
		Date						
		Date						
		Title	XVIII					
Cost Center Description	Title V	Part A	Part B	ніт	Title XIX			
	1.00	2.00	3.00	4.00	5.00			
PART III - SETTLEMENT SUMMARY 1.00 Hospital	0	90, 953	58, 62	0 0	0 1.00			
	1 1			-1 -				

1.00	Hospi tal	0	90, 953	58, 620	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	191, 080	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-49, 259		0	10.00
10.01	RURAL HEALTH CLINIC II	0		603		0	10.01
10. 02	RURAL HEALTH CLINIC III	0		6, 426		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		0		0	10.03
200.00	Total	0	282, 033	16, 390	0	0	200.00

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

	TAL AND HOSPITAL HEALTH CARE COMPLEX	IDENIIFICATION DATA	Provid	ler CCN: 1	15-1322	Period: From 01/01/ To 12/31/	2020	Workshe Part I Date/Ti 6/11/20	me Pre	pared
	1.00	2.00		3.00		4	4.00			
00	Hospital and Hospital Health Care Co Street: 8885 SR 237	PO Box: X								1.0
00	City: TELL CITY	State: IN	Zin Cod	e: 47586	Coun	ty: PERRY				2.0
		Component Name	CCN	CBSA	Provi der		Payme	nt Syst	em (P,	
			Number	Number	Туре	Certified	<u>Т,</u>	0, or	N)	
							V	XVIII	XIX	-
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospital and Hospital-Based Componer Hospital	PERRY COUNTY HOSPITAL	151322	99915	1	07/01/2004	N	0	Р	3.0
00	Subprovider - IPF		131322	77713	'	0770172004			'	4.0
00	Subprovider - IRF				1					5.
00	Subprovider - (Other)									6.0
00	Swing Beds - SNF	PERRY COUNTY HOSPI TAL	15Z322	99915		07/01/2004	N	0	N	7.
~~		SWI NG								
00 00	Swing Beds – NF Hospital-Based SNF									8. 9.
. 00	Hospi tal -Based NF									10.
00	Hospi tal -Based OLTC									11.
00	Hospital-Based HHA									12.
00										13.
00 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC	TELL CITY CLINIC	158516	99915		05/18/2015	N	0	N	14.
00	Hospital - Based Health Clinic - RHC	PERRY CO FAMILY	158517	99915		05/19/2015	N	0	N	15.
0.		PRACTICE	100017			2010				
02	Hospital-Based Health Clinic - RHC	TROY CLINIC	158518	99915		11/23/2015	N	0	N	15.
03	Hospital-Based Health Clinic - RHC	CANNELTON CLINIC	158519	99915		05/06/2016	N	0	N	15.
00	Hospital-Based Health Clinic - FQHC									16.
00										17.
. 00	Renal Dialysis									18.
. 00	Other									19.
						From:				1
						1.00				
. 00	Cost Reporting Period (mm/dd/yyyy)					1.00	020	12/31/	/2020	20.
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						020		2020	20. 21.
	Type of Control (see instructions)				1.00	01/01/2	020			1
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00	Type of Control (see instructions)				1.00 N	01/01/20	020	12/31/		1
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00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in column 2, "Y" for yes or "N reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aff Does this hospital contain at least counted in accordance with 42 CFR 47	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. ncompensated care paymen mm 1, "Y" for yes or "N eriod occurring prior to u" for no for the portio ter October 1. (see inst t requires final uncompe eport settlement? (see i u" for no, for the portio per 1. Enter in column 2 ne cost reporting period hic reclassification from rds for delineating stat column 1, "Y" for yes or ng period prior to Octob no for the portion of ti ter October 1. (see inst 100 but not more than 4 12.105)? Enter in column edicaid days on lines 24	th 42 CFF this endment ts for thi ' for no 1 October of nof the or outions) nsated can mstruction on of the "Y" for on or aff m urban to stical an "N" for r er 1. Enten cost of the ost "U" for an of the ost "Y" for on or aff stical an "N" for r er 1. Enten a cost of the ost of the ost stical an "Y" for an of the ost of the ost o	s for L. cost re ns) yes ter reas no er	N	01/01/20 9 2.00 N N N N	020	3. (00	21.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is in disproportionate share hospital adjuty §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section 8 hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aff Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. ncompensated care paymen umn 1, "Y" for yes or "N eriod occurring prior to "for no for the portio ter October 1. (see inst requires final uncompen- eport settlement? (see "for no, for the porti- ber 1. Enter in column 2 he cost reporting period hic reclassification from rds for delineating stat column 1, "Y" for yes or ng period prior to Octobe no for the portion of the ter October 1. (see inst 100 but not more than 4 12.105)? Enter in column edicaid days on lines 24 of admission, 2 if censi- of identifying the days	th 42 CFF this endment ts for thi ' for no 1 October of nof the construction on of the "Y" for on or aff m urban to stical ar "N" for r er 1. Ente stical ar "N" for r er 1. Ente acost ructions) 29 beds (a 3, "Y" for and/or 25 us days, of in this of	s for L. cost re ns) yes ter o reas no er as or 35 or 3	N	01/01/20 9 2.00 N N N N	020	3. (00	21. 22. 22. 22. 22.

Health Financial Sy HOSPITAL AND HOSPI	STEMS PERRY TAL HEALTH CARE COMPLEX IDENTIFICATION DA	COUNTY HOS	Provider CC	N: 15-1322	Peri od:		Workshe		2552-10
					From 01/01 To 12/31	/2020	Part I Date/Ti 6/11/20	me Pre)21 11:	pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Meo	ther li cai d lays	
24 00 If this prov	ider is an LPPS bespital optor the	1.00	2.00	3.00	4.00	5.00	0	<u>b. 00</u>	24.00
in-state Med Medicaid eli out-of-state out-of-state 4, Medicaid column 5, an 25.00 If this prov Medicaid pai Medicaid eli out-of-state Medicaid eli	ider is an IPPS hospital, enter the icaid paid days in column 1, in-state gible unpaid days in column 2, Medicaid paid days in column 3, Medicaid eligible unpaid days in column HMO paid and eligible but unpaid days in d other Medicaid days in column 6. ider is an IRF, enter the in-state d days in column 1, the in-state gible unpaid days in column 2, Medicaid days in column 3, out-of-state gible unpaid days in column 4, Medicaid eligible but unpaid days in column 5.	0	0		0		0	U	24.00
					Urban/Ru 1.0		Date of 2.0		-
	tandard geographic classification (not wa		at the beg	ginning of tl		2	2.0		26.00
27.00 Enter your s reporting pe	ng period. Enter "1" for urban or "2" for tandard geographic classification (not wa riod. Enter in column 1, "1" for urban or fective date of the geographic reclassifi	age) status r "2" for ru	ural. If ap		t	2			27.00
	sole community hospital (SCH), enter the e cost reporting period.	e number of	periods SC	CH status in	Begi nn	0 i.ng:	Endi	na.	35.00
					1.0		2. (
	able beginning and ending dates of SCH s n excess of one and enter subsequent date		cript line	36 for numbe	er				36.00
	Medicare dependent hospital (MDH), enter in the cost reporting period.	r the number	r of period	ds MDH statu	5	0			37.00
37.01 Is this hosp	ital a former MDH that is eligible for th ith FY 2016 OPPS final rule? Enter "Y" fo								37.01
38.00 If line 37 i	s 1, enter the beginning and ending dates 1, subscript this line for the number of								38.00
					Y/N 1.0		Y/ 2. (-
hospitals in 1 "Y" for ye accordance w	cility qualify for the inpatient hospital accordance with 42 CFR §412.101(b)(2)(i) s or "N" for no. Does the facility meet ith 42 CFR 412.101(b)(2)(i), (ii), or (ii o. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	ter in colum nts in	r		N		39.00
"N" for no i	ital subject to the HAC program reduction n column 1, for discharges prior to Octol 2, for discharges on or after October 1.	ber 1. Entei	°"Y" for y				N		40.00
						V	XVIII	XI X 3.00	-
						1 00			
	Payment System (PPS)-Capital					1.00			
45.00 Does this fa	cility qualify and receive Capital paymen	nt for disp	roporti onat	te share in a	accordance	1.00	N	N	45.00
45.00 Does this fa with 42 CFR46.00 Is this faci pursuant to		eption for e	extraordi na	ary circumsta	ances				45.00 46.00
 45.00 Does this fa with 42 CFR 46.00 Is this faci pursuant to Pt. III. 47.00 Is this a ne 48.00 Is the faci I 	cility qualify and receive Capital paymen Section §412.320? (see instructions) lity eligible for additional payment exce 42 CFR §412.348(f)? If yes, complete Wks w hospital under 42 CFR §412.300(b) PPS o ity electing full federal capital paymen	eption for (t. L, Pt. II capital? Er	extraordina ∣I and Wkst nter "Y for	ary circumsta t. L-1, Pt. r yes or "N"	ances I through for no.	N	N	N	
 45.00 Does this fa with 42 CFR 46.00 Is this faci pursuant to Pt. III. 47.00 Is this a ne 48.00 Is the facil Teaching Hos 56.00 Is this a ho "N" for no i 	cility qualify and receive Capital paymen Section §412.320? (see instructions) Lity eligible for additional payment exce 42 CFR §412.348(f)? If yes, complete Wks ⁻ w hospital under 42 CFR §412.300(b) PPS of ity electing full federal capital payment pitals spital involved in training residents in n column 1. If column 1 is "Y", are you i	eption for (t. L, Pt. II capital? En t? Enter "`` approved G impacted by	extraordina I and Wkst hter "Y for Y" for yes ME programs CR 11642 (ary circumsta t. L-1, Pt. yes or "N" or "N" for u s? Enter "Y"	ances I through for no. no. for yes or	N N N	N N N	N N N	46.00
 45.00 Does this fa with 42 CFR 46.00 Is this faci pursuant to Pt. III. 47.00 Is this a ne 48.00 Is the facil Teaching Hos 56.00 Is this a ho "N" for no i GME payment 57.00 If line 56 i GME programs is "Y" did r for yes or " 	cility qualify and receive Capital paymen Section §412.320? (see instructions) lity eligible for additional payment exce 42 CFR §412.348(f)? If yes, complete Wks w hospital under 42 CFR §412.300(b) PPS of ity electing full federal capital payment pitals spital involved in training residents in n column 1. If column 1 is "Y", are you i reduction? Enter "Y" for yes or "N" for s yes, is this the first cost reporting p trained at this facility? Enter "Y" for esidents start training in the first mon N" for no in column 2. If column 2 is "N	eption for (t. L, Pt. II capital? En t? Enter " approved G impacted by no in colur period durin r yes or "N" th of this (Y", complete	extraordina I and Wkst nter "Y for Y" for yes ME programs CR 11642 (nn 2. ng which re ' for no ir cost report e Worksheet	ary circumsta t. L-1, Pt. I or "N" for I ? Enter "Y" (or subsequent esidents in a n column 1. I ting period?	ances I through for no. no. for yes or nt CR), MA approved If column 1 Enter "Y"	N N N N N	N N N	N N N	46.00 47.00 48.00
 45.00 Does this fa with 42 CFR 46.00 Is this faci pursuant to Pt. III. 47.00 Is this a ne 48.00 Is the faci Teaching Hos 56.00 Is this a ho "N" for no i GME payment 57.00 If line 56 i GME programs is "Y" did r for yes or " 	cility qualify and receive Capital paymen Section §412.320? (see instructions) lity eligible for additional payment exce 42 CFR §412.348(f)? If yes, complete Wks w hospital under 42 CFR §412.300(b) PPS of ity electing full federal capital payment pitals spital involved in training residents in n column 1. If column 1 is "Y", are you i reduction? Enter "Y" for yes or "N" for s yes, is this the first cost reporting p trained at this facility? Enter "Y" for esidents start training in the first mon	eption for (t. L, Pt. II capital? En t? Enter "" approved G impacted by no in colur beriod durin r yes or "N" th of this (Y", complete I, if applic	extraordina II and Wkst hter "Y for Y" for yes ME programs CR 11642 (nn 2. ng which re for no ir cost report e Worksheet cable.	ary circumsta t. L-1, Pt. I or "N" for n s? Enter "Y" (or subsequen esidents in a n column 1. I ting period? t E-4. If col	ances I through for no. no. for yes or nt CR), MA approved If column 1 Enter "Y" lumn 2 is	N N N N N	N N N	N N N	46.00 47.00 48.00 56.00

ealth Financial Systems PERRY OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		HOSPITAL Provider CC	F	rom 01/01/2020 o 12/31/2020	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 6/11/2021 11:	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in colu is "Y", are you impacted by CR 11642 (or subsequent Cl adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1	1.00 N	2.00	3.00	60.00
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
 column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 						61.01
instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 						61.03
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04
current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.00
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	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. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program name. 				0.00		61. 20
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 Ser 2.00 Enter the number of FTE residents that your hospital				od for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progra Teaching Hospitals that Claim Residents in Nonprovide	tions) Teachi <u>ram. (s</u>	ng Health Cent see instruction	ter (THC) into		0.00	62.01
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, completion	ttings	during this co	67. (see instru	uctions)	N	63.00
			Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base year	2.00 is your cost r	3.00 reporting	
period that begins on or after July 1, 2009 and before 4.00 Enter in column 1, if line 63 is yes, or your facility in the base year period, the number of unweighted non- resident FTEs attributable to rotations occurring in a settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see in the set of the s	<u>e June</u> y trair -primar all nor non-pr columr	30, 2010. med residents ry care provider mary care n 3 the ratio	0.00			64.00

		ATA Provi der	Fr	eriod: com 01/01/2020		
			To	12/31/2020	Date/Time Pre 6/11/2021 11:	pared 56 am
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	позрітаі	4))	
	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
(+)). (See THISTI UCTIONS)		<u> </u>	Unweighted	Unweighted	Ratio (col. 1/	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current Y	/ear FTE Residents i	n Nonprovider Settir				
beginning on or after July 1, 201 .00 Enter in column 1 the number of u		•	0.00	0.00	0. 000000	
FTEs that trained in your hospita (column 1 divided by (column 1 +	column 2)). (see in					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
00 Enter in column 1, the program	Program Name	Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	U U		FTËs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
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	U U		FTĔs Nonprovi der Si te 3.00	FTES in Hospital 4.00 0.00	(col. 3 + col. 4)) 5.00 0.000000	_
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 25	2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
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 25 vchiatric Facility (2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
<pre>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)</pre>	1.00 1.00 2S /chiatric Facility (the facility have a ≥fore November 15, 2 umn 2: Did this fac ≥ 112.424 (d)(1)(iii) ;ate which program y	2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
<pre>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)</pre>	1.00 1.00 2S ychiatric Facility (the facility have a effore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y y PPS habilitation Facilit	2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	_

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I DENTIFICATION DATA	Provider C	CN: 15-1322	Peri od:	Worksheet S-2	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	epared.
					6/11/2021 11:	
					1.00	_
Long Term Care Hospital PPS					1.00	
80.00 Is this a long term care hospital (and "N" for	no.		N	80.00
81.00 Is this a LTCH co-located within an	other hospital for part o	r all of the o	cost reportin	g period? Enter	N	81.00
"Y" for yes and "N" for no. TEFRA Providers						-
85.00 Is this a new hospital under 42 CFR	Section §413 40(f)(1)(i)	TEERA? Ente	r "Y" for ves	or "N" for no	N	85.00
86.00 Did this facility establish a new O	ther subprovider (exclude		2			86.00
§413.40(f)(1)(ii)? Enter "Y" for y						
87.00 Is this hospital an extended neoplar 1886(d)(1)(B)(vi)? Enter "Y" for ye		l classified	under section		N	87.00
	<u>s or in 101 110.</u>			V	XI X	
				1.00	2.00	
Title V and XIX Services						
90.00 Does this facility have title V and yes or "N" for no in the applicable		I services? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for tit		he cost repor	t either in	N	N	91.00
full or in part? Enter "Y" for yes						
92.00 Are title XIX NF patients occupying			ion)? (see		N	92.00
instructions) Enter "Y" for yes or 93.00 Does this facility operate an ICF/I			d XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the ap	2 1 1					
94.00 Does title V or XIX reduce capital	cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
applicable column. 95.00 fline 94 is "Y", enter the reduct	ion percentage in the ann	licable colum	n	0.00	0.00	95.00
96.00 Does title V or XIX reduce operating				N 0.00	N 0.00	96.00
applicable column.						
97.00 If line 96 is "Y", enter the reduct				0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare stepdown adjustments on Wkst. B, Pt				Y	Y	98.00
column 1 for title V, and in column		01 yes of 11				
98.01 Does title V or XIX follow Medicare					Y	98.01
C, Pt. I? Enter "Y" for yes or "N" title XIX.	for no in column 1 for th	tle V, and in	column 2 for			
98.02 Does title V or XIX follow Medicare	(title XVIII) for the ca	Iculation of	observati on	Y	Y	98.02
bed costs on Wkst. D-1, Pt. IV, line		r "N" for no	in column 1			
for title V, and in column 2 for ti		ical accors b	ocpital (CAU)	N	N	98.03
98.03 Does title V or XIX follow Medicare reimbursed 101% of inpatient service					IN	90.03
for title V, and in column 2 for ti						
98.04 Does title V or XIX follow Medicare				N	N	98.04
outpatient services cost? Enter "Y" in column 2 for title XIX.	for yes or "N" for no In	COLUMN I TOP	title v, and			
98.05 Does title V or XIX follow Medicare	(title XVIII) and add ba	ck the RCE di	sallowance on	Y	Y	98.05
Wkst. C, Pt. I, col. 4? Enter "Y" f	or yes or "N" for no in c	olumn 1 for t	itle V, and i	n		
column 2 for title XIX.	(title V)/LLL) when cost	raimburgad fa		Y	Y	98.06
98.06 Does title V or XIX follow Medicare Pts. I through IV? Enter "Y" for ye	s or "N" for no in column	1 for title	V, and in	T	T	90.00
column 2 for title XIX.			·			
Rural Providers				V		105 00
105.00 Does this hospital qualify as a CAH 106.00 If this facility qualifies as a CAH		inclusive met	hod of navmen	t N		105.00
for outpatient services? (see instru			nou or puymen			100.00
107.00 Column 1: If line 105 is Y, is this	facility eligible for co	st reimbursem	ent for I&R	N		107.00
training programs? Enter "Y" for ye Column 2: If column 1 is Y and lin						
approved medical education program						
Enter "Y" for yes or "N" for no in	column 2. (see instructi	ons)	.,			
108.00 Is this a rural hospital qualifying CFR Section §412.113(c). Enter "Y"		CRNA fee sche	dul e? See 42	N		108.00
CFR Section 9412. 113(C). Enter Y	Tor yes or in Tor no.	Physi cal	Occupati ona	I Speech	Respi ratory	
		1.00	2.00	3.00	4.00	
109.00 If this hospital qualifies as a CAH		N	N	N	N	109.00
therapy services provided by outside for yes or "N" for no for each ther						
	<u></u>		I			
					1.00	
110.00 Did this hospital participate in the Demonstration) for the current cost					N	110.00
complete Worksheet E, Part A, lines						
applicable.				5		

		eri od:	Worksheet S-	-2
	FI To	rom 01/01/2020 o 12/31/2020		repared
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Com Health Integration Project (FCHIP) demonstration for this cost reporting pe "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, en integration prong of the FCHIP demo in which this CAH is participating in c Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter nter the column 2.	1.00 N	2.00	111.0
-	1.00	2.00	3.00	_
12.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.0
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	Ν			0115.0
16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Ν			116. 0
17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Ν			117.0
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	C			118. (
	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	_
18.01 List amounts of malpractice premiums and paid losses:	269, 111	C)	0118.0
		1.00	2.00	
8 02 Are malpractice premiums and paid losses reported in a cost center other th	an the			118 (
Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 9.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instru	st centers sion in ACA for yes or e Outpatient	N	N	119.
Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 9.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implantable devices	st centers sion in ACA for yes or Outpatient uctions)	N	N	119. 120.
 Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) 11.00 Did this facility incur and report costs for no. 12.00 Does the cost report contain heal thcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter 	st centers sion in ACA for yes or e Outpatient uctions) charged to v)(3) of the	N	N 5. 01	119. 120. 121.
 Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provisions state and amounts contained therein. 9.100 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision is a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 	st centers sion in ACA for yes or Outpatient actions) charged to v)(3) of the in column 2	N N Y Y		119. 120. 121. 122.
 Administrative and General? If yes, submit supporting schedule listing cost and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 10.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 200 Does the cost report contain healthcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" f yes, enter certification date(s) (mm/dd/yyyy) below. 	st centers sion in ACA for yes or e Outpatient uctions) charged to v)(3) of the in column 2	N N Y		119. 120. 121. 122. 125.
 Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" f yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 	st centers sion in ACA for yes or e Outpatient actions) charged to V)(3) of the in column 2	N N Y Y		119. 120. 121. 122. 125. 126.
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 Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru- Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" f yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 	st centers sion in ACA for yes or e Outpatient actions) charged to v)(3) of the in column 2 For no. If cation date cation date	N N Y Y		119. 120. 121. 122. 125. 126. 127. 128.
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 Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" f yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certific acolumn 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified pancreas transplant center, enter the certificatic column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified pancreas transplant center, enter the certificatic column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare c	st centers sion in ACA for yes or e Outpatient actions) charged to v)(3) of the in column 2 for no. If cation date cation date ation date in fication tification	N N Y Y		119. 120. 121. 122. 125. 126. 127. 128. 129. 130. 131.
 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" f yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified pancreas transplant center, enter the certific a column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the certific date in column 1 and termination date, if	st centers sion in ACA for yes or e Outpatient actions) charged to w)(3) of the in column 2 for no. If cation date cation date ation date in fication cation date in fication cation date	N N Y Y		1118. 1 119. 1 120. 1 121. 1 122. 1 122. 1 125. 1 126. 1 126. 1 127. 1 128. 1 129. 1 130. 1 131. 1 132. 1 133. 1 134. 1

USFITAL AND HUSFITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	Provider CC	N: 15-1322	Perio From	od: 01/01/2020	Worksheet S- Part I	-2
				То	12/31/2020	Date/Time Pr	
1.00	2.	00			3.00	6/11/2021 1	1:56 am
If this facility is part of a cha			ugh 143 the	e name a		of the	
home office and enter the home of	<u>fice contractor name and </u>		er.				
41.00 Name:	Contractor's Name:		Contra	ctor's	Number:		141. (
42.00 Street:	PO Box:		71 0 00	do.			142.0
43.00 Ci ty:	State:		Zip Co	de:			143. (
						1.00	-
44.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144. (
					1.00	2.00	
45.00 If costs for renal services are c	laimed on Wkst. A, line 74	4, are the costs	for				145. (
inpatient services only? Enter "Y							
no, does the dialysis facility in period? Enter "Y" for yes or "N"		i for this cost	reporting				
46.00 Has the cost allocation methodolo		ously filed cost	report?		Ν		146. (
Enter "Y" for yes or "N" for no i				lf			110.
yes, enter the approval date (mm/							
						1.00	
47.00 Was there a change in the statist						N	147.0
48.00 Was there a change in the order o				or ro		N N	148.0
49.00 Was there a change to the simplif	rea cost finding method? E	Part A	Part B		Title V	Title XIX	149. (
		1.00	2.00	,	3.00	4.00	_
Does this facility contain a prov	ider that qualifies for a			cation			
or charges? Enter "Y" for yes or							
55. 00 Hospi tal	•	Ν	N		N	N	155. (
56.00 Subprovi der – IPF		N	N		N	N	156. (
57.00 Subprovider – IRF		N	N		N	N	157. (
58. 00 SUBPROVI DER							158. (
59.00 SNF		N	N		N	N	159. (
60.00HOME HEALTH AGENCY 61.00CMHC		N	N N		N N	N	160.0
			IN		IN	N	161.0
						1.00	-
Multicampus							-
65.00 s this hospital part of a Multic	ampus hospital that has or	ne or more campu	ıses in dif	ferent	CBSAs?	N	165. 0
		· · ·					
65.00 Is this hospital part of a Multic	Name	County	State	Zip Cod	e CBSA	FTE/Campus	
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.		· · ·				FTE/Campus 5.00	
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each	Name	County	State	Zip Cod	e CBSA	FTE/Campus 5.00	_
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column	Name	County	State	Zip Cod	e CBSA	FTE/Campus 5.00	
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in 	Name	County	State	Zip Cod	e CBSA	FTE/Campus 5.00	_
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column	Name	County	State	Zip Cod	e CBSA	FTE/Campus 5.00	_
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, 	Name	County	State	Zip Cod	e CBSA	FTE/Campus 5.00	_
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in 	Name	County	State	Zip Cod	e CBSA	FTE/Campus 5.00 0.0	
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 	Name O	County 1.00	State 2.00	Zip Cod 3.00	e CBSA 4.00	FTE/Campus 5.00	
 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 	Name 0 T) incentive in the Americ	County 1.00	State 2.00	Zip Cod 3.00	e CBSA 4.00	FTE/Campus 5.00 0.0	00 166. (
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5511	AL AND NOTTINE HEALTH OAKE KETWOORGEWENT QUESTIONIVALKE		011. 10 1022	From 01/01/2020 To 12/31/2020	Part II Date/Time P 6/11/2021 1	repared
				Y/N	Date	1. 50 dll
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NU re	sponses. Ente	er all dates in t	he	
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1. (
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions Y/N) Date	V/I	_
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare P	rogram? If	N	2100	0.00	2. (
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe	ffices, drug ler or its if the board	N			3. (
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
1.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ilable in	Y	R		4. (
. 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					
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	s N		6. (
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	structions		Ν		7.0
. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		l during the	N		8. (
. 00	Are costs claimed for Interns and Residents in an approved		al education	Ν		9. (
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		he current	Ν		10. (
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. (13. (
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see in:	structions.	N	14.
5.00	Did total beds available change from the prior cost reporti	21	yes, see ins [.] t A	tructions. Par	N t B	15.
		Y/N	Date	Y/N	Date	
	DS*D Data	1.00	2.00	3.00	4.00	-
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4.(see	N		N		16. (
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/01/2021	Y	04/01/2021	17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19.

th Financial Systems PERRY COUNT PI TAL AND HOSPI TAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE PERRY COUNT		CN: 15-1322	Peri od:	u of Form CM Worksheet S	
			From 01/01/2020 To 12/31/2020	Date/Time P	
	Descr	iption	Y/N	6/11/2021 1 Y/N	1:56 8
		0	1.00	3.00	
00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		2'
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS H	IOSPI TALS)			
00 Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	2
Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	N	2			
20 Were new leases and/or amendments to existing leases entered lf yes, see instructions	ed into during	this cost re	porting period?	Ν	2
Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	'lfyes, see	Ν	2
Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	f yes, see	Ν	2
Has the provider's capitalization policy changed during the copy. Interest Expense	e cost reportir	ng period? If	yes, submit	N	2
00 Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into dur	ing the cost	reporting	N	2
 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr 		ebt Service R	eserve Fund)	Ν	2
Has existing debt been replaced prior to its scheduled matu instructions.		debt? If yes	s, see	Ν	3
Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	s, see	Ν	3
Purchased Services 00 Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	3
arrangements with suppliers of services? If yes, see instru 1f line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	Ν	3
Provi der-Based Physi ci ans					
Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	n provider-ba	ised physi ci ans?	Y	3
00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the	provi der-based	Ν	3
			Y/N	Date	
Home Office Costs			1.00	2.00	
Home Office Costs 00 Were home office costs claimed on the cost report?			N		3
00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			3
If yes, see instructions. 00 If line 36 is yes, was the fiscal year end of the home off					3
the provider? If yes, enter in column 2 the fiscal year end 00 If line 36 is yes, did the provider render services to othe	d of the home o	offi ce.			3
see instructions. 20 f ine 36 is yes, did the provider render services to the		-	N		4
instructions.		. ,03, 366	i v		4
	1.	00	2.	00	
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	CLINT		BRILL		4
respecti vel y.	BLUE & CO., LL	.C			4
	1		1		11
preparer. 20 Enter the telephone number and email address of the cost	5029923500		CBRI LL@BLUEAND	CO COM	4

Heal th	Financial Systems PERRY COU	NTY HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1322	Period: From 01/01/2020	Worksheet S-2 Part II	
			To 12/31/2020		pared: 56 am
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	MANAGER			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre	
						6/11/2021 11: /P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Avai I abl e 3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	25	9, 15		0.00	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
8.00	HMO IPF Subprovider						3.00
1.00	HMO IRF Subprovider						4.00
. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
. 00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		25	9, 15	50 48, 912. 00	0	7.00
	beds) (see instructions)		_			_	
3.00	INTENSIVE CARE UNIT	31.00	0		0 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)	40.00					12.0
3.00	NURSERY	43.00	25	0.11	40.010.00	0	
4.00 5.00	Total (see instructions)		25	9, 15	48, 912. 00	0	14.00 15.00
5.00 6.00	CAH visits SUBPROVIDER - IPF					0	16.00
7.00	SUBPROVIDER - IRF						17.00
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.00
20.00	NURSI NG FACILITY						20.00
1.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
4.00	HOSPI CE	116.00	0		0		24.0
4. 10	HOSPICE (non-distinct part)	30.00					24.1
5.00	CMHC - CMHC						25.0
6. 00	RURAL HEALTH CLINIC	88.00				0	26.0
6. 01	RURAL HEALTH CLINIC II	88. 01				0	26.0
6. 02	RURAL HEALTH CLINIC III	88. 02				0	26.0
6. 03	RURAL HEALTH CLINIC IV	88. 03				0	26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26. 2
7.00	Total (sum of lines 14-26)		25				27.0
8.00	Observation Bed Days					0	28.0
9.00	Ambulance Trips						29.00
0.00	Employee discount days (see instruction)						30.00
1. 00	Employee discount days - IRF						31.0
2.00	Labor & delivery days (see instructions)		0		0		32.0
2. 01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days						33.0
3.01	LTCH site neutral days and discharges						33.0

10SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CO		Period: From 01/01/2020	Worksheet S-3 Part I	
					To 12/31/2020	Date/Time Pre 6/11/2021 11:	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On	
		6.00	7.00	8.00	9,00	Payrol I 10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 147	41	2, 03		10.00	1.00
	8 exclude Swing Bed, Observation Bed and	.,		_,	-		
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	175	214				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	905	0	90	5		5.00
5.00	Hospital Adults & Peds. Swing Bed NF		0	23	2		6.00
7.00	Total Adults and Peds. (exclude observation	2,052	41	3, 17	5		7.00
	beds) (see instructions)						
3.00	INTENSIVE CARE UNIT	0	0		0		8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY		6	12	1		13.00
14.00	Total (see instructions)	2, 052	47	3, 29	6 0.00	197.38	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPI CE	0	0		0 0.00	0.00	24.0
4. 10	HOSPICE (non-distinct part)				0		24.1
25.00	CMHC - CMHC						25.0
6. 00	RURAL HEALTH CLINIC	2, 264	0	16, 88	0 0.00	25.90	26.0
6. 01	RURAL HEALTH CLINIC II	115	0	5, 58			
6. 02	RURAL HEALTH CLINIC III	281	0	1, 84			
6. 03	RURAL HEALTH CLINIC IV	0	0		0 0.00		
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.00	232.65	
8.00	Observation Bed Days		8	44	7		28.0
9.00	Ambulance Trips	960					29.0
0.00	Employee discount days (see instruction)				0		30.0
1. 00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	1	4	2		32.0
2. 01	Total ancillary labor & delivery room				0		32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.0
3 01	LTCH site neutral days and discharges	0				1	33. C

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL		PERRY COUNTY	Provider CCN: 15-1322			u of Form CMS-2 Worksheet S-3	
HUSPII	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der Co	UN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Part I Date/Time Prej 6/11/2021 11:5	pared:
		Full Time		Di s	charges		
	Component	Equi val ents	T: +1 o 1/			Totol All	
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	0		04 12	616	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)				45 58		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	3	04 12	616	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00 23.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						22.00 23.00
23.00	HOSPICE	0, 00					23.00
24.10	HOSPICE (non-distinct part)	0.00					24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26.01
26. 02	RURAL HEALTH CLINIC III	0.00					26.02
26. 03	RURAL HEALTH CLINIC IV	0.00					26.03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance 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)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days				0		33.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lieu of Form CMS-25		
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Peri od:	Worksheet S-8	;
			Component	CCN: 15-8516	From 01/01/2020 To 12/31/2020		
					RHC I	Cost	
					1.	00	
1 00	Clinic Address and Identification				100 IN ((1 00
1.00	Street		Ci	ty	109 IN-66 State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		TELL CITY			47586	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u			0	3.00
					t Award	Date	
	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 Ad						5.00
6.00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a ho		RHC or FQHC? En	ter "Y" for	N	0	10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of	ite number of o	other operation	ns in column			
	hours.)	<u> </u>					
			iday to		onday to	Tuesday from	
		<u>from</u> 1.00	to 2.00	from 3.00	to 4.00	5.00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00		
11.00	CLINIC			06: 30	17:00	06: 30	11.00
10.00				10	1.00	2.00	10.00
	Have you received an approval for an exception Is this a consolidated cost report as defined				N	0	12.00 13.00
13.00	30. 8? Enter "Y" for yes or "N" for no in colu				IN	0	13.00
	number of providers included in this report.						
	numbers below.						
					der name	CCN number	
11.00				-	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	1.00	2.00	0.00	1.00	0.00	15.00
	GME cost? Enter "Y" for yes or "N" for no in						
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)						
				inty			
				00			
2.00	City, State, ZIP Code, County	Tuocday	PERRY	ocdov		cday	2.00
		Tuesday to	from Wedne	esday to	from	rsday to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)	2.00					
11.00		17:00	06: 30	17:00	06: 30	17:00	11.00

					u of Form CMS-2	2552-10
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA			CN: 15-1322	Period:	Worksheet S-8	
		Component	CCN: 15-8516	From 01/01/2020 To 12/31/2020		
	_			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 COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	
			Component		From 01/01/2020 To 12/31/2020		
					RHC II	Cost	
					1.	00	
1.00	Clinic Address and Identification Street				315 MAIN STREE	T	1.00
1.00			Ci	ty	State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		TROY		LN	47588	2.00
2 00	HOSPITAL BASED FOURS ONLY. Designation Entr	or "D" for rur	al or "II" for i	rhan		1.00	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er k tor fura			t Award	Date	3.00
					I. 00	2.00	
	Source of Federal Funds					1	
4.00 5.00 6.00 7.00 8.00 9.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ct)					4.00 5.00 6.00 7.00 8.00 9.00
10.00			50100 5		1.00	2.00	10.00
10.00	Does this facility operate as other than a hory yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operation	ns in column	N	0	10.00
		Sun	iday	Мс	onday	Tuesday	
		from	to	from	to	from	
	Facility have after (1)	1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC		1	08: 00	17:00	08: 00	11.00
11.00				00.00	17.00		11.00
					1.00	2.00	
	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 colo number of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	-9, section nn 2 the	N N	0	12.00 13.00
					der name	CCN number	
				1	1.00	2.00	
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00			7.00	3.00	15.00
				unty			
2.00	City Ctota 71D Code County			00			2.00
2.00	City, State, ZIP Code, County	Tuesday	PERRY	esday	Thur	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLI NI C	17:00	10: 00	19:00	08:00	17:00	11.00

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu						2552-10
HOSPITAL-BASED RHC/FOHC STATISTICAL DATA	Provider C	CN: 15-1322	Peri od:	Worksheet S-8		
		Component	CCN: 15-8517	From 01/01/2020 To 12/31/2020	Date/Time Pre 6/11/2021 11:	
				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 HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Peri od:	Worksheet S-8	3
			Component		From 01/01/2020 To 12/31/2020		
					RHC III	Cost	
					1.	. 00	
1.00	Clinic Address and Identification Street				18485 OLD STAT		1.00
1.00			Ci	ty	State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		LEOPOLD		IN	47551	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rur:	al or "II" for i	Irhan		1.00	3.00
5.00	THOSE TREE DASED TREES ONET. Designation - Enter				t 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 Ad						5.00
6.00 7.00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	J(d), PHS ACT)					6.00 7.00
7.00 8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
				•			
					1.00	2.00	
10.00	Does this facility operate as other than a hory yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of (other operation	ns in column	N	0	10.00
		Sur	nday	Mc	onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1)			07.00	1(00	07.00	111 00
11.00				07:00	16:00	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the produ	uctivity standa	ard?	N		12.00
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapter enter in colur	r 9, section mn 2 the	Ν	0	13.00
	numbers below.						
					der name	CCN number	
14.00				1	1.00	2.00	14.00
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	1.00	2.00	0.00	1.00	0.00	15.00
	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)						
		L	Col	unty		1	
				00			
2.00	City, State, ZIP Code, County		PERRY				2.00
	Tuesday Wednesday Thu						
		to	from	to	from	to	
	Eacility hours of aparations (1)	6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	16: 00	07:00	11:00	07:00	16:00	11.00
	1	1	1	1	1-11.00	1.2.00	

					u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Peri od:	Worksheet S-8	
		Component	CCN: 15-8518	From 01/01/2020 To 12/31/2020	Date/Time Pre 6/11/2021 11:	
				RHC III	Cost	
	Fri	Friday 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 Lieu of Form CMS-2552-1		
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8519	From 01/01/2020 To 12/31/2020	Date/Time Pre 6/11/2021 11:	
			-		RHC IV	Cost	
					1	00	-
	Clinic Address and Identification		<u>.</u>	<u>.</u>		00	
1.00	Street						1.00
				ty	State	ZIP Code	
2.00	City State 71D Code County		1.	00	2.00	3.00	2.00
2.00	City, State, ZIP Code, County						2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for ι			0	3.00
				-	t Award	Date	
	Source of Federal Funds				1.00	2.00	
4.00 5.00 6.00 7.00 8.00 9.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ct)			_		4.00 5.00 6.00 7.00 8.00 9.00
					1.00	2.00	
10.00	Does this facility operate as other than a ho	ospital-based R	RHC or EOHC? Er	ter "Y" for	1.00	2.00	10.00
101 00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of c	other operation	ns in column			
		Sun	day	Мо	onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC						11.00
11.00					1.00	2.00	
	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 colu number of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section n 2 the	N	0	12.00 13.00
				Provi	der name	CCN number	
14.00					1.00	2.00	11.05
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
	County						
2.00	City State 71D Code County		4.	00			2.00
2.00	City, State, ZIP Code, County	Tuesday	Wedn	esday	Thur	sday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1)						11.00
11.00	CLINIC	ļ	I	I		l	11.00

Health Financial Systems PERRY COUNTY HOSPITAL Ir						2552-10
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA		Provider C	CN: 15-1322	Period: From 01/01/2020	Worksheet S-8	8
		Component	CCN: 15-8519	To 12/31/2020	Date/Time Pre 6/11/2021 11:	epared: 56 am
				RHC IV	Cost	
	Fri	day	lay Sa			
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC						11.00

Heal th	Financial Systems PERRY COUNTY HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-		eriod:	Worksheet S-1	0
				rom 01/01/2020 o 12/31/2020	Date/Time Pre 6/11/2021 11:	
					1 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202	column	8)	0. 372712	1.00
1.00	Medicaid (see instructions for each line)	rucu by trite 202	COLONIA	0)	0. 372712	1.00
2.00	Net revenue from Medicaid				2, 508, 965	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Ŷ	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments from	Medi cai	d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	rom Medicaid			0	
6.00	Medicaid charges				11, 215, 609	
7.00	Medicaid cost (line 1 times line 6)				4, 180, 192	
8.00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)		ofline	s 2 and 5; if	1, 671, 227	8.00
	Children's Health Insurance Program (CHIP) (see instructions fo	or each line)			-	
9.00	Net revenue from stand-al one CHIP				0	
10.00	Stand-alone CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (line 11 minue li	no 0. if	. Jone then	0	
12.00	enter zero)	TIME IT MINUS IT	ne 9; TI	< zero then	0	12.00
	Other state or local government indigent care program (see inst	ructions for eac	h line)			
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00
14.00	Charges for patients covered under state or local indigent care				0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14				0	
16.00	Difference between net revenue and costs for state or local ind	ligent care progr	am (line	15 minus line	0	16.00
	13; if < zero then enter zero)		1 :		- (
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state/loca	i indige	nt care program	is (see	
17 00	Private grants, donations, or endowment income restricted to fu	unding charity ca	re		0	17.00
18.00	Government grants, appropriations or transfers for support of h				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)			(sum of lines	1, 671, 227	
		Uni r	nsured	Insured	Total (col. 1	
			ients	pati ents	+ col. 2)	
		1	. 00	2.00	3.00	
~ ~ ~	Uncompensated Care (see instructions for each line)		F(0, 10)	0	E(0.104	00.00
20. 00	Charity care charges and uninsured discounts for the entire fac (see instructions)	liity	563, 124	· 0	563, 124	20.00
21.00	Cost of patients approved for charity care and uninsured discou	ints (see	209, 883	0	209, 883	21.00
21.00	instructions)	ants (366	207,000	0	207,003	21.00
22.00	Payments received from patients for amounts previously written	off as	C	0	0	22.00
	chari ty care			_	-	
23.00	Cost of charity care (line 21 minus line 22)		209, 883	0	209, 883	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	nt days beyond a	length c	f stay limit	Ν	24.00
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		program'	s length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see ins				2, 429, 170	
27.00	Medicare reimbursable bad debts for the entire hospital complex				309, 805	
27.01	Medicare allowable bad debts for the entire hospital complex (s	see instructions)			476, 624	
28.00	Non-Medicare bad debt expense (see instructions)				1, 952, 546	
29.00 30.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see Enstru	ictions)		894, 556	
	Cost of uncompensated care (line 23 column 3 plus line 29)	ne 30)			1, 104, 439	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			2, 775, 666	31.00

	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider C		Period: From 01/01/2020	Worksheet A	
					To 12/31/2020	Date/Time Pre 6/11/2021 11:	
	Cost Center Description	Sal ari es	Other	Total (col. '	Reclassi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	5.00	4.00	3.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 560, 642	2, 560, 64	2 110, 514	2, 671, 156	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		0 1, 144, 732	1, 144, 732	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	117, 738	2, 869, 959		7 225, 159	3, 212, 856	4.00
5.01	00540 ADMINISTRATIVE AND GENERAL	995, 766	2, 610, 758				•
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	1, 070, 658	1, 987, 740				•
7.00	00700 OPERATION OF PLANT	246, 401	1, 331, 260				
8.00	00800 LAUNDRY & LINEN SERVICE	0	72, 611				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	277, 989	103, 269			381, 258 199, 645	•
11.00	01100 CAFETERI A	0	586, 754 0		4 -387, 109 0 386, 684		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	198, 191	47, 138			245, 329	•
16.00	01600 MEDICAL RECORDS & LIBRARY	158, 036	88, 147			244, 531	16.00
10100	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1007000	00/11/	210/10	.,	211,001	
30.00	03000 ADULTS & PEDI ATRI CS	2, 577, 011	2, 267, 654	4, 844, 66	5 -5, 697	4, 838, 968	30.00
31.00	03100 INTENSIVE CARE UNIT	-5, 927	10, 773	4, 84	6 -4, 846	0	31.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS				-		
50.00	05000 OPERATING ROOM	451, 218	877, 575				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	304, 688			304, 688	
54.00	05400 RADI OLOGY-DI AGNOSTI C	813, 902	260, 043				•
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	744, 960 1, 343	1, 206, 589 71, 271				•
65.00	06500 RESPIRATORY THERAPY	466, 025	415, 638				•
66.00	06600 PHYSI CAL THERAPY	400, 023	83, 807				•
67.00	06700 OCCUPATI ONAL THERAPY	139, 246	13, 388			152, 634	1
68.00	06800 SPEECH PATHOLOGY	65, 446	11, 438			76, 884	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	573, 452				•
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	О	0		0 103, 226	103, 226	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	77, 808	2, 130, 789	2, 208, 59	7 18, 461	2, 227, 058	73.00
	OUTPATIENT SERVICE COST CENTERS	Ì				1	
88.00	08800 RURAL HEALTH CLINIC	2,010,285	775, 303				•
88.01	08801 RURAL HEALTH CLINIC II	532, 269	292, 296				88.01
88.02	08803 RURAL HEALTH CLINIC III	151, 715	62, 374				•
88.03	08802 RURAL HEALTH CLINIC IV 09000 CLINIC	202 001	3, 773			3, 773	
90. 00 90. 01	09000 CETNIC 09001 PALN MANAGEMENT	293, 901	85, 268 65, 671			396, 647 0	90.00
90.01 90.02	09002 WOUND CARE	210, 201	99, 387			-	
90.02 90.03	09003 ORTHOPEDIC CLINIC	70, 884	41, 872				•
91.00	09100 EMERGENCY	745, 790	1, 583, 183				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		.,,			_,,	92.00
	OTHER REIMBURSABLE COST CENTERS			•		•	1
95.00	09500 AMBULANCE SERVICES	802,037	327, 724	1, 129, 76	1 -23, 587	1, 106, 174	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE		1, 144, 732				113.00
	11600 HOSPI CE		0		0 0		116.00
118.00		13, 660, 521	24, 966, 966	38, 627, 48	7 86, 352	38, 713, 839	118.00
100.00	NONREI MBURSABLE COST CENTERS			1	0		190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 825, 675	0 298, 610		0 0 5 -86, 352		
200.00		14, 486, 196	25, 265, 576				
200.00		11, 100, 170	20,200,070	1 57,751,77	-1 0	1 07,701,772	

	i Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	PERRY COUNTY F EXPENSES	Provider CO	CN: 15-1322	Peri od:	u of Form (Worksheet	
					From 01/01/2020 To 12/31/2020	Date/Time	
	Cost Center Description	Adjustments	Net Expenses			6/11/2021	11:50 8
	·		<u>or Allocation</u>				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	r					
00	00100 NEW CAP REL COSTS-BLDG & FIXT	0	2, 671, 156				1
00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-13, 282	1, 131, 450				2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 212, 856				4
01	00540 ADMINISTRATIVE AND GENERAL	-1, 208, 804	2, 218, 512				5
02	00590 ADMINISTRATIVE AND GENERAL - OTHER	-83,067	2, 966, 076				5
00	00700 OPERATION OF PLANT	-2,015	1, 570, 730				7
00	00800 LAUNDRY & LINEN SERVICE	0	72, 611				8
00	00900 HOUSEKEEPI NG	0	381, 258				9
). 00	01000 DI ETARY	-1,272	198, 373				10
. 00	01100 CAFETERI A	-71, 532	315, 152	1			11
. 00	01300 NURSI NG ADMI NI STRATI ON	0	245, 329				13
. 00	01600 MEDI CAL RECORDS & LI BRARY	-2, 676	241, 855				16
~ ~	INPATIENT ROUTINE SERVICE COST CENTERS	010 105					
. 00	03000 ADULTS & PEDIATRICS	-319, 135	4, 519, 833	1			30
. 00		0	0				31
. 00	04300 NURSERY	0	0				43
~~~	ANCI LLARY SERVICE COST CENTERS	(40.005	<b>F(0,010</b>				
. 00	05000 OPERATING ROOM	-618, 385	560, 012	1			50
. 00	05200 DELIVERY ROOM & LABOR ROOM	-304,688	0				52
. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1,072,388				54
). 00		0	1, 950, 417				60
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	72, 614				62
5.00 5.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-267, 638	566, 037				65
		0	531,010				66
2.00 3.00	06800 SPEECH PATHOLOGY	0	152, 634 76, 884				67
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	683, 869				71
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	103, 226				72
3.00	07300 DRUGS CHARGED TO PATIENTS	-1, 950	2, 225, 108				73
. 00	OUTPATIENT SERVICE COST CENTERS	-1,930	2,225,106				/3
8. 00	08800 RURAL HEALTH CLINIC	-238	2, 752, 618				88
3. 00 3. 01	08801 RURAL HEALTH CLINIC II	-60	824, 527				88
3. 02		0	236, 669				88
3. 02		-3, 773	230,009				88
). 00		-26, 250	370, 397				90
0.00	09001 PALN MANAGEMENT	20, 230	370, 377				90
). 01		- 70, 909	285, 154				90
). 02		-70,909	77, 849				90
. 00	09100 EMERGENCY	0	2, 325, 387				91
. 00			2, 525, 507				92
. 50	OTHER REIMBURSABLE COST CENTERS	I					$-1^{\prime 2}$
. 00		-1, 448	1, 104, 726				95
. 55	SPECIAL PURPOSE COST CENTERS	1, 170	., 101, 120				-1
3.00	DI1300 INTEREST EXPENSE	0	0				113
	D 11600 HOSPI CE	0	0				116
8.00		-2, 997, 122	35, 716, 717				118
5. 5.	NONREI MBURSABLE COST CENTERS	2, , , , , , , , , , , , , , , , , , ,	56,716,717				
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
	19200 PHYSI CI ANS' PRI VATE OFFI CES	o	1,037,933				192
	TOTAL (SUM OF LINES 118 through 199)	-2, 997, 122	36, 754, 650				200

Financial Sy SIFICATIONS	<u>, - : 00</u>		PERRY COUNTY	Provi der CCN: 15-		Lieu of Form CMS-2552 Worksheet A-6
					To 12/31/20	020 020 Date/Time Prepar 6/11/2021 11:56
Co	st Center	I ncreases	Salary	Other		
	2.00	3.00	4.00	5.00		
A - CAFETER	IA COST					
CAFETERI A		<u>11.00</u>	0	<u>386, 684</u> 386, 684		1
B - INTERES	T EXPENSE	<u> </u>	0	380, 084		
	COSTS-MVBLE	2.00	0	1, 144, 732		1
EQUI P		$\vdash$ — — $\downarrow$		1, 144, 732		
C - LEASE E	XPENSE	<u>                                     </u>	U	1, 144, 732		
NEW CAP REL	COSTS-BLDG &	1.00	0	72, 904		1
FLXT		0.00	0	О		2
		0.00	0	0		3
		0.00	0	0		4
		0.00	0	0		Ę
		0.00 0.00	0	0		6
		0.00	0	0		8
		0.00	0	0		ç
		0.00	0	0		10
		0.00 0.00	0	0		11
		0.00	0	0		1:
		0.00	0	0		14
		0.00	0	0		1
		0.00 0.00	0	0		10
		0.00	0	0		18
0 — —			0	72,904		
D - INSURAN		1.00		07.(10		
FIXT	COSTS-BLDG &	1.00	0	37, 610		1
		0.00	О	0		2
0			0	37, 610		
E - DRUGS C	HARGED ED TO PATIENTS	73.00	0	37, 682		
	ED TO TATLENTS	0.00	0	0		
		0.00	0	0		3
O F - BILLABL			0	37, 682		
	PLIES CHARGED TO	71.00	0	213, 643		1
PATI ENTS			-	,		
		0.00	0	0		
		0.00 0.00	0	0		
		0.00	0	0		
		0.00	0	0		
L		0.00	o	0		
O G - IMPLANT	ABLE DEVICE	<u> </u>	0	213, 643		
IMPL. DEV.		72.00	0	103, 226		
PATI ENT		$\vdash$ $_$ $_$ $\downarrow$	↓			
U H - WOLIND C	ARE RECLASS		0	103, 226		
WOUND CARE	ARE RECEASS	90.02	71, 297	0		
		0.00	0	<u>0</u>		:
			71, 297	0		
RURAL HEALT	RUITING EXPENSE RI H CLINIC	88.00	0	9, 058		
0			o	9,058		
J - IV THER	APY			10 540		
		90.00	0	1 <u>8, 518</u> 18, 518		-
U K – SURGEON	RECLASS		U	10, 310		
OPERATING R		50.00	20, 815	0		-
0			20, 815	0		
L - TELL CI			0 000			
RURAL HEALT	H CLINIC II H CLINIC III	88. 01 88. 02	2, 088 24, 646	0		1
0			2 <u>4, 646</u> 26, 734	<u>0</u>		
M - ICU REC		· ·		-		
ADULTS & PE		30.00	0	10, 294		1
	ARE UNIT	31.00	5, 927	0		2

Heal th	Financial Systems	PERRY COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
RECLAS	RECLASSI FI CATI ONS			Provider C	Provider CCN: 15-1322		Worksheet A-	6
						From 01/01/2020 To 12/31/2020	Date/Time Pr 6/11/2021 11	epared: :56 am
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	N - PAIN MGMT							
1.00	ADMI NI STRATI VE AND GENERAL	5.01	0	65, 671				1.00
	TOTALS	T	0	65, 671				
	O - EMPLOYEE BENEFITS	· · · ·						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	225, 584				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
	TOTALS	T	0	225, 584				
500.00	Grand Total: Increases		124, 773	2, 325, 606				500.00

ASS	SEFECATIONS			Provider (	CCN: 15-1322	Peri od:	Worksheet A-6	- <u>2552</u> - 6
						From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Decreases					6/11/2021 11:	:56 a
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A - CAFETERIA COST	10.00			1			4
)	DI ETARY	<u>10.00</u>	0	<u>386, 6</u> 84 		0		1.
	B - INTEREST EXPENSE		U	300, 004				1
)	INTEREST EXPENSE	113.00	0	1, 144, 732	1	1		1.
	0		0	1, 144, 732				
	C – LEASE EXPENSE					1		
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	425		9		1.
	ADMINISTRATIVE AND GENERAL ADMINISTRATIVE AND GENERAL -	5. 01 5. 02	0	2, 598 9, 255		0		2.
	OTHER	5.02	0	9,200		0		3.
	OPERATION OF PLANT	7.00	0	4, 916		0		4.
)	DI ETARY	10.00	0	425		0		5.
	MEDICAL RECORDS & LIBRARY	16.00	0	1, 652		0		6.
	ADULTS & PEDIATRICS	30.00	0	8, 407		0		7.
	INTENSIVE CARE UNIT OPERATING ROOM	31.00 50.00	0	479		0		8.
	RADI OLOGY-DI AGNOSTI C	54.00	0	14, 457 1, 557		0		10.
	LABORATORY	60.00	0	1, 132		0		111.
	RESPI RATORY THERAPY	65.00	0	18, 301		0		12
00	PHYSICAL THERAPY	66.00	0	425		0		13.
	DRUGS CHARGED TO PATIENTS	73.00	0	425		0		14.
	CLINIC	90.00	0	1, 035		0		15.
	WOUND CARE	90.02	0	425		0		16.
		91.00 95.00	0	1, 819 5, 171		0		17.
	AMBULANCE_SERVICES		0	<u>5, 1/1</u> 72, 904		0		18.
	D - INSURANCE EXPENSE	I		72,704				1
	ADMI NI STRATI VE AND GENERAL	5.01	0	19, 194	1	0		1.
)	AMBULANCE_SERVICES	95.00	0	18, 416		0		2.
	0		0	37, 610				
	E - DRUGS CHARGED			4 070				
	ADMI NI STRATI VE AND GENERAL	5.01	0	1, 873		0		1.
	WOUND CARE ORTHOPEDIC CLINIC	90. 02 90. 03	0	902 34, 907		0		2.
,			0	37,682				3.
	F - BILLABLE SUPPLIES			077002				
	ADULTS & PEDIATRICS	30.00	0	1, 657		0		1.
	OPERATING ROOM	50.00	0	156, 754		0		2.
	RESPI RATORY THERAPY	65.00	0	29, 687		0		3.
	DRUGS CHARGED TO PATIENTS	73.00	0	278		0		4.
		90.00	0	22 405		0		5.
	WOUND CARE <u>EMERGENCY</u>	90. 02 91. 00	0	23, 495 1, 767				6. 7.
,			0	213, 643				/.
	G - IMPLANTABLE DEVICE		-1	,	I			1
	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	103, 226		0		1.
	PATI ENTS	+			<u> </u>	4		
	0 H - WOUND CARE RECLASS		0	103, 226				-
	RURAL HEALTH CLINIC	88.00	17, 250	0		0		1.
	PHYSICIANS' PRIVATE OFFICES	192.00	54, 047	0		0		2.
	0		71, 297			1		
	I - RHC RECRUITING EXPENSE REC				1			4
)	ADMI NI STRATI VE AND GENERAL	5.01	0	<u> </u>		0		1.
			0	9, 058				-
	J - IV THERAPY	70.00	~	10 510		0		
)	DRUGS_CHARGED_TO_PATIENTS	<u>73.00</u>	— — <u> </u>	1 <u>8, 5</u> 18 18, 518		Ō		1.
	K - SURGEON RECLASS		U	10, 510				1
)	PHYSICIANS' PRIVATE OFFICES	192.00	20, 815	0		0		1.
	0		20, 815	ö		1		
	L - TELL CITY RECLASS							
)	RURAL HEALTH CLINIC	88.00	18, 343	0		0		1.
)	PHYSICIANS' PRIVATE OFFICES	<u> </u>	8, 391	0	<u> </u>	익		2
			26, 734	0				-
	M – ICU RECLASS ADULTS & PEDIATRICS	30.00	5, 927	0		0		1.
)	INTENSIVE CARE UNIT	30.00	5, 927	10, 294		0		2.
-				10, 294		Ť		2.
				-, -, -				1
	N - PAIN MGMT							

	Financial Systems		PERRY COUNT			In Lieu of Form CMS-2552-10		
RECLASS	RECLASSI FI CATI ONS			Provider (	CCN: 15-1322	Peri od:	Worksheet A-6	5
						From 01/01/2020 To 12/31/2020	Date/Time Pre 6/11/2021 11:	
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6. 00	7.00	8.00	9.00	10.00			
	0 - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	212, 156		0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	6, 197		0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	2,066		0		3.00
4.00	RURAL HEALTH CLINIC III	88.02	0	2, 066		0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3, 099		0		5.00
	TOTALS			225, 584		7		
500.00	Grand Total: Decreases		124, 773	2, 325, 606				500.00

Provider CN: 15-1322         Provider CN: 15-1322         Period: From 01/01/2020 To 12/31/2020         Worksheet A- Part I Date/Time Pre- 6/11/2021 11:           Beginning Balances         Beginning Balances         Purchases         Donation         Total         Disposals and Period:           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         Land         0         0         0         0           2.00         Buildings and Fixtures         44,023,461         47,315         0         0         0         0           5.00         Building improvements         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	2552-10
Beginning Balances         Purchases         Donation         Total         Disposals and Retirements           1.00         2.00         3.00         4.00         5.00           2.00         Land         3,815,753         0         0         0         0           2.00         Land Improvements         66,330         0         0         0         0         6,973           3.00         Building and Fixtures         44,023,461         47,315         0         47,315         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<	
Bai ances         Bai ances         Retirements           1.00         2.00         3.00         4.00         5.00           1.00         Land         3.815,753         0         0         0         0           2.00         Land         3.815,753         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         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         <	
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         2.00         3.00         4.00         5.00           1.00         Land         3,815,753         0         0         0         0           2.00         Land Improvements         3,815,753         0         0         0         0         6,733           3.00         Buildings and Fixtures         44,023,461         47,315         0         47,315         0         67           4.00         Building Improvements         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<	
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         3,815,753         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	
1.00       Land       3,815,753       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	
2.00       Land Improvements       66,330       0       0       6,973         3.00       Buildings and Fixtures       44,023,461       47,315       0       47,315       0         4.00       Building Improvements       0       0       0       0       0       0         5.00       Fixed Equipment       2,330,717       87,872       0       87,872       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	
3.00       Buildings and Fixtures       44,023,461       47,315       0       47,315       0         4.00       Building Improvements       0       0       0       0       0       0         5.00       Fixed Equipment       2,330,717       87,872       0       87,872       0         6.00       Movable Equipment       16,721,887       1,000,448       0       1,000,448       0         7.00       HIT designated Assets       0       0       0       0       0       0         8.00       Subtotal (sum of lines 1-7)       66,958,148       1,135,635       0       1,135,635       6,973         9.00       Reconciling Items       0       0       0       0       0         10.00       Total (line 8 minus line 9)       66,958,148       1,135,635       0       1,135,635       6,973         10.00       Total (line 8 minus line 9)       66,958,148       1,135,635       0       1,135,635       6,973         10.00       Land       3,815,753       0       1,135,635       6,973       0         2.00       Land Improvements       59,357       0       0       0       0       0         3.00       Building Imp	1.00
4.00       Building Improvements       0       0       0       0       0       0         5.00       Fixed Equipment       2,330,717       87,872       0       87,872       0         6.00       Movable Equipment       16,721,887       1,000,448       0       1,000,448       0         7.00       HIT designated Assets       0       0       0       0       0       0         8.00       Subtotal (sum of lines 1-7)       66,958,148       1,135,635       0       1,135,635       6,973         9.00       Reconciling Items       0       0       0       0       0       0         10.00       Total (line 8 minus line 9)       66,958,148       1,135,635       0       1,135,635       6,973         10.00       Total (line 8 minus line 9)       66,958,148       1,135,635       0       1,135,635       6,973         10.00       Land       1       81 ance       Fully       Depreciated       Assets       6.00       7.00         2.00       Land       3,815,753       0       0       0       0       0       0       0         2.00       Land Improvements       59,357       0       0       0       0	2.00
5.00       Fixed Equipment       2,330,717       87,872       0       87,872       0         6.00       Movable Equipment       16,721,887       1,000,448       0       1,000,448       0         7.00       HIT designated Assets       0       0       0       0       0       0         8.00       Subtotal (sum of lines 1-7)       66,958,148       1,135,635       0       1,135,635       6,973         9.00       Reconciling Items       0       0       0       0       0       0       0         10.00       Total (line 8 minus line 9)       66,958,148       1,135,635       0       1,135,635       6,973         10.00       Total (line 8 minus line 9)       66,958,148       1,135,635       0       1,135,635       6,973         10.00       Total (line 8 minus line 9)       66,958,148       1,135,635       0       1,135,635       6,973         10.00       Land       Ing Bal ance       Full y       Depreci ated       Assets       6.00       7.00         1.00       Land       3,815,753       0       1.00       3.00       Suildings and Fixtures       44,070,776       0       0       0       0       0       0       0 <td< td=""><td>3.00</td></td<>	3.00
6.00       Movable Equipment       16,721,887       1,000,448       0       1,000,448       0         7.00       HIT designated Assets       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	4.00
7.00       HIT designated Assets       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 </td <td>5.00</td>	5.00
8.00       Subtotal (sum of lines 1-7)       66,958,148       1,135,635       0       1,135,635       6,973         9.00       Reconciling Items       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td>6.00</td></t<>	6.00
9.00       Reconciling Items       0       0       0       0       0         10.00       Total (line 8 minus line 9)       66,958,148       1,135,635       0       1,135,635       6,973         Image: Second se	7.00
10.00         Total (line 8 minus line 9)         66,958,148         1,135,635         0         1,135,635         6,973           Ending Balance         Fully         Depreciated         Assets         6.00         7.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         3,815,753         0         7.00         7.00           1.00         Land         3,815,753         0         7.00         7.00         7.00           2.00         Land Improvements         59,357         0         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         <	8.00
PART I     - ANALYSIS OF CHANGES IN CAPITAL ASSET     BALANCES       1.00     Land     3, 815, 753     0       2.00     Land     59, 357     0       3.00     Buildings and Fixtures     44, 070, 776     0       4.00     Building Improvements     0     0	9.00
PART I     - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES       1.00     Land       2.00     Land       3.00     Buildings and Fixtures       4.00     Building Improvements	10.00
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         3, 815, 753         0           2.00         Land Improvements         59, 357         0           3.00         Buildings and Fixtures         44, 070, 776         0           4.00         Building Improvements         0         0	
Barry         6.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         3,815,753         0           2.00         Land Improvements         59,357         0           3.00         Buildings and Fixtures         44,070,776         0           4.00         Building Improvements         0         0	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES1.00Land3,815,75302.00Land Improvements59,35703.00Buildings and Fixtures44,070,77604.00Building Improvements00	
1.00       Land       3,815,753       0         2.00       Land Improvements       59,357       0         3.00       Buildings and Fixtures       44,070,776       0         4.00       Building Improvements       0       0	
2.00       Land Improvements       59,357       0         3.00       Buildings and Fixtures       44,070,776       0         4.00       Building Improvements       0       0	
3.00         Buildings and Fixtures         44,070,776         0           4.00         Building Improvements         0         0	1.00
4.00 Building Improvements 0 0	2.00
	3.00
5.00 Fixed Equipment 2,418,589 0	4.00
	5.00
6.00 Movable Equipment 17, 722, 335 0	6.00
7.00 HIT designated Assets 0 0	7.00
8.00 Subtotal (sum of lines 1-7) 68,086,810 0	8.00
9.00 Reconciling Items 0 0	9.00
10.00 Total (line 8 minus line 9) 68,086,810 0	10.00

Heal th	Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Li	eu of Form CMS-:	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1322	Period: From 01/01/2020	Worksheet A-7	
					To 12/31/2020		pared:
						6/11/2021 11:	<u>56 am</u>
			SL	JMMARY OF CAF	21 TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			nd 2	-	1	
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 467, 746	0		0 89, 688	3, 208	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0 0	2.00
3.00	Total (sum of lines 1-2)	2, 467, 746			0 89, 688	3, 208	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 560, 642				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2, 560, 642				3.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2020 Fo 12/31/2020		
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 - col. 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI				-		
1.00 NEW CAP REL COSTS-BLDG & FIXT	50, 364, 475				0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	17, 722, 335				0	2.00
3.00 Total (sum of lines 1-2)	68, 086, 810		68, 086, 810		0	3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		-				
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2, 540, 650	37, 610	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0 0	-13, 282	2.00
3.00 Total (sum of lines 1-2)	0	0	(	2, 540, 650	24, 328	3.00
		Sl	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)			
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		00 (00	0.00		0 (71 45)	1 00
1.00 NEW CAP REL COSTS-BLDG & FIXT	0				2,671,156	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	1, 144, 732			0	1, 131, 450	2.00
3.00  Total (sum of lines 1-2)	1, 144, 732	89, 688	3, 208	5j U	3, 802, 606	3.00

DJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	
	· · · · · · · · · · · · · · · · · · ·			Expense Classification or	Worksheet A	6/11/2021 11:	56 a
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	-
		1.00	2.00	3.00	4.00	5.00	
00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		(	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1
00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	В	-78, 632	2NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2
00	Investment income - other		(	ס	0.00	0	3
00	(chapter 2) Trade, quantity, and time		C		0.00	0	4
	discounts (chapter 8)						
00	Refunds and rebates of expenses (chapter 8)		Ĺ		0.00	0	5
00	Rental of provider space by suppliers (chapter 8)		(	D	0.00	0	6
00	Telephone services (pay stations excluded) (chapter	А	-9, 820	ADMI NI STRATI VE AND GENERAL OTHER	- 5.02	0	7
00	21) Television and radio service	А	-2,015	5 OPERATION OF PLANT	7.00	0	6
00	(chapter 21) Parking lot (chapter 21)		ſ		0.00	0	Ģ
	Provider-based physician	A-8-2	-1, 606, 653	3	0.00	0	
. 00	adjustment Sale of scrap, waste, etc.		C		0.00	0	1.
. 00	(chapter 23) Related organization	A-8-1	65,350			0	12
	transactions (chapter 10) Laundry and linen service		(		0.00	0	
. 00	Cafeteria-employees and guests	В	-71, 532	2 CAFETERI A	11.00	0	
	Rental of quarters to employee and others	В	-60, 038	ADMINISTRATIVE AND GENERAL	5.01	0	1!
. 00	Sale of medical and surgical supplies to other than		C	þ	0.00	0	16
. 00	patients Sale of drugs to other than	В	-1, 950	DRUGS CHARGED TO PATIENTS	73.00	0	17
3. 00	patients Sale of medical records and	В	-2.676	5 MEDI CAL RECORDS & LI BRARY	16.00	0	18
	abstracts	_	_,				
9. 00	Nursing and allied health education (tuition, fees, books, etc.)		Ĺ		0.00	0	10
	Vending machines Income from imposition of	В	-1, 272	2DI ETARY	10. 00 0. 00	0	20 21
. 00	interest, finance or penalty		C		0.00	0	
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C	D	0.00	0	2:
2 00	repay Medicare overpayments	A-8-3	r	RESPI RATORY THERAPY	45.00		23
. 00	Adjustment for respiratory therapy costs in excess of	H-0-3	l	JIL SFIRATORT INERAPT	65.00		2
1.00	limitation (chapter 14) Adjustment for physical	A-8-3	(	PHYSICAL THERAPY	66.00		24
	therapy costs in excess of limitation (chapter 14)						
5. 00	Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25
. 00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26
	COSTS-BLDG & FIXT			FIXT			
. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		(	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27
	Non-physician Anesthetist		0	0 *** Cost Center Deleted ***	19.00	-	28
	Physicians' assistant Adjustment for occupational	A-8-3	( (	D OCCUPATI ONAL THERAPY	0.00 67.00	0	29
	therapy costs in excess of						
). 99	limitation (chapter 14) Hospice (non-distinct) (see		(	DADULTS & PEDIATRICS	30.00		30
	instructions)						
1.00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31

Heal th	Financial Systems		PERRY COUNT	Y HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1322	Peri od:	Worksheet A-8	
					From 01/01/2020 To 12/31/2020		narod
					10 12/31/2020	6/11/2021 11:	
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	····	1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	ADMINI STRATION MI SCELLANEOUS	В	-125, 275	ADMINISTRATIVE AND GENERAL	5.01	0	33.00
~~ ~ ~	REVENUE				05.00		
33.01	AMBULANCE MISC REVENUE	В		AMBULANCE SERVICES	95.00	0	00.01
33.02	ADMI NI STRATI ON-CONTRI BUTI ONS	A		ADMI NI STRATI VE AND GENERAL	5.01	0	33.02
33.03	ADMI NI STRATI ON-MI SC EXPENSES	A		ADMI NI STRATI VE AND GENERAL	- 5.02	0	33.03
22.04				OTHER	00.00		22.04
33.04	ADVERTISING - TELL CITY	A		RURAL HEALTH CLINIC	88.00	0	33.04
33.05	ADVERTISING - PCM	A		RURAL HEALTH CLINIC II	88.01	0	33.05
33.06	WOUND CENTER-ADVERTISING	A		WOUND CARE	90.02		00.00
33.07	ADMI NI STRATI ON-RECRUI TI NG	A B		ADMI NI STRATI VE AND GENERAL	5.01	0	00.07
33.08	HAF FEES			ADMI NI STRATI VE AND GENERAL	5.01	0	33.08
33.09	LOBBYING DUES	A		ADMI NI STRATI VE AND GENERAL	5.01	0	33.09
33.10	CANNELTON OFFSET	A	-3, 773	RURAL HEALTH CLINIC IV	88.03		001.10
33. 11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
50 00	TOTAL (sum of lines 1 thru 49)		-2, 997, 122				50.00
50.00	(Transfer to Worksheet A,		-2, 771, 122				30.00
	column 6, line 200.)						
							L

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	PERRY COUN	TY HOSPI TAL	In Lie	eu of Form CMS-2552-10	
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1322	Period: From 01/01/2020	Worksheet A-8	8-1
OFFI CE				To 12/31/2020		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	65, 350	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			65, 350	0	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

1105 110	L DEEL POSTEU LO MOLKSHEEL A,	corumns ranu/or z, the amount	it allowable si		or this part.	
				Related Organization(s) and/	or Home Office	
	Combal (1)	News	Demonstrate of	N =	Deverations of	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownership	
	1.00	2.00	3.00	4.00	5.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

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

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

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

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

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

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

Health Financial Systems	PERRY COUNTY HOSPITAL		In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORC	GANIZATIONS AND HOME Provid			orksheet A-8-1	
OFFICE COSTS		From	01/01/2020 12/31/2020 Da	ate/Time Prepared:	

			6/11/2021 11	<u>56 am</u>
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTM	ENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	65, 350	10		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	65, 350			5.00

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

nas not	been posted to worksheet A,	COLUMNS 1	anu/or z,	the amount	arrowabre	should be	Thui cateu	this part.	
	Related Organization(s)								
	and/or Home Office								
	Type of Business	1							
	51								
	6, 00	1							
		1							
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6.00 7.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
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.

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.

Heal th Financia PROVIDER BASED			PERRY COUN					2552-10
		I AN ADJUSTMENT		Provider C		Peri od:	Worksheet A-8	3-2
						From 01/01/2020 To 12/31/2020		
Wkst. A	Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
1.		2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	1, 124, 024	319, 135	804, 889		0	1.00
2.00		OPERATING ROOM	618, 385		(		-	2.00
3.00		DELIVERY ROOM & LABOR ROOM	304, 688		(	0 0	0	3.00
4.00		LABORATORY	16, 500		16, 500		0	4.00
5.00		RESPI RATORY THERAPY	267, 638		(		0	5.00
6.00		CLINIC	26, 250		(	0 0	0	6.00
7.00		WOUND CARE	70, 557	70, 557	(	0	0	7.00
8.00		EMERGENCY	1, 376, 669		1, 376, 669		0	8.00
9.00	0.00		0	0	(	0	0	9.00
10.00	0.00		0	0	(		0	10.00
200.00			3, 804, 711	1, 606, 653	2, 198, 058		0	200.00
Wkst. A	Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				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
1.00		ADULTS & PEDIATRICS	0	, i i i i i i i i i i i i i i i i i i i	(			1.00
2.00		OPERATING ROOM	0	0	(			2.00
3.00		DELIVERY ROOM & LABOR ROOM	0	0			-	3.00
4.00			0	0	(		0	4.00
5.00		RESPI RATORY THERAPY	0	0	(		0	5.00
6.00			0	0	(	0	0	6.00
7.00		WOUND CARE	0	0	(	0	0	7.00
8.00		EMERGENCY	0	0	(		0	8.00
9.00	0.00		0	0	(	, o	0	9.00
10.00	0.00		0	0	(		0	10.00
200.00			0	0		0	0	200.00
Wkst. A	Line #		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		ADULTS & PEDIATRICS	13.00	0				1.00
2.00		OPERATI NG ROOM	0	0				2.00
3.00		DELIVERY ROOM & LABOR ROOM	0	0	(			3.00
4.00		LABORATORY	0	0	(	001/000		4.00
5.00		RESPI RATORY THERAPY	0	0	(			4.00 5.00
6.00		CLINIC	0	0	(			6.00
7.00		WOUND CARE	0	0	(			7.00
8.00		EMERGENCY	0	0	(			7.00 8.00
9.00	91.00		0	0	(			8.00 9.00
9.00 10.00	0.00		0	0	(			9.00 10.00
200.00	0.00			0	-	-		200.00
200.001		I	0	0	C C	1,000,000	I I	200.00

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I	pared:
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1 00	GENERAL SERVICE COST CENTERS	0 (71 15)	0 (71 15)				1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	2, 671, 156 1, 131, 450	2, 671, 156	1, 131, 45	0		1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 212, 856	12, 716	5, 38			4.00
5.01	00540 ADMI NI STRATI VE AND GENERAL	2, 218, 512	205, 700	87, 13			5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	2, 966, 076	169, 972	71, 99		3, 463, 031	5. 02
7.00	00700 OPERATION OF PLANT	1, 570, 730	515, 661	218, 42		2, 363, 495	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	72, 611	4, 400	1, 86		78, 875	8.00
9.00	00900 HOUSEKEEPI NG	381, 258	29, 590	12, 53		489, 587	9.00
10.00	01000 DI ETARY	198, 373	112, 244	47, 54	4 0	358, 161	10.00
11.00	01100 CAFETERI A	315, 152	0		0 0	315, 152	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	245, 329	5, 940	2, 51	6 47, 201	300, 986	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	241, 855	33, 000	13, 97	8 37, 638	326, 471	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 519, 833	390, 985	165, 61		5, 688, 761	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	, ,,	0 0	0	31.00
43.00		0	15, 972	6, 76	0	22, 737	43.00
F0 00	ANCI LLARY SERVI CE COST CENTERS	560, 012	207.204	101 70	1 110 410	1 001 547	
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	560, 012	287, 386 70, 510	121, 73 29, 86		1, 081, 547 100, 377	50.00 52.00
54.00	05400 RADI OLOGY – DI AGNOSTI C	1, 072, 388	145, 464	61, 61		1, 473, 305	54.00
60.00	06000 LABORATORY	1, 950, 417	60, 104	25, 45		2, 213, 398	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	72, 614	00, 101	20, 10	0 320	72, 934	62.00
65.00	06500 RESPI RATORY THERAPY	566, 037	90, 376	38, 28		805, 683	65.00
66.00	06600 PHYSI CAL THERAPY	531,010	44, 440	18, 82		700, 880	66.00
67.00	06700 OCCUPATI ONAL THERAPY	152, 634	19, 294	8, 17		213, 264	67.00
68.00	06800 SPEECH PATHOLOGY	76, 884	10, 142	4, 29		106, 908	68.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	683, 869	0		0 0	683, 869	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	103, 226	0		0 0	103, 226	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 225, 108	33, 154	14, 04	3 18, 531	2, 290, 836	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	2, 752, 618	0		0 474, 397	3, 227, 015	88.00
88.01	08801 RURAL HEALTH CLINIC II	824, 527	0		0 127, 261	951, 788	88. 01
88.02	08803 RURAL HEALTH CLINIC III	236, 669	0		0 42,002	278, 671	88.02
88.03	08802 RURAL HEALTH CLINIC IV	0	0	14.00	0 0	0	88.03
90. 00 90. 01		370, 397	98, 890	41, 88		581, 170	90.00
90. 01 90. 02	09001 PALN MANAGEMENT 09002 WOUND CARE	285, 154	34, 804	14, 74	0 0 2 67,041	0 401, 741	90. 01 90. 02
	09003 ORTHOPEDIC CLINIC	285, 154	34, 604	14, 74	0 16, 882		90.02
	09100 EMERGENCY	2, 325, 387	150, 854	63, 89			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 323, 307	150, 054	00,07	/ ///,010	2,717,730	92.00
,2,00	OTHER REIMBURSABLE COST CENTERS	1					12:00
95.00	09500 AMBULANCE SERVICES	1, 104, 726	99, 000	41, 93	5 0	1, 245, 661	95.00
	SPECIAL PURPOSE COST CENTERS			·			
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0		0 0		116.00
118.00		35, 716, 717	2, 640, 598	1, 118, 50	6 3, 058, 252	35, 500, 509	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30, 558	12, 94		43, 502	
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 037, 933	0		0 172, 706	1, 210, 639	192.00
200.00			~		0		200.00
201.00		24 754 450	2 (71 15)	1 101 45			201.00
202.00	I TOTAL (SUM TIMES THE INFOUGH 201)	36, 754, 650	2, 671, 156	1, 131, 45	3, 230, 958	36, 754, 650	1202. UU

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2020 To 12/31/2020		nared
						6/11/2021 11:	56 am
	Cost Center Description	ADMI NI STRATI VE	Subtotal		OPERATION OF	LAUNDRY &	
		AND GENERAL		AND GENERAL -	PLANT	LINEN SERVICE	
		5.01	5A. 01	0THER 5.02	7.00	8.00	
	GENERAL SERVICE COST CENTERS	5.01	5A. 01	5.02	7.00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 ADMINISTRATIVE AND GENERAL	2, 748, 493					5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	279, 893	3, 742, 924	3, 742, 924	1		5.02
7.00	00700 OPERATION OF PLANT	191, 025	2, 554, 520	301, 589	2, 856, 109		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	6, 375	85, 250				8.00
9.00	00900 HOUSEKEEPI NG	39, 570	529, 157			19, 332	•
10.00	01000 DI ETARY	28, 948	387, 109				
11.00		25, 472	340, 624			0	
13.00	01300 NURSING ADMINISTRATION	24, 327	325, 313			0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	26, 386	352, 857	41,659	53, 337	0	16.00
30.00	03000 ADULTS & PEDIATRICS	459, 795	6, 148, 556	725, 913	631, 932	30, 938	30.00
31.00	03100 I NTENSI VE CARE UNI T	437, 775	0, 140, 330			0	1
43.00	04300 NURSERY	1,838	24, 575			-	
101 00	ANCI LLARY SERVICE COST CENTERS	1,000	21,070	2,70	20,010		
50.00	05000 OPERATI NG ROOM	87, 414	1, 168, 961	138,009	464, 492	7, 215	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 113	108, 490			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	119, 077	1, 592, 382	187, 998	3 235, 108	9, 915	54.00
60.00	06000 LABORATORY	178, 893	2, 392, 291	282, 436	97, 144	827	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	5, 895	78, 829	9, 30	7 0	0	
65.00	06500 RESPI RATORY THERAPY	65, 118	870, 801			876	
66.00	06600 PHYSI CAL THERAPY	56, 647	757, 527			2, 166	
67.00	06700 OCCUPATI ONAL THERAPY	17, 237	230, 501				
68.00	06800 SPEECH PATHOLOGY	8, 641	115, 549			0	68.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	55, 272	739, 141			0	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	8, 343	111, 569 2, 475, 988			0	
73.00	OUTPATIENT SERVICE COST CENTERS	185, 152	2,473,900	292, 310	3 53, 586	0	/3.00
88.00	08800 RURAL HEALTH CLINIC	260, 817	3, 487, 832	411, 77	7 0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	76, 926	1, 028, 714			-	
88.02	08803 RURAL HEALTH CLINIC III	22, 523	301, 194			0	88.02
88.03	08802 RURAL HEALTH CLINIC IV	0	C			0	
90.00	09000 CLINIC	46, 972	628, 142	74, 159	159, 832	3, 516	90.00
90.01	09001 PALN MANAGEMENT	0	C		0 0	0	90.01
90.02	09002 WOUND CARE	32, 470	434, 211	51, 263	3 56, 252	0	90.02
90.03	09003 ORTHOPEDIC CLINIC	7,656	102, 387			0	90.03
91.00	09100 EMERGENCY	219, 657	2,937,413		4 243, 820	27, 350	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		C				92.00
05 00	OTHER REIMBURSABLE COST CENTERS	400 (70	4 9 4 4 9 9 9	450.05	1/0.010		05 00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	100, 678	1, 346, 339	158, 950	0 160, 010	292	95.00
112 0	D11300 INTEREST EXPENSE			T			113.00
	11600 HOSPI CE	0	C		0	0	116.00
118.00		2, 647, 130	35, 399, 146	3, 737, 373	2, 806, 719		
. 10. 0	NONREI MBURSABLE COST CENTERS		33, 377, 140	5,767,070	2,000,717	102,727	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 516	47, 018	3 5, 55 [°]	49, 390	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	97, 847	1, 308, 486		0 0		192.00
200.00			C				200. 00
201.00		0	C	) (	0 0		201.00
202.00	)  TOTAL (sum lines 118 through 201)	2, 748, 493	36, 754, 650	3, 742, 924	2, 856, 109	102, 427	202.00

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lieu	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2020	Worksheet B Part I	
					To 12/31/2020	Date/Time Pre 6/11/2021 11:	pared:
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	
					ADMI NI STRATI ON	RECORDS &	
		9.00	10.00	11.00	13.00	LI BRARY 16.00	
	GENERAL SERVICE COST CENTERS	,					
1.00	OO1OO NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 ADMI NI STRATI VE AND GENERAL						5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE	(50 707					8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	658, 787	656, 893				9.00 10.00
11.00	01100 CAFETERIA	42,666	030, 893	380, 83	0		11.00
	01300 NURSI NG ADMI NI STRATI ON	2, 258	0	10, 12			13.00
	01600 MEDICAL RECORDS & LIBRARY	12, 544	0	12, 40		472, 798	1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	12, 344	9	12,40		472,770	10.00
30.00	03000 ADULTS & PEDI ATRI CS	148, 620	656, 893	107, 53	2 218, 319	135, 303	30.00
	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	1
	04300 NURSERY	6,071	0		0 0	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	109, 240	0	21, 04	3 42, 712	6, 081	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	26, 802	0	(	o c	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	55, 293	0	41, 95	в О	19, 763	54.00
60.00	06000 LABORATORY	22, 847	0	50, 440	0 0	30, 405	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	34, 353	0	26, 47		24, 324	1
66.00	06600 PHYSI CAL THERAPY	16, 892	0	20, 33		6, 081	66.00
67.00	06700 OCCUPATIONAL THERAPY	7, 334	0	6, 84		0	
68.00	06800 SPEECH PATHOLOGY	3, 855	0	2, 47		6, 081	68.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0			0	
	07300 DRUGS CHARGED TO PATIENTS	12,602	0	7, 35	-	0	1
73.00	OUTPATIENT SERVICE COST CENTERS	12,002	V	7,55		0	73.00
88.00	08800 RURAL HEALTH CLINIC	0	0	(	0 0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0			0	
88.02	08803 RURAL HEALTH CLINIC III	0	o	(	o o	0	88.02
88.03	08802 RURAL HEALTH CLINIC IV	0	0	(	0 0	0	1
90.00	09000 CLI NI C	37, 590	0	20, 52	9 41, 690	135, 302	90.00
90.01	09001 PALN MANAGEMENT	0	0	(	o c	0	90.01
90.02	09002 WOUND CARE	13, 230	0	12, 46	5 0	0	90.02
90.03	09003 ORTHOPEDIC CLINIC	0	0	(	0 0	0	90.03
91.00	09100 EMERGENCY	57, 342	0	40, 86	6 82, 978	92, 735	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	1 1			1		
95.00	09500 AMBULANCE SERVICES	37,632	0		0 0	16, 723	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		0			0	113.00
116.00 118.00	11600 HOSPICE	647 171	454 000	200 02	0 8 385, 699	0 472, 798	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	647, 171	656, 893	380, 83	oj <u>385, 699</u>	472, 798	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 616	0		0 0	0	190.00
	19000 PHYSI CLANS' PRI VATE OFFICES	11,010	0				190.00
200.00			0	,		0	200.00
200.00		0	0		o o	0	201.00
202.00		658, 787	656, 893	380, 83	385, 699	472, 798	
		1					

	Financial Systems	PERRY COUNTY			In Lieu of Form Cl	
COSTA	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1322	Period:WorksheetFrom 01/01/2020Part ITo12/31/2020Date/Time	
					6/11/2021	11:56 am
	Cost Center Description	Subtotal	Intern &	Total		
		F	Residents Cost			
			& Post			
			Stepdown			
		24.00	Adjustments 25.00	26.00		
	GENERAL SERVICE COST CENTERS	24.00	23.00	20.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540 ADMINISTRATIVE AND GENERAL					5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER					5.02
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	8, 804, 006	C	8, 804, 0	006	30.00
31.00	03100 INTENSIVE CARE UNIT	О	C		0	31.00
43.00	04300 NURSERY	59, 362	0	59, 3	62	43.00
	ANCI LLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1, 957, 753	C	1, 957, 7	53	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	262, 063	0	262, 0	063	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 142, 417	C	2, 142, 4	17	54.00
60.00	06000 LABORATORY	2, 876, 390	C	2, 876, 3	90	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	88, 136	C	88, 1	36	62.00
65.00	06500 RESPI RATORY THERAPY	1, 205, 706	C	1, 205, 7	'06	65.00
66.00	06600 PHYSI CAL THERAPY	964, 264	0	964, 2	264	66.00
67.00	06700 OCCUPATI ONAL THERAPY	303, 075	C	303, 0	075	67.00
68.00	06800 SPEECH PATHOLOGY	157, 993	0	157, 9	93	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	826, 405	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	124, 741	0	124, 7	41	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 841, 851	0	2, 841, 8	151	73.00
	OUTPATIENT SERVICE COST CENTERS			1		
88.00	08800 RURAL HEALTH CLINIC	3, 899, 609	C			88.00
88.01	08801 RURAL HEALTH CLINIC II	1, 150, 165	C			88. 01
88.02	08803 RURAL HEALTH CLINIC III	336, 753	C			88.02
88.03	08802 RURAL HEALTH CLINIC IV	0	C		0	88.03
90.00	09000 CLI NI C	1, 100, 760	0	1, 100, 7	60	90.00
90.01	09001 PALN MANAGEMENT	0	0		0	90.01
90.02	09002 WOUND CARE	567, 421	0			90.02
90.03	09003 ORTHOPEDIC CLINIC	114, 475	0			90.03
	09100 EMERGENCY	3, 829, 298	0		298	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
05 00	OTHER REIMBURSABLE COST CENTERS	1 710 014		4 740 0		
95.00	09500 AMBULANCE SERVICES	1, 719, 946	0	1, 719, 9	46	95.00
112 00	SPECIAL PURPOSE COST CENTERS					112.00
	11300 I NTEREST EXPENSE	0	0		0	113.00
118.00	11600 HOSPICE	25 222 E00	0		300	116.00
118.00		35, 332, 589	0	35, 332, 5	07	118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	110 575	0	110 -	75	100.00
170.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	113, 575 1, 308, 486	0	113, 5 1, 308, 4		190.00 192.00
102 00	117200 FRIDICIAND PRIVALE UFFICED	1, 308, 480	U	rj i, 3∪8, 4	-00	J192.00
			0		0	200 00
200.00	Cross Foot Adjustments	0	0		0	200.00
	Cross Foot Adjustments Negative Cost Centers	0 0 36, 754, 650	C C C		0	200. 00 201. 00 202. 00

ALLOCAT	Financial Systems	PERRY COUNTY	HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REL			Date/Time Pre 6/11/2021 11:	56 am
		-					
	Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	28	4.00	-
	DO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	DO200 NEW CAP REL COSTS-MVBLE EQUIP		10 74	5 00/	10.100	10,100	2.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 716	5, 386		18, 102	
	DO540 ADMINISTRATIVE AND GENERAL DO590 ADMINISTRATIVE AND GENERAL - OTHER	0	205, 700 169, 972	87, 131 71, 997		1, 328 1, 428	
	00700 OPERATION OF PLANT	0	515, 661	218, 422		329	
	DO800 LAUNDRY & LINEN SERVICE	0	4, 400	1, 864		0	
	DO900 HOUSEKEEPI NG	0	29, 590	12, 534		371	9.00
	D1000 DI ETARY	0	112, 244	47, 544		0	1
	D1100 CAFETERI A	0	0	C	0	0	
13.00	D1300 NURSING ADMINISTRATION	0	5, 940	2, 516	8, 456	264	13.00
16.00	D1600 MEDICAL RECORDS & LIBRARY	0	33, 000	13, 978	46, 978	211	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					
	D3000 ADULTS & PEDIATRICS	0	390, 985	165, 614		3, 433	
	D3100 INTENSIVE CARE UNIT	0	0	0	, v	0	
	D4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	15, 972	6, 765	22, 737	0	43.00
	D5000 OPERATING ROOM	0	287, 386	121, 731	409, 117	630	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	70, 510	29, 867		030	
	D5400 RADI OLOGY-DI AGNOSTI C	0	145, 464	61, 616		1.086	
	D6000 LABORATORY	0	60, 104	25, 459		994	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C		2	62.00
65.00	06500 RESPI RATORY THERAPY	0	90, 376	38, 282	128, 658	622	65.00
	D6600 PHYSI CAL THERAPY	0	44, 440	18, 824	63, 264	597	66.00
	06700 OCCUPATIONAL THERAPY	0	19, 294	8, 173		186	
	06800 SPEECH PATHOLOGY	0	10, 142	4, 296	14, 438	87	68.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71.00
	D7200 I MPL. DEV. CHARGED TO PATIENT D7300 DRUGS CHARGED TO PATIENTS	0	22 154	14 042	47 107	0	
	DUTPATIENT SERVICE COST CENTERS	0	33, 154	14, 043	47, 197	104	73.00
	D8800 RURAL HEALTH CLINIC	0	0	C	ol	2,657	88.00
	D8801 RURAL HEALTH CLINIC II	0	Ő	C	0	713	
	08803 RURAL HEALTH CLINIC III	0	0	C	0	235	
	D8802 RURAL HEALTH CLINIC IV	0	0	C	0 0	0	88.03
90.00	29000 CLI NI C	0	98, 890	41, 888	140, 778	392	90.00
	D9001 PAIN MANAGEMENT	0	0	C	0 0	0	
	09002 WOUND CARE	0	34, 804	14, 742	49, 546	376	
	09003 ORTHOPEDIC CLINIC	0	0	0	0	95	
	09100 EMERGENCY	0	150, 854	63, 899	214, 753	995	
	D9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92.00
	D9500 AMBULANCE SERVICES	0	99, 000	41, 935	140, 935	0	95.00
	SPECIAL PURPOSE COST CENTERS	0	77,000	41, 755	140, 733	0	/5.00
	11300 I NTEREST EXPENSE						113.00
116.001	11600 HOSPI CE	0	0	C	0 0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 640, 598	1, 118, 506	3, 759, 104		118.00
N	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30, 558	12, 944	43, 502		190.00
190.001							1400 00
190.001 192.001	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	967	192.00
190.001 192.001 200.00	Cross Foot Adjustments	0	0	C -	0		200.00
190.001 192.001		0	0 0 2, 671, 156	C C 1, 131, 450	0 0 0 3, 802, 606	0	

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre 6/11/2021 11:	epared: 56 am
	Cost Center Description	ADMI NI STRATI VE AND GENERAL	ADMI NI STRATI VE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.01	5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						1
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 ADMINISTRATIVE AND GENERAL	294, 159					5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	29, 955					5.02
7.00	00700 OPERATION OF PLANT	20, 444					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	682					8.00
9.00	00900 HOUSEKEEPI NG	4, 235	4, 562			66, 116	9.00
10.00	01000 DI ETARY	3, 098	3, 338	49, 346	0	4, 282	10.00
11.00	01100 CAFETERI A	2,726	2, 937	C	0 0	0	11.00
13.00	01300 NURSING ADMINISTRATION	2,604	2, 805	2, 611	0	227	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2,824	3, 042	14, 508	3 0	1, 259	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	49, 213	53, 020	171, 891	2, 905	14, 914	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	C	0 0	0	31.00
43.00	04300 NURSERY	197	212	7, 022	0	609	43.00
	ANCI LLARY SERVICE COST CENTERS				4		1
50.00	05000 OPERATI NG ROOM	9, 355	10, 079	126, 345	677	10, 963	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	868	935	30, 999	0	2, 690	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 744	13, 730	63, 951	931	5, 549	54.00
60.00	06000 LABORATORY	19, 146	20, 626	26, 424	1 78	2, 293	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	631	680	C	0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	6,969	7, 508	39, 732	82	3, 448	65.00
66.00	06600 PHYSI CAL THERAPY	6, 063	6, 531	19, 537	203	1, 695	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 845	1, 987	8, 482	2 0	736	67.00
68.00	06800 SPEECH PATHOLOGY	925	996	4, 459	0	387	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 915	6, 373	c	0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	893	962	c	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	19, 816	21, 348	14, 576	0	1, 265	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	27, 914	30, 072	C	0 0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	8, 233	8, 870	C	0 0	0	88. 01
88.02	08803 RURAL HEALTH CLINIC III	2, 411	2, 597	C	0 0	0	88. 02
88.03	08802 RURAL HEALTH CLINIC IV	0	0	C	0 0	0	88.03
90.00	09000 CLI NI C	5,027	5, 416	43, 475	5 330	3, 773	90.00
90.01	09001 PALN MANAGEMENT	0	0	C	0 0	0	90.01
90.02	09002 WOUND CARE	3, 475	3, 744	15, 301	0	1, 328	90.02
90.03	09003 ORTHOPEDIC CLINIC	819	883	C	0 0	0	90.03
91.00	09100 EMERGENCY	23, 509	25, 326	66, 321	2, 567	5, 755	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	10, 775	11, 608	43, 524	27	3, 777	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0	( C	0 0		116.00
118.00		283, 311	272, 947	763, 447	9, 615	64, 950	118.00
	NONREI MBURSABLE COST CENTERS	1		1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	376		13, 434	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	10, 472	0	C	0 0	0	192.00
200.00							200.00
	Negative Cost Centers	0	1 0		0	0	201.00
201.00		294, 159	273, 352	776, 881	9, 615		202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	PERRY COUNTY	Provider C	CN: 15-1322	Period:	u of Form CMS Worksheet B	2002-10
ALLUUP	THE REAL COSTS				From 01/01/2020 To 12/31/2020	Part II Date/Time Pre 6/11/2021 11:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	MEDI CAL N RECORDS & LI BRARY	Subtotal	
		10.00	11.00	13.00	16.00	24.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00 4.00 5.01 5.02 7.00 8.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMINISTRATIVE AND GENERAL 00590 ADMINISTRATIVE AND GENERAL - OTHER 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						1.00 2.00 4.00 5.01 5.02 7.00 8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	219, 852					10.00
11.00		0	5, 663		7		11.00
13.00 16.00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	0	150 184		, 0 69,006		13.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	UU	104	•	0 09,000		10.00
30.00	03000 ADULTS & PEDIATRICS	219, 852	1, 600	9, 68	9 19, 746	1, 102, 862	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	C		0 0	0	
43.00	04300 NURSERY	0	C		0 0	30, 777	43.00
50.00	ANCI LLARY SERVICE COST CENTERS		04.0	1.00	(	570.0/0	50.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	313 C		6 888 0 0	570, 263 135, 869	
52.00	05400 RADI OLOGY-DI AGNOSTI C	0	624		0 2,884	308, 579	1
60.00	06000 LABORATORY	0	750		0 4,438	160, 312	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	1, 313	
65.00	06500 RESPI RATORY THERAPY	0	394	Ļ	0 3, 550	190, 963	
66.00	06600 PHYSI CAL THERAPY	0	302		0 888	99, 080	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	102		0 0	40, 805	
68.00	06800 SPEECH PATHOLOGY	0	37		0 888	22, 217	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	C		0 0	12, 288	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	C 109		0 0 0 0	1, 855 104, 415	
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	109	,	0 0	104, 415	/3.00
88.00	08800 RURAL HEALTH CLINIC	0	C		0 0	60, 643	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	C		0 0	17, 816	
88. 02	08803 RURAL HEALTH CLINIC III	0	C		0 0	5, 243	88. 02
88. 03	08802 RURAL HEALTH CLINIC IV	0	C		0 0	0	
90.00	09000 CLINIC	0	305			221, 094	
90.01	09001 PALN MANAGEMENT	0	105			72 055	
90. 02 90. 03	09002 WOUND CARE 09003 ORTHOPEDIC CLINIC	0	185 C			73, 955 1, 797	
90.03 91.00	09100 EMERGENCY	0	608		2 13, 535	357, 051	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ŭ	000	0,00	10,000	007,001	92.00
	OTHER REIMBURSABLE COST CENTERS	L L		1	4		
95.00	09500 AMBULANCE SERVI CES	0	C	)	0 2, 441	213, 087	95.00
	SPECIAL PURPOSE COST CENTERS			1	1		
	11300 I NTEREST EXPENSE		-			-	113.00
	SUBTOTALS (SUM OF LINES 1 through 117)	210.952	E 443	17 11	0 0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	219, 852	5, 663	17, 11	7 69,006	3, 732, 284	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0	58.883	190.00
190.00		, V		1			
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0	11, 439	192.00
	19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments	0	C		0 0		192.00 200.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments Negative Cost Centers	0 0 219, 852	C 5, 663		o o	0 0	200. 00 201. 00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lieu of Form C	MS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1322	Period: Worksheet	В
				From 01/01/2020 Part II To 12/31/2020 Date/Time	Prenared
				6/11/2021	11:56 am
Cost Center Description	Intern &	Total			
	Residents Cost				
	& Post				
	Stepdown				
	Adjustments 25.00	26.00	-		
GENERAL SERVICE COST CENTERS	25.00	20.00			
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01 00540 ADMINI STRATI VE AND GENERAL					5. 01
5. 02 00590 ADMINISTRATIVE AND GENERAL - OTHER					5. 02
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
16.00 01600 MEDI CAL RECORDS & LI BRARY					16.00
INPATIENT ROUTINE SERVICE COST CENTERS	-		1		
30. 00 03000 ADULTS & PEDIATRICS	0	1, 102, 862			30.00
31.00 03100 INTENSIVE CARE UNIT	0	0			31.00
43. 00 04300 NURSERY	0	30, 777	/		43.00
ANCI LLARY SERVICE COST CENTERS		E 70 0/2			F0_00
50. 00 05000 OPERATING ROOM	0	570, 263			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	135, 869			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	308, 579	1		54.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	160, 312 1, 313	1		62.00
65. 00 06500 RESPI RATORY THERAPY	0	190, 963	1		65.00
66. 00 06600 PHYSI CAL THERAPY	0	99, 080	1		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	40, 805	1		67.00
68. 00 06800 SPEECH PATHOLOGY	0	22, 217	1		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 288	1		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 855	1		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	104, 415	•		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	60, 643	3		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	17, 816	5		88. 01
88.02 08803 RURAL HEALTH CLINIC III	0	5, 243	3		88. 02
88.03 08802 RURAL HEALTH CLINIC IV	0	C			88. 03
90. 00 09000 CLINIC	0	221, 094	1		90.00
90. 01 09001 PALN MANAGEMENT	0	0	D		90.01
90. 02 09002 WOUND CARE	0	73, 955			90.02
90. 03 09003 ORTHOPEDIC CLINIC	0	1, 797			90.03
91.00 09100 EMERGENCY	0	357, 051			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0				92.00
	0	213, 087	7		05.00
95. 00 09500 AMBULANCE SERVICES	0	213, 087	<u></u>		95.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE	0	C			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		3, 732, 284			118.00
NONREI MBURSABLE COST CENTERS	0	5,752,204	*		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58, 883	3		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	11, 439	1		192.00
200.00 Cross Foot Adjustments	0	(	1		200.00
201.00 Negative Cost Centers	0	C			201.00
202.00 TOTAL (sum lines 118 through 201)	0	3, 802, 606	6		202.00

Heal th	Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	pared:
		CAPITAL REL	ATED COSTS			6/11/2021 11:	56 am
		CAPITAL REL	ATED CUSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FLXT	EQUI P	BENEFITS		AND GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	
		1	1221)	SALARI ES)			
		1.00	2.00	4.00	5A. 01	5. 01	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	121, 416					1.00
	00200 NEW CAP REL COSTS-BLDG & FIXT	121, 410	121, 416				2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	578	578	13, 566, 421			4.00
	00540 ADMINISTRATIVE AND GENERAL	9, 350	9, 350	995, 766		34, 006, 157	5.01
	00590 ADMINISTRATIVE AND GENERAL - OTHER 00700 OPERATION OF PLANT	7,726	7,726	1, 070, 658		3, 463, 031	5.02
	00800 LAUNDRY & LINEN SERVICE	23, 439 200	23, 439 200	246, 401		2, 363, 495 78, 875	7.00 8.00
	00900 HOUSEKEEPI NG	1, 345	1, 345	277, 989	0	489, 587	9.00
	01000 DI ETARY	5, 102	5, 102	C	0 0	358, 161	10.00
	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 270	0 270	C 198, 191		315, 152	11.00 13.00
	01600 MEDICAL RECORDS & LIBRARY	1,500	270 1, 500	158, 036		300, 986 326, 471	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1,000	1,000	100,000	·	020, 111	10100
	03000 ADULTS & PEDI ATRI CS	17, 772	17, 772	2, 571, 084		5, 688, 761	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	0	C		0	31.00
43.00	ANCILLARY SERVICE COST CENTERS	726	726	C	0	22, 737	43.00
50.00	05000 OPERATI NG ROOM	13, 063	13, 063	472, 033	3 0	1, 081, 547	50.00
	05200 DELIVERY ROOM & LABOR ROOM	3, 205	3, 205	C	0 0	100, 377	52.00
	05400 RADI OLOGY-DI AGNOSTI C	6, 612	6, 612	813, 902		1, 473, 305	
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 732	2, 732 0	744, 960 1, 343		2, 213, 398 72, 934	
	06500 RESPI RATORY THERAPY	4, 108	4, 108	466, 025		805, 683	65.00
	06600 PHYSI CAL THERAPY	2, 020	2, 020	447, 628		700, 880	
	06700 OCCUPATI ONAL THERAPY	877	877	139, 246		213, 264	67.00
	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	461 0	461	65, 446		106, 908 683, 869	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	C	0	103, 226	72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 507	1, 507	77, 808	3 0	2, 290, 836	73.00
	OUTPATIENT SERVICE COST CENTERS	0		1 001 042		2 227 015	
	08800 RURAL HEALTH CLINIC II	0	0	1, 991, 942 534, 357		3, 227, 015 951, 788	
	08803 RURAL HEALTH CLINIC III	0	0	176, 361		278, 671	88. 02
	08802 RURAL HEALTH CLINIC IV	0	0	C	0 0	0	88. 03
	09000 CLINIC 09001 PAIN MANAGEMENT	4, 495	4, 495	293, 901	0	581, 170 0	90.00 90.01
	09002 WOUND CARE	1, 582	1, 582	281, 498		401, 741	
	09003 ORTHOPEDIC CLINIC	0	0	70, 884		94, 731	
	09100 EMERGENCY	6, 857	6, 857	745, 790	0 0	2, 717, 756	91.00
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	4, 500	4, 500	C	0	1, 245, 661	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 120, 027	0 120, 027	12, 841, 249	0 -2, 748, 493	0 32, 752, 016	116.00
	NONREIMBURSABLE COST CENTERS	120, 027	120, 027	12, 041, 245	-2,740,473	32, 732, 010	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 389	1, 389	C	) 0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	725, 172	2 0	1, 210, 639	
200.00 201.00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	2, 671, 156	1, 131, 450	3, 230, 958	3	2, 748, 493	
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	22. 000033	9. 318788			0. 080823	
204.00	Cost to be allocated (per Wkst. B, Part II)			18, 102		294, 159	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0.001334	l l	0. 008650	205.00
	11)						
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

	Financial Systems LOCATION - STATISTICAL BASIS	PERRY COUNT	Provi der C	CN: 15-1322	Period:	u of Form CMS-: Worksheet B-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	pare
	Cost Costar Description					6/11/2021 11:	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE AND GENERAL -	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (SQUARE	
			OTHER	(SQUARE	(POUNDS OF	FEET)	
			(ACCUM. COST NO PBP)	FEET)	LAUNDRY)		
		5A. 02	5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1	1				
	DO100 NEW CAP REL COSTS-BLDG & FIXT DO200 NEW CAP REL COSTS-MVBLE EQUIP						1
	DO400 EMPLOYEE BENEFITS DEPARTMENT						
	DO540 ADMINISTRATIVE AND GENERAL						5
02 0	DO590 ADMINISTRATIVE AND GENERAL - OTHER	-3, 742, 924	31, 703, 240				5
	DO700 OPERATION OF PLANT	C	2, 554, 520				7
	DO800 LAUNDRY & LINEN SERVICE DO900 HOUSEKEEPING		85, 250	200		70 770	8
	DIGO DI ETARY		529, 157 387, 109	1, 345 5, 102		78, 778 5, 102	
	D1100 CAFETERI A		340, 624			0,102	11
. 00 0	D1300 NURSING ADMINISTRATION	C	325, 313		0 0	270	13
-	D1600 MEDI CAL RECORDS & LI BRARY	C	352, 857	1, 500	0 0	1, 500	16
	NPATIENT ROUTINE SERVICE COST CENTERS		( 140 55 (	47 77		47 770	1
	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT			17, 772		17, 772 0	30
	D4300 NURSERY			726		726	
	ANCI LLARY SERVICE COST CENTERS		21,070	120		120	1 '`
. 00 0	D5000 OPERATING ROOM	C	1, 168, 961	13, 063	3 593	13, 063	50
	D5200 DELIVERY ROOM & LABOR ROOM	C	108, 490			3, 205	
	D5400 RADI OLOGY-DI AGNOSTI C	C	1, 592, 382	6, 612		6, 612	
	D6000 LABORATORY D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2, 392, 291 78, 829	2, 732		2, 732 0	60
	06500 RESPIRATORY THERAPY		870, 801	4, 108	-	4, 108	
	D6600 PHYSI CAL THERAPY	C	757, 527	2, 020		2,020	
. 00 0	D6700 OCCUPATI ONAL THERAPY	C	230, 501	87	7 0	877	67
	D6800 SPEECH PATHOLOGY	C	115, 549	461		461	68
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		739, 141			0	71
	D7200 IMPL. DEV. CHARGED TO PATIENT D7300 DRUGS CHARGED TO PATIENTS		111, 569 2, 475, 988		-	1, 507	72
	DUTPATIENT SERVICE COST CENTERS		2,473,700	1, 50		1,007	1
	D8800 RURAL HEALTH CLINIC	C	3, 487, 832	(	0 0	0	88
	D8801 RURAL HEALTH CLINIC II	C		(	-	0	88
	D8803 RURAL HEALTH CLINIC III	C	301, 194	(	-	0	88
	D8802 RURAL HEALTH CLINIC IV D9000 CLINIC		0 628, 142	4, 495	-	0 4, 495	88
	D9001 PALN MANAGEMENT		020, 142	4,470	0 0	4, 495	90
	09002 WOUND CARE	C	434, 211	1, 582	2 0	1, 582	90
	09003 ORTHOPEDIC CLINIC	C	102, 387	(	-	0	90
	D9100 EMERGENCY	C	2, 937, 413	6, 857	2, 248	6, 857	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	09500 AMBULANCE SERVICES	C	1, 346, 339	4, 500	24	4, 500	95
	SPECIAL PURPOSE COST CENTERS		1,010,007	1,000		1,000	
3.00	11300 INTEREST EXPENSE						113
	11600 HOSPI CE	C	0	(			116
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	-3, 742, 924	31, 656, 222	78, 934	4 8, 419	77, 389	1118
-	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		47, 018	1, 389	9 0	1, 389	1100
	19200 PHYSI CLANS' PRI VATE OFFICES	-1, 308, 486		(	o o		192
00 .C	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B,		3, 742, 924	2, 856, 109	9 102, 427	658, 787	202
3.00	Part I) Unit cost multiplier (Wkst. B, Part I)		0. 118061	35. 557798	3 12. 166172	8. 362576	203
3.00 4.00	Cost to be allocated (per Wkst. B,		273, 352			8. 362576 66, 116	
	Part II)		210,002	,,,0,00	2,015	50, 110	1
5.00	Unit cost multiplier (Wkst. B, Part		0. 008622	9. 671962	1. 142060	0. 839270	205
	11)						
06.00	NAHE adjustment amount to be allocated						206
07.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207
	Parts III and IV)	1					1-01

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C		eriod: Tom 01/01/2020	Worksheet B-1
				Тс	0 12/31/2020	Date/Time Prepared: 6/11/2021 11:56 am
	Cost Center Description	DI ETARY (MEALS	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS &	
		SERVED)	(112 0)		LI BRARY	
				(DI RECT NRSI NG HRS)	(TIME SPENT)	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	16.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2.00 4.00
5.01	00540 ADMINISTRATIVE AND GENERAL					5. 01
5.02 7.00	00590 ADMINISTRATIVE AND GENERAL - OTHER 00700 OPERATION OF PLANT					5. 02 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG	0 ( 00				9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	8, 690 0	11, 854			10.00 11.00
	01300 NURSI NG ADMI NI STRATI ON	0	315		0.1.1	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	386	0	311	16.00
30.00	03000 ADULTS & PEDI ATRI CS	8, 690	3, 347		89	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	0	-	0	31.00 43.00
10.00	ANCI LLARY SERVI CE COST CENTERS				<u> </u>	10.00
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	655 0		4 0	50.00 52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	1, 306	- U	13	54.00
		0	1, 570	0	20 0	60.00
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	0	824	0	16	62.00 65.00
	06600 PHYSI CAL THERAPY	0	633		4	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	213 77		0	67.00 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0 229	-	0	72.00 73.00
	OUTPATIENT SERVICE COST CENTERS	0			0	73.00
	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	0	-	0	88. 00 88. 01
	08803 RURAL HEALTH CLINIC III	0	0	0	0	88. 02
	08802 RURAL HEALTH CLINIC IV	0	0	0	0	88.03
	09000 CLINIC 09001 PAIN MANAGEMENT	0	639 0		89 0	90.00 90.01
90.02	09002 WOUND CARE	0	388	0	0	90. 02
	09003 ORTHOPEDIC CLINIC 09100 EMERGENCY	0	0 1, 272	26, 460	0 61	90. 03 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		.,			92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	0	11	95.00
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0	0	0	113. 00 116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 690	11, 854	122, 992	311	118.00
100 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	190.00
200.00						200. 00 201. 00
201.00 202.00	5	656, 893	380, 838	385, 699	472, 798	201.00
	Part I)	75 504000	00 407000	0.4050(0		000.00
203.00 204.00		75. 591830 219, 852	32. 127383 5, 663		1, 520. 250804 69, 006	203. 00 204. 00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part    )	25. 299425	0. 477729	0. 139172	221. 884244	205.00
206.00	NAHE adjustment amount to be allocated					206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					207.00
	Parts III and IV)					

Health Fina	ncial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1322	Peri od:	Worksheet C	
					From 01/01/2020	Part I Date/Time Pre	
					To 12/31/2020	6/11/2021 11:	
			Title	XVIII	Hospi tal	Cost	<u>50 alli</u>
					Costs	0001	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	•	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	TIENT ROUTINE SERVICE COST CENTERS	1					
	O ADULTS & PEDIATRICS	8, 804, 006		8, 804, 0		0	
	O INTENSIVE CARE UNIT	0			0 0	0	
	0 NURSERY	59, 362		59, 3	62 0	0	43.00
	LLARY SERVICE COST CENTERS	1			-		
	O OPERATING ROOM	1, 957, 753		1, 957, 7		0	
	O DELIVERY ROOM & LABOR ROOM	262, 063		262, 0	63 0	0	
	0 RADI OLOGY-DI AGNOSTI C	2, 142, 417		2, 142, 4		0	
	0 LABORATORY	2, 876, 390		2, 876, 3	90 0	0	60.00
	0 WHOLE BLOOD & PACKED RED BLOOD CELLS	88, 136		88, 1		0	1
	0 RESPI RATORY THERAPY	1, 205, 706		.,,		0	
	0 PHYSI CAL THERAPY	964, 264				0	
	O OCCUPATI ONAL THERAPY	303, 075		303, 0		0	
	O SPEECH PATHOLOGY	157, 993		157, 9		0	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	826, 405		826, 4		0	
	O I MPL. DEV. CHARGED TO PATIENT	124, 741		124, 7		0	
	0 DRUGS CHARGED TO PATIENTS	2, 841, 851		2, 841, 8	51 0	0	73.00
	ATIENT SERVICE COST CENTERS	1					
	O RURAL HEALTH CLINIC	3, 899, 609		3, 899, 6		0	1
	1 RURAL HEALTH CLINIC II	1, 150, 165		1, 150, 1		0	
	3 RURAL HEALTH CLINIC III	336, 753		336, 7		0	
	2 RURAL HEALTH CLINIC IV	0			0 0	0	
	O CLINIC	1, 100, 760		1, 100, 7	50 0	0	
	1 PAIN MANAGEMENT	0			0 0	0	
	2 WOUND CARE	567, 421		567, 4		0	
	3 ORTHOPEDIC CLINIC	114, 475		114, 4		0	
	O EMERGENCY	3, 829, 298		3, 829, 2		0	
	O OBSERVATION BEDS (NON-DISTINCT PART)	1, 156, 139		1, 156, 1	39	0	92.00
	R REIMBURSABLE COST CENTERS	4 740 044	1	1 740 0	4		05 00
	O AMBULANCE SERVICES	1, 719, 946		1, 719, 9	46 0	0	95.00
	I AL PURPOSE COST CENTERS	1		1			1112 00
116.001160					0	0	113.00
200.00	Subtotal (see instructions)	0		26 400 7	-		116.00 200.00
200.00	Less Observation Beds	36, 488, 728		36, 488, 7 1, 156, 1			200.00
201.00	Total (see instructions)	35, 332, 589					201.00
202.00		J 30, 332, 589	1 0	30, 332, 5	0 170	0	1202.00

Heal th Fi	nancial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 6/11/2021 11:	epared: 56 am
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	000 ADULTS & PEDI ATRI CS	5, 645, 721		5, 645, 72	21		30.00
	100 I NTENSI VE CARE UNI T	0			0		31.00
	300 NURSERY	114, 390		114, 39	90		43.00
	CILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
	000 OPERATING ROOM	1, 129, 303	5, 284, 842				
	200 DELIVERY ROOM & LABOR ROOM	441, 551	176, 304	617, 8			
54.00 05	400 RADI OLOGY-DI AGNOSTI C	1, 349, 753	16, 029, 565	17, 379, 31	0. 123274	0.00000	54.00
60.00 06	000 LABORATORY	1, 651, 392	16, 161, 674	17, 813, 00	66 0. 161476	0.00000	60.00
62.00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	60, 258	219, 522	279, 78	0. 315019	0.00000	62.00
65.00 06	500 RESPI RATORY THERAPY	1,007,330	2, 138, 608	3, 145, 93	38 0. 383258	0.00000	65.00
66.00 06	600 PHYSI CAL THERAPY	589, 420	2, 042, 646	2, 632, 00	0. 366353	0. 000000	66.00
67.00 06	700 OCCUPATIONAL THERAPY	484, 480	544, 123	1, 028, 60	0. 294647	0. 000000	67.00
68.00 06	800 SPEECH PATHOLOGY	114, 663	285, 554	400, 21	0. 394768	0. 000000	68.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 527, 194	2, 488, 711	4, 015, 90	0. 205783	0. 000000	71.00
72.00 07	200 IMPL. DEV. CHARGED TO PATIENT	0	129, 032	129, 03	0. 966745	0. 000000	72.00
73.00 07	300 DRUGS CHARGED TO PATIENTS	3, 519, 659	9, 692, 346	13, 212, 00	0. 215096	0. 000000	73.00
OU	TPATIENT SERVICE COST CENTERS						
88.00 08	800 RURAL HEALTH CLINIC	0	4, 134, 701	4, 134, 70	01		88.00
88.01 08	801 RURAL HEALTH CLINIC II	0	1, 593, 187	1, 593, 18	37		88.01
88. 02 08	803 RURAL HEALTH CLINIC III	0	484, 904	484, 90	04		88.02
88. 03 08	802 RURAL HEALTH CLINIC IV	0	0		0		88.03
90.00 09	000 CLINIC	80, 350	831, 130	911, 48	1. 207662	0. 000000	90.00
90.01 09	001 PALN MANAGEMENT	0	0		0 0.000000	0. 000000	90.01
90.02 09	002 WOUND CARE	20, 552	1, 777, 143	1, 797, 69	95 0. 315638	0. 000000	90.02
90.03 09	003 ORTHOPEDIC CLINIC	0	585, 127	585, 12	0. 195641	0.00000	90.03
91.00 09	100 EMERGENCY	422, 027	7, 353, 453	7, 775, 48	0. 492484	0.00000	91.00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)	42,017	685, 623	727, 64	1. 588889	0. 000000	92.00
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	0	3, 960, 372	3, 960, 3	0. 434289	0.00000	95.00
	ECIAL PURPOSE COST CENTERS						1
	300 I NTEREST EXPENSE						113.00
	600 HOSPI CE	0	0		0		116.00
200.00	Subtotal (see instructions)	18, 200, 060	76, 598, 567	94, 798, 62	-		200.00
201.00	Less Observation Beds	,,,	, , ,				201.00
202.00	Total (see instructions)	18, 200, 060	76, 598, 567	94, 798, 62	27		202.00
		,, 0000	, ,,	,	1	I	

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 6/11/2021 11:	epared: 56 am
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
70.00	OUTPATIENT SERVICE COST CENTERS	0.000000				1 / 0. 00
88.00	08800 RURAL HEALTH CLINIC					88.00
88.01	08801 RURAL HEALTH CLINIC II					88.01
88.02	08803 RURAL HEALTH CLINIC III					88.02
88.03	08802 RURAL HEALTH CLINIC IV					88.03
90.00	09000 CLINIC	0. 000000				90.00
90.00	09001 PALN MANAGEMENT	0.000000				90.00
90.01	09002 WOUND CARE	0. 000000				90.01
90.02 90.03	09003 ORTHOPEDIC CLINIC	0. 000000				90.02
90.03 91.00	09100 EMERGENCY	0. 000000				91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				91.00
92.00	OTHER REIMBURSABLE COST CENTERS	0.000000				92.00
05 00		0,000000				1 05 00
95.00	09500 AMBULANCE SERVICES	0.000000				95.00
110.00	SPECIAL PURPOSE COST CENTERS					1110.00
	11300 INTEREST EXPENSE					113.00
	11600 HOSPI CE					116.00
200.00						200.00
201.00						201.00
202.00	Total (see instructions)					202.00

Health Fina	ncial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1322	Peri od:	Worksheet C	
					From 01/01/2020	Part I	
					To 12/31/2020	Date/Time Pre 6/11/2021 11:	
				e XIX	Hospi tal	PPS	
			11.01		Costs	115	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance	iotal ocoto	
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	0 ADULTS & PEDIATRICS	8, 804, 006		8, 804, 00	0 0	8, 804, 006	30.00
31.00 0310	O INTENSIVE CARE UNIT	0			0 0	0	31.00
43.00 0430	0 NURSERY	59, 362		59, 30	52 0	59, 362	43.00
	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	1, 957, 753		1, 957, 7	53 0	1, 957, 753	50.00
	O DELIVERY ROOM & LABOR ROOM	262,063		262, 0	53 0	262, 063	52.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	2, 142, 417		2, 142, 4	17 0	2, 142, 417	54.00
60.00 0600	0 LABORATORY	2, 876, 390		2, 876, 39	90 0	2, 876, 390	60.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS	88, 136		88, 1	36 0	88, 136	62.00
65.00 0650	0 RESPI RATORY THERAPY	1, 205, 706	0	1, 205, 70	06 0	1, 205, 706	65.00
66.00 0660	0 PHYSI CAL THERAPY	964, 264	0	964, 20	54 0	964, 264	66.00
67.00 0670	0 OCCUPATI ONAL THERAPY	303, 075		303, 0	75 0	303, 075	67.00
	O SPEECH PATHOLOGY	157, 993		157, 9	93 0	157, 993	68.00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	826, 405		826, 40		826, 405	71.00
	OIMPL. DEV. CHARGED TO PATIENT	124, 741		124, 74		124, 741	
	O DRUGS CHARGED TO PATIENTS	2, 841, 851		2, 841, 8	51 0	2, 841, 851	73.00
	ATIENT SERVICE COST CENTERS						
	O RURAL HEALTH CLINIC	3, 899, 609		3, 899, 60			
	1 RURAL HEALTH CLINIC II	1, 150, 165		1, 150, 1		1, 150, 165	
	3 RURAL HEALTH CLINIC III	336, 753		336, 7	53 0	336, 753	1
	2 RURAL HEALTH CLINIC IV	0			0 0	0	
		1, 100, 760		1, 100, 7	50 0	1, 100, 760	
	1 PAIN MANAGEMENT	0			0 0	0	
	2 WOUND CARE	567, 421		567, 42		567, 421	
	3 ORTHOPEDIC CLINIC	114, 475		114, 4		114, 475	
	0 EMERGENCY	3, 829, 298		3, 829, 29		3, 829, 298	1
	O OBSERVATION BEDS (NON-DISTINCT PART)	1, 156, 139		1, 156, 13	39	1, 156, 139	92.00
	R REIMBURSABLE COST CENTERS	1			1		
	O AMBULANCE SERVI CES	1, 719, 946		1, 719, 9	16 0	1, 719, 946	95.00
	I AL PURPOSE COST CENTERS			1			
	0 INTEREST EXPENSE						113.00
116.001160		0	_		0		116.00
200.00	Subtotal (see instructions)	36, 488, 728					1
201.00	Less Observation Beds	1, 156, 139		1, 156, 1		1, 156, 139	
202.00	Total (see instructions)	35, 332, 589	0	35, 332, 58	39 0	35, 332, 589	J202. 00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 6/11/2021 11:	pared: 56 am
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	11					
30. 00 03000 ADULTS & PEDIATRICS	5, 645, 721		5, 645, 72	21		30.00
31.00 03100 I NTENSI VE CARE UNI T	0			0		31.00
43. 00 04300 NURSERY	114, 390		114, 39	90		43.00
ANCI LLARY SERVI CE COST CENTERS	,		1			
50.00 05000 OPERATING ROOM	1, 129, 303	5, 284, 842			0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	441, 551	176, 304			0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 349, 753	16, 029, 565			0.000000	
60. 00 06000 LABORATORY	1, 651, 392	16, 161, 674			0.000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	60, 258	219, 522			0.00000	
65. 00 06500 RESPI RATORY THERAPY	1,007,330	2, 138, 608			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	589, 420	2, 042, 646			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	484, 480	544, 123			0. 000000	
68.00 06800 SPEECH PATHOLOGY	114, 663	285, 554			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 527, 194	2, 488, 711			0.000000	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	129, 032			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 519, 659	9, 692, 346	13, 212, 00	0. 215096	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS	1 1					
88.00 08800 RURAL HEALTH CLINIC	0	4, 134, 701	4, 134, 70		0.000000	
88.01 08801 RURAL HEALTH CLINIC II	0	1, 593, 187			0.000000	
88.02 08803 RURAL HEALTH CLINIC III	0	484, 904	484, 90		0.000000	
88.03 08802 RURAL HEALTH CLINIC IV	0	0		0 0.000000	0.000000	
90. 00 09000 CLI NI C	80, 350	831, 130			0.000000	
90. 01 09001 PALN MANAGEMENT	0	0		0 0.000000	0.000000	
90. 02 09002 WOUND CARE	20, 552	1, 777, 143			0.000000	
90. 03 09003 ORTHOPEDIC CLINIC	0	585, 127			0.000000	
91.00 09100 EMERGENCY	422, 027	7, 353, 453			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	42,017	685, 623	727, 64	1. 588889	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVICES	0	3, 960, 372	3, 960, 37	0. 434289	0. 000000	95.00
SPECIAL PURPOSE COST CENTERS				-		
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	18, 200, 060	76, 598, 567	94, 798, 62	27		200.00
201.00 Less Observation Beds						201.00
202.00  Total (see instructions)	18, 200, 060	76, 598, 567	94, 798, 62	27		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-1322         Period: From 01/01/2020 To 12/31/2020         Worksheet C Part I Date/Time Prepared: 6/11/2021 11:56 am           Cost Center Description         PPS Inpatient Ratio 11:00         Title XIX         Hospital         PPS           INPATIENT ROUTINE SERVICE COST CENTERS         0:00000000000000000000000000000000000	Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
Cost Center Description         PPS Inpatient Ratio         PPS Inpatient Ratio         PPS Inpatient Ratio           11.00         INPATIENT ROUTINE SERVICE COST CENTERS         30.00         30.00         30.00         31.00           30.00         03000 ADULTS & PEDIATRICS         31.00         31.00         31.00         31.00           43.00         04300 NURSERY         43.00         31.00         31.00           ANCILLARY SERVICE COST CENTERS         50.00         50.00         50.00 DELIVERY ROOM & LABOR ROOM         0.424150         52.00           50.00         05000 DELIVERY ROOM & LABOR ROOM         0.424150         52.00         52.00           50.00         06000 LABORATORY         0.161476         60.00         60.00           60.00         06000 RESPIRATORY THERAPY         0.383258         65.00         65.00           60.00         06000 SPECH PATHOLOGY         0.394768         71.00         71.00         67.00         62.00 TOPLIENT ENT V         0.294647         68.00         68.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.0	COMPUT	ATION OF RATIO OF COSTS TO CHARGES			From 01/01/2020 To 12/31/2020	Part I Date/Time Pre 6/11/2021 11:	pared: 56 am
Ratio         11.00           11.00         11.00           30.00         03000 ADULTS & PEDIATRICS         30.00           31.00         03000 INTENIVE CARE UNIT         31.00           43.00         04300 NURSERY         43.00           ARCILLARY SERVICE COST CENTERS         50.00           50.00         5000 OPERATING ROOM         0.424150           52.00         65200 DELIVERY ROOM & LABOR ROOM         0.424150           54.00         05400 RADIOLOGY-DIAGNOSTIC         0.161476           60.00         06500 LABORATORY         0.161476           61.00         06600 PHYSICAL THERAPY         0.383258           65.00         06500 RESPIRATORY THERAPY         0.386353           66.00         06600 PHYSICAL THERAPY         0.394768           68.00         06800 SPEECH PATHOLOGY         0.394768           71.00         07100 IMPL. DEV. CHARGED TO PATIENTS         0.205783           73.00         07300 DRUCS CHARGED TO PATIENTS         0.215096           73.00         07300 D				Title XIX	Hospi tal	PPS	
INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00           03000 ADULTS & PEDI ATRI CS         31.00           43.00         03100 INTENSI VE CARE UNI T         43.00           ANCI LLARY SERVI CE COST CENTERS         50.00           50.00         05000 DPERATI NG ROOM         0.305224           50.00         05000 DELI VERY ROOM & LABOR ROOM         0.424150           52.00         05200 DELI VERY ROOM & LABOR ROOM         0.123274           60.00         06000 LABORATORY         0.11476           62.00         06200 WHOLE BLOOD & PACKED RED BLOOD CELLS         0.315019           62.00         06500 RESPI RATORY THERAPY         0.383258           65.00         06600 PHYSI CAL THERAPY         0.384353           66.00         06600 SPEECH PATHOLOGY         0.394768           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.294647           72.00         07300 DRUGS CHARGED TO PATI ENTS         0.205783           71.00         07100 INEL HECAPY INT         0.966745           72.00         07300 DRUGS CHARGED TO PATI ENTS         0.215096           73.00         07300 DRUGS CHARGED TO PATI ENTS         0.215096           73.00         07300 DRUGS CHARGED TO PATI ENTS         0.215096           73.00 <t< td=""><td></td><td>Cost Center Description</td><td>PPS Inpatient</td><td></td><td></td><td></td><td></td></t<>		Cost Center Description	PPS Inpatient				
INPATI ENT ROUTINE SERVICE COST CENTERS         30.00           30.00         03000 ADULTS & PEDI ATRICS         30.00           31.00         03100 INTENSIVE CARE UNIT         31.00           43.00         04300 NURSERY         43.00           ANCILLARY SERVICE COST CENTERS         50.00           50.00         05000 DPERATING ROOM         0.305224           50.00         05200 DELIVERY ROOM & LABOR ROOM         0.424150           52.00         05400 RADI OLOGY-DI AGNOSTI C         0.151476           60.00         06000 LABORATORY         0.161476           60.00         06500 RESPI RATORY THERAPY         0.336353           66.00         06500 RESPI RATORY THERAPY         0.36353           66.00         06600 LABORATORY         0.294647           67.00         06600 PHYSI CAL THERAPY         0.366353           67.00         06600 SPEECH PATHOLOGY         0.394768           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.295783           72.00         07300 DRUGS CHARGED TO PATIENTS         0.215096           73.00         07300 DRUGS CHARGED TO PATIENTS         0.215096           73.00         08801 RURAL HEALTH CLINIC II         0.721927           88.00         08803 RURAL HEALTH CLINIC III							
30. 00       03000       ADULTS & PEDIATRICS       30. 00         31. 00       03100       INTENSIVE CARE UNIT       31.00         43. 00       04300       NURSERY       43.00         ANCILLARY SERVICE COST CENTERS       50.00       05000       OPERATING ROOM       0.305224       50.00         52. 00       05200       DELIVERY ROOM & LABOR ROOM       0.424150       52.00       52.00         54. 00       05400 RADIUCRY ROM & LABOR ROOM       0.424150       54.00       60.00         64.00       06000 LABORATORY       0.161476       60.00       62.00       06200 WHOLE BLOOD & PACKED RED BLOOD CELLS       0.315019       62.00         65. 00       06500 RESPI RATORY THERAPY       0.383258       65.00       65.00       66.00       66.00       67.00       06700 OCCUPATIONAL THERAPY       0.394768       68.00         71. 00       07100 MEDICAL SUPPLIES CHARGED TO PATIENTS       0.294647       67.00       67.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       72.00       MPLL ES CHARGED TO PATIENTS       0.215096       72.00         073000       DRUBC CHARGED TO PATIENTS       0.215096       73.00       08803 RURAL H			11.00				
31.00       03100       INTENSIVE CARE UNIT       31.00         43.00       04300       NURSERY       43.00         ANCILLARY SERVICE COST CENTERS       50.00       05000       OPERATI NG ROOM       0.305224       50.00         50.00       05200       DELIVERY ROOM & LABOR ROOM       0.424150       52.00       52.00         54.00       05400       RADIOLOGY-DI AGNOSTI C       0.123274       54.00         60.00       06600       HASORATORY       0.161476       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.315019       62.00         65.00       06500       RESPI RATORY THERAPY       0.386353       66.00         66.00       06600       PHYSI CAL THERAPY       0.394768       66.00         67.00       06700       OCUPATI ONAL THERAPY       0.205783       71.00         71.00       OT100       MEUL CASUPELIES CHARGED TO PATI ENTS       0.205783       72.00         73.00       O7300       DRUSC CHARGED TO PATI ENTS       0.215096       72.00         73.00       O8803 RURAL HEALTH CLINIC II       0.721927       88.00       88.01         88.01       08802 RURAL HEALTH CLINIC II       0.72462       90.00       90.00 <td></td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td>			1				
43.00       04300       NURSERY       43.00         ANCI LLARY SERVICE COST CENTERS       50.00       05000       OPERATING ROOM       0.305224       50.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.424150       52.00       54.00         60.00       06400       LABORATORY       0.161476       60.00       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.315019       62.00       65.00         65.00       06500       RESPI RATORY THERAPY       0.386353       65.00       66.00         66.00       06600       PHYSI CAL THERAPY       0.366353       66.00       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.394768       68.00       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.205783       71.00         73.00       07300       PURCES CHARGED TO PATI ENTS       0.215096       73.00         008801       RURAL HEALTH CLINIC       0.943142       88.01         88.01       08803       RURAL HEALTH CLINIC III       0.721507       88.01         88.03       08802       RURAL HEALTH CLINIC III       0.721507       88.03         90.01 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
ANCI LLARY SERVICE COST CENTERS           50.00         05000 (PERATI NG ROOM         0.305224         50.00           52.00         05200 DELI VERY ROOM & LABOR ROOM         0.424150         52.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0.123274         54.00           60.00         06000 LABORATORY         0.161476         60.00           62.00         06200 WHOLE BLOOD & PACKED RED BLOOD CELLS         0.315019         62.00           65.00         06500 RESPI RATORY THERAPY         0.38258         65.00           66.00         06600 PHYSI CAL THERAPY         0.386353         66.00           67.00         06700 OCCUPATI ONAL THERAPY         0.394768         68.00           68.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.205783         71.00           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT         0.946745         72.00           73.00         07300 DRUGS CHARGED TO PATI ENT         0.215096         73.00           07300 DRUGS CHARGED TO PATI ENT         0.943142         88.00           88.01         08801 RURAL HEALTH CLINIC II         0.721927         88.00           88.03         08802 RURAL HEALTH CLINIC III         0.69474         88.01           88.03         088002 R							
50.00       05000       0PERATING ROOM       0.305224       50.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.424150       52.00         54.00       05400       RADIOLOGY-DI AGNOSTI C       0.123274       54.00         60.00       06000       LABORATORY       0.161476       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.315019       62.00         65.00       06500       RESPIRATORY THERAPY       0.383258       65.00         66.00       06600       PHYSI CAL THERAPY       0.394768       66.00         67.00       0C200 IMPL. DEV. CHARGED TO PATI ENTS       0.294647       67.00         70.00       MODICS CHARGED TO PATI ENTS       0.2945645       71.00         71.00       0T200 IMPL. DEV. CHARGED TO PATI ENTS       0.215096       73.00         72.00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0.215096       73.00         00TFATI ENT SERVICE COST CENTERS       0.943142       88.00       88.00         88.01       08801 RURAL HEALTH CLINIC III       0.721927       88.00       88.01         88.02       08802 RURAL HEALTH CLINIC IV       0.000000       88.03       90.00       90.001         90.01       <	43.00						43.00
52.00       05200       DELIVERY ROOM & LABOR ROOM       0.424150       52.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.123274       54.00         60.00       06000       LABORATORY       0.161476       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.315019       62.00         65.00       06600       PHYSI CAL THERAPY       0.383258       65.00         66.00       06600       PHYSI CAL THERAPY       0.366353       66.00         67.00       06700 OCCUPATI ONAL THERAPY       0.394768       68.00         68.00       SPEECH PATHOLOGY       0.394768       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.205783       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.215096       73.00         001700       DRUGS CHARGED TO PATI ENTS       0.215096       73.00         001700       DRUGS CHARGED TO PATI ENTS       0.215096       73.00         01000       DRUGS CHARGED TO PATI ENTS       0.215096       73.00         02100       DRUGS CHARGED TO PATI ENTS       0.215096       88.00         88.00       08800       RURAL HEALTH CLINIC III       0.943							
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.123274       54.00         60.00       06000       LABORATORY       0.161476       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.315019       62.00         65.00       06500       RESPI RATORY THERAPY       0.383258       65.00         66.00       06600       PHYSI CAL THERAPY       0.366353       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.394768       68.00         68.00       06800       SPEECH PATHOLOGY       0.394768       68.00         71.00       07100       MEDL SCHARGED TO PATI ENTS       0.205783       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.215096       73.00         07300       DRUGS CHARGED TO PATI ENTS       0.215096       73.00         01700 TURAL HEALTH CLINIC       0.943142       88.01         88.01       08801       RURAL HEALTH CLINIC III       0.721927       88.01         88.02       08803       RURAL HEALTH CLINIC III       0.694474       88.01         88.03       08802       RURAL HEALTH CLINIC IV       0.000000       88.03         90.01       09000       CLINIC <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
60.00         06000         LABORATORY         0.161476         60.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0.315019         62.00           65.00         06500         RESPI RATORY THERAPY         0.383258         65.00           66.00         06600         PHYSI CAL THERAPY         0.366353         66.00           67.00         06700         OCCUPATI ONAL THERAPY         0.394768         68.00           68.00         O6800         SPEECH PATHOLOGY         0.394768         68.00           71.00         O7100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.205783         71.00           72.00         07300         DRUGS CHARGED TO PATI ENT         0.966745         72.00           001DPATI ENT SERVICE COST CENTERS         0.215096         72.00         73.00           001PATI ENT SERVICE COST CENTERS         0.215096         72.00         73.00           08800         RURAL HEALTH CLINIC II         0.721927         88.00           88.01         08801         RURAL HEALTH CLINIC III         0.694474         88.02           88.03         08802         RURAL HEALTH CLINIC IV         0.000000         88.03           90.00         090000         CLINIC							•
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0.315019       62.00         65.00       06500       RESPIRATORY THERAPY       0.383258       65.00         66.00       06600       PHYSI CAL THERAPY       0.366353       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.294647       67.00         68.00       06800 SPEECH PATHOLOGY       0.394768       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.205783       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.215096       72.00         00100       OB8007 RURAL HEALTH CLINIC       0.943142       73.00         08800       RURAL HEALTH CLINIC III       0.721927       88.00         88.01       08801       RURAL HEALTH CLINIC III       0.694474       88.02         88.03       08802       RURAL HEALTH CLINIC IV       0.000000       88.03         90.00       09000       CLINIC       1.207662       90.01         90.01       090012       NANAGEMENT       0.000000       90.01         90.02       09002       WUND CARE       0.315638       90.02	54.00						
65.00       06500       RESPI RATORY THERAPY       0.383258       65.00         66.00       06600       PHYSI CAL THERAPY       0.366353       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.294647       67.00         68.00       06800       SPEECH PATHOLOGY       0.394768       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.205783       71.00         72.00       07200       JMPL. DEV. CHARGED TO PATI ENTS       0.215096       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.215096       73.00         OUTPATI ENT SERVICE COST CENTERS         88.01       08800       RURAL HEALTH CLINIC       0.943142       88.00         88.02       08303       RURAL HEALTH CLINIC III       0.694474       88.01         88.02       08303       RURAL HEALTH CLINIC IV       0.000000       88.03         90.00       09000       CLINIC       1.207662       90.00         90.01       09001       PAIN MANAGEMENT       0.000000       88.03         90.02       WUND CARE       0.315638       90.02	60.00						
66.00       06600       PHYSI CAL THERAPY       0.366353       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.294647       67.00         68.00       06800       SPEECH PATHOLOGY       0.394768       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.205783       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.966745       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.215096       73.00         0UTPATI ENT SERVICE COST CENTERS       0.943142       88.00         88.01       08800       RURAL HEALTH CLINIC II       0.721927       88.01         88.02       08303       RURAL HEALTH CLINIC III       0.694474       88.02         88.03       08002       RURAL HEALTH CLINIC IV       0.000000       88.03         90.00       09000       CLINIC       1.207662       90.00         90.01       09001       PAI NMANAGEMENT       0.030000       90.01         90.02       WUND CARE       0.315638       90.02	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 315019				62.00
67.00       06700       0CCUPATIONAL THERAPY       0.294647       67.00         68.00       06800       SPEECH PATHOLOGY       0.394768       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.205783       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0.966745       72.00         73.00       0700 DRUGS CHARGED TO PATIENTS       0.215096       72.00         0017PATIENT SERVICE COST CENTERS       0.943142       88.00         88.01       08800       RURAL HEALTH CLINIC II       0.721927       88.01         88.02       08803       RURAL HEALTH CLINIC III       0.694474       88.02         88.03       08802       RURAL HEALTH CLINIC IV       0.000000       88.03         90.00       09000       CLINIC       1.207662       90.00         90.01       09001       PAIN MANAGEMENT       0.000000       88.03         90.02       WUND CARE       0.315638       90.02	65.00	06500 RESPI RATORY THERAPY	0. 383258				65.00
68.00       06800       SPEECH PATHOLOGY       0.394768       68.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.205783       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0.966745       72.00         73.00       0700 DRUGS CHARGED TO PATIENT       0.215096       72.00         0UTPATIENT SERVICE COST CENTERS       0.943142       88.00         88.01       08801       RURAL HEALTH CLINIC II       0.721927         88.02       08803       RURAL HEALTH CLINIC III       0.694474         88.03       08802       RURAL HEALTH CLINIC IV       0.00000         88.03       08000       CLINIC       1.207662         90.00       09000       CLINIC       0.00000         90.01       09001       PAIN MANAGEMENT       0.00000         90.02       WUND CARE       0.315638       90.02	66.00	06600 PHYSI CAL THERAPY					66.00
68.00       06800       SPEECH PATHOLOGY       0.394768       68.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.205783       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0.966745       72.00         73.00       0700 DRUGS CHARGED TO PATIENT       0.215096       72.00         0UTPATIENT SERVICE COST CENTERS       0.943142       88.00         88.01       08801       RURAL HEALTH CLINIC II       0.721927         88.02       08803       RURAL HEALTH CLINIC III       0.694474         88.03       08802       RURAL HEALTH CLINIC IV       0.00000         88.03       08000       CLINIC       1.207662         90.00       09000       CLINIC       0.00000         90.01       09001       PAIN MANAGEMENT       0.00000         90.02       WUND CARE       0.315638       90.02	67.00	06700 OCCUPATI ONAL THERAPY	0. 294647				67.00
72.00         07200         IMPL. DEV. CHARGED TO PATIENT         0.966745         72.00         73.00           07300         DRUGS CHARGED TO PATIENTS         0.215096         73.00         73.00           0UTPATIENT SERVICE COST CENTERS         0.215096         88.00         88.00         88.00           88.00         08800         RURAL HEALTH CLINIC         0.943142         88.00           88.01         08801         RURAL HEALTH CLINIC II         0.721927         88.01           88.02         08803         RURAL HEALTH CLINIC III         0.694474         88.02           88.03         08802         RURAL HEALTH CLINIC IV         0.000000         88.03           90.00         09000         CLINIC         1.207662         90.00           90.01         09001         PAIN MANAGEMENT         0.00000         90.01           90.02         WUND CARE         0.315638         90.02         90.02	68.00	06800 SPEECH PATHOLOGY					68.00
73.00         DRUGS CHARGED TO PATIENTS         0.215096         73.00           OUTPATIENT SERVICE COST CENTERS         0.000         0.000         RURAL HEALTH CLINIC         0.000         88.00         88.00         88.00         88.00         88.00         88.00         88.01         0.8800         RURAL HEALTH CLINIC         0.000         88.01         88.00         88.01         88.01         88.01         88.01         88.01         88.01         88.01         88.01         88.01         88.01         88.01         88.01         88.01         88.02         88.03         88.02         88.03         88.02         88.03         90.00         0.00000         88.03         88.03         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.01         90.01         90.01         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02         90.02	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 205783				71.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0.943142         88.00           88.01         08801         RURAL HEALTH CLINIC         0.721927         88.01           88.02         08803         RURAL HEALTH CLINIC III         0.694474         88.02           88.03         08802         RURAL HEALTH CLINIC IV         0.000000         88.03           90.00         09000 CLINIC         1.207662         90.00           90.01         09001 PAIN MANAGEMENT         0.000000         90.01           90.02         WOUND CARE         0.315638         90.02	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 966745				72.00
88.00       08800       RURAL HEALTH CLINIC       0.943142       88.00         88.01       08801       RURAL HEALTH CLINIC II       0.721927       88.01         88.02       08803       RURAL HEALTH CLINIC III       0.694474       88.02         88.03       08802       RURAL HEALTH CLINIC IV       0.000000       88.03         90.00       09000       CLINIC       1.207662       90.00         90.01       09001       PAIN MANAGEMENT       0.000000       90.01         90.02       WOUND CARE       0.315638       90.02	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 215096				73.00
88. 01       08801       RURAL HEALTH CLINIC II       0.721927       88.01         88. 02       08803       RURAL HEALTH CLINIC III       0.694474       88.02         88. 03       08802       RURAL HEALTH CLINIC IV       0.000000       88.03         90. 00       09000       CLINIC       1.207662       90.00         90. 01       09001       PAIN MANAGEMENT       0.000000       90.01         90. 02       WOUND CARE       0.315638       90.02		OUTPATIENT SERVICE COST CENTERS					
88.02         08803         RURAL HEALTH CLINICIII         0.694474         88.02           88.03         08802         RURAL HEALTH CLINICIV         0.00000         88.03           90.00         09000         CLINIC         1.207662         90.00           90.01         09001         PAIN MANAGEMENT         0.000000         90.01           90.02         09002         WUND CARE         0.315638         90.02	88.00	08800 RURAL HEALTH CLINIC	0. 943142				88.00
88.03         08802         RURAL HEALTH CLINIC IV         0.000000         88.03           90.00         09000         CLINIC         1.207662         90.00           90.01         09001         PAIN MANAGEMENT         0.000000         90.01           90.02         09002         WOUND CARE         0.315638         90.02	88.01	08801 RURAL HEALTH CLINIC II	0. 721927				88.01
90.00         09000         CLINIC         1.207662         90.00           90.01         09001         PAIN MANAGEMENT         0.000000         90.01           90.02         09002         WOUND CARE         0.315638         90.02	88. 02	08803 RURAL HEALTH CLINIC III	0. 694474				88.02
90. 01         09001         PALN MANAGEMENT         0. 000000         90. 01           90. 02         09002         WOUND CARE         0. 315638         90. 02	88.03	08802 RURAL HEALTH CLINIC IV	0. 000000				88.03
90. 02 09002 WOUND CARE 0. 315638 90. 02	90.00	09000 CLINIC	1. 207662				90.00
	90.01	09001 PALN MANAGEMENT	0. 000000				90.01
	90.02	09002 WOUND CARE	0. 315638				90.02
90. 03 10900310KTH0PEDIC CLINIC   0. 195641  90. 03	90.03	09003 ORTHOPEDIC CLINIC	0. 195641				90.03
91.00 09100 EMERGENCY 0.492484 91.00	91.00	09100 EMERGENCY	0. 492484				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 1. 588889 92. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 588889				92.00
OTHER REIMBURSABLE COST CENTERS		OTHER REIMBURSABLE COST CENTERS	· ·				1
95. 00 09500 AMBULANCE SERVICES 0. 434289 95. 00	95.00	09500 AMBULANCE SERVI CES	0. 434289				95.00
SPECIAL PURPOSE COST CENTERS		SPECIAL PURPOSE COST CENTERS	· ·				1
113.00 11300 I NTEREST EXPENSE 113.00	113.00	11300 INTEREST EXPENSE					113.00
116.00 11600 HOSPI CE 116.00	116.00	11600 HOSPI CE					116.00
200.00 Subtotal (see instructions) 200.00	200.00	Subtotal (see instructions)					200.00
201.00 Less Observation Beds 201.00	201.00	Less Observation Beds					201.00
202.00 Total (see instructions) 202.00	202.00	Total (see instructions)					202.00

	ancial Systems	PERRY COUNTY				u of Form CMS-	2552-10
	N OF OUTPATIENT SERVICE COST TO CHARGE R/ FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part II Date/Time Pre 6/11/2021 11:	pared: 56 am
			Ti tl	e XIX	Hospi tal	PPS	_
	Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	1					
50.00 0500	DO OPERATING ROOM	1, 957, 753	570, 263	1, 387, 49	90 0	0	
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	262, 063	135, 869	126, 19	94 0	0	52.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	2, 142, 417	308, 579	1, 833, 83	38 0	0	54.00
60.00 0600	DO LABORATORY	2, 876, 390	160, 312	2, 716, 0	78 0	0	60.00
62.00 0620	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	88, 136	1, 313	86, 82	23 0	0	62.00
65.00 0650	00 RESPI RATORY THERAPY	1, 205, 706	190, 963	1, 014, 74	43 0	0	65.00
66.00 0660	0 PHYSI CAL THERAPY	964, 264	99, 080	865, 18	34 0	0	66.00
67.00 0670	OOOCCUPATIONAL THERAPY	303, 075	40, 805	262, 2	70 0	0	67.00
68.00 0680	DO SPEECH PATHOLOGY	157, 993	22, 217	135, 7	76 0	0	68.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	826, 405	12, 288	814, 1	17 0	0	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENT	124, 741	1,855	122, 88	36 0	0	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	2, 841, 851	104, 415	2, 737, 43	36 0	0	73.00
OUTP	PATIENT SERVICE COST CENTERS						1
88.00 0880	DO RURAL HEALTH CLINIC	3, 899, 609	60, 643	3, 838, 90	66 0	0	1 88. 00
88.01 0880	DI RURAL HEALTH CLINIC II	1, 150, 165	17, 816	1, 132, 34	49 0	0	88.01
88. 02 0880	3 RURAL HEALTH CLINIC III	336, 753	5, 243			0	88. 02
88. 03 0880	2 RURAL HEALTH CLINIC IV	0	C		0 0	0	88.03
90.00 0900	DOCLINIC	1, 100, 760	221, 094	879, 60	56 0	0	90.00
90.01 0900	D1 PALN MANAGEMENT	0	C		0 0	0	90.01
90. 02 0900	2 WOUND CARE	567, 421	73, 955	493, 40	56 0	0	90.02
90. 03 0900	03 ORTHOPEDIC CLINIC	114, 475	1, 797			0	90.03
	DO EMERGENCY	3, 829, 298				0	
	OO OBSERVATION BEDS (NON-DISTINCT PART)	1, 156, 139				0	
	R REIMBURSABLE COST CENTERS			.,	·	-	
	DO AMBULANCE SERVICES	1, 719, 946	213, 087	1, 506, 8	59 0	0	95.00
	CIAL PURPOSE COST CENTERS		,	, .,,		-	1
	DO INTEREST EXPENSE						1113. OC
116.00 1160		0	c c		0 0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	27, 625, 360	2, 743, 472	24, 881, 88			200.00
201.00	Less Observation Beds	1, 156, 139					201.00
202.00	Total (line 200 minus line 201)	26, 469, 221					202.00

ealth Financial Systems ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE EDUCTIONS FOR MEDICAID ONLY	PERRY COUNTY RATIOS NET OF		CN: 15-1322	Period: From 01/01/2020 To 12/31/2020		epared:
		Ti †I	e XIX	Hospi tal	PPS	00 411
Cost Center Description	Cost Net of	Total Charges				
		(Worksheet C,				
	Operating Cost					
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
0. 00 05000 OPERATI NG ROOM	1, 957, 753	6, 414, 145	0. 3052	24		50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	262,063			50		52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 142, 417	17, 379, 318	0. 1232	74		54.0
0. 00 06000 LABORATORY	2, 876, 390	17, 813, 066	0. 1614	76		60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	88, 136	279, 780	0. 3150	19		62. C
5. 00 06500 RESPI RATORY THERAPY	1, 205, 706	3, 145, 938	0. 3832	58		65.0
6. 00 06600 PHYSI CAL THERAPY	964, 264	2, 632, 066	0. 3663	53		66.0
7.00 06700 OCCUPATI ONAL THERAPY	303, 075	1, 028, 603	0. 2946	47		67.0
8.00 06800 SPEECH PATHOLOGY	157, 993			68		68.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	826, 405	4, 015, 905	0. 2057	83		71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	124, 741	129,032	0. 9667	45		72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	2, 841, 851	13, 212, 005	0. 2150	96		73.0
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC	3, 899, 609	4, 134, 701	0. 9431	42		88. 0
8.01 08801 RURAL HEALTH CLINIC II	1, 150, 165	1, 593, 187	0. 7219	27		88.0
8.02 08803 RURAL HEALTH CLINIC III	336, 753	484, 904	0. 6944	74		88.0
8.03 08802 RURAL HEALTH CLINIC IV	0	0	0.0000	00		88.0
0. 00 09000 CLINIC	1, 100, 760	911, 480	1. 2076	62		90.0
0. 01 09001 PALN MANAGEMENT	0	0	0.0000	00		90.0
0. 02 09002 WOUND CARE	567, 421	1, 797, 695	0. 3156	38		90.0
0. 03 09003 ORTHOPEDIC CLINIC	114, 475	585, 127	0. 1956	41		90.0
1.00 09100 EMERGENCY	3, 829, 298	7, 775, 480	0. 4924	84		91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 156, 139	727, 640	1. 5888	89		92.0
OTHER REIMBURSABLE COST CENTERS						
5. 00 09500 AMBULANCE SERVICES	1, 719, 946	3, 960, 372	0. 4342	89		95.0
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						113. 0
16. 00 11600 HOSPI CE	0		0.0000	00		116. (
00.00 Subtotal (sum of lines 50 thru 199)	27, 625, 360	89, 038, 516	,			200. 0
01.00 Less Observation Beds	1, 156, 139					201.0
02.00 Total (line 200 minus line 201)	26, 469, 221	89, 038, 516				202.0

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Pre 6/11/2021 11:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		-	1	1		
50.00 05000 OPERATI NG ROOM	570, 263					
52.00 05200 DELIVERY ROOM & LABOR ROOM	135, 869	617, 855	0. 21990	04 6, 192	1, 362	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	308, 579	17, 379, 318				54.00
60. 00 06000 LABORATORY	160, 312					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 313					62.00
65. 00 06500 RESPI RATORY THERAPY	190, 963	3, 145, 938	0.06070	436, 816	26, 515	65.00
66. 00 06600 PHYSI CAL THERAPY	99, 080		0. 03764	3 157, 700	5, 936	66.00
67.00 06700 OCCUPATI ONAL THERAPY	40, 805	1, 028, 603	0. 0396	70 102, 509	4, 067	67.00
68.00 06800 SPEECH PATHOLOGY	22, 217	400, 217	0. 0555	2 35, 703	1, 982	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 288	4, 015, 905	0.00306	568, 377	1, 739	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,855	129, 032	0.0143	76 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	104, 415	13, 212, 005	0.00790	1, 638, 382	12, 948	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	60, 643	4, 134, 701	0. 01466	07 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	17, 816	1, 593, 187	0. 01118	33 0	0	88. 01
88.02 08803 RURAL HEALTH CLINIC III	5, 243	484, 904	0. 0108	2 0	0	88. 02
88.03 08802 RURAL HEALTH CLINIC IV	0	0	0.0000	0 0	0	88. 03
90. 00 09000 CLINIC	221,094	911, 480	0. 24250	34, 499	8, 368	90.00
90. 01 09001 PALN MANAGEMENT	0	0	0.0000	0 0	0	90.01
90. 02 09002 WOUND CARE	73, 955	1, 797, 695	0. 04113	9, 823	404	90.02
90. 03 09003 ORTHOPEDIC CLINIC	1, 797	585, 127	0.0030	/1 0	0	90.03
91.00 09100 EMERGENCY	357,051	7, 775, 480	0. 04592	18, 878	867	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	144, 827	727, 640	0. 19903	3, 856	767	92.00
OTHER REIMBURSABLE COST CENTERS			•			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)	2, 530, 385	85, 078, 144		4, 298, 115	90, 081	200. 00

Heal th	Financial Systems	/ HOSPI TAL		In Lieu of Form		2552-10	
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PASS	S Provider C		Period: From 01/01/2020 To 12/31/2020		
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C	)	0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	0	C		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	C	)	0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C	)	0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	C		0 0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	C		0 0	0	88.01
88. 02	08803 RURAL HEALTH CLINIC III	0	C		0 0	0	88. 02
88.03	08802 RURAL HEALTH CLINIC IV	0	C		0 0	0	88.03
90,00	09000 CLI NI C	0	C		0 0	0	90,00
90.01	09001 PALN MANAGEMENT	0	C		0 0	0	90, 01
90.02	09002 WOUND CARE	0	C		0 0	0	90.02
90.03	09003 ORTHOPEDI C CLINI C	0	C		0 0	0	90.03
91.00	09100 EMERGENCY	0	C		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	) Total (lines 50 through 199)	0	C		0 0	0	200.00
							•

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	S Provider C	Provider CCN: 15-1322		Worksheet D	
THROUGH COSTS				From 01/01/2020		norod.
				To 12/31/2020	Date/Time Pre 6/11/2021 11:	pareu: 56 am
		Title	XVIII	Hospi tal	Cost	<u></u>
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	-	-	1			
50. 00 05000 OPERATING ROOM	0	0		0 6, 414, 145		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 617, 855		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 17, 379, 318		
60. 00 06000 LABORATORY	0	0		0 17, 813, 066		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 279, 780		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 3, 145, 938		1
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 632, 066		1
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 028, 603		
68.00 06800 SPEECH PATHOLOGY	0	0		0 400, 217		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 4, 015, 905		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 129, 032		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 212, 005	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS	1	1			1	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 4, 134, 701	0. 000000	
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 1, 593, 187		
88.02 08803 RURAL HEALTH CLINIC III	0	0		0 484, 904		
88.03 08802 RURAL HEALTH CLINIC IV	0	0		0 0	0. 000000	
90. 00 09000 CLINIC	0	0		0 911, 480		
90. 01 09001 PALN MANAGEMENT	0	0		0 0	0. 000000	
90. 02 09002 WOUND CARE	0	0		0 1, 797, 695		
90. 03 09003 ORTHOPEDIC CLINIC	0	0		0 585, 127		
91. 00 09100 EMERGENCY	0	0		0 7, 775, 480		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 727, 640	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS			1			
95.00 09500 AMBULANCE SERVICES	_	_				95.00
200.00  Total (lines 50 through 199)	0	0	1	0 85, 078, 144		200. 00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Period: From 01/01/2020	Worksheet D Part IV	
				To 12/31/2020	Date/Time Pre 6/11/2021 11:	pared: 56 am
		Title	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	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1		1			
50.00 05000 OPERATI NG ROOM	0. 000000	108, 655		0 0	-	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	6, 192		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	564, 192		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	597, 418		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	15, 115		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	436, 816		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	157, 700		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	102, 509		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	35, 703		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	568, 377		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 638, 382		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
88.02 08803 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88. 02
88.03 08802 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	0	88. 03
90. 00 09000 CLINIC	0. 000000	34, 499		0 0	0	90.00
90.01 09001 PALN MANAGEMENT	0. 000000	0		0 0	0	90.01
90. 02 09002 WOUND CARE	0. 000000	9, 823		0 0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	0. 000000	0		0 0	0	90.03
91.00 09100 EMERGENCY	0. 000000	18, 878		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	3, 856		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00  Total (lines 50 through 199)		4, 298, 115	l	0 0	0	200. 00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2020 To 12/31/2020	Part V Date/Time Pre	narod
				10 12/31/2020	6/11/2021 11:	
		Title	XVIII	Hospi tal	Cost	<u></u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				1		
50.00 05000 OPERATI NG ROOM	0. 305224		.,		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 424150	0			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 123274		5, 143, 87		0	54.00
60. 00 06000 LABORATORY	0. 161476	0	3, 085, 22	7 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 315019	0	85, 62	8 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 383258	0	646, 26	9 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 366353	0	634, 69	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 294647	0	149, 54	2 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 394768	0	33, 82	8 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 205783	0	650, 70	2 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 966745				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 215096	0	5, 011, 47		0	73.00
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II			1			88.01
88.02 08803 RURAL HEALTH CLINIC III			1			88.02
88.03 08802 RURAL HEALTH CLINIC IV						88.03
90. 00 09000 CLINIC	1. 207662	0	314, 04	0 0	0	90.00
90. 01 09001 PALN MANAGEMENT	0. 000000	0		0 0	0	90.01
90. 02 09002 WOUND CARE	0. 315638	0	966, 62	8 0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	0. 195641	0		0 0	0	90.03
91. 00 09100 EMERGENCY	0. 492484	0	2, 135, 35	3 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 588889	0	280, 27	7 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 434289			0		95.00
200.00 Subtotal (see instructions)		0	20, 369, 03	3 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	20, 369, 03	3 0	0	202.00

Heal th	Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 6/11/2021 11:	
			Title	XVIII	Hospi tal	Cost	
		Cos	sts		· · · · ·		
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
		6.00	7.00				
/	ANCILLARY SERVICE COST CENTERS						
50.00         52.00           52.00         60.00           62.00         65.00           65.00         66.00           67.00         68.00           71.00         72.00           73.00         6	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	358, 743 205 634, 105 498, 190 26, 974 247, 688 232, 521 44, 062 13, 354 133, 903 53, 821 1, 077, 949					50.00 52.00 54.00 60.00 62.00 65.00 66.00 67.00 68.00 71.00 72.00 73.00
88. 01 88. 02 88. 03 90. 00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08803 RURAL HEALTH CLINIC III 08802 RURAL HEALTH CLINIC IV 09000 CLINIC 09001 PAIN MANAGEMENT	379, 254 0	0				88. 00 88. 01 88. 02 88. 03 90. 00 90. 01
90.03	09002 WOUND CARE 09003 ORTHOPEDIC CLINIC 09100 EMERGENCY	305, 105 0 1, 051, 627	0 0 0	-			90. 02 90. 03 91. 00
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	445, 329	0				91.00
95.00 200.00 201.00	09500 AMBULANCE SERVICES Subtotal (see instructions) Less PBP Clinic Lab. Services-Program Only Charges	0 5, 502, 830 0	0				95.00 200.00 201.00
202.00	Net Charges (line 200 - line 201)	5, 502, 830	0				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP						2552-10
AFFORTIONMENT OF THEATTENT ROOTINE SERVICE CAT	TAL COSTS	Provider CC		Peri od:	Worksheet D	
				From 01/01/2020		
			· · · · · · · · · · · · · · · · · · ·	To 12/31/2020		
					6/11/2021 11:5	<u>36 am</u>
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	1
	(from Wkst. B,		Related Cost			1
	Part II, col.	/	(col. 1 - col.		(	
	26)	/	2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 ADULTS & PEDIATRICS	1, 102, 862	297, 724	4 805, 138	8 2, 485	324.00	30.00
31.00 INTENSIVE CARE UNIT	О		1	0 0	0.00	31.00
43.00 NURSERY	30, 777	1	30, 77	7 121		•
200.00 Total (lines 30 through 199)	1, 133, 639	1	835, 915		1	200.00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				1
		Capital Cost				
		(col. 5 x col.				1
		6)				
	6.00	7.00	1			1
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	41	13, 284				30.00
31.00 INTENSIVE CARE UNIT	o	0'			ļ	31.00
43.00 NURSERY	6	1, 526	1		1	43.00
200.00 Total (lines 30 through 199)	47	14, 810			ļ	200.00

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Pre 6/11/2021 11:	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1	1	-	
50.00 05000 OPERATI NG ROOM	570, 263					
52.00 05200 DELIVERY ROOM & LABOR ROOM	135, 869					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	308, 579					54.00
60. 00 06000 LABORATORY	160, 312					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 313				27	62.00
65. 00 06500 RESPI RATORY THERAPY	190, 963				2, 452	65.00
66. 00 06600 PHYSI CAL THERAPY	99, 080		0. 03764	4, 848	182	66.00
67.00 06700 OCCUPATI ONAL THERAPY	40, 805	1, 028, 603	0. 03967	70 1, 519	60	67.00
68.00 06800 SPEECH PATHOLOGY	22, 217	400, 217	0. 05551	2 453	25	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 288	4, 015, 905	0.00306	0 159, 028	487	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 855	129, 032	0. 01437	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	104, 415	13, 212, 005	0.00790	248, 359	1, 963	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	60, 643	4, 134, 701	0. 01466	07 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	17, 816	1, 593, 187	0. 01118	33 0	0	88. 01
88.02 08803 RURAL HEALTH CLINIC III	5, 243	484, 904	0. 01081	2 0	0	88. 02
88.03 08802 RURAL HEALTH CLINIC IV	0	0	0.00000	0 0	0	88.03
90. 00 09000 CLINIC	221, 094	911, 480	0. 24256	24, 111	5, 849	90.00
90. 01 09001 PALN MANAGEMENT	0	0	0.00000	0 0	0	90.01
90. 02 09002 WOUND CARE	73, 955	1, 797, 695	0.04113	9, 692	399	90.02
90. 03 09003 ORTHOPEDIC CLINIC	1, 797	585, 127	0. 00307	/1 0	0	90.03
91.00 09100 EMERGENCY	357,051	7, 775, 480	0. 04592	73, 328	3, 367	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	144, 827	727, 640	0. 19903	11,065	2, 202	92.00
OTHER REI MBURSABLE COST CENTERS	· · ·	•				
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 530, 385	85, 078, 144		1, 380, 287	89, 807	200. 00

Health Financial Systems	PERRY COUNTY H	IOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	IER PASS THROUGH COSTS	Provider C		Period: From 01/01/2020 Fo 12/31/2020	Date/Time Pre 6/11/2021 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng School Nu Post-Stepdown Adj ustments 1A	rsing School	Allied Health Post-Stepdowr Adjustments 2A	Cost	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2/1	2.00	0.00	
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	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 (s Amount (see 1 instructions) mi	Fotal Costs sum of cols. through 3, nus 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	000000000000000000000000000000000000000	2, 48 12 2, 60	0.00 1 0.00	0	30.00 31.00 43.00 200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		2,00	-1		
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         INTENSI VE CARE UNI T           43. 00         04300         NURSERY           200. 00         Total (lines 30 through 199)	0 0 0 0					30. 00 31. 00 43. 00 200. 00

Health Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 6/11/2021 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown	-	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS			_			
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66,00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ċ		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	Ċ		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	Ċ		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	-	-	1	-	-	
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	C		0 0	0	88.01
88.02 08803 RURAL HEALTH CLINIC III	0	C		0 0	0	88.02
88.03 08802 RURAL HEALTH CLINIC IV	0	C		0 0	0	88.03
90. 00 09000 CLINIC	0	C		0 0	0	90.00
90. 01 09001 PALN MANAGEMENT	0	C		0 0	0	90.01
90. 02 09002 WOUND CARE	0	C		0 0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	0			0 0	0	90.03
91. 00 09100 EMERGENCY	0			0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-	<u> </u>	1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00
			I	-		

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C	CN: 15-1322	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	6/11/2021 11:	56 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				<u> </u>	0.00000	
50.00 05000 OPERATING ROOM	0	0		0 6, 414, 145		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 617, 855		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 17, 379, 318		
60. 00 06000 LABORATORY	0	0		0 17, 813, 066		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 279, 780		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 3, 145, 938		
66.00 06600 PHYSI CAL THERAPY	0	0		0 2, 632, 066		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 028, 603		
68.00 06800 SPEECH PATHOLOGY	0	0		0 400, 217		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 4, 015, 905		
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 129, 032		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 212, 005	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS	-	-				
88.00 08800 RURAL HEALTH CLINIC	0	0		0 4, 134, 701	0.000000	
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 1, 593, 187		
88.02 08803 RURAL HEALTH CLINIC III	0	0		0 484, 904		
88.03 08802 RURAL HEALTH CLINIC IV	0	0		0 0	0.000000	
90. 00 09000 CLINIC	0	0		0 911, 480		
90. 01 09001 PALN MANAGEMENT	0	0		0 0	0. 000000	
90. 02 09002 WOUND CARE	0	0		0 1, 797, 695		
90. 03 09003 ORTHOPEDIC CLINIC	0	0		0 585, 127		
91.00 09100 EMERGENCY	0	0		0 7, 775, 480		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0		0 727, 640	0.000000	92.00
OTHER REI MBURSABLE COST CENTERS						0.5.05
95.00 09500 AMBULANCE SERVICES		_		0 05 070 1		95.00
200.00  Total (lines 50 through 199)	0	0	l	0 85, 078, 144		200. 00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C		Period: From 01/01/2020	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2020	Date/Time Pre	pared:
				11	6/11/2021 11:	56 am
Cast Castas Description	Outrationt		e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	charges	Costs (col.		Costs (col. 9	
	7)		x  col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	7.00	10.00	11.00	12.00	10.00	
50. 00 05000 OPERATI NG ROOM	0, 000000	374, 939		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	164, 284		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	110, 799		0 0	0	54.00
60. 00 06000 LABORATORY	0.000000	151,650		0 0	0	60,00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	5, 811		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	40, 401		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	4, 848		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 519		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	453		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	159, 028		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	248, 359		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
88.02 08803 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88. 02
88.03 08802 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	0	88. 03
90. 00 09000 CLINIC	0. 000000	24, 111		0 0	0	90.00
90. 01 09001 PALN MANAGEMENT	0. 000000	0		0 0	0	90.01
90. 02 09002 WOUND CARE	0. 000000	9, 692		0 0	0	90. 02
90. 03 09003 ORTHOPEDIC CLINIC	0. 000000	0		0 0	0	90.03
91. 00 09100 EMERGENCY	0. 000000	73, 328		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	11, 065		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	т — т		1	1		
95. 00 09500 AMBULANCE SERVICES				-	_	95.00
200.00  Total (lines 50 through 199)		1, 380, 287	l	0 0	0	200.00

Health Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2020 To 12/31/2020	Part V Date/Time Pre	narod
				10 12/31/2020	6/11/2021 11:	
		Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.005004		700.47	7	0	50.00
50. 00 05000 OPERATING ROOM	0. 305224		798, 47		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 424150	0	27,43		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 123274	0	1, 876, 40		0	54.00
	0. 161476		1, 839, 69		0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 315019		13, 88		0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 383258		172, 03		0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0. 366353	0	219, 66		0	66.00 67.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0. 294647 0. 394768	0	57, 16 34, 36		0	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 205783		436, 03		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 205785				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENT	0. 988745				0	72.00
OUTPATIENT SERVICE COST CENTERS	0.215090	0	050,25	0 0	0	73.00
88. 00 08800 RURAL HEALTH CLINIC						88.00
88. 01 08801 RURAL HEALTH CLINIC II						88.01
88. 02 08803 RURAL HEALTH CLINIC III						88.02
88. 03 08802 RURAL HEALTH CLINIC IV						88.03
90. 00 09000 CLINIC	1. 207662	0	89,06	7 0	0	90.00
90. 01 09001 PALN MANAGEMENT	0, 000000			0 0	0	90.01
90. 02 09002 WOUND CARE	0. 315638	0	102, 18	3 0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	0. 195641	0		0 0	0	90.03
91.00 09100 EMERGENCY	0. 492484	0	1, 100, 73	9 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.588889	0	57,77	5 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0. 434289	0	I	0		95.00
200.00 Subtotal (see instructions)		0	7, 480, 02	5 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	7, 480, 02	5 0	0	202.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	-2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-1322	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pro 6/11/2021 11:	epared: 56 am
			Titl	e XIX	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCI LLARY SERVICE COST CENTERS	-1					
	05000 OPERATING ROOM	243, 714		1			50.00
	05200 DELIVERY ROOM & LABOR ROOM	11, 636	0				52.00
	05400 RADI OLOGY-DI AGNOSTI C	231, 311	0				54.00
	06000 LABORATORY	297,066	0				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4, 374	0				62.00
65.00	06500 RESPI RATORY THERAPY	65, 935	0				65.00
66.00	06600 PHYSI CAL THERAPY	80, 476	0				66.00
67.00	06700 OCCUPATIONAL THERAPY	16, 842	0				67.00
68.00	06800 SPEECH PATHOLOGY	13, 565	0				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	89, 728	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	4, 703	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	139, 866	0				73.00
	OUTPATIENT SERVICE COST CENTERS		•				
88.00	08800 RURAL HEALTH CLINIC						88.00
88. 01	08801 RURAL HEALTH CLINIC II						88.01
88. 02	08803 RURAL HEALTH CLINIC III						88. 02
88. 03	08802 RURAL HEALTH CLINIC IV						88.03
90.00	09000 CLINIC	107, 563	0				90.00
90. 01	09001 PALN MANAGEMENT	0	0				90.01
90. 02	09002 WOUND CARE	32, 253	0				90.02
90.03	09003 ORTHOPEDIC CLINIC	0	0				90.03
91.00	09100 EMERGENCY	542,096	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	91, 798	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0					95.00
200.00		1, 972, 926	0				200.00
201.00		0					201.00
	Only Charges						
202.00	3 0	1, 972, 926	o				202.00

	Financial Systems PERRY COUNTY H ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1322	Period: From 01/01/2020	u of Form CMS-2 Worksheet D-1	
			To 12/31/2020	Date/Time Prep 6/11/2021 11:	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	INPATIENT DAYS			2 ( 22	
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-			3, 622 2, 485	
00	Private room days (excluding swing-bed and observation bed day	5,	rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	od dave)		2, 038	4
00	Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	2,038	
	reporting period		04 6 4		
00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	232	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m dave) after December 3	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	in days) arter becember s	of the cost	0	
00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	1, 147	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	room days)	905	10
	through December 31 of the cost reporting period (see instruct	tions)	5,		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XL		e room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XL	V oply (including privat	o room dave)	0	13
00	after December 31 of the cost reporting period (if calendar ye			0	
00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost		17
. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18
00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	155.02	19
00	reporting period			455 00	
00	Medicaid rate for swing-bed NF services applicable to services reporting period	S after December 31 of 1	ine cost	155.02	20
. 00	Total general inpatient routine service cost (see instructions			8, 804, 006	
. 00	Swing-bed cost applicable to SNF type services through December $5 \times 10^{-10}$	er 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	35, 965	2/
	7 x line 19)		0 1 1	55, 705	
. 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	Total swing-bed cost (see instructions)			2, 376, 693	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 427, 313	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28
00	Private room charges (excluding swing-bed charges)		5 /	0	29
	Semi -private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(coo instruc	stions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin			0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0.00	36
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	6, 427, 313	
. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
. 00					4
. 00		JSTMENTS			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			2, 586. 44	38
. 00 . 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	instructions) 38)		2, 586. 44 2, 966, 647 0	39

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1322	Peri od:	Worksheet D-1	l
					From 01/01/2020 To 12/31/2020		epare
			T: +1 a	XVIIII		6/11/2021 11:	
	Cost Center Description	Total	Total	XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Costlr		Diem (col. 1		(col. 3 x col.	
		1.00		<u>col.2)</u>	4.00	4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 0	5.00	42.
. 00	Intensive Care Type Inpatient Hospital Units	<u> </u>	0	0.	00 0	0	7 72.
. 00	INTENSIVE CARE UNIT	0	0	0.	00 00	0	
. 00	CORONARY CARE UNIT						44.
5.00 5.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1.00 1,005,615	48.
	Total Program inpatient costs (sum of lines			ns)		3, 972, 262	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	0	50.
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillarv	services (fr	om Wkst. D.	sum of Parts II	0	51.
	and IV)					_	
2.00	Total Program excludable cost (sum of lines					0	
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line 4		ated, non-phy	sician anesti	netist, and	0	53.
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	aet amount (l	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	ing obser and rang	got amount (i			0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996, u	pdated and c	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year o	cost report und	ated by the m	arket basket		0.00	60
1.00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% o ⁻	f the target		
2.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.
	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	·	·				
1.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Deceml	ber 31 of the	cost report	ng period (See	2, 340, 728	64.
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportin	a period (See	0	65.
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 64	4 plus line 6	5)(title XVI	ll only). For	2, 340, 728	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through I	December 31 d	f the cost r	eporting period	0	67.
	(line 12 x line 19)	0				_	
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost rep	orting period	0	68.
9 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (	routine costs (li	ine 67 + line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU						
. 00	Skilled nursing facility/other nursing facil	5			)		70
. 00 . 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71
. 00	Medically necessary private room cost application	·	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv	0	•				74
5.00	Capital-related cost allocated to inpatient	routine service (	costs (from W	orksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu						78
. 00 . 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· · ·		,	nus line 70)		79 80
. 00	Inpatient routine service cost per diem limi				103 THE /7)		81
. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82
. 00	Reasonable inpatient routine service costs (		)				83
. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		5)				84
. 00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<u> </u>				
1.00	Total observation bed days (see instructions					447 2, 586. 44	
3.00	Adjusted general inpatient routine cost per o						

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	Cost	
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	1, 102, 862	8, 804, 006	0. 12526	8 1, 156, 139	144, 827	90.00
91.00 Nursing School cost	0	8, 804, 006	0.00000	0 1, 156, 139	0	91.00
92.00 Allied health cost	0	8, 804, 006	0.00000	0 1, 156, 139	0	92.00
93.00 All other Medical Education	0	8, 804, 006	0.00000	0 1, 156, 139	0	93.00

	ATION OF INPATIENT OPERATING COST Provider CCN: 15-1322 Period: From 01/01/2020	u of Form CMS-2 Worksheet D-1	
	To         12/31/2020           Title XIX         Hospital	Date/Time Prep 6/11/2021 11:5 PPS	
	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 622	1.
. 00 . 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	2, 485 0	2. 3.
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	2, 038	4.
00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	905	5.
00	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)	0	6.
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	232	7.
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)	0	8
00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	41	9
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	905	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	232	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13
	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0 121	14 15
	Nursery days (title V or XIX only)	6	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17
. 00	5 11		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	155.02	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.02	20
	Total general inpatient routine service cost (see instructions)	8, 804, 006	
	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22
	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	
	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	35, 965	
5.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2, 376, 693 6, 427, 313	
2 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28
	Private room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges)	0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.00000	
	Average private room per diem charge (line 29 ÷ line 3)	0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 6, 427, 313	36 37
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
7.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
7.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         Adjusted general inpatient routine service cost per diem (see instructions)	2, 586. 44	
7.00 3.00 9.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	2, 586. 44 106, 044 0	

DMPUT	TATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1322	Period: From 01/01/2020	Worksheet D-1	
					To 12/31/2020	Date/Time Pre	
			Ti tl	e XIX	Hospi tal	6/11/2021 11: PPS	<u>50</u> č
	Cost Center Description	Total Inpatient Costl	Total npatient Davs	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
00	NURSERY (title V & XIX only)	59, 362	121	490. 0			42
~ ~	Intensive Care Type Inpatient Hospital Units						
00 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	0	0.0	0 0	0	43
. 00	BURN I NTENSI VE CARE UNI T						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	Cost center bescription					1.00	
00	Program inpatient ancillary service cost (Wk					414, 003	
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ns)		522, 991	49
. 00		atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	14, 810	50
00						00.007	54
. 00	Pass through costs applicable to Program inp and IV)	atient ancillary	services (Tr	OM WKST. D, S	sum of Parts II	89, 807	51
. 00	Total Program excludable cost (sum of lines					104, 617	
. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	netist, and	418, 374	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	J∠)				I	
. 00						0	54
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	aet amount (1	ing 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	The cost and tai	get amount (i	The 50 million	Time 53)	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ending 1996, u	pdated and co	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport und	lated by the m	arkat backat		0.00	60
. 00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that	n expected costs					
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62
. 00		ent (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST					1	
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	ber 31 of the	cost reporti	ng period (See	2, 340, 728	64
. 00		ts after Decembe	er 31 of the c	ost reporting	g period (See	0	65
	instructions) (title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	64 plus line 6	5)(title XVII	l only). For	2, 340, 728	66
. 00		e costs through	December 31 o	f the cost re	eporting period	35, 965	67
~~~	(line 12 x line 19)	<del></del> D-					
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter De	cemper 31 or	the cost repo	orting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient					35, 965	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				•	[70
. 00	Adjusted general inpatient routine service c						71
. 00	5			,			72
. 00	Medically necessary private room cost applic			ne 35)			73
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		orksheet B F	Part II column		74
. 00	26, line 45)			or Roneot D, 1			
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77
00	Aggregate charges to beneficiaries for exces		ovider record	s)			79
00	Total Program routine service costs for comp				nus line 79)		80
00	Inpatient routine service cost per diem limi						81
00 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82
. 00	Program inpatient ancillary services (see in		·)				84
. 00	Utilization review - physician compensation	(see instruction					85
. 00			ough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					447	87
	Adjusted general inpatient routine cost per		line 2)			2, 586. 44	
. 00	Observation bed cost (line 87 x line 88) (se					1, 156, 139	

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		Titl	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	1, 102, 862	8, 804, 006	0. 12526	8 1, 156, 139	144, 827	90.00
91.00 Nursing School cost	0	8, 804, 006	0.00000	0 1, 156, 139	0	91.00
92.00 Allied health cost	0	8, 804, 006	0.00000	0 1, 156, 139	0	92.00
93.00 All other Medical Education	0	8, 804, 006	0. 00000			93.00

Health Financial Systems PERRY COUNTY H				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1322	Period: From 01/01/2020	Worksheet D-3	
			To 12/31/2020		pared:
				6/11/2021 11:	
	Title	<u>XVIII</u>	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	1, 874, 074		30.00
31. 00 03100 NTENSI VE CARE UNI T			1, 874, 074		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					45.00
50. 00 05000 OPERATI NG ROOM		0. 3052	24 108, 655	33, 164	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 4241			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1232			
60. 00 06000 LABORATORY		0. 1614			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 3150			
65. 00 06500 RESPI RATORY THERAPY		0. 3832			
66. 00 06600 PHYSI CAL THERAPY		0.3663	53 157, 700	57, 774	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2946	47 102, 509	30, 204	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 3947	68 35, 703	14, 094	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2057	83 568, 377	116, 962	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.9667	45 C	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2150	96 1, 638, 382	352, 409	73.00
OUTPATIENT SERVICE COST CENTERS				-	
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
88.01 08801 RURAL HEALTH CLINIC II		0.0000		0	88.0
88.02 08803 RURAL HEALTH CLINIC III		0.0000		0	88. 02
88.03 08802 RURAL HEALTH CLINIC IV		0.0000		0	
90. 00 09000 CLINIC		1. 2076			
90. 01 09001 PALN MANAGEMENT		0.0000		0 0	90.0
90. 02 09002 WOUND CARE		0. 3156			90.0
90. 03 09003 ORTHOPEDIC CLINIC		0. 1956		0	
91.00 09100 EMERGENCY		0. 4924			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		1.5888	89 3, 856	6, 127	92.00
		1		1	
95.00 09500 AMBULANCE SERVICES			4 200 115	1 005 (15	95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(lino (1)		4, 298, 115		200.00
201.00Less PBP Clinic Laboratory Services-Program only charges202.00Net charges (line 200 minus line 201)	(THE OF)		4, 298, 115		201.00
zuz. vuj jivet chalges (The zuu illinus the zut)		I	4, 290, 113	'I	1202.00

Health Financial Systems P	ERRY COUNTY HOSPITAL		In Li	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1322	Peri od:	Worksheet D-3	}
	Component	CON. 15 7000	From 01/01/2020		norod.
	Component	CCN: 15-Z322	To 12/31/2020) Date/Time Pre 6/11/2021 11:	
	Title	e XVIII	Swing Beds - SN		<u>50 alli</u>
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
		5	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			(D	30.00
31. 00 03100 I NTENSI VE CARE UNI T			(31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 3052	24 1, 598	3 488	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4241	50 0	0 0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1232			
60. 00 06000 LABORATORY		0. 1614	76 113, 389	9 18, 310	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 3150			
65. 00 06500 RESPI RATORY THERAPY		0. 3832	58 162, 246	62, 182	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3663			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2946	47 279, 589	82, 380	67.00
68.00 06800 SPEECH PATHOLOGY		0. 3947	68 59, 506	5 23, 491	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2057	83 173, 021	35, 605	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 9667		-	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2150	96 359, 518	3 77, 331	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
88.01 08801 RURAL HEALTH CLINIC II		0.0000		0	
88.02 08803 RURAL HEALTH CLINIC III		0.0000		0	
88.03 08802 RURAL HEALTH CLINIC IV		0.0000		0	
90. 00 09000 CLINIC		1. 2076		1, 418	
90. 01 09001 PALN MANAGEMENT		0.0000		0 0	
90. 02 09002 WOUND CARE		0. 3156	38 163	3 51	90.02
90. 03 09003 ORTHOPEDIC CLINIC		0. 1956		0 0	
91. 00 09100 EMERGENCY		0. 4924	84 (0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 5888	39 (0 0	92.00
OTHER REIMBURSABLE COST CENTERS				1	
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 th			1, 472, 257	7 415, 897	
201.00 Less PBP Clinic Laboratory Services-Program	n only charges (line 61)		(ן ע	201.00
202.00 Net charges (line 200 minus line 201)			1, 472, 257	7	202.00

ealth Financial Sys	SERVICE COST APPORTIONMENT	RY COUNTY HOSPITAL	CN: 15-1322	Peri od:	eu of Form CMS- Worksheet D-3	
MIATIENT ANGLEANT	SERVICE COST ALLORTIONWENT	i i ovi dei c	CN. 13-1322	From 01/01/2020		,
				To 12/31/2020) Date/Time Pre	
					6/11/2021 11:	56 am
Coot Coo			e XIX Ratio of Cos	Hospi tal	PPS	
COST CEI	ter Description		To Charges	t Inpatient Program	Inpatient Program Costs	
			TO charges	Charges	(col. 1 x col.	
				onar ges	2)	
			1.00	2.00	3.00	<u> </u>
I NPATI ENT ROUT	INE SERVICE COST CENTERS		1			
30.00 03000 ADULTS 8				247, 021		30. 0
31.00 03100 INTENSI V	E CARE UNIT			C		31.0
13.00 04300 NURSERY				5, 580		43.0
	I CE COST CENTERS					
50.00 05000 OPERATI N			0. 30522			
	ROOM & LABOR ROOM		0. 4241			
54.00 05400 RADI OLOG			0. 1232			
0.00 06000 LABORATO			0. 1614			
	OOD & PACKED RED BLOOD CELLS		0. 3150			
5. 00 06500 RESPI RAT			0. 38325			
56. 00 06600 PHYSI CAL			0. 3663			
57.00 06700 0CCUPATI			0. 29464			
8.00 06800 SPEECH F			0. 39476			
	SUPPLIES CHARGED TO PATIENTS		0. 20578			
	V. CHARGED TO PATIENT		0.96674		-	
	ARGED TO PATIENTS		0. 2150	248, 359	53, 421	73.0
	AVICE COST CENTERS		0.94314	10		
38. 00 08800 RURAL HE 38. 01 08801 RURAL HE			0. 72192			
	ALTH CLINIC III		0. 6944			
	ALTH CLINIC IV		0. 00000			
0. 00 09000 CLINIC	ALTI CLINIC IV		1. 2076			
0.01 09001 PALN MAN	ACEMENT		0. 00000		0	
0. 02 09002 WOUND CA			0. 31563			
0. 03 09003 ORTHOPED			0. 19564		0	
1.00 09100 EMERGENC			0. 49248			
	ION BEDS (NON-DISTINCT PART)		1. 58888			
	ABLE COST CENTERS		1.00000	11,000	1,,001	1 /2.0
5. 00 09500 AMBULANC						95.0
	um of lines 50 through 94 and 96 throu	uah 98)		1, 380, 287	414, 003	
	Clinic Laboratory Services-Program of			(201.0
	ges (line 200 minus line 201)	J - J - (1	1, 380, 287	,	202.0

	Financial Systems PERRY COUNTY HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-1		eu of Form CMS-2 Worksheet E	2552-10
0/12002		From 01/01/2020 To 12/31/2020	Part B	
	Title XVIII	Hospi tal	Cost	
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)		5, 502, 830 0	
3.00	OPPS payments		0	
4.00	Outlier payment (see instructions)		0	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)		0.000	
6.00	Line 2 times line 5		0	
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 2	200	0	
10.00	Organ acqui si ti ons		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES		5, 502, 830	11.00
	Reasonable charges			
	Ancillary service charges		0	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)		0	
11.00	Customary charges			11.00
15.00	Aggregate amount actually collected from patients liable for payment for service		0	
16.00	Amounts that would have been realized from patients liable for payment for servi had such payment been made in accordance with 42 CFR §413.13(e)	ces on a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	1
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 excee	de lino 11) (coo	0	
19.00	instructions)	eus IThe IT) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 excee	eds line 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)		5, 557, 858	21.00
22.00	Interns and residents (see instructions)		0	
	Cost of physicians' services in a teaching hospital (see instructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		56, 285	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of line	-	3, 485, 874 2, 015, 699	
27.00	instructions)		2,015,099	27.00
	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)		0 2, 015, 699	
31.00	Primary payer payments		137	
32.00			2, 015, 562	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		429, 385	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		279, 100	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)		290, 648 2, 294, 662	
38.00	MSP-LCC reconciliation amount from PS&R		0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	39.50 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see ir	nstructions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)		2, 294, 662 15, 145	1
40.01	Demonstration payment adjustment amount after sequestration		0	1
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00 41.01			2, 220, 897	41.00 41.01
41.01	Interim payments-PARHM Tentative settlement (for contractors use only)		0	
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)		58, 620	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 1 §115.2	5-2, chapter 1,	0	
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)		0	90.00
	Outlier reconciliation adjustment amount (see instructions)		0	
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)		0	93.00 94.00
,			1 0	1 7 1. 00

Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 Total interim payments payable on individual bills, either services rendered in the cost reporting period. If none, write "NWE" or enter a zero. 3,341,834 0 2,220,897 3.00 List speaked ty each reporting period. If none, write "NWE" or enter a zero. 3,341,834 0 2,220,897 3.01 List speaked ty each reporting period. If none, payment. If none, write "NWE" or enter a zero. 0 0 0 1.01 Drovider 0 07/13/2020 268,600 0 0 3.01 AJUSTWENTS TO PROVIDER 07/13/2020 268,600 0 0 0 3.02 A.03 0 0 0 0 0 0 3.03 A.04 0 0 0 0 0 0 0 3.04 AJUSTWENTS TO PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <th>ANALYS</th> <th>SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED</th> <th>Provider CO</th> <th></th> <th></th> <th>Worksheet E-1 Part I Date/Time Pre 6/11/2021 11:</th> <th>pared:</th>	ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO			Worksheet E-1 Part I Date/Time Pre 6/11/2021 11:	pared:
mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 Total InterIm payments paid to provider 1.00 2.00 3.00 4.00 2.00 InterIm payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NNE" or enter a zero 3.341.83 2.220.897 3.00 List separately each retroactive lung sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NOE" or enter a zero. (1) 7/13/2020 266.600 0 7.01 ADUSTMENTS TO PROVIDER 07/13/2020 266.600 0 0 3.03 ADUSTMENTS TO PROVIDER 07/13/2020 266.600 0 0 3.04 0 0 0 0 0 0 3.05 3.90 ADUSTMENTS TO PROGRAM 0 0 0 0 3.50 0 0 0 0 0 0 0 3.51 0 0 0 0 0 0 0 0 3.51 0 <th></th> <th></th> <th></th> <th></th> <th>Hospi tal</th> <th></th> <th></th>					Hospi tal		
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write 'MONE'' or enter a zero. 3.341.83 2.220.897 3.00 List separately each retroactive lump sum adjustment anount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'MONE'' or enter a zero. (1) 07/13/2020 268,600 0 0 7.01 ADJUSTMENTS TO PROVIDER 07/13/2020 268,600 0			Inpatien	t Part A	Par	rt B	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MORE" or enter a zero 3.341.83 2.220.897 3.00 List separately each retroactive lump sum adjustment anount based on subsequent revision of the Interim rate for the cost reporting period. Also show date of each payment. If none, write "NORE" or enter a zero. (1) 07/13/2020 268,600 0 7.01 ADJUSTMENTS TO PROVIDER 07/13/2020 268,600 0 0 3.03 ADJUSTMENTS TO PROGRAM 0 0 0 0 0 3.50 ADJUSTMENTS 10 PROGRAM 0 0 0 0 0 0 0 3.51 ADJUSTMENTS 10 PROGRAM 0				Amount	mm/dd/vvvv	Amount	
2.00 Interim payments payable on individual bills, either sorvices rendered in the cost reporting period. If none, write "NONE" or enter a zero. 0 0 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 Program to Provider 0 0 3.01 AJUSTMENTS TO PROVIDER 07/13/2020 268,600 0 3.03 0 0 0 0 3.03 0 0 0 0 3.04 AJUSTMENTS TO PROVIDER 0 0 0 3.05 Provider to Program 0 0 0 0 3.05 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.80) 0 0 0 0 0 0 3.51 0 </th <th></th> <th></th> <th></th> <th></th> <th></th> <th>4.00</th> <th></th>						4.00	
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 ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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, 341, 83			1.00 2.00
ADJUSTMENTS TO PROVIDER 07/13/2020 268,600 0 0 3.01 0.0 0 <td>3.00</td> <td>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)</td> <td></td> <td></td> <td></td> <td></td> <td>3.00</td>	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)					3.00
3.03 0	3. 01		07/13/2020	268, 60	00	0	3.01
3.04 0 0 0 ADJUSTMENTS TO PROGRAM 0 0 0 3.50 0 0 0 0 3.51 0 0 0 0 0 3.52 0							3. 02
3.05 — 0 0 0 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 0 3.51 0 0 0 0 0 0 3.52 0							3. 03 3. 04
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.51 0 0 0 3.52 0 0 0 0 3.53 0 0 0 0 0 3.53 0 0 0 0 0 0 3.54 0							3.04
3.51 0 0 0 3.52 0 0 0 3.53 0 0 0 3.54 0 0 0 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 268,600 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,610,434 2,220,897 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 1 1 1 To Be COMPLETED BY CONTRACTOR 0 0 0 5.00 Lis separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 1 1 0 0 Program to Provider 0 0 0 0 0 0 5.00 TENTATI VE TO PROGRAM 0	0.00	Provider to Program	L				0.00
3.52 0 0 3.53 0 0 3.54 0 0 3.754 0 0 3.54 0 0 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 1, 2, and 3.99) 3,610,434 2,220,897 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,610,434 2,220,897 (transfer to Wkst. E-or Wkst. E-3, line and column as appropriate) 1 1 TO BE COMPLETED BY CONTRACTOR 1 1 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 1 Program to Provider 0 0 5.01 TENTATIVE TO PROVIDER 0 5.02 0 0 5.03 0 0 0 5.04 50 0 0 0 5.50 50 50 0 0 0 5.50 59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.0-5.49 minus sum of lines 5.50-5.98) 0 0 5.97 Subtotal (sum of lines settlement amount (balance due) based on the cost repo		ADJUSTMENTS TO PROGRAM					3.50
3.53 0 0 0 3.54 0 0 0 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 3.610,434 2,220,897 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3.610,434 2,220,897 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 3.610,434 2,220,897 TO BE COMPLETED BY CONTRACTOR 0 0 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 0 Program to Provider 0 0 0 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 0 5.03 0 0 0 5.04 D Provider 0 0 5.05 52 0 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.00 0 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.00 0 0 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1)							3.51 3.52
3.54 0 0 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 268,600 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,610,434 2,220,897 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 0 0 TO BE COMPLETED BY CONTRACTOR 0 0 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 0 Program to Provider 0 0 0 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 0 5.03 TENTATIVE TO PROGRAM 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 6.01 SETTLEMENT TO PROGRAM 0 0 6.02 SETTLEMENT TO PROGRAM 0 0 7.00 Total Medicare program liability (see instructions) 3,701,387 2,279,517						-	3.52
3. 50-3.98) 3, 50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 3, 610, 434 2, 220, 897 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							3.54
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 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 5.00 TENTATIVE TO PROVIDER 0	3. 99			268, 60	00	0	3.99
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Image: Contractor Provider Program to Provider 0 0 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 0 7.01 TENTATIVE TO PROVIDER 0 0 5.03 0 0 0 9 Order to Program 0 0 5.50 TENTATIVE TO PROGRAM 0 0 5.51 0 0 0 5.52 0 0 0 0 5.52 0 0 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 90,953 58,620 0 6.01 SETTLEMENT TO PROVIDER 90,953 58,620 0 6.02 SETTLEMENT TO PROGRAM 0 2,279,517 0 7.00 Total Medicare program liability (see instructions) 3,701,387 Contractor NPR Date (Mo/Day	4.00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 610, 43	34	2, 220, 897	4.00
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Frond to Provider 0 5.01 TENTATIVE TO PROVIDER 0 0 0	5 00						5.00
5.01 TENTATI VE TO PROVIDER 0 0 5.02 0 0 0 5.03 0 0 0 Provider to Program 0 0 0 5.50 TENTATI VE TO PROGRAM 0 0 5.51 0 0 0 5.52 0 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 90,953 58,620 6.01 SETTLEMENT TO PROGRAM 0 0 7.00 Total Medicare program liability (see instructions) 3,701,387 2,279,517 7.00 Contractor NPR Date (Mo/Day/Yr) NPR Date (Mo/Day/Yr)	5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5.02 0 0 0 5.03 Provider to Program 0 0 5.50 TENTATI VE TO PROGRAM 0 0 5.51 0 0 0 5.52 0 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 90,953 58,620 6.01 SETTLEMENT TO PROGRAM 0 0 0 7.00 Total Medicare program liability (see instructions) 3,701,387 2,279,517	5.01				0	0	5.01
Provider to Program 5.50 TENTATIVE TO PROGRAM 5.51 5.52 0 0 5.59 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 PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 3, 701, 387 2, 279, 517					0	0	5. 02
5.50 TENTATIVE TO PROGRAM 0 0 5.51 0 0 0 5.52 0 0 0 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 90,953 58,620 6.01 SETTLEMENT TO PROVIDER 90,953 58,620 6.02 SETTLEMENT TO PROGRAM 0 0 7.00 Total Medicare program liability (see instructions) 3,701,387 2,279,517	5.03				0	0	5.03
5.51 0 0 5.52 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 6.01 SETTLEMENT TO PROVIDER 90,953 58,620 6.02 SETTLEMENT TO PROGRAM 0 0 7.00 Total Medicare program liability (see instructions) 3,701,387 2,279,517 Contractor NPR Date (Mo/Day/Yr)	5 50						5.50
5.52 0 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 0 6.01 SETTLEMENT TO PROVIDER 90,953 58,620 0 6.02 SETTLEMENT TO PROGRAM 0 0 0 7.00 Total Medicare program liability (see instructions) 3,701,387 2,279,517 Contractor NUMBER							5.5
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 3,701,387 2,279,517 Contractor NPR Date (Mo/Day/Yr)							5. 52
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)	5. 99				0	0	5.99
6.02 SETTLEMENT TO PROGRAM 0 0 0 7.00 Total Medicare program liability (see instructions) 3,701,387 2,279,517 Contractor NPR Date (Mo/Day/Yr)		the cost report. (1)					6.00
7.00 Total_Medicare_program liability (see instructions) 3,701,387 2,279,517 Contractor NUmber (Mo/Day/Yr)				90, 95	53		6.01
Contractor NPR Date Number (Mo/Day/Yr)				3 701 29	37	-	6.02 7.00
	,			1 3, 701, 30	Contractor	NPR Date	7.00
0 1.00 2.00			()	1.00	2.00	

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-1322	Period: From 01/01/2020	Worksheet E-1 Part I	
		Component (CCN: 15-Z322	To 12/31/2020		
		Title	XVIII	Swing Beds - SN	F Cost	
		I npati en	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 209, 0	64 0	0	
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER	07/13/2020	362, 0	00	0	3.0
02			, -	0	0	
03				0	0	3.
04				0	0	
05				0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.
50 51	ADJUSTINIENTS TO PROGRAM			0	0	
52				0	0	
53				0	0	3.
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		362, 0		0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 571, 0	64	0	4.
00	TO BE COMPLETED BY CONTRACTOR 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)					5.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
01				0	0	
03				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		
	5. 50-5. 98)			0		
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER		191, 0	80	0	6
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		2, 762, 1		0	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	()	1.00	2.00	8

Heal th	Financial Systems PERRY COUNT	Y HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Date/Time Pr 6/11/2021 11	epared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				
1.00	Total hospital discharges as defined in AARA §4102 from Wks		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	Bline 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168 $$	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	on (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	lline 31) (see instruction	ns)		32.00

CALCULAT	FION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Provider CCN: 15-1322 Component CCN: 15-Z322	Period: From 01/01/2020 To 12/31/2020	Worksheet E-2 Date/Time Pre 6/11/2021 11:	pared:
	Title XVIII	Swing Beds - SNF		
		Part A	Part B	
		1.00	2.00	
	OMPUTATION OF NET COST OF COVERED SERVICES	2 2(4 125	0	1 00
	npatient routine services - swing bed-SNF (see instructions)	2, 364, 135	0	1.00 2.00
	npatient routine services - swing bed-NF (see instructions) .ncillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D,	420, 056	0	3.00
	art V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see		0	3.00
	nstructions)	, 		
1	lursing and allied health payment-PARHM (see instructions)			3.0
	er diem cost for interns and residents not in approved teaching program (see		0.00	4.00
i	nstructions)			
.00 P	rogram days	905	0	5.00
	nterns and residents not in approved teaching program (see instructions)		0	6.00
	tilization review – physician compensation – SNF optional method only	0		7.00
	ubtotal (sum of lines 1 through 3 plus lines 6 and 7)	2, 784, 191	0	8.00
	rimary payer payments (see instructions)	0	0	9.00
	ubtotal (line 8 minus line 9)	2, 784, 191	0	10.00
	eductibles billed to program patients (exclude amounts applicable to physician	0	0	11.00
	rofessional services)	2, 784, 191	0	12.00
	ubtotal (line 10 minus line 11) coinsurance billed to program patients (from provider records) (exclude coinsurance	2, 784, 191	0	13.00
	or physician professional services)	3, 090	0	13.00
	0% of Part B costs (line 12 x 80%)		0	14.00
	ubtotal (see instructions)	2, 780, 495	0	15.00
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	2,,00,170	0	16.00
	vioneer ACO demonstration payment adjustment (see instructions)			16.50
	ural community hospital demonstration project (§410A Demonstration) payment	0		16.55
a	djustment (see instructions)			
6.99 D	emonstration payment adjustment amount before sequestration	0	0	16.99
	llowable bad debts (see instructions)	0	0	17.00
	djusted reimbursable bad debts (see instructions)	0	0	17.01
	llowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
	otal (see instructions)	2, 780, 495	0	19.00
	equestration adjustment (see instructions)	18, 351	0	19.01
	emonstration payment adjustment amount after sequestration) equestration adjustment-PARHM pass-throughs	0	0	19.02 19.03
	nterim payments	2, 571, 064	0	20.00
	nterim payments-PARHM	2, 371, 004	0	20.0
	entative settlement (for contractor use only)	0	0	21.00
	entative settlement-PARHM (for contractor use only)	-	-	21.01
	alance due provider/program (line 19 minus lines 19.01, 20, and 21)	191, 080	0	22.00
2. 01 B	alance due provider/program-PARHM (see instructions)			22.01
3. 00 P	rotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	0	0	23.00
	hapter 1, §115.2			
	ural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
	s this the first year of the current 5-year demonstration period under the 21st			200. 00
	entury Cures Act? Enter "Y" for yes or "N" for no.			
	ost Reimbursement ledicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line			201.00
	6 (title XVIII hospital))			201.00
	ledicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, lir	ne		202.00
	00 (title XVIII swing-bed SNF))			202.00
	otal (sum of lines 201 and 202)			203.00
04.00 M	ledicare swing-bed SNF discharges (see instructions)			204.00
C	omputation of Demonstration Target Amount Limitation (N/A in first year of the curre	ent 5-year demonst	ration	
	eri od)			
	ledicare swing-bed SNF target amount			205.00
	ledicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			007 6
1	Program reimbursement under the §410A Demonstration (see instructions)	1		207.00
	ledicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines			208.00
	nd 3) divistment to Medicare swing-bed SNE PPS payments (see instructions)			209.00
	djustment to Medicare swing-bed SNF PPS payments (see instructions) eserved for future use			209.00
	omparision of PPS versus Cost Reimbursement			12 I U. U
	otal adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see			215.00
	nstructions)	1		1

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1322	Period: From 01/01/2020	Worksheet E-3 Part V	
			To 12/31/2020		
		Title XVIII	Hospi tal	Cost	
				1.00	-
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	RE PART A SERVICES - COST		1.00	-
00	Inpatient services		KEIMBORGEMENT	3, 972, 262	1 1
00	Nursing and Allied Health Managed Care payment (see instruct	ti ons)		0	2
00	Organ acquisition			0	3
00	Subtotal (sum of lines 1 through 3)			3, 972, 262	
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 011, 985	6
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable charges Routine service charges			0	1 7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
0.00	Total reasonable charges			0	
	Customary charges				
. 00	Aggregate amount actually collected from patients liable for	r payment for services on	a charge basis	0	11
. 00	Amounts that would have been realized from patients liable f	for payment for services c	n a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.13((e)			
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
. 00	Total customary charges (see instructions)			0	
. 00	Excess of customary charges over reasonable cost (complete c	only if line 14 exceeds li	ne 6) (see	0	15
. 00	instructions) Excess of reasonable cost over customary charges (complete c	only if line 6 exceeds lin	0 14) (600	0	16
. 00	instructions)	on y i i ine o exceeds i i	14) (566	0	
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
. 00	Direct graduate medical education payments (from Worksheet E	E-4, line 49)		0	18
. 00	Cost of covered services (sum of lines 6, 17 and 18)			4, 011, 985	
. 00	Deductibles (exclude professional component)			316, 712	
. 00	Excess reasonable cost (from line 16)			0	
. 00	Subtotal (line 19 minus line 20 and 21)			3, 695, 273	
. 00	Coinsurance			0	1 -
. 00	Subtotal (line 22 minus line 23) Allowable bad debts (exclude bad debts for professional serv	(coc) (coo instructions)		3, 695, 273 47, 239	
. 00	Adjusted reimbursable bad debts (see instructions)	(see filst detfolis)		30, 705	
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		26, 532	
. 00	Subtotal (sum of lines 24 and 25, or line 26)	· · · · · · · · · · · · · · · · · · ·		3, 725, 978	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0,720,770	
. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29
. 99	Demonstration payment adjustment amount before sequestration			0	1 -
. 00	Subtotal (see instructions)			3, 725, 978	
. 01	Sequestration adjustment (see instructions)			24, 591	
. 02	Demonstration payment adjustment amount after sequestration			0	
0.03	Sequestration adjustment-PARHM			0 (10 :0;	30
. 00	Interim payments			3, 610, 434	
. 01	Interim payments-PARHM Tentative settlement (for contractor use only)			0	31
. 00 . 01	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)			0	32
. 00	Balance due provider/program (line 30 minus lines 30.01, 30.	(12, 31, and 32)		90, 953	
. 00	Balance due provider/program-PARHM (lines 2, 3, 18, and 26,		and 32,01)	70, 703	33
		dance with CMS Pub. 15-2,			34

	Financial Systems PERRY COUNTY E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2020	u of Form CMS-: Worksheet G	
y)			1	Го 12/31/2020	6/11/2021 11:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	12, 734, 144	(0	1.0
00	Temporary investments	3, 179, 496	(0	
00 00	Notes receivable Accounts receivable	12 557 492			0	
00	Other receivable	13, 557, 683 -458, 300		-	0	
00	Allowances for uncollectible notes and accounts receivable	-8, 430, 354			0	
00	Inventory	726, 796	(-	0	
00	Prepai d expenses	376, 977	(-	0	
00	Other current assets	1 920 000			0	
	Due from other funds Total current assets (sum of lines 1-10)	1, 820, 000 23, 506, 442		-	0	
00	FIXED ASSETS	23, 300, 442			0	1
00	Land	3, 815, 753	(0 0	0	12.
00	Land improvements	59, 357	(0	
	Accumulated depreciation	-11, 237, 575	(0	
	Buildings Accumulated depreciation	44, 070, 776			0	
	Leasehold improvements	-2, 739, 236			0	
	Accumulated depreciation	0			0	
	Fixed equipment	2, 418, 589	(0 0	0	
	Accumulated depreciation	-170, 349	(0	
	Automobiles and trucks	477, 834	(0	
	Accumulated depreciation	-379, 809			0	
	Major movable equipment Accumulated depreciation	17, 244, 501 -9, 482, 113			0	
	Mi nor equipment depreciable	-9,402,113			0	
	Accumulated depreciation	0	(0	
00	HIT designated Assets	0	(0 0	0	27
	Accumulated depreciation	0	0		0	
	Minor equipment-nondepreciable	0	(0	
00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	44, 077, 728	(0 0	0	30
00	Investments	0	(0 0	0	31
00	Deposits on Leases	0		0 0	0	32
00	Due from owners/officers	0	(0 0	0	
00	Other assets	0	(-	0	
00	Total other assets (sum of lines 31-34)	(7 504 170	(0	
00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	67, 584, 170	(0 0	0	36
	Accounts payable	1, 556, 849	0		0	
00	Salaries, wages, and fees payable	0	(0	
	Payroll taxes payable Notes and Loans payable (short term)	518, 654 1, 031, 010			0	
	Deferred income	1, 031, 010			0	
00	Accel erated payments	0				42
	Due to other funds	0	(0 0	0	43
	Other current liabilities	2, 283, 549			0	
00	Total current liabilities (sum of lines 37 thru 44)	5, 390, 062	(0 0	0	45
00	LONG TERM LIABILITIES Mortgage payable	0	(0 0	0	46
00	Notes payable	36, 052, 000			0	
00	Unsecured Loans	0		o o	0	
00	Other long term liabilities	0	(0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	36, 052, 000			0	
00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	41, 442, 062	(0 0	0	51
00	General fund balance	26, 142, 108				52
00	Specific purpose fund	20, 172, 100	(53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
00	Total fund balances (sum of lines 52 thru 58)	26, 142, 108	(0 0	0	59
		,, . 00	i v		0	1 2 /

Heal th F	inancial Systems	PERRY COUNTY	HOSPI TAL			In Lie	u of Form CMS-	2552-10
	NT OF CHANGES IN FUND BALANCES		Provider CC		Fro To	riod: om 01/01/2020 12/31/2020	Worksheet G- Date/Time Pro 6/11/2021 11	epared: 56 am
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	i
						4.00	5.00	
1.00 F	Fund balances at beginning of period	1.00	2.00 23,064,288	3.00		4.00	5.00	1.00
2.00 N 3.00 T 4.00 F 5.00 6.00 7.00 8.00 9.00 10.00 T 11.00 S	Vet income (loss) (from Wkst. G-3, line 29) Fotal (sum of line 1 and line 2) FREE STANDING HOME HEALTH Fotal additions (sum of line 4–9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	588, 397 0 0 0 0 0 0 0 0 0	2, 489, 423 25, 553, 711 588, 397 26, 142, 108			0 0 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
15.00 16.00 17.00 18.00 19.00	Fotal deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	00000	0 26, 142, 108		0 0 0	0	()) 15.00) 16.00
		Endowment Fund	PI ant	Fund				
1 00 1		6.00	7.00	8.00				
2.00 M 3.00 T	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TREE STANDING HOME HEALTH	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 1 11.00 5 12.00 1 13.00 1 14.00 15.00 16.00 17.00 18.00 1 19.00 F	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0 0		0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

FEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet G-2 Parts I & II Date/Time Pre 6/11/2021 11:	epare
Cost Center Description		I npati ent	Outpati ent	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					-
General Inpatient Routine Services		F (00.0)	2	E (00 007	
) Hospital		5, 620, 33	37	5, 620, 337	
SUBPROVIDER - I PF					2
SUBPROVIDER - IRF					3
SUBPROVIDER				0	4
) Swing bed - SNF			0	0	
) Swing bed - NF			0	0	
) SKILLED NURSING FACILITY NURSING FACILITY					7
O OTHER LONG TERM CARE					9
	0)	5, 620, 33	7	5, 620, 337	
00 Total general inpatient care services (sum of lines 1- Intensive Care Type Inpatient Hospital Services	9)	0, 020, 33	57	5, 020, 337	
INTENSIVE CARE UNIT		150, 50)6	150, 506	11
O CORONARY CARE UNIT		100, 00		150, 500	12
DO BURN INTENSIVE CARE UNIT					13
DO SURGICAL INTENSIVE CARE UNIT					14
00 OTHER SPECIAL CARE (SPECIFY)					15
00 Total intensive care type inpatient hospital services	(sum of lines	150, 50)6	150, 506	
11-15)		100,00		100,000	
00 Total inpatient routine care services (sum of lines 10	and 16)	5, 770, 84	13	5, 770, 843	17
00 Ancillary services		12, 406, 95		80, 078, 995	
00 Outpatient services			0 0	0	
DO RURAL HEALTH CLINIC			0 4, 134, 701	4, 134, 701	
DI RURAL HEALTH CLINIC II			0 1, 593, 187	1, 593, 187	
2 RURAL HEALTH CLINIC III			0 484, 904	484, 904	
03 RURAL HEALTH CLINIC IV			0 0	0	20
DO FEDERALLY QUALIFIED HEALTH CENTER		1	0 0	0	21
DO HOME HEALTH AGENCY					22
DO AMBULANCE SERVICES			0 3, 960, 372	3, 960, 372	23
DO CMHC					24
DO AMBULATORY SURGICAL CENTER (D. P.)					25
DO HOSPICE			0 0	0	
00 OTHER (SPECIFY)			0 0	0	
00 Total patient revenues (sum of lines 17-27)(transfer c	olumn 3 to Wkst.	18, 177, 79	77, 845, 205	96, 023, 002	28
G-3, line 1)					-
PART II - OPERATING EXPENSES			20 751 772		1 20
00 Operating expenses (per Wkst. A, column 3, line 200) 00 ADD (SPECIFY)			39, 751, 772 0		29
00 ADD (SPECIFI)			0		31
			0		32
			0		33
			0		34
			õ		35
00 Total additions (sum of lines 30-35)			~ 		36
DO DEDUCT (SPECIFY)			0		37
			0		38
00		1	0		39
00			0		40
00			0		41
00 Total deductions (sum of lines 37-41)			0		42
00 Total operating expenses (sum of lines 29 and 36 minus	line 42)(transfer		39, 751, 772		43
to Wkst. G-3, line 4)					

eal th	Financial Systems	PERRY COUNTY HOSPIT	AL	In Lie	u of Form CMS-2	2552-
STATEM	ENT OF REVENUES AND EXPENSES	Prov	ider CCN: 15-1322	Peri od:	Worksheet G-3	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	nared
				10 12/01/2020	6/11/2021 11:	
					1.00	
. 00	Total patient revenues (from Wkst. G-2, Par				96, 023, 002	1. (
. 00	Less contractual allowances and discounts on	n patients' accounts			61, 059, 337	2.0
3.00	Net patient revenues (line 1 minus line 2)					3. (
1.00	Less total operating expenses (from Wkst. G				39, 751, 772	
5.00	Net income from service to patients (line 3	minus line 4)			-4, 788, 107	5.0
	OTHER INCOME					
o. 00	Contributions, donations, bequests, etc				380, 725	6.1
. 00	Income from investments				78, 632	
. 00	Revenues from telephone and other miscellane	eous communication servi	ces		0	8.
. 00	Revenue from television and radio service				0	
	Purchase di scounts				0	10.
	Rebates and refunds of expenses				45, 497	
	Parking lot receipts				0	12.
	Revenue from laundry and linen service				0	13.
	Revenue from meals sold to employees and gu	ests			71, 532	
	Revenue from rental of living quarters				0	15.
	Revenue from sale of medical and surgical s		atients		0	16.
	Revenue from sale of drugs to other than pa				0	17.
	Revenue from sale of medical records and ab				0	18.
	Tuition (fees, sale of textbooks, uniforms,				0	
	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.
	Rental of vending machines				0	
	Rental of hospital space				60, 038	
	Governmental appropriations				0	23.
	OTHER OPERATING INCOME				3, 362, 745	
	COVI D-19 PHE Fundi ng				3, 278, 361	
	Total other income (sum of lines 6-24)				7, 277, 530	
	Total (line 5 plus line 25)				2, 489, 423	
	OTHER EXPENSES (SPECIFY)				0	27.
	Total other expenses (sum of line 27 and sul				0	28.
9.00	Net income (or loss) for the period (line 2	6 minus line 28)			2, 489, 423	29.

Heal th	Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-1	
			Component	CCN: 15-8516	From 01/01/2020 To 12/31/2020		
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Reclassi fied	
				+ 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	1, 279, 460	0		50 -18, 343		1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	187, 981	0	187, 9	-17, 250	170, 731	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	191, 367	0	191, 3	67 0	191, 367	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	184, 328	0	101/0			9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 843, 136	0	1, 843, 1	36 - 35, 593	1, 807, 543	1
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	Medical Supplies	0	14, 043	14, 0	43 0	14, 043	
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14, 043			14, 043	
22.00	Total Cost of Health Care Services (sum of	1, 843, 136	14, 043	1, 857, 1	79 -35, 593	1, 821, 586	22.00
	Lines 10, 14, and 21)						
~~ ~~	COSTS OTHER THAN RHC/FQHC SERVICES		07.5/0	07.5	(0)	07.5/0	
23.00	Pharmacy	0	37, 562	37, 5			
24.00	Dental	0	0		0 0	-	24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0			0	
25.02	Chronic Care Management	0	0			-	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs	0	27 542	27 5	52 0	27 542	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	37, 562	37, 5	02 0	37, 562	28.00
	through 27) FACILITY OVERHEAD						
29.00	Facility Costs	0	0	1	0 0	0	29.00
29.00 30.00	Administrative Costs	200, 295	690, 552	890, 8			
30.00	Total Facility Overhead (sum of lines 29 and	200, 295 200, 295					1
51.00	30)	200, 295	070, 002	070,0	2,001	075,700	51.00
32.00	Total facility costs (sum of lines 22, 28	2, 043, 431	742, 157	2, 785, 5	-32, 732	2, 752, 856	32.00
52.00	and 31)	2,010,401	, 12, 107	2,,00,0	02,102	2, , 52, 000	52.00
		I I		1	I	1	

	Financial Systems	PERRY COUNTY				u of Form CMS	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-	1
			Component	CCN: 15-8516	From 01/01/2020 To 12/31/2020	Date/Time Pr 6/11/2021 11	
					RHC I	Cost	
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
		(00	6)	-			
		6.00	7.00				-
1.00	FACILITY HEALTH CARE STAFF COSTS Physi ci an	0	1, 261, 117				1.00
2.00	Physician Assistant	0	1, 201, 117				2.00
3.00	Nurse Practitioner	0	170, 731				3.00
4.00	Visiting Nurse	0	170,731				4.00
5.00	Other Nurse	0	191, 367				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				8.00
9.00	Other Facility Health Care Staff Costs	0	184, 328				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 807, 543				10.00
11.00	Physician Services Under Agreement	Ő	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	14,043				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	14, 043				21.00
22.00	Total Cost of Health Care Services (sum of	0	1, 821, 586				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	37, 562	•			23.00
24.00	Dental	0	0	1			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	37, 562				28.00
	through 27)						_
29.00	FACILITY OVERHEAD	0	0				29.00
30.00	Facility Costs Administrative Costs	-238	893, 470				30.00
30.00	Total Facility Overhead (sum of lines 29 and	-238 -238	893, 470				30.00
31.00	30)	-238	073, 470				31.00
32.00	Total facility costs (sum of lines 22, 28	-238	2, 752, 618				32.00
	10ta 10011 ty 003t3 (300 01 11163 22, 20	-230	2, 102, 010	1			1 52.00

Heal th	Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-1	
			Component	CCN: 15-8517	From 01/01/2020 To 12/31/2020	Date/Time Pre 6/11/2021 11:	
-					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati		
				+ 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	327, 764	0	327, 7	64 0	327, 764	1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	38, 521	0	38, 53	21 2, 088	40, 609	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	25, 338	0	25, 3	38 0	25, 338	
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	96, 021	0	96, 02		96, 021	9.00
10.00	Subtotal (sum of lines 1 through 9)	487,644	0	487, 64	44 2, 088	489, 732	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	Medical Supplies	0	801	80	01 0	801	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	801	80		801	21.00
22.00	Total Cost of Health Care Services (sum of	487, 644	801	488, 44	45 2, 088	490, 533	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES		404.000	101.0		101.000	
23.00	Pharmacy	0	121, 293	121, 29		121, 293	
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 0	0	
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs	0	101 000	101.0		101 000	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	121, 293	121, 29	93 0	121, 293	28.00
	through 27) FACILITY OVERHEAD						
29.00	FACILITY OVERHEAD Facility Costs	0	0		0 0	0	29.00
29.00 30.00	Admi ni strati ve Costs	44,625	170, 202	214, 8			30.00
30.00	Total Facility Overhead (sum of lines 29 and	44, 625 44, 625					30.00
31.00	30)	44, 025	170, 202	214, 8.	-2,000	212, /01	31.00
32.00	Total facility costs (sum of lines 22, 28	532, 269	292, 296	824, 5	5 22	824, 587	32.00
52.00	and 31)	552,207	272,270	024, 0	22	027, 307	52.00
		I I		1	I.	I	1

	Financial Systems	PERRY COUNTY				u of Form CMS	-2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-	1
			Component (CCN: 15-8517	From 01/01/2020 To 12/31/2020	Date/Time Pr 6/11/2021 11	
					RHC II	Cost	
		Adjustments	Net Expenses				
		f	or Allocation				
			(col. 5 + col.				
			6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	327, 764	1			1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	40, 609				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	25, 338				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Technician	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	96, 021				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	489, 732				10.00
11.00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	-				12.00
	Other Costs Under Agreement	0	0				13.00
	Subtotal (sum of lines 11 through 13) Medical Supplies	0	801				14.00
	Transportation (Health Care Staff)	0	0				16.00
	Depreciation-Medical Equipment	0	0				17.00
	Professional Liability Insurance	0	0				17.00
	Other Health Care Costs	0	0				19.00
	Allowable GME Costs	0	0				20.00
20.00	Subtotal (sum of lines 15 through 20)	0	801				20.00
21.00	Total Cost of Health Care Services (sum of	0	490, 533				21.00
22.00	lines 10, 14, and 21)	Ŭ	470, 333				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	121, 293				23.00
	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
	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	121, 293				28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0				29.00
30.00	Administrative Costs	-60	212, 701				30.00
31.00	Total Facility Overhead (sum of lines 29 and	-60	212, 701				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-60	824, 527				32.00
	and 31)			1			1

Heal th	Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-1	
			Component	CCN: 15-8518	From 01/01/2020 To 12/31/2020		
					RHC III	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Reclassi fied	
				+ 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			
1.00	Physi ci an	0		13, 94			1.00
2.00	Physician Assistant	0	0		0 0	, o	2.00
3.00	Nurse Practitioner	83, 129	C	83, 12	29 24, 646	107, 775	3.00
4.00	Visiting Nurse	0	C		0 0	0	4.00
5.00	Other Nurse	6, 075	C	6, 0	75 0	6, 075	5.00
6.00	Clinical Psychologist	0	C		0 0	0	6.00
7.00	Clinical Social Worker	0	C		0 0	0	7.00
8.00	Laboratory Techni ci an	0	C		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	C		0 0	-	9.00
10.00	Subtotal (sum of lines 1 through 9)	89, 204	13, 943	103, 14	24, 646	127, 793	1
11.00	Physician Services Under Agreement	0	C		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	-		0 0	0	12.00
13.00	Other Costs Under Agreement	0	-		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	C		0 0	0	14.00
15.00	Medical Supplies	0	216		6 0	216	1
16.00	Transportation (Health Care Staff)	0	C		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	C		0 0	0	17.00
18.00	Professional Liability Insurance	0	C		0 0	0	18.00
19.00	Other Health Care Costs	0	C		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	216			216	
22.00	Total Cost of Health Care Services (sum of	89, 204	14, 159	103, 30	24, 646	128, 009	22.00
	lines 10, 14, and 21)						
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	0	()00	()((200	222.00
23.00	Pharmacy	0	6, 298	6, 29			1
24.00 25.00	Dental	0			0 0	0	24.00 25.00
25.00 25.01	Optometry Telehealth	0			0 0	0	25.00
25.01	Chronic Care Management	0				0	25.01
25.02	All other nonreimbursable costs	0				0	25.02
28.00	Nonallowable GME costs	0			0	0	27.00
27.00	Total Nonreimbursable Costs (sum of lines 23	0	6, 298	6, 29	08	6, 298	
20.00	through 27)	0	0, 290	0, 2	0	0, 290	20.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0			0 0	0	29.00
30.00	Administrative Costs	62, 511	41, 917	104, 42	0		
31.00	Total Facility Overhead (sum of lines 29 and	62, 511					1
51.00	30)	02,011			2,000	102, 302	
32.00	Total facility costs (sum of lines 22, 28	151, 715	62, 374	214, 08	22, 580	236, 669	32.00
	and 31)	,,,,,					
		· ·		'	1		

	Financial Systems	PERRY COUNTY			In Lieu of Form CMS-2		
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-	1
			Component (CCN: 15-8518	From 01/01/2020 To 12/31/2020	Date/Time Pr 6/11/2021 11	
					RHC III	Cost	
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7.00				_
1.00	FACILITY HEALTH CARE STAFF COSTS Physi ci an	0	13, 943				1.00
2.00	Physician Assistant	0	13, 943				2.00
3.00	Nurse Practi ti oner	0	107, 775				3.00
4.00	Visiting Nurse	0	107, 775				4.00
5.00	Other Nurse	0	6, 075				5.00
6.00	Clinical Psychologist	0	0,079				6.00
7.00	Clinical Social Worker	0	0				7.0
8.00	Laboratory Techni ci an	0	0				8.0
9.00	Other Facility Health Care Staff Costs	0	0				9.0
10.00	Subtotal (sum of lines 1 through 9)	o	127, 793				10.0
11.00	Physician Services Under Agreement	0	0				11.0
12.00	Physician Supervision Under Agreement	0	0				12.0
13.00	Other Costs Under Agreement	0	0				13.0
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.0
15.00	Medical Supplies	0	216				15.0
16.00	Transportation (Health Care Staff)	0	0				16.0
17.00	Depreciation-Medical Equipment	0	0				17.0
18.00	Professional Liability Insurance	0	0				18.0
19.00	Other Health Care Costs	0	0				19.0
	Allowable GME Costs						20.0
21.00	Subtotal (sum of lines 15 through 20)	0	216				21.0
22.00	Total Cost of Health Care Services (sum of	0	128, 009				22.00
	Lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23.00	Pharmacy	0	6, 298				23.0
23.00	Dental	0	0, 298	1			23.00
25.00	Optometry	0	0				24.0
25.00	Tel eheal th	0	0				25.0
25.02	Chronic Care Management	0	0				25. 0
26.00	All other nonreimbursable costs	0	0				26.0
27.00	Nonallowable GME costs	J	0				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	o	6, 298				28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0				29.00
30.00	Administrative Costs	0	102, 362				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	102, 362				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	236, 669				32.00
	and 31)						

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-1	
			Component (CCN: 15-8519	From 01/01/2020 To 12/31/2020	Date/Time Pre 6/11/2021 11:	
					RHC IV	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi ficati	Reclassi fied	
				+ 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 0		1.00
2.00	Physician Assistant	0	0		0 0		2.00
3.00	Nurse Practitioner	0	0		0 0	0	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	0	0		0 0	0	5.00
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 0	0	10.00
11.00	Physician Services Under Agreement	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		14.00
15.00	Medical Supplies	0	0		0 0	0	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0		16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0		18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		0 0	0	21.00
22.00	Total Cost of Health Care Services (sum of	0	0		0 0	0	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES					-	
	Pharmacy	0	0		0 0		23.00
24.00	Dental	0	0		0 0		24.00
25.00	Optometry	0	0		0 0	Ű	25.00
25.01	Tel eheal th	0	0		0 0	0	25.01
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs		0				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)						
29.00	FACILITY OVERHEAD	0	0	1	0 0	0	29.00
29.00 30.00	Facility Costs Administrative Costs	0	3, 773				30.00
		0					
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	3, 773	3, 7	0	3, 773	31.00
32.00	Total facility costs (sum of lines 22, 28	0	3, 773	3, 7	73 0	3, 773	32.00
52.00	and 31)	0	5, 775	3,7	, 3	3,773	32.00
	1	I I		1	I	I	I

neur tri	Financial Systems	PERRY COUNTY	HOSPITAL		In Lie	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CO	CN: 15-1322	Peri od:	Worksheet M-	1
			Component (CCN: 15-8519	From 01/01/2020 To 12/31/2020	Date/Time Pre 6/11/2021 11:	
					RHC IV	Cost	oo uii
		Adjustments	Net Expenses				
		, i	for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS			I			_
1.00	Physi ci an	0	0				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	0				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	0				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	0				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0				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	0				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	0				21.00
22.00	Total Cost of Health Care Services (sum of	0	0				22.00
	Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23.00	Pharmacy	0	0				23.00
23.00	Dental	0	0	•			23.00
24.00	Optometry	0	0				24.00
25.00	Tel eheal th	0	0				25.00
25.01	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs	0	0				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
20.00	through 27)	0	0				20.00
	FACILITY OVERHEAD	1					
29.00	Facility Costs	0	0				29.00
30.00	Admi ni strati ve Costs	-3,773	0				30.00
31.00	Total Facility Overhead (sum of lines 29 and	-3, 773	0				31.00
	30)	2, 1, 0	0				
32.00	Total facility costs (sum of lines 22, 28	-3, 773	0				32.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-1
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period: From 01/01/2020	Worksheet M-2	
			Component		To 12/31/2020		
					RHC I	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	2.50	9, 801	4, 20			1.0
. 00	Physician Assistant	0.00		2, 10			2.0
. 00	Nurse Practitioner	2.37	7, 079	2, 10	0 4, 977		3.0
. 00	Subtotal (sum of lines 1 through 3)	4.87	16, 880		15, 477	16, 880	4.0
00	Visiting Nurse	0.00	0 0			0	5.0
00	Clinical Psychologist	0.00	0)		0	6.1
00	Clinical Social Worker	0.00	0)		0	7.0
01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.0
02	Diabetes Self Management Training (FQHC	0.00	C			0	7.0
00	only) Total FTEs and Visits (sum of lines 4	4.87	16, 880			16, 880	8.0
00	through 7)	4.07	10,000			10, 880	0.0
. 00	Physician Services Under Agreements		0			0	9. (
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BASE	ED RHC/FQHC SER	VI CES			
0. 00	Total costs of health care services (from	Wkst. M-1, col. 7	7, line 22)			1, 821, 586	10.0
1.00	Total nonreimbursable costs (from Wkst. M-	1, col. 7, line 2	28)			37, 562	11. (
2.00	Cost of all services (excluding overhead)	(sum of lines 10	and 11)			1, 859, 148	12.0
	Ratio of hospital-based RHC/FQHC services					0. 979796	
	Total hospital-based RHC/FQHC overhead - (ne 31)		893, 470	14.0
	Parent provider overhead allocated to faci					1, 146, 991	
	Total overhead (sum of lines 14 and 15)	J (- /			2, 040, 461	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					2, 040, 461	
	Overhead applicable to hospital-based RHC/	FQHC services (li	ne 13 x line 1	8)		1, 999, 236	
						1,777,200	

 20.00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 3,820,822
 20.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552- <u>1</u> 0
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period: From 01/01/2020	Worksheet M-2	
			Component		To 12/31/2020		
		_	_		RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		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. 72					1.00
2.00	Physician Assistant	0.00	C	2, 10	0 0		2.00
3.00	Nurse Practitioner	0. 59	2, 413	2, 10	0 1, 239		3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 31	5, 581		4, 263	5, 581	4.00
5.00	Visiting Nurse	0.00	C			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	1. 31	5, 581			5, 581	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			VICES		1.00	
10.00	Total costs of health care services (from Wk	· · · · · · · · · · · · · · · · · · ·		VICLO		490, 533	10.00
	Total nonreimbursable costs (from Wkst. M-1,					121, 293	
	Cost of all services (excluding overhead) (s					611, 826	
13.00	Ratio of hospital-based RHC/FQHC services (I					0, 801752	
14.00	Total hospital-based RHC/FQHC overhead - (fr			no 21)		212, 701	
15.00	Parent provider overhead allocated to facili			10 31)		325, 638	
	Total overhead (sum of lines 14 and 15)	cy (see matruc	50 013/			538, 339	
	Allowable GME overhead (see instructions)					0	
18.00	Enter the amount from line 16					538, 339	
	Overhead applicable to hospital-based RHC/FC	HC services (Li	ne 13 v line 1	8)		431, 614	
17.00	overhead appricable to hospital-based RHC/FC			0)		431,014	17.00

 20.00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 922, 147
 20.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-1
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period:	Worksheet M-2	
			Component		From 01/01/2020 To 12/31/2020		narod
			component	CCN. 13-0310	10 12/31/2020	6/11/2021 11:	
					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						-
~~	Positions						1
. 00	Physi ci an	0.04					1.0
. 00	Physician Assistant	0.00		2, 100			2.0
. 00	Nurse Practitioner	0.79					3.0
. 00	Subtotal (sum of lines 1 through 3)	0.83			1, 827		4.0
. 00	Visiting Nurse	0.00				0	
. 00	Clinical Psychologist	0.00				0	6.0
. 00	Clinical Social Worker	0.00				0	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
. 02	Diabetes Self Management Training (FQHC only)	0.00				0	7.0
. 00	Total FTEs and Visits (sum of lines 4	0. 83	1, 847			1, 847	8.0
. 00	through 7)	0. 83	1, 047			1,047	0.0
. 00	Physician Services Under Agreements		0			0	9.0
. 00			<u> </u>			Ŭ	7.0
						1,00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BASE	D RHC/FQHC SER	VI CES		i	
0. 00	Total costs of health care services (from W	kst. M-1, col. 7	7, line 22)			128, 009	10.0
1.00	Total nonreimbursable costs (from Wkst. M-1	, col. 7, line 2	28)			6, 298	11.0
2.00	Cost of all services (excluding overhead) (sum of lines 10	and 11)			134, 307	12.0
3.00	Ratio of hospital-based RHC/FQHC services (line 10 divided	by line 12)			0. 953107	13.0
1.00	Total hospital-based RHC/FQHC overhead - (f	rom Worksheet. N	1-1, col. 7, li	ne 31)		102, 362	14. (
5.00	Parent provider overhead allocated to facil	ity (see instruc	ctions)			100, 084	15.0
	Total overhead (sum of lines 14 and 15)					202, 446	16. (
7.00	Allowable GME overhead (see instructions)					0	17.0
8.00	Enter the amount from line 16					202, 446	18. (
	Overhead applicable to hospital-based RHC/F					192, 953	
0 00	Tatal allowable and af beautiful based DUC/		C L !	1 4 0)		000 0/0	1 00 (

 20. 00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 320, 962
 20. 00

	Financial Systems PERRY COUNTY H ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	OSPITAL Provider CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C		Component CCN: 15-1322	From 01/01/2020 To 12/31/2020	Date/Time Pre	
			10 12/01/2020	6/11/2021 11:	
		Title XVIII	RHC I	Cost	
			-	1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		3, 820, 822	1 1.
. 00	Cost of vaccines and their administration (from Wkst. M-4, lin			142, 711	
. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			3, 678, 111	3.
. 00	Total Visits (from Wkst. M-2, column 5, line 8)			16, 880	4
. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I	line 9)		0	5
. 00	Total adjusted visits (line 4 plus line 5)			16, 880	
. 00	Adjusted cost per visit (line 3 divided by line 6)			217.90	7
			Calculation	OT LIMIT (I)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Period 2)	<u> </u>
00	Der vieit normant Limit (fram CNC Dub 100.04 abortor 0. 520	(on your contractor)	1.00	2.00	
. 00 . 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20. Rate for Program covered visits (see instructions)	. o or your contractor)	84.70 217.90	86. 31 217. 90	
. 00	CALCULATION OF SETTLEMENT		217.90	217.90	1 7
0.00	Program covered visits excluding mental health services (from	contractor records)	0	2, 264	1 10
1.00	Program cost excluding costs for mental health services (line		0	493, 326	
2.00	Program covered visits for mental health services (from contra		0	0	12
3.00	Program covered cost from mental health services (line 9 x lin	ne 12)	0	0	13
4.00	Limit adjustment for mental health services (see instructions))	0	0	14
5.00	Graduate Medical Education Pass Through Cost (see instructions				15
6.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	493, 326	
6.01	Total program charges (see instructions) (from contractor's red	· · · · · · · · · · · · · · · · · · ·		626, 798	
6. 02 6. 03	Total program preventive charges (see instructions)(from provi Total program preventive costs ((line 16.02/line 16.01) times	-		68, 192 53, 671	
6.04	Total Program non-preventive costs ((line 16 minus lines 16.07)	-		309, 361	
0.01	(Titles V and XIX see instructions.)			007,001	
6. 05	Total program cost (see instructions)		0	363, 032	
7.00	Primary payer amounts			0	17
8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		52, 954	18
0 00	records)			05 000	10
9.00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		95, 800	19
0. 00	Net Medicare cost excluding vaccines (see instructions)			363, 032	20
1.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		35, 411	
2.00	Total reimbursable Program cost (line 20 plus line 21)			398, 443	22
3.00	Allowable bad debts (see instructions)			0	23
3. 01	Adjusted reimbursable bad debts (see instructions)			0	
4.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50 5.99	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
5.99 6.00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			398, 443	
6. 01	Sequestration adjustment (see instructions)			2, 630	
6. 02	Demonstration payment adjustment amount after sequestration			2,000	
7.00	Interim payments			445, 072	
8.00	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		-49, 259	29
9.00 0.00	Protested amounts (nonallowable cost report items) in accorda			0	30

eal th Financial Systems PERRY COUNTY HO			u of Form CMS-2	
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC ERVICES	Provider CCN: 15-1322	Period: From 01/01/2020	Worksheet M-3	
ERVICES	Component CCN: 15-8517	To 12/31/2020	Date/Time Pre	pared
	T I II NO (111	5110.11	6/11/2021 11:	56 ar
	Title XVIII	RHC I I	Cost	
		-	1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1100	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst. M-2, line 20)		922, 147	1.
.00 Cost of vaccines and their administration (from Wkst. M-4, lin	e 15)		44, 707	
.00 Total allowable cost excluding vaccine (line 1 minus line 2)			877, 440	
.00 Total Visits (from Wkst. M-2, column 5, line 8)			5, 581	4.
.00 Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5.
.00 Total adjusted visits (line 4 plus line 5)			5, 581	6.
.00 Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	157.22	7.
		Carcuration		
		Prior to Jan.	On or After	
		1 (Rate Period	Jan. 1 (Rate	
		1)	Period 2)	
		1.00	2.00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	84.70	86.31	8. 9.
.00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		157.22	157.22	9.
0.00 Program covered visits excluding mental health services (from	contractor records)	0	115	10.
1.00 Program cost excluding costs for mental health services (line		0	18, 080	
2.00 Program covered visits for mental health services (from contra		0	0	
3.00 Program covered cost from mental health services (line 9 x lin	,	0	0	13.
4.00 Limit adjustment for mental health services (see instructions)		0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instructions				15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	18, 080	
6.01 Total program charges (see instructions)(from contractor's rec			23, 922	
6.02 Total program preventive charges (see instructions) (from provi			4, 388	
6.03 Total program preventive costs ((line 16.02/line 16.01) times 6.04 Total Program non-preventive costs ((line 16 minus lines 16.03			3, 316 7, 974	
(Titles V and XIX see instructions.)	and 18) trilles . 60)		7,974	10.
6.05 Total program cost (see instructions)		0	11, 290	16.
7.00 Primary payer amounts			0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		4, 797	18.
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	s) (from contractor		2, 947	19.
records)			44.000	
0.00 Net Medicare cost excluding vaccines (see instructions)	M 4 15 - 14)		11, 290	
1.00 Program cost of vaccines and their administration (from Wkst. 2.00 Total reimbursable Program cost (line 20 plus line 21)	M-4, IIne 16)		4, 845 16, 135	
3.00 Allowable bad debts (see instructions)			10, 135	
3.01 Adjusted reimbursable bad debts (see instructions)			0	
4.00 Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.
5.50 Pioneer ACO demonstration payment adjustment (see instructions)		0	25.
5.99 Demonstration payment adjustment amount before sequestration			0	
6.00 Net reimbursable amount (see instructions)			16, 135	
6.01 Sequestration adjustment (see instructions)			106	
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments 8.00 Tentative settlement (for contractor use only)			15, 426	1
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0	2, 27, and 28		0 603	
0.00 Protested amounts (nonallowable cost report items) in accordan			003	
			0	1 30.

leal th Financial Systems CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPI	PERRY COUNTY H	Provider CCN: 15-1322	Peri od:	u of Form CMS-2	
SERVICES	TAL-BASED RHC/FQHC	Provider CCN: 15-1322	From 01/01/2020	Worksheet M-3	
SERVICES		Component CCN: 15-8518	To 12/31/2020	Date/Time Pre	
		Title XVIII	RHC III	6/11/2021 11: Cost	56 ai
				0031	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RH					
.00 Total Allowable Cost of hospital-based RHC				320, 962	
2.00 Cost of vaccines and their administration (2.00 Total allowable cost excluding vaccine (lin	•	ne 15)		23, 717	2. 3.
.00 Total allowable cost excluding vaccine (lir .00 Total Visits (from Wkst. M-2, column 5, lir				297, 245 1, 847	4.
.00 Physicians visits under agreement (from Wks		line 9)		1, 047	5.
.00 Total adjusted visits (line 4 plus line 5)	5t. m 2, 66t ann 6,			1, 847	6.
.00 Adjusted cost per visit (line 3 divided by	line 6)			160.93	
	·		Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2)	
			1.00	2.00	
.00 Per visit payment limit (from CMS Pub. 100-		.6 or your contractor)	84.70	86.31	8.
. 00 Rate for Program covered visits (see instru	uctions)		160. 93	160. 93	9
CALCULATION OF SETTLEMENT 0.00 Program covered visits excluding mental hea	alth services (from	contractor records)	0	281	1 10
1.00 Program cost excluding costs for mental hea		-	0	45, 221	
2.00 Program covered visits for mental health se			0	43, 221	
3.00 Program covered cost from mental health ser			0	0	
4.00 Limit adjustment for mental health services			0	0	14
5.00 Graduate Medical Education Pass Through Cos	st (see instruction	s)			15
6.00 Total Program cost (sum of lines 11, 14, ar			0	45, 221	
6.01 Total program charges (see instructions)(fr				43, 800	
6.02 Total program preventive charges (see instr		-		3, 436	
6.03 Total program preventive costs ((line 16.02				3, 547	16
6.04 Total Program non-preventive costs ((line 1 (Titles V and XIX see instructions.)	16 minus lines 16.0	3 and 18) times .80)		26, 801	16
6.05 Total program cost (see instructions)			0	30, 348	16
7.00 Primary payer amounts			0	00,010	17
8.00 Less: Beneficiary deductible for RHC only	(see instructions)	(from contractor		8, 173	
records)	`````				
9.00 Beneficiary coinsurance for RHC/FQHC servic	ces (see instructio	ns) (from contractor		6, 438	19
records) 0.00 Net Medicare cost excluding vaccines (see i	nstructions)			30, 348	20
1.00 Program cost of vaccines and their administ		M-4. line 16)		4, 961	
2.00 Total reimbursable Program cost (line 20 pl				35, 309	
3.00 Allowable bad debts (see instructions)	,			0	
3.01 Adjusted reimbursable bad debts (see instru	uctions)			0	23
4.00 Allowable bad debts for dual eligible benef	•	ructions)		0	
5. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI				0	25
5.50 Pioneer ACO demonstration payment adjustmer	•	S)		0	
5.99 Demonstration payment adjustment amount bef 6.00 Net reimbursable amount (see instructions)	ore sequestration			0 35, 309	25 26
6.01 Sequestration adjustment (see instructions)				35, 309 233	
6.02 Demonstration payment adjustment amount af				233	
7.00 Interim payments				28, 650	
8.00 Tentative settlement (for contractor use or	nl y)			20,000	28.
9.00 Balance due component/program (line 26 minu	5.	02, 27, and 28)		6, 426	
30.00 Protested amounts (nonallowable cost report				0	30
chapter I, §115.2					

Heal th	Financial Systems PERRY COUNTY H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1322	Period:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-8516	From 01/01/2020 To 12/31/2020	Date/Time Prep 6/11/2021 11:	pared: 56 am
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 807, 543		
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				
3.00	Pneumococcal and influenza vaccine health care staff cost (li		5, 383		
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f		37, 688	14, 320	
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	sline 4)	43, 071	24, 966	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)) 1, 821, 586	1, 821, 586	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 999, 236	1, 999, 236	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 023645	0. 013706	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x		47, 272		
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	90, 343	52, 368	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	181	358	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	499.13	146. 28	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	56	51	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	27, 951	7, 460	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3			142, 711	15.00
16. 00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		35, 411	16. 00

Heal th	Financial Systems PERRY COUNTY F	IOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1322	Peri od:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-8517	From 01/01/2020 To 12/31/2020		pared: 56 am
		Title XVIII	RHC II	Cost	
			Pneumococcal	I nfl uenza	
	1		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		489, 732		
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	1, 557		
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f		12, 012		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	ıs line 4)	13, 569	10, 213	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22) 490, 533	490, 533	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		431, 614	431, 614	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 027662	0. 020820	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x		11, 939		
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	25, 508	19, 199	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	52	146	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	490.54	131.50	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	8	3 7	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	3, 924	921	14.00
15.00				44, 707	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		4, 845	16. 00

Heal th	Financial Systems PERRY COUNTY H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1322	Peri		Worksheet M-4	
VACCIN	E COST	Component CCN: 15-8518	From To	n 01/01/2020 12/31/2020	Date/Time Prep 6/11/2021 11:5	bared: 56 am
		Title XVIII		RHC III	Cost	
			Pi	neumococcal	I nfl uenza	
				1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)			127, 793	127, 793	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot		е	0. 002897	0. 005118	
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,		370	654	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f			6, 315	2, 120	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu			6, 685	2, 774	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	128, 009	128, 009	6.00
7.00	Total overhead (from Wkst. M-2, line 19)			192, 953	192, 953	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5		0. 052223	0. 021670	8.00
	divided by line 6)					
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x			10, 077	4, 181	
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of		16, 762	6, 955	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)		30	53	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)		558.73	131.23	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin beneficiaries	istered to Program		7	8	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration		3, 911	1, 050	14.00
	(line 12 x line 13)					
15.00	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3				23, 717	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)			4, 961	16.00

Health Financial Systems PERRY COUNT	Y HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1322	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2020		
	Component CCN: 15-8516	To 12/31/2020		
		DUC I	6/11/2021 11:5	56 am
		RHC I	Cost	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC		1.00	445, 072	1.00
2.00 Interim payments payable on individual bills, either submit	ttad or to be submitted to		445,072	2.00
the contractor for services rendered in the cost reporting			0	2.00
"NONE" or enter a zero	perrod. In none, write			
3.00 List separately each retroactive lump sum adjustment amount	t based on subsequent			3.00
revision of the interim rate for the cost reporting period.				5.00
payment. If none, write "NONE" or enter a zero. (1)	Arso show date of cach			
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program				0.00
3. 50			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 3.50-3.	98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		445, 072	4.00
27)				
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after des	sk review. Also show date o	f		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
5. 01			0	5.01
5. 02			0	5.02
5.03			0	5.03
Provider to Program				
5. 50			0	5.50
5. 51			0	5.51
5. 52	>		0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.99
6.00 Determined net settlement amount (balance due) based on the	e cost report. (1)			6.00
6.01 SETTLEMENT TO PROVIDER			0	6.01
6.02 SETTLEMENT TO PROGRAM			49, 259	6.02
7.00 Total Medicare program liability (see instructions)			395, 813	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	0.00
8.00 Name of Contractor	1	1		8.00

alth Financial Systems PERRY COUNT	Y HOSPI TAL	In Lie	eu of Form CMS-2	2552-1
ALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1322	Peri od:	Worksheet M-5	
RVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN, 15, 0517	From 01/01/2020		oorod.
	Component CCN: 15-8517	To 12/31/2020	Date/Time Prep 6/11/2021 11:5	
		RHC II	Cost	<u></u>
			TT B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
00 Total interim payments paid to hospital-based RHC/FQHC			15, 426	1.00
00 Interim payments payable on individual bills, either submit			0	2.00
the contractor for services rendered in the cost reporting	period. If none, write			
"NONE" or enter a zero				
00 List separately each retroactive lump sum adjustment amount				3.00
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	3. 0 [.]
02			0	3.0
03			0	3.0
04			0	3.0
05			0	3.0
Provider to Program				0.0
50			0	3.5
51			0	3.5
52			0	3.5
53			0	3.5
54			0	3.5
99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.9
00 Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		15, 426	4.0
27)				
TO BE COMPLETED BY CONTRACTOR		<u></u>		
00 List separately each tentative settlement payment after des	sk review. Also show date o	f		5.0
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider			0	5.0
02			0	5.0
03			0	5.0
Provider to Program		1	0	5.0
50			0	5.5
51			0	5.5
52			0	5.5
99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.9
00 Determined net settlement amount (balance due) based on the	e cost report. (1)			6.0
01 SETTLEMENT TO PROVIDER	• • •		603	6.0
02 SETTLEMENT TO PROGRAM			0	6.0
00 Total Medicare program liability (see instructions)			16, 029	7.0
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	-
00 Name of Contractor			1	8.00

Heal th	n Financial Systems PERRY COUN	In Lieu of Form CMS-2552-10			
		Provider CCN: 15-1322	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES			From 01/01/2020		
		Component CCN: 15-8518	To 12/31/2020		
				6/11/2021 11:5	56 am
	· · · · · · · · · · · · · · · · · · ·		RHC III	Cost	
			mm/dd/yyyy 1.00	Amount	
1 00	Total interim normante neid to beenited based DUC/FOUC		1.00	2.00	1.00
1.00 2.00	Total interim payments paid to hospital-based RHC/FQHC Interim payments payable on individual bills, either submi	ttad on to be submitted to		28, 650	2.00
2.00	the contractor for services rendered in the cost reporting period. If none, write			0	2.00
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amour	t based on subsequent			3.00
5.00	revision of the interim rate for the cost reporting period				5.00
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3.01
3.02				0	3. 02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program		I		
3.50	<u>_</u>			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					3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)				28, 650	4.00
	TO BE COMPLETED BY CONTRACTOR		-		5.00
5.00	5.00 List separately each tentative settlement payment after desk review. Also show date of				
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03	Dura da la ta Dura man			0	5.03
E 50	Provider to Program				F F0
5.50				0	5.50
5.51				0	5.51
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5	00)		0	5.52 5.99
5.99 6.00	Determined net settlement amount (balance due) based on th			0	5.99 6.00
6.00 6.01	SETTLEMENT TO PROVIDER			6, 426	6.00 6.01
6.01 6.02	SETTLEMENT TO PROVIDER			0, 420	6.01
6.02 7.00	Total Medicare program liability (see instructions)			35, 076	6.02 7.00
7.00			Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	
8.00	Name of Contractor	Ŭ Ŭ	1.00	2.00	8.00
5.00	1	1	1	I I	0.00