Heal th Financi		PERRY COUNTY HO			ı of Form CMS-2552-10
	s required by law (42 USC 1395g; 42 since the beginning of the cost re				FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND H AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST F SUMMARY	REPORT CERTIFICATION	Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 6/24/2022 9:41 am
PART I - COST	REPORT STATUS				
Provi der use onl y	1. [X] Electronically prepared co 2. [] Manually prepared cost re 3. [0] If this is an amended repu	port ort enter the number (of times the provider r	Date: 6/24/202 resubmitted this c	
	4. [F] Medicare Utilization. Ent	er "F" for full or "L'	' for low.		·
Contractor use only	(1) As Submitted 7. Cc (2) Settled without Audit 8. [te Received: ntractor No. N]Initial Report for N]Final Report for 1	11.0 this Provider CCN12.[IPR Date: Contractor's Vendo 0]If line 5, co number of tim	pr Code: 4 Iumn 1 is 4: Enter wes reopened = 0-9.
PART LL - CERT	FIFICATION BY A CHIEF FINANCIAL OF	FLCER OR ADMINISTRATO	R OR PROVIDER(S)		
MI SREPRESENTAT ADMI NI STRATI VE PROVI DED OR PF	TION OR FALSIFICATION OF ANY INFORME ACTION, FINE AND/OR IMPRISONMENT ROCURED THROUGH THE PAYMENT DIRECTI ACTION, FINES AND/OR IMPRISONMENT	MATION CONTAINED IN TH UNDER FEDERAL LAW. F Y OR INDIRECTLY OF A	HIS COST REPORT MAY BE FURTHERMORE, IF SERVICE	S IDENTIFIED IN T	HIS REPORT WERE
CERTII	FICATION BY CHIEF FINANCIAL OFFICE	R OR ADMINISTRATOR OF	PROVI DER(S)		
electi Stater begini are ti applio regare	EBY CERTIFY that I have read the all conically filed or manually submit ment of Revenue and Expenses prepain ing 01/01/2021 and ending 12/31/20 rue, correct, complete and prepare cable instructions, except as noted ding the provision of health care s ded in compliance with such laws a	ted cost report and survey red by PERRY COUNTY Ho 221 and to the best of d from the books and d. I further certify services, and that the	ubmitted cost report ar DSPITAL (15-1322) for f my knowledge and beli records of the provider that I am familiar with	nd the Balance She the cost reporti ef, this report a in accordance wi the laws and reg	eet and ng period und statement th uulations
SI GNATUR	E OF CHIEF FINANCIAL OFFICER OR AD	MI NI STRATOR CHECKB	OX	ELECTRONI C	
	1	2	SIG	IATURE STATEMENT	
1			I have read and aground statement. I certify signature on this co binding equivalent of	y that I intend my ertification be th	y electronic ne legally

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	246, 559	-546, 380	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	166, 885	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC - TCC I	0		35, 375		0	10.00
10.01	RURAL HEALTH CLINIC II - PCFP	0		11, 505		0	10.01
10. 02	RURAL HEALTH CLINIC III - 13TH	0		9, 192		0	10.02
10.03	RURAL HEALTH CLINIC IV - SPENCER	0		26, 419		0	10.03
200.00	Total	0	413, 444	-463, 889	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.

2 Signatory Printed Name 3 Signatory Title

4 Date

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al th SPI ⁻	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI (PERRY COUNTY CATION DATA	Provi c	ler CCN:		Period: From 01/01/ To 12/31/		Worksho Part I Date/Ti 6/24/20	ime Pre	2 epare
	1.00		2.00		3.00		4	4.00	0/24/20	JZZ 7	
0	Hospital and Hospital Health Care Co	omplex Ad	dress: P0 Box: X								1
0 0	Street: 8885 SR 237 City: TELL CITY		State: IN	Zip Cod	e: 47586	Count	ty: PERRY				1.
0		Comp	ponent Name	CCN	CBSA	Provi der	1	Payme	ent Syst	em (P,	
				Number	Number	Туре	Certi fi ed		<u>, 0, or</u>		
			1 00	2.00	2.00	4.00	F 00	V	XVIII		_
	Hospital and Hospital-Based Componer	nt Identi	1.00 fication:	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
0	Hospi tal		UNTY HOSPITAL	151322	99915	1	07/01/2004	N	0	Р	3
0	Subprovider - IPF										4
0	Subprovi der – IRF										5
0	Subprovider - (Other)										6
0	Swing Beds - SNF		UNTY HOSPITAL	15Z322	99915		07/01/2004	N	0	N	7
0	Swing Beds - NF	SWI NG									8
0	Hospital - Based SNF										9
00	Hospital -Based NF										10
00	Hospital-Based OLTC										11.
00	Hospital-Based HHA										12
00	Separately Certified ASC										13.
00	Hospital -Based Hospice			15051/	99915		05 (10 (2015		0		14
00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - RHC	TELL CIT PERRY CO		158516 158517	99915		05/18/2015 05/19/2015	N N	0	N N	15
51		PRACTICE		100017	77713		00010000			''	13.
02	Hospital-Based Health Clinic - RHC		SURG - 13TH ST	158560	99915		03/24/2021	N	0	N	15.
~~		ODENIOED		4505/0	00015		00 /04 /0004				4.5
03	Hospital-Based Health Clinic - RHC	SPENCER	CO CLINIC	158562	99915		03/24/2021	N	0	N	15
00	Hospital-Based Health Clinic - FQHC										16.
00											17.
00	Renal Dialysis										18
00	Other										19
											17
		1					From:				
00	-						1.00		2.	00	
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)SPI T.	Financial Systems PERRY AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	COUNTY HOS	Provider CC	CN: 15-1322	Period: From 01/0		Workshe Part I	eet S-2	2
					To 12/3	31/2021	Date/Ti 6/24/20		
2 00	Which method is used to determine Medicaid days on Li	noo 04 one	1/an 25	1.00	2.	00	3. (00	
	Which method is used to determine Medicaid days on libelow? In column 1, enter 1 if date of admission, 2 if date of discharge. Is the method of identifying the reporting period different from the method used in the reporting period? In column 2, enter "Y" for yes or	if census c he days in he prior co	lays, or 3 this cost ost		2 1	J.			23.0
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Mec	ther Ii cai d Iays	
		1.00	2.00	3.00	4.00	5.00	6	5.00	-
5. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state	0	o				0	C	24.0
	Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
				1		Rural S			
5.00	Enter your standard geographic classification (not wa	age) status	at the be	ainning of	1. the	00 2	2.0	00	26.0
7.00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban of	r rural. age) status	at the en	d of the co		2			27.0
5. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	ication in	column 2.		n	0			35.0
					Begi n		Endi		
5.00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	e 36 for num	lber	00	2. (0	36.0
7.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		er of perio	ods MDH stat	us	О			37.0
7.01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37.0
	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.0
					Y/		Y/		_
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? En e requireme	nter in colu ents in	Imn		<u>2.</u> (N		39.0
0. 00	"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1.	ber 1. Ente	er "Y" for			J	N	l	40.0
		,	, , , , ,		·	V 1.00	XVIII 2.00		-
	Prospective Payment System (PPS)-Capital						-		
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco					e N N	N	N N	45.0
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS o				C C	N	N	N	47.0
	Is the facility electing full federal capital payment Teaching Hospitals					<u>N</u>	<u>N</u>	N	48.0
	Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME po year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col	e to columr rograms in cable CRs) lumn 2.	1 is "Y", the prior MA direct	or if this year or pen GME payment	hospital ultimate reduction				56.0
	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	r yes or "N th of this Y", complet	l" for no i cost repor e Workshee	n column 1. ting period	lf column ? Enter "`				57.0

Health Financial Systems PERR	Y COUNTY	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ΑΤΑ	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 6/24/2022 9:4	pared:
			k	V	XVIII XIX 0 2.00 3.00	
58.00 If line 56 is yes, did this facility elect cost rein			ans' services		2.00 3.00	58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If ye			, Pt. I.	N		59.00
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
60.00 Are you claiming nursing and allied health education		agata far	1.00 N	2.00	3.00	60.00
any programs that meet the criteria under 42 CFR 41: instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	3.85? (s olumn 1. CR) NAHE	see If column 1	IN IN			00.00
	Y/N	I ME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 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
61.02 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)	e					61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
 current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line (1.04 minute line (1.02)) (see instructions)) 	Э					61.05
 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.06
	Pro	ogram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61.10 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.				0.00	0.00	01.10
61.20 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.				0.00	0.00	61.20
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.	ſ					
			•		1 00	
ACA Provisions Affecting the Health Resources and S	ervi ces i	Administratior	n (HRSA)		1.00	
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru	traineo	d in this cost	reporting pe	eriod for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	a Teachi ogram. (s	<u>see instructio</u>		to your hospital	0.00	62.01
 63.00 Has your facility trained residents in nonprovider s "Y" for yes or "N" for no in column 1. If yes, compl 	settings	during this c			N	63.00

SPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION D	ATA Provider CO	Fr	eriod: com 01/01/2021	Worksheet S-2 Part I	
			To	12/31/2021	Date/Time Pre 6/24/2022 9:4	
			Unweighted	Unweighted	Ratio (col.	
			FTEs	FTEs in	1/ (col. 1 +	
			Nonprovider	Hospi tal	col. 2))	
			Si te 1.00	2.00	3.00	-
Section 5504 of the ACA Base Year	FTE Residents in N	lonprovider Settinas				
period that begins on or after Ju	ly 1, 2009 and befo	ore June 30, 2010.	····· - ···· · ···· · ····			
00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	er of unweighted no ations occurring in number of unweighte r hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
	-		FTEs	FTEs in	3/ (col. 3 +	
			Nonprovi der	Hospi tal	col. 4))	
	1.00	0.00	Site		5.00	-
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	45.00
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)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col. 2))	_
Section 5504 of the ACA Current Y	laar ETE Daaidanta i	n Nonnrovidor Sotting	1.00	2.00	3.00	
beginning on or after July 1, 201		n Nonprovider Setting	JSLITECTIVE I	or cost report	ing perious	
DO Enter in column 1 the number of u		ry care resident	0.00	0.00	0. 000000	66.00
FTEs attributable to rotations oc	curring in all nonp	rovider settings.				
Enter in column 2 the number of u						
FTEs that trained in your hospita (column 1 divided by (column 1 +						
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
	3		FTĔs	FTEsin	3/ (col. 3 +	
			Nonprovi der	Hospi tal	col. 4))	
			Site			-
00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	67 0
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						

Heal th	Financial Systems PERRY COUNTY HOSPITAL	ı I	ו Lieu	of Form	n CMS-2	2552-10
HOSPI T		Period: From 01/01/	/2021	Workshe Part I		
		To 12/31/		Date/Ti 6/24/20		
			1 00	2.00	3 00	
	Inpatient Psychiatric Facility PPS			2.00	3.00	
70.00	ls this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF su Enter "Y" for yes or "N" for no.	bprovi der?	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program ir				0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new tea					
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for	no.				
	Column 3: If column 2 is Y, indicate which program year began during this cost reporti (see instructions)	ng period.				
	Inpatient Rehabilitation Facility PPS			· ·		
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program ir	the most			0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes no. Column 2: Did this facility train residents in a new teaching program in accordanc					
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is	Υ,				
	indicate which program year began during this cost reporting period. (see instructions)				
				1.0	0	
80, 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
	Is this a LTCH co-located within another hospital for part or all of the cost reportir	g period? H	Enter	N		81.00
	"Y" for yes and "N" for no. TEFRA Providers					
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes		no.	N		85.00
	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Secti §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	on				86.00
	Is this hospital an extended neoplastic disease care hospital classified under sectior			Ν		87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	V		XIX	(
		1.00		2.0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
	yes or "N" for no in the applicable column.					
	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			Ν		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N		Ν		93.00
04.00	"Y" for yes or "N" for no in the applicable column.					04.00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0.00		0. 0 N	0	95.00
90.00	applicable column.	N		IN		96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00 Y		0. 0 Y	0	97.00 98.00
96.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	T		T		90.00
09 01	column 1 for title V, and in column 2 for title XIX.	. Y		Y		98.01
96.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for			T		90.01
98 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	Y		Y		98.02
70. UZ	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1					70.02
98.03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N		N		98.03
70.00	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column			i.		/0.05
98 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N		N		98.04
,	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and					
98.05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance or	Y		Y		98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and i					
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	Y		Y		98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in					
	column 2 for title XIX. Rural Providers					
	Does this hospital qualify as a CAH?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of paymer for outpatient services? (see instructions)	t N				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R	N				107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an					
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?					
	Enter "Y" for yes or "N" for no in column 2. (see instructions)	1				I

Health Financial Systems PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C			Worksheet S- Part I Date/Time Pr 6/24/2022 9:	epared:
			V 1.00	XI X 2.00	-
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					107.00
110.00Did this hospital participate in the Rural Community Hospita			104	1.00 N	110.00
Demonstration)for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes or	"N" for no. I	f yes,	N	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this constrained in the the temperature of the FCHIP demonstration for the temperature of the FCHIP demonstration prong of the FCHIP demonstration that apply: "A" for Ambulance services; "B" for action tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	Ν		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	period? s "Y", enter ne	N	2.00	5.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care of psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	93" percent (includes rs) based on				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	rance? Enter	N			117.00
118.00 Is the mal practice insurance a claims-made or occurrence pol		0			118.00
if the policy is claim-made. Enter 2 if the policy is occurr	rence.	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00 C	3.00	0118.01
			1.00		_
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.			<u>1.00</u> N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment	n column 1, "N ualifies for 1	f" for yes or the Outpatient	Ν	N	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	antable device	es charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00Does the cost report contain healthcare related taxes as def	fined in §1903	3(w)(3) of the	Y	5.01	122.00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information					
125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N'	'for no. If	Ν		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, er		fication date			126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, en		fication date			127.00
in column 1 and termination date, if applicable, in column 2	2.				
 128.00 If this is a Medicare certified liver transplant center, entine column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 	2.				128.00 129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		DUNTY HOSPITAL Provider CC	N· 15-1322	Peri od:		u of Form CMS- Worksheet S-:	
			N. 13 1322	From 01	/01/2021 2/31/2021	Part I Date/Time Pri 6/24/2022 9:	epared:
					1.00	2.00	-
30.00 If this is a Medicare certified p			ti fi cati on				130.00
date in column 1 and termination 31.00 If this is a Medicare certified i			erti fi cati o	n			131.00
date in column 1 and termination							122.00
32.00 If this is a Medicare certified i in column 1 and termination date,			cation date	9			132.00
 33.00 Removed and reserved 34.00 If this is an organ procurement o and termination date, if applicab 		er the OPO number i	n column 1				133.00 134.00
All Providers 40.00 Are there any related organizatio chapter 10? Enter "Y" for yes or	"N" for no in column 1	. If yes, and home	office cost	ts	Y		140. 00
are claimed, enter in column 2 th 1.00	e home office chain nu	2.00	tions)		3.00		
If this facility is part of a cha			ugh 143 the	name and	d address	of the home	
office and enter the home office 41.00 Name:	Contractor hame and co		Contrac	tor's Nur	mber:		141.00
42.00 Street:	PO Box:		7:				142.00
43.00 City:	State:		Zip Cod	e:			143.00
44.00 Are provider based physicians' co	ata inaludad in Warkah	100t 10				1.00 Y	144.00
44. 00 Are provider based physicians co	Sts Included In Worksh	leet A?				ř	144.00
45.00 f costs for renal services are c	Laimad on Wkat A Lin	a 74 and the east	for		1.00	2.00	145.00
 inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 	" for yes or "N" for n clude Medicare utiliza for no in column 2. gy changed from the pr n column 1. (See CMS P	no in column 1. If o ition for this cost reviously filed cos ⁻	column 1 is reporting t report?		N		146.00
						1.00	-
47.00 Was there a change in the statist	ical basis? Entor "V"						
						N N	147.00
	f allocation? Enter "Y	" for yes or "N" fo	or no.	or po		N N	148.0
	f allocation? Enter "Y	" for yes or "N" fo d? Enter "Y" for ye Part A	or no. <u>es or "N" fo</u> Part B	Ti	tle V	N N Title XIX	148.0
49.00Was there a change to the simplif	f allocation? Enter "Y ied cost finding metho	" for yes or "N" fo d? Enter "Y" for ye Part A 1.00	or no. es or "N" fo Part B 2.00	Ti	3. 00	N N Title XIX 4.00	148.0
49.00Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or	f allocation? Enter "Y ied cost finding metho ider that qualifies fo	" for yes or "N" for d? Enter "Y" for ye Part A 1.00 or an exemption fro	or no. es or "N" fo Part B 2.00 m the appli	cation of	3.00 f the low	N N Title XIX 4.00 er of costs	148.0
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital	f allocation? Enter "Y ied cost finding metho ider that qualifies fo	" for yes or "N" for d? Enter "Y" for ye Part A 1.00 or an exemption fro mponent for Part A N	or no. es or "N" fo Part B 2.00 m the appli and Part B N	cation of	3.00 f the low 2 CFR §41 N	N N Title XIX 4.00 er of costs 3.13) N	148.0 149.0 149.0
49.00Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00Hospital 56.00Subprovider - IPF	f allocation? Enter "Y ied cost finding metho ider that qualifies fo	" for yes or "N" fo d? Enter "Y" for ye Part A 1.00 or an exemption fro omponent for Part A	or no. es or "N" fo Part B 2.00 m the appli and Part B	cation of	3.00 f the low 2 CFR §41	N N Title XIX 4.00 er of costs 3.13)	148.0 149.0 - 155.0 156.0
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER	f allocation? Enter "Y ied cost finding metho ider that qualifies fo	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro omponent for Part A N N N	or no. es or "N" fo Part B 2.00 m the appli and Part B N N N	cation of	3.00 f the low 2 CFR §41 N N	N N Title XIX 4.00 er of costs 3.13) N N N	148. 0 149. 0 155. 0 156. 0 157. 0 158. 0
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF	f allocation? Enter "Y ied cost finding metho ider that qualifies fo	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro omponent for Part A N N N N	or no. es or "N" fo Part B 2.00 m the appli and Part B N N N	cation of	3.00 f the low 2 CFR §41 N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY	f allocation? Enter "Y ied cost finding metho ider that qualifies fo	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro omponent for Part A N N N	or no. es or "N" fo Part B 2.00 m the appli and Part B N N N	cation of	3.00 f the low 2 CFR §41 N N	N N Title XIX 4.00 er of costs 3.13) N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY	f allocation? Enter "Y ied cost finding metho ider that qualifies fo	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro omponent for Part A N N N N	or no. es or "N" fo Part B 2.00 m the appli and Part B N N N N N	cation of	3.00 f the Iow 2 CFR §41 N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N N N N	147.00 148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus	f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro omponent for Part A N N N N N	or no. es or "N" fo Part B 2.00 m the appli and Part B N N N N N N	Cation of . (See 42	3.00 f the low 2 CFR §41 N N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus	f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro omponent for Part A N N N N N	or no. es or "N" fo Part B 2.00 m the appli and Part B N N N N N N	Cation of . (See 42	3.00 f the low 2 CFR §41 N N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic	f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co ampus hospital that ha	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro mponent for Part A N N N N N N N N N N County	or no. es or "N" for Part B 2.00 m the appli and Part B N N N N N N N N N N N N N	ferent CE	3.00 f the low 2 CFR §41 N N N N N 3SAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N T.00	148.0 149.0 155.0 156.0 157.0 158.0 159.0 160.0 161.0
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co ampus hospital that ha	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro proponent for Part A N N N N N N N N	or no. es or "N" fo Part B 2.00 m the appli and Part B N N N N N N N N N N N N	ferent CE	3.00 f the low 2 CFR §41 N N N N N N 3SAs?	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N TI.00 N FTE/Campus 5.00	148.0 149.0 155.0 156.0 157.0 158.0 159.0 160.0 160.0 160.0 160.0
49.00Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00Hospital 56.00Subprovider - IPF 57.00Subprovider - IRF 58.00SUBPROVIDER 59.00SNF 50.00HOME HEALTH AGENCY 51.00CMHC Multicampus 55.00Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 56.00If 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,	f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co ampus hospital that ha	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro mponent for Part A N N N N N N N N N N County	or no. es or "N" for Part B 2.00 m the appli and Part B N N N N N N N N N N N N N	ferent CE	3.00 f the low 2 CFR §41 N N N N N 3SAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148.0 149.0 155.0 156.0 157.0 158.0 159.0 160.0 161.0 161.0
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 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) Heal th Information Technology (HI	f allocation? Enter "Y ied cost finding metho ider that qualifies for "N" for no for each co ampus hospital that ha Name 0 T) incentive in the Am	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption fro mponent for Part A N N N N N N N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 m the appli and Part B N N N N N N N N N N N N N	Ferent CE	3.00 f the low 2 CFR §41 N N N N N 3SAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148.0 149.0 155.0 156.0 157.0 157.0 157.0 159.0 160.0 161.0 165.0 165.0
49.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 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) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1	f allocation? Enter "Y ied cost finding metho ider that qualifies for "N" for no for each co ampus hospital that ha Name 0 1 1) incentive in the Am r under §1886(n)? Ent 05 is "Y") and is a me	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption from mponent for Part A N N N N N N N N N N N N N	or no. es or "N" fo Part B 2.00 m the appli and Part B N N N N N N N N N N N N N	ferent CE i p Code 3.00	3.00 f the low 2 CFR §41 N N N N N 33SAS? CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 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)	f allocation? Enter "Y ied cost finding metho ider that qualifies for "N" for no for each co "N" for no for each co ampus hospital that ha Name 0 T) incentive in the Am r under \$1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru not a meaningful user,	" for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption from mponent for Part A N N N N N N N N N N N N N	or no. es or "N" fo Part B 2.00 m the appli and Part B N N N N N N N N N N N N N	Ferent CE ip Code 3.00	3.00 f the low 2 CFR §41 N N N N 3SAS? CBSA 4.00 - the	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148.00 149.00 155.00 156.00 157.00 158.00 159.00 160.00 161.00 165.00 0 166.00 0 166.00

Health Financial Systems	PERRY COUNTY H	OSPI TAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	TIFICATION DATA			Worksheet S-2 Part I	
			To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginni period respectively (mm/dd/yyyy)	ng date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider h section 1876 Medicare cost plans reporte			N	C	171.00
"Y" for yes and "N" for no in column 1. 1876 Medicare days in column 2. (see ins	lf column 1 is yes, en		n		

^{6/24/2022 9:41} am

10SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1322	Period:	u of Form CMS- Worksheet S-	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pr 6/24/2022 9:	
				Y/N	Date	41 011
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	lfor all NO r	esponses. En	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					_
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	a beginning of	the cost	N		1.
. 00	reporting period? If yes, enter the date of the change in o	column 2. (see	instruction			1.
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.
3. 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 relationships? (see instructions)	offices, drug der or its of the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
l. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	tified Public	Y	R		4.
	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.					
5. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2: Ifyes, i	s the provid	er N		6.
. 00 . 00	is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during t	N Ne N		7.
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		0			9.
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	ns.		Ν		10.
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	Ν		11.
					Y/N 1.00	
2 00	Bad Debts		tions		V	110
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 13.
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	f yes, see i	nstructions.	N	14.
5.00	Did total beds available change from the prior cost reporti	<u><u>v</u> 1</u>			N	15.
		Par Y/N	t A Date	Par Y/N	t B Date	
		1.00	Date 2.00	3.00	Date 4.00	
	PS&R Data					
6.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Ν		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	04/29/2022	Y Y	04/29/2022	17.
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	Ν		Ν		19.

100111	Financial Systems PERRY COUNTY FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN	: 15-1322	Period:	Worksheet S	-2
				From 01/01/2021 To 12/31/2021		
		Descrip	tion	Y/N	6/24/2022 9 Y/N	41 am
		0		1.00	3.00	
0.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	Ν	20.0
		Y/N	Date	Y/N	Date	
1.00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.0
1.00	records? If yes, see instructions.					21.1
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	SPI TALS)			
2.00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.0
3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		ls made du	ring the cost	N	23.
4.00		ed into during t	his cost r	eporting period?	Ν	24.
5.00	Have there been new capitalized leases entered into during instructions.	the cost report	ing period	?lfyes, see	Ν	25.
5.00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reportin	g period?	lfyes, see	Ν	26.
7.00	Has the provider's capitalization policy changed during the copy.	e cost reporting	period? I	fyes, submit	Ν	27.
3. 00	Interest Expense	ntered into duri	ng the cos	t reporting	N	28.
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (Deb	t Service	Reserve Fund)	Ν	29.
). 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		ebt? If ye	s, see	Ν	30.
. 00		ssuance of new d	ebt? If ye	s, see	Ν	31.
	instructions. Purchased Services					
2.00	Have changes or new agreements occurred in patient care ser		through c	ontractual	Ν	32.
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		to compet	itive bidding? If	N	33.
	Provi der-Based Physi ci ans					
1.00	Are services furnished at the provider facility under an ar	rrangement with	provi der-b	ased physicians?	Y	34.
5. 00			s with the	provi der-based	Ν	35.
	physicians during the cost reporting period? If yes, see in			Y/N	Date	
	Home Office Costs			1.00	2.00	
6.00	Were home office costs claimed on the cost report?			N		36.
. 00	If line 36 is yes, has a home office cost statement been pr	repared by the h	ome office	? N		37.
. 00				f N		38.
. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.			s, N		39.
		home office? I	fyes, see	N		40.
). 00		1.00)	2.	00	_
0.00		1.00	,	Ζ.	00	
0.00	Cost Report Preparer Contact Information					144
	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		BRI LL		41.
1. 00 2. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINT BLUE & CO., LLC		BRILL		41.

Health Financial Systems PERRY COU	NTY HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1322	Period: From 01/01/2021	Worksheet S-2 Part II		
		To 12/31/2021		pared: <u>1 am</u>	
	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,					
respectively.					
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.					

^{6/24/2022 9:41} am

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PERRY COUNTY	Provider C	N. 1E 1000		u of Form CMS-	
05PI I	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der Co	N: 15-1322	Period: From 01/01/2021	Worksheet S-3	3
					To 12/31/2021	Date/Time Pre 6/24/2022 9:4	eparec 41 am
						I/P Days /	
						0/P Visits /	
						Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2:00	9, 1		0.00 C	1.0
	8 exclude Swing Bed, Observation Bed and		-				
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)						2.
. 00	HMO I PF Subprovi der						3.
. 00	HMO I RF Subprovi der						4.
. 00	Hospital Adults & Peds. Swing Bed SNF					C	
. 00	Hospital Adults & Peds. Swing Bed NF		25	0.1		C	
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 1	25 53, 040. 00	C	7.
. 00	INTENSIVE CARE UNIT	31.00	0		0 0.00	c	8.
00	CORONARY CARE UNIT	51.00	0		0.00		9.
). 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12
	NURSERY	43.00				C	13.
4.00	Total (see instructions)		25	9, 1	25 53, 040. 00	C	14.
5.00	CAH visits					C	15.
5.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVI DER – I RF						17.
3.00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.
. 00	NURSING FACILITY						20
	OTHER LONG TERM CARE						21.
	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.)	11/ 00	0				23
. 00	HOSPICE	116.00	0		0		24
. 10	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24
. 00	RURAL HEALTH CLINIC - TCC	88.00				C	
	RURAL HEALTH CLINIC - TCC RURAL HEALTH CLINIC II - PCFP	88.00					
	RURAL HEALTH CLINIC III - 13TH	88.02					
	RURAL HEALTH CLINIC IV - SPENCER	88.03					
. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				Ċ	
	Total (sum of lines 14-26)		25			-	27
. 00	Observation Bed Days					C	
. 00	Ambul ance Trips						29.
0. 00	Employee discount days (see instruction)						30.
. 00	Employee discount days - IRF						31.
2. 00	Labor & delivery days (see instructions)		0		0		32.
2. 01	Total ancillary labor & delivery room						32.
	outpatient days (see instructions)						
	LTCH non-covered days						33.
. 01	LTCH site neutral days and discharges				1		33

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PERRY COUNTY AL DATA	Provider CC	N· 15-1322	Period:	u of Form CMS-2 Worksheet S-3	
55111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC				From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
		L/P Davs	/ O/P Visits	/ Trins	Full Time	 Equi val ents	
		in bajo	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,po		-qui fui onco	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		(00	7.00	Patients	& Residents	Payrol I	-
00	Hospital Adults & Peds. (columns 5, 6, 7 and	6.00	7.00	<u>8.00</u> 2,21	9.00	10.00	1.
00	8 exclude Swing Bed, Observation Bed and	909	33	2, 21	0		1.
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)	335	248				2.
00	HMO IPF Subprovider	0	0				3.
00	HMO IRF Subprovider	0	0				4.
00	Hospital Adults & Peds. Swing Bed SNF	824	0	82	4		5.
00	Hospital Adults & Peds. Swing Bed NF		0	21	3		6.
00	Total Adults and Peds. (exclude observation	1, 783	33	3, 24	7		7.
	beds) (see instructions)						
00	INTENSIVE CARE UNIT	0	0		0		8.
00	CORONARY CARE UNIT						9
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGI CAL INTENSI VE CARE UNI T						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY		0	12			13
. 00	Total (see instructions)	1, 783	33	3, 36		211.45	
. 00	CAH visits	0	0		0		15
. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER - IRF						17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0 00	0.00	23
. 00 . 10	HOSPICE	0	0		0 0.00 0	0.00	24 24
00	HOSPICE (non-distinct part) CMHC - CMHC				0		24
. 00	RURAL HEALTH CLINIC - TCC	2, 401	о	14, 80	0.00	23.50	
. 00	RURAL HEALTH CLINIC - TCC RURAL HEALTH CLINIC II - PCFP	2,401	0	14,80		6.84	
. 01	RURAL HEALTH CLINIC III - PCFP	109	0	4, 15		4. 51	
. 02	RURAL HEALTH CLINIC IV - SPENCER	271	0	4, 13		6.60	
. 25	FEDERALLY QUALIFIED HEALTH CENTER	2/1	0		0.00		
. 00	Total (sum of lines 14-26)	0	0		0.00		
. 00	Observation Bed Days		12	46		202.70	28
. 00	Ambul ance Trips	838	12	40			29
. 00	Employee discount days (see instruction)	000			D		30
. 00	Employee discount days - IRF				0		31
. 00	Labor & delivery days (see instructions)	0	2	3	-		32
. 01	Total ancillary labor & delivery room	ő	2		0		32
	outpatient days (see instructions)				-		``
3.00	LTCH non-covered days	0					33
	LTCH site neutral days and discharges	0					33

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 6/24/2022 9:4	pared
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	13.00	14.00	Patients 15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	0		53 9		1.0
. 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		0	2.	,	000	1.0
00	for the portion of LDP room available beds)				70 70		2.0
2.00 8.00	HMO and other (see instructions) HMO IPF Subprovider				78 70 0		3.0
. 00	HMO IRF Subprovider				0		4.0
5. 00	Hospital Adults & Peds. Swing Bed SNF				0		5.0
. 00 . 00	Hospital Adults & Peds. Swing Bed SNI Hospital Adults & Peds. Swing Bed NF						6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.0
8.00	INTENSIVE CARE UNIT						8.0
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11. (
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY						13.0
4.00	Total (see instructions)	0.00	0	2	53 9	630	14.0
5.00	CAH visits						15.0
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17.
8.00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.
0.00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00 3.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						22. 23.
4.00	HOSPICE	0.00					23.
4.10	HOSPICE (non-distinct part)	0.00					24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC - TCC	0, 00					26.
6.01	RURAL HEALTH CLINIC II - PCFP	0.00					26.
6. 02	RURAL HEALTH CLINIC III - 13TH	0.00					26.
6.03	RURAL HEALTH CLINIC IV - SPENCER	0.00					26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.
7.00	Total (sum of lines 14-26)	0.00					27.
8.00	Observation Bed Days						28.
9.00	Ambul ance Trips						29.
0. 00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF						31.
2.00	Labor & delivery days (see instructions)						32.
2.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.
3.00	LTCH non-covered days				0		33.

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		Period:	Worksheet S-8	;
			Component		From 01/01/2021 To 12/31/2021		
					RHC I	Cost	
					1.	. 00	
1 00	Clinic Address and Identification				100 111 (/		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
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for	urban		1.00	3.00
3.00	THOSE TRE-BASED TORCS ONET. Designation - Ent				Award	Date	3.00
					. 00	2.00	
	Source of Federal Funds			T		I.	
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00 6.00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34						5.00 6.00
7.00	Appal achi an Regi onal Commi ssi on						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)				_		9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h	osni tal -based	RHC or EOHC? E	nter "Y" for	1.00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column	TV TV		10.00
		Sun	iday	Мо	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC			07:00	20: 00	07:00	1 11 00
11.00				07.00	20.00	07.00	11.00
					1.00	2.00	
	Have you received an approval for an excepti				N		12.00
13.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				N	0	13.00
	number of providers included in this report. numbers below.	List the name	s of all provi	ders and			
	· · ·				ler 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						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)		Col	l Inty			
				00	_		
2.00	City, State, ZIP Code, County		PERRY				2.00
		Tuesday	Wedn	esday	Thu	rsday	
		to	from	to	from	to	
	Facility hours of operations (1)	6.00	7.00	8.00	9.00	10.00	
11.00		20: 00	07:00	20: 00	07:00	20: 00	11.00
	·	•	•		1		

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Period:	Worksheet S-8	
		Component	CCN: 15-8516	From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	pared: 1 am
	_			RHC I	Cost	
	Fri	Friday S		turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	20: 00				11.00

^{6/24/2022 9:41} am

Heal th	Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-		
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 01/01/202 To 12/31/202		pared:
						6/24/2022 9:4	
					RHC II	Cost	
					1	. 00	
	Clinic Address and Identification						
1.00	Street		Ci	ty	18485 STATE R State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		LEOPOLD			N 47551	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rur	al or "II" for i	urban		1.00	3.00
5.00	Those Transberry Transberry Designation - Entry				Award	Date	3.00
					. 00	2.00	
	Source of Federal Funds	A + >					
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ad						4.00 5.00
6.00	Health Services for the Homeless (Section 329(d), Fils A						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	0	10.00
	yes or "N" for no in column 1. If yes, indica						
	2. (Enter in subscripts of line 11 the type or hours.)	r otner operat	ion(s) and the	operating			
		Sun	day	Мо	nday	Tuesday	
		from	to	from	to	from	
	Facility hours of anomations (1)	1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC			07: 00	16: 00	07: 00	11.00
11.00				07.00	10.00	07.00	11.00
					1.00	2.00	
	Have you received an approval for an exception				N		12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu				Ν	0	13.00
	number of providers included in this report.						
	numbers below.						
					ler name . 00	CCN number 2.00	
14.00	RHC/FQHC name, CCN number				. 00	2.00	14.00
		Y/N	V	XVIII	XI X	Total Visits	
45.00		1.00	2.00	3.00	4.00	5.00	45.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.						
	(see instructions)						
				inty 00	_		
2.00	City, State, ZIP Code, County		4. PERRY	00			2.00
2.00	orty, State, Zri Code, County	Tuesday		esday	Thu	irsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	16: 00			07:00	16: 00	11.00
11.00		10.00	I	I	01.00	1.0.00	1 11.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Peri od:	Worksheet S-8	}
		Component	CCN: 15-8517	From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	pared: 1 am
	_			RHC II	Cost	
	Fri	Friday S		turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	16: 00				11.00

^{6/24/2022 9:41} am

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	CN: 15-1322	Peri od:	Worksheet S-8	;
			Component	CCN: 15-8560	From 01/01/2021 To 12/31/2021		pared:
					DUO LLI	6/24/2022 9:4	<u>1 am</u>
			<u> </u>		RHC III	Cost	
					1.	. 00	
	Clinic Address and Identification						-
1.00	Street		Ci	ty	148 13TH STREE State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		TELL CITY		IN	47586	2.00
						1 00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban		1.00	3.00
0.00	Internet brieze rande ener beergnation ent				t Award	Date	0100
				1	1.00	2.00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		1		1	4.00
4.00 5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
7.00			-	1			7.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	0	10.00
	yes or "N" for no in column 1. If yes, indica 2.(Enter in subscripts of line 11 the type o						
	hours.)						
		Sun			onday to	Tuesday	
		from 1.00	to 2.00	from 3.00	to 4.00	from 5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08: 00	16: 00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the prod	uctivity stand	ard?	1.00	2.00	12.00
13.00	Is this a consolidated cost report as define				Ν	0	13.00
	30.8? Enter "Y" for yes or "N" for no in coll number of providers included in this report.						
	numbers below.						
					der name	CCN number	
14.00	DHC/EOHC name CCN number			1	1.00	2.00	14 00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XI X	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.						
	(see instructions)						
				unty	_		
2.00	City, State, ZIP Code, County		4. PERRY	00			2.00
2.00	orty, State, ZFr Code, county	Tuesday		esday	Thu	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	16: 00	08: 00	16: 00	08: 00	16:00	11.00
11.00		10.00	00.00	1.0.00	00.00	1.0.00	1 11.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Period:	Worksheet S-8	
		Component	CCN: 15-8560	From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	pared: 1 am
				RHC III	Cost	
	Fri	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	16: 00				11.00

^{6/24/2022 9:41} am

Heal th	Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Period:	Worksheet S-8	3
			Component	CCN: 15-8562	From 01/01/2021 To 12/31/2021		
					RHC IV	Cost	
					1.	00	
	Clinic Address and Identification					-	
1.00	Street		Ci	ty	105 2ND STREET State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		ROCKPORT			47635	2.00
			•				
2.00	HOCDITAL DASED FOLICE ONLY: Decimpation Fat	n "D" fan nun	al an "II" fan i	urshan		1.00	2.00
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ente	er k tor fur			t Award	Date	3.00
					1. 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 A 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	0.00	
10.00	Does this facility operate as other than a ho	osni tal -based	RHC or EOHC2 E	nter "V" for	1.00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type or hours.)	ate number of	other operatio	ns in column	N		10.00
			iday		onday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00				07: 30	17:00	07: 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 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. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Ν	0	12.00 13.00
			-	Provi	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 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				inty			
2.00	City State 71D Cade County			00			2.00
2.00	City, State, ZIP Code, County	Tuesday	SPENCER	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)	17.00		47.00		47.00	
11.00	CLINIC	17:00	07: 30	17:00	07: 30	17:00	11.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL						
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1322	Period:	Worksheet S-8	;		
		Component	CCN: 15-8562	From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	pared: 1 am		
	_			RHC IV	Cost			
	Fri	Fri day Sa		turday				
	from	to	from	to				
	11.00	12.00	13.00	14.00				
Facility hours of operations (1)								
11. 00 CLINIC	07: 30	17:00				11.00		

^{6/24/2022 9:41} am

Heal th	Financial Systems PERRY COUNTY H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10				
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO		Peri od:	Worksheet S-1	0				
				From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4					
					1.00					
	Uncompensated and indigent care cost computation				1.00					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	divided by li	ne 202 colum	n 8)	0. 363884	1.00				
	Medicaid (see instructions for each line)									
2.00	Net revenue from Medicaid				3, 798, 139	2.00				
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00				
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme			ai d?	Y	4.00				
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medicai	d		0	5.00				
6.00 7.00	Medicaid charges				14, 958, 915	6.00 7.00				
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	n (line 7 mir	ous sum of li	nes 2 and 5 if	5, 443, 310 1, 645, 171	8.00				
0.00	< zero then enter zero)	•			1, 043, 171	0.00				
	Children's Health Insurance Program (CHIP) (see instructions	for each lir	ne)		-					
9.00	Net revenue from stand-al one CHIP				0					
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00 11.00				
12.00	Difference between net revenue and costs for stand-alone CHIF) (line 11 mi	nus line 9.	if < zero then	0					
12.00	enter zero)		nus ime 7,	II < Zero then	0	12.00				
	Other state or local government indigent care program (see instructions for each line)									
13.00	Net revenue from state or local indigent care program (Not in	ncluded on li	nes 2, 5 or	9)	0	13.00				
14.00	5 1 5 1									
	10)									
15.00	State or local indigent care program cost (line 1 times line			45	0					
16.00	Difference between net revenue and costs for state or local i 13; if < zero then enter zero)	ndigent care	e program (II	ne 15 minus line	0	16.00				
	Grants, donations and total unreimbursed cost for Medicaid, (CHIP and stat	te/local indi	gent care progra	ams (see					
	instructions for each line)									
17.00	Private grants, donations, or endowment income restricted to	5	5		0					
18.00	Government grants, appropriations or transfers for support of				0	18.00				
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loc 8, 12 and 16)	cal indigent	care program	s (sum of lines	1, 645, 171	19.00				
			Uni nsured	Insured	Total (col. 1					
			patients	patients	+ col. 2)					
			1.00	2.00	3.00					
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire 1	Facility	485, 85	4 0	485, 854	20.00				
20.00	(see instructions)	actificy	405, 05	0	405, 054	20.00				
21.00	Cost of patients approved for charity care and uninsured disc	counts (see	176, 79	04 0	176, 794	21.00				
22.00	instructions) Payments received from patients for amounts previously writte	en off as		o o	0	22.00				
23.00	charity care Cost of charity care (line 21 minus line 22)		176, 79	4 0	176, 794	23 00				
20100						20100				
24.00	Deep the ensure on Line 20 column 2, include channes for not		und a Lawath		1.00	24.00				
24.00	Does the amount on line 20 column 2, include charges for pati imposed on patients covered by Medicaid or other indigent car		yond a rength	or stay rimit	N	24.00				
25.00	If line 24 is yes, enter the charges for patient days beyond		t care progra	m's length of	0	25.00				
24 00	stay limit		`		0 100 (70	24 00				
26.00 27.00	Total bad debt expense for the entire hospital complex (see i Medicare reimbursable bad debts for the entire hospital compl		2, 188, 670 250, 032							
27.00	Medicare allowable bad debts for the entire hospital complex		250, 032 384, 665							
27.01	Non-Medicare bad debt expense (see instructions)	(See That ut	511 01137		1, 804, 005					
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt	expense (see	instructions)	791, 082					
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			•	967, 876					
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			2, 613, 047					

	Financial Systems	PERRY COUNTY				u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
	Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS			0.550.00		0 (70 5 (0	1
	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 553, 988				1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP	100 70/	0		0 1, 132, 939		2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	122, 796	386, 198				4.00
	00540 ADMINI STRATI VE AND GENERAL	1, 472, 627	1, 238, 524				5.01
	00590 ADMINISTRATIVE AND GENERAL - OTHER	1, 089, 553	4, 194, 296				5.02
	00700 OPERATION OF PLANT	264, 016	1, 681, 880				
	00800 LAUNDRY & LINEN SERVICE	0	76, 329				8.00
	00900 HOUSEKEEPI NG	273, 221	177, 053			450, 274	9.00
	01000 DI ETARY	0	614, 145				10.00
	01100 CAFETERI A	0	0		0 377, 519		11.00
	01300 NURSI NG ADMI NI STRATI ON	290, 304	90, 860			381, 164	13.00
	01600 MEDI CAL RECORDS & LI BRARY	191, 003	126, 426	317, 42	9 -1, 525	315, 904	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.000.050	0.405.047	5 00 (00		5 7 10 700	
	03000 ADULTS & PEDIATRICS	2, 820, 350	3, 105, 947				30.00
	03100 I NTENSI VE CARE UNI T	0	0		0 0		31.00
	04300 NURSERY	0	0		0 0	0	43.00
	ANCI LLARY SERVICE COST CENTERS			4 (00 54	0 010 155	4 474 944	
	05000 OPERATING ROOM	527, 401	1, 163, 118				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	123, 564			,	52.00
	05400 RADI OLOGY-DI AGNOSTI C	841, 856	618, 778				54.00
	06000 LABORATORY	749, 752	1, 513, 425			2, 262, 133	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	384	84, 594			84, 978	
	06500 RESPIRATORY THERAPY	475, 629	968, 641	1, 444, 27			
	06600 PHYSI CAL THERAPY	498, 436	111, 124				66.00
	06700 OCCUPATI ONAL THERAPY	161, 731	38, 560			200, 291	67.00
	06800 SPEECH PATHOLOGY	80, 115	14, 721			94, 836	68.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	516, 559	516, 55			71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0 000 7/	0 116, 970		72.00
	07300 DRUGS CHARGED TO PATIENTS	94, 281	2, 808, 488	2, 902, 76	9 -13, 442	2, 889, 327	73.00
	OUTPATIENT SERVICE COST CENTERS	0.070.(10	1 1 1 5 001			0.000.0/0	
	08800 RURAL HEALTH CLINIC - TCC	2,078,610	1, 145, 831				
	08801 RURAL HEALTH CLINIC II - PCFP	606, 018	402, 744			.,	
	08802 RURAL HEALTH CLINIC III - 13TH	1, 806, 169	607, 937				
	08803 RURAL HEALTH CLINIC IV - SPENCER	586, 991	275, 713				88.03
	09000 CLINIC	293, 536	261, 560				90.00
	09001 PALN MANAGEMENT	0	0		0 0	0	90.01
	09002 WOUND CARE	215, 248	89, 216				90.02
	09003 ORTHOPEDIC CLINIC	86, 992	19, 718				90.03
	09100 EMERGENCY	692, 751	1, 641, 249	2, 334, 00	0 -2, 197	2, 331, 803	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	(50 (57	474.000	1 104 40		4 407 050	05 00
	09500 AMBULANCE SERVICES	659, 657	474, 828	1, 134, 48	5 -27, 126	1, 107, 359	95.00
	SPECIAL PURPOSE COST CENTERS		1 100 000	1 100 00			
110 00	11300 INTEREST EXPENSE		1, 132, 939				113.00
	11600 HOSPI CE	0	0		0 0		116.00
116.00		1/ 070 /07					
116. 00 118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	16, 979, 427	28, 258, 953	45, 238, 38	0 -590, 187	44, 648, 193	110.00
116. 00 118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS				-		
116. 00 118. 00 190. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
116. 00 118. 00 190. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES			145, 85	0 0 3 590, 187	0 736, 040	190. 00 192. 00

	Financial Systems	PERRY COUNT					F Form CMS	-2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der C	CN: 15-1322	Period: From 01/01/		rksheet A	
					To 12/31/	'2021 Da	te/Time Pr 24/2022 9:	
	Cost Center Description	Adjustments	Net Expenses				2172022 7.	
		(See A-8)	For					
			Allocation					
		6.00	7.00					
1 00	GENERAL SERVICE COST CENTERS	0						1 1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	0						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	64, 420		1				2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMINISTRATIVE AND GENERAL	0 -1, 074, 706		1				4.00
5.01	00590 ADMINI STRATI VE AND GENERAL - OTHER	-118, 571	5, 138, 441	1				5.02
5.02 7.00	00700 OPERATION OF PLANT	-2, 018						7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-2,018		1				8.00
9.00	00900 HOUSEKEEPING	0						9.00
10.00	01000 DI ETARY	-13, 269						10.00
11.00	01100 CAFETERI A	-62, 776						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-02,770						13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-3, 396	312, 508					16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	-3, 370	512, 500	1				10.00
30.00	03000 ADULTS & PEDIATRICS	-97,000	5, 651, 780					30.00
31.00	03100 I NTENSI VE CARE UNI T	000		1				31.00
43.00	04300 NURSERY	0						43.00
45.00	ANCI LLARY SERVICE COST CENTERS	0	0	1				- 45.00
50.00	05000 OPERATING ROOM	-682, 677	788, 687					50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-123, 564	00,007	1				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		•				54.00
60.00	06000 LABORATORY	0		1				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	84, 978	1				62.00
65.00	06500 RESPI RATORY THERAPY	-374, 319		1				65.00
66.00	06600 PHYSI CAL THERAPY	0		1				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0		1				67.00
68.00	06800 SPEECH PATHOLOGY	0	94, 836	1				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	801, 954	1				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0		1				72.00
72.00	07300 DRUGS CHARGED TO PATIENTS	-24	2, 889, 303	1				73.00
73.00	OUTPATIENT SERVICE COST CENTERS	-24	2,007,303	1				13.00
88.00	08800 RURAL HEALTH CLINIC - TCC	0	2, 999, 368					88.00
88.01	08801 RURAL HEALTH CLINIC II - PCFP	-70						88.01
88.02	08802 RURAL HEALTH CLINIC III - 13TH	-70						88.02
88.03	08803 RURAL HEALTH CLINIC IV - SPENCER	-38						88.03
90.00	09000 CLINIC	-26, 250						90.00
90.00 90.01	09001 PALN MANAGEMENT	-20, 230						90.00
90.01 90.02	09002 WOUND CARE	-123, 323						90.01
90.02 90.03	09003 ORTHOPEDIC CLINIC	- 123, 323						90.02
90.03 91.00	109003 ORTHOPEDIC CEINIC	0						90.03
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 331, 603					91.00
72.00	OTHER REIMBURSABLE COST CENTERS		l					- 72.00
95,00	09500 AMBULANCE SERVICES	-569	1, 106, 790					95.00
,0.00	SPECIAL PURPOSE COST CENTERS		1,100,770	I				
113.00	11300 I NTEREST EXPENSE	0	0					113.00
	11600 HOSPI CE	0		1				116.00
118.00		-2, 638, 150	-					118.00
	NONREI MBURSABLE COST CENTERS	2,000,100	2,010,040	1				1
			1	1				H
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0					190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0		1				190.00 192.00

I FI CATI ONS			Provider CCN: 15-1	From 01/01/20	Worksheet A-
				To 12/31/20	021 Date/Time Pr 6/24/2022 9:
Cost Contor	Increases	Salary	Othor		
Cost Center 2.00	Line # 3.00	Salary 4.00	0ther 5.00		
A - CAFETERIA COST	0.00	1.00	0.00		
	<u>11.</u> 00	0	37 <u>7,519</u>		
D		0	377, 519		
NEW CAP REL COSTS-MVBLE	2.00	0	1, 132, 939		
EQUI P					
		0	1, 132, 939		
C - LEASE EXPENSE NEW CAP REL COSTS-BLDG &	1.00	0	79, 347		
FIXT	1.00	Ŭ	77, 347		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	Ő	Ő		
	0.00	о	0		
	0.00	0			
D - INSURANCE EXPENSE		0	79, 347		
NEW CAP REL COSTS-BLDG &	1.00	0	39, 233		
FLXT					
	0.00	<u>o</u>			
E - DRUGS CHARGED			07,200		
DRUGS CHARGED TO PATIENTS	73.00	0	3, 837		
	0.00 0.00	0	0		
	0.00	o o			
F - BILLABLE SUPPLIES					
MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	402, 365		
PATTENTS	0.00	0	0		
	0.00	Ō	0		
	0.00	0	0		
	0.00 0.00	0 0	0 0		
	0.00	o	0		
		0	402, 365		
G - IMPLANTABLE DEVICE	72.00		114 070		
IMPL. DEV. CHARGED TO PATIENT	72.00	0	116, 970		
		0	116, 970		
H - WOUND CARE RECLASS	00.00	00 (01			
NOUND CARE	90.02 0.00	99, 631	0 0		
		99,631	— — <u> </u>		
- RHC RECRUITING EXPENSE RE			- 1		
RURAL HEALTH CLINIC - TCC	88.00	0	8, 701		
RURAL HEALTH CLINIC III - 13TH	88.02	0	15, 875		
D	+		24,576		
J - IV THERAPY					
	<u>90.00</u>	º	1 <u>6, 886</u> 16, 886		
L - TELL CITY RECLASS		U	10, 880		
RURAL HEALTH CLINIC III -	88. 02	286, 593	0		
13TH			_		
RURAL HEALTH CLINIC IV -	88. 03	2, 501	0		
<u>SPENCER</u>	+		— — <u> </u>		
M - RHC CERTIFICALTON RECLASS					
PHYSICIANS' PRIVATE OFFICES	192.00	544, 198	200, 940		
TOTALS		0 544, 198	0 200, 940		
		044 198	//// 94//		

						From 01/01/2021 To 12/31/2021	Date/Time Prepare
					I	10 12/01/2021	
		Decreases					6/24/2022 9:41 am
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00		
0	A - CAFETERIA COST						
	<u>DIETARY</u>	<u>10.</u> 00	0 _	37 <u>7,5</u> 19		Ō	1
	B - INTEREST EXPENSE		U	377, 519	/		
	INTEREST EXPENSE	113.00	0	1, 132, 939	1	1	1
				1, 132, 939		4	
Ī	C - LEASE EXPENSE	I		1,102,707	·]	1	
-	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	393	3 1	0	1.
0	ADMINISTRATIVE AND GENERAL	5.01	0	2, 399		0	2
	ADMINISTRATIVE AND GENERAL -	5.02	0	7,675	5	0	3
	OTHER						
	OPERATION OF PLANT	7.00	0	3, 663		0	4
	DIETARY	10.00	0	393		0	5.
	MEDICAL RECORDS & LIBRARY	16.00	0	1, 525		0	6
	ADULTS & PEDIATRICS	30.00	0	6, 244		0	7.
	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	22, 755		0	8
	LABORATORY	60.00	0	1, 437 1, 044		0	10
	RESPI RATORY THERAPY	65.00	0	20, 950		0	10
	PHYSICAL THERAPY	66.00	0	393		0	12
	DRUGS CHARGED TO PATIENTS	73.00	0	393		0	13
	CLINIC	90.00	ő	956		0	14
	WOUND CARE	90.02	õ	393		0	15
	EMERGENCY	91.00	0	1, 679		0	16
00	AMBULANCE SERVICES	95.00	0	7,055		0	17.
ſ	0		0	79, 347	7	1	
	D – INSURANCE EXPENSE						
0	ADMINISTRATIVE AND GENERAL -	5.02	0	19, 162	2 1	0	1.
	OTHER						
0	AMBULANCE_SERVICES	95.00	• •	2 <u>0, 0</u> 71		Q	2
- F	0		0	39, 233	8		
	E - DRUGS CHARGED	5.04		4 000			
	ADMINISTRATIVE AND GENERAL	5.01	0	1, 230		0	1.
	WOUND CARE	90. 02 90. 03	0	1, 228 1, 379		0	2.
		90.03	— — — (4	3
	F - BILLABLE SUPPLIES		0	5,057			
	ADULTS & PEDIATRICS	30.00	0	171, 273	3	0	1.
	OPERATI NG ROOM	50.00	0	196, 400		o	2
0 1	RESPI RATORY THERAPY	65.00	0	30, 444	Ļ	0	3
0 0	PHYSI CAL THERAPY	66.00	0	111		0	4
00	ORTHOPEDIC CLINIC	90. 03	0	72	2	o	5
	WOUND CARE	90. 02	0	3, 547	7	0	6
0	EMERGENCY	91.00	0	518	3	o	7
(0		0	402, 365			
	G - IMPLANTABLE DEVICE		. 1		. [
	MEDICAL SUPPLIES CHARGED TO	71.00	0	116, 970		0	1.
	PATI ENTS	+	- — — /	116, 970	<u> </u>	-	
	H - WOUND CARE RECLASS		0	110, 970	́и	1	
	RURAL HEALTH CLINIC - TCC	88.00	13, 724	0)	0	1.
	PHYSICIANS' PRIVATE OFFICES	192.00	85, 907	0		0	2
ĺ			99, 631	— — — Ö		Ĩ	
i i	I - RHC RECRUITING EXPENSE REC	LASS	,				
	ADMINISTRATIVE AND GENERAL	5.01	0	24, 576)	0	1.
0		0.00	0	0		o	2
[0		0	24, 576			
	J - IV THERAPY				1	-	
0	DRUGS_CHARGED_TO_PATIENTS	73.00	<u>0</u>	1 <u>6,886</u>		ol	1.
0			0	16, 886			
	L - TELL CITY RECLASS	00.00	220.050	~			-
	RURAL HEALTH CLINIC - TCC	88.00	220, 050	0		0	1
0	PHYSICIANS' PRIVATE OFFICES	1 <u>92.00</u>	<u> </u>	0		<u>o</u>	2
[M - RHC CERTIFICALTON RECLASS		289, 094	U			
	RURAL HEALTH CLINIC III -	88. 02	410, 718	138, 244		0	1
	13TH	00.02	410,710	130, 244			1.
	RURAL HEALTH CLINIC IV -	88. 03	133, 480	62, 696		0	2.
	SPENCER	20.00	, 100	32, 370			2.
	TOTALS	+	544, 198	200, 940		1	

Heal th	Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lieu of Form CMS-2552-10		
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1322	Period: From 01/01/2027 To 12/31/2027		pared:
				Acquisition	s		
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES					
1.00	Land	3, 815, 753	0		0 (10,000	1.00
2.00	Land Improvements	59, 357	212, 920		0 212, 920	0 0	2.00
3.00	Buildings and Fixtures	44, 070, 776	0		0 0	89, 534	3.00
4.00	Building Improvements	0	0		0 0	0 0	4.00
5.00	Fixed Equipment	2, 418, 589	188, 116		0 188, 116	6 0	5.00
6.00	Movable Equipment	17, 722, 335	764, 186		0 764, 186	5 O	6.00
7.00	HIT designated Assets	0	0		0 0		7.00
8.00	Subtotal (sum of lines 1-7)	68, 086, 810	1, 165, 222		0 1, 165, 222	99, 534	•
9.00	Reconciling Items	0	0		0 0		
10.00	Total (line 8 minus line 9)	68, 086, 810	1, 165, 222		0 1, 165, 222	99, 534	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6,00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES					
1.00	Land	3, 805, 753	0				1.00
2.00	Land Improvements	272, 277	0				2.00
3.00	Buildings and Fixtures	43, 981, 242	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2,606,705	0				5.00
6.00	Movable Equipment	18, 486, 521	0				6.00
7.00	HIT designated Assets	10, 100, 021	0				7.00
8.00	Subtotal (sum of lines 1-7)	69, 152, 498	0				8.00
9.00	Reconciling Items	0,102,170	0				9.00
	Total (line 8 minus line 9)	69, 152, 498	0				10.00
		21, 102, 170	, o	1			1

^{6/24/2022 9:41} am

Heal th	Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
RECONO	CILIATION OF CAPITAL COSTS CENTERS	_	Provider C	CN: 15-1322	Period: From 01/01/2021 To 12/31/2021		epared:	
			SL	IMMARY OF CAP	ITAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see instructions)	instructions)		
		9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 449, 648	0		0 95,000	9, 340	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	2, 449, 648			0 95,000	9, 340	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1)	1				
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	<u>MN 2, LINES 1 a</u>	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 553, 988				1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
3.00	Total (sum of lines 1-2)	0	2, 553, 988				3.00	

^{6/24/2022 9:41} am

Health Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2021 To 12/31/2021		
	COMF	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	2.00	<u>col.2)</u> 3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	50, 665, 977	0	50, 665, 97	0. 732670	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	18, 486, 521	0	18, 486, 52	0. 267330	0	2.00
3.00 Total (sum of lines 1-2)	69, 152, 498		69, 152, 498			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5			
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0	0		2, 449, 648	118, 580	1.00
2.00 NEW CAP REL COSTS-BLDG & FIXT				2,449,048	64, 420	2.00
3.00 Total (sum of lines 1-2)	0			2,449,648		3.00
		SL	IMMARY OF CAPI		100,000	0.00
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
cost center bescription	Interest	(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see		
				instructions)	, the ought inj	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	1			1		
1.00 NEW CAP REL COSTS-BLDG & FIXT	0		9, 340	0	2, 672, 568	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	1, 132, 939			0	1, 197, 359	2.00
3.00 Total (sum of lines 1-2)	1, 132, 939	95, 000	9, 340	ט וי	3, 869, 927	3.00

^{6/24/2022 9:41} am

Heal th Financial	Systems
AD HISTMENTS TO E	VDENCES

	MENTS TO EXPENSES				Period: From 01/01/2021 Fo 12/31/2021	Worksheet A-8 Date/Time Prep 6/24/2022 9:4	parec
				Expense Classification on 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		C	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1. (
00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter	В	-929	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.
00	2) Investment income - other (chapter 2)		C		0.00	0	3.
00	Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4.
00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.
00	Rental of provider space by suppliers (chapter 8)		C		0.00	0	6.
00	Telephone services (pay stations excluded) (chapter 21)	A	-5,850	ADMINISTRATIVE AND GENERAL - OTHER	- 5.02	0	7.
00	Tel evision and radio service (chapter 21)	А	-2, 018	OPERATION OF PLANT	7.00	0	8
	Parking lot (chapter 21) Provider-based physician	A-8-2	C -1, 427, 613	3	0.00	0 0	
00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11
. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	65, 349			0	12
	Laundry and linen service		C		0.00	0	
	Cafeteria-employees and guests Rental of quarters to employee	B B		CAFETERIA ADMINISTRATIVE AND GENERAL	11. 00 5. 01	0 0	
00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16
00	patients Sale of drugs to other than patients	В	-24	DRUGS CHARGED TO PATIENTS	73.00	0	17
00	Sale of medical records and abstracts	В	-3, 396	MEDICAL RECORDS & LIBRARY	16.00	0	18
00	Nursing and allied health education (tuition, fees, books, etc.)		C		0.00	0	19
	Vending machines Income from imposition of	В	-13, 269	DI ETARY	10. 00 0. 00	0	
	interest, finance or penal ty charges (chapter 21)						
. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		C		0.00	0	22
00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23
00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24
00	limitation (chapter 14) 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	О	26
00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		C	FIXT NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27
	Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00		28
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29 30
. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30

Heal th	Financial Systems		PERRY COUNT	Y HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	nared
					10 12/31/2021	6/24/2022 9:4	
				Expense Classification o			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)				Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
22.00	limitation (chapter 14) CAH HIT Adjustment for		0		0, 00	0	32.00
32.00	Depreciation and Interest		0		0.00	0	32.00
33 00	ADMI NI STRATI ON MI SCELLANEOUS	В	-136 230	ADMINISTRATIVE AND GENERAL	5. 01	0	33,00
55.00	REVENUE	D	130, 230	ADMINI STRATI VE AND GENERAL	5.01	0	33.00
33.01	NONPATIENT SERVICES-CPR/EDU	В	-569	AMBULANCE SERVICES	95.00	0	33.01
	CLASSES-						
33.02	ADMI NI STRATI ON-MI SC EXPENSES	A		ADMINISTRATIVE AND GENERAL	- 5.02	0	33.02
				OTHER			
33.03	ADVERTISING - PCM	A		RURAL HEALTH CLINIC II -	88.01	0	33.03
33.04	ADVERTISING - SPENCER	А		PCFP RURAL HEALTH CLINIC IV -	88.03	0	33.04
33.04	ADVERTISING - SPENCER	А		SPENCER	00.03	0	33.04
33.05	WOUND CENTER-ADVERTISING	А		WOUND CARE	90.02	0	33.05
33.06		A		ADMI NI STRATI VE AND GENERAL	5. 01	0	
33.07	HAF FEES	В		ADMI NI STRATI VE AND GENERAL	5. 01	0	
33.08	LOBBYING DUES	А		ADMINISTRATIVE AND GENERAL	5. 01	0	
33.09	CANNELTON OFFSET	А	-3,351	ADMINISTRATIVE AND GENERAL	5. 01	0	33.09
50.00	TOTAL (sum of lines 1 thru 49)		-2, 638, 150				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	PERRY COUNT	FY HOSPI TAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1322	Peri od:	Worksheet A-8	3-1
OFFI CE	COSTS			From 01/01/2021 To 12/31/2021		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OF	R CLAIMED HOME	
	OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	65, 349	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			65,349	0	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas	s not	been	posted to	worksneet A	COLIMINS	and/or 2	, the amou	nt allowable si	noul a be	Indicated in co	Jiumn 4	or this part.	
									Rel ated	Organization(s)	and/or	Home Office	
										3			
			Symbol	(1)		Name		Percentage of		Name	P	ercentage of	
			-					Ownership				Ownershi p	
			1.0	0		2.00		3.00		4.00		5.00	
		B. INT	FERRELATI O	NSHIP TO REL	ATED ORGAN	ZATION(S)	AND/OR HO	ME OFFICE:					

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

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

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

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

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

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

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

organi zati on.

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

Health Financial Systems	PERRY COUNTY H	OSPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1322	From 01/01/2021	
			To 12/31/2021	Date/Time Prepared:

								6/24/2022 9:	<u>41 am</u>
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6.00	7.00							
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED	AS A RESULT OF	TRANSACTIONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:								
1.00	65, 349	10							1.00
2.00	0	0							2.00
3.00	0	0							3.00
4.00	0	0							4.00
5.00	65, 349								5.00

* The amounts on 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	INT DEEL POSTED TO MOLKSHEET A,		2, th	e amount	arrowabre	siloui u be	Thui cateu	TH COLUMN 4 OF	this part.	
	Rel ated Organi zati on(s)									
	and/or Home Office									
	Type of Business									
	51									
	6.00									
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION	(S) AND	O/OR HOME	OFFLCE:					

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

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

6.00		6.00							
7.00 8.00		7.00							
8.00		8.00							
9.00		9.00							
9.00 10.00 100.00		10.00							
100.00		100.00							

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

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

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

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

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

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

Heal th I	Financial Syste	ems	PERRY COUN	TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC			Provider (CCN: 15-1322	Peri od:	Worksheet A-8	3-2
						From 01/01/202 To 12/31/202		
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMINISTRATIVE AND GENERAL	685			0 0		
2.00		ADULTS & PEDIATRICS	926, 036					
3.00		OPERATING ROOM	682, 677			0 0		
4.00		DELIVERY ROOM & LABOR ROOM	123, 564	123, 564		0 0	0	4.00
5.00	60.00	LABORATORY	18,000	0	18, 00	0 0	0	5.00
6.00	65.00	RESPI RATORY THERAPY	374, 319	374, 319		0 0	0	6.00
7.00	90.00	CLINIC	26, 250	26, 250		0 0	0	7.00
8.00	90. 02	WOUND CARE	123, 118	123, 118		o o	0	8.00
9.00	91.00	EMERGENCY	1, 284, 357	0	1, 284, 35	7 0	0	9.00
10.00	0.00		0	0		o o	0	10.00
200.00			3, 559, 006	1, 427, 613	2, 131, 39	3	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5. 01	ADMINISTRATIVE AND GENERAL	0	0		0 0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0		o o	0	2.00
3.00	50.00	OPERATING ROOM	0	0		o l	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0		o l	0	4.00
5.00	60.00	LABORATORY	0	0		o l	0	5.00
6.00	65.00	RESPI RATORY THERAPY	0	l o		o l	0	6.00
7.00	90, 00	CLINIC	0	0			0	7.00
8.00		WOUND CARE	0	0			0	
9.00		EMERGENCY	0	0			0	
10.00	0.00		0	0			-	
200.00	0.00		0	0				200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	-	
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5. 01	ADMI NI STRATI VE AND GENERAL	0	0		0 685		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0		97,000		2.00
3.00	50.00	OPERATING ROOM	0	0		0 682,677		3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0		0 123, 564		4.00
5.00	60.00	LABORATORY	0	0		0 0		5.00
6.00		RESPIRATORY THERAPY	0	0		374, 319		6.00
7.00		CLINIC	0	0		26, 250	1	7.00
8.00		WOUND CARE	0	Ö		123, 118		8.00
9.00		EMERGENCY	0	0			1	9.00
10.00	0.00		0	0				10.00
200.00	5.00		0	0		1, 427, 613		200.00
	1	1			I	., .2., 510	I	

Health Financial Systems PERRY COUNTY HOSPITAL In	Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1322 Period: From 01/01/2 To 12/31/2	Worksheet B 1021 Part I
CAPI TAL RELATED COSTS	
Cost Center Description Net Expenses NEW BLDG & NEW MVBLE EMPLOYER for Cost FIXT EQUIP BENEFITS Allocation (from Wkst A col. 7) DEPARTMEN	;
0 1.00 2.00 4.00	4A
GENERAL SERVICE COST CENTERS	
	947 1, 952, 202 5. 01
7.00 00700 OPERATION OF PLANT 1,940,215 515,935 231,147 8,	995 5, 418, 689 5. 02 238 2, 695, 535 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 76, 329 4, 402 1, 972 9. 00 00900 HOUSEKEEPI NG 450, 274 29, 606 13, 264 8, 10. 00 D1000 DI ETARY 222, 964 112, 303 50, 314	0 82,703 8.00 525 501,669 9.00 0 385,581 10.00
11. 00 01100 CAFETERIA 314, 743 0 0	0 314, 743 11. 00 058 398, 828 13. 00
16.00 01600 MEDI CAL RECORDS & LI BRARY 312, 508 33, 017 14, 792 5, I NPATI ENT ROUTI NE SERVI CE COST CENTERS 5	959 366, 276 16.00
	989 6, 306, 221 30.00
31. 00 03100 INTENSIVE CARE UNIT 0 0 0 43. 00 04300 NURSERY 0 15, 980 7, 160 ANCILLARY SERVICE COST CENTERS 0 15, 980 7, 160	0 0 31.00 0 23,140 43.00
	455 1, 221, 502 50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 70, 547 31, 607 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 459, 197 145, 541 65, 205 26,	0 102, 154 52. 00 267 1, 696, 210 54. 00
	393 2, 372, 604 60.00 12 84, 900 62, 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 84, 978 0 0 65.00 06500 RESPI RATORY THERAPY 1, 018, 557 90, 424 40, 512 14,	12 84, 990 62.00 840 1, 164, 333 65.00
	552 688, 992 66. 00
	046 233, 290 67.00
	500 112, 029 68. 00 0 801, 954 71. 00
71. 00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 801, 954 0 0 0 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 116, 970 0 0 0	0 801, 954 71.00 0 116, 970 72.00
	942 2, 940, 278 73.00
OUTPATIENT SERVICE COST CENTERS	
	561 3, 056, 929 88. 00 1, 027, (20) 20, 01
	908 1,027,600 88.01 481 2,220,093 88.02
	228 683, 219 88. 03
	159 697, 205 90.00
90. 01 09001 PALN MANAGEMENT 0 0 0	0 0 90.01
	825 335, 852 90. 02
	714 107, 973 90. 03
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	615 2, 571, 973 91.00 0 92.00
OTHER REIMBURSABLE COST CENTERS	<u>500</u> 1.070.001 05.00
95. 00 09500 AMBULANCE SERVICES 1, 106, 790 99, 052 44, 377 20, SPECIAL PURPOSE COST CENTERS	<u>582</u> <u>1, 270, 801</u> 95. 00
113. 00 11300 I NTEREST EXPENSE	113.00
116.00 HOSPI CE 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 42,010,043 2,641,994 1,183,661 513,	0 0 116.00
NONREI MBURSABLE COST CENTERS	0 44 272 100 00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 30, 574 13, 698 192.00 PHYSI CLANS' PRI VATE OFFICES 736, 040 0 0 13, 200.00 Cross Foot Adjustments 736, 040 0 0 13,	0 44, 272 190. 00 233 749, 273 192. 00 0 200. 00
201.00 Negative Cost Centers 0 0 202.00 TOTAL (sum Lines 118 through 201) 42,746,083 2,672,568 1,197,359 527,	0 0 201.00

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	PERRY COUNTY	Provi der C	CN: 15-1322	Period:	u of Form CMS-2 Worksheet B	2002 10
00017				1	From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
	Cost Center Description	ADMI NI STRATI V	Subtotal	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	
		E AND GENERAL		E AND GENERAL	PLANT	LINEN SERVICE	
		5.01	54.04	- OTHER	7.00	0.00	
	GENERAL SERVICE COST CENTERS	5.01	5A. 01	5.02	7.00	8.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1	-		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	1, 952, 202					5.01
5.02	00590 ADMINI STRATI VE AND GENERAL - OTHER	259, 311	5, 678, 000	5, 678, 00	0		5.02
7.00	00700 OPERATION OF PLANT	128, 995	2, 824, 530	442, 01	6 3, 266, 546		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 958	86, 661	13, 56	2 8, 134	108, 357	8.00
9.00	00900 HOUSEKEEPI NG	24, 007	525, 676	82, 26	4 54, 698	18, 534	9.00
10.00	01000 DI ETARY	18, 452	404, 033			0	
11.00	01100 CAFETERI A	15, 062	329, 805			0	
13.00	01300 NURSING ADMINISTRATION	19, 086	417, 914			0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	17, 528	383, 804	60, 06	2 61, 001	0	16.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	004 705		1 004 40		00.700	
30.00	03000 ADULTS & PEDIATRICS	301, 795	6, 608, 016			33, 723	1
31.00	03100 I NTENSI VE CARE UNI T	0	0			0	
43.00	04300 NURSERY	1, 107	24, 247	3, 79	4 29, 525	0	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	58, 455	1, 279, 957	200, 30	3 531, 241	8, 305	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 889	107,043			0, 303	
54.00	05400 RADI OLOGY-DI AGNOSTI C	81, 172	1, 777, 382			11, 798	1
60.00	06000 LABORATORY	113, 541	2, 486, 145			307	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4,067	89,057			0	1
65.00	06500 RESPIRATORY THERAPY	55, 719	1, 220, 052			2, 526	1
66.00	06600 PHYSI CAL THERAPY	32, 972	721, 964			2, 332	
67.00	06700 OCCUPATI ONAL THERAPY	11, 164	244, 454	38, 25	5 35, 666	0	67.00
68.00	06800 SPEECH PATHOLOGY	5, 361	117, 390	18, 37	1 18, 748	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38, 378	840, 332	131, 50	5 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5, 598	122, 568			0	
73.00	07300 DRUGS CHARGED TO PATIENTS	140, 707	3, 080, 985	482, 15	0 61, 286	0	73.00
	OUTPATIENT SERVICE COST CENTERS				-	-	
88.00	08800 RURAL HEALTH CLINIC - TCC	146, 289	3, 203, 218			0	
88.01	08801 RURAL HEALTH CLINIC II - PCFP	49, 176	1,076,776			0	
88.02	08802 RURAL HEALTH CLINIC III - 13TH	106, 243	2, 326, 336			0	
88. 03 90. 00	08803 RURAL HEALTH CLINIC IV - SPENCER 09000 CLINIC	32, 695 33, 365	715, 914 730, 570			2, 844	1
90.00 90.01	09001 PALN MANAGEMENT	33, 305	/30, 570		0 102, 001	2, 844	1
90.01	09002 WOUND CARE	16, 072	351, 924		-	0	90.02
90.02	09003 ORTHOPEDIC CLINIC	5, 167	113, 140			0	90.02
91.00	09100 EMERGENCY	123, 082	2, 695, 055			27, 772	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	120,002	2,0,0,000		2/0/000	2.,	92.00
	OTHER REIMBURSABLE COST CENTERS	J		1			
95.00	09500 AMBULANCE SERVI CES	60, 814	1, 331, 615	208, 38	7 183, 004	216	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0		0 0		116.00
118.00		1, 914, 227	41, 914, 563	5, 670, 74	0 3, 210, 059	108, 357	118.00
	NONREI MBURSABLE COST CENTERS	1			1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 119	46, 391		0 56, 487		190.00
							1102 00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	35, 856	785, 129		0		192.00
192.00 200.00	Cross Foot Adjustments	35, 856	785, 129 0				200.00
192.00	Cross Foot Adjustments Negative Cost Centers	35, 856 0 1, 952, 202	785, 129 0 0 42, 746, 083		0 0 0 3, 266, 546	0	200. 00 201. 00

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 6/24/2022 9:4	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	
		9.00	10.00	11.00	13.00	16.00	
	GENERAL SERVICE COST CENTERS			-			
1.00 2.00 4.00 5.01 5.02	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						1.00 2.00 4.00 5.01 5.02
7.00 8.00 9.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	681, 172					7.00 8.00 9.00
10.00 11.00 13.00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	44, 116 0 2, 335	718, 863 0 0	381, 41 9, 39	3 506, 022		10.00 11.00 13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	12, 970	0	13, 35	0 0	531, 187	16.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	153, 669 0	718, 863 0		1 321, 302 0 0	156, 329 0	30.00 31.00
43.00	04300 NURSERY	6, 278	0		00	0	43.00
F0 00	ANCILLARY SERVICE COST CENTERS	112.052	0	22.50	2 50.020	10.00/	
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	112, 952 27, 713	0		2 58, 830 0 0	10, 086 0	50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	57, 172	0	40, 50		16, 810	
60.00	06000 LABORATORY	23, 623	0	46, 48		40, 343	•
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65.00	06500 RESPIRATORY THERAPY	35, 521	0	24, 16		26, 896	•
66.00	06600 PHYSI CAL THERAPY	17, 466	0	21, 14		6, 724	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	7, 583 3, 986	0	6, 76 2, 65		0 6, 724	67.00 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 700	0	2,00	0 0	0,724	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	13, 031	0		2 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC - TCC	0	0		0 0	0	
88.01	08801 RURAL HEALTH CLINIC II - PCFP	0	0		0 0	0	88.01
88. 02 88. 03	08802 RURAL HEALTH CLINIC III - 13TH 08803 RURAL HEALTH CLINIC IV - SPENCER	0	0		0 0	0	88.02 88.03
90.00	09000 CLINIC	38, 867	0	13, 62	-	141, 202	90.00
90.01	09001 PALN MANAGEMENT	0	0		0 0	0	90.01
90.02	09002 WOUND CARE	13, 679	0	11, 65	9 0	0	90.02
90.03	09003 ORTHOPEDIC CLINIC	0	0	5,40	7 0	0	90.03
91.00	09100 EMERGENCY	59, 291	0	34, 55	3 90, 307	119, 349	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	38, 910	0		0 0	6, 724	95.00
95.00	SPECIAL PURPOSE COST CENTERS	30, 710	0			0,724	95.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0		0 0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	669, 162	718, 863	381, 41	7 506, 022	531, 187	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 010	0		0 0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
200.00 201.00			0			0	200.00 201.00
201.00		681, 172	718, 863	381, 41	7 506, 022	531, 187	

Heal th	Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lieu	of Form CMS-2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1322	From 01/01/2021 F	Vorksheet B Part I
					To 12/31/2021	Date/Time Prepared: 5/24/2022 9:41 am
	Cost Center Description	Subtotal	Intern &	Total		
			Residents			
			Cost & Post			
			Stepdown			
		24.00	Adjustments 25.00	26.00		
	GENERAL SERVICE COST CENTERS	21.00	20.00	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 ADMI NI STRATI VE AND GENERAL					5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER 00700 OPERATION OF PLANT					5.02
7.00 8.00	00800 LAUNDRY & LINEN SERVICE					7.00 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					
30.00	03000 ADULTS & PEDIATRICS	9, 871, 717	0			30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0	31.00
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	63, 844	0	63, 8	44	43.00
50.00	05000 OPERATI NG ROOM	2, 224, 176	0	2, 224, 1	76	50.00
	05200 DELIVERY ROOM & LABOR ROOM	281,847	Ő			52.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 450, 706	0			54.00
60.00	06000 LABORATORY	3, 097, 068	0	3, 097, 0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	102, 994	0	102, 9	94	62.00
65.00	06500 RESPI RATORY THERAPY	1, 667, 149	0			65.00
	06600 PHYSI CAL THERAPY	964, 760	0			66.00
67.00	06700 OCCUPATI ONAL THERAPY	332, 724	0			67.00
	06800 SPEECH PATHOLOGY	167, 877	0	167,8		68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	971, 837 141, 749	0			71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	3, 643, 704	0			73.00
70.00	OUTPATIENT SERVICE COST CENTERS	0,010,701	0	0,010,7		70.00
88.00	08800 RURAL HEALTH CLINIC - TCC	3, 704, 496	0	3, 704, 4	96	88.00
88.01	08801 RURAL HEALTH CLINIC II - PCFP	1, 245, 283	0	1, 245, 2	83	88.01
	08802 RURAL HEALTH CLINIC III - 13TH	2, 690, 389	0	2, 690, 3	89	88.02
88.03	08803 RURAL HEALTH CLINIC IV - SPENCER	827, 949	0			88.03
	09000 CLINIC	1, 259, 817	0	1, 259, 8		90.00
	09001 PALN MANAGEMENT 09002 WOUND CARE	0 496, 671	0	404 4	0	90. 01 90. 02
90.02 90.03	09002 WOUND CARE 09003 ORTHOPEDIC CLINIC	496, 671 136, 253		496, 6 136, 2		90.02
	09100 EMERGENCY	3, 726, 940	0			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,720,710	0		10	92.00
	OTHER REIMBURSABLE COST CENTERS			1		
95.00	09500 AMBULANCE SERVICES	1, 768, 856	0	1, 768, 8	56	95.00
	SPECIAL PURPOSE COST CENTERS			1		
	11300 I NTEREST EXPENSE					113.00
	11600 HOSPI CE	0	0		0	116.00
118.00		41, 838, 806	0	41, 838, 8	06	118.00
100 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	122, 148	0	122, 1	48	190.00
	19000 PHYSICIANS' PRIVATE OFFICES	785, 129		785, 1		190.00
200.00		000, 127	0		0	200.00
201.00		Ō	0		0	201.00
202.00		42, 746, 083	C	42, 746, 0	83	202.00

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOC	ATION OF CAPITAL RELATED COSTS		Provider CO	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre	pared:
						6/24/2022 9:4	1 am
			CAPITAL REL	LATED COSTS			
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FLXT	EQUI P		BENEFITS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	,		1	1		
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
2.00 4.00	00200 New CAP REL COSTS-MUBLE EQUIP	0	12, 723	5, 700	18, 423	18, 423	4.00
5.01	00540 ADMI NI STRATI VE AND GENERAL	0	205, 809			1, 607	5.01
5.02	00590 ADMINI STRATI VE AND GENERAL - OTHER	0	170, 062	76, 191	246, 253	1, 189	5.02
7.00	00700 OPERATION OF PLANT	0	515, 935			288	
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	4,402			0 298	
9.00	01000 DI ETARY	0	29, 606 112, 303			298	9.00 10.00
11.00	01100 CAFETERI A	0	0	(0	
13.00	01300 NURSING ADMINISTRATION	0	5, 943	2,663	8, 606	317	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	33, 017	14, 792	2 47, 809	208	16.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		201 101	175 0/2		2 071	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	391, 191 0	175, 26		3, 071 0	
43.00	04300 NURSERY	0	15, 980		-	0	
	ANCILLARY SERVICE COST CENTERS	1 1					
50.00	05000 OPERATING ROOM	0	287, 538			575	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	70, 547			0	
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	145, 541 60, 136	65, 205 26, 942		918 818	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	00, 130	20, 742		010	
65.00	06500 RESPI RATORY THERAPY	0	90, 424	40, 512	130, 936	519	
66.00	06600 PHYSI CAL THERAPY	0	44, 464			544	
67.00	06700 OCCUPATI ONAL THERAPY	0	19, 304			176	•
68.00 71.00	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 147 0	4,546		87 0	68.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		° I	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	33, 172		-	103	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC - TCC	0	0			2, 013	1
88. 01 88. 02	08801 RURAL HEALTH CLINIC II - PCFP	0	0			661	88.01
88.02	08802 RURAL HEALTH CLINIC III - 13TH 08803 RURAL HEALTH CLINIC IV - SPENCER	0	0			1, 835 498	•
90.00	09000 CLINIC	0	98, 942	44, 328	° °	320	
90.01	09001 PALN MANAGEMENT	0	0	(0 0	0	90.01
90.02	09002 WOUND CARE	0	34, 822	15, 601	50, 423	344	•
90.03	09003 ORTHOPEDIC CLINIC	0	0)			90.03
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	150, 934	67, 621	218, 555 0	756	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS				0		92.00
95.00	09500 AMBULANCE SERVICES	0	99, 052	44, 37	7 143, 429	720	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		-			_	113.00
	11600 HOSPICE	0	0	1 102 (//			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	2, 641, 994	1, 183, 66	3, 825, 655	17, 960	118.00
190.00	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30, 574	13, 698	3 44, 272	0	190.00
192.0	19200 PHYSICIANS' PRIVATE OFFICES	0	0	(0 0	463	192.00
200.0					0		200.00
201.0							201.00
202.0	J TOTAL (Sum TITIES ITS LITUUGH 201)	0	2, 672, 568	1, 197, 359	3, 869, 927	18, 423	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	PERRY COUNT	Provider C	°N· 15_1322	Period:	u of Form CMS-: Worksheet B	2552-10
ALLOOP	THON OF CALLER RELATED COSTS		in ovider of		From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	
	Cost Center Description	ADMI NI STRATI V	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	6/24/2022 9: 4 HOUSEKEEPI NG	i am
			E AND GENERAL - OTHER	PLANT	LINEN SERVICE	HOUSEREEFTING	
		5. 01	5. 02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1 1	-				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 ADMINI STRATI VE AND GENERAL	299, 622					5.01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	39, 800			-		5.02
7.00	00700 OPERATION OF PLANT	19, 799					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	607					8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 685				65, 884	1
11.00	01100 CAFETERI A	2, 832 2, 312			0 0 0 0	4, 267 0	
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 312			-	226	
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 424				1, 254	1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,090	3,039	14, 74	4 0	1, 234	10.00
30.00	03000 ADULTS & PEDIATRICS	46, 311	52, 305	174, 69	1 2, 998	14, 864	30.00
31.00	03100 I NTENSI VE CARE UNI T	0			0 0	0	
43.00	04300 NURSERY	170		7, 13	-	607	
40.00	ANCI LLARY SERVICE COST CENTERS	1/0	172	7,13	0	007	45.00
50.00	05000 OPERATING ROOM	8, 972	10, 133	128, 40	2 738	10, 925	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	750				2,680	
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 459				5, 530	
60.00	06000 LABORATORY	17, 427	19, 683			2, 285	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	624	705		0 0	0	1
65.00	06500 RESPI RATORY THERAPY	8, 552	9, 659	40, 37	9 225	3, 436	65.00
66.00	06600 PHYSI CAL THERAPY	5, 061	5, 716	19, 85	5 207	1, 689	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 714	1, 935	8, 62	0 0	733	67.00
68.00	06800 SPEECH PATHOLOGY	823	929	4, 53	1 0	386	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 890	6, 653		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	859			0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 596	24, 392	14, 81	3 0	1, 260	73.00
	OUTPATIENT SERVICE COST CENTERS	1	I				
88.00	08800 RURAL HEALTH CLINIC - TCC	22, 453			0 0	0	
88.01	08801 RURAL HEALTH CLINIC II - PCFP	7, 548			0 0	0	
88.02	08802 RURAL HEALTH CLINIC III - 13TH	16, 307			0 0	0	
88.03	08803 RURAL HEALTH CLINIC IV - SPENCER	5, 018			0 0	0	
90.00	09000 CLINIC 09001 PAIN MANAGEMENT	5, 121	5, 784			3, 759	
90. 01 90. 02	09002 WOUND CARE	0	0		0 0 0 0	0	
90. 02 90. 03	09002 WOUND CARE 09003 ORTHOPEDIC CLINIC	2, 467	2, 786 896		0 0	1, 323 0	
90.03 91.00	09100 EMERGENCY	18, 891	21, 337		0		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 071	21, 337	07,40	2,409	5,755	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95 00	09500 AMBULANCE SERVICES	9, 334	10, 542	44, 23	3 19	3 763	95.00
/01/00	SPECIAL PURPOSE COST CENTERS	,,,	10/012	11,20		0,100	10100
113.00	11300 I NTEREST EXPENSE						113.00
	11600 H0SPI CE	0	0		o o	0	116.00
118.00		293, 794	286, 875	775, 87	9, 633		118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	325	367	13, 65	3 0	1, 162	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	5, 503	0		0 0	0	192.00
192.00							1
200.00							200.00
	Negative Cost Centers	0 299, 622	0 287, 242	789, 53	0 0 1 9,633		200.00 201.00 202.00

Cost Center Description DIETARY CAFETERIA NURSING ADMINISTRATIO Percentation Decoder Station Part II Decoder Station 1:00 DIETARY CAFETERIA NURSING ADMINISTRATIO MEDICAL Stational		Financial Systems	PERRY COUNTY				u of Form CMS-	2552-10
ADMINISTRATION ADMINISTRATION RECORDS & 1 100 00100 [NEW CAP REL COSTS - BLO & FLXT 1.00 13.00 16.00 24.00 100 00100 [NEW CAP REL COSTS - BLO & FLXT 1.00 1.00 1.00 24.00 100 00100 [NEW CAP REL COSTS - BLO & FLXT 1.00 1.00 2.00 3.00 1.00	ALLOC	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1322		Date/Time Pre	
ENERGY SERVICE COST CENTERS 1.0 1.00 000100 NEW CAP REL COSTS-BLUG & FLXT 1.0 2.00 00200 NEW CAP REL COSTS-BLUG & FLXT 2.00 5.01 00540 ADM INSTRATIVE AND GENERAL 5.0 5.01 00540 ADM INSTRATIVE AND GENERAL 5.0 7.00 000000 ADM INSTRATIVE AND GENERAL 5.0 7.00 000000 ADM INSTRATIVE AND GENERAL 7.0 7.00 000000 ADMINSTRATIVE AND GENERAL 7.0 7.00 000000 ADMERS & IBRARY 0 121 18.162 7.00 01000 ADITS & FERVICE COST CENTERS 7.00 0 0 0 8.00 0300 AURS NO ALING & FERVICE COST CENTERS 7.00 0		Cost Center Description	DI ETARY	CAFETERI A	ADMI NI STRATI	0 RECORDS &	Subtotal	
1:00 00100/LEW CAP REL COSTS-MUBLE COULP 1.00 0:00 00400 EWP CAP REL COSTS-MUBLE FOULP 2.0 0:00 0.00 DAMIN ISTRATIVE AND GENERAL - OTHER 5.0 0:00 0.0000 PERATION OF PLANT 0.0000 PERATION OF PLANT 5.0 0:00 0.0000 PERATION OF PLANT 0.0000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0:00 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0:00 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0:00 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0:00 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0:00 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0:00 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0:00 0.00000 PERATION OF PLANT 0.00000 PERATION OF PLANT 0.00000 PERATION PLANT 0:00000 PERATION PLANT 0.00000 PERATION PLANT 0.00000000 PERATION PLANT 0.000000000000			10.00	11.00	13.00	16.00	24.00	
2.00 00200 NEW CAP REL COSTS-MUBLE FOULP 2.00 00200 NEW CAP REL COSTS-MUBLE FOULPS ENERAL 5.01 00540 ADM NISTRATIVE AND GENERAL 5.01 00540 ADM NISTRATIVE AND GENERAL 5.01 00540 ADM NISTRATIVE AND GENERAL 5.01 00700 OPERATION OF PLANT 3.01 00700 OPERATION OF 0.01 000 OPERATION OF PLANT 3.01 00700 OPERATION OF 0.01 000 OPERATION OF PLANT 3.01 00700 OPERATION OF 0.01 000 OPERATION	1 00							1 00
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118.00 SUBTOTALS (SUM OF LINES 1 through 117) 223,065 4,923 18,162 69,916 3,804,182 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 59,779 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 5,966 192.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00 0 0 0 0 201.00 0 0 0 0 201.00 0 0 0 0 201.00 0 0 0 0 201.00 0 0 0 0 201.00 0 0 0 0 201.00 0 0 201.00 0 0 0 201.00 0 0 0 10 10 10 10 10 10 10				0		0	0	
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 59,779 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 5,966 192.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00			222 065	4 022	10 1	0 0 52 60 016		
190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 59,779 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 5,966 192.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	116.00		225,000	4, 923	10, 10	02 09,910	3, 004, 102	1110.00
192.00 192.00 PHYSI CLANS' PRI VATE OFFICES 0 0 0 5,966 192.00 200.00 Cross Foot Adjustments 200.00 0 0 0 0 200.00 0 200.00 0 0 0 0 200.0	190 00		n	0		0 0	59 779	190 00
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0			-	0		0 0		
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>200.00</td>							0	200.00
			О	0		0 0	0	201.00
	202.00	TOTAL (sum lines 118 through 201)	223, 065	4, 923	18, 10	69, 916		

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lieu of Fo	orm CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider (CCN: 15-1322	Period: Works	heet B
				To 12/31/2021 Date/	Time Prepared:
Cost Center Description	Intern &	Total		6/24/2	2022 9:41 am
	Residents	rotar			
	Cost & Post				
	Stepdown				
	Adjustments 25.00	26.00	-		
GENERAL SERVICE COST CENTERS	20.00	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 ADMINI STRATI VE AND GENERAL					5.01
5. 02 00590 ADMINI STRATI VE AND GENERAL - OTHER 7. 00 00700 OPERATI ON OF PLANT					5.02
8. 00 00800 LAUNDRY & LI NEN SERVI CE					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 O1600 MEDI CAL RECORDS & LI BRARY					16.00
INPATIENT ROUTINE SERVICE COST CENTERS		1 117 45			20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0	1, 117, 453 (30.00 31.00
43. 00 04300 NURSERY	0	31, 245			43.00
ANCI LLARY SERVICE COST CENTERS		51,240			43.00
50. 00 05000 OPERATI NG ROOM	0	579, 83	5		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	137, 934			52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	312, 502	2		54.00
60. 00 06000 LABORATORY	0	160, 082	1		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 329	1		62.00
65. 00 06500 RESPI RATORY THERAPY	0	197, 558	1		65.00 66.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	98, 614 41, 218	1		67.00
68. 00 06800 SPEECH PATHOLOGY	0	22, 368	1		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 543	1		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 829	9		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	110, 278	3		73.00
OUTPATIENT SERVICE COST CENTERS		40.00	.]		
88.00 08800 RURAL HEALTH CLINIC - TCC	0	49,820	1		88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP 88.02 08802 RURAL HEALTH CLINIC III - 13TH	0	16, 734 36, 560			88. 01 88. 02
88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER	0	11, 184			88.03
90. 00 09000 CLINIC	0	222, 728			90.00
90. 01 09001 PALN MANAGEMENT	0	(90.01
90. 02 09002 WOUND CARE	0	73, 043	3		90.02
90. 03 09003 ORTHOPEDIC CLINIC	0	1, 854			90.03
91.00 09100 EMERGENCY	0	354, 540			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0				92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	212, 925	5		95.00
SPECIAL PURPOSE COST CENTERS		212,720	21		,0.00
113.00 11300 INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE	0	(116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)) 0	3, 804, 182	2		118.00
NONREI MBURSABLE COST CENTERS	-1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59, 779	1		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 200.00 Cross Foot Adjustments	0	5,960			192.00 200.00
200.00 ICIOSS FOOT Adjustments 201.00 Negative Cost Centers	0	(200.00
202.00 TOTAL (sum lines 118 through 201)	0	3, 869, 92	-1		202.00
	1				1

	Financial Systems	PERRY COUNTY		N. 15 1222		u of Form CMS-2	
CUSI AI	LLOCATION - STATISTICAL BASIS		Provider CC	F	eriod: rom 01/01/2021	Worksheet B-1	
		1		1	o 12/31/2021	Date/Time Pre 6/24/2022 9:4	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconci l i ati o		
		FI XT (SQUARE	EQUI P (SQUARE	BENEFI TS DEPARTMENT	n	E AND GENERAL (ACCUM. COST)	
		FEET)	FEET)	(GROSS		(ACCOM. COST)	
		1.00	2.00	SALARI ES)	FA 01	F 01	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5A. 01	5.01	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	121, 416					1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	578	121, 416 578	16, 891, 512			2.00
	00540 ADMINI STRATI VE AND GENERAL	9, 350	9, 350	1, 472, 627		40, 793, 881	5.0
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	7, 726	7, 726	1, 089, 553		5, 418, 689	5.0
	00700 OPERATION OF PLANT	23, 439	23, 439	264, 016		2, 695, 535	7.00
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	200 1, 345	200 1, 345	0 273, 221	0	82, 703 501, 669	8.00 9.00
	01000 DI ETARY	5, 102	5, 102	273, 221	0	385, 581	10.00
	01100 CAFETERI A	0	0	0	0	314, 743	
	01300 NURSI NG ADMI NI STRATI ON	270	270	290, 304	-	398, 828	
	01600 MEDICAL RECORDS & LIBRARY	1, 500	1, 500	191, 003	0	366, 276	16.00
	03000 ADULTS & PEDIATRICS	17, 772	17, 772	2, 820, 350	0	6, 306, 221	30.00
	03100 I NTENSI VE CARE UNI T	0	0	0		0,000,221	31.00
	04300 NURSERY	726	726	0	0	23, 140	43.00
	ANCI LLARY SERVI CE COST CENTERS	13, 063	13, 063	527, 401	0	1, 221, 502	50.00
	05200 DELIVERY ROOM & LABOR ROOM	3, 205	3, 205	527,401	-	102, 154	
	05400 RADI OLOGY-DI AGNOSTI C	6, 612	6, 612	841, 856	-	1, 696, 210	
60.00	06000 LABORATORY	2, 732	2, 732	749, 752		2, 372, 604	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	384		84, 990	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 108 2, 020	4, 108 2, 020	475, 629 498, 436		1, 164, 333 688, 992	65.00 66.00
	06700 OCCUPATI ONAL THERAPY	877	877	161, 731		233, 290	
	06800 SPEECH PATHOLOGY	461	461	80, 115		112, 029	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	-	801, 954	
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0 1, 507	0 1, 507	0 94, 281	0	116, 970	
	OUTPATIENT SERVICE COST CENTERS	1, 507	1, 507	94, 201	0	2, 940, 278	/ 3.00
88.00	08800 RURAL HEALTH CLINIC - TCC	0	0	1, 844, 836	0	3, 056, 929	88.00
	08801 RURAL HEALTH CLINIC II - PCFP	0	0	606, 018		1, 027, 600	
	08802 RURAL HEALTH CLINIC III – 13TH 08803 RURAL HEALTH CLINIC IV – SPENCER	0	0	1, 682, 044		2, 220, 093	
	09000 CLINIC	0 4, 495	4, 495	456, 012 293, 536		683, 219 697, 205	88.03 90.00
	09001 PALN MANAGEMENT	0	0	270,000		0,7,200	90.0
	09002 WOUND CARE	1, 582	1, 582	314, 879		335, 852	
	09003 ORTHOPEDIC CLINIC	0	0	86, 992		107, 973	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 857	6, 857	692, 751	0	2, 571, 973	91.00
	OTHER REIMBURSABLE COST CENTERS						12.00
95.00	09500 AMBULANCE SERVICES	4, 500	4, 500	659, 657	0	1, 270, 801	95.00
	SPECIAL PURPOSE COST CENTERS						112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0	0	0	0	113.00 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	120, 027	120, 027	16, 467, 384	-	40, 000, 336	
	NONREI MBURSABLE COST CENTERS		,		.,,		1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 389	1, 389	0	-	44, 272	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	424, 128	0	749, 273	
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200.00 201.00
201.00	Cost to be allocated (per Wkst. B,	2, 672, 568	1, 197, 359	527, 024		1, 952, 202	
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	22. 011662	9. 861624	0.031201		0.047855	
204.00	Cost to be allocated (per Wkst. B, Part II)			18, 423		299, 622	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0. 001091		0.007345	205.00
	11)			2.00.071			
	NAUE adjustment empurit to be all posted	1 1			1		206.00
206. 00	NAHE adjustment amount to be allocated						200.00
206. 00 207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00

		cial Systems	PERRY COUNT		N 45 4000 D		u of Form CMS-2	
COST A	ALLOCAT	ION - STATISTICAL BASIS		Provider CO		eriod: rom 01/01/2021	Worksheet B-1	
					Т	o 12/31/2021	Date/Time Pre	
		Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	6/24/2022 9: 4 HOUSEKEEPI NG	
		·	n	E AND GENERAL	PLANT	LINEN SERVICE	(SQUARE	
				- OTHER	(SQUARE	(POUNDS OF	FEET)	
				(ACCUM. COST NO PBP)	FEET)	LAUNDRY)		
			5A. 02	5. 02	7.00	8.00	9.00	
	GENER	AL SERVICE COST CENTERS						
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00		NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02		ADMI NI STRATI VE AND GENERAL ADMI NI STRATI VE AND GENERAL - OTHER	-5, 678, 000	36, 282, 954				5.01
7.02		OPERATION OF PLANT	-3, 078, 000		80, 323			7.02
8.00		LAUNDRY & LINEN SERVICE	0		200			8.00
9.00		HOUSEKEEPI NG	0	525, 676	1, 345		78, 778	
10.00		DI ETARY	0	404, 033	5, 102	0	5, 102	10.00
11.00		CAFETERIA	0	02//000	0	-	0	
13.00		NURSING ADMINISTRATION	0		270		270	
16.00		MEDICAL RECORDS & LIBRARY	0	383, 804	1, 500	0	1, 500	16.00
30.00		ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	6, 608, 016	17, 772	2, 964	17, 772	30.00
31.00		INTENSIVE CARE UNIT	0		0		0	
43.00		NURSERY	0		726		726	
		ARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1, 279, 957	13, 063	730	13, 063	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0		3, 205		3, 205	
54.00		RADI OLOGY-DI AGNOSTI C	0		6, 612		6, 612	
60.00	1 1	LABORATORY	0		2, 732		2, 732	
62.00 65.00		WHOLE BLOOD & PACKED RED BLOOD CELLS RESPI RATORY THERAPY	0	077007	0 4, 108	-	0 4, 108	
66.00		PHYSICAL THERAPY		721, 964	2, 020		2,020	
67.00		OCCUPATIONAL THERAPY	0		877		877	
68.00		SPEECH PATHOLOGY	0	117, 390	461	0	461	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	840, 332	0	0	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENT	0		0	-	0	
73.00		DRUGS CHARGED TO PATIENTS	0	3, 080, 985	1, 507	0	1, 507	73.00
88.00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC - TCC	0	3, 203, 218	0	0	0	88.00
88.00		RURAL HEALTH CLINIC - TCC RURAL HEALTH CLINIC II - PCFP	0		0	-	0	
88.02		RURAL HEALTH CLINIC III - 13TH	0		0		0	
88.03		RURAL HEALTH CLINIC IV - SPENCER	0		0	-	0	
90.00		CLINIC	0	730, 570	4, 495	250	4, 495	90.00
90.01		PAIN MANAGEMENT	0	0	0	0	0	90. 0 ⁻
90.02		WOUND CARE	0	351, 924	1, 582		1, 582	
90.03		ORTHOPEDIC CLINIC	0		0	0	0	
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 695, 055	6, 857	2, 441	6, 857	91.00
92.00	09200	REIMBURSABLE COST CENTERS						92.00
95.00		AMBULANCE SERVICES	0	1, 331, 615	4, 500	19	4, 500	95.00
		AL PURPOSE COST CENTERS		.,	.,		.,	
113.00		INTEREST EXPENSE						113.00
		HOSPI CE	0		0	-		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5, 678, 000	36, 236, 563	78, 934	9, 524	77, 389	118.00
100 00		MBURSABLE COST CENTERS	-	44 001	4.000		4 000	100.01
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0 -785, 129		1, 389	0		190.00 192.00
200.00		Cross Foot Adjustments	-705, 129	0	0	0	0	200.00
200.00		Negative Cost Centers						200.00
202.00		Cost to be allocated (per Wkst. B,		5, 678, 000	3, 266, 546	108, 357	681, 172	
		Part I)						
203.00		Unit cost multiplier (Wkst. B, Part I)		0. 156492	40. 667629		8.646729	
204.00		Cost to be allocated (per Wkst. B,		287, 242	789, 531	9, 633	65, 884	204.00
205 00		Part II)		0 007047	0.000454	1 011445	0.00/005	205 00
205.00		Unit cost multiplier (Wkst. B, Part II)		0. 007917	9. 829451	1.011445	0.836325	205.00
206.00		NAHE adjustment amount to be allocated						206.00
		(per Wkst. B-2)						
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Prepared: 6/24/2022 9:41 am
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	
		10.00	11.00	13.00	16.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00 \end{array}$	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT O0200 NEW CAP REL COSTS-MVBLE EQUIP O0400 EMPLOYEE BENEFITS DEPARTMENT O0540 ADMINISTRATIVE AND GENERAL 00590 ADMINISTRATIVE AND GENERAL - OTHER 00700 OPERATION OF PLANT O0800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	9, 243 0 0	12, 628 311	133, 365		1.00 2.00 4.00 5.01 5.02 7.00 8.00 9.00 10.00 11.00 13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	442	0	316	16.00
30. 00 31. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY	9, 243 0 0	4, 071 0 0	84, 681 0 0	93 0 0	30. 00 31. 00 43. 00
	ANCI LLARY SERVICE COST CENTERS			15 505		
50.00 52.00 54.00 60.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY	0 0 0	745 0 1, 341 1, 539	15, 505 0 0 0	6 0 10 24	50.00 52.00 54.00 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 557	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	800	0	16	65.00
66.00	06600 PHYSI CAL THERAPY	0	700	0	4	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	224	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	88	0	4	68.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0 207	0	0	72.00 73.00
75.00	OUTPATIENT SERVICE COST CENTERS	0	207	0	0	/3.00
88.00	08800 RURAL HEALTH CLINIC - TCC	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II - PCFP	0	0	0	О	88.01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0	0	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	88.03
90.00	09000 CLINIC	0	451	9, 378	84	90.00
90. 01 90. 02	09001 PALN MANAGEMENT 09002 WOUND CARE	0	0 386	0	0	90. 01 90. 02
90.02 90.03	09003 ORTHOPEDIC CLINIC	0	179		0	90.02
91.00	09100 EMERGENCY	0	1, 144		71	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			.,		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0	4	95.00
112 00	SPECIAL PURPOSE COST CENTERS			1		112.00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0	_ 	0	113.00 116.00
118.00		9, 243	12, 628	133, 365	316	118.00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	192.00
200.00						200.00
201.00 202.00	Cost to be allocated (per Wkst. B, Part I)	718, 863	381, 417		531, 187	201. 00 202. 00
203.00 204.00		77. 773775 223, 065	30. 204070 4, 923		1, 680. 971519 69, 916	203. 00 204. 00
205.00	Unit cost multiplier (Wkst. B, Part	24. 133398	0. 389848	0. 136183	221. 253165	205.00
206.00						206.00
207.00						207.00

Heal th Finar	ncial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1322	Peri od:	Worksheet C	
					From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
			Title	XVIII	Hospi tal	Cost	
			, iiii		Costs	0001	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	···· · · · · · · · · · · · · · · · · ·	(from Wkst.	Adj.		Di sal l owance		
		B, Part I,	,				
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9, 871, 717		9, 871, 7	17 0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0			0 0	0	31.00
	NURSERY	63, 844		63, 8	44 0	0	43.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	2, 224, 176		2, 224, 1	76 0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	281, 847		281, 8		0	52.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	2, 450, 706		2, 450, 7	0 0	0	54.00
60.00 06000	LABORATORY	3, 097, 068		3, 097, 0	68 0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	102, 994		102, 9	94 0	0	62.00
65.00 06500	RESPI RATORY THERAPY	1, 667, 149	0	1, 667, 1	49 0	0	65.00
66.00 06600	PHYSI CAL THERAPY	964, 760	0	964, 7	60 0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	332, 724	0	332, 7	24 0	0	67.00
	SPEECH PATHOLOGY	167, 877	0	167, 8	77 0	0	68.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	971, 837		971, 8		0	71.00
	IMPL. DEV. CHARGED TO PATIENT	141, 749		141, 7		0	72.00
	DRUGS CHARGED TO PATIENTS	3, 643, 704		3, 643, 7	04 0	0	73.00
	TIENT SERVICE COST CENTERS	1					
	RURAL HEALTH CLINIC - TCC	3, 704, 496		3, 704, 4		0	•
	RURAL HEALTH CLINIC II - PCFP	1, 245, 283		1, 245, 2		0	88.01
	RURAL HEALTH CLINIC III - 13TH	2, 690, 389		2, 690, 3		0	
	RURAL HEALTH CLINIC IV - SPENCER	827, 949		827, 9		0	88.03
	CLINIC	1, 259, 817		1, 259, 8		0	90.00
	PAIN MANAGEMENT	0			0 0	0	
	WOUND CARE	496, 671		496, 6		0	90.02
	ORTHOPEDIC CLINIC	136, 253		136, 2		0	90.03
	EMERGENCY	3, 726, 940		3, 726, 9		0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	1, 293, 170		1, 293, 1	70	0	92.00
	REIMBURSABLE COST CENTERS					-	
	AMBULANCE SERVICES	1, 768, 856		1, 768, 8	56 0	0	95.00
	AL PURPOSE COST CENTERS	1		1	-		
						-	113.00
116.0011600		0	_	10 101 0	0		116.00
200.00	Subtotal (see instructions)	43, 131, 976					200.00
201.00	Less Observation Beds	1, 293, 170		1, 293, 1			201.00
202.00	Total (see instructions)	41, 838, 806	0	41, 838, 8	0 0	0	202.00

Health Financial Systems	PERRY COUNTY				u of Form CMS-	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 6/24/2022 9:4	epared: 1 am
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
	(7.00		0.00	Ratio	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	5, 886, 773		5, 886, 77	2		30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 880, 773		5,000,77	0		31.00
43. 00 04300 NURSERY	118, 941		118, 94	-		43.00
ANCI LLARY SERVI CE COST CENTERS	110, 741		110, 74			
50. 00 05000 OPERATING ROOM	1, 375, 247	9,011,040	10, 386, 28	0, 214145	0, 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	469, 607	218, 410			0. 000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 209, 317	18, 141, 421	19, 350, 73		0.000000	
60. 00 06000 LABORATORY	1, 880, 132	19, 368, 751	21, 248, 88		0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	51, 358	314, 220	365, 57	0. 281729	0.000000	62.00
65. 00 06500 RESPI RATORY THERAPY	1, 184, 966	3, 050, 388	4, 235, 35	0. 393627	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	609, 701	2, 322, 358	2, 932, 05	0. 329038	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	513, 251	722, 774	1, 236, 02	0. 269189	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	97, 265	350, 499			0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 022, 233	3, 323, 368			0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	150, 891	150, 89		0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 292, 563	12, 602, 423	16, 894, 98	0. 215668	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS			1 070 05			
88.00 08800 RURAL HEALTH CLINIC - TCC	0	4, 378, 254	4, 378, 25			88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP 88.02 08802 RURAL HEALTH CLINIC III - 13TH	0	1, 842, 063 1, 614, 104	1, 842, 06 1, 614, 10			88.01
88.02 08802 RURAL HEALTH CLINIC III - ISTH 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0	913, 674				88.02
90. 00 09000 CLINIC	38, 132	913, 074 918, 965	913, 07		0. 000000	
90. 01 09001 PALN MANAGEMENT	30, 132	910, 905 0	937,05	0 0.000000	0.000000	
90. 02 09002 WOUND CARE	15, 573	1, 458, 674	1, 474, 24		0.000000	
90. 03 09003 ORTHOPEDIC CLINIC	0	648, 363	648, 36		0.000000	
91. 00 09100 EMERGENCY	456, 596	8,041,946	8, 498, 54		0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	41, 224	673, 484	714, 70		0.000000	
OTHER REIMBURSABLE COST CENTERS	, 22 1	0,0,101	,,,,,,	11007000	0.00000	1 /2:00
95. 00 09500 AMBULANCE SERVICES	0	4, 649, 416	4, 649, 41	6 0. 380447	0.000000	95.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	20, 262, 879	94, 715, 486	114, 978, 36	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	20, 262, 879	94, 715, 486	114, 978, 36	5		202.00

Health Financial Systems	PERRY COUNTY I	HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1322	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepa 6/24/2022 9:41			
		Title XVIII	Hospi tal	Cost			
Cost Center Description	PPS Inpatient						
	Ratio						
	11.00						
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS					30.00		
31.00 03100 INTENSIVE CARE UNIT				3	31.00		
43. 00 04300 NURSERY				4	43.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0. 000000			5	50.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			Ę	52.00		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			Ę	54.00		
60. 00 06000 LABORATORY	0. 000000			6	60.00		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			6	62.00		
65. 00 06500 RESPI RATORY THERAPY	0. 000000			16	65.00		
66. 00 06600 PHYSI CAL THERAPY	0. 000000			16	66.00		
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00		
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00		
73.00 07300 DRUGS CHARGED TO PATI ENTS	0. 000000				73.00		
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC - TCC				3	88.00		
88.01 08801 RURAL HEALTH CLINIC II - PCFP					88.01		
88. 02 08802 RURAL HEALTH CLINIC III - 13TH					88.02		
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER					88.03		
90. 00 09000 CLINIC	0, 000000				90.00		
90. 01 09001 PALN MANAGEMENT	0. 000000				90.01		
90. 02 09002 WOUND CARE	0. 000000				90.02		
90. 03 09003 ORTHOPEDIC CLINIC	0. 000000				90.02 90.03		
91. 00 09100 EMERGENCY	0. 000000				91.00		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00		
OTHER REIMBURSABLE COST CENTERS	0.000000				72.00		
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00		
SPECIAL PURPOSE COST CENTERS	0.000000				<i>y</i> J. 00		
113. 00 11300 I NTEREST EXPENSE				11	13.00		
116. 00 11600 HOSPI CE					16.00		
200.00 Subtotal (see instructions)					00.00		
201.00 Less Observation Beds					00.00		
202.00 Total (see instructions)					02.00		
	1			120	02.00		

Heal th	Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1322	Peri od:	Worksheet C	
					From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 6/24/2022 9:4	epared:
			Ti +I	e XIX	Hospi tal	072472022 9:2 PPS	
	· · · · · · · · · · · · · · · · · · ·		1111		Costs	ггэ	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	cost center bescription	(from Wkst.	Adj.		Di sal I owance	10101 00313	
		B, Part I,	Auj .		DI Sal I Owalice		
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30, 00	03000 ADULTS & PEDIATRICS	9, 871, 717		9, 871, 7	17 0	9, 871, 717	30.00
31.00	03100 I NTENSI VE CARE UNI T	0		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0	0,071,717	
	04300 NURSERY	63, 844		63, 8		63, 844	
45.00	ANCI LLARY SERVICE COST CENTERS	00,044		00,0	0	03, 044	45.00
50.00	05000 OPERATI NG ROOM	2, 224, 176		2, 224, 1	76 0	2, 224, 176	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	281,847		281,8		281,847	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 450, 706		2, 450, 7		2, 450, 706	
60.00	06000 LABORATORY	3, 097, 068		3, 097, 0		3, 097, 068	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	102, 994		102, 9		102, 994	
65.00	06500 RESPIRATORY THERAPY	1, 667, 149	0			1, 667, 149	
66.00	06600 PHYSI CAL THERAPY	964, 760		964, 7		964, 760	
67.00	06700 OCCUPATI ONAL THERAPY	332, 724		332, 7		332, 724	
68.00	06800 SPEECH PATHOLOGY	167, 877		167, 8		167, 877	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	971, 837	0	971, 8		971,837	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	141, 749		141, 7		141, 749	
	07300 DRUGS CHARGED TO PATIENTS	3, 643, 704		3, 643, 7		3, 643, 704	
75.00	OUTPATIENT SERVICE COST CENTERS	3, 043, 704		3, 043, 7	0	3, 043, 704	/ 5.00
88.00	08800 RURAL HEALTH CLINIC - TCC	3, 704, 496		3, 704, 4	96 0	3, 704, 496	88.00
88.01	08801 RURAL HEALTH CLINIC II - PCFP	1, 245, 283		1, 245, 2		1, 245, 283	
88.02	08802 RURAL HEALTH CLINIC III - 13TH	2, 690, 389		2, 690, 3		2, 690, 389	
	08803 RURAL HEALTH CLINIC IV - SPENCER	827, 949		827,9		827, 949	
90.00	09000 CLINIC	1, 259, 817		1, 259, 8		1, 259, 817	
	09001 PALN MANAGEMENT	0		1,207,0	0 0	0	
90.02	09002 WOUND CARE	496, 671		496, 6	-	496, 671	
	09003 ORTHOPEDIC CLINIC	136, 253		136, 2		136, 253	
91.00	09100 EMERGENCY	3, 726, 940		3, 726, 9		3, 726, 940	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 293, 170		1, 293, 1		1, 293, 170	
72.00	OTHER REIMBURSABLE COST CENTERS	1,275,170		1,275,1	10	1,275,170	/2.00
95.00	09500 AMBULANCE SERVICES	1, 768, 856		1, 768, 8	56 0	1, 768, 856	95.00
75.00	SPECIAL PURPOSE COST CENTERS	1,700,000		1,700,0	0	1,700,000	/0.00
113 00	11300 I NTEREST EXPENSE	1					113.00
	11600 HOSPI CE	0			0	0	116.00
200.00		43, 131, 976	0	43, 131, 9	-	43, 131, 976	
200.00		1, 293, 170		1, 293, 1		1, 293, 170	
201.00		41, 838, 806					
202.00		1 71,000,000	0	1 71,000,0	0	т, 000, 000	202.00

Health Financial Systems	PERRY COUNTY	' HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 6/24/2022 9:4	epared:
		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)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-			
30. 00 03000 ADULTS & PEDIATRICS	5, 886, 773		5, 886, 77	'3		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
43. 00 04300 NURSERY	118, 941		118, 94	1		43.00
ANCILLARY SERVICE COST CENTERS			_			
50.00 O5000 OPERATING ROOM	1, 375, 247	9, 011, 040	10, 386, 28	0. 214145	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	469, 607	218, 410	688, 0 ⁻	0. 409651	0.000000	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 209, 317	18, 141, 421	19, 350, 73	0. 126647	0.000000	54.00
60. 00 06000 LABORATORY	1, 880, 132	19, 368, 751	21, 248, 88	0. 145752	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	51, 358	314, 220	365, 57	0. 281729	0.000000	62.00
65. 00 06500 RESPI RATORY THERAPY	1, 184, 966	3, 050, 388			0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	609, 701	2, 322, 358			0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	513, 251	722, 774			0.000000	
68.00 06800 SPEECH PATHOLOGY	97, 265	350, 499			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,022,233	3, 323, 368			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	150, 891			0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 292, 563	12, 602, 423			0. 000000	1
OUTPATIENT SERVICE COST CENTERS	1/2/2/000	12/002/120	10/0/1//	01210000	0.000000	,
88.00 08800 RURAL HEALTH CLINIC - TCC	0	4, 378, 254	4, 378, 25	0. 846113	0.00000	88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP	0	1, 842, 063			0. 000000	1
88. 02 08802 RURAL HEALTH CLINIC III - 13TH	0	1,614,104			0. 000000	
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0	913, 674			0.000000	
90. 00 09000 CLINIC	38, 132	918, 965			0.000000	1
90. 01 09001 PALN MANAGEMENT	0	0		0 0.000000	0.000000	
90. 02 09002 WOUND CARE	15, 573	1, 458, 674			0.000000	
90. 03 09003 ORTHOPEDIC CLINIC	13, 373	648, 363			0.000000	
91. 00 09100 EMERGENCY	456, 596	8, 041, 946			0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	430, 570	673, 484			0.000000	1
OTHER REIMBURSABLE COST CENTERS	41, 224	073, 404	/14, /(1.007300	0.00000	92.00
95.00 09500 AMBULANCE SERVICES	0	4, 649, 416	4, 649, 41	6 0. 380447	0. 000000	95.00
SPECIAL PURPOSE COST CENTERS		4, 049, 410	4, 049, 4	0.300447	0.00000	95.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 H0SPI CE	0	0		0		116.00
	20, 262, 879	0 94, 715, 486		-		200.00
	20, 202, 879	94, / 15, 486	114, 978, 30	00		200.00
201.00 Less Observation Beds 202.00 Total (see instructions)	20, 262, 879	94, 715, 486	114, 978, 36	E		201.00
	20, 202, 8/9	94,710,480	114, 978, 30		l	202.00

Health Financial Systems	PERRY COUNTY I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 6/24/2022 9:41 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43.00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 214145			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 409651			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 126647			54.00
60. 00 06000 LABORATORY	0. 145752			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 281729			62.00
65. 00 06500 RESPI RATORY THERAPY	0. 393627			65.00
66.00 06600 PHYSI CAL THERAPY	0. 329038			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 269189			67.00
68.00 06800 SPEECH PATHOLOGY	0. 374923			68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 181801			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 939413			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 215668			73.00
OUTPATIENT SERVICE COST CENTERS	0.210000			78.00
88.00 08800 RURAL HEALTH CLINIC - TCC	0. 846113			88.00
88. 01 08801 RURAL HEALTH CLINIC II - PCFP	0. 676026			88.01
88. 02 08802 RURAL HEALTH CLINIC III - 13TH	1. 666800			88.02
88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER	0. 906176			88.03
90. 00 09000 CLINIC	1. 316290			90.00
90. 01 09001 PALN MANAGEMENT	0. 000000			90.00
90. 02 09002 WOUND CARE	0. 336898			90.01
90. 02 09002 WOUND CARE 90. 03 09003 ORTHOPEDIC CLINIC	0. 330898			90.02
90. 03 109003 ORTHOPEDIC CEINIC 91. 00 109100 EMERGENCY	0. 210149			90.03
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 809368			92.00
OTHER REIMBURSABLE COST CENTERS	0.000447			
95. 00 09500 AMBULANCE SERVICES	0. 380447			95.00
SPECIAL PURPOSE COST CENTERS	1			
113.00 11300 I NTEREST EXPENSE				113.00
116.00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Fin	ancial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATIC	ON OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider C	CN: 15-1322	Peri od:	Worksheet C	
REDUCTI ONS	S FOR MEDICAID ONLY				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narod
					10 12/31/2021	6/24/2022 9:4	1 am
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	·	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
		Part I, col.	Part II col.	Capital Cos	t	Reducti on	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	I LLARY SERVICE COST CENTERS	1					
	00 OPERATING ROOM	2, 224, 176				, o	
	OO DELIVERY ROOM & LABOR ROOM	281, 847				-	
	00 RADI OLOGY-DI AGNOSTI C	2, 450, 706				0	
	00 LABORATORY	3, 097, 068				0	00.00
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	102, 994				0	
		1, 667, 149				0	
	00 PHYSI CAL THERAPY	964, 760				0	00.00
	00 OCCUPATI ONAL THERAPY	332, 724				0	07100
	00 SPEECH PATHOLOGY	167, 877				0	
	00 MEDI CAL SUPPLIES CHARGED TO PATIENTS	971, 837				0	
	00 I MPL. DEV. CHARGED TO PATIENT	141, 749				0	1 2.00
	00 DRUGS CHARGED TO PATIENTS PATIENT SERVICE COST CENTERS	3, 643, 704	110, 278	3, 533, 4	26 0	0	73.00
		2 704 404	10,027	2 (54 (70 0	0	00.00
	00 RURAL HEALTH CLINIC - TCC 01 RURAL HEALTH CLINIC II - PCFP	3, 704, 496				-	
	02 RURAL HEALTH CLINIC III - POPP	1, 245, 283					
	02 RURAL HEALTH CLINIC IV - ISTH	2, 690, 389 827, 949					
	00 CLINIC	1, 259, 817	222, 728				1
	01 PALN MANAGEMENT	1, 239, 817	0		0 0		
	02 WOUND CARE	496, 671	73, 043		0		
	03 ORTHOPEDIC CLINIC	136, 253				0	1
	00 EMERGENCY	3, 726, 940				0	
	00 OBSERVATION BEDS (NON-DISTINCT PART)	1, 293, 170				0	
	ER REIMBURSABLE COST CENTERS	1,273,170	140, 303	1, 140, 7	5/ 0	0	/2.00
	00 AMBULANCE SERVICES	1, 768, 856	212, 925	1, 555, 9	31 0	0	95.00
	CIAL PURPOSE COST CENTERS	1,700,000	212,720	1,000, 7	0		,0.00
	00 INTEREST EXPENSE						113.00
116.00116		0	0		0 0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	33, 196, 415	-			-	200.00
201.00	Less Observation Beds	1, 293, 170					201.00
202.00	Total (line 200 minus line 201)	31, 903, 245					202.00
'							

lealth Financial Systems	PERRY COUNTY			In Lie	u of Form CMS-2	552-1
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE	RATIOS NET OF	Provider C	CN: 15-1322	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 01/01/2021 To 12/31/2021	Part II Date/Time Prep	oorod.
				10 12/31/2021	6/24/2022 9:41	lam
			e XIX	Hospi tal	PPS	- cim
Cost Center Description		Total Charges	Outpati ent			
	Capital and	(Worksheet C,				
	Operati ng	Part I,	Charge Rati	C		
	Cost	column 8)	(col. 6 /			
	Reducti on		col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	2, 224, 176					50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	281, 847					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 450, 706					54.00
50. 00 06000 LABORATORY	3, 097, 068					60.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	102, 994					62.0
55. 00 06500 RESPI RATORY THERAPY	1, 667, 149					65.0
56. 00 06600 PHYSI CAL THERAPY	964, 760	2, 932, 059	0. 32903	38		66.0
7. 00 06700 OCCUPATI ONAL THERAPY	332, 724	1, 236, 025	0. 2691	39		67.0
08.00 06800 SPEECH PATHOLOGY	167, 877	447, 764	0. 3749	23		68.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	971, 837	5, 345, 601	0. 1818	01		71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	141, 749	150, 891	0. 9394	13		72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 643, 704	16, 894, 986	0. 2156	58		73.0
OUTPATIENT SERVICE COST CENTERS						
38.00 08800 RURAL HEALTH CLINIC - TCC	3, 704, 496	4, 378, 254	0. 8461	13		88.0
38.01 08801 RURAL HEALTH CLINIC II - PCFP	1, 245, 283	1, 842, 063	0. 6760	26		88.0
38.02 08802 RURAL HEALTH CLINIC III - 13TH	2, 690, 389	1, 614, 104	1. 66680	00		88.0
38.03 08803 RURAL HEALTH CLINIC IV - SPENCER	827, 949	913, 674	0. 9061	76		88.0
20. 00 09000 CLINIC	1, 259, 817	957, 097	1. 3162	70		90.0
20. 01 09001 PALN MANAGEMENT	0	0	0.0000	00		90.0
0. 02 09002 WOUND CARE	496, 671	1, 474, 247	0. 3368	78		90.0
0. 03 09003 ORTHOPEDIC CLINIC	136, 253			49		90.0
1.00 09100 EMERGENCY	3, 726, 940	8, 498, 542	0. 4385	39		91.0
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 293, 170			68		92.0
OTHER REIMBURSABLE COST CENTERS			•			
95. 00 09500 AMBULANCE SERVI CES	1, 768, 856	4, 649, 416	0. 3804	47		95.0
SPECIAL PURPOSE COST CENTERS						
113.0011300 INTEREST EXPENSE					1	113.00
116.00 11600 HOSPI CE	0	0	0.0000	00	1	116. 0
200.00 Subtotal (sum of lines 50 thru 199)	33, 196, 415	108, 972, 651			2	200.00
201.00 Less Observation Beds	1, 293, 170				2	201.00
202.00 Total (line 200 minus line 201)	31, 903, 245				-	202.00

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 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 6/24/2022 9:4	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1	-	1			
50.00 05000 OPERATING ROOM	579, 835					
52.00 05200 DELIVERY ROOM & LABOR ROOM	137, 934				1, 102	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	312, 502				7, 373	
60. 00 06000 LABORATORY	160, 082				4, 298	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 329					62.00
65. 00 06500 RESPI RATORY THERAPY	197, 558					
66. 00 06600 PHYSI CAL THERAPY	98, 614				4, 970	
67.00 06700 OCCUPATI ONAL THERAPY	41, 218	1, 236, 025			3, 588	67.00
68.00 06800 SPEECH PATHOLOGY	22, 368	447, 764				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 543	5, 345, 601			1, 400	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 829				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	110, 278	16, 894, 986	0. 00652	1, 404, 220	9, 165	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC	49, 826	4, 378, 254	0. 01138	30 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP	16, 734	1, 842, 063	0. 00908	34 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III - 13TH	36, 560	1, 614, 104	0. 02265	50 O	0	88.02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	11, 184	913, 674	0. 01224	1 0	0	88.03
90. 00 09000 CLINIC	222, 728	957, 097	0. 23271	2 12, 354	2, 875	90.00
90.01 09001 PALN MANAGEMENT	0	0	0.00000	0 0	0	90.01
90. 02 09002 WOUND CARE	73, 043	1, 474, 247	0. 04954	6 3, 386	168	90.02
90. 03 09003 ORTHOPEDIC CLINIC	1, 854	648, 363	0. 00286	0 0	0	90.03
91.00 09100 EMERGENCY	354, 540	8, 498, 542	0. 04171	8 22, 610	943	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	146, 383	714, 708	0. 20481	5 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	2, 588, 942	104, 323, 235		3, 980, 827	67, 660	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1322 Period: From 01/01/201 To 12/31/201 Worksheet D Bate/Time Prepared: 0/24/2022 9:41 am Cost Title XVIII Houspital Cost Mursing Program Provider CCN: 15-1322 Period: To 12/31/201 Pariod: Date/Time Prepared: 0/24/2022 9:41 am Cost Mursing Program Nursing Program Program Pursing Program Post-Stepdown Adjustments Allied Health Allied Health 50:00 05000 (DPERATING ROOM 05000 (DPENATING ROOM 0 0 0 0	Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Li	eu of Form CMS-	2552-10
Cost Center Description Non Physician Anesthetist Cost Nursing Program Adjustments Nursing Program Adjustments Nursing Program Adjustments Allied Health Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 More that the that t		RVICE OTHER PAS			From 01/01/202	1 Part IV 1 Date/Time Pre	
Anesthetist Cost Program Post-Stepdown Adjustments Program Adjustments Program Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS 0			Title	XVIII	Hospi tal	Cost	
Cost Post-Stepdom Adj ustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 ANCI LLARY SERVICE COST CENTERS 0	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
Adjustments Adjustments Adjustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 DELIVERY ROOM & LABOR ROOM 0 <t< td=""><td></td><td>Anesthetist</td><td>Program</td><td>Program</td><td>Post-Stepdowr</td><td>n </td><td></td></t<>		Anesthetist	Program	Program	Post-Stepdowr	n	
I.00 2A 2.00 3A 3.00 ANCI LLARY SERVICE COST CENTERS		Cost			Adjustments		
ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATINE ROOM 0							
50.00 05000 0PERATING ROM 0 0 0 0 0 0 0 0 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 </td <td></td> <td>1.00</td> <td>2A</td> <td>2.00</td> <td>3A</td> <td>3.00</td> <td></td>		1.00	2A	2.00	3A	3.00	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 54.00 05400 RADI OLGY-DI AGNOSTI C 0 0 0 0 54.00 60.00 L6000 LABORATORY 0 0 0 0 0 64.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 65.00 65.00 06600 PRYST CAL THERAPY 0 0 0 0 66.00 66.00 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 67.00 0C700 0CLGAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 67.00 68.00 0FIVST CAL THERAPY 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 72.00 73.00 OTAOL RURAL HEALTH CLINIC 1 I - PCFP 0 0 0 0	ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C 0	50.00 05000 OPERATING ROOM	0	0		0	0 0	50.00
60.00 CABORATORY 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0 0	52.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 65.00 66.00 06700 OCUPATIONAL THERAPY 0 0 0 0 0 66.00 67.00 06700 OCUPATIONAL THERAPY 0 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 71.00 OTION MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 0017141 EVT SERVICE COST CENTERS 0 0 0 0 0 73.00 0101741 EVT SERVICE COST CENTERS 0 0 0 0 0 88.00 88.01 08800 RURAL H	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	54.00
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IPUL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 08801 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.00 08802 RURAL HEALTH CLINIC 111 - 13TH 0 0 0 0 88.03 90.00 09000 CLINIC 0 0 0	60. 00 06000 LABORATORY	0	0		0	0 0	60.00
66.00 06600 PHYSI CAL THERAPY 0<	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0 0	62.00
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 0 72.00 0 0 0 0 73.00 0 0 0 0 0 73.00 0 0 0 0 88.00 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.02 88.02 88.03 88.03 88.03 88.03 88.03 88.03 88.03 88.03 88.03 88.03 90.01 90.01 91.01 90.0	65. 00 06500 RESPI RATORY THERAPY	0	0		0	0 0	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 71.00 00 0 0 0 0 0 0 71.00 72.00 0 0 0 0 0 0 0 0 72.00 0 0 0 0 0 0 0 72.00 73.00 0 0 0 0 0 0 0 0 0 0 0 0 0 72.00 73.00 70.00 0	66. 00 06600 PHYSI CAL THERAPY	0	0		0	0 0	66.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 72.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 73.00 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC III - PCFP 0 0 0 0 88.02 88.02 08802 RURAL HEALTH CLINIC IV - SPENCER 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0 <td< td=""><td>67.00 06700 OCCUPATI ONAL THERAPY</td><td>0</td><td>0</td><td></td><td>0</td><td>0 0</td><td>67.00</td></td<>	67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	67.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 73.00 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.01 88.01 08801 RURAL HEALTH CLINIC III - PCFP 0 0 0 0 88.01 88.02 08803 RURAL HEALTH CLINIC III - 13TH 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC O 0 0 0 90.00 90.01 90.01 09001 PAIN MANAGEMENT 0 0 0 0 0 90.02 90.02 09002 WOUND CARE 0 0 0 0 0 90.02 90.03 09003 <td< td=""><td>68.00 06800 SPEECH PATHOLOGY</td><td>0</td><td>0</td><td></td><td>0</td><td>0 0</td><td>68.00</td></td<>	68.00 06800 SPEECH PATHOLOGY	0	0		0	0 0	68.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0 0	71.00
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II - PCFP 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0 0 0 0 88.02 80.00 09000 CLINIC 0 0 0 0 88.02 80.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC V - SPENCER 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.00 90.01 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.03 90.03 90.03 90.03 90.03 90.03 90.	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0 0	72.00
88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC III - PCFP 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC V - SPENCER 0 0 0 0 90.00 90.01 09000 CLINIC V - SPENCER 0 0 0 0 90.00 90.02 09000 CLINIC V - SPENCER 0 0 0 90.00 90.03 09002 WUND CARE 0 0 0 0 90.02 90.03 09100 EMEGENCY 0 0 0 0 90.02 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 0 92.00 0 0 0 0 0 0 0	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	73.00
88.01 08801 RURAL HEALTH CLINICIII - PCFP 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINICIII - 13TH 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINICIV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC V SPENCER 0 0 0 0 90.00 90.01 09000 CLINIC V SPENCER 0 0 0 0 90.00 90.01 09000 CLINIC V SPENCER 0 0 0 0 90.00 90.02 09002 WUND CARE 0 0 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00	OUTPATIENT SERVICE COST CENTERS						
88.02 08802 RURAL HEALTH CLINICIII - 13TH 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINICIV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 0 0 0 90.01 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 950.0 950.0 950.0 950.0 950.0 950.0	88.00 08800 RURAL HEALTH CLINIC - TCC	0	0		0	0 0	88.00
88.03 08803 RURAL HEALTH CLINICIV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 0 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 0 90.03 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 91.00 92.00 07HER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	88.01 08801 RURAL HEALTH CLINIC II - PCFP	0	0		0	0 0	88.01
90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 0 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 07HER REIMBURSABLE COST CENTERS	88.02 08802 RURAL HEALTH CLINIC III - 13TH	0	0		0	0 0	88.02
90.01 09001 PAIN MANAGEMENT 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 0 0 0 90.02 90.03 09003 ORTHOPEDI C CLINIC 0 0 0 0 90.03 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 92.00 07HER REIMBURSABLE COST CENTERS	88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0	0		0	0 0	88.03
90.02 09002 WOUND CARE 0 0 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 07HER REI MBURSABLE COST CENTERS 0 0 0 95.00 </td <td>90. 00 09000 CLINIC</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0 0</td> <td>90.00</td>	90. 00 09000 CLINIC	0	0		0	0 0	90.00
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 0 0 0 0 0 0 0 92.00 0 0 0 0 0 0 95.00 95.00	90.01 09001 PALN MANAGEMENT	0	0		0	0 0	90.01
91.00 09100 EMERGENCY 09200 00 0 0 0 91.00 92.0	90. 02 09002 WOUND CARE	0	0		0	o o	90.02
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00 95.00	90. 03 09003 ORTHOPEDIC CLINIC	0	0		0	o o	90.03
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	91.00 09100 EMERGENCY	0	0		0	o o	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
200.00 Total (lines 50 through 199) 0 0 0 0 0 0 0 200.00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)	0	0		0	o o	200.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS	S Provider C	CN: 15-1322	Period: From 01/01/2021	Worksheet D Part IV	
				To 12/31/2021		pared:
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0		0 10, 386, 287	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 688, 017		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 19, 350, 738		
60. 00 06000 LABORATORY	0	0		0 21, 248, 883		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 365, 578		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 4, 235, 354	0.000000	•
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 932, 059		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 236, 025		
68.00 06800 SPEECH PATHOLOGY	0	0		0 447, 764		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 5, 345, 601	0.000000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 150, 891	0.00000	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 16, 894, 986	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC	0	-		0 4, 378, 254	0.000000	
88.01 08801 RURAL HEALTH CLINIC II - PCFP	0	0		0 1, 842, 063		
88.02 08802 RURAL HEALTH CLINIC III - 13TH	0	0		0 1, 614, 104		
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0	0		0 913, 674	0.00000	
90. 00 09000 CLINIC	0	0		0 957, 097	0.00000	
90. 01 09001 PALN MANAGEMENT	0	0		0 0	0.000000	
90. 02 09002 WOUND CARE	0	0		0 1, 474, 247	0.000000	
90. 03 09003 ORTHOPEDIC CLINIC	0	0		0 648, 363		
91.00 09100 EMERGENCY	0	0		0 8, 498, 542		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 714, 708	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 104, 323, 235		200.00

APPORT OWNENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CN: 15-1322 Poil Period: Poil Period: Poil Period: Poil Period: Poil Period: Poil Worksheet D Part IV Date (24/2022) Worksheet D Date (24/2022) Worksheet D Part IV Date (24/2022) Worksheet D Part IV Date (20/20) Worksheet D Part IV Date (24/2022) Worksheet D Date (24/2022) Worksheet D Date (24/2022) Worksheet D Date (20/20) Worksheet D Date (24/2022) Workshee	Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges Inpatient Program (col. 6) Outpatient Program (col. 6) 50.00 05000 (PERATING ROOM 05000 (PERATING ROOM 52.00 0.000000 219,543 0 0 0 50.00 50.00 05000 (PERATING ROOM 6200 (PECATING ROOM 62.00 0.000000 219,543 0 0 0 52.00 54.00 05000 RADI CLOSCP UI AGNOSTI C 0.000000 18,345 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 0 66.00 67.00 0 66.00 67.00 0 66.00 67.00 0 67.00 0 67.00 0 67.00 0 67.00 0 67.00 0 67.00 0 67.00 0 77.00 0 67.00 0					From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	
Ratio of Cost to Charges Program Charges Program Charges Program Charges Program Charges Program Costs (col. 8 x col. 12) ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 3.00 50.00 05000 (PERATING ROOM 0.000000 219,543 0 0 0 50.00 52.00 05200 (DELIVERY ROOM & LABOR ROOM 0.000000 456,549 0 0 54.00 60.00 06000 (ABORADICOSY DI AGNOSTI C 0.000000 570,546 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 68.00 68.00 68.00 0 0 0 71.00 0 68.00 0 0 0 72.00 71.00 0 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 <			Title	XVIII	Hospi tal		
Image: trip of the second se	Cost Center Description						
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$			Program				
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ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 OPERATING ROOM 0.000000 54.90 0 0 52.00 54.00 05000 OPERATING ROOM 0.000000 54.99 0 0 52.00 54.00 05400 RADI LOGY-DI AGNOSTI C 0.000000 54.949 0 0 0 52.00 65.00 06500 RESPI RATORY THERAPY 0.000000 570,546 0 0 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 147,771 0 0 66.00 66.00 06600 SPECH PATHORY THERAPY 0.000000 107,587 0 0 66.00 67.00 06800 SPECH PATHORY THERAPY 0.000000 20,520 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 596,789 0 0 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 72.00 73.00 73.00 73.00 73.00 </td <td></td> <td></td> <td></td> <td></td> <td>8</td> <td></td> <td></td>					8		
ANCL LLARY SERVICE COST CENTERS 50.00 05000 DECATI NG ROOM 0.000000 219,543 0 0 0 55.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 54.499 0 0 55.00 60.00 06200 PLI UERY ROOM & LABOR ROOM 0.000000 56.499 0 0 52.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 570,546 0 0 66.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 18,345 0 0 66.00 65.00 06500 RESPI RATORY THERAPY 0.000000 147,771 0 0 66.00 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.000000 20,520 0 0 67.00 66.00 68.00 PEECH PATHOLOGY 0.000000 20,520 0 0 71.00 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 72.00 73.00 073000 DRUGS CHARGED TO PA							
50.00 OSO00 OPERATING ROM 0.000000 219, 543 0 0 0 50.00 52.00 DELIVERY ROM & LABOR ROM 0.000000 5, 499 0 0 0 52.00 64.00 S200 DELIVERY ROM & LABOR ROM 0.000000 54, 499 0 0 0 54.00 65.00 OS000 LABORATORY 0.000000 570, 546 0 0 66.00 62.00 D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 383, 45 0 0 65.00 65.00 OS600 RESPIRATORY HERAPY 0.000000 147, 771 0 0 66.00 67.00 OG700 OCCUPATI ONAL THERAPY 0.000000 107, 587 0 0 66.00 68.00 OF200 OCCUPATI ONAL THERAPY 0.000000 20, 520 0 0 68.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 20, 520 0 0 0 71.00 73.00 OT200 INPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00		9.00	10.00	11.00	12.00	13.00	
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62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 18,345 0 0 62.00 65.00 06500 RESPIRATORY THERAPY 0.000000 395,108 0 0 65.00 66.00 06700 0CUPATIONAL THERAPY 0.000000 147,771 0 0 0 66.00 67.00 06700 0CUPATIONAL THERAPY 0.000000 107,587 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 20,520 0 0 0 68.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 596,789 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 73.00 001704T ENT SERVICE COST CENTERS 0.000000 0 0 0 0 88.00 80.0 08800 RURAL HEALTH CLINIC I T - PCFP 0.000000 0 0 0 88.02 <t< td=""><td></td><td></td><td></td><td></td><td>0 0</td><td>0</td><td></td></t<>					0 0	0	
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67.00 06700 0CCUPATI ONAL THERAPY 0.00000 107,587 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 20,520 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 596,789 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,404,220 0 0 0 73.00 00TPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 88.00 88.01 88.01 88.01 08801 RURAL HEALTH CLINIC - TCC 0.000000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - PCFP 0.000000 0 0 88.01 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 88.02 90.01 09001 PAI MANAGEMENT 0.000000 0 0 0 90.00 <td< td=""><td>65. 00 06500 RESPI RATORY THERAPY</td><td>0. 000000</td><td>395, 108</td><td></td><td>0 0</td><td>0</td><td>65.00</td></td<>	65. 00 06500 RESPI RATORY THERAPY	0. 000000	395, 108		0 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0.00000 20,520 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 596,789 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 1,404,220 0 0 0 73.00 000TPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC 1 I - PCFP 0.000000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC I II - 13TH 0.000000 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 0 0 0 0 0 0 88.02 90.00 09000 CLINIC 0 0.000000 12,354 0 0 0 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	0. 000000	147, 771		0 0	0	66.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 596,789 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 0 0 0 72.00 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 73.00 88.00 08800 RURAL HEALTH CLINIC - TCC 0.000000 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC - IT - PCFP 0.000000 0 0 0 88.00 88.02 08802 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.02 90.02 90.02 90.02 90.02 9	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	107, 587		0 0	0	67.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1,404,220 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS	68.00 06800 SPEECH PATHOLOGY	0. 000000	20, 520		0 0	0	68.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.00000 1,404,220 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC - TCC 0.00000 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC III - PCFP 0.000000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 0 88.02 80.03 08903 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 0 88.02 80.03 08903 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	596, 789		0 0	0	71.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 0.000000 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II - PCFP 0.000000 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 0.000000 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 0 0 88.02 90.00 09000 CLINIC 0.000000 0 <t< td=""><td>72.00 07200 IMPL. DEV. CHARGED TO PATIENT</td><td>0. 000000</td><td>0</td><td></td><td>0 0</td><td>0</td><td>72.00</td></t<>	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
88.00 08800 RURAL HEALTH CLINIC - TCC 0.000000 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC III - PCFP 0.000000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 0.000000 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0.000000 0 0 0 0 88.03 90.00 09000 CLINIC 0.000000 0 0 0 0 90.00 90.01 09000 CLINIC 0.000000 0 0 0 0 90.00 90.02 09002 WUND CARE 0.000000 0 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0.000000 0 0 0 91.00 91.00 91.00 91.03 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 0 0 91.00 92.00 0 92.00 0 92.00 92.00 92.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 404, 220		0 0	0	73.00
88.01 08801 RURAL HEALTH CLINICIII - PCFP 0.000000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINICIII - 13TH 0.000000 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINICIV - SPENCER 0.000000 0 0 0 88.03 90.00 09000 CLINIC 0.000000 12,354 0 0 90.00 90.01 09000 CLINIC 0.000000 0 0 0 90.00 90.02 09000 CLINIC 0.000000 0 0 0 90.00 90.01 09000 CLINIC 0.000000 0 0 0 90.01 90.02 09002 WOUND CARE 0.000000 0 0 0 90.02 90.03 09003 ORTHOPEDI C CLINIC 0.000000 22,610 0 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.000000 22,610 0 0 92.00 0 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0	OUTPATIENT SERVICE COST CENTERS			_			
88.02 08802 RURAL HEALTH CLINICIII - 13TH 0.000000 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINICIV - SPENCER 0.000000 0 0 0 88.03 90.00 09000 CLINIC 0.000000 12,354 0 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0.000000 0 0 0 90.01 90.02 09002 WOUND CARE 0.000000 0 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0.000000 3,386 0 0 90.02 91.00 09100 EMERGENCY 0.000000 0 0 0 90.03 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 22,610 0 0 92.00 92.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	88.00 08800 RURAL HEALTH CLINIC - TCC	0. 000000	0		0 0	0	88.00
88.03 08803 RURAL HEALTH CLINICIV - SPENCER 0.000000 0 0 0 88.03 90.00 09000 CLINIC 0.000000 12,354 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0.000000 0 0 0 90.01 90.02 09002 WOUND CARE 0.000000 0 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0.000000 0 0 0 90.02 91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 92.00 092EVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92.00 07HER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	88.01 08801 RURAL HEALTH CLINIC II - PCFP	0. 000000	0		0 0	0	88.01
90.00 09000 CLINIC 0.00000 12,354 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0.000000 0 0 0 90.01 90.02 09002 WOUND CARE 0.000000 3,386 0 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0.000000 0 0 0 90.03 91.00 09100 EMERGENCY 0.000000 22,610 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 22,610 0 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 0 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 95.00 95.00 95.00 95.00 95.00	88.02 08802 RURAL HEALTH CLINIC III - 13TH	0. 000000	0		0 0	0	88.02
90.01 09001 PAIN MANAGEMENT 0.000000 0 0 0 0 90.01 90.02 09002 WOUND CARE 0.000000 3,386 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0.000000 0 0 0 90.03 91.00 09100 EMERGENCY 0.000000 22,610 0 0 0 91.00 92.00 09SERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 0 92.00 07HER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0. 000000	0		0 0	0	88.03
90. 02 09002 WOUND CARE 0.000000 3, 386 0 0 0 90. 02 90. 03 09003 ORTHOPEDIC CLINIC 0.000000 0 0 0 90. 03 91. 00 09100 EMERGENCY 0.000000 22, 610 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92. 00 07HER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90. 00 09000 CLINIC	0. 000000	12, 354		0 0	0	90.00
90.03 09003 ORTHOPEDIC CLINIC 0.00000 0 0 0 90.03 91.00 09100 EMERGENCY 0.000000 22,610 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	90. 01 09001 PALN MANAGEMENT	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY 0.000000 22,610 0 0 91.00 91.00 92.00 92.00 0 0 0 92.00 92.00 0 0 0 92.00	90. 02 09002 WOUND CARE	0. 000000	3, 386		0 0	0	90.02
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00	90. 03 09003 ORTHOPEDIC CLINIC	0. 000000	0		0 0	0	90.03
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	91.00 09100 EMERGENCY	0. 000000	22, 610		0 0	0	91.00
95.00 09500 AMBULANCE SERVICES 95.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
200.00 Total (lines 50 through 199) 3, 980, 827 0 0 0 200.00	95.00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)		3, 980, 827		0 0	0	200.00

Health Finan	cial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMEN	NT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1322	Peri od:	Worksheet D	
					From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	narod
					10 12/31/2021	6/24/2022 9:4	1 am
			Title	e XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see		Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS	0.014445		1 700 00		-	
	OPERATING ROOM	0. 214145				0	
	DELIVERY ROOM & LABOR ROOM	0. 409651			0 0	0	52.00
	RADI OLOGY-DI AGNOSTI C	0. 126647		4, 808, 78		0	54.00
	LABORATORY	0. 145752		2, 858, 44		0	60.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 281729		113, 11		0	62.00
	RESPI RATORY THERAPY	0. 393627		746, 24		0	65.00
	PHYSI CAL THERAPY	0. 329038		625, 02		0	66.00
	OCCUPATI ONAL THERAPY	0. 269189		171, 45		0	67.00
	SPEECH PATHOLOGY	0. 374923	0	38, 99		0	68.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 181801	0	614, 21		0	71.00
	IMPL. DEV. CHARGED TO PATIENT	0. 939413				0	72.00
	DRUGS CHARGED TO PATIENTS	0. 215668	0	5, 547, 53	36 1, 702	0	73.00
	TIENT SERVICE COST CENTERS	1		1	-		
	RURAL HEALTH CLINIC - TCC						88.00
	RURAL HEALTH CLINIC II - PCFP						88.01
	RURAL HEALTH CLINIC III - 13TH						88. 02
	RURAL HEALTH CLINIC IV - SPENCER						88.03
	CLINIC	1. 316290		138, 65	5 23, 916	0	90.00
	PAIN MANAGEMENT	0. 000000			0 0	0	90.01
	WOUND CARE	0. 336898		576, 29	98 0	0	90.02
	ORTHOPEDIC CLINIC	0. 210149	0		0 0	0	90.03
	EMERGENCY	0. 438539		1, 974, 83	39 0	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	1.809368	0	210, 69	91 0	0	92.00
	REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	0. 380447			0		95.00
200.00	Subtotal (see instructions)		0	20, 209, 49	25, 618		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, 209, 49	25, 618	0	202.00

Heal th Fi	inancial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTI O	INMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pr 6/24/2022 9:-	
			Title	XVIII	Hospi tal	Cost	
		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				
	NCI LLARY SERVICE COST CENTERS	0(4.004					50.00
	5000 OPERATING ROOM	364, 881	0				50.00
	5200 DELIVERY ROOM & LABOR ROOM	0	-				52.00
	5400 RADI OLOGY-DI AGNOSTI C	609, 018					54.00
	6000 LABORATORY	416, 624					60.00
	5200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 868					62.00
	6500 RESPIRATORY THERAPY	293, 740					65.00
	6600 PHYSI CAL THERAPY 5700 OCCUPATI ONAL THERAPY	205, 658					66.00 67.00
	5700 OCCOPATIONAL THERAPY 5800 SPEECH PATHOLOGY	46, 153 14, 619					68.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 619					71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	76, 391	0				72.00
	7300 DRUGS CHARGED TO PATIENTS	1, 196, 426					73.00
	JTPATIENT SERVICE COST CENTERS	1, 190, 420					/3.00
	3800 RURAL HEALTH CLINIC - TCC						88.00
	3801 RURAL HEALTH CLINIC II - PCFP						88.01
	3802 RURAL HEALTH CLINIC III - 13TH						88.02
	3803 RURAL HEALTH CLINIC IV - SPENCER						88.03
	9000 CLINIC	182, 510	31, 480				90.00
	9001 PALN MANAGEMENT	0	0 0				90.01
	9002 WOUND CARE	194, 154					90.02
	9003 ORTHOPEDIC CLINIC	0	0				90.03
	9100 EMERGENCY	866, 044	0				91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	381, 218					92.00
	THER REIMBURSABLE COST CENTERS			1			
95.00 09	9500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	4, 990, 968	31, 847				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	4, 990, 968	31, 847				202.00

Health Financial Systems	PERRY COUNTY HOSPITAL			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 6/24/2022 9:4	epared:
		Ti +1	e XIX	Hospi tal	072472022 9.4 PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
		Aujustillent	Related Cost		•	
	(from Wkst.				col. 4)	
	B, Part II,		(col. 1 -			
	col . 26)	0.00	col . 2)	1.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 117, 453	267, 791	849, 66	2 2, 670		
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	
43.00 NURSERY	31, 245		31, 24			
200.00 Total (lines 30 through 199)	1, 148, 698		880, 90	7 2, 792		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 ADULTS & PEDIATRICS	33	10, 502				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	33	10, 502				200.00
		107002	1			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CON: 15-1322 Period: Part II Date 11 Worksheet D Part II Date 71 Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Title XIX Hospital Post II Provider CON: 15-1322 Period: Part II Date 71 Date 71 ANCILLARY SERVICE COST CENTERS Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Cost 20 3.00 4.00 5.00 50:00 05000 DELIVERY NOW & LABOR ROOM 579, 835 10.366.287 0.055827 450, 117 25, 129 50.00 50:00 05000 DELIVERY NOW & LABOR ROOM 137, 934 688, 017 0.200481 184, 593 37, 075 52.00 60:00 06000 DELIVERY NOW & LABOR ROOM 137, 934 0.016144 96, 150 1, 553 54.00 60:00 06000 PHYSICAL HERAPY 197, 555 0.03633 8, 273 30 62.00 60:00 06000 OPHYSICAL HERAPY 98, 614 2, 92, 059 0.03363 5, 577 188, 004 1, 416 60.00 71:00 00700 OCUPATIONAL THERAPY 98, 614 <th>Health Financial Systems</th> <th>PERRY COUNT</th> <th>Y HOSPI TAL</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description Capital Related Cost (From Wkst. B, Part II, col. 28) Total Charges to Capital Crow Wkst. C, Part II, col. 28) Inpatient Col and Capital Costs (col umn 3 x col umn 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 DEELIVERY ROOM & LABOR ROOM 579, 835 10.386, 287 0.055827 450, 117 25, 129 50.00 52.00 05400 RADI LOGY-DI AGNOSTI C 312, 502 19, 350, 738 0.016149 96, 153 54.00 55, 60, 00 55, 80, 00 55, 80, 00 55, 80, 00 55, 54.00 55, 60, 00 56, 00 66, 00	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 6/24/2022 9:4	
Related Cost (from Wkst. (col. 2) to Charges (col. 1+ col. 2) Program (col. 1+ col. 2) Col umn 3 x col umn 4) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 MACI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 055000 (PERATI NG ROOM 137, 934 688, 017 0.200481 184, 593 37, 007 52.00 52.00 054000 (Apd Icody-DI AGNOSTI C 312, 502 19, 350, 738 0.01514 188, 004 1, 416 60.00 60.00 064000 (Apd Icody-DI AGNOSTI C 312, 502 19, 350, 738 0.007534 188, 004 1, 416 60.00 61.00 065000 [RESPI RATORY THERAPY 197, 558 4, 2, 32, 059 0.033635 8, 273 30 62.00 66.00 066000 [RESPI RATORY THERAPY 98, 614 2, 932, 059 0.033637 3, 577 188 66.00 66.00 06600 [RESPI RATORY THERAPY 12, 243 5, 345, 601 0.002346 268, 821 63.10 71.00 07100 [CUPAT IONAL THERAPY							
ANCI LLARY SERVICE COST CENTERS (col. 8) (col. 8) (col. 2) Charges col umn 4) 50.00 05000 OPERATI NG ROOM 579,835 10,386,287 0.055827 450,117 25,129 50.00 52.00 05200 DELVERY ROM & LABOR ROOM 137,934 688,017 0.00411 184,593 37,007 52.00 50.00 05400 RADI LLARY ROM & LABOR ROOM 137,934 688,017 0.20481 184,593 37,007 52.00 60.00 06000 RADI LGON & PACKED RED BLOOD CELLS 1,329 365,578 0.03635 8,273 30 62.00 60.00 06500 RESPI RATORY THERAPY 197,558 4,235,354 0.04645 61,903 2,887 65.00 67.00 06700 OCCUPATI ONAL THERAPY 98,614 2,932,059 0.03333 5,577 188 66.00 68.00 06800 SPECH PATHOLOGY 22,368 447,764 0.049955 1,877 94 68.00 68.00 068000 NECKARED TO PATI ENTS <td>Cost Center Description</td> <td></td> <td></td> <td>Ratio of Cos</td> <td>t Inpatient</td> <td></td> <td></td>	Cost Center Description			Ratio of Cos	t Inpatient		
B Part II, col. 26) col. 2) col. 2) col. 20 ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROM 579, 835 10.386, 287 0.055827 450, 117 25, 129 50.00 52.00 05200 DELI VERY ROM & LABOR ROM 137, 934 688, 017 0.200481 184, 593 37, 007 52.00 64.00 06400 RADI OLGGY - DI AGNOSTI C 312, 502 19, 350, 738 0.016149 96, 150 1, 553 54.00 65.00 065000 RESPI RATORY 160, 082 21, 248, 883 0.007534 188, 004 1, 416 60.00 65.00 06500 RESPI RATORY THERAPY 196, 614 2, 932, 059 0.033633 5, 577 188 66.00 66.00 06600 PHYSI CAL THERAPY 98, 614 2, 932, 059 0.033633 5, 577 188 66.00 67.00 06700 OCCUPATI ONAL THERAPY 41, 218 1, 236, 025 0.033347 3, 652 122, 67.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED			(from Wkst.	to Charges	Program		
col. 26) col. 26) dot dot ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATING ROOM 579, 835 10, 386, 287 0.055827 450, 117 25, 129 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 137, 934 688, 017 0.200481 184, 593 37, 007 52.00 60.00 06000 D6400 RADIOLOGY-DI AGNOSTIC 1160, 082 21, 248, 883 0.007534 188, 004 1, 416 60.00 62.00 06020 WOLE BLOOD & PACKED RED BLOOD CELLS 1.329 365, 578 0.03363 5, 277 188 66.00 65.00 06500 RESPIRATORY THERAPY 98, 614 2, 932, 059 0.033633 5, 577 188 66.00 60.00 06000 SPECCH PATHOLOGY 22, 368 447, 764 0.049955 1, 877 94 68.00 61.00 07100 DVDT HARCE DTO PATI ENTS 12, 543 5, 345, 601 0.002346 268, 821 631 </td <td></td> <td></td> <td></td> <td></td> <td>Charges</td> <td>column 4)</td> <td></td>					Charges	column 4)	
ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 579,835 10,386,287 0.055827 450,117 25,129 50.00 52.00 05500 DELIVERY ROM & LABOR ROM 137,934 688,017 0.200481 184,593 37,007 55.20 54.00 O5600 LABORATORY 1160,082 21,248,883 0.007534 188,004 1,416 60.00 60.00 06000 LABORATORY 160,082 21,248,883 0.007534 188,004 1,416 60.00 65.00 O6500 RESPIRATORY THERAPY 197,558 4,235,354 0.046454 61.903 2,887 65.00 66.00 06600 SPECH PATHORY THERAPY 98,614 2,932,059 0.033633 5,577 188 66.00 67.00 06600 SPECH PATHORY THERAPY 41,218 1,236,025 0.033433 5,577 188 66.00 68.00 O6600 SPECH PATHOLOGY 22,368 447,764 0.049955 1			col. 8)	col. 2)			
ANCL LLARY SERVICE COST CENTERS 50.00 OPERATI NG ROOM 579, 835 10, 386, 287 0.055827 450, 117 25, 129 50.00 52.00 DESCOD PELI VERY ROOM & LABOR ROOM 137, 934 688, 017 0.200481 184, 593 37, 007 52.00 54.00 DS400 RADI OLGGY-DI AGNOSTI C 312, 502 19, 350, 738 0.016149 96, 150 1.553 54.00 60.00 D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1.329 365, 578 0.003635 8, 273 30 62.00 06500 RESPI RATORY THERAPY 197, 558 4, 235, 354 0.046645 61, 903 2, 887 65.00 66.00 06500 QCUPATI ONAL THERAPY 98, 614 2, 932, 059 0.033633 5, 577 188 66.00 67.00 06700 CUCPATI ONAL THERAPY 41, 218 1, 236, 025 0.033347 3, 652 122 67.00 007100 MEDI CAL SUPPLIE SC HARGED TO PATI ENTS 12, 543 5, 345, 601 0.002346 268, 821 631 71.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 11							
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52.00 05200 DELI VERY ROOM & LABOR ROOM 137, 934 688, 017 0.200481 184, 593 37, 007 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 312, 502 19, 350, 738 0.016149 96, 150 1, 553 54.00 60.00 LOBONC LABORATORY 160, 082 21, 248, 883 0.007534 188, 004 1, 416 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 329 365, 578 0.003635 8, 273 30 62.00 65.00 06500 RESPI RATORY THERAPY 197, 558 4, 235, 354 0.046645 61, 903 2, 887 65.00 66.00 OCCUPATI ONAL THERAPY 98, 614 2, 932, 0559 0.033633 5, 577 188 66.00 67.00 OC700 OCUPATI ONAL THERAPY 22, 368 447, 764 0.049955 1, 877 94 68.00 71.00 OT300 DRUG CHARGED TO PATI ENTS 12, 543 5, 345, 601 0.002346 268, 821 631 71.00 72.00 07200 IMPL, DEV. CHARGED TO PATI ENTS 10, 278 16, 894, 986 0.006527		1		-	1		
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60.00 CABORATORY 160,082 21,248,883 0.007534 188,004 1,416 60.00 62.00 MO200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1,329 365,578 0.003635 8,273 30 62.00 65.00 RESPI RATORY THERAPY 197,558 4,235,354 0.046645 61,903 2,887 65.00 66.00 O6600 PHYSI CAL THERAPY 98,614 2,932,059 0.033633 5,577 188 66.00 67.00 O6700 OCCUPATI ONAL THERAPY 41,218 1,236,025 0.033347 3,652 122 67.00 68.00 SPEECH PATHOLOGY 22,368 447,764 0.049955 1,877 468.00 71.00 OTICOLAL SUPPLIES CHARGED TO PATIENTS 12,543 5,345,601 0.002346 268,821 63.1 71.00 72.00 O7300 DRUSC CHARGED TO PATIENTS 110,278 16,894,986 0.006527 481,714 3,144 73.00 007300 DRUSC CHARGED TO PATIENTS 110,278 16,894,986 0.011380 0 0 88.01 88.00 0880							
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1,329 365,578 0.003635 8,273 30 62.00 65.00 06500 RESPIRATORY THERAPY 197,558 4,235,354 0.046645 61,903 2,887 65.00 66.00 06700 0CCUPATIONAL THERAPY 98,614 2,932,059 0.033633 5,577 188 66.00 67.00 06700 0CCUPATIONAL THERAPY 41,218 1,236,025 0.033347 3,652 122 67.00 68.00 06800 SPEECH PATHOLOGY 22,368 447,764 0.049955 1,877 94 68.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 12,543 5,345,601 0.002346 28,821 631 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 110,278 16,894,986 0.006527 481,714 3,144 73.00 0017941 UNTAL HEALTH CLINIC C IT C 49,826 4,378,254 0.011380 0 88.01 88.01 88.01 08803 RURAL HEALTH CLINIC III - PCFP 16,734 1,842,063 0.009084 0<							
65.00 06500 RESPI RATORY THERAPY 197, 558 4, 235, 354 0.046645 61, 903 2, 887 65.00 66.00 06600 PHYSI CAL THERAPY 98, 614 2, 932, 059 0.033633 5, 577 188 66.00 67.00 06700 0CCUPATI ONAL THERAPY 41, 218 1, 236, 025 0.033347 3, 652 122 67.00 68.00 06800 SPEECH PATHOLOGY 22, 368 447, 764 0.049955 1, 877 94 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 12, 543 5, 345, 601 0.002346 268, 821 631 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 110, 278 16, 894, 986 0.006527 481, 714 3, 144 73.00 OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 49, 826 4, 378, 254 0.011380 0 0 88.00 88.01 08802 RURAL HEALTH CLINIC I I - PCFP 16, 734 1, 842, 063 0.009084 0 0 88.02 90.00 090000 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
66.00 06600 PHYSI CAL THERAPY 98, 614 2, 932, 059 0.033633 5, 577 188 66.00 67.00 06700 0CCUPATI ONAL THERAPY 41, 218 1, 236, 025 0.033347 3, 652 122 67.00 68.00 06800 SPEECH PATHOLOGY 22, 368 447, 764 0.049955 1, 877 94 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 12, 543 5, 345, 601 0.002346 268, 821 631 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 110, 278 16, 894, 986 0.006527 481, 714 3, 144 73.00 001794TI ENT SERVICE COST CENTERS 110, 278 16, 894, 986 0.006527 481, 714 3, 144 73.00 88.00 08800 RURAL HEALTH CLINIC - TCC 49, 826 4, 378, 254 0.011380 0 88.01 88.01 08801 RURAL HEALTH CLINIC III - 9CFP 16, 734 1.842, 063 0.009084 0 0 88.01 80.10 08803 RURAL HEALTH CLINIC III - 13TH 36, 560 1, 614, 104 0.022650 0		1, 329					62.00
67.00 06700 0CCUPATI ONAL THERAPY 41, 218 1, 236, 025 0.033347 3, 652 122 67.00 68.00 06800 SPEECH PATHOLOGY 22, 368 447, 764 0.049955 1, 877 94 68.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 12, 543 5, 345, 601 0.002346 268, 821 631 71.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 110, 278 16, 894, 986 0.006527 481, 714 3, 144 73.00 017PATI ENT SERVICE COST CENTERS 0 0 73.00 08801 RURAL HEALTH CLINIC - TCC 49, 826 4, 378, 254 0.011380 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC TIT - PCFP 16, 734 1, 842, 063 0.009084 0 88.01 88.02 88.03 08803 RURAL HEALTH CLINIC TIT - SPENCER 111, 184 913, 674 0.012241 0 0 88.03 90.01 09000 CLINIC 22, 728 957, 097 0.232712 18, 081 4, 208 90.00 90.02 <td></td> <td>197, 558</td> <td></td> <td></td> <td></td> <td></td> <td>65.00</td>		197, 558					65.00
68.00 06800 SPEECH PATHOLOGY 22, 368 447, 764 0.049955 1, 877 94 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 12, 543 5, 345, 601 0.002346 268, 821 631 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 829 150, 891 0.012121 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 110, 278 16, 894, 986 0.006527 481, 714 3, 144 73.00 0UTPATIENT SERVICE COST CENTERS 0 08800 RURAL HEALTH CLINIC - TCC 49, 826 4, 378, 254 0.011380 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC TI - PCFP 16, 734 1, 842, 063 0.009084 0 88.01 88.02 08803 RURAL HEALTH CLINIC III - 13TH 36, 560 1, 614, 104 0.022650 0 0 88.02 80.00 09000 CLINIC 0 0 0.000000 0 88.03 90.00 09000 CLINIC 1, 854 648, 363 0.002660		98, 614	2, 932, 059				
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 12,543 5,345,601 0.002346 268,821 631 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1,829 150,891 0.012121 0 0 72.00 73.00 D7300 DRUGS CHARGED TO PATIENTS 110,278 16,894,986 0.005527 481,714 3,144 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 88.00 08800 RURAL HEALTH CLINIC - TCC 49,826 4,378,254 0.011380 0 0 88.00 88.00 08801 RURAL HEALTH CLINIC III - PCFP 16,734 1,842,063 0.009084 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 36,560 1,614,104 0.022650 0 0 88.03 90.00 09000 CLINIC V SPENCER 11,184 913,674 0.012241 0 0 88.03 90.01 09001 ON MANAGEMENT 0 0.0000000 0 0 0.011 90.02 09002 WOUND CARE 73,043 <		41, 218	1, 236, 025			122	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1,829 150,891 0.012121 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 110,278 16,894,986 0.006527 481,714 3,144 73.00 0UTPATIENT SERVICE COST CENTERS 0 08800 RURAL HEALTH CLINIC - TCC 49,826 4,378,254 0.011380 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC II - PCFP 16,734 1,842,063 0.009084 0 88.01 88.01 08803 RURAL HEALTH CLINIC III - 13TH 36,560 1,614,104 0.022650 0 0 88.02 80.00 09000 CLINIC SPENCER 11,184 913,674 0.012241 0 0 88.03 90.00 09000 CLINIC 222,728 957,097 0.232712 18,081 4,208 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0.0000000 0 0 90.02 90.02 09002 WOUND CARE 73,043 1,474,247 0.049546 8,628 427	68.00 06800 SPEECH PATHOLOGY	22, 368	447, 764	0. 04995	55 1, 877	94	68.00
73.00 07300 DRUGS CHARGED TO PATIENTS 110,278 16,894,986 0.006527 481,714 3,144 73.00 0UTPATIENT SERVICE COST CENTERS 0 08800 RURAL HEALTH CLINIC - TCC 49,826 4,378,254 0.011380 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II - PCFP 16,734 1,842,063 0.009084 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 36,560 1,614,104 0.022650 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 11,184 913,674 0.012241 0 0 88.03 90.00 09000 CLINIC 0 0 0.000000 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0.0000000 0 0 90.01 90.02 09002 WOUND CARE 73,043 1,474,247 0.049546 8,628 427 90.02 90.03 09003 ORTHOPEDI C CLINIC 1,854 648,363 0.002860 0 0 90.03 </td <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>12, 543</td> <td>5, 345, 601</td> <td>0.00234</td> <td>6 268, 821</td> <td>631</td> <td>71.00</td>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 543	5, 345, 601	0.00234	6 268, 821	631	71.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 49,826 4,378,254 0.011380 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II - PCFP 16,734 1,842,063 0.009084 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 36,560 1,614,104 0.022650 0 0 88.03 09000 OP000 CLINIC V SPENCER 11,184 913,674 0.012241 0 0 88.03 90.00 09000 CLINIC 0 222,728 957,097 0.232712 18,081 4,208 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 0 90.00 90.02 09002 WOUND CARE 73,043 1,474,247 0.049546 8,628 427 90.02 90.03 09003 ORTHOPEDIC CLINIC 1,854 648,363 0.002860 0 0 90.03 91.00 09100 EMERGENCY 354,540 8,498,542 0.041718 89,768	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 829	150, 891	0. 01212	21 0	0	
88.00 08800 RURAL HEALTH CLINIC - TCC 49,826 4,378,254 0.011380 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II - PCFP 16,734 1,842,063 0.009084 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 36,560 1,614,104 0.022650 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 11,184 913,674 0.012241 0 0 88.03 90.00 09000 CLINIC 0 0 0 0.00000 0 90.00 90.01 09001 PAI N MANAGEMENT 0 0 0 0.000000 0 90.01 90.02 09002 WOUND CARE 73,043 1,474,247 0.049546 8,628 427 90.02 90.03 097HOPEDI C CLINIC 11 1854 648,363 0.002860 0 0 90.03 91.00 092020 OBSERVATION BEDS (NON-DI STINCT PART) 146,383 714,708 0.204815 6,819 1,397 92.00 092200<		110, 278	16, 894, 986	0. 00652	481, 714	3, 144	73.00
88.01 08801 RURAL HEALTH CLINICII - PCFP 16,734 1,842,063 0.009084 0 0 88.01 88.02 08802 RURAL HEALTH CLINICIII - 13TH 36,560 1,614,104 0.022650 0 0 88.02 88.03 08803 RURAL HEALTH CLINICIV - SPENCER 11,184 913,674 0.012241 0 0 88.03 90.00 09000 CLINIC 222,728 957,097 0.232712 18,081 4,208 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0.000000 0 90.01 90.01 90.02 09002 WOUND CARE 73,043 1,474,247 0.049546 8,628 427 90.02 90.03 09703 ORTHOPEDI C CLINIC 1,854 648,363 0.002860 0 90.03 91.00 092020 OBSERVATION BEDS (NON-DISTINCT PART) 146,383 714,708 0.204815 6,819 1,397 92.00 02200 OBSERVATION BEDS (NON-DISTINCT PART) 146,383 714,708 0.204815 6,819 1,397 92.00 02	OUTPATIENT SERVICE COST CENTERS			_			
88.02 08802 RURAL HEALTH CLINIC III - 13TH 36,560 1,614,104 0.022650 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 11,184 913,674 0.012241 0 0 88.03 90.00 09000 CLINIC V SPENCER 11,184 913,674 0.012241 0 0 88.03 90.00 09000 CLINIC V SPENCER 11,184 913,674 0.012241 0 0 88.03 90.01 09001 PAIN MANAGEMENT 0 0 0.000000 0 0 90.01 90.02 09002 WOUND CARE 73,043 1,474,247 0.049546 8,628 427 90.02 90.03 09003 ORTHOPEDI C CLINIC 1,854 648,363 0.002860 0 0 90.03 91.00 09100 EMERGENCY 354,540 8,498,542 0.041718 89,768 3,745 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 146,383 714,708 0.204815 6,819 1,397	88.00 08800 RURAL HEALTH CLINIC - TCC	49, 826	4, 378, 254	0. 01138	30 0	0	88.00
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 11,184 913,674 0.012241 0 0 88.03 90.00 09000 CLINIC 222,728 957,097 0.232712 18,081 4,208 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0.000000 0 0 90.01 90.02 09002 WOUND CARE 73,043 1,474,247 0.049546 8,628 427 90.02 90.03 09003 ORTHOPEDI C CLINIC 1,854 648,363 0.002860 0 0 90.03 91.00 09100 EMERGENCY 354,540 8,498,542 0.041718 89,768 3,745 91.00 92.00 09200/UBSERVATION BEDS (NON-DISTINCT PART) 146,383 714,708 0.204815 6,819 1,397 92.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	88.01 08801 RURAL HEALTH CLINIC II - PCFP	16, 734	1, 842, 063	0.00908	34 0	0	88.01
90. 00 09000 CLINIC 222,728 957,097 0.232712 18,081 4,208 90.00 90. 01 09001 PAIN MANAGEMENT 0 0 0.000000 0 90.01 90. 02 09002 WOUND CARE 73,043 1,474,247 0.049546 8,628 427 90.02 90. 03 09003 ORTHOPEDIC CLINIC 1,854 648,363 0.002860 0 0 90.03 91. 00 09100 EMERGENCY 354,540 8,498,542 0.041718 89,768 3,745 91.00 92. 00 09500 OBSERVATI ON BEDS (NON-DI STINCT PART) 146,383 714,708 0.204815 6,819 1,397 92.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	88.02 08802 RURAL HEALTH CLINIC III - 13TH	36, 560	1, 614, 104	0. 02265	50 O	0	88.02
90. 01 09001 PAI N MANAGEMENT 0 0 0.000000 0 0 90. 01 90. 02 09002 WOUND CARE 73, 043 1, 474, 247 0.049546 8, 628 427 90. 02 90. 03 09003 ORTHOPEDIC CLINIC 1, 854 648, 363 0.002860 0 90. 03 91. 00 09100 EMERGENCY 354, 540 8, 498, 542 0.041718 89, 768 3, 745 91. 00 92. 00 095ERVATI ON BEDS (NON-DI STINCT PART) 146, 383 714, 708 0.204815 6, 819 1, 397 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 95.00	88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	11, 184	913, 674	0. 01224	1 0	0	88.03
90. 02 09002 WOUND_CARE 73, 043 1, 474, 247 0. 049546 8, 628 427 90. 02 90. 03 09003 ORTHOPEDIC_CLINIC 1, 854 648, 363 0. 002860 0 90. 03 91. 00 09100 EMERGENCY 354, 540 8, 498, 542 0. 041718 89, 768 3, 745 91. 00 92. 00 09200 OBSERVATI ON_BEDS_(NON-DI STINCT PART) 146, 383 714, 708 0. 204815 6, 819 1, 397 92. 00 0THER_REI_MBURSABLE_COST_CENTERS 95. 00 09500 AMBULANCE_SERVICES 95. 00	90. 00 09000 CLINIC	222, 728	957, 097	0. 2327	2 18, 081	4, 208	90.00
90. 03 09003 ORTHOPEDIC CLINIC 1,854 648,363 0.002860 0 90.03 91. 00 09100 EMERGENCY 354,540 8,498,542 0.041718 89,768 3,745 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 146,383 714,708 0.204815 6,819 1,397 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90.01 09001 PALN MANAGEMENT	0	0	0.0000	0 0	0	90.01
91. 00 09100 EMERGENCY 354, 540 8, 498, 542 0. 041718 89, 768 3, 745 91. 00 92. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 146, 383 714, 708 0. 204815 6, 819 1, 397 92. 00 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90. 02 09002 WOUND CARE	73, 043	1, 474, 247	0. 04954	8, 628	427	90.02
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 146, 383 714, 708 0. 204815 6, 819 1, 397 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90. 03 09003 ORTHOPEDIC CLINIC	1,854	648, 363	0. 00286	0 0	0	90.03
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	91.00 09100 EMERGENCY	354, 540	8, 498, 542	0. 0417	8 89, 768	3, 745	91.00
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	146, 383	714, 708	0. 2048	5 6, 819	1, 397	92.00
200.00 Total (lines 50 through 199) 2,588,942 104,323,235 1,873,977 81,978 200.00	95.00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)	2, 588, 942	104, 323, 235		1, 873, 977	81, 978	200.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVI	CE OTHER PASS THROUGH COS			Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	epared: 41 am
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Education	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CEN	ITERS					
30. 00 03000 ADULTS & PEDIATRICS	C)	0	0 0	C	30.00
31.00 03100 INTENSIVE CARE UNIT	C		o	0 0	l c	31.00
43. 00 04300 NURSERY	C		ol	0 0	l c	43.00
200.00 Total (lines 30 through 199)	C		0	0 0	l c	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CEN						
30, 00 03000 ADULTS & PEDIATRICS	C)	0 2,67	0.00	33	30.00
31.00 03100 INTENSIVE CARE UNIT			0	0 0.00		31.00
43. 00 04300 NURSERY			0 12			
200.00 Total (lines 30 through 199)			2,79			200.00
Cost Center Description	I npati ent		-/	_i		
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9,00	-				
INPATIENT ROUTINE SERVICE COST CEN		1				
30.00 03000 ADULTS & PEDIATRICS	C					30.00
31.00 03100 INTENSIVE CARE UNIT						31.00
43. 00 04300 NURSERY						43.00
200.00 Total (lines 30 through 199)						200.00
	1	1				-00.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1322 Period: From 01/01/2021 Morksheet D To 12/31/2021 Part IV Date/Time Prepared: 0/24/2022 9: 41 am (2/222 9: 41 am) Cost Center Description Non Physician Anesthetist Cost Nursing Program Nursing Program Allied Health Allied Health Allied Health Allied Health AucilLLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 0	Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
Cost Center Description Non Physician Anesthetist Cost Nursing Program Ost-Stepdown Adjustments Nursing Program Adjustments Nursing Program Adjustments Nursing Program Adjustments Nursing Program Adjustments Allied Health Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 Model 05000 (DPERATING ROOM 00000 (DeFD AGNOSTIC 0 0 0 0 50.00 52.00 (D5000 (DADION-DI AGNOSTIC 0 0 0 0 0 52.00 64.00 (D6000 (LABORATORY 0 0 0 0 0 0 52.00 65.00 (D600 (LABORATORY 0 0 0 0 0 0 0 62.00 65.00 (D600 (RSPI RATORY THERAPY 0		RVICE OTHER PAS	S Provider C	CN: 15-1322	From 01/01/2021	Part IV Date/Time Pre	
Anesthetist Cost Program Post-Stepdown Adjustments Program Adjustments Program Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 50.00 0 0 0 0 0 0 0 0 0 0 50.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 54.00 0 0 0 0 52.00<			Titl	e XIX	Hospi tal	PPS	
Cost Post-Stepdown Adjustments Adjustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 MACI LLARY SERVICE COST CENTERS 0 <t< td=""><td>Cost Center Description</td><td>Non Physician</td><td>Nursi ng</td><td>Nursi ng</td><td>Allied Health</td><td>Allied Health</td><td></td></t<>	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
Adj ustments Adj ustments Adj ustments Adj ustments Adj ustments 50.00 05000 0PERATI NG ROOM 0		Anesthetist	Program	Program	Post-Stepdown		
I.00 2A 2.00 3A 3.00 ANCI LLARY SERVICE COST CENTERS		Cost	Post-Stepdown		Adjustments		
ANCI LLARY SERVICE COST CENTERS Image: Control of the co							
50.00 05000 0PERATING ROOM 0 0 0 0 0 0 0 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0		1.00	2A	2.00	3A	3.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 54.00 05400 RADIOLGCY-DIAGNOSTIC 0 0 0 0 54.00 60.00 LABORATORY 0 0 0 0 0 0 64.00 62.00 MADICARTORY 0 0 0 0 0 64.00 62.00 MADICARTORY 0 0 0 0 0 64.00 64.00 OS500 RESPIRATORY THERAPY 0 0 0 0 65.00 65.00 OS600 SPECH PATHOLOGY 0 0 0 0 66.00 67.00 OS700 OCCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 OS200 SPECH PATHOLOGY 0 0 0 0 0 71.00 71.00 OTOMEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72							
54.00 05400 RADI OLOGY-DI AGNOSTI C 0	50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
60.00 06000 LABORATORY 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 0	0	52.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0	0	54.00
65.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72.00 72.00 07200 IPUL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 00 0 DUPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 72.00 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.01 08802 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.02 08803 RURAL HEALTH CLINIC III - 13TH 0 0 0 0 88.03 90.00 09000 CLINIC V SPENCER <td>60. 00 06000 LABORATORY</td> <td>0</td> <td>0</td> <td>)</td> <td>0 0</td> <td>0</td> <td>60.00</td>	60. 00 06000 LABORATORY	0	0)	0 0	0	60.00
66.00 06600 PHYSI CAL THERAPY 0<	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0)	0 0	0	62.00
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 71.00 OT100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 0 0 0 0 72.00 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 0 72.00 0 0 0 0 0 72.00 0 0 0 0 0 72.00 0 0 0 0 0 0 72.00 73.00 0 0 0 0 0 0 0 0 73.00 73.00 0 0 0 0 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.02 88.01 88.02 88.03 88.03 88.03 88.03 88.03 88.03 88.03 90.00 90.001 9	65. 00 06500 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 71.00 00 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 72.00 0	66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 73.00 07000 DRUGS CHARGED TO PATIENTS 0 0 0 0 72.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 73.00 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC III - PCFP 0 0 0 0 88.02 88.02 08802 RURAL HEALTH CLINIC IV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC V SPENCER 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.02 <t< td=""><td>67.00 06700 OCCUPATI ONAL THERAPY</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>67.00</td></t<>	67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 73.00 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC III - PCFP 0 0 0 0 88.01 88.02 08803 RURAL HEALTH CLINIC III - 13TH 0 0 0 0 88.03 90.00 09000 CLINIC O 0 0 0 88.03 90.01 09000 CLINIC V SPENCER 0 0 0 90.00 90.02 09000 CLINIC O 0 0 0 0 90.00 90.01 09001 PAI MANAGEMENT 0 0 0 0 0 0 90.02 90.02 09002 WOUND CARE<	68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II - PCFP 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0 0 0 0 88.02 90.00 09000 CLINIC 0 0 0 0 88.02 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 0 0 0 0 0 90.02 90.03 09003 ORTHOPEDI C CLINIC 0 0 0 0 0 91.00 92.00 092000 OBSERVATI ON BEDS (NON-DI STINCT PART) <td>72.00 07200 IMPL. DEV. CHARGED TO PATIENT</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>72.00</td>	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC III - PCFP 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC V - SPENCER 0 0 0 0 90.00 90.01 09000 CLINIC V - SPENCER 0 0 0 0 90.00 90.02 09002 WUND CARE 0 0 0 0 90.01 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 0 095.00 AMBULANCE SERVICES 95.00 95.00 95.	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
88.01 08801 RURAL HEALTH CLINICIII - PCFP 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINICIII - 13TH 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINICIV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC V SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC V SPENCER 0 0 0 0 90.00 90.01 09000 CLINIC V SPENCER 0 0 0 0 90.00 90.02 09002 WOUND CARE 0 0 0 0 90.01 90.02 09003 ORTHOPEDI CLINIC 0 0 0 0 90.02 90.03 09003 ORTHOPEDI CLINIC 0 0 0 90.03 91.00 90.03 91.00 90.03 91.00 90.03 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00	OUTPATIENT SERVICE COST CENTERS						
88.02 08802 RURAL HEALTH CLINICIII - 13TH 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINICIV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 09001 PAI N MANAGEMENT 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 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 0 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	88.00 08800 RURAL HEALTH CLINIC - TCC	0	0)	0 0	0	88.00
88.03 08803 RURAL HEALTH CLINICIV - SPENCER 0 0 0 0 88.03 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 0 0 0 90.02 90.03 09003 ORTHOPEDIC CLINIC 0 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 92.00 07HER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	88.01 08801 RURAL HEALTH CLINIC II - PCFP	0	0		0 0	0	88.01
90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 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 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 92.00 92.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00	88.02 08802 RURAL HEALTH CLINIC III - 13TH	0	0		0 0	0	88.02
90.01 09001 PAIN MANAGEMENT 0 0 0 0 0 90.01 90.02 09002 WOUND CARE 0 0 0 0 0 90.02 90.03 09003 ORTHOPEDI C CLINIC 0 0 0 0 0 90.03 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 92.00 07HER REIMBURSABLE COST CENTERS	88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0	0		0 0	0	88.03
90.02 09002 WOUND CARE 0 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 07HER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90.00 09000 CLINIC	0	0		0 0	0	90.00
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 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 0 95.00 95.00 95.00	90.01 09001 PALN MANAGEMENT	0	0		0 0	0	90.01
91.00 09100 EMERGENCY 0 0 0 0 91.00 91.00 92.00	90. 02 09002 WOUND CARE	0	0		0 0	0	90.02
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90. 03 09003 ORTHOPEDIC CLINIC	0	0		0 0	0	90.03
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	91.00 09100 EMERGENCY	0	0		0 0	0	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	·				·	1
200.00 Total (lines 50 through 199) 0 0 0 0 0 0 0 0 0 0 0	95.00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-1322	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021	Part IV	
				To 12/31/2021	Date/Time Pre 6/24/2022 9:4	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	1					
50.00 OPERATING ROOM	0	0		0 10, 386, 287	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 688, 017		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 19, 350, 738		
60. 00 06000 LABORATORY	0	0		0 21, 248, 883		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 365, 578		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 4, 235, 354	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 932, 059		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 236, 025		
68.00 06800 SPEECH PATHOLOGY	0	0		0 447, 764	0.00000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 5, 345, 601	0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 150, 891	0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 16, 894, 986	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC	0	0		0 4, 378, 254	0.000000	
88.01 08801 RURAL HEALTH CLINIC II - PCFP	0	0		0 1, 842, 063		
88.02 08802 RURAL HEALTH CLINIC III - 13TH	0	0		0 1, 614, 104		
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0	0		0 913, 674	0.00000	
90. 00 09000 CLINIC	0	0		0 957, 097	0.00000	
90. 01 09001 PALN MANAGEMENT	0	0		0 0	0.00000	
90. 02 09002 WOUND CARE	0	0		0 1, 474, 247	0.00000	
90. 03 09003 ORTHOPEDIC CLINIC	0	0		0 648, 363		
91. 00 09100 EMERGENCY	0	0		0 8, 498, 542		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 714, 708	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 104, 323, 235		200.00

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 6/24/2022 9:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	1		1	- 1		
50.00 05000 OPERATING ROOM	0. 000000	450, 117		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	184, 593		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	96, 150		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	188, 004		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	8, 273		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	61, 903		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	5, 577		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	3, 652		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 877		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	268, 821		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	481, 714		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP	0. 000000	0		0 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III - 13TH	0. 000000	0		0 0	0	88.02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	0. 000000	0		0 0	0	88.03
90. 00 09000 CLINIC	0. 000000	18, 081		0 0	0	90.00
90. 01 09001 PALN MANAGEMENT	0. 000000	0		0 0	0	90.01
90. 02 09002 WOUND CARE	0. 000000	8, 628		0 0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	0. 000000	0		0 0	0	90.03
91.00 09100 EMERGENCY	0. 000000	89, 768		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	6, 819		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		1, 873, 977		0 0	0	200.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL			u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	nared
				10 12/31/2021	6/24/2022 9: 4	1 am
		Ti tl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.01/1/5	1	1 1 1 2 7	-		
50.00 05000 OPERATI NG ROOM	0. 214145				0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 409651		41, 87		0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 126647		2, 118, 14		0	54.00
60. 00 06000 LABORATORY	0. 145752		2, 368, 43		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 281729		10, 57		0	62.00
65.00 06500 RESPI RATORY THERAPY	0. 393627		361, 50		0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 329038		255, 45		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 269189		112, 21		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 374923		74, 75		0	68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 181801		496, 85		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 939413		4, 04		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 215668	0	1, 289, 32	2 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1	1	1			
88.00 08800 RURAL HEALTH CLINIC - TCC						88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP						88.01
88.02 08802 RURAL HEALTH CLINIC III - 13TH						88.02
88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER 90. 00 09000 CLINIC	1 21/200		00.71	-	0	88.03
	1. 316290		90, 71	5 0	0	90.00
90. 01 09001 PALN MANAGEMENT 90. 02 09002 WOUND CARE	0.000000		140 54	0 0	0	90.01
	0. 336898		148, 56		0	90.02
90. 03 09003 ORTHOPEDIC CLINIC	0. 210149			0 0	0	90.03
91.00 09100 EMERGENCY	0. 438539		1, 233, 99		0	91.00 92.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	1. 809368	0	75, 99	<u> </u> 0	0	92.00
95. 00 09500 AMBULANCE SERVICES	0. 380447	0	88, 79	9		95.00
200.00 Subtotal (see instructions)	0.000447	0			0	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ		0 0	0	201.00
Only Charges				ĭ		
202.00 Net Charges (line 200 - line 201)		0	10, 214, 00	5 0	0	202.00

Health Financial Systems	PERRY COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CC	CN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 6/24/2022 9:4	epared: 41 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				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	308, 961	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	17, 154	0				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	268, 257	0				54.00
60. 00 06000 LABORATORY	345, 204	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 980	0				62.00
65. 00 06500 RESPI RATORY THERAPY	142, 297	0				65.00
66.00 06600 PHYSI CAL THERAPY	84, 055	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	30, 208	0				67.00
68.00 06800 SPEECH PATHOLOGY	28, 026	0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	90, 328	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	3, 797	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	278, 065	0				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC						88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP						88.01
88.02 08802 RURAL HEALTH CLINIC III - 13TH						88.02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER						88.03
90. 00 09000 CLINIC	119, 407	0				90.00
90. 01 09001 PALN MANAGEMENT	0	0				90.01
90. 02 09002 WOUND CARE	50, 050	0				90.02
90. 03 09003 ORTHOPEDIC CLINIC	0	0				90.03
91.00 09100 EMERGENCY	541, 156	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	137, 496	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	33, 783					95.00
200.00 Subtotal (see instructions)	2, 481, 224	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	2, 481, 224	0				202.00

	Financial Systems PERRY COUNTY H ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	nare
			10 12/31/2021	6/24/2022 9:4	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	cost center bescription			1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s. excluding newborn)		3, 707	1 1
00	Inpatient days (including private room days, excluding swing-			2, 670	
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(ave)		2, 210	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	824	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro 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 roo	m davs) through Decembe	r 31 of the cost	213	7
	reporting period	5, 6			
00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excludin	a swing-bed and	959	9
	newborn days) (see instructions)	o the mogram (exertation	g swing bed and	,0,	ĺ
00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	824	10
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o	tions) nlv (including private	room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e		room days) arter	0	''
00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	Y only (including prive	to room days)	0	13
00	after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	
00	Total nursery days (title V or XIX only)			0	
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost		17
	reporting period				
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost		18
00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 c	f the cost	231.10	19
~ ~	reporting period				
00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of	the cost	231.10	20
00	Total general inpatient routine service cost (see instruction	s)		9, 871, 717	21
00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22
00	5 x line 17)	21 of the east report	ng pariod (line	0	1 22
00	Swing-bed cost applicable to SNF type services after December x line 18)	SI UL THE COST LEPOLT	ng period (inne d	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	49, 224	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost concrtin	a pariad (line 0	0	25
. 00	x line 20)	ST OF THE COST TEPOLITI	g period (The a	0	25
. 00	Total swing-bed cost (see instructions)			2, 365, 694	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 506, 023	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)		nur geo)	0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
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 of	ifferential (lind	0 7, 506, 023	
00	27 minus line 36)	and private room cost o		7, 300, 023	3/
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY				1
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			0.011.05	
00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			2, 811. 25 2, 695, 989	
	Medically necessary private room cost applicable to the Progr			2,075,707	
	Total Program general inpatient routine service cost (line 39	. ,		2, 695, 989	

	Financial Systems ATION OF INPATIENT OPERATING COST	PERRY COUNTY		CN: 15-1322	Period:	u of Form CMS- Worksheet D-1	
					From 01/01/2021		
					To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
	Cost Center Description	Total		e XVIII Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpatient	Inpatient	Diem (col.		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
2.00	Intensive Care Type Inpatient Hospital Units		(<u> </u>			42.
	INTENSIVE CARE UNIT	0	(0. (0 00	0	
4.00	CORONARY CARE UNIT						44.
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 46.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
3. 00	Program inpatient ancillary service cost (W	kst D-3 col 3	line 200)	-		1.00 874,874	48.
	Total Program inpatient costs (sum of lines		,	ons)		3, 570, 863	
	PASS THROUGH COST ADJUSTMENTS	0				1	
0. 00	Pass through costs applicable to Program in	patient routine s	services (fro	m Wkst. D, su	m of Parts I and	0	50.
1.00	III) Pass through costs applicable to Program in	patient ancillary	v services (f	rom Wkst. D.	sum of Parts II	0	51.
	and IV)	· -	,				
2.00	Total Program excludable cost (sum of lines		ated at 1	vol ol ····	hatiot !	0	
3.00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		ated, non-pn	iysi ci an anest	netist, and	0	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient opera	ting cost and tai	raet amount (line 56 minus	line 53)	0	
B. 00 Bonus payment (see instructions)							58.
9.00	Lesser of lines 53/54 or 55 from the cost r	eporting period e	endi ng 1996,	updated and c	compounded by the	0.00	59.
0. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report up	dated by the	market basket		0.00	60.
1.00	If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less th		s (lines 54 x	: 60), or 1% c	f the target		
2.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.
2.00 3.00	Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST					1	
4.00	Medicare swing-bed SNF inpatient routine co	sts through Decer	mber 31 of th	e cost report	ing period (See	2, 316, 470	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decembe	er 31 of the	cost reportir	a period (See	0	65.
	instructions)(title XVIII only)					_	
6.00	Total Medicare swing-bed SNF inpatient rout	ine costs (line d	64 plus line	65)(title XVI	II only). For	2, 316, 470	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost r	eporting period	0	67.
	(line 12 x line 19)	no oborto rin ough		01 110 0001 1	opor tring por rou		
8.00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 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 (l	ine 67 ± lin	e 68)		0	69.
/. 00	PART III - SKILLED NURSING FACILITY, OTHER I			· · · · · · · · · · · · · · · · · · ·		<u> </u>	, 07.
0. 00	Skilled nursing facility/other nursing faci)		70.
1.00 2.00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ne 70 ÷ line	= 2)			71.
	Medically necessary private room cost appli-		(line 14 x l	ine 35)			73.
4.00	Total Program general inpatient routine ser	vice costs (line	72 + line 73)			74.
5.00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75.
5.00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76.
. 00	Program capital-related costs (line 9 x lin	e 76)					77.
. 00	Inpatient routine service cost (line 74 min			ide)			78.
. 00 . 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)		80.
. 00	Inpatient routine service cost per diem lim	•					81.
. 00	Inpatient routine service cost limitation (line 9 x line 81)					82.
3.00	Reasonable inpatient routine service costs		5)				83.
4.00 5.00	Program inpatient ancillary services (see i Utilization review - physician compensation		ns)				84. 85.
	Total Program inpatient operating costs (su					<u> </u>	86.
	PART IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST					
7.00	Total observation bed days (see instruction					460	
8.00	Adjusted general inpatient routine cost per	diem (line 27 ·	line 2)			2, 811. 24	

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 117, 453	9, 871, 717	0. 11319	7 1, 293, 170	146, 383	90.00
91.00 Nursing Program cost	0	9, 871, 717	0.00000	0 1, 293, 170	0	91.00
92.00 Allied health cost	0	9, 871, 717	0.00000	0 1, 293, 170	0	92.00
93.00 All other Medical Education	0	9, 871, 717	0.00000	0 1, 293, 170	0	93.00

^{6/24/2022 9:41} am

	Financial Systems PERRY COUNTY H ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
. 00	Inpatient days (including private room days and swing-bed day	/s, excluding newborn)		3, 707	1.0
. 00	Inpatient days (including private room days, excluding swing-			2,670	
. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3.0
. 00	Semi-private room days (excluding swing-bed and observation b	oed days)		2, 210	4.
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decemb	er 31 of the cost	824	5.
. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.
. 00	reporting period (if calendar year, enter 0 on this line)	Som days) arter becomber		0	0.
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	213	7.
. 00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December	31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)			Ū.	
00	Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	33	9.
D. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10.
	through December 31 of the cost reporting period (see instruc	ctions)	3 /		
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.
2.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12.
	through December 31 of the cost reporting period		•	-	
3.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.
1.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.
5.00	Total nursery days (title V or XIX only)			122	
6.00	Nursery days (title V or XIX only)			0	16.
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	res through December 31	of the cost		17.
. 00	reporting period	thi bugh becomber of			
3.00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost		18.
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	231.10	19.
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	231.10	20.
	reporting period			0 074 747	0.1
1.00 2.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb	<i>,</i>	ting period (line	9, 871, 717 0	
2.00	5 x line 17)	lei 31 01 the cost repor	ting period (ine	0	22.
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporti	ng period (line 6	0	23.
4.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	49, 224	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25.
5.00	x line 20)	ST OF the cost reportin	g period (The o	0	25.
6.00	Total swing-bed cost (see instructions)			2, 365, 694	
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		7, 506, 023	27.
3. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28.
9.00	Private room charges (excluding swing-bed charges)		<u> </u>	0	29.
0. 00	Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
. 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	,		0.00	
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
		USTMENTS			1
	PROGRAM INPATIENT OPERATING COST DEFORE PASS INKOUGH COST ADJ				4
3. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			2, 811. 24	38.
8.00 9.00 0.00		e instructions) e 38)		2, 811. 24 92, 771 0	39.

	Financial Systems ATION OF INPATIENT OPERATING COST	PERRY COUNTY	HOSPITAL Provider C	CN: 15-1322	In Lie Period:	u of Form CMS- Worksheet D-1	
JUNFUT	ATTON OF THEATTENT OF ERATTING COST		FIOVIDEI C	GN. 15-1522	From 01/01/2021		
					To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col.	5	Program Cost (col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	63, 844	122	523.3	31 0	0	42.0
3.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.0	0 00	0	43.0
4.00	CORONARY CARE UNIT	0	0	0.0	0	0	44.0
	BURN INTENSIVE CARE UNIT						45.0
6.00	SURGICAL INTENSIVE CARE UNIT						46.0
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
	cost center bescription					1.00	
18.00	Program inpatient ancillary service cost (W	<st. 3<="" col.="" d-3,="" td=""><td>, line 200)</td><td></td><td></td><td>472, 982</td><td>48.0</td></st.>	, line 200)			472, 982	48.0
19.00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		565, 753	49.0
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	nationt routine	services (fro	m Wkst D su	m of Parts I and	10, 502	50.0
0.00			361 11 663 (11 6	m wkst. D, Su		10, 302	. 50.0
51.00	Pass through costs applicable to Program in	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	81, 978	51.0
	and IV)	EQ and 51				00 400	50 0
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		lated non-ph	vsician anest	hetist and	92, 480 473, 273	
	medical education costs (line 49 minus line						
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0 0. 00	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient opera	ting cost and ta	irget amount (line 56 minus	line 53)	0	
8.00	Bonus payment (see instructions)	-	-			0	
9.00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.0
0.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by the	market basket		0.00	60.0
51.00	If line 53/54 is less than the lower of line					0	61.0
	which operating costs (line 53) are less the		s (lines 54 x	60), or 1% o	f the target		
52.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				C	62.0
	Allowable Inpatient cost plus incentive pay	ment (see instru	ictions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
54.00	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of th	e cost report	ing period (See	0	64. C
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reportin	a period (See	C	65.0
	instructions) (title XVIII only)				g por lou (oco	c.	
66.00	Total Medicare swing-bed SNF inpatient rout	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. C
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31	of the cost r	enorting period	C	67.0
57.00	(line 12 x line 19)	le costs through	December 31	of the cost i	eporting period	0	07.0
68.00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost rep	orting period	0	68.0
(0.00	(line 13 x line 20)	routino posto (line (7 . lin	a (0)		0	
59.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER M					0	0 69. C
70.00	Skilled nursing facility/other nursing faci)		70.0
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.0
2.00 3.00	Program routine service cost (line 9 x line Medically necessary private room cost appli	,	(line 14 v l	ino 25)			72.0
4.00	Total Program general inpatient routine services	U	•				74.0
75.00	Capital-related cost allocated to inpatient	•			Part II, column		75.0
	26, line 45)						
76.00 7.00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x line						76.0
7.00 8.00	Inpatient routine service cost (line 74 min						78.0
9.00	Aggregate charges to beneficiaries for exce	,	orovi der recor	ds)			79.0
0.00	Total Program routine service costs for com		ost limitatio	n (line 78 mi	nus line 79)		80.
1.00 2.00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation ()				81. 82.
2.00	Reasonable inpatient routine service cost frim tation (82.
4.00	Program inpatient ancillary services (see in	•	- /				84.
5.00	Utilization review - physician compensation	(see instructio					85.
36.00	Total Program inpatient operating costs (su		rough 85)				86. (
37.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instruction					460	87.0
	Adjusted general inpatient routine cost per		line 2)			2, 811. 24	
38.00	naj de ted general inpatrient i editine eter per		11110 2)			=, = · · · = ·	00.0

Health Financial Systems	PERRY COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 117, 453	9, 871, 717	0. 11319	7 1, 293, 170	146, 383	90.00
91.00 Nursing Program cost	0	9, 871, 717	0. 00000	0 1, 293, 170	0	91.00
92.00 Allied health cost	0	9, 871, 717	0. 00000	0 1, 293, 170	0	92.00
93.00 All other Medical Education	0	9, 871, 717	0.00000	0 1, 293, 170	0	93.00

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	NTY HOSPITAL	CN 15 1000		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1322	Period: From 01/01/2021	Worksheet D-3	5
			To 12/31/2021	Date/Time Pre	epared:
				6/24/2022 9:4	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			1, 650, 554		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 OPERATING ROOM		0. 2141		47,014	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4096		2, 253	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1266		57, 821	
60. 00 06000 LABORATORY		0. 1457		83, 158	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 28172		5, 168	
65. 00 06500 RESPI RATORY THERAPY		0. 3936		155, 525	
66. 00 06600 PHYSI CAL THERAPY		0. 32903		48, 622	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2691		28, 961	
68.00 06800 SPEECH PATHOLOGY		0. 37492		7,693	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1818		108, 497	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 9394		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2156	68 1, 404, 220	302, 845	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC - TCC		0.0000		0	
88.01 08801 RURAL HEALTH CLINIC II - PCFP		0.0000		0	
88.02 08802 RURAL HEALTH CLINIC III - 13TH		0.0000	00	0	00.02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER		0.0000	00	0	88.03
90. 00 09000 CLINIC		1. 3162		16, 261	90.00
90. 01 09001 PALN MANAGEMENT		0.0000	0 00	0	90.01
90. 02 09002 WOUND CARE		0. 3368		1, 141	90.02
90. 03 09003 ORTHOPEDIC CLINIC		0. 2101	49 0	0	90.03
91. 00 09100 EMERGENCY		0. 4385	39 22, 610	9, 915	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.8093	68 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 9	8)		3, 980, 827	874, 874	200.00
201.00 Less PBP Clinic Laboratory Services-Program only c			0		201.00
202.00 Net charges (line 200 minus line 201)	/	1	3, 980, 827		202.00

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1322	Peri		Worksheet D-3	
	Component	CCN: 15-Z322	From To	01/01/2021 12/31/2021	Date/Time Pre	narod
	Component	CON. 13-2322	10	12/31/2021	6/24/2022 9: 4	
	Title	e XVIII	Swi ng	g Beds - SNF		_
Cost Center Description		Ratio of Cos		Inpatient	I npati ent	
		To Charges		Program	Program Costs	
				Charges	(col. 1 x	
		1.00		0.00	col . 2)	
		1.00		2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 O3000 ADULTS & PEDI ATRI CS			-			20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT						30.00
43. 00 04300 NURSERY						43.00
ANCI LLARY SERVI CE COST CENTERS						43.00
50. 00 05000 OPERATING ROOM		0. 2141	45	236	51	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 4096		230	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1266		3, 518		
60. 00 06000 LABORATORY		0. 1457		141, 093	20, 565	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2817	-	0	0	
65. 00 06500 RESPIRATORY THERAPY		0. 3936		99, 450	39, 146	
66. 00 06600 PHYSI CAL THERAPY		0. 3290	38	292, 446	96, 226	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 2691	89	276, 723	74, 491	67.00
68.00 06800 SPEECH PATHOLOGY		0. 3749	23	45, 117	16, 915	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1818	01	189, 921	34, 528	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 9394	13	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2156	68	339, 850	73, 295	73.00
OUTPATIENT SERVICE COST CENTERS		1				
88.00 08800 RURAL HEALTH CLINIC - TCC		0.0000			0	
88.01 08801 RURAL HEALTH CLINIC II - PCFP		0.0000			0	
88. 02 08802 RURAL HEALTH CLINIC III - 13TH		0.0000			0	88.02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER		0.0000		0.45	0	
90. 00 09000 CLINIC		1. 3162		845	1, 112	•
90. 01 09001 PALN MANAGEMENT		0.0000		0	0	
90. 02 09002 WOUND CARE		0.3368		0	0	90.02
90. 03 09003 ORTHOPEDIC CLINIC 91. 00 09100 EMERGENCY		0. 2101		0	0	90.03
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.8093		0	0	91.00
00109200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 6093	00	0	0	92.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (sum of lines 50 through 94 and 96	through 98)			1, 389, 199	356, 775	
201.00 Less PBP Clinic Laboratory Services-Progr				1, 307, 177	000,770	200.00
202.00 Net charges (line 200 minus line 201)				1, 389, 199		202.00

Health Financial Systems PERRY COUNTY				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1322	Period:	Worksheet D-3	3
			From 01/01/2021 To 12/31/2021	Date/Time Pre	•nared·
			10 12/31/2021	6/24/2022 9: 4	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description	·	Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 O3000 ADULTS & PEDIATRICS			313, 425		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43.00 04300 NURSERY			1, 934		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2141			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.4096			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1266			
60. 00 06000 LABORATORY		0. 1457			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2817			
65. 00 06500 RESPI RATORY THERAPY		0. 3936			
66. 00 06600 PHYSI CAL THERAPY		0. 3290			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2691			
68.00 O6800 SPEECH PATHOLOGY		0. 3749			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1818		48, 872	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 9394		-	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2156	68 481, 714	103, 890	73.00
OUTPATIENT SERVICE COST CENTERS		1		I	
88.00 08800 RURAL HEALTH CLINIC - TCC		0. 8461		-	
88.01 08801 RURAL HEALTH CLINIC II - PCFP		0.6760		, v	
88.02 08802 RURAL HEALTH CLINIC III - 13TH		1.6668		0	
88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER		0. 9061		Ŭ	
90. 00 09000 CLINIC		1. 3162		23, 800	
90. 01 09001 PALN MANAGEMENT		0.0000		0	
90. 02 09002 WOUND CARE		0. 3368			
90. 03 09003 ORTHOPEDI C CLI NI C		0. 2101		, v	
91. 00 09100 EMERGENCY		0. 4385			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.8093	68 6, 819	12, 338	92.00
OTHER REIMBURSABLE COST CENTERS		1		1	
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 873, 977		
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			1, 873, 977		202.00

	Financial Systems PERRY COUNTY H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Pre	pared:
		Title XVIII	Hospi tal	6/24/2022 9:4 Cost	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	+!)		5, 022, 815	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	tions)		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 instru	ctions)		0 0. 000	4.01 5.00
6.00	Line 2 times line 5	· · · · ,		0	6.00
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 5, 022, 815	10.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 022, 013	11.00
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo	r payment for services		0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0.000000	17.00
18.00	Total customary charges (see instructions)			0	
19.00	Excess of customary charges over reasonable cost (complete on instructions)	ly if line 18 exceeds l	ne 11) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds l	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			5, 073, 043	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)		0	
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				21.00
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin		suctions)	31, 579 3, 429, 604	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•	· ·	1, 611, 860	
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	The SO)		0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29)			1, 611, 860 1, 016	
31.00	Primary payer payments Subtotal (line 30 minus line 31)			1, 610, 844	
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)		0	
	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0 352, 828	
35.00	Adjusted reimbursable bad debts (see instructions)			229, 338	35.00
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		223, 981 1, 840, 182	•
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	s)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instru	ctions)	0	39.98 39.99
40.00	Subtotal (see instructions)			1, 840, 182	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	
40.02	Sequestration adjustment-PARHM pass-throughs			0	40.02
	Interim payments			2, 386, 562	
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			F 4 / 000	42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-546, 380	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	chapter 1,	123, 490	
00.00	TO BE COMPLETED BY CONTRACTOR				
90.00 91.00	Original outlier amount (see instructions) 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
				, o	,

VALY	n Financial Systems PERRY COUNTY SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1322	Peri od:	Worksheet E-1	
				From 01/01/2021 To 12/31/2021		pare
		Title	XVIII	Hospi tal	Cost	I dili
			t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		3, 061, 7		2, 241, 662	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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)					
01	Program to Provider ADJUSTMENTS TO PROVIDER	10/28/2021	27, 5	00 10/28/2021	144, 900	3.
01	ADJUSTMENTS TO PROVIDER	10/28/2021	27,5	0 10/28/2021	144, 900	
03				0	0	
04				0	0	
05				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52 53				0	0	
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		27, 5	-	144, 900	
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 089, 2	05	2, 386, 562	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	1 .
01 02	IENTATIVE TO PROVIDER			0	0	5
03				0	0	
	Provider to Program				-	1
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		246, 5		0	6
02	SETTLEMENT TO PROGRAM			0	546, 380	
00	Total Medicare program liability (see instructions)		3, 335, 7		1, 840, 182	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1, 00	2.00	
00	Name of Contractor					8

VALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1322	Period: From 01/01/202	Worksheet E-1 1 Part I	1
		Component	CCN: 15-Z322	To 12/31/202		epare 41 am
		Title	XVIII	Swing Beds - SN		
		Inpati en	t Part A	Pa	nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		2, 437, 43		0	
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3
	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)					
01	Program to Provider ADJUSTMENTS TO PROVIDER	10/28/2021	92, 50		0) 3
01	ADJUSTMENTS TO PROVIDER	10/20/2021	92, 50	0	0	
02				0	0	
04				0	0	
05				0	0) 3
	Provider to Program				1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52 53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		92, 50		0	
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 529, 93	39	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					1 5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
~ -	Program to Provider				1	
01 02	TENTATI VE TO PROVIDER			0	0	
)2)3				0	0	
	Provider to Program					1
50	TENTATI VE TO PROGRAM			0	0	0 5
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0) 5
00	Determined net settlement amount (balance due) based on					6
00	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		166, 88	35	0	6
02	SETTLEMENT TO PROGRAM			0	0	6 6
00	Total Medicare program liability (see instructions)		2, 696, 82		0) 7
				Contractor	NPR Date	
)	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
		(J	1.00	2.00	1

Heal th	Financial Systems PERRY COUN	TY HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021		epared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT:				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA	-			1
1.00	Total hospital discharges as defined in AARA §4102 from W				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, reporting periods beginning on or after 10/01/2013, line		for cost		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of li reporting periods beginning on or after 10/01/2013, line		d plus for cost		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col.				6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168		Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruction	s)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestrat	ion (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 a	nd line 31) (see instructio	ns)		32.00

ALCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Prov	vider CCN: 15-1322	Peri od:	Worksheet E-2	2552
	Com	oonent CCN: 15-Z322	From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
		Title XVIII	Swing Beds - SNF		
			Part A 1.00	Part B 2.00	
C	OMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	npatient routine services - swing bed-SNF (see instructions)		2, 339, 635	0	1 1.
	npatient routine services - swing bed-NF (see instructions)				2.
F	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-be			0	3.
	nstructions)				2
	lursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teaching (program (see		0.00	3
	instructions)	or ogram (see		0.00	-
	Program days		824	0	5
00 I	nterns and residents not in approved teaching program (see instru	uctions)		0	6
	Jtilization review - physician compensation - SNF optional method	onl y	0		7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2, 699, 978	0	
	Primary payer payments (see instructions)		0	0	9
	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applicable	to phycician	2, 699, 978	0	10 11
	professional services)	e to physician	0	0	''
	Subtotal (line 10 minus line 11)		2, 699, 978	0	12
	Coinsurance billed to program patients (from provider records) (ex	kclude coinsurance	3, 154	0	
	for physician professional services)				
	30% of Part B costs (line 12 x 80%)			0	
	Subtotal (see instructions)		2, 696, 824	0	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions) Rural community hospital demonstration project (§410A Demonstratio	an) navmont	0		16 16
	adjustment (see instructions)	bit) payment	0		
	Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		0	0	17
01 A	Adjusted reimbursable bad debts (see instructions)		0	0	17
	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)	0	0	
	Total (see instructions)		2, 696, 824	0	
	Sequestration adjustment (see instructions)		0	0	
	Demonstration payment adjustment amount after sequestration) Dequestration adjustment-PARHM pass-throughs		0	0	19
	Sequestration for non-claims based amounts (see instructions)		0	0	
	nterim payments		2, 529, 939	0	
	nterim payments-PARHM				20
00 T	Fentative settlement (for contractor use only)		0	0	21
	<pre>fentative settlement-PARHM (for contractor use only)</pre>				21
	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19	9.25, 20, and 21)	166, 885	0	
1	Balance due provider/program-PARHM (see instructions)	with CMS Dub 1E 0	0	0	22
	Protested amounts (nonallowable cost report items) in accordance v Chapter 1, §115.2	WITH CWS PUD. 13-2,	0	0	23
	ural Community Hospital Demonstration Project (§410A Demonstratio	on) Adiustment			1
	s this the first year of the current 5-year demonstration period				200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement	<u> </u>			
	Medicare swing-bed SNF inpatient routine service costs (from Wkst.	D-1, Pt. II, line			201
	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from Wk:	st D_3 col 3 li	20		202
	200 (title XVIII swing-bed SNF))	St. D-3, COI. 3, II			202
	Total (sum of lines 201 and 202)				203
1. 00 N	Medicare swing-bed SNF discharges (see instructions)				204
	omputation of Demonstration Target Amount Limitation (N/A in firs	st year of the curr	ent 5-year demons	strati on	
	eriod)				
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 times	Lino 204)			205 206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursemer				200
	Program reimbursement under the §410A Demonstration (see instructi				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, co		1		208
	and 3)				
	djustment to Medicare swing-bed SNF PPS payments (see instruction	ns)			209
	Reserved for future use				210
	omparision of PPS versus Cost Reimbursement	olus line 210) (see			

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1322	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prep 6/24/2022 9:4	pare
		Title XVIII	Hospi tal	Cost	i aii
				1.00	
00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR ME	EDICARE PART A SERVICES - COS	T RETMBURSEMENT	0.570.0(0	
. 00 . 00	Inpatient services	structions)		3, 570, 863	1.
. 00	Nursing and Allied Health Managed Care payment (see ins Organ acquisition	structions)		0	2. 3.
. 00	Subtotal (sum of lines 1 through 3)			3, 570, 863	
. 00	Primary payer payments			3, 682	
. 00	Total cost (line 4 less line 5). For CAH (see instructi	ions)		3, 602, 890	
	COMPUTATION OF LESSER OF COST OR CHARGES		•		
	Reasonable charges				
. 00	Routine service charges			0	
. 00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
0. 00	Total reasonable charges			0	10
1 00	Customary charges Aggregate amount actually collected from patients liabl	La far normant far convious on	a abarga basi a	0	1 1 1
1.00 2.00	Amounts that would have been realized from patients lia			0	11
. 00	had such payment been made in accordance with 42 CFR 47		on a charge basis	0	'2
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	13. 13(0)		0. 000000	13
. 00	Total customary charges (see instructions)			0	
. 00	Excess of customary charges over reasonable cost (compl	lete only if line 14 exceeds l	ine 6) (see	0	15
	instructions)	-			
5.00	Excess of reasonable cost over customary charges (compl	lete only if line 6 exceeds li	ne 14) (see	0	16
	instructions)			_	
7.00	Cost of physicians' services in a teaching hospital (see COMPUTATION OF REIMBURSEMENT SETTLEMENT	ee instructions)		0	17
2 00	Direct graduate medical education payments (from Works)	heat E_4 line 49		0	18
9.00	Cost of covered services (sum of lines 6, 17 and 18)	neet L-4, The 47)		3, 602, 890	
. 00	Deductibles (exclude professional component)			287, 820	
. 00	Excess reasonable cost (from line 16)			0	21
2. 00	Subtotal (line 19 minus line 20 and 21)			3, 315, 070	22
8.00	Coinsurance			0	23
. 00	Subtotal (line 22 minus line 23)			3, 315, 070	24
	Allowable bad debts (exclude bad debts for professional	l services) (see instructions)		31, 837	
. 00	Adjusted reimbursable bad debts (see instructions)			20, 694	
. 00	Allowable bad debts for dual eligible beneficiaries (se	ee instructions)		23, 653	
. 00	Subtotal (sum of lines 24 and 25, or line 26)			3, 335, 764	
. 00 . 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see inst	ructions)		0	29
. 98	Recovery of accel erated depreciation.	ructions)		0	29
). 99	Demonstration payment adjustment amount before sequest	ration		0	29
. 00	Subtotal (see instructions)			3, 335, 764	
. 01	Sequestration adjustment (see instructions)			0	30
. 02	Demonstration payment adjustment amount after sequestra	ation		0	30
. 03	Sequestration adjustment-PARHM				30
. 00	Interim payments			3, 089, 205	
. 01	Interim payments-PARHM				31
2.00	Tentative settlement (for contractor use only)			0	
2.01	Tentative settlement-PARHM (for contractor use only)	1 20 02 21 - 1 22		044 550	32
B. 00	Balance due provider/program (line 30 minus lines 30.07		and 22 01)	246, 559	33
3.01 1.00	Balance due provider/program-PARHM (lines 2, 3, 18, and Protested amounts (nonallowable cost report items) in a			11, 143	33 34

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2021 o 12/31/2021	Worksheet G Date/Time Pre 6/24/2022 9:4	
		General Fund	Specific Purpose Fund 2.00	Endowment Fund 3.00	Plant Fund 4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	14, 978, 154		0	0	
. 00	Temporary investments	3, 920, 204	0	0	0	
. 00	Notes receivable	15 502 001	0	0	0	3.00
. 00 . 00	Accounts receivable Other receivable	15, 502, 881 1, 209, 934	0	0	0	4.00
. 00	Allowances for uncollectible notes and accounts receivable		0	0	0	6.0
. 00	Inventory	730, 398	0	0	0	
. 00	Prepai d expenses	449, 574	0	0	0	
. 00	Other current assets	0	0	0	0	
0.00	Due from other funds	1, 820, 000	0	0	0	10.0
1. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	28, 624, 287	0	0	0	11.0
2.00	Land	3, 805, 753	0	0	0	12.0
3.00	Land improvements	272, 277	0	0	0	13.0
4.00	Accumulated depreciation	-13, 551, 924	0	0	0	•
5.00	Bui I di ngs	43, 981, 242	0	0	0	15.0
6.00	Accumulated depreciation	-2, 713, 126	0	0	0	16.0
7.00	Leasehold improvements	0	0	0	0	
8.00 9.00	Accumulated depreciation Fixed equipment	2, 606, 705	0	0	0	18.0
9.00 0.00	Accumulated depreciation	-167, 416	0	0	0	20.0
1.00	Automobiles and trucks	477, 834	0	0	0	21.0
2.00	Accumulated depreciation	-445, 159	0	0	0	22.0
3.00	Major movable equipment	18, 008, 687	0	0	0	23.0
4.00	Accumulated depreciation	-9, 880, 174	0	0	0	24.0
	Minor equipment depreciable	0	0	0	0	25.0
6.00	Accumulated depreciation	0	0	0	0	26.0
7.00 8.00	HIT designated Assets Accumulated depreciation		0	0	0	27.0 28.0
	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.0
	Total fixed assets (sum of lines 12-29)	42, 394, 699	0	0	0	
	OTHER ASSETS					
1.00	Investments	0	0	0	0	31.0
2.00	Deposits on Leases	0	0	0	0	32.0
3.00 4.00	Due from owners/officers Other assets		0	0	0	33.0 34.0
5.00	Total other assets (sum of lines 31-34)		0	0	0	35.0
	Total assets (sum of lines 11, 30, and 35)	71, 018, 986	0	0	0	
	CURRENT LI ABI LI TI ES					1
	Accounts payable	1, 414, 572	0	0	0	37.0
8.00	Salaries, wages, and fees payable	0	0	0	0	
9.00 0.00	Payroll taxes payable Notes and Loans payable (short term)	671, 530	0	0	0	
1.00	Deferred income	2, 394, 187	0	0	0	
2.00	Accel erated payments	0	Ű	0	Ŭ	42.0
3.00	Due to other funds	0	0	0	0	
4.00	Other current liabilities	2, 338, 726	0	0	0	44.0
5.00	Total current liabilities (sum of lines 37 thru 44)	6, 819, 015	0	0	0	45.0
	LONG TERM LIABILITIES					1 44 0
6.00 7.00	Mortgage payable Notes payable	35, 376, 000	0	0	0	
8.00	Unsecured Loans	35, 378, 000	0	0	0	
9.00	Other long term liabilities	0	0	0	0	49.0
0.00	Total long term liabilities (sum of lines 46 thru 49)	35, 376, 000	0	0	0	
1.00	Total liabilities (sum of lines 45 and 50)	42, 195, 015	0	0	0	51.C
	CAPITAL ACCOUNTS	1	r			
2.00	General fund balance	28, 823, 971				52.0
3.00	Specific purpose fund		0	0		53.0 54.0
4.00 5.00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54.0
6.00	Governing body created - endowment fund balance			0		56.0
7.00	Plant fund balance - invested in plant			0	0	
8.00	Plant fund balance - reserve for plant improvement,				0	58.0
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	28, 823, 971	0	0	0	59.0
9.00 0.00	Total liabilities and fund balances (sum of lines 51 and	71, 018, 986		0	0	•

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL			In Lie	u of Form CM	S-2!	552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC		То	01/01/2021 12/31/2021	Worksheet G Date/Time P 6/24/2022 9	rep	
		General	Fund	Speci al	Purpo	se Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5.00	+	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) FREE STANDING HOME HEALTH 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	-412, 626 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26, 612, 118 2, 624, 479 29, 236, 597 -412, 626 28, 823, 971 0 28, 823, 971			0 0 0 0 0 0		0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 7.\ 00\\ 10.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ $
	sheet (line 11 minus line 18)	Endowment Fund	PI ant						
1.00	Fund balances at beginning of period	6.00 0	7.00	8.00	0				1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) FREE STANDING HOME HEALTH	0	0 0 0 0		0				2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	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	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0				19.00

	Financial Systems PERRY COUNTY				eu of Form CMS-2	
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1322	Period: From 01/01/2021 To 12/31/2021		epared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services		1	- 1	1	
	Hospi tal		6, 105, 5	97	6, 105, 597	
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER			0		4.00
5.00	Swing bed - SNF Swing bed - NF			0	0	
6.00 7.00	SKILLED NURSING FACILITY			0	0	6.00 7.00
	NURSING FACILITY					8.00
	OTHER LONG TERM CARE					9.00
	Total general inpatient care services (sum of lines 1-9)		6, 105, 5	97	6, 105, 597	
	Intensive Care Type Inpatient Hospital Services		0,100,0		0,100,077	10100
	INTENSIVE CARE UNIT			0	0	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum o	flines		0	0	16.00
	11-15)					
	Total inpatient routine care services (sum of lines 10 and 1	6)	6, 105, 5		6, 105, 597	
	Ancillary services		14, 132, 8	53 81, 487, 408		
	Outpatient services			0 (
	RURAL HEALTH CLINIC - TCC			0 4, 378, 254 0 1, 842, 063		
	RURAL HEALTH CLINIC II - PCFP RURAL HEALTH CLINIC III - 13TH			0 1, 842, 083		
	RURAL HEALTH CLINIC IV - SPENCER			0 1, 182, 597		
	FEDERALLY QUALIFIED HEALTH CENTER			0 1, 102, 547		
	HOME HEALTH AGENCY					22.00
	AMBULANCE SERVICES			0 4, 649, 416	4, 649, 416	
	CMHC			.,		24.00
	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE			0 0	0 0	26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	20, 238, 4	50 95, 628, 923	115, 867, 373	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		1			
	Operating expenses (per Wkst. A, column 3, line 200)			45, 384, 233	3	29.00
	ADD (SPECI FY)			0		30.00
31.00 32.00				0		31.00
32.00				0		33.00
34.00				0		34.00
35.00				0		35.00
	Total additions (sum of lines 30-35)			(36.00
	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		45, 384, 233	3	43.00
	to Wkst. G-3, line 4)		1	1		1

Health I	Financial Systems	PERRY COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
STATEME	NT OF REVENUES AND EXPENSES	Provi de	er CCN: 15-1322	Peri od:	Worksheet G-3	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
				10 12/31/2021	6/24/2022 9:4	
					1.00	
	Total patient revenues (from Wkst. G-2, Part				115, 867, 373	1.00
	Less contractual allowances and discounts on	patients' accounts			73, 988, 861	2.00
	Net patient revenues (line 1 minus line 2)				41, 878, 512	3.00
	Less total operating expenses (from Wkst. G-				45, 384, 233	4.00
	Net income from service to patients (line 3)	minus line 4)			-3, 505, 721	5.00
	OTHER INCOME				445.005	(00
	Contributions, donations, bequests, etc Income from investments				445, 895	6.00
	Revenues from telephone and other miscellane	ous communication convict			93, 375 0	7.00 8.00
	Revenues from television and radio service	ous communication service	15		0	8.00 9.00
	Purchase di scounts				0	9.00 10.00
	Rebates and refunds of expenses				92, 597	11.00
	Parking lot receipts				72, 377 0	12.00
	Revenue from Laundry and Linen service				0	13.00
	Revenue from meals sold to employees and gue	sts			62, 776	14.00
	Revenue from rental of living quarters				02,770	15.00
	Revenue from sale of medical and surgical su	pplies to other than pati	ents		0	16.00
	Revenue from sale of drugs to other than pat				0	17.00
	Revenue from sale of medical records and abs				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	nd canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00 I	Rental of hospital space				79, 584	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER OPERATING INCOME				3, 288, 158	24.00
24.50	COVID-19 PHE Funding				2, 067, 815	24.50
	Total other income (sum of lines 6-24)				6, 130, 200	
	Total (line 5 plus line 25)				2, 624, 479	
	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and sub				0	28.00
29.00 1	Net income (or loss) for the period (line 26	minus line 28)			2, 624, 479	29.00

	Financial Systems	PERRY COUNTY				u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Period:	Worksheet M-1	
			Component	CCN: 15-8516	From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
					RHC I	Cost	
		Compensati on	Other Costs	Total (col.	1 Reclassi fi cat		
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physician	1, 272, 673	0	1, 272, 6	73 -225, 073	1, 047, 600	1.00
2.00	Physician Assistant	1, 272, 073	0		0 -225,073	1, 047, 800	2.00
2.00	Nurse Practitioner	225, 105	0		-	225, 105	3.00
4.00	Visiting Nurse	225, 105	0	223, 1	0 0	225, 105	4.00
4.00 5.00	Other Nurse	197, 903	0	197, 9		197, 903	
6.00	Clinical Psychologist	197, 905	0	177, 7		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	182, 293	44,000	226, 2	93 0	226, 293	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,877,974	44,000				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	23, 854	23, 8	54 0	23, 854	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	
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	23, 854			23, 854	
22.00	Total Cost of Health Care Services (sum of	1, 877, 974	67, 854	1, 945, 8	28 -225, 073	1, 720, 755	22.00
	Lines 10, 14, and 21)						
23.00	COSTS OTHER THAN RHC/FQHC SERVICES	0	36, 632	36, 6	32 0	36, 632	23.00
23.00	Dental	0	30, 032		0 0	0	23.00
24.00	Optometry	0	0		0 0		24.00
25.00	Tel eheal th	0	0			0	25.00
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	0		0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	36, 632	36, 6	32 0	36, 632	
201.00	through 27)	0	00,002			00,002	20.00
	FACILITY OVERHEAD						1
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Administrative Costs	200, 636	1, 041, 345	1, 241, 9	81 0	1, 241, 981	30.00
31.00	Total Facility Overhead (sum of lines 29 and	200, 636	1, 041, 345	1, 241, 9	81 0	1, 241, 981	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	2, 078, 610	1, 145, 831	3, 224, 4	41 -225, 073	2, 999, 368	32.00
	and 31)			1		1	1

	Financial Systems	PERRY COUNT				u of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Period: From 01/01/2021	Worksheet M-1	1
			Component	CCN: 15-8516	To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
			_		RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6. 00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				-
1.00	Physi ci an	0	1,047,600)			1.00
2.00	Physician Assistant	0		1			2.00
3.00	Nurse Practitioner	0	-				3.00
4.00	Visiting Nurse	0		1			4.00
5.00	Other Nurse	0	197, 903				5.00
6.00	Clinical Psychologist	0		1			6.00
7.00	Clinical Social Worker	0	C				7.00
8.00	Laboratory Techni ci an	0	c c				8.00
9.00	Other Facility Health Care Staff Costs	0	226, 293				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 696, 901				10.00
11.00	Physician Services Under Agreement	0	-				11.0
12.00	Physician Supervision Under Agreement	0	-				12.0
13.00	Other Costs Under Agreement	0	C				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	-				14.00
15.00	Medical Supplies	0	/				15.00
16.00	Transportation (Health Care Staff)	0	-	•			16.00
17.00	Depreciation-Medical Equipment	0	C				17.00
	Professional Liability Insurance	0		•			18.00
	Other Health Care Costs	0	C				19.00
	Allowable GME Costs	0	22.054				20.00
	Subtotal (sum of lines 15 through 20) Total Cost of Health Care Services (sum of	0		•			
22.00	lines 10, 14, and 21)	0	1, 720, 755				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						-
23.00	Pharmacy	0	36, 632				23.00
24.00	Dental	0		•			24.00
25.00	Optometry	0	-	•			25.00
25.01	Tel eheal th	0	C C				25.0
25. 02	Chronic Care Management	0	C				25.0
26.00	All other nonreimbursable costs	0	C				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	36, 632				28.00
	through 27)						
	FACILITY OVERHEAD		r	1			
	Facility Costs	0	-				29.00
30.00	Administrative Costs	0		•			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	1, 241, 981				31.00
22.22	30)	-					
32.00	Total facility costs (sum of lines 22, 28	0	2, 999, 368	5			32.00
	and 31)		I	1			1

	Financial Systems	PERRY COUNTY					u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322		eriod:	Worksheet M-1	
			Component	CCN: 15-8517	Tc	rom 01/01/2021 0 12/31/2021	Date/Time Pre 6/24/2022 9:4	
						RHC II	Cost	
		Compensati on	Other Costs	Total (col.	1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
							col. 4)	
		1.00	2.00	3.00		4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS							
1. 00	Physi ci an	425, 958	0			0	425, 958	1.0
2.00	Physician Assistant	0	0		0	0	0	2.0
3.00	Nurse Practitioner	0	0		0	0	0	3.0
4.00	Visiting Nurse	0	0		0	0	0	4.0
5.00	Other Nurse	34, 965	0	34, 9		0	34, 965	5.0
6.00	Clinical Psychologist	0	0		0	0	0	6.0
7.00	Clinical Social Worker	0	0		0	0	0	7.0
3.00	Laboratory Techni ci an	0	0		0	0	0	8.0
9.00	Other Facility Health Care Staff Costs	92, 421	0	92, 4	21	0	92, 421	9.0
10.00	Subtotal (sum of lines 1 through 9)	553, 344	0	553, 3	44	0	553, 344	10.0
1.00	Physician Services Under Agreement	0	0		0	0	0	11.0
2.00	Physician Supervision Under Agreement	0	0		0	0	0	12.0
3.00	Other Costs Under Agreement	0	0		0	0	0	13.0
4.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14.C
5.00	Medical Supplies	0	8, 916	8, 9	16	0	8, 916	15.0
6.00	Transportation (Health Care Staff)	0	0		0	0	0	16.0
7.00	Depreciation-Medical Equipment	0	0		0	0	0	17.C
8.00	Professional Liability Insurance	0	0		0	0	0	18.0
9.00	Other Health Care Costs	0	0		0	0	0	19.0
0.00	Allowable GME Costs							20.0
1.00	Subtotal (sum of lines 15 through 20)	0	8, 916	8,9	16	0	8, 916	21.0
22.00	Total Cost of Health Care Services (sum of	553, 344	8, 916	562, 2	60	0	562, 260	22.0
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
3.00	Pharmacy	0	97, 049	97, 0	49	0	97, 049	
4.00	Dental	0	0		0	0	0	24.0
5.00	Optometry	0	0		0	0	0	25.0
5.01	Tel eheal th	0	0		0	0	0	25.0
5.02	Chronic Care Management	0	0		0	0	0	25.0
6.00	All other nonreimbursable costs	0	0		0	0	0	26.0
7.00	Nonallowable GME costs							27.0
8.00	Total Nonreimbursable Costs (sum of lines 23	0	97, 049	97, 0	49	0	97, 049	28.0
	through 27)							
	FACILITY OVERHEAD				_			
	Facility Costs	0	0		0	0	0	29.0
0. 00	Administrative Costs	52, 674	296, 779			0	349, 453	
1.00	Total Facility Overhead (sum of lines 29 and	52, 674	296, 779	349, 4	53	0	349, 453	31.0
	30)							
32.00	Total facility costs (sum of lines 22, 28	606, 018	402, 744	1, 008, 7	62	0	1, 008, 762	32.0
	and 31)			1				I

Heal th	Financial Systems	PERRY COUNTY	(ΗΟΣΡΙΤΑΙ		Inlie	u of Form CMS-	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS			CN: 15-1322	Peri od:	Worksheet M-	
				CCN: 15-8517	From 01/01/2021 To 12/31/2021	Date/Time Pro	epared:
					RHC II	6/24/2022 9: 4 Cost	
		Adjustments	Net Expenses		KIIC II	0031	
		Aujustilientis	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00	1			
	FACILITY HEALTH CARE STAFF COSTS			•			
1.00	Physi ci an	0	425, 958				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	34, 965				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	92, 421				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	553, 344				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	O				14.00
15.00	Medical Supplies	0	8, 916				15.00
16.00	Transportation (Health Care Staff)	0	0	1			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
	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8, 916				21.00
22.00	Total Cost of Health Care Services (sum of	0	562, 260)			22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	97, 049				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	0				25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	97, 049				28.00
	through 27)						
	FACILITY OVERHEAD			1			
		0	0				29.00
30.00	Administrative Costs	-70		1			30.00
31.00	Total Facility Overhead (sum of lines 29 and	-70	349, 383				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-70	1, 008, 692				32.00
	and 31)			1			I

	Financial Systems	TERRI COUNT	/ HOSPI TAL				2552-1
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Period:	Worksheet M-1	
			Component	CCN: 15-8560	From 01/01/2021 To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
				_	RHC III	Cost	
		Compensati on	Other Costs	Total (col.	1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS					1	
1.00	Physi ci an	1, 564, 088	0				
2.00	Physician Assistant	0	0		0 0	0	
3.00	Nurse Practitioner	0	0		0 286, 593	286, 593	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	122, 060	0	122, 0	60 -27, 756	94, 304	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	89, 013	0	89, 0	13 -20, 241	68, 772	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 775, 161	0	1, 775, 1	61 -101, 200	1, 673, 961	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	14, 170	14, 1	70 -3, 222	10, 948	
16.00	Transportation (Health Care Staff)	0	0		0 0		
17.00	Depreciation-Medical Equipment	0	0		0 0		
18.00	Professional Liability Insurance	0	0		0 0	-	
19.00	Other Health Care Costs	0	0			0	
	Allowable GME Costs	Ű	0				20.0
21.00	Subtotal (sum of lines 15 through 20)	0	14, 170	14, 1	70 -3, 222	10, 948	
22.00	Total Cost of Health Care Services (sum of	1, 775, 161	14, 170				
22.00	lines 10, 14, and 21)	1,775,101	14, 170	1,707,3	-104, 422	1,004,909	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			I		1	1
23.00	Pharmacy	0	17, 478	17,4	78 - 3, 974	13, 504	23.00
24.00	Dental	0	0		0 0		
25.00	Optometry	0	0		0 0		
25.00	Tel eheal th	0	0			0	
25.02	Chronic Care Management	0	0				
26.02	All other nonreimbursable costs	0	0			-	
27.00	Nonallowable GME costs	0	0			, U	27.00
27.00	Total Nonreimbursable Costs (sum of lines 23	0	17, 478	17, 4	78 -3, 974	13, 504	
20.00	through 27)	0	17,470	17,4	-3, 9/4	13, 304	20.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Admini strati ve Costs	31,008	576, 289			-	
31.00	Total Facility Overhead (sum of lines 29 and 30)	31, 008	576, 289	607, 2	97 – 138, 098	469, 199	31.00
32.00	Total facility costs (sum of lines 22, 28	1, 806, 169	607, 937	2, 414, 1	-246, 494	2, 167, 612	32.00
JZ. UU	TIOLAI TACITILY CUSLS (SUII UT TITLES 22, 20	1,000,109	007, 937	∠, 414, 1	-240, 494		1 32.00

	Financial Systems	PERRY COUNTY HOSPITAL			In Lieu	2552-1	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-	1
			Component	CCN: 15-8560	From 01/01/2021 To 12/31/2021	Date/Time Pro 6/24/2022 9:4	
			_		RHC III	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 + col. 6)				
		6. 00	7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00	1			
1.00	Physi ci an	0	1, 224, 292				1.0
2.00	Physician Assistant	0		1			2.0
3.00	Nurse Practitioner	0	286, 593				3.0
4.00	Visiting Nurse	0	C				4.0
5.00	Other Nurse	0	94, 304				5.0
5.00	Clinical Psychologist	0	C				6.0
7.00	Clinical Social Worker	0	C				7.0
8.00	Laboratory Techni ci an	0	C				8.0
0. 00	Other Facility Health Care Staff Costs	0					9.0
0.00	Subtotal (sum of lines 1 through 9)	0	1, 673, 961				10.0
1.00	Physician Services Under Agreement	0	C				11.
2.00	Physician Supervision Under Agreement	0	C				12.
3.00	Other Costs Under Agreement	0	C				13.
4.00	Subtotal (sum of lines 11 through 13)	0	-				14.0
5.00	Medical Supplies	0	10, 948	1			15.0
6.00	Transportation (Health Care Staff)	0	C	1			16. (
7.00	Depreciation-Medical Equipment	0	C	1			17.0
8.00 9.00	Professional Liability Insurance Other Health Care Costs	0		•			18.0
9.00	Allowable GME Costs	0					20.0
1.00	Subtotal (sum of lines 15 through 20)	0	10, 948				20.0
2.00	Total Cost of Health Care Services (sum of	0		•			22.0
2.00	Lines 10, 14, and 21)	0	1,004,909				22.1
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
3.00	Pharmacy	0	13, 504				23.
4.00	Dental	0		1			24.
5.00	Optometry	0	C				25.
5. 01	Tel eheal th	0	C				25.
5.02	Chronic Care Management	0	c c				25.
6.00	All other nonreimbursable costs	0	C				26.
7.00	Nonallowable GME costs						27.
8.00	Total Nonreimbursable Costs (sum of lines 23	0	13, 504				28.0
	through 27)						
	FACILITY OVERHEAD		-	1			
9.00	Facility Costs	0	-				29.
0.00	Administrative Costs	0					30.0
1. 00	Total Facility Overhead (sum of lines 29 and	0	469, 199				31. (
32.00	30) Total facility costs (sum of lines 22, 28	0	2, 167, 612				32.0
12. UU	TIVIAL TACITLY CUSIS (SUILUT TITLES 22, 20	0	2,107,012	-			1 JZ. (

	Financial Systems	PERRY COUNTY				eu of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1322	Peri od:	Worksheet M-1	
			Commente	CON 15 05/0	From 01/01/2021		
			component	CCN: 15-8562	To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
					RHC IV	Cost	i aiii
		Compensati on	Other Costs	Total (col	1 Reclassi fi cat		
		compensation	Uther Costs	+ col . 2)	ions	Trial Balance	
				+ COI. 2)	10115	(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	5.00	4.00	5.00	
1.00	Physi ci an	393, 071	0	393, 0	71 -86, 881	306, 190	1.00
2.00	Physician Assistant	0,0,0,1	0		0 0		2.00
3.00	Nurse Practitioner	0	0		0 0		3.00
4.00	Visiting Nurse	0	0				4.00
4.00 5.00	Other Nurse	115, 904	0		-26, 357	-	5.00
			0		J4 -20, 357		
6.00	Clinical Psychologist	0	Ũ		0 0	0	6.00
7.00	Clinical Social Worker	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	25, 422	0	==,			9.00
10.00	Subtotal (sum of lines 1 through 9)	534, 397	0		97 – 119, 019	415, 378	
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	1	0 0	0	14.00
15.00	Medical Supplies	0	194	1 1	-44	150	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0		
17.00	Depreciation-Medical Equipment	0	0		0 0		
	Professional Liability Insurance	0	0		0 0	-	18.00
19.00	Other Health Care Costs	0	0		0 0	-	19.00
	Allowable GME Costs	0	0		0		20.00
20.00	Subtotal (sum of lines 15 through 20)	0	194	1	-44	150	
		F24 207					
22.00	Total Cost of Health Care Services (sum of	534, 397	194	534, 5	-119, 063	415, 528	22.00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	15, 624	15, 6	24 -3, 553	12,071	23.00
23.00	Dental	0	15, 024		0 0		
		-	-		-		
25.00	Optometry	0	0		0 0	, i i i i i i i i i i i i i i i i i i i	25.00
25.01	Tel eheal th	0	0		0 0	0	25.01
25.02	Chronic Care Management	0	0		0 0	, i i i i i i i i i i i i i i i i i i i	
26.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	15, 624	15, 6	24 - 3, 553	12, 071	28.00
	through 27)						
	FACILITY OVERHEAD				_	-	
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Administrative Costs	52, 595	259, 895	312, 4	-71,060	241, 430	30.00
31.00	Total Facility Overhead (sum of lines 29 and	52, 595	259, 895	312, 4	-71, 060	241, 430	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	586, 992	275, 713	862, 7	-193, 676	669, 029	32.00

Heal th	Financial Systems	PERRY COUNT	Υ ΗΟΣΡΙΤΑΙ		Inlie	u of Form CMS-	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS			CN: 15-1322	Peri od:	Worksheet M-	
,				CCN: 15-8562	From 01/01/2021 To 12/31/2021	Date/Time Pro	epared:
					RHC IV	6/24/2022 9: Cost	<u>+1 am</u>
		Adjustments	Net Expenses		KIIC I V	COST	
		Aujustilientis	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00	1			
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	306, 190)			1.00
2.00	Physician Assistant	0	C				2.00
3.00	Nurse Practitioner	0	(C				3.00
4.00	Visiting Nurse	0	(C				4.00
5.00	Other Nurse	0	89, 547	,			5.00
6.00	Clinical Psychologist	0	C				6.00
7.00	Clinical Social Worker	0	(C				7.00
8.00	Laboratory Techni ci an	0	c				8.00
9.00	Other Facility Health Care Staff Costs	0	19, 641				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	415, 378				10.00
11.00	Physician Services Under Agreement	0		1			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					14.00
15.00	Medical Supplies	0	150				15.00
16.00	Transportation (Health Care Staff)	0	C				16,00
17.00	Depreciation-Medical Equipment	0					17.00
18.00	Professional Liability Insurance	0					18.00
19.00	Other Health Care Costs	0	c				19.00
	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	150				21.00
22.00	Total Cost of Health Care Services (sum of	0	415, 528				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES		•				
23.00	Pharmacy	0	12, 071				23.00
24.00	Dental	0	C				24.00
25.00	Optometry	0	C				25.00
25.01	Tel eheal th	0	C				25.01
25.02	Chronic Care Management	0	C				25.02
26.00	All other nonreimbursable costs	0	C				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	12, 071				28.00
	through 27)						
	FACILITY OVERHEAD			1			
		0	-	1			29.00
30.00	Administrative Costs	-38		•			30.00
31.00	Total Facility Overhead (sum of lines 29 and	-38	241, 392	2			31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-38	668, 991				32.00
	and 31)		l	1			I

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-1
ALLOCATION OF OVERHEAD TO HOSPITAL-BASE	RHC/FQHC SERVICES	Provider C		Period: From 01/01/2021	Worksheet M-2	
		Component		To 12/31/2021	Date/Time Pre	
				RHC I	Cost	
	Number of FTE	Total Visits	Producti vi ty	Minimum	Greater of	
	Personnel		Standard (1)	Visits (col.	col. 2 or	
				1 x col. 3)	col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Posi ti ons						
. 00 Physi ci an	2.17	7, 532				1.0
.00 Physician Assistant	0.00) C	2, 10	0 0		2.0
.00 Nurse Practitioner	3. 17	7, 268	2, 10	0 6, 657		3.0
.00 Subtotal (sum of lines 1 through	3) 5.34	14,800		15, 771	15, 771	4.C
.00 Visiting Nurse	0.00) C			0	5.0
00 Clinical Psychologist	0.00) C			0	6.0
.00 Clinical Social Worker	0.00) C			0	7.0
.01 Medical Nutrition Therapist (FQHC					0	7.0
.02 Diabetes Self Management Training	(FQHC 0.00) C			0	7.0
onl y)						
.00 Total FTEs and Visits (sum of lir	es 4 5.34	14,800			15, 771	8.0
through 7)						
0.00 Physician Services Under Agreemer	ts	C)		0	9.0
					1.00	<u> </u>
DETERMINATION OF ALLOWABLE COST A	PPLICABLE TO HOSPITAL-BAS	ED RHC/EOHC SE	RVLCES		1.00	
0.00 Total costs of health care service					1, 720, 755	1 10 0
1.00 Total nonreimbursable costs (from					36, 632	
2.00 Cost of all services (excluding o		,			1, 757, 387	
3.00 Ratio of hospital-based RHC/FQHC					0. 979155	
4.00 Total hospital-based RHC/FQHC over			ine 31)		1, 241, 981	
5.00 Parent provider overhead allocate					705, 128	
6.00 Total overhead (sum of lines 14 a					1, 947, 109	
7.00 Allowable GME overhead (see instr					0	
8.00 Enter the amount from line 16					1, 947, 109	18.0
9.00 Overhead applicable to hospital-b	ased RHC/FQHC services (1	ine 13 x line	18)		1, 906, 522	
0.00 Total allowable cost of bespital					2 4 27 277	

^{20.00} Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19) 3,627,277 20.00

Health Financial Systems		PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF OVERHEAD TO HOSPITAL	-BASED RHC/FQHC S	SERVI CES	Provider C		Period: From 01/01/2021	Worksheet M-2	
			Component	CCN: 15-8517	To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
					RHCII	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Posi ti ons					- 1	1	
1.00 Physician		0.72					1.00
2.00 Physician Assistant		0.00					2.00
3.00 Nurse Practitioner		0.00					3.00
4.00 Subtotal (sum of lines 1 th	rough 3)	0. 72			3, 024		4.00
5.00 Visiting Nurse		0.00		1		0	5.00
5.00 Clinical Psychologist		0.00				0	6.00
7.00 Clinical Social Worker		0.00				0	7.00
7.01 Medical Nutrition Therapist		0.00				0	7.01
7.02 Diabetes Self Management Tra	aining (FQHC	0.00	C			0	7.02
onl y)							
3.00 Total FTEs and Visits (sum o	oflines 4	0. 72	1, 986			3, 024	8.00
through 7)							
9.00 Physician Services Under Agi	reements		C			0	9.00
						1.00	
				0.4.050		1.00	
DETERMINATION OF ALLOWABLE O				RVICES		F(0,0/0	10.00
0.00 Total costs of health care s						562, 260	
1.00 Total nonreimbursable costs						97,049	
2.00 Cost of all services (exclud						659, 309	
3.00 Ratio of hospital -based RHC,						0.852802	
4.00 Total hospital-based RHC/FQ				ine 31)		349, 383	
5.00 Parent provider overhead all		ty (see instruc	CTIONS)			236, 591	
16.00 Total overhead (sum of lines						585, 974	
17.00 Allowable GME overhead (see						0	17.00
18.00 Enter the amount from line				10)		585, 974	
19.00 Overhead applicable to hospi						499, 720	
20.00 Total allowable cost of hos	pital-based RHC/F	UHC services (sum of lines 1	U and 19)		1, 061, 980	20.00

Heal th	Financial Systems	PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCAT	FION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period: From 01/01/2021	Worksheet M-2	
			Component	CCN: 15-8560	To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
					RHC III	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
H	VISITS AND PRODUCTIVITY						
- F	Positions	- 1	r		-	r	
	Physi ci an	1.49					1.00
	Physician Assistant	0.00					2.00
	Nurse Practitioner	0.49					3.00
	Subtotal (sum of lines 1 through 3)	1.98			5, 630		4.00
	Visiting Nurse	0.00				0	5.00
	Clinical Psychologist	0.00				0	6.00
	Clinical Social Worker	0.00				0	7.00
	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
	only)	1 00				F (00	0.00
	Total FTEs and Visits (sum of lines 4	1. 98	4, 157			5, 630	8.00
	through 7) Physician Services Under Agreements		0			0	9.00
9.00	Physician services under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BASE	ED RHC/FQHC SEI	RVICES			
0.00	Total costs of health care services (from V	Vkst. M-1, col.	7, line 22)			1, 684, 909	10.00
	Total nonreimbursable costs (from Wkst. M-					13, 504	11.00
2.00	Cost of all services (excluding overhead)	(sum of lines 10	and 11)			1, 698, 413	12.00
3.00	Ratio of hospital -based RHC/FQHC services	(line 10 divided	by line 12)			0. 992049	13.00
14.00	Total hospital-based RHC/FQHC overhead - (1	From Worksheet. I	M-1, col. 7, li	ne 31)		469, 199	14.00
	Parent provider overhead allocated to facil			-		522, 777	15.OC
16.00	Total overhead (sum of lines 14 and 15)					991, 976	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					991, 976	18.00
19.00	Overhead applicable to hospital-based RHC/F	FQHC services (li	ine 13 x line '	18)		984, 089	19.00
20.00	Total allowable cost of hospital-based RHC	/FQHC services (sum of lines 10) and 19)		2, 668, 998	20.00

Health Financial Systems	PERRY COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-1
ALLOCATION OF OVERHEAD TO HOSPITAL-BASE	D RHC/FQHC SERVICES	Provider C		Period: From 01/01/2021	Worksheet M-2	
		Component		To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
				RHC IV	Cost	
	Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
	Personnel		Standard (1)	Visits (col.	col. 2 or	
				1 x col. 3)	col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Posi ti ons						
00 Physician	0.9	1 4,009	3, 24	5 2, 953		1.0
00 Physician Assistant	0.0	0 0	1,62	2 0		2.0
00 Nurse Practitioner	0.0	0 0	1,62	2 0		3.0
00 Subtotal (sum of lines 1 through	3) 0.9	1 4,009	9	2, 953	4,009	4.0
00 Visiting Nurse	0.0	0 0			0	5.0
00 Clinical Psychologist	0.0	0 0			0	6.0
00 Clinical Social Worker	0.0	0 0			0	7.0
01 Medical Nutrition Therapist (FQH	only) 0.0	0 0			0	7.0
02 Diabetes Self Management Training	(FQHC 0.0	0 0			0	7.0
onl y)						
00 Total FTEs and Visits (sum of lin	les 4 0.9	1 4,009	9		4,009	8.0
through 7)						
00 Physician Services Under Agreemer	its	(0	9. (
					1.00	
DETERMINATION OF ALLOWABLE COST A	PPLICABLE TO HOSPITAL-BA	SED RHC/FQHC SE	RVICES			
.00 Total costs of health care service					415, 528	10.0
.00 Total nonreimbursable costs (from					12,071	11.0
.00 Cost of all services (excluding o					427, 599	12.0
.00 Ratio of hospital-based RHC/FQHC					0. 971770	13.0
.00 Total hospital-based RHC/FQHC ove	erhead - (from Worksheet.	M-1, col. 7, I	ine 31)		241, 392	14.
.00 Parent provider overhead allocate			•		158, 958	15.0
.00 Total overhead (sum of lines 14 a	ind 15)	-			400, 350	16.
.00 Allowable GME overhead (see inst					0	17.
.00 Enter the amount from line 16	-				400, 350	18.
0.00 Overhead applicable to hospital-k	ased RHC/FQHC services (line 13 x line	18)		389, 048	19.0
00 Total allowable cost of bosnital.					901 576	20 1

^{20.00} Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 804, 576 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 CI			From 01/01/2021	worksneet w-5	
		Component CCN: 15-8516	To 12/31/2021	Date/Time Pre	
		Title XVIII	RHC I	6/24/2022 9:4 Cost	I dili
		· · · ·			
				1.00	
1	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			0 (07 077	
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			3, 627, 277	1.
. 00	Cost of injections/infusions and their administration (from W			84, 143	2.
00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	innus inne 2)		3, 543, 134 15, 771	3. 4.
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		13, 771	4. 5.
.00	Total adjusted visits (line 4 plus line 5)			15, 771	6.
.00	Adjusted cost per visit (line 3 divided by line 6)			224.66	
			Cal cul ati on		
			Rate Period 1		
			(01/01/2021	(04/01/2021	
			through 03/31/2021)	through 12/31/2021)	
			1.00	2.00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or your contractor)	87.52	220. 95	8.
. 00	Rate for Program covered visits (see instructions)	<u> </u>	224.66	220. 95	9.
	CALCULATION OF SETTLEMENT				
	Program covered visits excluding mental health services (from		600	1, 801	
	Program cost excluding costs for mental health services (line		134, 796	397, 931	
	Program covered visits for mental health services (from contr		0	0	
3.00	Program covered cost from mental health services (line 9 x li		0	0	
4.00 5.00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction	-	0	0	14
6.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	532, 727	
6.01	Total program charges (see instructions) (from contractor's re		0	565, 503	
6. 02	Total program preventive charges (see instructions) (from prov			124, 649	
6.03	Total program preventive costs ((line 16.02/line 16.01) times			117, 424	
6.04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		293, 109	16
	(Titles V and XIX see instructions.)				
6. 05	Total program cost (see instructions)		0	410, 533	
7.00	Primary payer amounts			0	17.
8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		48, 917	18
9.00	records) Beneficiary coinsurance for RHC/FQHC services (see instructio	uns) (from contractor		78, 388	19.
/. 00	records)			10, 300	'7.
0.00	Net Medicare cost excluding vaccines (see instructions)			410, 533	20.
1.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		32, 671	
2.00	Total reimbursable Program cost (line 20 plus line 21)			443, 204	22
	Allowable bad debts (see instructions)			0	23
	Adjusted reimbursable bad debts (see instructions)			0	23
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- >		0	
	Pioneer ACO demonstration payment adjustment (see instruction	5)		0	
5.99 6.00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 443, 204	
6.00	Sequestration adjustment (see instructions)			443, 204	
6. 02	Demonstration payment adjustment amount after sequestration			0	20.
	Interim payments			407, 829	
8.00	Tentative settlement (for contractor use only)			0	28.
		02 27 and 28)		35, 375	
9.00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, 010, 20)		00,070	2

ealth Financial Systems PERRY COUNTY HO ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC			u of Form CMS-2	
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HUSPITAL-BASED RHC/FUHC	Provider CCN: 15-1322	Period: From 01/01/2021	Worksheet M-3	
ERVICES	Component CCN: 15-8517	To 12/31/2021	Date/Time Pre	
	T	DUO LI	6/24/2022 9:4	1 am
	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	n Wkst. M-2, line 20)		1, 061, 980	1 1.
.00 Cost of injections/infusions and their administration (from Wk	st. M-4, line 15)		329, 879	2.
.00 Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		732, 101	3.
.00 Total Visits (from Wkst. M-2, column 5, line 8)			3, 024	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)			3, 024	6.
.00 Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	242.10	7.
		Carcuration		
		Rate Period 1		
		(01/01/2021	(04/01/2021	
		through	through	
		03/31/2021)	<u>12/31/2021)</u> 2.00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	87.52	159.42	8.
.00 Rate for Program covered visits (see instructions)		242.10	159.42	
CALCULATION OF SETTLEMENT				1
0.00 Program covered visits excluding mental health services (from		42	127	10.
1.00 Program cost excluding costs for mental health services (line	•	10, 168	20, 246	
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 4.00 Limit adjustment for mental health services (see instructions)		0	0	13. 14.
4.00 Limit adjustment for mental health services (see instructions) 5.00 Graduate Medical Education Pass Through Cost (see instructions)		0	0	14.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	30, 414	
6.01 Total program charges (see instructions)(from contractor's rec		Ū	43, 867	
6.02 Total program preventive charges (see instructions) (from provi			12, 446	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	line 16)		8, 629	16.
6.04 Total Program non-preventive costs ((line 16 minus lines 16.03	8 and 18) times .80)		15, 390	16.
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	24, 019	
7.00 Primary payer amounts 8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		2, 547	17. 18.
records)			2, 347	10.
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	s) (from contractor		5, 775	19.
records)	<i>,</i> , ,			
0.00 Net Medicare cost excluding vaccines (see instructions)			24, 019	
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		10, 820	
2.00 Total reimbursable Program cost (line 20 plus line 21)			34, 839	
3.00 Allowable bad debts (see instructions)			0	23
3.01 Adjusted reimbursable bad debts (see instructions) 4.00 Allowable bad debts for dual eligible beneficiaries (see instr	suctions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50 Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
5. 99 Demonstration payment adjustment amount before sequestration	-		0	
6.00 Net reimbursable amount (see instructions)			34, 839	
6.01 Sequestration adjustment (see instructions)			0	26.
6.02 Demonstration payment adjustment amount after sequestration			0	26.
7.00 Interim payments			23, 334	
8.00 Tentative settlement (for contractor use only)			0	28.
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0 0.00 Protested amounts (nonallowable cost report items) in accordan			11, 505	
			0	30.

ealth Financial Systems PERRY COUNTY HC ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVICES	Provider CCN. 15-1322	From 01/01/2021	WULKSHEEL M-3	
LINIGES	Component CCN: 15-8560	To 12/31/2021	Date/Time Pre	
		DUCLU	6/24/2022 9:4	1 am
	Title XVIII	RHC III	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	n Wkst. M-2, line 20)		2, 668, 998	1.0
.00 Cost of injections/infusions and their administration (from We			16, 444	2. (
.00 Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		2, 652, 554	3.
.00 Total Visits (from Wkst. M-2, column 5, line 8)			5, 630	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, 630	6.
.00 Adjusted cost per visit (line 3 divided by line 6)			471.15	7.
		Cal cul ati on	of Limit (1)	
		Rate Period 1		
		(01/01/2021	(04/01/2021	
		through	through	
		03/31/2021)	12/31/2021)	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	1.00	2.00	8.
.00 Rate for Program covered visits (see instructions)		471.15	100.00	
CALCULATION OF SETTLEMENT		1/1.10	100.00	
0.00 Program covered visits excluding mental health services (from	contractor records)	28	83	10.
1.00 Program cost excluding costs for mental health services (line	9 x line 10)	13, 192	8, 300	11.
2.00 Program covered visits for mental health services (from contra	actor records)	0	0	12.
3.00 Program covered cost from mental health services (line 9 x lir	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	21, 492	
6.01 Total program charges (see instructions)(from contractor's red	-		23, 675	
6.02 Total program preventive charges (see instructions)(from provi	-		727	
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			660 10, 821	16. 16.
(Titles V and XIX see instructions.)	s and to) trilles . ob)		10, 621	10.
6.05 Total program cost (see instructions)		0	11, 481	16.
7.00 Primary payer amounts			8	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		7, 306	18.
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		3, 129	19.
records) 0.00 Net Medicare cost excluding vaccines (see instructions)			11, 473	20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		1, 416	
2.00 Total reimbursable Program cost (line 20 plus line 21)			12, 889	
3.00 Allowable bad debts (see instructions)			0	23.
3.01 Adjusted reimbursable bad debts (see instructions)			0	23.
4.00 Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24.
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50 Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
5.99 Demonstration payment adjustment amount before sequestration			0	
6.00 Net reimbursable amount (see instructions)			12, 889	
6.01 Sequestration adjustment (see instructions)			0	26.
6.02 Demonstration payment adjustment amount after sequestration			0	26.
7.00 Interim payments 8.00 Tentative settlement (for contractor use only)			3, 697 0	27. 28.
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0	$12 \ 27 \ and \ 28$		9, 192	
0.00 Protested amounts (nonallowable cost report items) in accordar			9, 192	
			0	1 30.

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	OSPITAL Provider CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVICES		From 01/01/2021	WULKSHEEL M-3	
	Component CCN: 15-8562	To 12/31/2021	Date/Time Pre	
		DUC IV	6/24/2022 9:4	1 am
· · · · · · · · · · · · · · · · · · ·	Title XVIII	RHC I V	Cost	
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		804, 576	1 1.
.00 Cost of injections/infusions and their administration (from W			70, 614	2.
.00 Total allowable cost excluding injections/infusions (line 1 m			733, 962	3.
.00 Total Visits (from Wkst. M-2, column 5, line 8)	·		4,009	4.
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
.00 Total adjusted visits (line 4 plus line 5)			4,009	6.
.00 Adjusted cost per visit (line 3 divided by line 6)			183.08	7.
		Cal cul ati on	of Limit (1)	
		Rate Period 1		
		(01/01/2021	(04/01/2021	
		through	through	
		03/31/2021)	12/31/2021)	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	1.00	2.00	8.
.00 Rate for Program covered visits (see instructions)		183.08		
CALCULATION OF SETTLEMENT		103.00	100.00	
0.00 Program covered visits excluding mental health services (from	contractor records)	68	203	10
1.00 Program cost excluding costs for mental health services (line		12, 449	20, 300	
2.00 Program covered visits for mental health services (from contr		0	20,000	12
3.00 Program covered cost from mental health services (line 9 x li		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 instruction	·			15
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	32, 749	16.
6.01 Total program charges (see instructions)(from contractor's re	-		64, 229	16.
6.02 Total program preventive charges (see instructions)(from prov	ider's records)		727	16.
6.03 Total program preventive costs ((line 16.02/line 16.01) times	-		371	16.
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		4, 190	16.
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	4, 561	16.
7.00 Primary payer amounts			0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		27, 141	18.
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instructio	ns) (from contractor		7, 273	19.
			4 5 4 4	
0.00 Net Medicare cost excluding vaccines (see instructions)	M 4 15 1/)		4, 561	20
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, IIne 16)		22, 449	
2.00 Total reimbursable Program cost (line 20 plus line 21)			27, 010	
3.00 Allowable bad debts (see instructions)			0	23
3.01 Adjusted reimbursable bad debts (see instructions) 4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	23
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructrons)		0	
	c)		0	
5.50 Pioneer ACO demonstration payment adjustment (see instruction 5.99 Demonstration payment adjustment amount before sequestration	37		0	
6.00 Net reimbursable amount (see instructions)			27,010	
6.01 Sequestration adjustment (see instructions)			27,010	26.
6.02 Demonstration payment adjustment amount after sequestration			0	26
7.00 Interim payments			591	
8.00 Tentative settlement (for contractor use only)			0	28
9.00 Balance due component/program (line 26 minus lines 26.01, 26.	02. 27. and 28)		26, 419	
0.00 Protested amounts (nonallowable cost report items) in accorda			20,417	30.
			0	

Heal th	Financial Systems PERRY COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	FATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider Concernent	CN: 15-1322 CCN: 15-8516	Peri od: From 01/01/2021 To 12/31/2021		pared:
			XVIII	RHC I	6/24/2022 9:4 Cost	1 am
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCINES	VACCINES	VACCINES	ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 696, 901 0. 001110	1, 696, 90 0. 0051		1, 696, 901 0. 000000	1.00 2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1, 884	8, 7	35 0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	15, 408			0	4.00
5.00 6.00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	17, 292 1, 720, 755			e e e e e e e e e e e e e e e e e e e	5.00 6.00
7.00 8.00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 906, 522 0. 010049				7.00 8.00
9.00 10.00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	19, 159 36, 451				9. 00 10. 00
11.00	Total number of injections/infusions (from your records)	74		45 0	-	
12.00 13.00	Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	492.58 29		24 0.00 33 0		
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	14, 285	18, 3	36 0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		84, 14	43		15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		32, 6	71		16.00

Heal th	Financial Systems PERRY COUNTY	(HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CC Component C	CN: 15-1322 CCN: 15-8517	Period: From 01/01/2021 To 12/31/2021		pared:
					6/24/2022 9:4	<u>1 am</u>
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	553, 344 0. 042279			553, 344 0. 000000	1.00 2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	23, 395	38, 4	78 0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	87, 780	25, 0	0 00	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	111, 175	63, 4	78 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	562, 260				6.00
7.00	Total overhead (from Wkst. M-2, line 19)	499, 720				7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 197729	0. 1128	98 0. 000000	0. 000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	98, 809			0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	209, 984	119, 8	95 0	0	10.00
11.00	Total number of injections/infusions (from your records)	380		25 0		11.00
12.00	Cost per injection/infusion (line 10/line 11)	552.59				
13.00	Number of injection/infusion administered to Program beneficiaries	5		42 0	0	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2, 763	8, 0	57 0	0	14.00
15.00			329, 8	79		15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		10, 8	20		16.00

Heal th	Financial Systems PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider C	CN: 15-1322	Period: From 01/01/2021	Worksheet M-4	
		Component	CCN: 15-8560	To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
		Title	XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 673, 961 0. 002590	1, 673, 9 0. 0035			1.00 2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4, 336	5, 8	94 0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	64		87 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4, 400	5, 9	81 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 684, 909	1, 684, 9	09 1, 684, 909	1, 684, 909	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	984, 089	984, 0	89 984, 089	984, 089	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 002611	0. 0035	0. 000000	0. 000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2, 569			0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6, 969	9, 4	75 0	0	10.00
11.00	Total number of injections/infusions (from your records)	64		87 0		11.00
12.00	Cost per injection/infusion (line 10/line 11)	108.89				
13.00	Number of injection/infusion administered to Program beneficiaries	1		12 0	0	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	109	1, 3	07 0	0	14.00
15.00			16, 4	44		15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1, 4	16		16.00

Heal th	Financial Systems PERRY COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider C		Period: From 01/01/2021	Worksheet M-4	
		Component (CCN: 15-8562	To 12/31/2021	Date/Time Pre 6/24/2022 9:4	
		Title	XVIII	RHCIV	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	415, 378 0. 003434				1.00 2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1, 426	12, 4	34 0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9, 009	13, 6	0 00	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10, 435	26, 0	34 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	415, 528	415, 5	28 415, 528	415, 528	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	389, 048	389, 0			7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 025113	0. 0626	0. 000000	0. 000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	9, 770	24, 3	75 0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20, 205	50, 4	0 0	0	10.00
11.00	Total number of injections/infusions (from your records)	39		40 0		11.00
12.00	Cost per injection/infusion (line 10/line 11)	518.08				
13.00	Number of injection/infusion administered to Program beneficiaries	15		99 0	0	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	7, 771	14, 6	78 0	0	14.00
15.00			70, 6	14		15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		22, 4	49		16.00

Health	Financial Systems	PERRY COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-1322	Peri od:	Worksheet M-5		
			From 01/01/2021			
02.000			Component CCN: 15-8516	To 12/31/2021		
				5110.1	6/24/2022 9:4	1 am
				RHC I	Cost	
					t B	
				mm/dd/yyyy	Amount	
	1			1.00	2.00	
1.00	Total interim payments paid to hospital-bas				407, 829	1.00
2.00	Interim payments payable on individual bil				0	2.00
	the contractor for services rendered in the cost reporting period. If none, write					
	"NONE" or enter a zero					
3.00	List separately each retroactive lump sum a					3.00
	revision of the interim rate for the cost		Also show date of each			
	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					
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	fer to Worksheet M-3, line	9	407, 829	4.00
	27)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement		k review. Also show date o	of		5.00
	each payment. If none, write "NONE" or ent	er 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.	98)		0	5.99
6.00	Determined net settlement amount (balance (due) based on the	cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER				35, 375	6.01
6.02	SETTLEMENT TO PROGRAM				0	6.02
7.00	Total Medicare program liability (see inst	ructions)			443, 204	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1,00		
			0	1.00	2.00	

Heal th	n Financial Systems PERRY COUNTY		Inlie	eu of Form CMS-2	2552-10
	SIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provi der CCN: 15-1322	Peri od:	Worksheet M-5	1002 10
SERVICES RENDERED TO PROGRAM BENEFICIARIES			From 01/01/2021		
02		Component CCN: 15-8517	To 12/31/2021		
			DUO LI	6/24/2022 9:4	1 am
			RHC I I	Cost	
			mm/dd/yyyy	t B Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1.00	23, 334	1.00
2.00	Interim payments payable on individual bills, either submit	tted or to be submitted to		23, 334	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 amount	t based on subsequent			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				
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				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54	Subtatal (sum of lines 2 01 2 40 minus sum of lines 2 50 2	08)		0	3.54 3.99
3.99 4.00	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. Total interim payments (sum of lines 1, 2, and 3.99) (trans			23, 334	3.99 4.00
4.00	27)	STEP LO WORKSNEEL M-3, TINE	2	23, 334	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)				0.00	
	Program to Provider		1		
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			11, 505	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			34, 839	7.00
			Contractor	NPR Date	
		0	Number 1.00	(Mo/Day/Yr)	
8,00	Name of Contractor	0	1.00	2.00	8.00
0.00			I	i I	0.00

Heal th	Financial Systems PERRY COUNTY		Inlie	u of Form CMS-2	552-10
		Provi der CCN: 15-1322	Peri od:	Worksheet M-5	002 10
			From 01/01/2021		
02.000		Component CCN: 15-8560	To 12/31/2021		
				6/24/2022 9:4	1 am
			RHC III	Cost	
			mm/dd/yyyy	t B Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1.00	3, 697	1.00
2.00	Interim payments payable on individual bills, either submit	tted or to be submitted to		3, 047	2.00
2.00	the contractor for services rendered in the cost reporting period. If none, write			Ŭ	2.00
	"NONE" or enter a zero				
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. Also show date of each				
	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				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53 3.54				0	3.53 3.54
3. 94 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	00)		0	3. 34
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		x	3, 697	4.00
4.00	27)	stel to worksheet m-5, ittle		5,077	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program				
5.50				0	5.50
5.51				0	5.51
5.52		22)		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. (I)		0 100	6.00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			9, 192 0	6. 01 6. 02
6.02 7.00	Total Medicare program liability (see instructions)			12, 889	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				8.00
		1	ļ	ı 1	

Heal th	Financial Systems PERRY COUNTY	ή μωςρί ται	Inlie	eu of Form CMS-2	2552_10
		Provi der CCN: 15-1322	Peri od:	Worksheet M-5	002 10
			From 01/01/2021		
0 E M M		Component CCN: 15-8562	To 12/31/2021		
			DUO LV	6/24/2022 9:4	1 am
			RHC I V	Cost	
			Par mm/dd/yyyy	t B Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1.00	2.00	1.00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	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 amount	t based on subsequent			3.00
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54		20)		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	ster to worksneet M-3, Tine	3	591	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review Also show date (of		5.00
each payment. If none, write "NONE" or enter a zero. (1)				5.00	
	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			26, 419	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			27,010	7.00
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
8,00	Name of Contractor	U	1.00	2.00	8.00
0.00			I.	I I	0.00