This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1322 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/23/2024 4: 14 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/23/2024 4:14 pm] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

[1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR

number of times reopened = 0-9.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PERRY COUNTY HOSPITAL (15-1322) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-734, 141	-224, 837	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	-671, 813	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
10.00	RURAL HEALTH CLINIC - TCC I	0		7, 556		0	10.00
10. 01	RURAL HEALTH CLINIC II - PCFP	0		790		0	10. 01
10. 02	RURAL HEALTH CLINIC III - 13TH	0		3, 491		0	10. 02
10.03	RURAL HEALTH CLINIC IV - SPENCER	0		22, 895		0	10. 03
200.0	TOTAL	0	-1, 405, 954	-190, 105	0	0	200. 00

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

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

Contractor use only

Health Financial Systems PERRY COUNTY HOSPITAL IN Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1322 Period: Worksheet S-2

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 4:14 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 8885 SR 237 1.00 PO Box: X 1.00 Zip Code: 47586 2.00 City: TELL CITY State: IN County: PERRY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal PERRY COUNTY HOSPITAL 151322 99915 07/01/2004 Ν 0 3.00 Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF 5.00 Subprovider - (Other) 6.00 6.00 7 00 Swing Beds - SNF PERRY COUNTY HOSPITAL 15Z322 99915 07/01/2004 N 0 N 7 00 SWI NG 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 11.00 Hospi tal -Based OLTC 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC TELL CITY CLINIC 158516 99915 05/18/2015 N 15.00 N 0 15 00 Hospital-Based Health Clinic - RHC | PERRY CO FAMILY PRACTICE 158517 99915 05/19/2015 0 15.01 N 15. 02 Hospital-Based Health Clinic - RHC PERRY CO SURG - 13TH ST 158560 99915 03/24/2021 N 0 15.02 Hospital-Based Health Clinic - RHC I SPENCER CO CLINIC 158562 N 15. 03 15 03 99915 03/24/2021 0 N Hospital-Based Health Clinic - FQHC 16.00 16.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20 00 21.00 Type of Control (see instructions) 9 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim UCPs, including supplemental UCPs, for 22 01 N N this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1 Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be determined 22 02 Ν Ν at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for

If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

58.00

yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1322 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 4: 14 pm XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any 60.00 programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IME Direct GME IME Direct GME 1. 00 2. 00 3. 00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA section Ν 0.00 0.00 61.00 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care and/or 61 03 general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery 61.04 allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used 61.06 for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count Enter in column 4, the direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 62.00 62.00 0.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00

for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

In Lieu of Form CMS-2552-10 Health Financial Systems PERRY COUNTY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1322 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 4:14 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64. 00 0.00 0.00 0.000000 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Ratio (col. 3/ Unwei ghted Unwei ghted Program Name Program Code FTEs FTEs in (col. 3 + col.Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col FTES FTEs in Nonprovi der Hospi tal 2)) Si te 2.00 1.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs 0.00 0.00 0.000000 66.00 attributable to rotations occurring in all nonprovider settings. column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + col. FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 0.000000 67.00 67.00 Enter in column 1, the program 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1322 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/23/2024 4:14 pm 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 68.00 68.00 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no.
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.

76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 75.00 76.00 0 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80 00 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adjustment Permanent (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see 0 88.00 Ν instructions) Column 2: Enter the number of approved permanent adjustments. Wkst. A Line Effective Date Approved No. Permanent Adjustment Amount Per Di scharge 1.00 2.00 3.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on 0.00 0 89.00 which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XI X 1 00 2 00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes 90.00 Ν Υ 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. 91.00 91.00 Ν N Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y 93.00 Ν for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν 94.00 94.00 Ν applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. 95 00 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column.

0.00

0.00

97.00

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

Health Finand	HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	/ HOSPITAL	CN: 15-1322 P	eri od:	u of Form CMS Worksheet S-	
103PITAL AND	HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	rom 01/01/2023 o 12/31/2023	Part I	
				V	5/23/2024 4: XI X	14 pm
				1. 00	2.00	
stepdo	citle V or XIX follow Medicare (title XVIII) for the income adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" title V, and in column 2 for title XIX.			Y umn	Y	98. (
8.01 Does t	citle V or XIX follow Medicare (title XVIII) for the r P Enter "Y" for yes or "N" for no in column 1 for titl				Y	98. (
8.02 Does t	citle V or XIX follow Medicare (title XVIII) for the con Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "				Y	98. (
8.03 Does t	d in column 2 for title XIX. citle V or XIX follow Medicare (title XVIII) for a cri ursed 101% of inpatient services cost? Enter "Y" for y			N	N	98.
8.04 Does t	tle V, and in column 2 for title XIX. itle V or XIX follow Medicare (title XVIII) for a CAH ces cost? Enter "Y" for yes or "N" for no in column 1	nt N	N	98.		
8.05 Does t	tle XIX. itle V or XIX follow Medicare (title XVIII) and add b C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in			Y	Y	98.
8.06 Does t	n 2 for title XIX. citle V or XIX follow Medicare (title XVIII) when cost yh IV? Enter "Y" for yes or "N" for no in column 1 for XIX.				Y	98.
Rural	Provi ders					
06.00 f thi	this hospital qualify as a CAH? s facility qualifies as a CAH, has it elected the all	-inclusive met	hod of payment	Y N		105. 106.
07.00 Col umr trai ni	utpatient services? (see instructions) n 1: If line 105 is Y, is this facility eligible for c ng programs? Enter "Y" for yes or "N" for no in colum	n 1. (see ins	tructions)	N		107.
medica yes or	n 2: If column 1 is Y and line 70 or line 75 is Y, do al education program in the CAH's excluded IPF and/or - "N" for no in column 2. (see instructions)	IRF unit(s)?	Enter "Y" for	ed		
rei mbu	s facility is a REH (line 3, column 4, is "12"), is i ursement for L&R training programs? Enter "Y" for yes uctions)					107.
08.00 Is thi Sectio	s a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 42 (CFR N		108.
	on §412.113(c). Enter "Y" for yes or "N" for no.					
	on 9412.113(c). Enter Y for yes of N for no.	Physi cal	Occupational	Speech	Respiratory	
therap	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" for "N" for no for each therapy.	1.00 N	Occupati onal 2.00 N	Speech 3.00 N	Respiratory 4.00 N	109.
therap	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" fo	1.00 N	2.00	3.00	4.00 N	
therap yes or 10.00 Did th Demons	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" fo "N" for no for each therapy. This hospital participate in the Rural Community Hospit stration) for the current cost reporting period? Enter	1.00 N al Demonstrati "Y" for yes or	2.00 N on project (§4' "N" for no. I	3.00 N	4. 00 N	109.
therap yes or 10.00 Did th Demons	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" fo "N" for no for each therapy. This hospital participate in the Rural Community Hospit	1.00 N al Demonstrati "Y" for yes or	2.00 N on project (§4' "N" for no. I	3.00 N	4. 00 N	
therap yes or 10.00 Did th Demons Worksh	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" for "N" for no for each therapy. This hospital participate in the Rural Community Hospit stration) for the current cost reporting period? Enter neet E, Part A, lines 200 through 218, and Worksheet E	1.00 N al Demonstrati "Y" for yes or -2, lines 200	2.00 N on project (§4' "N" for no. In through 215, as	3.00 N 10A f yes, complete s applicable.	4. 00 N	109.
therapyes or 10.00 Did the Demons Worksh 11.00 If this Integrous or prong	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" for "N" for no for each therapy. This hospital participate in the Rural Community Hospit stration) for the current cost reporting period? Enter neet E, Part A, lines 200 through 218, and Worksheet E as facility qualifies as a CAH, did it participate in ration Project (FCHIP) demonstration for this cost reporting period? For no in column 1. If the response to column 1 of the FCHIP demo in which this CAH is participating "A" for Ambulance services; "B" for additional beds;	1.00 N al Demonstrati "Y" for yes or -2, lines 200 the Frontier C orting period? is Y, enter th in column 2. E	on project (§4' "N" for no. In through 215, as ommunity Healt! Enter "Y" for e integration nter all that	3.00 N 10A f yes, complete s applicable.	4. 00 N	109.
therapyes or 10.00 Did the Demons Worksh 11.00 If this Integrate or prong apply:	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" for "N" for no for each therapy. This hospital participate in the Rural Community Hospit stration) for the current cost reporting period? Enter neet E, Part A, lines 200 through 218, and Worksheet E as facility qualifies as a CAH, did it participate in ration Project (FCHIP) demonstration for this cost reporting period? For no in column 1. If the response to column 1 of the FCHIP demo in which this CAH is participating "A" for Ambulance services; "B" for additional beds;	1.00 N al Demonstrati "Y" for yes or -2, lines 200 the Frontier C orting period? is Y, enter th in column 2. E	on project (§4' "N" for no. In through 215, as ommunity Healtl Enter "Y" for e integration nter all that r tele-health	3.00 N 10A f yes, complete s applicable.	4. 00 N	109.
therapyes or 0.00 Did the Demons Worksh 1.00 If this Integrate of prong apply: service 2.00 Did the (PARHW periode enter demons partice)	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" for "N" for no for each therapy. This hospital participate in the Rural Community Hospit stration) for the current cost reporting period? Enter neet E, Part A, lines 200 through 218, and Worksheet E at a facility qualifies as a CAH, did it participate in ration Project (FCHIP) demonstration for this cost reporting period? For no in column 1. If the response to column 1 of the FCHIP demo in which this CAH is participating "A" for Ambulance services; "B" for additional beds; res. This hospital participate in the Pennsylvania Rural Heam (1) demonstration for any portion of the current cost reportion of the current	1.00 N al Demonstrati "Y" for yes or -2, lines 200 the Frontier Corting period? is Y, enter th in column 2. E and/or "C" fo	on project (§4' "N" for no. In through 215, as: ommunity Healt! Enter "Y" for e integration nter all that r tele-health 1.00 N	3.00 N	4. 00 N	1109
0.00 Did the Demons Worksh 1.00 If thi Integryes or prong apply: service 2.00 Did the (PARHW period enter demons partice) Miscel 5.00 Is thi column column short psychi	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" for "N" for no for each therapy. This hospital participate in the Rural Community Hospit stration) for the current cost reporting period? Enter neet E, Part A, lines 200 through 218, and Worksheet E at a sa CAH, did it participate in ration Project (FCHIP) demonstration for this cost reporting period? Enter "N" for no in column 1. If the response to column 1 of the FCHIP demo in which this CAH is participating "A" for Ambulance services; "B" for additional beds; res. This hospital participate in the Pennsylvania Rural Heam (A) demonstration for any portion of the current cost response to column 2, the date the hospital began participating stration. In column 3, enter the date the hospital cestipation in the demonstration, if applicable. I anneous Cost Reporting Information s an all-inclusive rate provider? Enter "Y" for yes on 1. If column 2 is "E", enter the method used (A, B, 2. If column 2 is "E", enter in column 3 either "93" term hospital or "98" percent for long term care (incarric, rehabilitation and long term hospitals provide	al Demonstrati "Y" for yes or -2, lines 200 the Frontier Corting period? is Y, enter th in column 2. E and/or "C" fo I th Model eporting olumn 1 is "Y" g in the ased r "N" for no i or E only) in percent for I udes	on project (§4' "N" for no. In through 215, as ommunity Healtl Enter "Y" for e integration nter all that r tele-health 1.00 N	3.00 N	4. 00 N	1109.
therapyes or 10.00 Did the Demons Worksh 11.00 If this Integryes or prong apply: service 12.00 Did the (PARHW periodenter demons particell for the column short psychistic demons to the demons to	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" for "N" for no for each therapy. In this hospital participate in the Rural Community Hospit stration) for the current cost reporting period? Enter meet E, Part A, lines 200 through 218, and Worksheet E as facility qualifies as a CAH, did it participate in ration Project (FCHIP) demonstration for this cost reporting period? Enter "N" for no in column 1. If the response to column 1 of the FCHIP demo in which this CAH is participating "A" for Ambulance services; "B" for additional beds; esc. In this hospital participate in the Pennsylvania Rural Heam (1) demonstration for any portion of the current cost of the column 2, the date the hospital began participating stration. In column 3, enter the date the hospital cestion in the demonstration, if applicable. I aneous Cost Reporting Information I an all-inclusive rate provider? Enter "Y" for yes on 1. If column 1 is yes, enter the method used (A, B, 12. If column 2 is "E", enter in column 3 either "93" term hospital or "98" percent for long term care (incolumn caric, rehabilitation and long term hospitals provide effinition in CMS Pub. 15-1, chapter 22, \$2208. 1. Is facility classified as a referral center? Enter "Y"	al Demonstrati "Y" for yes or -2, lines 200 the Frontier Corting period? in column 2. E and/or "C" fo Ith Model eporting olumn 1 is "Y" g in the ased r "N" for no ior E only) in percent for ludes rs) based on	on project (§4' "N" for no. It through 215, as ommunity Healt! Enter "Y" for e integration nter all that r tele-health 1.00 N	3.00 N	4. 00 N	1109.
therapyes or 10.00 Did the Demons Worksh 11.00 If thi Integryes or prong apply: service 12.00 Did the (PARHW periodenter demons particell of the demons particell of the demons the demo	s hospital qualifies as a CAH or a cost provider, are by services provided by outside supplier? Enter "Y" for "N" for no for each therapy. In this hospital participate in the Rural Community Hospit stration) for the current cost reporting period? Enter meet E, Part A, lines 200 through 218, and Worksheet E as facility qualifies as a CAH, did it participate in ration Project (FCHIP) demonstration for this cost reporting period? Enter "N" for no in column 1. If the response to column 1 of the FCHIP demo in which this CAH is participating "A" for Ambulance services; "B" for additional beds; esc. In this hospital participate in the Pennsylvania Rural Heam (1) demonstration for any portion of the current cost of the column 2, the date the hospital began participating stration. In column 3, enter the date the hospital cestion in the demonstration, if applicable. I aneous Cost Reporting Information I an all-inclusive rate provider? Enter "Y" for yes on 1. If column 1 is yes, enter the method used (A, B, 12. If column 2 is "E", enter in column 3 either "93" term hospital or "98" percent for long term care (incolumn caric, rehabilitation and long term hospitals provide effinition in CMS Pub. 15-1, chapter 22, \$2208. 1. Is facility classified as a referral center? Enter "Y"	al Demonstrati "Y" for yes or -2, lines 200 the Frontier Corting period? is Y, enter th in column 2. E and/or "C" fo I th Model eporting olumn 1 is "Y" g in the ased r "N" for no i or E only) in percent for ludes rs) based on for yes or "N rance? Enter	on project (§4' "N" for no. It through 215, as ommunity Healt! Enter "Y" for e integration nter all that r tele-health 1.00 N	3.00 N	4. 00 N	109.

Health Financial Systems PERRY COUNTY F	HOSPI TAL		In Lie	u of Form CM	/S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Peri od: From 01/01/2023 To 12/31/2023	Worksheet	S-2
		Dromiumo		5/23/2024	4:14 pm
		Premiums	Losses	Insurance	
		1.00	0.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00	2.00	3.00	0118.01
The office and the office promitant and para recession					0110101
110 02 has not associate a social large and asid large associated in a social large and asid large as a social larg			1.00	2. 00	110.00
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedul amounts contained therein.			nd nd		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in of for no. Is this a rural hospital with < 100 beds that qualific Harmless provision in ACA §3121 and applicable amendments? (see	column 1, "Y" es for the Ou	for yes or utpatient Hol	" N" d	N	119. 00 120. 00
column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implan	table devices	s charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no.	nod in \$1002/	(w) (2) of the	V	F 02	122 00
122.00 Does the cost report contain healthcare related taxes as defined the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is Worksheet A line number where these taxes are included.				5. 02	122. 00
123.00 Did the facility and/or its subproviders (if applicable) purcle.g., legal, accounting, tax preparation, bookkeeping, payroll		onal service	s, Y	N	123. 00
management/consulting services, from an unrelated organization yes or "N" for no.		1, enter "Y"	for		
If column 1 is "Y", were the majority of the expenses, i.e.,					
professional services expenses, for services purchased from un located in a CBSA outside of the main hospital CBSA? In column			_N		
for no.					
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant cer	nter? Enter "	Y" for ves a	nd N		125. 00
"N" for no. If yes, enter certification date(s) (mm/dd/yyyy) I	bel ow.	,			
126.00 f this is a Medicare-certified kidney transplant program, encolumn 1 and termination date, if applicable, in column 2.					126. 00
127.00 If this is a Medicare-certified heart transplant program, enterprise column 1 and termination date, if applicable, in column 2.	er the certif	ication date	in		127. 00
128.00 If this is a Medicare-certified liver transplant program, ento	er the certif	ication date	in		128. 00
column 1 and termination date, if applicable, in column 2. 129.00 f this is a Medicare-certified lung transplant program, enter	r the certifi	cation date	i n		129. 00
column 1 and termination date, if applicable, in column 2. 130.00 olf this is a Medicare-certified pancreas transplant program,	enter the cer	tification d	ate		130. 00
in column 1 and termination date, if applicable, in column 2. 131.00 of this is a Medicare-certified intestinal transplant program,	enter the c	erti fi cati on			131. 00
date in column 1 and termination date, if applicable, in column	mn 2.				
132.00 If this is a Medicare-certified islet transplant program, enti- column 1 and termination date, if applicable, in column 2.	er the certif	ication date	in		132. 00
133.00 Removed and reserved	DO)t th	000			133. 00
134.00 f this is a hospital-based organ procurement organization (Ol column 1 and termination date, if applicable, in column 2.	PO), enter tr	ie upo number	I I		134. 00
All Providers 140.00 Are there any related organization or home office costs as de	fined in CMS	Dub 15_1	N		140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye	es, and home	office costs			140.00
claimed, enter in column 2 the home office chain number. (see	instructions	5)	3.00		
If this facility is part of a chain organization, enter on li		0		of the	
home office and enter the home office contractor name and con 141.00 Name: Contractor's Name:	tractor number		or's Number:		141. 00
142.00 Street: PO Box:					142. 00
143. 00 Ci ty: State:		Zi p Code:	:		143. 00
144 000				1.00	144.00
144.00 Are provider based physicians' costs included in Worksheet A?				Y	144. 00
445 001 0			1.00	2.00	
145.00 If costs for renal services are claimed on Wkst. A, line 74, a services only? Enter "Y" for yes or "N" for no in column 1. It dialysis facility include Medicare utilization for this cost of for yes or "N" for no in column 2.	f column 1 is	no, does th	e		145. 00
146.00 Has the cost allocation methodology changed from the previousl "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, character the approval date (mm/dd/yyyy) in column 2.			er N		146. 00

Health Financial Systems	PERRY COU	INTY HOSPITAL		In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der C	CN: 15-1322	Period: From 01/01/2023 To 12/31/2023		epared:
					1.00	+
147.00 Was there a change in the statisti	cal basis? Enter "Y" fo	or ves or "N" for	no.		1.00 N	147. 00
148.00 Was there a change in the order of					N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method?				N	149. 00
		Part A	Part B		Title XIX	
D 11: 6 :1:1	1 11 1 1:6:	1.00	2.00	3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "						
155.00 Hospi tal		N	N	N	N	155. 00
156.00 Subprovi der - IPF		N	N	N	N	156. 00
157. 00 Subprovi der – IRF		N	N	N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N	l N	N	N	158. 00 159. 00
160.00 HOME HEALTH AGENCY		N	N N	N N	N N	160. 00
161. OO CMHC		IN	N N	N N	N N	161. 00
TOT. GO OMITO				1, 1,	14	101.00
La constant de la con					1. 00	
Multicampus 165.00 Is this hospital part of a Multica	mpus hospital that has	one or more camp	uses in dif	ferent CBSAs? En	ter N	165. 00
"Y" for yes or "N" for no.	Name	County	State	Zip Code CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00 4. 00	5. 00	
166.00 If line 165 is yes, for each	9	11.00	2.00	0.00		00 166. 00
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)						
					1. 00	
Health Information Technology (HIT				ent Act	Y	4.7.00
167.00 Is this provider a meaningful user				") ontor the	Y	167. 00 168. 00
reasonable cost incurred for the H			e 107 13 1), enter the		100.00
168.01 If this provider is a CAH and is r	•	,	r qualify fo	or a hardship		168. 01
exception under §413.70(a)(6)(ii)?						
169.00 If this provider is a meaningful u		and is not a CAH	(line 105 i	s "N"), enter the	0.0	00169.00
transition factor. (see instruction	ns)			Dogi ppi pg	Fadi as	
				Begi nni ng 1. 00	Endi ng 2. 00	+
170.00 Enter in columns 1 and 2 the EHR b	eginning date and endir	ng date for the r	eporting pe		2.00	170. 00
n espectively (mm/ du/ yyyy)				1.00	0.00	
171.00 If line 167 is "Y", does this prov	ider have any days for	individuals oppo	lled in sec	1.00 tion N	2.00	0171.00
1876 Medicare cost plans reported and "N" for no in column 1. If col	on Wkst. S-3, Pt. I, li umn 1 is yes, enter the	ne 2, col. 6? En	ter "Y" for	yes		0171.00
days in column 2. (see instruction	S)					1

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1322 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/23/2024 4:14 pm Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If yes 2.00 2.00 Ν enter in column 2 the date of termination and in column 3, "V" voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug o medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 4 00 R Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, o for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. 5 00 5 00 Ν Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7 00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 N 9.00 program in the current cost report? If yes, see instructions.

Was an approved Intern and Resident GME program initiated or renewed in the current cost 10.00 Ν 10.00 reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Ν 11.00 Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions 14.00 Bed Complement N 15.00 Did total beds available change from the prior cost reporting period? If yes, 15.00 see instructions Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? If N N 16.00 either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for 04/11/2024 04/11/2024 17.00 17.00 Υ totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in column's 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R N N 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems PERRY COUNTY AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CO	 CN: 15-1322	Peri od:	eu of Form CM: Worksheet S	
701 1 1	THE THE THE TENENT SINCE RETIRED NOTICE AND THE TENENT ASSESSMENT	Trovider ex	JN. 10 1022	From 01/01/2023 To 12/31/2023	Part II Date/Time P	repare
		Descri	ption	Y/N	5/23/2024 4 Y/N	. 14 pm
)	1. 00	3.00	
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R		<u>, </u>	N N	N N	20.
	Report data for Other? Describe the other adjustments:	Y/N	Doto	Y/N	Doto	
		1.00	2.00	3. 00	4.00	_
00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.
. 00	records? If yes, see instructions.	IN		IN		21.
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS H	OSPI TALS)			
. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions			l N	
. 00	Have changes occurred in the Medicare depreciation expense		als made du	ring the cost	N	23
. 00	reporting period? If yes, see instructions.	duc to apprais	ar 3 made dar	riig tiic cost	'`	23
. 00	Were new leases and/or amendments to existing leases entere	ed into durina	this cost re	eportina period?	lf N	24
	yes, see instructions					- '
. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	? If yes, see	N	25
	instructions.	•		-		
. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	e cost reporti	ng period? I	f yes, see	N	26
	instructions.					
. 00	Has the provider's capitalization policy changed during the	cost reportin	g period? If	fyes, submit cop	y. N	27
	Interest Expense					
. 00	Were new loans, mortgage agreements or letters of credit en	itered into dur	ing the cost	t reporting perio	d? N	28
00	If yes, see instructions.					
00	Did the provider have a funded depreciation account and/or		bt Service F	Reserve Fund)	N	29
. 00	treated as a funded depreciation account? If yes, see instr		dobt2 lf vor	s coo instructio	ns. N	30
. 00						
. 00	Purchased Services	sadice of flew	debt: 11 yes	s, see mistructro	ηs. N	31
. 00	Have changes or new agreements occurred in patient care ser	vices furnishe	d through co	ontractual	l N	32
	arrangements with suppliers of services? If yes, see instru					-
. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		g to competi	tive bidding? If	N	33
	no, see instructions.	•	· .			
	Provi der-Based Physi ci ans					
. 00	Were services furnished at the provider facility under an a	rrangement wit	h provider-k	pased physicians?	lf Y	34
	yes, see instructions.					
. 00	If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	N	35
	physicians during the cost reporting period? If yes, see in	istructi ons.		V/ (b)	5 .	
				Y/N	Date	
	11 000			1. 00	2. 00	
00	Home Office Costs			N		
	Were home office costs claimed on the cost report?	onered by the	homo office	N N		36
. 00	If line 36 is yes, has a home office cost statement been pr yes, see instructions.	epared by the	nome office:	? I 🕴 N		37
00	lf line 36 is yes, was the fiscal year end of the home off	ica different	from that of	f the N		38
. 00	provider? If yes, enter in column 2 the fiscal year end of			THE IN		30
. 00	If line 36 is yes, did the provider render services to othe			s, N		39
	see instructions.	ona oompon	oo joc			"
. 00		home office?	If yes, see	N		40
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information					T 41
. 00	Enter the first name, last name and the title/position held	CLINT		BRI LL		41
. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	CLI NT		BRI LL		41
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			BRI LL		41
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer		С	BRI LL CBRI LL@BLUEAND		42

Health Financial Systems PERRY	COUNTY HOSPITAL	ΓΥ HOSPITAL In Lieu			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	Provider CCN: 15-1322	From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/23/2024 4:14 pm		
	3.00	_			
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer that the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer to the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and email address of the cost report preparer than the telephone number and the	n heldMANAGER		41. 00 42. 00 43. 00		
report preparer in columns 1 and 2, respectively.			l		

 Heal th Financial
 Systems
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1322

				'	0 12/31/2023	5/23/2024 4: 1	
						I/P Days / 0/P	7 (5111
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	·	Line No.		Avai I abl e			
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 125	54, 768. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for						
2. 00	the portion of LDP room available beds)						2. 00
3. 00	HMO and other (see instructions) HMO IPF Subprovider						3. 00
4. 00	HMO IRF Subprovider						4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		25	9, 125	54, 768. 00	-	7. 00
7.00	beds) (see instructions)		20	7, 120	01,700.00	o o	7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		25	9, 125	54, 768. 00	0	14.00
15. 00	CAH visits					0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00 23. 00	HOME HEALTH AGENCY						22. 00 23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						24. 00
24. 00	HOSPICE (non-distinct part)	30. 00					24. 00
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC - TCC	88. 00				0	26. 00
26. 01	RURAL HEALTH CLINIC II - PCFP	88. 01				0	26. 01
26. 02	RURAL HEALTH CLINIC III - 13TH	88. 02				Ö	26. 02
26. 03	RURAL HEALTH CLINIC IV - SPENCER	88. 03				Ö	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		25				27. 00
28. 00	Observation Bed Days					0	28. 00
29.00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges	00.00					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	34.00

Health Financial Systems PERRY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1322

Peri od: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Date/Ti me Prepared: 5/23/2024 4:14 pm Peri od:

		1 (5 5	(0 /5) //	/ T I		<u> 5/23/2024 4: 1</u>	4 pm
		I /P Days	/ O/P Visits	/ Irips	Full lime	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	II the Aviii	II LIE XIX	Patients	& Residents	Payrol I	
		6. 00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	71.00	0.00	7. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 043	9	2, 282			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for	-					
	the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	489	101				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	881	0	881			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	544			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 924	9	3, 707			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		0	7,			12.00
13. 00 14. 00	NURSERY	1, 924	0	-		204. 71	13. 00 14. 00
15. 00	Total (see instructions) CAH visits	1, 924	9	3, 783		204. / 1	15.00
15. 00	REH hours and visits		0				15. 00
16. 00	SUBPROVI DER - I PF	U	U				16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			C)		24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC - TCC	2, 393	0	15, 972	0.00	24. 31	26.00
26. 01	RURAL HEALTH CLINIC II - PCFP	163	0	3, 782	0.00	7. 10	26. 01
26. 02	RURAL HEALTH CLINIC III - 13TH	507	0	4, 536	0.00	11. 19	26. 02
26. 03	RURAL HEALTH CLINIC IV - SPENCER	956	0	5, 444			1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		1
27. 00	Total (sum of lines 14-26)				0.00	255. 62	1
28. 00	Observation Bed Days		10	702			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31. 00	Employee discount days - IRF	_	_	C			31.00
32. 00	Labor & delivery days (see instructions)	0	1	20			32. 00
32. 01	Total ancillary labor & delivery room			C	'		32. 01
33. 00	outpatient days (see instructions)	o					33. 00
33. 00	LTCH non-covered days LTCH site neutral days and discharges						33.00
	Temporary Expansi on COVID-19 PHE Acute Care		0	C			34.00
34.00	Tremporary Expansion Covid-19 File Acute Care	ı Y	U	١ ٠	П	I	J 34. 00

 Heal th Financial
 Systems
 PERRY

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

				To	12/31/2023	Date/Time Pre 5/23/2024 4:1	
		Full Time Equivalents		Di sch	arges	37 237 2024 4. 1	4 рііі
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	-	0	233	2	556	1.00
2.00	HMO and other (see instructions)			98	24		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	233	2	556	14. 00
15. 00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVIDER - I RF						17.00
18. 00 19. 00	SUBPROVI DER						18. 00 19. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC - TCC	0. 00					26. 00
26. 01	RURAL HEALTH CLINIC II - PCFP	0. 00					26. 01
26. 02	RURAL HEALTH CLINIC III - 13TH	0. 00					26. 02
26. 03	RURAL HEALTH CLINIC IV - SPENCER	0. 00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29.00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1322	Peri od:	Worksheet S	8-3	
			Component	CCN: 15-8516	From 01/01/202 To 12/31/202			
					RHC I	Cost		, p
							=	
	Clinic Address and Identification				1	. 00	_	
. 00	Street				109 I N-66		\neg	1. (
	1000000		Ci	ty	State	ZIP Code		
	To the state of th			00	2. 00	3. 00		
. 00	City, State, ZIP Code, County		TELL CITY			N 47586		2. (
						1.00	_	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for	urban		11.00	0	3. (
	•			Gra	nt Award	Date		
	Course of Fodougl Funds				1. 00	2. 00		
. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		T				4. (
. 00	Mi grant Health Center (Section 329(d), PHS Ac						ı	5. (
. 00	Health Services for the Homeless (Section 340							6. (
. 00	Appalachian Regional Commission							7. (
. 00	Look-Alikes OTHER (SPECIFY)							8. 9.
. 00	OTTLER (SECOND)							7.
					1. 00	2. 00		
0. 00	Does this facility operate as other than a ho						0	10.
	or "N" for no in column 1. If yes, indicate r in subscripts of line 11 the type of other op				nter			
	The subscripts of time in the type of other of	Sun			Monday	Tuesday		
		from	to	from	to	from		
		1. 00	2. 00	3.00	4. 00	5. 00		
1 00	Facility hours of operations (1) CLINIC			07: 00	19: 00	07: 00		11. (
1.00	OETHI O			07.00	17.00	07.00		11.0
					1. 00	2. 00		
2.00	Have you received an approval for an exception	•	•		N			12. (
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu				N ner		0	13. (
	of providers included in this report. List the	ne names of all	provi ders and	d numbers bel	OW.			
3. 01	If line 13, column 1, is "Y", are you reporti						0	13. (
	CMS Pub. 100-02, chapter 13, section 80.2)? enter in column 2 the number of consolidated				5,			
	Worksheet S-8 for each consolidated RHC group							
	comprised exclusively of grandfathered consol	idated RHCs in			ł			
	exclusively of new consolidated RHCs in the o	groupi ng.		Draw	i dor. nomo	CCN		
				Prov	<u>ider name</u> 1.00	2. 00		
4. 00	RHC/FQHC name, CCN					2.00		14. 0
		Y/N	V	XVIII	XIX	Total Visit	s	
F 00	House you provided all are substantially	1. 00	2.00	3. 00	4. 00	5. 00		15 1
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in							15. (
	column 1. If yes, enter in columns 2, 3 and 4	1						
	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		PERRY 4.	00				2. (
			ILL KK I					/ /

Health Financial Systems	PERRY COUNT	Y HOSPITAL	In Lie	In Lieu of Form CMS-2		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Period: From 01/01/2023	Worksheet S-8	
		Component	CCN: 15-8516	To 12/31/2023	Date/Time Pre 5/23/2024 4:1	pared: 4 pm
				RHC I	Cost	
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7. 00	8. 00	9. 00	10. 00	
Facility hours of operations (1)						
11. 00 CLINIC	19: 00	07: 00	19: 00	07: 00	19: 00	11. 00
	Fri	day	y Sat			
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	19: 00				11. 00

	Financial Systems FAL-BASED RHC/FQHC STATISTICAL DATA	PERRY COUNTY		CN: 15-1322	Peri od:	eu of Form CMS Worksheet S		
				CCN: 15-8517	From 01/01/202 To 12/31/202			
					RHC II	Cost		+ piii
					1,110			
	Total Control of the				1	. 00		
00	Clinic Address and Identification				10.40F CTATE D	040.27	_	1 0
. 00	Street		Ci	ty	18485 STATE R State	ZIP Code	\dashv	1. (
				00	2. 00	3. 00	_	
2. 00	City, State, ZIP Code, County		LEOPOLD			N 47551		2. C
	LIOCOLTAL DACED FOLICE ONLY Designation Fint	"D" 6				1.00		2 (
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er k for rura	ii or u for t		nt Award	Date	0	3. 0
				Ol d	1. 00	2.00		
	Source of Federal Funds							
1.00	Community Health Center (Section 330(d), PHS							4. C
. 00	Migrant Health Center (Section 329(d), PHS Ad							5. (
6. 00 7. 00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	J(u), PHS ACT)						6. 0 7. 0
3. 00	Look-Alikes							8. (
. 00	OTHER (SPECIFY)							9. (
					1.00		_	
0. 00	Does this facility operate as other than a ho	penital based F	DUC or EOUC2 Er	tor "V" for	1.00 ves N	2.00	0	10. (
0. 00	or "N" for no in column 1. If yes, indicate in						۷	10. (
	in subscripts of line 11 the type of other op							
		Sun			Monday	Tuesday		
		from	to	from	to	from	_	
	Facility hours of operations (1)	1.00	2. 00	3. 00	4. 00	5. 00	-	
11.00	CLINIC	1		07: 00	16: 00	07: 00		11. C
	III.				1. 00	2. 00	_	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined	•	•		N N		0	12. C
3.00	30. 8? Enter "Y" for yes or "N" for no in colu						۷	13. (
	of providers included in this report. List the	ne names of all	provi ders and	d numbers bel	OW.			
13. 01	If line 13, column 1, is "Y", are you reporti						0	13.0
	CMS Pub. 100-02, chapter 13, section 80.2)? enter in column 2 the number of consolidated				5,			
	Worksheet S-8 for each consolidated RHC group							
	comprised exclusively of grandfathered consol		n the grouping	or comprised	i			
	exclusively of new consolidated RHCs in the	groupi ng.		D	i don nomo	CCN	-	
				Prov	<u>ider name</u> 1.00	2. 00	-	
4. 00	RHC/FQHC name, CCN					2.00	\neg	14. C
		Y/N	V	XVIII	XIX	Total Visit	s	
E 00	III	1. 00	2. 00	3. 00	4. 00	5. 00		45
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in							15. C
	column 1. If yes, enter in columns 2, 3 and 4							
	the number of program visits performed by			1		i .	- 1	
	Intern & Residents for titles V, XVIII, and						- 1	
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the							
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.							
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		Cou	ınty				
2. 00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.			unty 00				2. 0

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od: From 01/01/2023	Worksheet S-8	
		Component	CCN: 15-8517	To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
				RHC II	Cost	
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	16: 00	09: 00	18: 00	07: 00	16: 00	11. 00
	Fri	day	Sat	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

HOSPI TAL	-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1322	Peri od:	Worksheet S	8-8	2552-1
			Component	CCN: 15-8560	From 01/01/2023 To 12/31/2023			
					RHC III	Cos		4 рііі
					15			
CI	: -: - Add				1.	. 00		
	inic Address and Identification treet				148 13TH STREE	т	\neg	1.
. 00 3	ti oct		C	ty	State	ZIP Code		
			1.	00	2. 00	3. 00		
. 00 Ci	ity, State, ZIP Code, County		TELL CITY		11	47586		2. (
						1.00		
3. 00 H	OSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for	urban		1.00	0	3.
	<u> </u>				nt Award	Date		
					1. 00	2. 00		
	ource of Federal Funds ommunity Health Center (Section 330(d), PHS	Act)		T		T		4. (
	igrant Health Center (Section 330(d), PHS Ac							5. (
	ealth Services for the Homeless (Section 340							6.
	ppalachian Regional Commission	ŕ						7.
	ook-Alikes							8.
. 00 0	THER (SPECIFY)							9.
					1. 00	2. 00		
	oes this facility operate as other than a ho						0	10.
	r "N" for no in column 1. If yes, indicate r				inter			
I r	n subscripts of line 11 the type of other op 	eration(s) and Sun			 Monday	Tuesday		
		from	to	from	to	from		
		1.00	2. 00	3.00	4. 00	5. 00		
	acility hours of operations (1)			loo 00	47.00	loo 00		
1. 00 CL	LINIC			08: 00	17: 00	08: 00		11. (
					1. 00	2. 00		
	ave you received an approval for an exception	n to the produ	ictivity standa	ard?				12. (
	s this a consolidated cost report as defined				N		0	13.
	O.8? Enter "Y" for yes or "N" for no in colu f providers included in this report. List th							
3. 01 11	f line 13, column 1, is "Y", are you reporti	ng multiple co	nsolidated RH	Cs (as define	edin N		0	13. (
CN	MS Pub. 100-02, chapter 13, section 80.2)?	Enter "Y" for	yes or "N" for	no. If yes				
	nter in column 2 the number of consolidated							
	orksheet S-8 for each consolidated RHC group omprised exclusively of grandfathered consol				ı			
	xclusively of new consolidated RHCs in the c		i the grouping	or comprised				
				Prov	ider name	CCN		
4 00 DI	HO /FOHO CON				1. 00	2. 00		111
4. UU RI	HC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visit	S	14. (
		1.00	2.00	3.00	4. 00	5. 00		
	ave you provided all or substantially all							15.
	ME cost? Enter "Y" for yes or "N" for no in							
	olumn 1. If yes, enter in columns 2, 3 and 4 he number of program visits performed by	+						
	ntern & Residents for titles V, XVIII, and							
XI	IX, as applicable. Enter in column 5 the							
	umber of total visits for this provider.							
1 (5	see instructions)		Col	l unty				
				00			į	
. 00 Ci	ity, State, ZIP Code, County							2.

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co		Peri od:	Worksheet S-8	
		Component	CCN: 15-8560	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
				RHC III	Cost	
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11. 00
	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	17: 00				11. 00

HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA	PERRY COUNT		CCN: 15-1322	Peri od:	eu of Form CM Worksheet		
			Component	CCN: 15-8562	From 01/01/202 To 12/31/202			
					RHC IV	Cos		+ piii
			- '					
						. 00		
. 00	Clinic Address and Identification Street				105 2ND STREE	Т	_	1. (
. 00	John Gert		С	i ty	State	ZIP Code		1. '
				. 00	2. 00	3. 00		
2. 00	City, State, ZIP Code, County		ROCKPORT		I	N 47635		2. (
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	r "R" for rura	or "II" for	urhan		1.00	0	3. (
. 00	THOSE THE BASED TRIES ONET. DOST GRACE OF LETTER	i k Tol Tule	11 01 0 101		nt Award	Date		J. 1
					1. 00	2. 00		
	Source of Federal Funds			1		1		
. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac							4. (5. (
. 00	Health Services for the Homeless (Section 340							6.
. 00	Appal achi an Regional Commission	(1,7,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1						7.
. 00	Look-Alikes							8.
. 00	OTHER (SPECIFY)							9.
					1. 00	2.00		
0. 00	Does this facility operate as other than a ho	spital-based R	RHC or FQHC? E	nter "Y" for		2.00	0	10.
	or "N" for no in column 1. If yes, indicate r							
	in subscripts of line 11 the type of other op					- .		
		Sun from	day to	from	Monday to	Tuesday from		
		1. 00	2.00	3.00	4. 00	5. 00		
	Facility hours of operations (1)							
1. 00	CLINIC			07: 30	17: 00	07: 30		11. (
					1.00	2.00		
2. 00	Have you received an approval for an exception	on to the produ	ictivity stand	ard?	1. 00	2. 00		12. (
3. 00	Is this a consolidated cost report as defined	•	-		N		0	
	30.8? Enter "Y" for yes or "N" for no in colu							
2 01	of providers included in this report. List the	ne names of all	providers an	d numbers bel	OW.			10
3. 01	If line 13, column 1, is "Y", are you reporti CMS Pub. 100-02, chapter 13, section 80.2)?						0	13. (
	enter in column 2 the number of consolidated				21			
	Worksheet S-8 for each consolidated RHC group	oing. Consolid	lated RHC grou	oings are				
	comprised exclusively of grandfathered consol exclusively of new consolidated RHCs in the consol		n the grouping	or comprised	i			
	jexcrusivery of new consortdated RHCS III the g	groupi ng.		Prov	ider name	CCN		
					1. 00	2.00		
4. 00	RHC/FQHC name, CCN							14. (
		Y/N	V 2.00	XVIII	XIX	Total Visit	ts	
5. 00	Have you provided all or substantially all	1. 00	2. 00	3.00	4. 00	5. 00		15. (
5. 00	GME cost? Enter "Y" for yes or "N" for no in							15.
	column 1. If yes, enter in columns 2, 3 and 4	1						
	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				
. 00	City, State, ZIP Code, County		SPENCER 4	. 00				2. (

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 15-1322	Period: From 01/01/2023	Worksheet S-8	
		Component	CCN: 15-8562	To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
				RHC IV	Cost	
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	07: 30	17: 00	07: 30	17: 00	11. 00
	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

SPI TAL	UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 15-1322	Peri od: From 01/01/2023	Worksheet S-10 Parts I & II	0				
			To 12/31/2023	Date/Time Pre					
				5/23/2024 4: 1	4 pm				
				1. 00					
PA	ART I - HOSPITAL AND HOSPITAL COMPLEX DATA			11.00					
	ncompensated and Indigent Care Cost-to-Charge Ratio								
00 <u>Co</u>	ost to charge ratio (see instructions)			0. 328333	1.				
	edicaid (see instructions for each line) et revenue from Medicaid			4, 955, 463	2.				
	id you receive DSH or supplemental payments from Medicaid?			Y 4, 933, 403	3.				
	fline 3 is yes, does line 2 include all DSH and/or supplemental	payments from Medic	ai d?	N N	4.				
00 Me	0 Medicaid charges								
	edicaid cost (line 1 times line 6)		7, 363, 494 1, 567, 034						
	Difference between net revenue and costs for Medicaid program (see instructions) Children's Health Insurance Program (CHIP) (see instructions for each line)								
	et revenue from stand-alone CHIP	each Tine)		0	9.				
	tand-allone CHIP charges			0					
	tand-alone CHIP cost (line 1 times line 10)			l o					
	ifference between net revenue and costs for stand-alone CHIP (se	ee instructions)		0					
	her state or local government indigent care program (see instru								
	et revenue from state or local indigent care program (Not includ narges for patients covered under state or local indigent care p			0					
	1'								
	tate or local indigent care program cost (line 1 times line 14) ifference between net revenue and costs for state or local indic	ont care program (co	o instructions)	0					
	rants, donations and total unreimbursed cost for Medicaid, CHIP				1 10				
	nstructions for each line)	and State/Todai Thai	gent care program	113 (300					
	rivate grants, donations, or endowment income restricted to fund	ding charity care		0					
	overnment grants, appropriations or transfers for support of hos			0					
	otal unreimbursed cost for Medicaid , CHIP and state and local i 2 and 16)	ndigent care program	s (sum of lines 8	1, 567, 034	19				
		Uni nsured	Insured	Total (col. 1					
		patients	pati ents	+ col . 2)					
Llo	ncompensated care cost (see instructions for each line)	1.00	2. 00	3. 00					
	narity care charges and uninsured discounts (see instructions)	488, 5	80 0	488, 580	20				
	ost of patients approved for charity care and uninsured discount								
	nstructions)								
	ayments received from patients for amounts previously written of	f as	0 0	0	22				
	narity care	1/0 /	.17 0	1/0 /17	22				
00 Co	ost of charity care (see instructions)	160, 4	0	160, 417	23				
				1. 00					
00 Do	pes the amount on line 20 col. 2, include charges for patient da	ays beyond a Length o	f stay limit	N	24				
lim	mposed on patients covered by Medicaid or other indigent care pr								
	fline 24 is yes, enter the charges for patient days beyond the	indigent care progra	m's length of sta	y 0	25				
00 I f	imit narges for insured patients' liability (see instructions)			0	25				
00 If				2, 286, 234					
00 f 				2, 260, 234					
00 I f I i 01 Ch 00 Ba	ad debt amount (see instructions)								
00 I f I i 01 Ch 00 Ba 00 Me				400, 266					
00 I f I i 01 Ch 00 Ba 00 Me 01 Me	ad debt amount (see instructions) edicare reimbursable bad debts (see instructions)				27				
00 I f I i 01 Ch 00 Ba 00 Me 01 Me 00 No 00 Co	ad debt amount (see instructions) edicare reimbursable bad debts (see instructions) edicare allowable bad debts (see instructions) on-Medicare bad debt amount (see instructions) ost of non-Medicare and non-reimbursable Medicare bad debt amour	nts (see instructions)	400, 266 1, 885, 968 759, 319	27 28 29				
00 I fi I i O1 Ch O0 Ba O0 Me O1 Me O0 Co O0 O0 O0 O0 O0 O0 O0 O	ad debt amount (see instructions) edicare reimbursable bad debts (see instructions) edicare allowable bad debts (see instructions) on-Medicare bad debt amount (see instructions)	•)	400, 266 1, 885, 968	27 28 29 30				

USDI 1	Financial Systems PERRY COUNTY HOS AL UNCOMPENSATED AND INDIGENT CARE DATA	rovi der CCN: 15-1322	Peri od:	u of Form CMS-2 Worksheet S-1			
/3F1 1	AL UNCOMPLINATED AND INDIGENT CARE DATA	TOVIUEI CON. 13-1322	From 01/01/2023 To 12/31/2023	Parts I & II Date/Time Pre 5/23/2024 4:1	pare		
				1. 00			
	PART II - HOSPITAL DATA						
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
00	Cost to charge ratio (see instructions)] 1		
	Medicaid (see instructions for each line)						
0	Net revenue from Medicaid				2		
0	Did you receive DSH or supplemental payments from Medicaid?				3		
0	If line 3 is yes, does line 2 include all DSH and/or supplementa		cai d?		4		
00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicaid			5		
00	Medi cai d charges				6		
0	Medicaid cost (line 1 times line 6)				7		
0	Difference between net revenue and costs for Medicaid program (SCHER)				3		
	Children's Health Insurance Program (CHIP) (see instructions for	each line)	T		۱,		
0	Net revenue from stand-alone CHIP Stand-alone CHIP charges				10		
0.00 Stand-alone CHIP charges 0.00 Stand-alone CHIP cost (line 1 times line 10)							
2.00 Difference between net revenue and costs for stand-alone CHIP (see instructions)							
00	Other state or local government indigent care program (see instr		2)		12		
00	Net revenue from state or local indigent care program (Not included in the care program in the care program (Not included in the care program in the car				13		
00	Charges for patients covered under state or local indigent care)	14		
00	State or local indigent care program cost (line 1 times line 14)			,	15		
00	Difference between net revenue and costs for state or local indi		ee instructions)		16		
00	Grants, donations and total unreimbursed cost for Medicaid, CHIF			s (see			
00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur</pre>	ading charity care			17		
00	Government grants, appropriations or transfers for support of he				18		
00	Total unreimbursed cost for Medicaid , CHIP and state and local		ms (sum of lines &		19		
00	12 and 16)	Thangert care program	iis (suiii or rrries u	,	l '		
		Uni nsured	l Insured	Total (col. 1			
		pati ents	pati ents	+ col . 2)			
		1. 00	2. 00	3.00			
	Uncompensated care cost (see instructions for each line)				4		
00	Charity care charges and uninsured discounts (see instructions)				20		
00	Cost of patients approved for charity care and uninsured discoulinstructions)	nts (see			21		
00	Payments received from patients for amounts previously written of	off as			22		
	charity care						
00	Cost of charity care (see instructions)				23		
				1. 00			
00	Does the amount on line 20 col. 2, include charges for patient of	days beyond a Length	of stay limit		24		
	imposed on patients covered by Medicaid or other indigent care ;	3					
00	If line 24 is yes, enter the charges for patient days beyond the	e indigent care progr	am's length of sta	У	25		
	limit						
01	Charges for insured patients' liability (see instructions)				25		
00	Bad debt amount (see instructions)				26		
00	Madiana minkunahia kadadaka (ana inakanakiana)		1		۱ ۵		

27.00

27. 01

28.00

29. 00

30. 00 31. 00

27.00 Medicare reimbursable bad debts (see instructions)

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

27.01 Medicare allowable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF		Provi der Co	CN: 15-1322 I	Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
						5/23/2024 4:1	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	
	, , , , , , , , , , , , , , , , , , ,			+ col . 2)	ons (See A-6)	Trial Balance	
				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	0.10 (000 /1 0)	(col. 3 +-	
						col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1 00			2 044 170	2 044 17	7 (22	2 051 011	1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 844, 178			2, 851, 811	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 088, 905			1, 088, 905	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	155, 557	4, 132, 168			4, 287, 725	4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL	852, 917	883, 567	1, 736, 48	1 -199, 298	1, 537, 186	5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	1, 259, 981	4, 931, 289	6, 191, 270	-22, 363	6, 168, 907	5. 02
7.00	00700 OPERATION OF PLANT	283, 247	1, 715, 068	1, 998, 31	-3, 917	1, 994, 398	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	140, 778			140, 778	8.00
9. 00	00900 HOUSEKEEPI NG	337, 641	79, 862			417, 503	9.00
10. 00	01000 DI ETARY	0	779, 716			281, 945	10.00
	01100 CAFETERI A	=	117, 110				1
11.00		0	0		497, 771	497, 771	11.00
13. 00	01300 NURSING ADMINISTRATION	0	0	(100,000	150, 658	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	213, 776	126, 080	339, 85	6 0	339, 856	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 357, 467	2, 700, 057	5, 057, 52	-51, 296	5, 006, 228	30.00
43.00	04300 NURSERY	0	0		o o	0	43.00
	ANCILLARY SERVICE COST CENTERS						ĺ
50.00	05000 OPERATI NG ROOM	726, 538	2, 037, 807	2, 764, 34	-325, 430	2, 438, 915	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	30, 600			30, 600	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	937, 399	360, 417			1, 297, 441	54.00
60.00	06000 LABORATORY	820, 150					60.00
	1 1		1, 390, 224			2, 198, 050	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	110, 690			110, 690	62. 00
65.00	06500 RESPI RATORY THERAPY	619, 673	907, 531	1, 527, 20		1, 467, 113	65. 00
66.00	06600 PHYSI CAL THERAPY	606, 807	102, 456	709, 26	3 0	709, 263	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	198, 360	18, 458	216, 81	3 0	216, 818	67.00
68.00	06800 SPEECH PATHOLOGY	145, 983	14, 990	160, 97	3 0	160, 973	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	818, 558		336, 867	1, 155, 425	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	o	. 0		85, 620	85, 620	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	96, 257	3, 994, 134	4, 090, 39		4, 211, 259	73. 00
70.00	OUTPATIENT SERVICE COST CENTERS	70, 201	0, 7, 1, 101	1,070,07	120,000	1, 211, 207	70.00
88. 00	08800 RURAL HEALTH CLINIC - TCC	2, 550, 982	803, 987	3, 354, 96	-183, 492	3, 171, 477	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP					997, 201	
		579, 568	394, 242			· ·	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	2, 064, 622	523, 019			2, 409, 339	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	660, 831	261, 192			1, 007, 358	88. 03
90.00	09000 CLI NI C	367, 646	76, 289	443, 93	18, 390	462, 325	90.00
90. 01	09001 PALN MANAGEMENT	0	0		0	0	90. 01
90. 02	09002 WOUND CARE	223, 202	225, 281	448, 483	157, 465	605, 948	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	90, 126	31, 251	121, 37	-6, 767	114, 610	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	132, 699	16, 178			232, 701	90. 04
91. 00	09100 EMERGENCY	2, 451, 181	131, 927			2, 581, 415	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,431,101	131, 727	2, 303, 100	-1,073	2, 301, 413	92.00
92.00							92.00
05 00	OTHER REIMBURSABLE COST CENTERS	0.40.000	200 400	1 000 11		1 010 711	
95. 00	09500 AMBULANCE SERVICES	949, 308	389, 109	1, 338, 41	7 -24, 703	1, 313, 714	95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE		0		0		113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	19, 681, 918	32, 060, 008	51, 741, 92	6 0	51, 741, 926	118. 00
	NONREI MBURSABLE COST CENTERS						1
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	18, 576		-		
200.00	1	19, 681, 918	32, 078, 584				
230.00	1.5.7.2 (55 5. 2.1425 116 till dagn 177)	.,, 551, 710	32, 373, 304	1 0., 700, 00.	- ₁	5.,700,002	1-00.00

Provider CCN: 15-1322

| Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/23/2024 4:14 pm |

				5/23/2024 4:	14 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	0	2, 851, 811		1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-254, 054	834, 851		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	4, 287, 725		4. 00
5.01	00540 ADMINISTRATIVE AND GENERAL	-1, 245, 584	291, 602		5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL - OTHER	-65, 481	6, 103, 426		5. 02
7.00	00700 OPERATION OF PLANT	-1, 179	1, 993, 219		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	o	140, 778		8. 00
9.00	00900 HOUSEKEEPI NG	0	417, 503		9. 00
10. 00	01000 DI ETARY	-215	281, 730		10.00
11. 00	01100 CAFETERI A	-80, 638	417, 133		11. 00
13. 00	01300 NURSING ADMINISTRATION	0	150, 658		13. 00
	01600 MEDICAL RECORDS & LIBRARY	-3, 088	336, 768		16. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3,000	000,700		1 .0.00
30. 00	03000 ADULTS & PEDIATRICS	-101, 299	4, 904, 929		30.00
	04300 NURSERY	0	0		43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		75.00
50. 00	05000 OPERATING ROOM	-1, 365, 005	1, 073, 910		50.00
	05200 DELIVERY ROOM & LABOR ROOM	-30, 600	0		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-30,000	1, 297, 441		54.00
60. 00	06000 LABORATORY	0	2, 198, 050		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	110, 690		62.00
65. 00	06500 RESPIRATORY THERAPY	-649, 393	817, 720		65. 00
66. 00	06600 PHYSI CAL THERAPY	-049, 393	709, 263		66.00
	06700 OCCUPATI ONAL THERAPY	0			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	216, 818 160, 973		68.00
		0			71.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	1, 155, 425		
	07200 NPL. DEV. CHARGED TO PATIENT	-2, 323	85, 620		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-2, 323	4, 208, 936		73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	110	2 171 2/7		4 00 00
88. 00	08800 RURAL HEALTH CLINIC - TCC	-110	3, 171, 367		88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	997, 201		88. 01
	08802 RURAL HEALTH CLINIC III - 13TH	0	2, 409, 339		88. 02
	08803 RURAL HEALTH CLINIC IV - SPENCER	0	1, 007, 358		88. 03
90.00	09000 CLINIC	-66, 793	395, 532		90.00
	09001 PAI N MANAGEMENT	0	0		90. 01
90. 02	09002 WOUND CARE	-322, 165	283, 783		90. 02
	09003 ORTHOPEDIC CLINIC	0	114, 610		90. 03
90. 04	09004 BEHAVI ORAL HEALTH	-139, 280	93, 421		90. 04
91. 00	09100 EMERGENCY	0	2, 581, 415		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-1, 635	1, 312, 079		95. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 I NTEREST EXPENSE	0	0		113. 00
118.00		-4, 328, 842	47, 413, 084		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	18, 576		192. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-4, 328, 842	47, 431, 660		200. 00

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

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/23/2024 4:14 pm Provider CCN: 15-1322

					5/23/2024 4: 14	4 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - CAFETERIA COST					
1. 00	CAFETERI A	<u>11.</u> 00		<u>497, 7</u> 71		1. 00
	0		0	497, 771		
	C - LEASE EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	98, 779		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	ol	0		4.00
5.00		0.00	ol	0		5. 00
6.00		0.00	ol	0		6. 00
7. 00		0.00	0	0	•	7. 00
8.00		0.00	0	0	•	8. 00
9. 00		0.00	0	0	•	9. 00
9.00				98, 779		9. 00
	D INCUDANCE EVDENCE		U	98, 779		
	D - INSURANCE EXPENSE	4 00	ما	0, 700		
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	36, 703		1. 00
2.00		0.00	•	0		2. 00
	0		0	36, 703		
	E - DRUGS CHARGED					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	11, 420		1. 00
2.00		0. 00	О	0		2.00
3.00		0. 00	ol	0		3. 00
				11, 420		
	F - BILLABLE SUPPLIES		-	,,		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	422, 487		1. 00
1.00	PATI ENTS	71.00	Ĭ	122, 107		1. 00
2.00	TATTENTS	0.00	0	0	•	2. 00
3. 00		0.00		0		3. 00
			0	0		
4.00		0.00	U	0	•	4. 00
5.00		0.00	O	0		5. 00
6.00		0. 00	0	0		6. 00
7.00		0.00	0	0		7. 00
	0		0	422, 487		
	G - IMPLANTABLE DEVICE					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	85, 620		1.00
				85, 620		
	H - WOUND CARE RECLASS		<u> </u>			
1.00	WOUND CARE	90. 02	186, 264	0		1. 00
2.00	WOOND STATE	0.00	100, 201			2. 00
2.00			186, 264	0	•	2.00
	L DUC DECOULTING EXPENSE DEC	LACC	100, 204	U _I		
1 00	I - RHC RECRUITING EXPENSE REC			22.000		1 00
1.00	RURAL HEALTH CLINIC II - PCFP	88. 01	0	22, 000		1.00
2.00	RURAL HEALTH CLINIC III -	88. 02	0	22, 000		2. 00
	13TH	+	_ — — 🖶			
	U TUEDADY		0	44, 000		
	J - IV THERAPY					
1.00	CLINIC	90.00	•	1 <u>8, 4</u> 01		1. 00
	0		0	18, 401		
	L - RAETZ RECLASS					
1.00	RURAL HEALTH CLINIC II - PCFP	88. 01	1, 391	0		1. 00
2.00	RURAL HEALTH CLINIC IV -	88. 03	85, 335	0		2. 00
	SPENCER					
		+	86, 726	₀	1	
	M - CNO EXPESE		20, , 20	3		
1.00	NURSING ADMINISTRATION	13.00	126, 561	24, 097		1. 00
1. 50	TOTALS	13.00	126, 561	$-\frac{24,077}{24,097}$	1	1.00
	N - PHARMACY		120, 301	24, 07/		
1 00	DRUGS CHARGED TO PATIENTS	72 00	ما	127 040		1 00
1. 00				127, 849		1. 00
	TOTALS		0	127, 849		
	O - BEHAVIORALL HEALTH RECLASS					
1 00	BEHAVI ORAL HEALTH	<u>90.</u> 04	0	83, 824		1. 00
1.00	TOTALS		0	83, 824	 	
1.00						
1.00	P - PULMONARY RECLASS					
1. 00	P - PULMONARY RECLASS RESPIRATORY THERAPY	65.00	ol	26, 980		1. 00
		65.00	0	26, 980 26, 980		1. 00

Provider CCN: 15-1322

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/23/2024 4:14 pm

	Parameter			5/23/2024 4:14 pm		
		Decreases			1	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - CAFETERIA COST					
1.00	DI ETARY	10.00	0	497, 771	0	1.
Ī	$\frac{1}{0} - \frac{1}{0} - \frac{1}{0} - \frac{1}{0} - \frac{1}{0}$			497, 771		
la	C - LEASE EXPENSE		-1	,		
	ADMINISTRATIVE AND GENERAL	5. 01	0	1, 920	10	1.
		l l	0			
	ADMINISTRATIVE AND GENERAL -	5. 02	U	1, 795	0	2.
	OTHER					
	OPERATION OF PLANT	7. 00	0	3, 917	0	3.
4.00	ADULTS & PEDIATRICS	30.00	0	2, 265	0	4.
5.00	OPERATING ROOM	50.00	O	44, 533	ol	5.
	RADI OLOGY-DI AGNOSTI C	54.00	0	375	0	6.
	RESPIRATORY THERAPY	65.00	o	34, 732	o	7.
			-		- 1	· · · · · · · · · · · · · · · · · · ·
	EMERGENCY	91.00	0	674	0	8.
9.00	AMBULANCE SERVICES	<u>95.</u> 00		<u>8, 5</u> 68	0	9.
Į(0		0	98, 779		
li li	D - INSURANCE EXPENSE					
1.00	ADMINISTRATIVE AND GENERAL -	5. 02	0	20, 568	12	1.
	OTHER	0.02	J	20, 000	1-	
		05 00		14 125		
2.00	AMBULANCE SERVICES	95.00	— — — —	16, 135	0	2.
Ĺ	U		0	36, 703		
	E - DRUGS CHARGED					
1.00	ADMINISTRATIVE AND GENERAL	5. 01	0	2, 720	0	1.
2.00	WOUND CARE	90. 02	o	1, 933	ol	2.
	ORTHOPEDIC CLINIC	90. 03	o	6, 767	0	3.
3.00	OKTIOLEDIC CETATO	— - 70. 03			— — —	3.
I	0		U	11, 420		
	F - BILLABLE SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	49, 031	0	1.
2.00	OPERATING ROOM	50.00	ol	280, 897	ol	2.
	LABORATORY	60.00	0	12, 324	ol	3.
	RESPIRATORY THERAPY	65.00	o	52, 339	ol	4.
			o o		o	· · · · · · · · · · · · · · · · · · ·
	CLINIC	90.00	0	11	0	5.
	WOUND CARE	90. 02	0	26, 866	0	6.
7.00	EMERGENCY	91.00	0	1, 019	0	7.
Ī	$\frac{1}{0} = \frac{1}{0} = \frac{1}{0}$	T		422, 487		
1	G - IMPLANTABLE DEVICE		-		<u> </u>	
	MEDICAL SUPPLIES CHARGED TO	71. 00	0	85, 620	0	1.
		71.00	۷	65, 620	٩	1.
	PATI ENTS	+	+			
	0		0	85, 620		
	H - WOUND CARE RECLASS					
1.00	RURAL HEALTH CLINIC - TCC	88. 00	12, 942	0	0	1.
2.00	RURAL HEALTH CLINIC III -	88. 02	173, 322	0	ol	2.
	13TH					
l,	<u> </u>	+	186, 264			
H	I - RHC RECRUITING EXPENSE RE	CLACC	100, 204	U _I		
	ADMINISTRATIVE AND GENERAL	5. 01	0	44, 000	0	1.
2.00		0.00	0	0	0	2.
l l	0		0	44, 000		
	J - IV THERAPY					
	DRUGS CHARGED TO PATIENTS	73.00	n	18, 401	O	1.
1.00	O TAITENTS	— 73. 00	+	18, 401	— — —	''
L.	U		<u> </u>	10, 401		
<u> </u>	L - RAETZ RECLASS					
1.00 I	RURAL HEALTH CLINIC - TCC	88. 00	86, 726	0	0	1.
2.00		0.00	0	0	ol	2.
	$\frac{1}{0} - \frac{1}{0} - \frac{1}{0} - \frac{1}{0} - \frac{1}{0} - \frac{1}{0}$		86, 726			
	M - CNO EXPESE		00,720	٥		
-		F 01	10/ 5/1	24 007		1
-	ADMI NI STRATI VE AND GENERAL		126, 561	<u>24, 0</u> 97	0	1.
	TOTALS		126, 561	24, 097		
	N - PHARMACY					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	127, 849	10	1.
	TOTALS	+		127, 849		
-	O - BEHAVI ORALL HEALTH RECLASS	S	٦	.27,317		
	RURAL HEALTH CLINIC - TCC		ام	02 024		1
-		88.00		8 <u>3, 8</u> 24	0	1.
	TOTALS		0	83, 824		
	P - PULMONARY RECLASS					
1.00	RURAL HEALTH CLINIC III -	88. 02	0	26, 980	0	1.
	13TH		-	.,	-	
		+	+	26, 980	— — 	
	IOTALS					
	TOTALS Grand Total: Decreases		399, 551	1, 477, 931		500.

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

					Date/Time Prepared: 5/23/2024 4:14 pm		
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3, 693, 378	0	(0	0	1. 00
2.00	Land Improvements	45, 658	46, 399	(46, 399	0	2.00
3.00	Buildings and Fixtures	44, 036, 233	1, 102, 673	(1, 102, 673	0	3. 00
4.00	Building Improvements	0	0	(0	0	4.00
5.00	Fixed Equipment	2, 606, 705	0	(0	0	5.00
6.00	Movable Equipment	19, 782, 924	321, 928	(321, 928	0	6.00
7.00	HIT designated Assets	0	0	(0	0	7.00
8.00	Subtotal (sum of lines 1-7)	70, 164, 898	1, 471, 000	(1, 471, 000	0	8. 00
9.00	Reconciling Items	O	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	70, 164, 898	1, 471, 000	(1, 471, 000	0	10.00
		Ending Balance	Fully				
		,	Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	3, 693, 378	0				1. 00
2.00	Land Improvements	92, 057	0				2.00
3.00	Buildings and Fixtures	45, 138, 906	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	20, 104, 852	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	71, 635, 898	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	71, 635, 898	0				10. 00

Heal th	Financial Systems	PERRY COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider CO		Period: From 01/01/2023 To 12/31/2023		pared:
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 837, 104	0		0 0	7, 074	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	1, 088, 90	5 0	0	2. 00
3.00	Total (sum of lines 1-2)	2, 837, 104	0	1, 088, 90	5 0	7, 074	3. 00
		SUMMARY OF	CAPITAL				
	Cost Center Description	0ther	Γotal (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 844, 178				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1, 088, 905			ļ	2. 00
3. 00	Total (sum of lines 1-2)	0	3, 933, 083				3. 00

Health Financial Systems	PERRY COUNT	Y HOSPITAL		In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-1322		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:14	pared:
	COMPUTATION OF RATIOS ALLOCATION OF			OTHER CAPITAL		
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	instructions)	Insurance	
	1.00	2. 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CI				_		
1.00 NEW CAP REL COSTS-BLDG & FLXT	51, 531, 046		51, 531, 04		0	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	20, 104, 852		20, 104, 85			2. 00
3.00 Total (sum of lines 1-2)	71, 635, 898		71, 635, 89			3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				F CAPITAL	
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6. 00	7. 00	8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	NTERS	<u> </u>		<u>'</u>		
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0)	2, 837, 104	-29, 070	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	-254, 054	2. 00
3.00 Total (sum of lines 1-2)	0	0)	2, 837, 104	-283, 124	3. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see		Other Capi tal -Rel ate	Total (2) (sum of cols. 9	
		Tristi deti olis)	Thisti detrons)	d Costs (see	through 14)	
	11 00	12.00	12.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12. 00	13.00	14. 00	15. 00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	LIVILKS	36, 703	7, 07	1	2, 851, 811	1. 00
2.00 NEW CAP REL COSTS-BLDG & FIXT	1, 088, 905			0 0	834, 851	2.00
3.00 Total (sum of lines 1-2)	1, 088, 905		1	٥		
3. 00 10 tat (Suiii 01 111165 1-2)	1,000,900	1 30, 703	7,07	+1 0	3,000,002	3.00

PERRY COUNTY HOSPITAL Provider CCN: 15-1322 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 4:14 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4.00 5.00 1.00 1. 00 Investment income - NEW CAP RE ONEW CAP REL COSTS-BLDG & FIX 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - NEW CAP RE В -254, 054 NEW CAP REL COSTS-MVBLE EQUIP 2.00 10 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of expenses 0.00 5.00 (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -5, 175 ADMINISTRATIVE AND GENERAL -7.00 5.02 0 7.00 Α stations excluded) (chapter 21 OTHER -1, 179 OPERATION OF PLANT 8.00 Television and radio service Α 7.00 8.00 (chapter 21) 9.00 Parking Lot (chapter 21) 0.00 9.00 Provider-based physician -2, 636, 996 A-8-2 10.00 10.00 adi ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 12.00 transactions (chapter 10) Laundry and linen service 13.00 0.00 13.00 -80, 638 CAFETERI A 14.00 Cafeteria-employees and guests В 11.00 0 14 00 15.00 Rental of quarters to employee В -24, 925 ADMINISTRATIVE AND GENERAL 5.01 15.00 and others 16.00 Sale of medical and surgical 0.00 16.00 supplies to other than patients Sale of drugs to other than 17 00 0 00 O 17 00 pati ents 18.00 Sale of medical records and В -3, 088 MEDICAL RECORDS & LIBRARY 16.00 18.00 abstracts 19.00 Nursing and allied health 0 0.00 19.00 education (tuition, fees, books, etc.) -215 DI ETARY 20.00 20.00 Vending machines В 10.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical therapy 24 00 A-8-3 OPHYSICAL THERAPY 66 00 24 00 costs in excess of limitation (chapter 14) Utilization review -0 *** Cost Center Deleted *** 114.00 25.00 25.00 physicians' compensation (chapter 21) 26, 00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & FIXT 1.00 26.00 COSTS-BLDG & FIXT ONEW CAP REL COSTS-MVBLE EQUIP 27.00 Depreciation - NEW CAP REL 2.00 27 00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29.00 29.00 Physicians' assistant 0.00 30.00 Adjustment for occupational A - 8 - 3OOCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.99 30.99 30.00 instructions) 31.00 Adjustment for speech pathology A-8-3 OSPEECH PATHOLOGY 68.00 31.00 costs in excess of limitation (chapter 14) CAH HIT Adjustment for 0.00 32.00 32.00

-366, 162 ADMINISTRATIVE AND GENERAL

-36, 793 CLINIC

5.01

90.00

33.00

0 33. 01

REVENUE

33.00

33 01

Depreciation and Interest

CLINIC MISC REVENUE

ADMINISTRATION MISCELLANEOUS

В

В

				'	0 12/31/2023	5/23/2024 4: 1	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33. 02		В	-1, 635	AMBULANCE SERVICES	95.00	0	33. 02
	I NCOME-MI SCELLANEOUS-H						
33. 03	EMPLOYEE PURCHASES-PHARMACY	В	-2, 323	DRUGS CHARGED TO PATIENTS	73.00	0	33. 03
	SUPPLI ES						
33. 04	ADMI NI STRATI ON-CONTRI BUTI ONS	A	-7, 017	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 04
33. 05	MARKETI NG-ADVERTI SI NG	A	-60, 306	ADMINISTRATIVE AND GENERAL -	5. 02	0	33. 05
				OTHER			
33. 06	CASE MANAGEMENT-ADVERTISING	A	-49	ADULTS & PEDIATRICS	30.00	0	33. 06
33. 07	TELL CITY CLINIC-ADVERTISING	A	-110	RURAL HEALTH CLINIC - TCC	88. 00	0	33. 07
33. 08	WOUND CARE-ADVERTISING	A	-697	WOUND CARE	90. 02	0	33. 08
33.09	HAF FEES	В	-840, 997	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 09
33. 10	LOBBYING DUES	A	-6, 483	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 10
50.00	TOTAL (sum of lines 1 thru 49)		-4, 328, 842				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).
- 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.

| Period: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1322

					-	To 12/31/2023	B Date/Time Pre 5/23/2024 4:1	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	ı pııı
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	30. 00	ADULTS & PEDIATRICS	912, 108	101, 250		0	0	1. 00
2.00	50.00	OPERATING ROOM	1, 365, 005	1, 365, 005	0	0	0	2. 00
3.00	52. 00	DELIVERY ROOM & LABOR ROOM	30, 600	30, 600		0	0	3. 00
4.00	60.00	LABORATORY	18, 000	(18, 000	0	0	4. 00
5.00	65. 00	RESPI RATORY THERAPY	649, 393	649, 393	0	0	0	5. 00
6.00	90.00	CLINIC	30,000	30, 000	0	0	0	6. 00
7.00	90. 02	WOUND CARE	321, 468	321, 468	3	0	0	7. 00
8.00	90. 04	BEHAVI ORAL HEALTH	139, 280			0	0	8. 00
9.00	91. 00	EMERGENCY	1, 449, 742			0	0	9. 00
10.00	0.00		0	1)	0	0	10. 00
200.00			4, 915, 596	2, 636, 996	2, 278, 600)	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1.00		ADULTS & PEDIATRICS	0	(-		1	1. 00
2.00		OPERATING ROOM	0	(1	2. 00
3.00		DELIVERY ROOM & LABOR ROOM	0	C			0	3. 00
4.00		LABORATORY	0	(0	0	0	4. 00
5.00		RESPI RATORY THERAPY	0	(0	0	0	5. 00
6.00		CLINIC	0	(0	0	0	6. 00
7. 00		WOUND CARE	0	(0	0	0	
8. 00		BEHAVI ORAL HEALTH	0	(0	0	0	8. 00
9. 00		EMERGENCY	0	(0	0	0	9. 00
10.00	0. 00		0	(0	0	0	10. 00
200.00			0	C	0		0	200. 00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18.00	-	
1.00		ADULTS & PEDIATRICS	15.00	16.00				1. 00
2.00		OPERATING ROOM						2. 00
3.00		DELIVERY ROOM & LABOR ROOM						3. 00
4.00		LABORATORY			-	1		4. 00
4. 00 5. 00		RESPI RATORY THERAPY				1		4. 00 5. 00
6.00		CLINIC						6. 00
6. 00 7. 00		WOUND CARE				1		7. 00
					,	1 02.7.00		
8. 00 9. 00		BEHAVI ORAL HEALTH				139, 280	1	8. 00 9. 00
		EMERGENCY						
10.00	0. 00					2 (2(20)		10.00
200.00			1	۱ ر	ار 🗸	2, 636, 996		200.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1322

				To	12/31/2023	Date/Time Pre 5/23/2024 4:1	
			CAPITAL RELATED COSTS			3/23/2024 4. 1	4 piii
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		for Cost Allocation	FLXT	EQUI P	BENEFITS DEPARTMENT		
		(from Wkst A			DEFARTMENT		
		col . 7)					
		0	1.00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	0 054 044	0.051.011	I .			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	2, 851, 811	2, 851, 811				1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	834, 851 4, 287, 725	14, 758	834, 851 4, 320	4, 306, 803		2. 00 4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL	291, 602	206, 688		160, 208	719, 005	5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL - OTHER	6, 103, 426	125, 063		277, 906	6, 543, 006	5. 02
7. 00	00700 OPERATION OF PLANT	1, 993, 219	296, 257		62, 474	2, 438, 678	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	140, 778	0	0	0	140, 778	8. 00
9. 00	00900 HOUSEKEEPI NG	417, 503	36, 221	10, 603	74, 471	538, 798	9. 00
10.00	01000 DI ETARY	281, 730	137, 397		0	459, 349	1
11. 00	01100 CAFETERI A	417, 133	0		0	417, 133	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	150, 658	7, 271		27, 915	187, 973	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	336, 768	15, 566	4, 557	47, 151	404, 042	16. 00
30. 00	03000 ADULTS & PEDIATRICS	4, 904, 929	561, 006	164, 231	519, 972	6, 150, 138	30.00
43. 00	04300 NURSERY	0	19, 551		0	25, 275	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 073, 910	351, 787		160, 248	1, 688, 929	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	86, 311		0	111, 578	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 297, 441	178, 061		206, 756	1, 734, 384	ł
60.00	06000 LABORATORY	2, 198, 050	73, 573 0		180, 896	2, 474, 057	60.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	110, 690 817, 720	77, 343		0 136, 678	110, 690 1, 054, 383	62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	709, 263	94, 794	·	133, 840	965, 647	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	216, 818	23, 618	·	43, 751	291, 101	67. 00
68. 00	06800 SPEECH PATHOLOGY	160, 973	12, 415		32, 199	209, 221	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 155, 425	78, 932	23, 107	0	1, 257, 464	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	85, 620	0	0	0	85, 620	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 208, 936	40, 584	11, 881	21, 231	4, 282, 632	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	0 474 0/7	Ō		540 ((a)	0.740.000	00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC - TCC 08801 RURAL HEALTH CLINIC II - PCFP	3, 171, 367	0	-	540, 663	3, 712, 030	1
88. 01	08802 RURAL HEALTH CLINIC III - PCFP	997, 201 2, 409, 339	0	0	128, 139 417, 153	1, 125, 340 2, 826, 492	88. 01 88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	1, 007, 358	0	-	164, 577	1, 171, 935	•
90. 00	09000 CLINIC	395, 532	79, 551		81, 089	579, 460	1
90. 01	09001 PAIN MANAGEMENT	0	0	0	0	0	90. 01
90. 02	09002 WOUND CARE	283, 783	57, 684	16, 887	90, 313	448, 667	90. 02
90. 03	09003 ORTHOPEDI C CLI NI C	114, 610	0	0	19, 879	134, 489	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	93, 421	0	0	29, 269	122, 690	1
91. 00	09100 EMERGENCY	2, 581, 415	239, 974	70, 251	540, 642	3, 432, 282	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92. 00
95 00	09500 AMBULANCE SERVICES	1, 312, 079	0	0	209, 383	1, 521, 462	95.00
75. 00	SPECIAL PURPOSE COST CENTERS	1,312,077		<u> </u>	207, 303	1, 321, 402	75.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		47, 413, 084	2, 814, 405	823, 901	4, 306, 803	47, 364, 728	118. 00
40-	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37, 406		0	48, 356	
	19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments	18, 576	0	0	0	18, 576	
200. 00 201. 00	, ,		0	0	0		200. 00 201. 00
201.00		47, 431, 660	2, 851, 811		4, 306, 803		
50	, , , , , , , , , , , , , , , , , , ,	,,,	, , , - , .		., 222, 200	,, 200	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | To 12/

				10	0 12/31/2023	Date/lime Prep 5/23/2024 4:14	
	Cost Center Description	ADMI NI STRATI VE	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	+ piii
		AND GENERAL		AND GENERAL -	PLANT	LINEN SERVICE	
				OTHER			
		5. 01	5A. 01	5. 02	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL	719, 005	/ / 40 704	((40 704			5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	100, 715	6, 643, 721		0 070 700		5. 02
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	37, 536	2, 476, 214		2, 879, 738 0	1// 220	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	2, 167 8, 293	142, 945 547, 091		47, 218	166, 239 18, 196	9. 00
10.00	01000 DI ETARY	7, 070	466, 419		47, 218 179, 113	10, 190	10. 00
11. 00	01100 CAFETERI A	6, 421	423, 554		179, 113	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 893	190, 866		9, 479	0	13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	6, 219	410, 261		20, 291	0	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0,217	110, 201	00,000	20, 271	- O	10.00
30.00	03000 ADULTS & PEDIATRICS	94, 663	6, 244, 801	1, 017, 645	731, 335	55, 760	30. 00
43.00	04300 NURSERY	389	25, 664	4, 182	25, 487	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	25, 996	1, 714, 925	279, 464	458, 594	12, 441	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 717	113, 295	18, 463	112, 516	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	26, 696	1, 761, 080		232, 123	22, 740	
60.00	06000 LABORATORY	38, 081	2, 512, 138		95, 911	950	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 704	112, 394		0	0	62.00
65. 00	06500 RESPI RATORY THERAPY	16, 229	1, 070, 612		100, 825	2, 291	65. 00
66. 00	06600 PHYSI CAL THERAPY	14, 863	980, 510		123, 574	2, 868	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	4, 481	295, 582		30, 788	0	67. 00
68.00	06800 SPEECH PATHOLOGY	3, 220	212, 441		16, 184	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 355	1, 276, 819		102, 897	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	1, 318 65, 918	86, 938 4, 348, 550		0 52, 905	0	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	00, 910	4, 346, 330	708, 640	52, 905	U	73.00
88. 00	08800 RURAL HEALTH CLINIC - TCC	57, 136	3, 769, 166	614, 223	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	17, 321	1, 142, 661		0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	43, 505	2, 869, 997		0	o	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	18, 038	1, 189, 973		0	0	88. 03
90.00	09000 CLI NI C	8, 919	588, 379		103, 704	6, 165	90. 00
90. 01	09001 PAIN MANAGEMENT	O	0		0	0	90. 01
90. 02	09002 WOUND CARE	6, 906	455, 573	74, 240	75, 198	1, 173	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	2,070	136, 559	22, 254	0	0	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	1, 888	124, 578	20, 301	0	0	90. 04
91. 00	09100 EMERGENCY	52, 830	3, 485, 112	567, 934	312, 833	43, 208	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
	OTHER REIMBURSABLE COST CENTERS			1			
95. 00	09500 AMBULANCE SERVICES	23, 418	1, 544, 880	251, 754	0	447	95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE	Т		I			112 00
113.00		717, 975	47, 363, 698	6, 635, 720	2, 830, 975	166, 239	113.00
110.00	NONREI MBURSABLE COST CENTERS	717, 775	47, 303, 070	0,035,720	2, 630, 473	100, 234	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	49, 100	8, 001	48, 763	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	286	18, 862		0	-	192. 00
200.00			0				200. 00
201.00	1 1	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	719, 005	47, 431, 660	6, 643, 721	2, 879, 738	166, 239	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | To 12/ Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1322

					o 12/31/2023	Date/lime Pre 5/23/2024 4:1	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	4 piii
	oost center bescription	HOOSEKEELTING	DI E IANKI	ON ETERIN	ADMI NI STRATI ON	RECORDS &	
						LI BRARY	
		9.00	10.00	11. 00	13.00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL - OTHER						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	701, 659					9. 00
10.00	01000 DI ETARY	44, 369	765, 909				10.00
11.00	01100 CAFETERIA	0	0	492, 576	1		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 348	0	3, 806		500 545	13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	5, 027	0	18, 080	0	520, 515	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	101 1/2	7/5 000	145 500	125 (72)	122 004	20.00
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS	181, 163	765, 909	•		133, 994	1
43.00	04300 NURSERY	6, 314	0	C)J U	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	113, 601	ol	37, 987	35, 391	8, 589	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	27, 872	0	37, 967	1	0, 369	52.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	57, 500	0	53, 631	-	29, 204	
60.00	06000 LABORATORY	23, 759	0	58, 617		29, 204	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	23, 737	o	30, 017	1	27, 204	62.00
65. 00	06500 RESPIRATORY THERAPY	24, 976	0	27, 900		13, 743	1
66. 00	06600 PHYSI CAL THERAPY	30, 611	0	30, 755	1	6, 871	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	7, 627	0	10, 125	1	0, 0, 1	
68. 00	06800 SPEECH PATHOLOGY	4,009	o	6, 395		6, 871	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 489	o	0,010	1	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	o	O		0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	13, 105	o	6, 128	o o	0	73. 00
	OUTPATIENT SERVICE COST CENTERS				'		1
88. 00	08800 RURAL HEALTH CLINIC - TCC	0	0	C	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	0	C	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0	0	C	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	0	C	0	0	88. 03
90.00	09000 CLI NI C	25, 689	0	20, 250	18, 869	137, 430	
90. 01	09001 PAIN MANAGEMENT	0	0	C	1 1	0	
90. 02	09002 WOUND CARE	18, 628	0	15, 187		0	
90. 03	09003 ORTHOPEDIC CLINIC	0	0	6, 966		0	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	0	0	C	1 1	0	90. 04
91. 00	09100 EMERGENCY	77, 493	0	51, 157	47, 670	154, 609	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
05.00	OTHER REIMBURSABLE COST CENTERS		ما				05.00
95. 00	09500 AMBULANCE SERVICES	0	0	C) 0	0	95. 00
112 00	SPECIAL PURPOSE COST CENTERS		1				112 00
	11300 INTEREST EXPENSE	400 500	745 000	400 E74	227 (02	E20 E1E	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	689, 580	765, 909	492, 576	237, 603	520, 515	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 079	ol	C	ol ol	^	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,079	0	0			190.00
200.00		١	4		ή	U	200. 00
201.00	1 1		n	0		Λ	201.00
202. 00		701, 659	765, 909	492, 576	237, 603	520, 515	1
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		, .0,	, 3 , 0		,0	

PERRY COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/23/2024 4:14 pm	Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1322

					10 12/31/2023	5/23/2024 4: 14 pm
	Cost Center Description	Subtotal	Intern &	Total		
	·	R	Residents Cost			
			& Post			
			Stepdown			
			Adjustments			
		24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.01	00540 ADMINISTRATIVE AND GENERAL					5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER					5. 02
7.00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11.00
13.00	01300 NURSING ADMINISTRATION					13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				<u>'</u>	
30.00	03000 ADULTS & PEDIATRICS	9, 411, 872	0	9, 411, 87	2	30.00
43.00	04300 NURSERY	61, 647	0	61, 64	7	43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	2, 660, 992	0	2, 660, 99	2	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	272, 146	0	272, 14	6	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 443, 264	O	2, 443, 26	4	54.00
60.00	06000 LABORATORY	3, 129, 957	0	3, 129, 95	7	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	130, 710	0	130, 71	0	62. 00
65.00	06500 RESPI RATORY THERAPY	1, 414, 814	0	1, 414, 81	4	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 334, 973	0	1, 334, 97	3	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	392, 290	0	392, 29	0	67. 00
68.00	06800 SPEECH PATHOLOGY	280, 519	O	280, 51	9	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 613, 275	O	1, 613, 27	5	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	101, 105	O	101, 10	5	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 129, 328	0	5, 129, 32	8	73. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC - TCC	4, 383, 389	0	4, 383, 38	9	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	1, 328, 869	0	1, 328, 86	9	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	3, 337, 692	0	3, 337, 69	2	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	1, 383, 891	0	1, 383, 89	1	88. 03
90.00	09000 CLI NI C	996, 368	0	996, 36	8	90.00
90. 01	09001 PAIN MANAGEMENT	0	0		0	90. 01
90. 02	09002 WOUND CARE	639, 999	0	639, 99	9	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	165, 779	0	165, 77	9	90. 03
90.04	09004 BEHAVI ORAL HEALTH	144, 879	0	144, 87	9	90. 04
91.00	09100 EMERGENCY	4, 740, 016	0	4, 740, 01	6	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	1, 797, 081	0	1, 797, 08	1	95. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	47, 294, 855	0	47, 294, 85	5	118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	117, 943	0	117, 94	3	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	18, 862	0	18, 86	2	192. 00
200.00	Cross Foot Adjustments	0	0		0	200. 00
201.00		0	0		0	201. 00
202.00	TOTAL (sum lines 118 through 201)	47, 431, 660	0	47, 431, 66	0	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | | Par Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322

				Io	12/31/2023	Date/lime Pre 5/23/2024 4:1	
			CAPI TAL REI	LATED COSTS		372372024 4. 1	4 piii
			07 7 77.2 77.2	271728 00010			
	Cost Center Description	Di rectl y	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FIXT	EQUI P		BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	14, 758	4, 320	19, 078	19, 078	4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL	0	206, 688		267, 195	710	5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL - OTHER	0	125, 063	36, 611	161, 674	1, 231	5. 02
7.00	00700 OPERATION OF PLANT	0	296, 257	86, 728	382, 985	277	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	36, 221	10, 603	46, 824	330	9. 00
10.00	01000 DI ETARY	0	137, 397	40, 222	177, 619	0	10.00
11.00	01100 CAFETERI A	0	0	0	0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	0	7, 271	2, 129	9, 400	124	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	15, 566	4, 557	20, 123	209	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	561, 006	164, 231	725, 237	2, 303	30. 00
43.00	04300 NURSERY	0	19, 551	5, 724	25, 275	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	351, 787		454, 771	710	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	86, 311		111, 578	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	178, 061		230, 187	916	1
60. 00	06000 LABORATORY	0	73, 573		95, 111	801	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	-	0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0	77, 343		99, 985	605	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	94, 794		122, 544	593	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	23, 618		30, 532	194	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	12, 415		16, 049	143	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	78, 932		102, 039	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	10 504	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	40, 584	11, 881	52, 465	94	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS	0			٥	2 204	00.00
	08800 RURAL HEALTH CLINIC - TCC	0	0	- 1	0	2, 394	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	0	_	0	568	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0	0	0	0	1, 848	•
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER 09000 CLINIC	0	70 FF1	0	102 020	729	88. 03
90.00	09000 CLINIC 09001 PAIN MANAGEMENT	0	79, 551	23, 288	102, 839	359	90.00
90. 01 90. 02	09001 PATN MANAGEMENT	0	F7 404	1, 007	74 571	0 400	90. 01
90. 02	09003 ORTHOPEDI C CLI NI C	0	57, 684 0		74, 571	88	90. 02 90. 03
90. 03	09004 BEHAVI ORAL HEALTH	0	0	0	0	130	90.03
90.04	09100 EMERGENCY	0	239. 974	-	210 225		90.04
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	U	239, 974	70, 251	310, 225 0	2, 395	91.00
92.00	OTHER REIMBURSABLE COST CENTERS				U _I		92.00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	927	95. 00
75.00	SPECIAL PURPOSE COST CENTERS	ı o	0	U U	<u> </u>	721	75.00
113 00	11300 I NTEREST EXPENSE						113. 00
118.00	1	0	2, 814, 405	823, 901	3, 638, 306		
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	2,014,400	023, 701	3, 030, 300	17, 0/0	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37, 406	10, 950	48, 356	Ω	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		37, 400		40, 330		192. 00
200.00			0		0		200. 00
201.00	1 1		0	0	0		201. 00
202.00		0	2, 851, 811	834, 851	3, 686, 662		
202.00	1.51/12 (5am 111165 116 till bagil 201)	١	2,001,011	1 334, 631	3, 300, 002	17,070	1-02.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5/23/2024 4:14 pm	Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322

				'	0 12/01/2020	5/23/2024 4: 1	4 pm
	Cost Center Description	ADMI NI STRATI VE	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	'	AND GENERAL	AND GENERAL -	PLANT	LINEN SERVICE		
			OTHER				
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS			•			
1.00	00100 NEW CAP REL COSTS-BLDG & 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	267, 905					5. 01
5. 02		37, 532					5. 02
	00590 ADMINISTRATIVE AND GENERAL - OTHER						
7.00	00700 OPERATION OF PLANT	13, 986					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	807	703		1, 510		8. 00
9.00	00900 HOUSEKEEPI NG	3, 090				59, 811	9. 00
10. 00	01000 DI ETARY	2, 634	2, 293			3, 782	1
11. 00	01100 CAFETERI A	2, 392	2, 082	•	0	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 078				200	1
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 317	2, 017	2, 885	0	428	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	35, 271	30, 718	103, 974	506	15, 443	30. 00
43.00	04300 NURSERY	145	126	3, 624	0	538	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 686	8, 431	65, 200	113	9, 684	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	640	557	15, 997	0	2, 376	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 947	8, 657	33, 002	207	4, 901	54.00
60.00	06000 LABORATORY	14, 189	12, 350		9	2, 025	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	635	553			0	62. 00
65. 00	06500 RESPIRATORY THERAPY	6, 047	5, 263			2, 129	ł
66. 00	06600 PHYSI CAL THERAPY	5, 538				2, 609	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 669	1, 453		0	650	
68. 00	06800 SPEECH PATHOLOGY	1, 200			0	342	
71. 00		7, 212				2, 173	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	491	6, 277			· ·	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENT		427		_	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	24, 561	21, 377	7, 522	0	1, 117	73. 00
	OUTPATIENT SERVICE COST CENTERS	04.000	10.500				
88. 00	08800 RURAL HEALTH CLINIC - TCC	21, 288				0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	6, 454				0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	16, 210				0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	6, 721	5, 850		_	0	88. 03
90.00	09000 CLI NI C	3, 323	2, 892	14, 744	56	2, 190	1
90. 01	09001 PAIN MANAGEMENT	0	0	1	0	0	90. 01
90. 02	09002 WOUND CARE	2, 573	2, 240	10, 691	11	1, 588	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	771	671	0	0	0	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	704	612	0	0	0	90. 04
91.00	09100 EMERGENCY	19, 684	17, 133	44, 476	392	6, 606	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	8, 726	7, 595	0	4	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	267, 521	200, 196	402, 488	1, 510	58, 781	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	277	241	6, 933	0	1, 030	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	107	0	0	0	0	192. 00
200.00		1					200. 00
201.00		0	0	0	0	0	201. 00
202.00		267, 905	200, 437	409, 421	1, 510	59, 811	202. 00
		•	•	•		•	-

Provider CCN: 15-1322

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | To 12/31/2024

				10	12/31/2023	5/23/2024 4: 1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	
	·			ADMI NI STRATI ON	RECORDS &		
					LI BRARY		
	OFWERN, OFRICAS COOK OF WEIGHT	10. 00	11. 00	13.00	16. 00	24. 00	
	GENERAL SERVICE COST CENTERS						1 00
	00100 NEW CAP REL COSTS-BLDG & FLXT						1. 00 2. 00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						4. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMINISTRATIVE AND GENERAL						
	00540 ADMINISTRATIVE AND GENERAL - OTHER						5. 01 5. 02
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY	211, 793					10.00
	01100 CAFETERI A	0	4, 474				11. 00
	01300 NURSI NG ADMI NI STRATI ON	o	35				13. 00
	01600 MEDICAL RECORDS & LIBRARY	o	164		28, 143		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		-	· · ·		
30. 00	03000 ADULTS & PEDIATRICS	211, 793	1, 323	7, 493	7, 245	1, 141, 306	30. 00
43.00	04300 NURSERY	0	0	0	o	29, 708	43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	345	1, 955	464	551, 359	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	131, 148	
	05400 RADI OLOGY-DI AGNOSTI C	0	487		1, 579	289, 883	54.00
	06000 LABORATORY	0	532		1, 579	140, 232	60. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	-	0	1, 188	62. 00
	06500 RESPI RATORY THERAPY	0	253		743	129, 381	65. 00
	06600 PHYSI CAL THERAPY	0	279		372	154, 350	66. 00
	06700 OCCUPATI ONAL THERAPY	0	92		0	38, 967	67. 00
	06800 SPEECH PATHOLOGY	0	58		372	21, 509	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	132, 330 918	71. 00 72. 00
	07200 TMPL. DEV. CHARGED TO PATTENT	0	56		0	107, 192	72.00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	30	<u> </u>	<u> </u>	107, 172	73.00
	08800 RURAL HEALTH CLINIC - TCC	0	0	0	ol	42, 211	88. 00
	08801 RURAL HEALTH CLINIC II - PCFP	Ö	0		Ö	12, 639	88. 01
	08802 RURAL HEALTH CLINIC III - 13TH	o	0		ol	32, 167	88. 02
	08803 RURAL HEALTH CLINIC IV - SPENCER	o	0	o	ōl	13, 300	88. 03
	09000 CLI NI C	0	184	1, 042	7, 430	135, 059	90. 00
90. 01	09001 PALN MANAGEMENT	О	0	0	O	0	90. 01
90. 02	09002 WOUND CARE	0	138	0	o	92, 212	90. 02
	09003 ORTHOPEDIC CLINIC	0	63	0	0	1, 593	90. 03
	09004 BEHAVI ORAL HEALTH	0	0		0	1, 446	90. 04
	09100 EMERGENCY	0	465	2, 633	8, 359	412, 368	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS			T _T			
	09500 AMBULANCE SERVI CES	0	0	0	0	17, 252	95. 00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	T			Т		112 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	211, 793	4, 474	13, 123	28, 143	3, 629, 718	113.00
	NONREI MBURSABLE COST CENTERS	211, 775	4, 4/4	13, 123	20, 143	3, 027, 710	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	56, 837	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	ol	0	-	o		192. 00
200.00	Cross Foot Adjustments	7			1		200. 00
201.00	Negative Cost Centers	О	0	o	o	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	211, 793	4, 474	13, 123	28, 143	3, 686, 662	202. 00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1322 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/23/2024 4:14 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 ADMINISTRATIVE AND GENERAL 5. 01 5.01 00590 ADMINISTRATIVE AND GENERAL - OTHER 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1, 141, 306 30.00 04300 NURSERY 43.00 0 29, 708 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 551, 359 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 131, 148 52.00 05400 RADI OLOGY-DI AGNOSTI C 289, 883 54.00 0000000000 54.00 06000 LABORATORY 60 00 140, 232 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 1, 188 62.00 06500 RESPIRATORY THERAPY 129, 381 65.00 66.00 06600 PHYSI CAL THERAPY 154, 350 66.00 06700 OCCUPATIONAL THERAPY 38, 967 67 00 67 00 06800 SPEECH PATHOLOGY 68.00 21, 509 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 132, 330 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 918 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 107<u>, 192</u> 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - TCC 0 88.00 88 00 42, 211 08801 RURAL HEALTH CLINIC II - PCFP 08802 RURAL HEALTH CLINIC III - 13TH 88.01 000000000 88.01 12,639 88 02 32, 167 88 02 88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER 13, 300 88.03 09000 CLI NI C 90.00 135, 059 90.00 09001 PALN MANAGEMENT 90.01 90.01 09002 WOUND CARE 92, 212 90.02 90.02 90.03 09003 ORTHOPEDIC CLINIC 1, 593 90.03 90.04 09004 BEHAVI ORAL HEALTH 90.04 1, 446 09100 EMERGENCY 91.00 91.00 412, 368 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 17, 252 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 3, 629, 718 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 56, 837 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 0 0 0 107 Cross Foot Adjustments 200.00 200. 00 0 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 3, 686, 662 202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1322 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/23/2024 4:14 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE FIXT **FOULP** BENEFITS AND GENERAL (SQUARE (SOUARE DEPARTMENT (ACCUM. COST) FEET) FEET) (GROSS SALARI ES) 1.00 2.00 5A. 01 5. 01 GENERAL SERVICE COST CENTERS 105 897 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 105, 897 00400 EMPLOYEE BENEFITS DEPARTMENT 548 548 19, 526, 361 00540 ADMINISTRATIVE AND GENERAL 7 675 7 675 726, 356 -719, 005 46, 712, 655 00590 ADMINISTRATIVE AND GENERAL - OTHER 4,644 4,644 1, 259, 981 6, 543, 006 00700 OPERATION OF PLANT 11,001 11,001 283, 247 2, 438, 678 0 00800 LAUNDRY & LINEN SERVICE 140, 778 C 00900 HOUSEKEEPI NG 538, 798 1 345 1, 345 337, 641 01000 DI ETARY 5, 102 5, 102 C 0 459, 349 01100 CAFETERI A 0 C 417, 133 01300 NURSING ADMINISTRATION 270 270 0 187, 973 126, 561 01600 MEDICAL RECORDS & LIBRARY 578 578 213, 776 404, 042 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 20,832 20,832 2, 357, 467 6, 150, 138 04300 NURSERY 0 726 726 25, 275 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 13, 063 13, 063 1, 688, 929 726, 538 0 05200 DELIVERY ROOM & LABOR ROOM 3, 205 3, 205 0 111, 578 05400 RADI OLOGY-DI AGNOSTI C 0 937.399 1, 734, 384 6,612 6, 612 06000 LABORATORY 2,732 2,732 820, 150 2, 474, 057 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 110, 690 06500 RESPIRATORY THERAPY 2,872 2, 872 619, 673 1, 054, 383 06600 PHYSI CAL THERAPY 3, 520 3, 520 606, 807 965, 647 0 06700 OCCUPATI ONAL THERAPY 877 877 198, 360 291, 101 0 06800 SPEECH PATHOLOGY 461 461 145, 983 209, 221 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 931 2, 931 0 1, 257, 464 07200 IMPL. DEV. CHARGED TO PATIENT 0 Λ 85, 620 07300 DRUGS CHARGED TO PATIENTS 1,507 1,507 96, 257 4, 282, 632 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - TCC 0 2.451.314 0 3, 712, 030 0 08801 RURAL HEALTH CLINIC II - PCFP 0 580, 959 1, 125, 340 08802 RURAL HEALTH CLINIC III - 13TH 1, 891, 300 0 0 2, 826, 492 08803 RURAL HEALTH CLINIC IV - SPENCER 1, 171, 935 746, 166 0 09000 CLINIC 579, 460 2,954 2, 954 367, 646 09001 PAIN MANAGEMENT 0 0 0 09002 WOUND CARE 2, 142 2, 142 409, 466 448, 667 09003 ORTHOPEDIC CLINIC 90 126 134 489 0 09004 BEHAVI ORAL HEALTH 132, 699 122, 690 09100 EMERGENCY 8, 911 8, 911 2, 451, 181 3, 432, 282 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 949, 308 0 1, 521, 462 SPECIAL PURPOSE COST CENTERS -719, 005 SUBTOTALS (SUM OF LINES 1 through 117) 19, 526, 361 104, 508 104, 508 NONREIMBURSABLE COST CENTERS 1, 389 1, 389 0 ol Cross Foot Adjustments

MCRI F32 - 22. 2. 178. 1

Heal th	Financial Systems	PERRY COUNT	Y HUSPITAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provider Co	F T	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B-1 Date/Time Pre 5/23/2024 4:1	pared:
	Cost Center Description	Reconciliation	ADMI NI STRATI VE AND GENERAL - OTHER (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	
		5A. 02	5. 02	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL - OTHER	-6, 643, 721	1	•			5. 02
7.00	00700 OPERATION OF PLANT	0	_,,				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			-,		8. 00
9.00	00900 HOUSEKEEPI NG	0	547, 091	1, 345		80, 684	1
10.00	01000 DI ETARY	0	466, 419			5, 102	
11. 00	01100 CAFETERI A	0	423, 554		-	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0				270	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	410, 261	578	0	578	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1	4 244 001	20.022	2 004	20.022	20.00
30.00	03000 ADULTS & PEDI ATRI CS	0		20, 832		20, 832	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	25, 664	726	0	726	43. 00
50. 00	05000 OPERATING ROOM	0	1, 714, 925	13, 063	668	13, 063	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM					3, 205	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		1, 761, 080			6, 612	
60.00	06000 LABORATORY		2, 512, 138			2, 732	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		112, 394			2, 732	1
65. 00	06500 RESPIRATORY THERAPY	0	1, 070, 612			2, 872	
66. 00	06600 PHYSI CAL THERAPY	0	1			3, 520	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	1			877	1
68. 00	06800 SPEECH PATHOLOGY	Ö	l .	461	1	461	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1			2, 931	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0				0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1	•	o	1, 507	73.00
	OUTPATIENT SERVICE COST CENTERS	•					
88. 00	08800 RURAL HEALTH CLINIC - TCC	0	3, 769, 166	C	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	1, 142, 661	C	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0	2, 869, 997	0	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	1, 189, 973			0	
90. 00	09000 CLI NI C	0	588, 379	2, 954	331	2, 954	
90. 01	09001 PAIN MANAGEMENT	0	0	C	0	0	
90. 02	09002 WOUND CARE	0	455, 573			2, 142	
90. 03	09003 ORTHOPEDIC CLINIC	0			0	0	
90. 04	09004 BEHAVI ORAL HEALTH	0	1,		0	0	
91.00	09100 EMERGENCY	0	3, 485, 112	8, 911	2, 320	8, 911	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1	1, 544, 880	C	24	0	95. 00
75.00	SPECIAL PURPOSE COST CENTERS	0	1, 544, 660		24		75.00
113 00	11300 INTEREST EXPENSE						113. 00
118.00		-6, 643, 721	40, 719, 977	80, 640	8, 926	79 295	118. 00
110.00	NONREI MBURSABLE COST CENTERS	0,010,721	10,717,777	00,010	0, 720	77,270	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49, 100	1, 389	ol	1. 389	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	-18, 862		0	ol		192. 00
200.00	I I						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part	t	6, 643, 721	2, 879, 738	166, 239	701, 659	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 162960	35. 106340	18. 624132	8. 696383	
204.00	Cost to be allocated (per Wkst. B, Part	t	200, 437	409, 421	1, 510	59, 811	204.00
	[1]						
205.00			0. 004916	4. 991174	0. 169169	0. 741299	
206.00							206. 00
007 6	(per Wkst. B-2)						007.05
207. 00							207. 00
	Parts III and IV)	1	I	I	1		I

<u>Heal</u> th	Financial Systems	PERRY COUNTY	HOSPI TAL		<u> </u>	u of Form CMS-2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der Co		riod: com 01/01/2023 12/31/2023	Worksheet B-1 Date/Time Prepared: 5/23/2024 4:14 pm
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	
	CENEDAL CEDVICE COST CENTEDS	10.00	11. 00	13. 00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00	00200 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 ADMINISTRATIVE AND GENERAL 00590 ADMINISTRATIVE AND GENERAL - OTHER 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	10, 745 0 0	12, 941 100 475	139, 347	303	2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	'			'	
30. 00 43. 00	03000 ADULTS & PEDIATRICS 04300 NURSERY ANCILLARY SERVICE COST CENTERS	10, 745 0	3, 825 0		78 0	30. 00 43. 00
50. 00 52. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	998	0	5	50.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	1, 409 1, 540		17 17	54. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1, 540		0	62. 00
65. 00	06500 RESPIRATORY THERAPY	Ö	733	_	8	65. 00
66.00	06600 PHYSI CAL THERAPY	O	808	0	4	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	266		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	168	1	4	68.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	-	0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		161	0	o	73.00
70.00	OUTPATIENT SERVICE COST CENTERS	9	101	<u> </u>	<u> </u>	70.00
88. 00	08800 RURAL HEALTH CLINIC - TCC	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0	0	0	0	88. 02
88. 03 90. 00	08803 RURAL HEALTH CLINIC IV - SPENCER 09000 CLINIC	0	532	11, 066	0 80	88. 03 90. 00
90.00	09000 CETNIC		332 0	11,000	00	90.00
90. 02	09002 WOUND CARE		399	١	o	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	O	183	0	o	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	0	0	0	0	90. 04
91. 00	09100 EMERGENCY	0	1, 344	27, 957	90	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	o	0	0	0	95. 00
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	70.00
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	10, 745	12, 941	139, 347	303	113. 00 118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	O	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	Ö	0	Ö	o	192. 00
200.00	Cross Foot Adjustments					200. 00
201.00						201. 00
202.00		765, 909	492, 576	237, 603	520, 515	202. 00
203. 00 204. 00		71. 280503 211, 793	38. 063210 4, 474		1, 717. 871287 28, 143	203. 00 204. 00
205. 00 206. 00		19. 710842	0. 345723	0. 094175	92. 881188	205. 00 206. 00
207. 00	1 "					207. 00
	Parts III and IV)					

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: Worksheet C From 01/01/2023 Part I

Title XVIII							To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
Total Cost Total Costs Total Costs Cfrom West B, Part I , col , 26) Total Costs Cfrom West B, Part I , col , 26) Total Costs Total Costs Total Costs Total Costs Part I , col , 26) Total Costs Total Costs Part I , col , 26) Total Costs Total Costs Part I , col , 26) Total Costs Part I , col , 27) Total Costs Part I , col ,					Title	: XVIII	Hospi tal	Cost	•
NPATI ENT ROUTINE SERVICE COST CENTERS Part I, col. 26) 1.00 2.00 3.00 4.00 5.00							Costs		
Part I , col . 26) 1.00 2.00 3.00 4.00 5.00			Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
1.00 2.00 3.00 4.00 5.00			·	(from Wkst. B,	Adj .		Di sal I owance		
INPATI ENT ROUTI NE SERVICE COST CENTERS				Part I, col.	•				
INPATIENT ROUTINE SERVICE COST CENTERS 9,411,872 9,411,872 0 0 30.00 30.00				26)					
30.00				1.00	2.00	3.00	4. 00	5. 00	
43.00		I NPAT	IENT ROUTINE SERVICE COST CENTERS						
ANCILLARY SERVICE COST CENTERS Section Cost	30.00	03000	ADULTS & PEDIATRICS	9, 411, 872		9, 411, 87	72 0	0	30. 00
50.00	43.00	04300	NURSERY	61, 647		61, 64	17 0	0	43. 00
52.00 05200 DELI VERY ROOM & LABOR ROOM 272, 146 272, 146 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 443, 264 2, 443, 264 0 0 54.00 64.00 06000 LABORATORY 3, 129, 957 0 66.00 65.00 06500 RESPI RATORY THERAPY 1, 310, 710 130, 710 0 65.00 65.00 06500 RESPI RATORY THERAPY 1, 414, 814 0 1, 414, 814 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 334, 973 0 1, 334, 973 0 66.00 67.00 06600 PHYSI CAL THERAPY 1, 334, 973 0 1, 334, 973 0 0 67.00 68.00 06600 PHYSI CAL THERAPY 392, 290 0 392, 290 0 67.00 68.00 06600 SPECEN PATHOLOGY 280, 519 0 280, 519 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 613, 275 1, 613, 275 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 5, 129, 328 5, 129, 328 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 5, 129, 328 5, 129, 328 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 5, 129, 328 5, 129, 328 0 0 73.00 74.00 08801 RURAL HEALTH CLINIC III - 13TH 3, 337, 692 3, 337, 692 0 0 88.01 75.00 08802 RURAL HEALTH CLINIC III - 13TH 3, 337, 692 3, 337, 692 0 0 88.02 75.00 09000 CLINIC 996, 368 996, 368 0 0 0 0 75.00 09000 CLINIC 100, 100 0 0 0 0 75.00 09000 00000 00000 00000 000000 000000									
54.00 05400 RADI OLOGY_DI AGNOSTI C 2, 443, 264 2, 443, 264 0, 0 0 54.00 0 0 0 0 0 0 0 0 0	50.00	05000	OPERATING ROOM	2, 660, 992		2, 660, 99	92 0	0	50. 00
60. 00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0	52.00	05200	DELIVERY ROOM & LABOR ROOM	272, 146		272, 14	16 0	0	52. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 130,710 130,710 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 1,414,814 0 1,414,814 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1,334,973 0 1,334,973 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 392,290 0 392,290 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 280,519 0 280,519 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1,613,275 1,613,275 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1,613,275 1,613,275 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 5,129,328 0 0 73. 00 0 0 0 0 0 0 0 0 0 0	54.00	05400	RADI OLOGY-DI AGNOSTI C	2, 443, 264		2, 443, 20	64 0	0	54.00
65. 00 06500 RESPI RATORY THERAPY 1, 414, 814 0 1, 414, 814 0 0 65. 00 06600 PHYSI CAL THERAPY 1, 334, 973 0 0 66. 00 067. 00 067. 00 067. 00 067. 00 06700 06700 06700 06800 SPEECH PATHOLOGY 280, 519 0 280, 519 0 0 68. 00 06800 SPEECH PATHOLOGY 280, 519 0 280, 519 0 0 68. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1, 613, 275 1, 613, 275 0 0 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 101, 105 101, 105 0 072. 00 072. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 129, 328 5, 129, 328 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 5, 129, 328 5, 129, 328 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 5, 129, 328 5, 129, 328 0 0 73. 00 08001 RURAL HEALTH CLINIC - TCC 4, 383, 389 4, 383, 389 0 0 88. 00 08800 RURAL HEALTH CLINIC - TCC 4, 383, 389 1, 328, 869 0 0 88. 01 08801 RURAL HEALTH CLINIC III - 13TH 3, 337, 692 3, 337, 692 0 0 88. 02 08802 RURAL HEALTH CLINIC III - 13TH 3, 337, 692 3, 337, 692 0 0 88. 02 08803 RURAL HEALTH CLINIC III - 13TH 3, 337, 692 3, 337, 692 0 0 88. 02 08800 0880	60.00	06000	LABORATORY	3, 129, 957		3, 129, 9	57 0	0	60. 00
66. 00 06600 PHYSICAL THERAPY 1, 334, 973 0 1, 334, 973 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 392, 290 0 392, 290 0 0 67. 00 68. 00 08600 SPECT PATHOLOGY 280, 519 0 280, 519 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 613, 275 1, 613, 275 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 613, 275 101, 105 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 5, 129, 328 5, 129, 328 0 0 73. 00 00UTPATI ENT SERVICE COST CENTERS	62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	130, 710		130, 7	10 0	0	62. 00
67. 00 06700 0CCUPATI ONAL THERAPY 392, 290 0 392, 290 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 280, 519 0 280, 519 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1, 613, 275 1, 613, 275 0 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENT 101, 105 101, 105 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 5, 129, 328 5, 129, 328 0 0 73. 00 88. 00 08800 RURAL HEALTH CLINIC TCC 4, 383, 389 4, 383, 389 0 0 88. 01 88. 01 08801 RURAL HEALTH CLINIC II - PCFP 1, 328, 869 1, 328, 869 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC II - 13TH 3, 337, 692 3, 337, 692 0 0 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER 1, 383, 891 1, 383, 891 0 0 88. 03 90. 00 09000 CLINIC 996, 368 996, 368 0 090. 00 90. 01 09001 PAIN MANAGEMENT 0 0 0 0 0 90. 02 09002 WOUND CAPE 639, 999 639, 999 0 0 90. 03 90. 03 09003 ORTHOPEDIC CLINIC 165, 779 165, 779 0 0 90. 03 90. 04 09004 BEHAVI ORAL HEALTH 144, 879 144, 879 0 0 90. 04 91. 00 09100 EMERGENCY 4, 740, 016 4, 740, 016 0 91. 00 92. 00 09SERVATI ON BEDS (NON-DISTINCT PART) 1, 683, 164 0 0 0THER REIMBURSABLE COST CENTERS 113. 00 113. 00 Subtotal (see instructions) 48, 978, 019 0 48, 978, 019 0 0 00. 00 00 00 00 00	65.00	06500	RESPI RATORY THERAPY	1, 414, 814	0	1, 414, 8	14 0	0	65. 00
67. 00 06700 0CCUPATI ONAL THERAPY 392, 290 0 392, 290 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 280, 519 0 280, 519 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 613, 275 1, 613, 275 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 101, 105 101, 105 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 5, 129, 328 5, 129, 328 0 0 73. 00 88. 00 08800 RURAL HEALTH CLINIC - TCC 4, 383, 389 4, 383, 389 0 0 88. 01 88. 01 08801 RURAL HEALTH CLINIC III - PCFP 1, 328, 869 1, 328, 869 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III - 13TH 3, 337, 692 3, 337, 692 0 0 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER 1, 383, 891 1, 383, 891 0 0 88. 03 90. 00 09000 CLINIC 996, 368 996, 368 0 090. 00 90. 01 09001 PAIN MANAGEMENT 0 0 0 0 0 90. 02 09002 WOUND CARE 639, 999 639, 999 0 0 90. 02 90. 03 09003 ORTHOPEDIC CLINIC 165, 779 165, 779 0 0 90. 03 90. 04 09004 BEHAVI ORAL HEALTH 144, 879 144, 879 0 90. 04 91. 00 09100 EMERGENCY 4, 740, 016 4, 740, 016 0 91. 00 92. 00 09500 AMBULANCE SERVI CES 1, 797, 081 1, 797, 081 0 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 113. 00 1300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 48, 978, 019 0 48, 978, 019 0 0. 200. 00 10 07000 07000 07000 07000 07000 07000 07000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 0700000 0700000000	66. 00	06600	PHYSI CAL THERAPY	1, 334, 973	0	1, 334, 9	73 0	0	66. 00
68. 00	67. 00	06700	OCCUPATI ONAL THERAPY		0			0	67. 00
71. 00	68. 00	06800	SPEECH PATHOLOGY	1	0			0	68. 00
72. 00	71. 00							0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS 5, 129, 328 5, 129, 328 0 0 0 73. 00 OVER THE OF THE O									
SERVICE COST CENTERS						1		0	
88. 00									
88. 01	88. 00			4, 383, 389		4, 383, 38	39 0	0	88. 00
88. 02								0	88. 01
88. 03								0	
90. 00	88 03			1 1				0	
90. 01								0	
90. 02				0			0	0	
90. 03				639 999		639 99	99	0	
90. 04									
91. 00								-	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 1,683,164 1,683,164 0 92. 00 0THER REI MBURSABLE COST CENTERS 1,797,081 0 0 0 95. 00 0 0 0 0 0 0 0 0 0								ū	
0THER REI MBURSABLE COST CENTERS 95. 00									
95. 00 09500 AMBULANCE SERVICES 1,797,081 0 0 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 48,978,019 0 48,978,019 0 0 200. 00	72.00			1,000,101		1,000,10	2 1		72.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 48,978,019 0 48,978,019 0 0 200.00	95 00			1 797 081		1 797 08	81 0	0	95.00
113. 00	70.00			.,,,,,,,,,		1,7,7,7,00	<u>, , i </u>		70.00
200.00 Subtotal (see instructions) 48,978,019 0 48,978,019 0 200.00	113 00			I					113 00
				48 978 019	0	48 978 0°	n		
1,000,101					O				
202.00 Total (see instructions) 47,294,855 0 47,294,855 0 0/202.00		1			0				

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1322	Period: Worksheet C From 01/01/2023 Part I

Title XVIII	· · · · · · · · · · · · · · · · · · ·					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	
Charges				Title	XVIII	Hosni tal		4 piii
INPATIENT ROUTINE SERVICE COST CENTERS					XVIII	Tiospi tui	0031	
NPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 7.00 8.00 9.00 10.00		Cost Center Description	I npati ent				Inpati ent	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 ADULTS & PEDI ATRI CS 7,558,859 82,634 82,634 82,634 82,634 30.00 ADULTS & PEDI ATRI CS 7,558,859 82,634			6.00	7 00	8 00	9 00		
30. 00		INPATIENT POLITIME SERVICE COST CENTERS	0.00	7.00	8.00	7.00	10.00	
43.00	30 00		7 558 859		7 558 85	9		30 00
ANCILLARY SERVICE COST CENTERS								
50.00 050000 05000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 05000000 0500000 0500000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 050000000 05000000 050000000 050000000 0500000000	43.00		02,034		02,00	T		1 43.00
52.00 05200 05200 0540	50 00		1 321 166	11 711 824	13 032 99	0 204174	0.000000	50 00
54.00 05400 RADIOLOGY-DIAGNOSTIC 1, 406, 935 19, 340, 198 20, 747, 133 0, 117764 0,000000 54.000 60.00 06000 LABORATORY 2, 137, 989 20, 801, 473 22, 939, 462 0, 136444 0,000000 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 53, 698 394, 341 448, 039 0, 291738 0,000000 62.00 65.00 66.00 06500 RESPIRATORY THERAPY 1, 024, 025 2, 871, 780 3, 895, 805 0, 342669 0, 000000 65.00 66.00 06600 PHYSI CAL THERAPY 11, 024, 025 2, 871, 780 3, 895, 805 0, 342669 0, 000000 67.00 68.00 06600 PHYSI CAL THERAPY 712, 197 852, 235 1, 564, 432 0, 250756 0, 000000 67.00 68.00 06800 SPEECH PATHOLOGY 241, 615 618, 826 860, 441 0, 326018 0, 000000 68.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0, 222604 0, 000000 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0, 222604 0, 000000 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0, 222604 0, 000000 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0, 222604 0, 000000 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0, 222604 0, 000000 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0, 222604 0, 000000 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0, 222604 0, 000000 73.00 08800 RURAL HEALTH CLINIC II I - PCFP 0, 1, 976, 301 1, 9								1
60. 00 06000 LABORATORY 2, 137, 989 20, 801, 473 22, 939, 462 0. 136444 0. 000000 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 53, 698 394, 341 448, 039 0. 291738 0. 000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 1, 212, 662 3, 875, 592 5, 088, 254 0. 278055 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 212, 662 2, 871, 780 3, 895, 805 0. 342669 0. 000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 1712, 197 852, 235 1, 564, 432 0. 250756 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 241, 615 618, 826 860, 441 0. 326018 0. 000000 68. 00 67. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1, 798, 445 4, 596, 869 6, 395, 314 0. 252259 0. 000000 72. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0. 222604 0. 000000 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0. 222604 0. 000000 73. 00 74. 00 07400 MEDI CAL EALTH CLINIC - TCC 0 5, 379, 947 5, 379, 947 88. 01 88. 00 08800 RURAL HEALTH CLINIC III - PCFP 0 1, 976, 301 1, 976, 301 88. 01 88. 01 08802 RURAL HEALTH CLINIC III - T3TH 0 31, 33, 401 88. 01 88. 02 08802 RURAL HEALTH CLINIC III - SPENCER 0 1, 773, 111								
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 53,698 394,341 448,039 0.291738 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 1,212,662 3,875,592 5,088,254 0.278055 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 1,024,025 2,871,780 3,895,805 0.342669 0.000000 65.00 67.00 06700 0CCUPATI ONAL THERAPY 712,197 852,235 1,564,432 0.250756 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 241,615 618,826 860,441 0.326018 0.000000 67.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1,798,445 4,596,869 6,395,314 0.252259 0.000000 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 2,988,224 20,054,193 23,042,417 0.252259 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2,988,224 20,054,193 23,042,417 0.222604 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2,988,224 20,054,193 23,042,417 0.222604 0.000000 73.00 88.01 08800 RURAL HEALTH CLINIC III - PCFP 0 1,976,301 1,976,301 88.01 88.02 08802 RURAL HEALTH CLINIC III - PSPENCER 0 1,773,111			1 1					
65. 00 06500 RESPIRATORY THERAPY 1, 212, 662 3, 875, 592 5, 088, 254 0. 278055 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 212, 662 3, 875, 592 3, 895, 805 0. 342669 0. 000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 712, 197 852, 235 1, 564, 432 0. 250756 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 241, 615 618, 826 860, 441 0. 326018 0. 000000 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 798, 445 4, 596, 869 6, 395, 314 0. 252259 0. 000000 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 2, 988, 224 20, 054, 193 23, 042, 417 0. 222604 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 988, 224 20, 054, 193 23, 042, 417 0. 222604 0. 000000 73. 00 88. 01 08800 RURAL HEALTH CLINIC TOC 0 5, 379, 947 5, 379, 947 88. 01 88. 02 08800 RURAL HEALTH CLINIC III - PCFP 0 1, 976, 301 1, 976, 301 88. 02 88. 03 08801 RURAL HEALTH CLINIC III - 13TH 0 3, 133, 401 3, 133, 401 88. 02 88. 03 08803 RURAL HEALTH CLINIC III - 13TH 0 3, 133, 401 3, 133, 401 88. 02 89. 00 09000 CLINIC 34, 422 1, 090, 746 1, 125, 168 0. 885528 0. 000000 90. 01 90. 01 09001 PAIN MANAGEMENT 0 0 0 0. 000000 0. 000000 90. 02 90. 02 09002 WOUND CARE 10, 414 1, 303, 111 1, 313, 525 0. 487238 0. 000000 90. 02 90. 03 09003 ORTHOPEDIC CLINIC 0 335, 341 342, 541 342, 541 0. 422954 0. 000000 90. 02 90. 04 09004 BEHAVI ORAL HEALTH 0 0 342, 541 342, 541 0. 422954 0. 000000 90. 02 90. 05 09500 AMBULANCE SERVICES 0 4, 717, 776 4, 717, 776 0. 380917 0. 000000 92. 00 90. 06 O9500 AMBULANCE SERVICES 0 4, 717, 776 4, 717, 776 0. 380917 0. 000000 92. 00 90. 01 O9500 AMBULANCE SERVICES 0 4, 717, 776 4, 717, 776 0. 380917 0. 000000 92. 00 90. 01 O9500 AMBULANCE SERVICES 0 4, 717, 776 4, 717, 776 0.								
66. 00 06600 PHYSI CAL THERAPY 1, 024, 025 2, 871, 780 3, 895, 805 0. 342669 0. 000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 712, 197 852, 235 1, 564, 432 0. 250756 0. 000000 67. 00 07. 00								
67. 00 06700 06700 06700 06700 06700 06700 06700 06700 06800			1 1					
68.00 06800 SPECH PATHOLOGY 241, 615 618, 826 860, 441 0. 326018 0. 000000 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 798, 445 4, 596, 869 6, 395, 314 0. 252259 0. 000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2, 988, 224 20, 054, 193 23, 042, 417 0. 222604 0. 000000 73.00 07300 DRUGS CHARGED TO PATI ENTS 2, 988, 224 20, 054, 193 23, 042, 417 0. 222604 0. 000000 73.00 OUTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC T - PCFP 0 1, 976, 301 1, 976, 301 88.01 88.01 08801 RURAL HEALTH CLINIC III - 13TH 0 3, 133, 401 3, 133, 401 88.02 88.02 08802 RURAL HEALTH CLINIC IV - SPENCER 0 1, 773, 111 1, 773, 111 1, 773, 111 90.00 09000 CLINIC 344, 422 1, 090, 746 1, 125, 168 0. 885528 0. 000000 90.00 90.01 09001 PAIN MANAGEMENT 0 0 0 0 0. 000000 0. 000000 90.00 90.02 09002 WOUND CARE 10, 414 1, 303, 111 1, 313, 525 0. 487238 0. 000000 90.00 90.04 09004 BEHAVI ORAL HEALTH 0 342, 541 342, 541 0. 422954 0. 000000 90.00 90.04 09004 BEHAVI ORAL HEALTH 0 342, 541 342, 541 0. 422954 0. 000000 90.00 90.04 09004 BEHAVI ORAL HEALTH 0 342, 541 342, 541 0. 422954 0. 000000 90.00 90.05 09500 OBSERVATI ON BEDS (NON-DISTINCT PART) 46, 833 1, 416, 993 1, 463, 826 1. 149839 0. 000000 95.00 91.00 09500 OBSERVATION BEDS (CENTERS 0 4, 717, 776 4, 717, 776 0. 380917 0. 000000 95.00 ODGO ODGO			1 1					
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1,798,445 4,596,869 6,395,314 0.252259 0.000000 71.00 72.00 72.00 72.00 73								1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 160, 965 160, 965 0.628118 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0.222604 0.000000 73.00 08001 RURAL HEALTH CLINIC - TCC 0 5, 379, 947 5, 379, 947 88.00 08800 RURAL HEALTH CLINIC II - PCFP 0 1, 976, 301 1, 976, 301 88.01 88.02 08802 RURAL HEALTH CLINIC III - 13TH 0 3, 133, 401 3, 133, 401 88.02 888.01 888.03 RURAL HEALTH CLINIC IV - SPENCER 0 1, 773, 111 1, 773, 111 0, 90.00 0, 9000 CLINIC 0 0 0 0, 0000000 0, 0000000 0, 0000000 0, 0000000 0, 00000000			1 1					71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 988, 224 20, 054, 193 23, 042, 417 0. 222604 0. 000000 73. 00			1					
Section Sect			2, 988, 224					
88. 00			<u> </u>			•		
88. 02 08802 RURAL HEALTH CLINIC III - 13TH	88.00	08800 RURAL HEALTH CLINIC - TCC	0	5, 379, 947	5, 379, 94	7		88. 00
88. 02 08802 RURAL HEALTH CLINIC III - 13TH	88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	1, 976, 301	1, 976, 30	1		88. 01
90. 00 09000 CLINIC 34, 422 1, 090, 746 1, 125, 168 0. 885528 0. 000000 90. 00 90. 01 90. 01 90. 02 90. 01 PAIN MANAGEMENT 0 0 0 0 0 0. 000000 90. 01 90. 02 90. 02 90. 02 90. 03 09003 ORTHOPEDIC CLINIC 0 335, 341 335, 341 0. 494359 0. 000000 90. 03 90. 04 09004 BEHAVI ORAL HEALTH 0 342, 541 342, 541 0. 422954 0. 000000 90. 04 91. 00 09100 EMERGENCY 521, 132 15, 705, 072 16, 226, 204 0. 292121 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 46, 833 1, 416, 993 1, 463, 826 1. 149839 0. 000000 92. 00 09500 AMBULANCE SERVI CES 0 4, 717, 776 4, 717, 776 0. 380917 0. 000000 95. 00 09500 AMBULANCE SERVI CES 0 4, 717, 776 4, 717, 776 0. 380917 0. 000000 95. 00 09500 AMBULANCE SERVI CES 0 4, 717, 776 4, 717, 776 0. 380917 0. 000000 95. 00 09500 AMBULANCE SERVI CES 0 4, 717, 776 4, 717, 776 0. 380917 0. 0000000 95. 00 09500 AMBULANCE SERVI CES 0 4, 717, 776 4, 717, 776 0. 380917 0. 0000000 95. 00 09500 AMBULANCE SERVI CES 0 4, 717, 776 4, 717, 776 0. 380917 0. 0000000 95. 00 09500	88. 02		0	3, 133, 401	3, 133, 40	1		88. 02
90. 01	88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	1, 773, 111	1, 773, 11	1		88. 03
90. 02	90.00	09000 CLI NI C	34, 422	1, 090, 746	1, 125, 16	0. 885528	0.000000	90.00
90. 03	90. 01		0	0		0. 000000	0. 000000	90. 01
90. 04 09004 BEHAVI ORAL HEALTH 0 342, 541 342, 541 0. 422954 0. 000000 90. 04 91. 00 09100 EMERGENCY 521, 132 15, 705, 072 16, 226, 204 0. 292121 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 46, 833 1, 416, 993 1, 463, 826 1. 149839 0. 000000 92. 00 OTHER REI MBURSABLE COST CENTERS 0 4, 717, 776 4, 717, 776 0. 380917 0. 000000 95. 00 OSSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 OSSERVATI ON BEDS (NON-DI STI NCT PART) 46, 833 1, 416, 993 1, 463, 826 1. 149839 0. 000000 92. 00 OTHER REI MBURSABLE COST CENTERS 0 4, 717, 776 4, 717, 776 0. 380917 0. 000000 95. 00 OSSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 OSSERVATI ON BEDS (NON-DI STI NCT PART) 13. 00 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 13. 00 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART) 144, 045, 210 OSSERVATI ON BEDS (NON-DI STI NCT PART)	90. 02		10, 414	1, 303, 111	1, 313, 52	5 0. 487238	0. 000000	90. 02
91. 00	90. 03	09003 ORTHOPEDIC CLINIC	0	335, 341	335, 34	0. 494359	0. 000000	90. 03
92. 00	90.04	09004 BEHAVI ORAL HEALTH	0	342, 541	342, 54	0. 422954	0.000000	90. 04
OTHER REIMBURSABLE COST CENTERS 95.00 95.00 AMBULANCE SERVI CES 0 4,717,776 4,717,776 0.380917 0.000000 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 21,467,798 122,577,412 144,045,210 200.00 201.00 Less Observation Beds 201.00	91. 00		521, 132	15, 705, 072			0.000000	91. 00
95. 00 09500 AMBULANCE SERVICES 0 4,717,776 4,717,776 0.380917 0.000000 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE Subtotal (see instructions) 21,467,798 122,577,412 144,045,210 200. 00 Less Observation Beds	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	46, 833	1, 416, 993	1, 463, 82	6 1. 149839	0. 000000	92. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 21,467,798 122,577,412 144,045,210 200.00 201.00 Less Observation Beds 201.00								
113.00	95.00		0	4, 717, 776	4, 717, 77	6 0. 380917	0.000000	95. 00
200.00 Subtotal (see instructions) 21,467,798 122,577,412 144,045,210 200.00 201.00 Less Observation Beds 200.00								
201.00 Less Observation Beds 201.00								
			21, 467, 798	122, 577, 412	144, 045, 21	O		
202. 00 Total (see instructions) 21, 467, 798 122, 577, 412 144, 045, 210 202. 00								
	202.00	Total (see instructions)	21, 467, 798	122, 577, 412	144, 045, 21	O		202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1322	From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/23/2024 4:14 pm		

			10 12/31/2023	5/23/2024 4: 14 pm	
		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.	
43. 00 04300 NURSERY				43.	00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000			50.	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.	00
60. 00 06000 LABORATORY	0. 000000			60.	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.	
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.	00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.	00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.	00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.	00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.	00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.	00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.	00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC - TCC				88.	00
88.01 08801 RURAL HEALTH CLINIC II - PCFP				88.	01
88.02 08802 RURAL HEALTH CLINIC III - 13TH				88.	02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER				88.	03
90. 00 09000 CLI NI C	0. 000000			90.	00
90. 01 09001 PAI N MANAGEMENT	0. 000000			90.	01
90. 02 09002 WOUND CARE	0. 000000			90.	02
90. 03 09003 ORTHOPEDI C CLI NI C	0. 000000			90.	03
90. 04 09004 BEHAVI ORAL HEALTH	0. 000000			90.	04
91. 00 09100 EMERGENCY	0. 000000			91.	00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.	00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.	00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE				113.	00
200.00 Subtotal (see instructions)				200.	00
201.00 Less Observation Beds				201.	00
202.00 Total (see instructions)				202.	00
•					

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1322	Peri od: Worksheet C
		From 01/01/2023 Part I
		To 12/21/2022 Doto/Time Dropored.

					To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
			Ti tl	e XIX	Hospi tal	PPS	•
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	9, 411, 872		9, 411, 87.	2 0	9, 411, 872	
43.00	04300 NURSERY	61, 647		61, 64	7 0	61, 647	43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	2, 660, 992		2, 660, 99		2, 660, 992	
52.00	05200 DELIVERY ROOM & LABOR ROOM	272, 146		272, 14		272, 146	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 443, 264		2, 443, 26		2, 443, 264	
60.00	06000 LABORATORY	3, 129, 957		3, 129, 95		3, 129, 957	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	130, 710		130, 71		130, 710	
65.00	06500 RESPI RATORY THERAPY	1, 414, 814	0	., ,		1, 414, 814	
66. 00	06600 PHYSI CAL THERAPY	1, 334, 973	0	1, 334, 97		1, 334, 973	
67. 00	06700 OCCUPATI ONAL THERAPY	392, 290	0	392, 29		392, 290	
68. 00	06800 SPEECH PATHOLOGY	280, 519	0	280, 51		280, 519	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 613, 275		1, 613, 27		1, 613, 275	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	101, 105		101, 10		101, 105	
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 129, 328		5, 129, 32	8 0	5, 129, 328	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC - TCC	4, 383, 389		4, 383, 38		4, 383, 389	
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	1, 328, 869		1, 328, 86		1, 328, 869	
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	3, 337, 692		3, 337, 69		3, 337, 692	
	08803 RURAL HEALTH CLINIC IV - SPENCER	1, 383, 891		1, 383, 89		1, 383, 891	
90.00	09000 CLI NI C	996, 368		996, 36	8 0	996, 368	
90. 01	09001 PAIN MANAGEMENT	0			0 0	0	90. 01
	09002 WOUND CARE	639, 999		639, 99		639, 999	
	09003 ORTHOPEDIC CLINIC	165, 779		165, 77		165, 779	
90. 04	09004 BEHAVI ORAL HEALTH	144, 879		144, 87		144, 879	
	09100 EMERGENCY	4, 740, 016		4, 740, 01	6 0	4, 740, 016	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 683, 164		1, 683, 16	4	1, 683, 164	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 797, 081		1, 797, 08	1 0	1, 797, 081	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
200.00		48, 978, 019	0	48, 978, 01	9 0	48, 978, 019	
201.00		1, 683, 164		1, 683, 16		1, 683, 164	
202.00	Total (see instructions)	47, 294, 855	0	47, 294, 85	5 0	47, 294, 855	202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: Worksheet C
		From 01/01/2023 Part I
		T- 10/01/0000 D-+-/T! D

					o 12/31/2023	Date/Time Pre 5/23/2024 4:1	
			Titl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
	[6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00	03000 ADULTS & PEDI ATRI CS	7, 558, 859		7, 558, 859			30. 00
43. 00	04300 NURSERY	82, 634		82, 634			43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	1, 321, 166	11, 711, 824			0. 000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	316, 548	124, 776			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 406, 935	19, 340, 198			0. 000000	
60.00	06000 LABORATORY	2, 137, 989	20, 801, 473			0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	53, 698	394, 341	448, 039	1	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	1, 212, 662	3, 875, 592		l l	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	1, 024, 025	2, 871, 780			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	712, 197	852, 235			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	241, 615	618, 826		1	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 798, 445	4, 596, 869			0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	160, 965		1	0. 000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 988, 224	20, 054, 193	23, 042, 417	0. 222604	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS				1		
88. 00	08800 RURAL HEALTH CLINIC - TCC	0	5, 379, 947			0. 000000	
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	1, 976, 301			0. 000000	
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0	3, 133, 401			0. 000000	
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	1, 773, 111			0. 000000	
90.00	09000 CLI NI C	34, 422	1, 090, 746			0. 000000	
90. 01	09001 PAI N MANAGEMENT	0	0	0	0.00000	0. 000000	
90. 02	09002 WOUND CARE	10, 414	1, 303, 111	1, 313, 525		0. 000000	
90. 03	09003 ORTHOPEDIC CLINIC	0	335, 341	335, 341		0. 000000	
90. 04	09004 BEHAVI ORAL HEALTH	0	342, 541			0. 000000	1
91. 00	09100 EMERGENCY	521, 132	15, 705, 072			0. 000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	46, 833	1, 416, 993	1, 463, 826	1. 149839	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	0	4, 717, 776	4, 717, 776	0. 380917	0. 000000	95. 00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						113. 00
200.00		21, 467, 798	122, 577, 412	144, 045, 210			200. 00
201.00	1 1						201. 00
202.00	Total (see instructions)	21, 467, 798	122, 577, 412	144, 045, 210			202. 00

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

				10 12/31/2023	5/23/2024 4:14 pm
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30.00
	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0. 204174			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 616658			52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 117764			54.00
	06000 LABORATORY	0. 136444			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 291738			62. 00
	06500 RESPI RATORY THERAPY	0. 278055			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 342669			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 250756			67. 00
68.00	06800 SPEECH PATHOLOGY	0. 326018			68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 252259			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 628118			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 222604			73. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC - TCC	0. 814764			88. 00
	08801 RURAL HEALTH CLINIC II - PCFP	0. 672402			88. 01
	08802 RURAL HEALTH CLINIC III - 13TH	1. 065198			88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0. 780488			88. 03
	09000 CLI NI C	0. 885528			90.00
	09001 PAIN MANAGEMENT	0. 000000			90. 01
	09002 WOUND CARE	0. 487238			90. 02
90. 03	09003 ORTHOPEDIC CLINIC	0. 494359			90. 03
90. 04	09004 BEHAVI ORAL HEALTH	0. 422954			90. 04
91.00	09100 EMERGENCY	0. 292121			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 149839			92. 00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0. 380917			95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 I NTEREST EXPENSE				113. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
CALCULATION OF OUTPATIENT SERVICE COST TO REDUCTIONS FOR MEDICALD ONLY	O CHARGE RATIOS NET OF	Provi der CCN: 15-1322	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part II Date/Time Prepared: 5/23/2024 4:14 pm		

				1	0 12/31/2023	5/23/2024 4:1	
			Ti tl	e XIX	Hospi tal	PPS	. p
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col. 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	2, 660, 992	551, 359		0	0	00.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	272, 146	131, 148	140, 998	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 443, 264	289, 883	2, 153, 381	0	0	54. 00
60.00	06000 LABORATORY	3, 129, 957	140, 232	2, 989, 725	0	0	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	130, 710	1, 188	129, 522	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	1, 414, 814	129, 381	1, 285, 433	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 334, 973	154, 350	1, 180, 623	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	392, 290	38, 967	353, 323	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	280, 519	21, 509	259, 010	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 613, 275	132, 330	1, 480, 945	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	101, 105	918	100, 187	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 129, 328	107, 192	5, 022, 136	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC	4, 383, 389	42, 211	4, 341, 178	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	1, 328, 869	12, 639	1, 316, 230	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	3, 337, 692	32, 167	3, 305, 525	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	1, 383, 891	13, 300	1, 370, 591	0	0	88. 03
90.00	09000 CLI NI C	996, 368	135, 059	861, 309	0	0	90.00
90. 01	09001 PAIN MANAGEMENT	0	0	0	0	0	90. 01
90. 02	09002 WOUND CARE	639, 999	92, 212	547, 787	0	0	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	165, 779	1, 593	164, 186	0	0	90. 03
90.04	09004 BEHAVI ORAL HEALTH	144, 879	1, 446	143, 433	0	0	90. 04
91.00	09100 EMERGENCY	4, 740, 016	412, 368	4, 327, 648	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 683, 164	204, 104	1, 479, 060	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 797, 081	17, 252	1, 779, 829	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	39, 504, 500	2, 662, 808	36, 841, 692	0	0	200. 00
201.00	Less Observation Beds	1, 683, 164	204, 104	1, 479, 060	0	0	201. 00
202.00	Total (line 200 minus line 201)	37, 821, 336	2, 458, 704	35, 362, 632	0	0	202. 00

Health Financial Systems	PERRY COUNTY HO	OSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-1322	From 01/01/2023	Worksheet C Part II Date/Time Prepared:

					10 12/31/2023	5/23/2024 4: 1	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	·	Capital and	(Worksheet C,	Cost to Charg	e		
		Operating Cost	Part I, column	Ratio (col.	5		
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	2, 660, 992	13, 032, 990	0. 20417	4		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	272, 146	441, 324	0. 61665	8		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 443, 264	20, 747, 133	0. 11776	4		54.00
60.00	06000 LABORATORY	3, 129, 957	22, 939, 462				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	130, 710	448, 039	0. 29173	8		62. 00
65.00	06500 RESPI RATORY THERAPY	1, 414, 814	5, 088, 254				65. 00
66.00	06600 PHYSI CAL THERAPY	1, 334, 973	3, 895, 805	0. 34266	9		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	392, 290	1, 564, 432	0. 25075	6		67. 00
68.00	06800 SPEECH PATHOLOGY	280, 519	860, 441	0. 32601	8		68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 613, 275	6, 395, 314	0. 25225	9		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	101, 105	160, 965	0. 62811	8		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 129, 328	23, 042, 417	0. 22260	14		73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC	4, 383, 389	5, 379, 947	0. 81476	4		88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	1, 328, 869	1, 976, 301	0. 67240	2		88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	3, 337, 692	3, 133, 401	1. 06519	8		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	1, 383, 891	1, 773, 111	0. 78048	8		88. 03
90.00	09000 CLI NI C	996, 368	1, 125, 168	0. 88552	8		90.00
90. 01	09001 PAIN MANAGEMENT	0	0	0.00000	0		90. 01
90. 02	09002 WOUND CARE	639, 999	1, 313, 525	0. 48723	8		90. 02
90. 03	09003 ORTHOPEDIC CLINIC	165, 779	335, 341	0. 49435	9		90. 03
90.04	09004 BEHAVI ORAL HEALTH	144, 879	342, 541	0. 42295	4		90. 04
91.00	09100 EMERGENCY	4, 740, 016	16, 226, 204	0. 29212	:1		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 683, 164	1, 463, 826	1. 14983	9		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 797, 081	4, 717, 776	0. 38091	7		95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	39, 504, 500	136, 403, 717				200. 00
201.00	Less Observation Beds	1, 683, 164	0				201. 00
202.00	Total (line 200 minus line 201)	37, 821, 336	136, 403, 717				202. 00

Health Financial Systems	PERRY COUNTY	' HOSPI	TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Pro	ovider CC	N: 15-1322	Peri od:	Worksheet D	
					From 01/01/2023	Part II	
					To 12/31/2023	Date/Time Pre	
						5/23/2024 4: 1	4 pm
			Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total	Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from V	Nkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I	I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8	8)	2)			

			10	12/31/2023	Date/IIme Pre 5/23/2024 4:1	
			xVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T		,			
50.00 05000 OPERATING ROOM	551, 359			374, 688	15, 851	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	131, 148			0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	289, 883			536, 914	7, 502	54.00
60. 00 06000 LABORATORY	140, 232			765, 333	4, 678	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 188			17, 576	47	62. 00
65. 00 06500 RESPI RATORY THERAPY	129, 381	5, 088, 254	0. 025427	414, 495	10, 539	65. 00
66. 00 06600 PHYSI CAL THERAPY	154, 350	3, 895, 805	0. 039620	253, 084	10, 027	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	38, 967	1, 564, 432	0. 024908	159, 074	3, 962	67. 00
68. 00 06800 SPEECH PATHOLOGY	21, 509	860, 441	0. 024998	56, 261	1, 406	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	132, 330	6, 395, 314	0. 020692	654, 627	13, 546	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	918	160, 965	0. 005703	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	107, 192	23, 042, 417	0. 004652	1, 092, 106	5, 080	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC	42, 211	5, 379, 947	0. 007846	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II - PCFP	12, 639	1, 976, 301	0. 006395	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III - 13TH	32, 167	3, 133, 401	0. 010266	0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	13, 300	1, 773, 111	0. 007501	0	0	88. 03
90. 00 09000 CLI NI C	135, 059	1, 125, 168	0. 120035	9, 975	1, 197	90.00
90. 01 09001 PAI N MANAGEMENT	0	0	0.000000	0	0	90. 01
90. 02 09002 WOUND CARE	92, 212	1, 313, 525	0. 070202	7, 608	534	90. 02
90. 03 09003 ORTHOPEDI C CLI NI C	1, 593	335, 341	0.004750	0	0	90. 03
90. 04 09004 BEHAVI ORAL HEALTH	1, 446	342, 541	0. 004221	o	0	90. 04
91. 00 09100 EMERGENCY	412, 368	16, 226, 204	0. 025414	22, 451	571	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	204, 104	1, 463, 826	0. 139432	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	2, 645, 556	131, 685, 941		4, 364, 192	74, 940	200. 00

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

From 01/01/2023 | Part IV To 12/31/2023 | Date/Ti THROUGH COSTS Date/Time Prepared: 5/23/2024 4:14 pm Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Cost Post-Stepdown Adjustments Adjustments 1.00 ЗА 3.00 2A 2.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 06000 LABORATORY 0 0 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0 62.00 0 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 Λ 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 o 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 0 88.00 88. 01 08801 RURAL HEALTH CLINIC II - PCFP 0 0 0 0 0 0 0 0 0 0 0 88. 01 0 0 0 0 0 0 08802 RURAL HEALTH CLINIC III - 13TH 0 88.02 88 02 0 0 0 08803 RURAL HEALTH CLINIC IV - SPENCER 88. 03 0 88.03 90.00 09000 CLI NI C 0 0 90.00 09001 PAIN MANAGEMENT 0 90. 01 90.01 0 09002 WOUND CARE 0 90. 02 90 02 Ω Ω 09003 ORTHOPEDIC CLINIC 0 90.03 0 90.03 09004 BEHAVI ORAL HEALTH 0 0 90.04 90.04 0 0 o 91.00 09100 EMERGENCY Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00

0

0

0

0

0 200.00

200.00

Total (lines 50 through 199)

	Financial Systems	PERRY COUNT				eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Peri od: From 01/01/2023	Worksheet D Part IV	
THRUUG	H COSTS					Date/Time Pre	pared:
			-	20011		5/23/2024 4: 1	4 pm
		1 11 011		XVIII	Hospi tal	Cost	
	Cost Center Description	All Other Medical	Total Cost	Total		Ratio of Cost	
			(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5. 00	6. 00	7. 00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00	05000 OPERATING ROOM	0	0		0 13, 032, 990	0.000000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	_		0 441, 324		1
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 20, 747, 133	•	
	06000 LABORATORY	0	0		0 22, 939, 462	•	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 448, 039		
65. 00	06500 RESPI RATORY THERAPY	0	0		0 5, 088, 254	I	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 3, 895, 805		•
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 1, 564, 432		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 860, 441	•	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 6, 395, 314	•	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 160, 965	•	1
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 23, 042, 417	•	1
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>		•			
88.00	08800 RURAL HEALTH CLINIC - TCC	0	0		0 5, 379, 947	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0	0		0 1, 976, 301	0.000000	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0	0		0 3, 133, 401	0.000000	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0	0		0 1, 773, 111	0.000000	88. 03
90.00	09000 CLI NI C	0	0		0 1, 125, 168	0.000000	90.00
90. 01	09001 PAIN MANAGEMENT	0	0		0	0.000000	90. 01
90. 02	09002 WOUND CARE	0	0		0 1, 313, 525	0.000000	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	0	0		0 335, 341	0.000000	90. 03
90.04	09004 BEHAVI ORAL HEALTH	0	0		0 342, 541	0.000000	90. 04
91.00	09100 EMERGENCY	0	0		0 16, 226, 204	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 463, 826	0.000000	92.00

0

1, 463, 826

131, 685, 941

0.000000

92.00 95.00

200. 00

111 41-	Figure 1 Contains	DEDDY COUNTY	HOCDI TAI		1-11-	£ [CMC :	2552 10
APPORT	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	PERRY COUNTY EVICE OTHER PASS	Provi der CC		Peri od: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 5/23/2024 4:1	pared:
				XVIII	Hospi tal	Cost	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col.		Outpatient Program Pass-Through Costs (col. 9	
		7)	10. 00	x col. 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 000000	374, 688 0		0 0	0	50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0.000000	536, 914		0	0	54.00
60.00	06000 LABORATORY	0. 000000	765, 333			0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	17, 576			0	62.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	414, 495		0 0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	253, 084		0 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	159, 074		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	56, 261		0 0	0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	654, 627		0 0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 092, 106		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		,				
88. 00	08800 RURAL HEALTH CLINIC - TCC	0. 000000	0		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0. 000000	0		0 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0. 000000	0		0 0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0. 000000	0		0 0	0	88. 03
90.00	09000 CLI NI C	0. 000000	9, 975		0 0	0	90. 00
90. 01	09001 PAIN MANAGEMENT	0. 000000	0		0 0	0	90. 01
90. 02	09002 WOUND CARE	0. 000000	7, 608		0 0	0	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	0. 000000	0		0 0	0	90. 03
90.04	09004 BEHAVI ORAL HEALTH	0. 000000	0		0 0	0	90. 04
91. 00	09100 EMERGENCY	0. 000000	22, 451		0 0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92. 00

4, 364, 192

0

0

95. 00 0 200. 00

95. 00 | 09500 | AMBULANCE SERVICES 200. 00 | Total (Lines 50 through 199)

91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS

| Period: | Worksheet D | From 01/01/2023 | Part V | To 12/31/2023 | Date/Time Prepared: | 5/23/2024 4:14 pm
 Heal th Financial
 Systems
 PERRY COUNT

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-1322

						5/23/2024 4: 1	4 pm
			Title	: XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 204174	0	2, 531, 072	2 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 616658	0	(0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 117764	0	4, 663, 508	3 0	0	54.00
60.00	06000 LABORATORY	0. 136444	0	2, 651, 45	5 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 291738	0	221, 584	4 O	0	62.00
65.00	06500 RESPIRATORY THERAPY	0. 278055	0	844, 262	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 342669	0	791, 098	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 250756	0	107, 676	6 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 326018	0	38, 840	0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 252259	0	981, 51;	3	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 628118	0	56, 382	2 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 222604	0	7, 325, 922	3, 883	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
88. 00	08800 RURAL HEALTH CLINIC - TCC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP						88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH						88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER						88. 03
90.00	09000 CLI NI C	0. 885528	0	403, 78°	1 0	0	90.00
90. 01	09001 PALN MANAGEMENT	0. 000000	0		0	0	90. 01
90. 02	09002 WOUND CARE	0. 487238	0	743, 373	0	0	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	0. 494359	0		0	0	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	0. 422954	0	2, 47 ⁻	0	0	90. 04
91. 00	09100 EMERGENCY	0. 292121	0			0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 149839	0			0	•
	OTHER REIMBURSABLE COST CENTERS		-		-1		
95. 00	09500 AMBULANCE SERVI CES	0. 380917					95. 00
200.00			0	24, 541, 39	4, 308	0	200. 00
201.00			· ·	= 1, 2 1 1, 0 /	0 .,000		201. 00
	Only Charges]			
202.00			0	24, 541, 394	4, 308	0	202. 00
	1 3 (1	_		1	•	

Health Financial Systems			PERRY COUNTY H	OSPI TAL	In Lieu	of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SE	ERVICES AND VA	ACCINE COST	Provider CCN	Peri od: From 01/01/2023	Worksheet D Part V
					To 12/31/2023	Date/Time Prepared

					To 12/31/2023	Date/Time Pro	
			Title	: XVIII	Hospi tal	Cost	1 1 p
		Cos					
	Cost Center Description	Cost	Cost				
	· · · · · · · · · · · · · · · · · · ·	Rei mbursed	Rei mbursed				
		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 OPERATI NG ROOM	516, 779	0				50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	549, 193	0				54.00
60.00	06000 LABORATORY	361, 775	0				60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	64, 644	0				62. 00
65.00	06500 RESPI RATORY THERAPY	234, 751	0				65. 00
66.00	06600 PHYSI CAL THERAPY	271, 085	0				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	27, 000	0				67. 00
68.00	06800 SPEECH PATHOLOGY	12, 663	0				68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	247, 595	0				71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	35, 415	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 630, 780	864				73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP						88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH						88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER						88. 03
90.00	09000 CLI NI C	357, 559	0				90.00
90. 01	09001 PAIN MANAGEMENT	0	0				90. 01
90. 02	09002 WOUND CARE	362, 200	0				90. 02
90. 03	09003 ORTHOPEDIC CLINIC	0	0				90. 03
90.04	09004 BEHAVI ORAL HEALTH	1, 045	0				90. 04
91.00	09100 EMERGENCY	842, 977	124				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	336, 610	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0			<u> </u>		95. 00
200.00	Subtotal (see instructions)	5, 852, 071	988				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	5, 852, 071	988				202. 00

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023		
-		Ti +1	e XIX	Hospi tal	5/23/2024 4: 1 PPS	4 piii
0 1 0 1 0 1 1	0 111					
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 141, 306	273, 716	867, 59	0 2, 984	290. 75	30.00
43. 00 NURSERY	29, 708		29, 70	8 76	390. 89	43.00
200.00 Total (lines 30 through 199)	1, 171, 014		897, 29	8 3, 060		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	•		•			
30. 00 ADULTS & PEDI ATRI CS	9	2, 617				30. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	9	2, 617				200. 00

Health Financial Systems		PERRY COUNTY H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT A	ANCILLARY SERVICE CAPITAL	COSTS	Provider CCN: 15-1322	Peri od: From 01/01/2023	Worksheet D Part II

APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/23/2024 4:1	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpatient	Capital Costs	
		Related Cost		to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	_					
50.00	05000 OPERATING ROOM	551, 359		1			
52.00	05200 DELIVERY ROOM & LABOR ROOM	131, 148	· ·				
54.00	05400 RADI OLOGY-DI AGNOSTI C	289, 883	20, 747, 133	0. 01397	2 111, 884	1, 563	54.00
60.00	06000 LABORATORY	140, 232	22, 939, 462	0.00611	3 149, 980	917	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 188	448, 039	0. 00265	2 8, 140	22	62. 00
65.00	06500 RESPI RATORY THERAPY	129, 381	5, 088, 254	0. 02542	7 42, 348	1, 077	65. 00
66.00	06600 PHYSI CAL THERAPY	154, 350	3, 895, 805	0. 03962	0 11, 030	437	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	38, 967	1, 564, 432	0. 02490	7, 586	189	67. 00
68.00	06800 SPEECH PATHOLOGY	21, 509	860, 441	0. 02499	8 1, 519	38	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	132, 330	6, 395, 314	0. 02069	2 162, 253	3, 357	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	918	160, 965	0.00570	3 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	107, 192	23, 042, 417	0.00465	2 190, 612	887	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC	42, 211	5, 379, 947	0.00784	6 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	12, 639	1, 976, 301	0.00639	5 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	32, 167	3, 133, 401	0. 01026	6 0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	13, 300	1, 773, 111	0.00750	1 0	0	88. 03
90.00	09000 CLI NI C	135, 059	1, 125, 168	0. 12003	5 8, 966	1, 076	90.00
90. 01	09001 PALN MANAGEMENT	0	0	0.00000	o o	0	90. 01
90. 02	09002 WOUND CARE	92, 212	1, 313, 525	0. 07020	2 0	0	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	1, 593	335, 341	0.00475	o o	ĺ	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	1, 446	342, 541	0.00422	1 0	0	90. 04
91.00	09100 EMERGENCY	412, 368	16, 226, 204	0. 02541	4 90, 907	2, 310	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	204, 104			2 11, 247	1, 568	
	OTHER REIMBURSABLE COST CENTERS			•			1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	2, 645, 556	131, 685, 941		1, 206, 507	59, 878	200. 00

Health Financial Systems	PERRY COUNTY			In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		1
30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0 0 0	0 0 0		0 0 0 0	0 0	00.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0 0 0	2, 98 7 3, 06	6 0.00	0	00.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0					30. 00 43. 00 200. 00

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

From 01/01/2023 | Part IV To 12/31/2023 | Date/Time Prepared: THROUGH COSTS 5/23/2024 4:14 pm Title XIX Hospi tal PPS Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Program Post-Stepdown Program Post-Stepdown Cost Adj ustments Adjustments 1.00 ЗА 3.00 2A 2.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 06000 LABORATORY 0 0 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 0 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - TCC 0 0 0 0 0 0 0 0 0 0 0 0 0 88.00 88. 01 08801 RURAL HEALTH CLINIC II - PCFP 0 0 0 88. 01 0 0 0 0 0 08802 RURAL HEALTH CLINIC III - 13TH 0 88. 02 0 88.02 0 08803 RURAL HEALTH CLINIC IV - SPENCER 88.03 0 0 88.03 90.00 09000 CLI NI C 0 0 90.00 09001 PAIN MANAGEMENT 0 90. 01 90.01 0 09002 WOUND CARE 0 90. 02 90 02 Ω Ω 09003 ORTHOPEDIC CLINIC 0 90.03 0 0 90.03 09004 BEHAVI ORAL HEALTH 0 0 90.04 90.04 0 09100 EMERGENCY 0 o 91.00 Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 0 Total (lines 50 through 199) 0 0 0 200.00 200.00

	Financial Systems	PERRY COUNTY				eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/2023 Fo 12/31/2023		nared:
					10 12/31/2023	5/23/2024 4: 1	
			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. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCI LLARY SERVI CE COST CENTERS			1			
50. 00	05000 OPERATING ROOM	0	0		13, 032, 990		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 441, 324		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		20, 747, 133		54. 00
60.00	06000 LABORATORY	0	0	1	22, 939, 462		60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1	448, 039		62. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	1	5, 088, 254		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	1	3, 895, 805		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	1, 564, 432		
68. 00		0	0	1	860, 441		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	6, 395, 314		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	1	160, 965		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	23, 042, 417	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS				5 070 047		
	08800 RURAL HEALTH CLINIC - TCC	0	0	1	5, 379, 947		
	08801 RURAL HEALTH CLINIC II - PCFP	0	0	1	1, 976, 301		
	08802 RURAL HEALTH CLINIC III - 13TH	0	0	1	3, 133, 401		
	08803 RURAL HEALTH CLINIC IV - SPENCER	0	0	1	1, 773, 111		
	09000 CLI NI C	0	0	1	1, 125, 168		
	09001 PAIN MANAGEMENT	0	0	1	0	0.000000	
	09002 WOUND CARE	0	0	1	1, 313, 525		
	09003 ORTHOPEDIC CLINIC	0	0	1	335, 341	0.000000	

0

0

342, 541 16, 226, 204

1, 463, 826

131, 685, 941

90. 04 91. 00

92.00 95.00

200. 00

0. 000000 0. 000000

0.000000

200.00

90. 03 09003 0RTHOPEDIC CLINIC
90. 04 09004 BEHAVI ORAL HEALTH
91. 00 09100 EMERGENCY
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)
OTHER REI MBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVI CES

Total (lines 50 through 199)

Heal th	Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	Provider CO		Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through		Outpatient Program Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	10.00	x col . 10)	12.00	x col . 12)	
	ANCILLARY SERVICE COST CENTERS	9. 00	10.00	11. 00	12. 00	13.00	
50. 00	05000 OPERATING ROOM	0. 000000	295, 893		0 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	114, 142		0 0	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	111, 884		0 0	0	54.00
60.00	06000 LABORATORY	0. 000000	149, 980		0 0	o o	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	8, 140		0 0	l ő	62.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	42, 348		0 0	Ō	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	11, 030		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	7, 586		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	1, 519		0 0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	162, 253		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	190, 612		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC	0. 000000	0		0	0	
88. 01	08801 RURAL HEALTH CLINIC II - PCFP	0. 000000	0		0	0	
88. 02	08802 RURAL HEALTH CLINIC III - 13TH	0. 000000	0		0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER	0. 000000	0		0 0	0	88. 03
90. 00	09000 CLI NI C	0. 000000	8, 966		0 0	0	90. 00
90. 01	09001 PAIN MANAGEMENT	0. 000000	0		0 0	0	90. 01
90. 02	09002 WOUND CARE	0. 000000	0		0	0	90. 02
90. 03	09003 ORTHOPEDI C CLI NI C	0. 000000	0		0 0	0	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	0.000000	0		0 0	0	90. 04
91.00	09100 EMERGENCY	0.000000	90, 907		0 0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	11, 247		0 0	0	92. 00

0

0

1, 206, 507

95. 00 0 200. 00

95. 00 | 09500 | AMBULANCE SERVICES 200. 00 | Total (Lines 50 through 199)

91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS

Provider CCN: 15-1322

				'	0 12/31/2023	5/23/2024 4: 1	
			Ti tl	e XIX	Hospi tal	PPS	
	·			Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	0. 204174	l .	1,001,001		0	00.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 616658		1,		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 117764	l .	2, 257, 366		0	
60.00	06000 LABORATORY	0. 136444		2, 379, 463		0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 291738	l .	17, 126		0	
65.00	06500 RESPI RATORY THERAPY	0. 278055		395, 635		0	00.00
66. 00	06600 PHYSI CAL THERAPY	0. 342669		215, 907	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 250756		114, 390		0	
68. 00	06800 SPEECH PATHOLOGY	0. 326018		76, 910	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 252259	C	471, 426	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 628118	C) (0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 222604	C	3, 061, 459	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP						88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH						88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER						88. 03
90.00	09000 CLI NI C	0. 885528	C	128, 114	0	0	90.00
90. 01	09001 PAIN MANAGEMENT	0. 000000	C) (0	0	90. 01
90. 02	09002 WOUND CARE	0. 487238	C) (0	0	90. 02
90. 03	09003 ORTHOPEDIC CLINIC	0. 494359	C) (0	0	90. 03
90. 04	09004 BEHAVI ORAL HEALTH	0. 422954	C) (0	0	90. 04
91.00	09100 EMERGENCY	0. 292121	C	2, 511, 893	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 149839	C	107, 565	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0. 380917	C)			95. 00
200.00	Subtotal (see instructions)		C	13, 096, 829	0	0	200. 00
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		C	13, 096, 829	0	0	202. 00

Hea	alth Financial Systems				PERRY	COUNTY H	OSPI TAL				In Lieu	u of Form CMS-2552-10
AP	PORTIONMENT OF MEDICAL,	OTHER HEALTH	SERVI CES	AND V	ACCI NE	COST	Provi der	CCN:	15-1322	From	01/01/2023	Worksheet D Part V Date/Time Prepared:

					To 12/31/2023	Date/Time Pre 5/23/2024 4:	
			Titl	e XIX	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATI NG ROOM	266, 306	0)			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	34, 081	0)			52.00
	05400 RADI OLOGY-DI AGNOSTI C	265, 836	0)			54.00
60.00	06000 LABORATORY	324, 663	0				60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4, 996	0				62. 00
65.00	06500 RESPI RATORY THERAPY	110, 008	0				65. 00
66.00	06600 PHYSI CAL THERAPY	73, 985	0)			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	28, 684	0)			67. 00
68.00	06800 SPEECH PATHOLOGY	25, 074	0				68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	118, 921	0)			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0)			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	681, 493	0)			73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - TCC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP						88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH						88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER						88. 03
90.00	09000 CLI NI C	113, 449	0				90.00
90. 01	09001 PAIN MANAGEMENT	o	0				90. 01
90. 02	09002 WOUND CARE	o	0				90. 02
90. 03	09003 ORTHOPEDIC CLINIC	o	0				90. 03
90. 04	09004 BEHAVI ORAL HEALTH	l ol	0)			90. 04
91.00	09100 EMERGENCY	733, 777	0				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	123, 682	0				92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0					95. 00
200.00		2, 904, 955	0)			200. 00
201. 00		0					201. 00
	Only Charges						
202.00		2, 904, 955	0)			202. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lie	eu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1322	Peri od: From 01/01/2023	Worksheet D-1		
		To 12/31/2023	Date/Time Pre 5/23/2024 4:1		
	Title XVIII	Hospi tal	Cost		
Cost Center Description					

		Title XVIII	Hospi tal	Cost	4 piii
	Cost Center Description	,			
	[1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	excluding newborn)		4, 409	1. 00
2.00	Inpatient days (including private room days, excluding swing-k			2, 984	2.00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,		3. 00
	not complete this line.	, , , , , , , , , , , , , , , , , , ,			
4.00	Semi-private room days (excluding swing-bed and observation be			2, 282	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	om days) through December	31 of the cost	881	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) after becember 3	or or the cost	U	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	544	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	. +b - D (l		1 042	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	Swing-bed and	1, 043	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private ro	oom davs) through	n 881	10. 00
	December 31 of the cost reporting period (see instructions)	3 ()			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	room davs) afte	er 0	13. 00
	December 31 of the cost reporting period (if calendar year, er				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	lays)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost		17. 00
	reporting period	g			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost reportin	ng	18. 00
40.00	peri od			0// 00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services period	s through December 31 of	the cost reporti	ng 266. 32	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost reporting	266. 32	20. 00
	peri od		·		
21. 00	Total general inpatient routine service cost (see instructions			9, 411, 872	1
22. 00	Swing-bed cost applicable to SNF type services through December 1 line 17)	er 31 of the cost reporti	ng period (line	5 0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	x 0	23. 00
	line 18)		, p		
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line 7	x 144, 878	24. 00
25 00	line 19)	of the cost reporting	nominal (lime O)	0	25. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	of the cost reporting	period (iine 8 x	i U	25.00
26. 00				2, 257, 225	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 154, 647	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	irges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	20)		0.00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir	, ,	i ons)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	•
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	0 27 7, 154, 647	36. 00 37. 00
37.00	minus line 36)	ina private room cost arr	recentral (LINE	21 1, 104, 047	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	•		2, 397. 67	1
39.00	Program general inpatient routine service cost (line 9 x line	•		2, 500, 770	1
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 2, 500, 770	
	1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	,	ı	=, 555, .76	,

	Financial Systems	PERRY COUNT				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-1322	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	
						5/23/2024 4:1	
	Cost Contor Description	Total	Ti tl Total	Average Pe	Hospital Program Days	Cost	
	Cost Center Description	Inpatient Cost				Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	0 3.00	4. 00 00 0	5. 00	42.00
12.00	Intensive Care Type Inpatient Hospital Units			5,	00, 0] .2.00
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	B, line 200)			936, 832	48. 00
48. 01	Program inpatient cellular therapy acquisition				, column 1)	0	
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48.0	01)(see instru	uctions)		3, 437, 602	49. 00
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	om Wkst. D, su	m of Parts I and	0	50.00
F1 00	III)	-+:	(4	6 WI+ D			F1 00
51. 00	Pass through costs applicable to Program inpa	atrent ancillar	y Services (1	IIOM WKST. D,	Sum OF PARTS II 8	ind 0	51.00
52. 00	Total Program excludable cost (sum of lines!					0	
53. 00	Total Program inpatient operating cost excluded aducation costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	elated, non-ph	nysician anest	hetist, and medio	al 0	53. 00
54.00	Program di scharges					0	54. 00
55. 00	Target amount per discharge						55. 00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor o	ise only)					55. 01 55. 02
56. 00	Target amount (line 54 x sum of lines 55, 55.					0.00	
57.00	Difference between adjusted inpatient operati	ng cost and ta	rget amount ((line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, o	or lino EE from	the cost rea	aarting nariad	anding 1004	0 00	58. 00 59. 00
59.00	updated and compounded by the market basket)	or time 55 from	i the cost rep	orting period	ending 1996,	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year	cost report,	updated by the	0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61. 00
	are less than expected costs (lines 54 x 60), zero. (see instructions)	or 1 % of the	e target amour	nt (line 56),	otherwise enter		
62. 00	Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ıcti ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mher 31 of th	ne cost report	ing period (See	2, 112, 347	64 00
0 11 00	instructions)(title XVIII only)	to timough book		.o 0001 .opo. t	9 po ou (000		
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only); for CAH	l, 2, 112, 347	66.00
	see instructions						
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 ot	f the cost rep	orting period (li	ne 0	68. 00
69. 00	13 x line 20)	routine costs (line 67 : lie	ne 68)		_	69. 00
J 7. UU	Total title V or XIX swing-bed NF inpatient I PART III – SKILLED NURSING FACILITY, OTHER NU					0	., 07.00
70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	ıtine service	cost (line 37)		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ine 70 ÷ line	e 2)			71.00
73. 00	Medically necessary private room cost applica		n (line 14 x l	ine 35)			73. 00
74.00	Total Program general inpatient routine servi	ce costs (line	e 72 + line 73	3)			74. 00
75. 00	Capital-related cost allocated to inpatient (line 45)	routine service	costs (from	Worksheet B,	Part II, column 2	26,	75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77.00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der reco	rds)			78. 00 79. 00
80.00	Total Program routine service costs for compa			*.	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi				•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (:						82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins		13)				84. 00
85.00	Utilization review - physician compensation	(see instructio					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions)					702	87. 00
88. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷				2, 397. 67	88. 00
89.00	Observation bed cost (line 87 x line 88) (see					1, 683, 164	· vu nn

Health Financial Systems	PERRY COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023	5	
				To 12/31/2023	Date/Time Prep 5/23/2024 4:14	
		Title	XVIII	Hospi tal	Cost	1 piii
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 141, 306	9, 411, 872	0. 12126	2 1, 683, 164	204, 104	90.00
91.00 Nursing Program cost	0	9, 411, 872	0.00000	0 1, 683, 164	0	91.00
92.00 Allied health cost	0	9, 411, 872	0.00000	0 1, 683, 164	0	92.00
93.00 All other Medical Education	0	9, 411, 872	0.00000	0 1, 683, 164	0	93. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1322	Period: From 01/01/2023	Worksheet D-1		
		To 12/31/2023	Date/Time Pre 5/23/2024 4:1	pared: 4 pm	
	Title XIX	Hospi tal	PPS		
Cost Center Description					
			1. 00		
PART I - ALL PROVIDER COMPONENTS					

	If the XIX Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 409	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	2, 984 do 0	2. 00 3. 00
3.00	Inot complete this line.	uo o	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2, 282	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	881	5. 00
	reporting period		, ,,
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	544	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	9	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	9	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through	0	10.00
	December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period	_	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after	er 0	13. 00
14. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	76	
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting	na	18. 00
10.00	period	'9	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reportion	ng 266. 32	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting	266. 32	20. 00
21. 00	period Total general inpatient routine service cost (see instructions)	9, 411, 872	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 line 18)	x 0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7	′ x 144, 878	24. 00
2 00	line 19)	χ, σ, σ	2 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	2, 257, 225	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7, 154, 647	27. 00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	0	00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	27 7, 154, 647	37. 00
	minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 397. 67	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	21, 579	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 21, 579	40.00
4 I. UU	Total Program general inpatient routine service cost (line 39 + line 40)	∠1, 5/9	i 4 i. UU

	Financial Systems ATION OF INPATIENT OPERATING COST	PERRY COUNTY		CCN: 15-1322	Peri od		eu of Form CN Worksheet D	
00				3011 13 1022	From C	 01/01/2023 12/31/2023	 Date/Time F	Prepared
			Ti	tle XIX	Но	spi tal	5/23/2024 ⁴ PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Poys Diem (col. col. 2)	er Prog	gram Days	Program Cos (col. 3 x co 4)	
		1.00	2. 00	3.00		4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	61, 647	-	76 811	. 14	0	1	0 42.0
43. 00	INTENSIVE CARE UNIT							43.0
44. 00	CORONARY CARE UNIT							44. 0
45. 00 46. 00	BURN INTENSIVE CARE UNIT							45. 0
47.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							46. C
	Cost Center Description							
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)				1. 00 315, 5	557 48.0
48. 01	Program inpatient cellular therapy acquisiti			t III, line 1	O, colum	ın 1)	313, 3	0 48.0
49. 00	Total Program inpatient costs (sum of lines						337, 1	136 49.0
EO 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	corvi coc (fr	om Wkst D s	um of Do	rts L and	2.4	517 50. C
50. 00	[Flass through costs appricable to Program Trip	atrent routine	services (iii	JIII WKSt. D, S	ulli 01 Pa	its i allu	2, 0	517 50.0
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (from Wkst. D,	sum of	Parts II a	and 59, 8	378 51. C
52. 00	IV) Total Program excludable cost (sum of lines	50 and 51)					62, 4	495 52. C
53. 00	Total Program inpatient operating cost exclu		lated, non-p	hysician anes	thetist,	and medio		
	education costs (line 49 minus line 52)		·					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges							0 54.0
55. 00	Target amount per discharge						0.	00 55.0
55. 01	Permanent adjustment amount per discharge						1	00 55.0
55. 02 56. 00	1 3 1					0.	00 55. C	
57. 00						0 57.0		
58.00	Bonus payment (see instructions)	9	9			·		0 58.0
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	the cost re	porting perio	d endi ng	1996,	0.	00 59.0
60. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year	cost report,	updated	l by the	0.	00 60.0
	market basket)							
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les						3)	0 61.0
	are less than expected costs (lines 54 x 60)		,	•	0	•		
	zero. (see instructions)							0 (0 (
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)					0 62.0
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of t	he cost repor	ting per	iod (See		0 64.0
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporti	na perio	d (See		0 65.0
	instructions)(title XVIII only)			·	0 .	•		
66. 00	Total Medicare swing-bed SNF inpatient routi see instructions	ne costs (line	64 plus line	65)(title XV	'III only); for CAL	₩,	0 66.0
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost	reporti n	ig peri od		0 67.0
	(line 12 x line 19)			6.11				0 (0 (
68. 00	Title V or XIX swing-bed NF inpatient routin 13 x line 20)	e costs after L	ecember 31 o	r the cost re	porting	perioa (ii	i ne	0 68.0
69. 00	Total title V or XIX swing-bed NF inpatient							0 69.0
70.00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil				7)			-
70. 00 71. 00	Adjusted general inpatient routine service c	•			1)			70. C
72.00	Program routine service cost (line 9 x line	71)						72.0
73.00	Medically necessary private room cost applic Total Program general inpatient routine serv							73. 0
74. 00 75. 00	Capital -related cost allocated to inpatient				Part II	. column :	26.	74. C
	line 45)		,			,		
76. 00 77. 00	Program capital related costs (line 75 ÷ li							76. C
78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu							78. 0
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p						79. 0
80. 00 81. 00	Total Program routine service costs for comp		ost limitati	on (line 78 m	inus lin	e 79)		80. C
82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)					82.0
83.00	Reasonable inpatient routine service costs (see instruction						83. 0
84.00	Program inpatient ancillary services (see in		une)					84.0
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum							85. C
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST						
	Total observation bed days (see instructions)					1 7	702 87. C
87. 00 88. 00	Adjusted general inpatient routine cost per		line 2)				2, 397.	67 88.0

Health Financial Systems	PERRY COUNTY	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 Fo 12/31/2023		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 141, 306	9, 411, 872	0. 12126	1, 683, 164	204, 104	90.00
91.00 Nursing Program cost	0	9, 411, 872	0.00000	1, 683, 164	0	91.00
92.00 Allied health cost	0	9, 411, 872	0.00000	1, 683, 164	0	92.00
93.00 All other Medical Education	0	9, 411, 872	0. 000000	1, 683, 164	0	93. 00

Health Financial Systems	PERRY COUNTY HOSPITAL		In Li€	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2023 To 12/31/2023		nared:
			10 12/31/2023	5/23/2024 4: 1	4 pm
	Title		Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		4.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			1, 992, 900		30.00
43. 00 04300 NURSERY			1, 772, 700		43. 00
ANCILLARY SERVICE COST CENTERS					45.00
50. 00 05000 OPERATI NG ROOM		0. 20417	4 374, 688	76, 502	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 61665	· ·		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11776		63, 229	54. 00
60. 00 06000 LABORATORY		0. 13644	· ·		1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 29173	8 17, 576	5, 128	62.00
65. 00 06500 RESPIRATORY THERAPY		0. 27805	5 414, 495	115, 252	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 34266	9 253, 084	86, 724	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 25075	6 159, 074	39, 889	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 32601	8 56, 261	18, 342	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 25225	9 654, 627	165, 136	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 62811			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 22260	1, 092, 106	243, 107	73. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC - TCC		0. 00000		0	88. 00
88.01 08801 RURAL HEALTH CLINIC II - PCFP		0. 00000		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III - 13TH		0.00000		0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER		0.00000		0	88. 03
90. 00 09000 CLI NI C		0. 88552			
90. 01 09001 PAIN MANAGEMENT		0.00000		0	90. 01
90. 02 09002 WOUND CARE		0. 48723	· ·		90. 02
90. 03 09003 ORTHOPEDIC CLINIC		0. 49435		0	90. 03
90. 04 09004 BEHAVI ORAL HEALTH 91. 00 09100 EMERGENCY		0. 42295 0. 29212		0 6, 558	90. 04 91. 00
91. 00 U9100 EMERGENCY		0. 29212		6, 558	91.00

4, 364, 192

4, 364, 192

936, 832 200. 00 201. 00 202. 00

92.00 0

95.00

1. 149839

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

Net charges (line 200 minus line 201)

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

200. 00 201. 00

Health Financial Systems	PERRY COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CO		Peri od:	Worksheet D-3	
			From 01/01/2023		
	Component	CCN: 15-Z322	To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
	Title	XVIII	Swing Beds - SNF		4 рііі
Cost Center Description	11 (10	Ratio of Cos		Inpati ent	
000 00 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			3	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 20417		441	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 61665		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11776		2, 121	
60. 00 06000 LABORATORY		0. 13644	-,	24, 378	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 29173		0	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 27805		25, 977	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 34266		126, 181	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 25075		72, 046	
68. 00 06800 SPEECH PATHOLOGY		0. 32601			
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS		0. 25225			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 62811		0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 22260	4 263, 607	58, 680	73. 00
OUTPATIENT SERVICE COST CENTERS		0.00000		0	88. 00
88.00 08800 RURAL HEALTH CLINIC - TCC 88.01 08801 RURAL HEALTH CLINIC II - PCFP		0. 00000 0. 00000		0	88.00
88. 02 08802 RURAL HEALTH CLINIC III - PCFP		0. 00000		0	88. 02
88. 03 08803 RURAL HEALTH CLINIC III - 131H 88. 03 08803 RURAL HEALTH CLINIC IV - SPENCER		0. 00000		0	88. 02
90. 00 09000 CLINIC V - SPENCER		0. 88552		72	90.00
90. 00 09000 CETNTC 90. 01 09001 PALN MANAGEMENT		0. 00000		0	90.00
90. 01 09001 PATN MANAGEMENT 90. 02 09002 WOUND CARE		0. 48723		0	90.01
90. 02 09002 WOUND CARE 90. 03 09003 ORTHOPEDI C CLI NI C		0. 49435		0	90.02
90. 03 09003 OKTHOPEDI C CETNI C 90. 04 09004 BEHAVI ORAL HEALTH		0. 42295		0	90.03
91. 00 09100 BERGENCY		0. 42293		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 14983		0	92.00
72. 00 07200 0DSERVATION DEDS (NON-DISTINCT PART)		1. 14703	, ₁ 0		1 /2.00

1, 426, 872

1, 426, 872

370, 711 200. 00 201. 00 202. 00

95.00

Net charges (line 200 minus line 201)

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

OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

200. 00 201. 00

Heal th	Financial Systems	PERRY COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIE	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			4 00	0.00	2)	
-	NIDATI ENT DOUTINE CERVICE COCT CENTERS		1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1	2/2 124		20.00
	03000 ADULTS & PEDI ATRI CS 04300 NURSERY			263, 124		30. 00 43. 00
	ANCILLARY SERVICE COST CENTERS			0		43.00
	D5000 OPERATING ROOM		0. 20417	4 295, 893	60, 414	50. 00
	D5200 DELIVERY ROOM & LABOR ROOM		0. 20417		•	52. 00
1	05400 RADI OLOGY-DI AGNOSTI C		0. 01003		•	
	06000 LABORATORY		0. 11776		•	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 13044		•	
1	06500 RESPIRATORY THERAPY		0. 27805		11, 775	
	06600 PHYSI CAL THERAPY		0. 34266	·	3, 780	1
	06700 OCCUPATI ONAL THERAPY		0. 25075		1, 902	
	06800 SPEECH PATHOLOGY		0. 32601		495	
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 25225		40, 930	
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 62811		0	72. 00
1	07300 DRUGS CHARGED TO PATIENTS		0. 22260		42, 431	73. 00
C	DUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC - TCC		0. 81476	4 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - PCFP		0. 67240	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III - 13TH		1. 06519	8 0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV - SPENCER		0. 78048	8 0	0	88. 03
90.00	09000 CLI NI C		0. 88552	8, 966	7, 940	90. 00
90. 01	09001 PAIN MANAGEMENT		0. 00000	0	0	90. 01
	09002 WOUND CARE		0. 48723	8 0	0	90. 02
90. 03	09003 ORTHOPEDIC CLINIC		0. 49435	9 0	0	90. 03
	D9004 BEHAVI ORAL HEALTH		0. 42295		0	
01 00 0	20100 EMEDGENCY		0 00010	1 00 007	2/ 55/	01 00

0. 292121

1. 149839

26, 556 12, 932

315, 557 200. 00 201. 00 202. 00

91.00

92.00 95.00

90, 907

11, 247

1, 206, 507

1, 206, 507

91.00

200. 00 201. 00

202.00

09100 EMERGENCY

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

Net charges (line 200 minus line 201)

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

	T'II WALL		5/23/2024 4: 1	4 pm
	Title XVIII	Hospi tal	Cost	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		11.00	
1.00	Medical and other services (see instructions)		5, 853, 059	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2. 00
3.00	OPPS or REH payments		0	
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)		0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)		0. 000	
6. 00	Line 2 times line 5		0.000	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7. 00
8. 00	Transitional corridor payment (see instructions)		0	8. 00
9.00	Ancillary service other pass through costs including REH direct graduate medical ed	ucation costs from	0	9. 00
40.00	Wkst. D, Pt. IV, col. 13, line 200			10.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)		0 5, 853, 059	10.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES		5, 655, 059	11.00
	Reasonable charges			1
12. 00	Ancillary service charges		0	12. 00
13.00			0	13. 00
14. 00	3 (0	14. 00
	Customary charges			
15. 00	Aggregate amount actually collected from patients liable for payment for services o	•	0	1
16. 00	Amounts that would have been realized from patients liable for payment for services such payment been made in accordance with 42 CFR §413.13(e)	on a chargebasis i	ad 0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)		0	1
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds	line 11) (see	0	19. 00
	instructions)			
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds	line 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)		5, 911, 590	21. 00
22. 00			0, 411, 540	22.00
23. 00			ő	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)		49, 730	1
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see ins		4, 312, 490	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines	22 and 23] (see	1, 549, 370	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)			28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		1, 549, 370	
31.00	Primary payer payments		968	31. 00
32.00	,		1, 548, 402	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		0	22.00
33. 00 34. 00			0 370, 141	
35. 00	·		240, 592	
	1 3		161, 818	
37.00			1, 788, 994	
38. 00	MSP-LCC reconciliation amount from PS&R		0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		_	39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration		0	
39. 97 39. 98	Partial or full credits received from manufacturers for replaced devices (see instr	uctions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	40110113)	0	39. 99
40. 00	Subtotal (see instructions)		1, 788, 994	1
40. 01	Sequestration adjustment (see instructions)		35, 780	
40. 02	Demonstration payment adjustment amount after sequestration		0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			40. 03
41.00			1, 978, 051	
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)		0	41. 01 42. 00
42. 01	Tentative settlement (for contractor use only)			42. 01
43. 00	Balance due provider/program (see instructions)		-224, 837	1
43. 01	Balance due provider/program-PARHM (see instructions)		, 50,	43. 01
44. 00		, chapter 1, §115.2	129, 549	1
	TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)		0	90.00
91.00			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)		0. 00 0	
94.00			0	
	1 and Some at three at the ray			

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2023	Worksheet E Part B	
			Date/Time Pr 5/23/2024 4:	epared: 14 pm
	Title XVIII	Hospi tal	Cost	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				0 200. 00

Health Financial Systems PE
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1322

				10 12/31/2023	5/23/2024 4: 14	
		Title	XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 706, 18		1, 978, 051	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services			0	0	2. 00
	rendered in the cost reporting period. If none, write					
	"NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment amount					3. 00
0.00	based on subsequent revision of the interim rate for the					0.00
	cost reporting period. Also show date of each payment. If					
	none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/25/2023	159, 60		0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM			ol	0	2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0	0	3. 50 3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54				0	Ö	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		159, 60		o l	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 865, 78	9	1, 978, 051	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T			
5.00	List separately each tentative settlement payment after des	<				5. 00
	review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02	TERMINE TO THOUSEN			0	0	5. 02
5. 03				0	ol	5. 03
	Provider to Program		•			
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
,	5. 50-5. 98)					,
6. 00	Determined net settlement amount (balance due) based on the					6. 00
6. 01	cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROVIDER		734, 14	-	224, 837	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 131, 64		1, 753, 214	7. 00
,.00	1.0 ta. moar our o program readility (300 moth dott ons)		5, 151, 04	Contractor	NPR Date	,. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

		Component	CCN. 15-Z322	10 12/31/2023	5/23/2024 4: 1	
		Titl∈	XVIII S	wing Beds - SNF		•
		Inpatier	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 918, 55°	1	0	1. 00
2.00	Interim payments payable on individual bills, either				0	2.00
	submitted or to be submitted to the contractor for services					
	rendered in the cost reporting period. If none, write					
	"NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment amount					3.00
	based on subsequent revision of the interim rate for the					
	cost reporting period. Also show date of each payment. If					
	none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/25/2023	210, 600	D	0	3. 0
3.02				D	0	3. 02
3.03					0	3.03
3.04				D	0	3.0
3.05			(0	3. 0
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM				0	3. 50
3.51					0	3. 5
3. 52					0	3. 5
3.53					0	3. 5
3.54					0	3. 5
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		210, 600		0	3. 9
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 129, 15	1	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			_		
5.00	List separately each tentative settlement payment after des	k				5.00
	review. Also show date of each payment. If none, write					
	"NONE" or enter a zero. (1)					
	Program to Provider		1	_1	_	
5. 01	TENTATI VE TO PROVI DER				0	5. 0
5.02					0	5. 02
5.03				<u> </u>	0	5. 03
	Provi der to Program		1	-I		
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51					0	5. 5
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines)	0	5. 99
,	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on the					6. 00
<i>(</i> 01	cost report. (1)		,		0	
6. 01	SETTLEMENT TO PROVIDER		1			6.0
6. 02	SETTLEMENT TO PROGRAM		671, 813		0	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 457, 338		0	7. 00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr)	
8. 00	Name of Contractor		J	1.00	2. 00	8. 00
0.00	INAME OF COLLI ACTO					J 0.00

Health Financial Systems PERRY COUNTY HOSPITAL In Lieu					2552-10
CALCUL				Worksheet E-1	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	
		T: 11		5/23/2024 4: 1	4 pm
		Title XVIII	Hospi tal	Cost	
				1, 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		: 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30. 00
31. 00	1 · · · · · · · · · · · · · · · · · · ·		,		31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)		32.00

		Component CCN: 15-Z322	To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPTED OFFICE		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		2 122 470	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		2, 133, 470	U	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and sum of Wkst D	374, 418	0	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swind		·	Ŭ	0.00
	instructions)	, ,			
3.01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teaching	ng program (see		0. 00	4. 00
	instructions)				
5.00	Program days	- + · · · - · · · · · · · · · ·	881	0	5. 00
6. 00 7. 00	Interns and residents not in approved teaching program (see insultilization review - physician compensation - SNF optional methods.)	and only	0	U	6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	lod offi y	2, 507, 888	0	1
9. 00	Primary payer payments (see instructions)		2, 307, 000	0	
10. 00	Subtotal (line 8 minus line 9)		2, 507, 888	0	
11. 00	Deductibles billed to program patients (exclude amounts applications)	able to physician	0	0	
	professional services)	. 3			
12. 00	Subtotal (line 10 minus line 11)		2, 507, 888	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records)	(exclude coinsurance f	or 400	0	13. 00
	physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)		2 507 400	0	
15.00	Subtotal (see instructions)		2, 507, 488	0	1
16. 00 16. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		0	U	16. 00 16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstra		nt 0		16. 55
10. 55	(see instructions)	atron) payment adjustme	0		10. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	0	0	18. 00
19. 00	Total (see instructions)		2, 507, 488	0	
19. 01	Sequestration adjustment (see instructions)		50, 150	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		2 120 151	0	19. 25 20. 00
20. 00 20. 01	Interim payments Interim payments-PARHM		3, 129, 151	U	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	
21. 00	Tentative settlement-PARHM (for contractor use only)			O	21. 00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02,	19, 25, 20, and 21)	-671, 813	0	
22. 01	Balance due provider/program-PARHM (see instructions)	,			22. 01
23.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstra				
200.00	Is this the first year of the current 5-year demonstration peri Cures Act? Enter "Y" for yes or "N" for no.	od under the 21st Cent	ury		200. 00
	Cost Reimbursement				
201 00	Medicare swing-bed SNF inpatient routine service costs (from W	cst D-1 Pt II line	66		201. 00
201.00	(title XVIII hospital))				2011 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lin	e		202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in f	first year of the curre	nt 5-year demonsi	ration	
205.00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF larget amount Medicare swing-bed SNF inpatient routine cost cap (line 205 time)	mas lina 204)			206.00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				200.00
207.00	Program reimbursement under the §410A Demonstration (see instru				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,		1		208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209. 00
210.00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 20	09 plus line 210) (see			215. 00
	instructions)		I	l	I

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		From 01/01/2023	Worksheet E-3 Part V Date/Time Prepared: 5/23/2024 4:14 pm
	T: 11 \0.0111		0 1

				5/23/2024 4: 14	4 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART	A SERVICES - COST	REIMBURSEMENT		
1.00	Inpati ent servi ces			3, 437, 602	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2. 00
3.00	Organ acqui si ti on		0	3. 00	
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			3, 437, 602	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 471, 978	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for paymen			0	11. 00
12. 00	Amounts that would have been realized from patients liable for paym	nent for services o	n a charge basis	0	12. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13. 00
14. 00	Total customary charges (see instructions)			0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only if	line 14 exceeds li	ne 6) (see	0	15. 00
47.00	instructions)		44) (47.00
16. 00	Excess of reasonable cost over customary charges (complete only if	line 6 exceeds lin	e 14) (see	0	16. 00
17 00	instructions)	0	17. 00		
17. 00	Cost of physicians' services in a teaching hospital (see instruction COMPUTATION OF REIMBURSEMENT SETTLEMENT	nis)		U	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4, lin	20. 40)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	16 49)		3, 471, 978	
20. 00	Deductibles (exclude professional component)			296, 000	
21. 00	Excess reasonable cost (from line 16)			270,000	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 175, 978	
23. 00	Coi nsurance			0, 173, 770	23. 00
24. 00	Subtotal (line 22 minus line 23)			3, 175, 978	
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		30, 125	
26. 00	Adjusted reimbursable bad debts (see instructions)	.555 1.151. 451. 51.57		19, 581	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)		12, 407	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	,		3, 195, 559	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30. 00	Subtotal (see instructions)			3, 195, 559	
30. 01	Sequestration adjustment (see instructions)			63, 911	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31. 00	Interim payments			3, 865, 789	
31. 01	Interim payments-PARHM			., ,	31. 01
32. 00	Tentative settlement (for contractor use only)			0	32. 00
32. 01	Tentative settlement-PARHM (for contractor use only)			-	32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31,	and 32)		-734, 141	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus l		and 32.01)	•	33. 01
34.00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	chapter 1, §115.2	10, 544	34. 00

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

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/23/2024 4:14 pm |

				12/01/2020	5/23/2024 4: 1	4 pm
		General Fund		Endowment Fund	Plant Fund	
			Purpose Fund			
	I	1.00	2. 00	3. 00	4. 00	
4 00	CURRENT ASSETS	10.5/7.004	1 0	ما		4 00
1.00	Cash on hand in banks	18, 567, 004		0	0	
2.00	Temporary investments	3, 887, 882		0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	· -		0	0	
5.00	Other recei vable	14, 577, 142 789, 463		0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	-9, 244, 637		0	0	
7. 00	Inventory	758, 847		0	0	1
8. 00	Prepaid expenses	375, 958		0	0	1
9. 00	Other current assets	0,70,700	ő	0	0	1
10. 00	Due from other funds	1, 820, 000		0	0	
11. 00	Total current assets (sum of lines 1-10)	31, 531, 659		0	0	1
	FIXED ASSETS					
12.00	Land	3, 693, 378	0	0	0	12. 00
13.00	Land improvements	92, 057	0	0	0	13. 00
14.00	Accumulated depreciation	-17, 581, 602	0	0	0	14. 00
15. 00	Bui I di ngs	45, 138, 906	1	0	0	
16. 00	Accumulated depreciation	-2, 932, 661	1	0	0	
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	
19.00	Fi xed equipment	2, 606, 705		0	0	
20.00	Accumulated depreciation	-206, 613		0	0	
21. 00	Automobiles and trucks	504, 442	1	0	0	
22. 00	Accumulated depreciation	-481, 160	1	0	0	
23. 00 24. 00	Major movable equipment Accumulated depreciation	19, 600, 410 -10, 957, 797	1	0	0	1
25. 00	Mi nor equi pment depreci abl e	-10, 937, 797		0	0	25. 00
26. 00	Accumulated depreciation			0	0	1
27. 00	HIT designated Assets		0	0	0	
28. 00	Accumul ated depreciation	0	ő	0	Ö	
29. 00	Mi nor equi pment-nondepreci abl e	l o	o o	0	0	1
30. 00	Total fixed assets (sum of lines 12-29)	39, 476, 065	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	1
34. 00	Other assets	1, 028, 459		0	0	
35. 00	Total other assets (sum of lines 31-34)	1, 028, 459		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	72, 036, 183	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	978, 539	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	770, 337		0	0	1
39. 00	Payrol I taxes payable	686, 044		0	0	
40. 00	Notes and Loans payable (short term)	1, 367, 799	1	0	Ö	40. 00
41. 00	Deferred income	0	o	0	0	
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	0	0	43. 00
44.00	Other current liabilities	5, 227, 451	0	0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	8, 259, 833	0	0	0	45. 00
	LONG TERM LIABILITIES	Ι .	1	ام		
46. 00	Mortgage payable	0	_	0	0	
47. 00	Notes payable	33, 908, 000		0	0	1
48. 00 49. 00	Unsecured Loans Other Long term Liabilities		0	0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	33, 908, 000		0	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	42, 167, 833			0	
31.00	CAPITAL ACCOUNTS	1 42, 107, 033	<u> </u>	<u> </u>	<u> </u>	31.00
52.00	General fund balance	29, 868, 350				52. 00
53.00	Specific purpose fund	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
EO 00	replacement, and expansion	20.0/0.050	_	_ ا	_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and 59	29, 868, 350 72, 036, 183		0	0	
50.00	Trocar Transfirties and Fund Datances (Sum Of Titles 31 and 59	1, 12,030,183	ı U	ı V	0	1 00.00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES PERRY COUNTY HOSPITAL

Provider CCN: 15-1322

					To		Date/Time Pre 5/23/2024 4:1	pared: 4 pm
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		28, 444, 574			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		1, 581, 623 30, 026, 197			0		2. 00 3. 00
4. 00	FREE STANDING HOME HEALTH	-157, 847	30, 020, 177		0	O	О	4. 00
5.00		0			0		0	5. 00
6.00		0			0		0	6.00
7. 00 8. 00					0		0	7. 00 8. 00
9. 00					0		Ö	9. 00
10.00	Total additions (sum of line 4-9)		-157, 847			0	l	10. 00
11.00	Subtotal (line 3 plus line 10)		29, 868, 350			0	l	11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)				0		0	12. 00 13. 00
14. 00					0		Ö	14. 00
15. 00		0			0		0	15. 00
16.00		0			0		0	16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		0		U	0	0	17. 00 18. 00
19. 00	Fund balance at end of period per balance		29, 868, 350			0	l .	19. 00
	sheet (line 11 minus line 18)		DI I					
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0			0			2. 00 3. 00
4. 00	FREE STANDING HOME HEALTH		0		Ŭ			4. 00
5.00			0					5. 00
6. 00 7. 00			0					6. 00 7. 00
8. 00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		0			11. 00 12. 00
13. 00	beddetrons (debrt adjustments) (specify)		0					13. 00
14.00			0					14. 00
15.00			0					15.00
16. 00 17. 00			0					16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	0	O		0			18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	O			0			19. 00

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

			То	12/31/2023	Date/Time Prep 5/23/2024 4:14	
	Cost Center Description	I npati ent		Outpati ent	Total	трііі
	5555 551151 55551 Pt 1511	1, 00		2. 00	3. 00	
	PART I - PATIENT REVENUES	,		2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	7, 862, 7	32		7, 862, 732	1. 00
2.00	SUBPROVIDER - I PF	1 ,,,,,,,	-		.,,	2. 00
3.00	SUBPROVIDER - IRF					3. 00
4.00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6. 00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY				J.	7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	7, 862, 7	32		7, 862, 732	10.00
	Intensive Care Type Inpatient Hospital Services	,,002,,	<u> </u>		7,002,702	
11. 00	INTENSIVE CARE UNIT					11. 00
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of line	es 11-15)	0		0	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	7, 862, 7	32		7, 862, 732	17. 00
18. 00	Ancillary services	13, 072, 1		86, 511, 360	99, 583, 541	18. 00
19. 00	Outpati ent servi ces	521, 1		20, 858, 339	21, 379, 449	19. 00
20. 00	RURAL HEALTH CLINIC - TCC	321,1	0	5, 379, 947	5, 379, 947	
20. 00	RURAL HEALTH CLINIC II - PCFP		0	1, 976, 301	1, 976, 301	20. 00
20. 01	RURAL HEALTH CLINIC III - 13TH		0	3, 133, 401	3, 133, 401	20. 01
20. 02	RURAL HEALTH CLINIC IV - SPENCER		0	1, 773, 111	1, 773, 111	20. 02
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	1, 773, 111	1, 773, 111	21. 00
22. 00	HOME HEALTH AGENCY		٧	o o	U	22. 00
23. 00	AMBULANCE SERVICES		0	4, 717, 776	4, 717, 776	23. 00
24. 00	CMHC		U	4, /17, //0	4, 717, 770	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)			+		25. 00
26. 00	HOSPICE			+		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 V	Wkst. 21,456,0	22	124, 350, 235	145, 806, 258	28. 00
26.00	G-3, line 1)	VKS1. 21, 450, 0	123	124, 330, 233	143, 600, 236	26.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			51, 760, 502		29. 00
30. 00	ADD (SPECIFY)		0	31, 700, 302		30. 00
31. 00	ADD (SECTED)		0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0	+		35. 00
36. 00	Total additions (sum of lines 30-35)		U	0		36. 00
37. 00	DEDUCT (SPECIFY)		0	U		37. 00
38. 00	DEDUCT (SPECIFT)		0			38. 00
			-			
39. 00			0			39. 00
40.00			0			40.00
41. 00	T-t-1 d-du-ti (1: 27 41)		U			41.00
42.00	Total deductions (sum of lines 37-41)	-onofor		U 51 7/0 F00		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(the Wkst C 3 Line 4)	anster		51, 760, 502		43.00
	to Wkst. G-3, line 4)	I	- 1	I		

Heal th	Financial Systems PE	ERRY COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1322	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	nared:
			10 12/31/2023	5/23/2024 4: 14	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, c			145, 806, 258	
2.00	Less contractual allowances and discounts on pati	ents' accounts		96, 938, 726	
3.00	Net patient revenues (line 1 minus line 2)			48, 867, 532	
4.00	Less total operating expenses (from Wkst. G-2, Pa			51, 760, 502	
5.00	Net income from service to patients (line 3 minus	line 4)		-2, 892, 970	5. 00
	OTHER I NCOME			470.750	, ,,
6.00	Contributions, donations, bequests, etc			179, 752	
7. 00 8. 00	Income from investments	ammuni aati an aamul aaa		355, 652 0	
9.00	Revenues from telephone and other miscellaneous c Revenue from television and radio service	ommuni cation services		0	
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			339, 026	
12. 00	Parking lot receipts			339, 020	
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			80, 638	
15. 00	Revenue from rental of living quarters			00,000	
16. 00	Revenue from sale of medical and surgical supplie	s to other than patients		0	
	Revenue from sale of drugs to other than patients			ol	17. 00
				0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			o	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and ca	nteen		0	20. 00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			54, 501	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING INCOME			3, 465, 024	24. 00
	COVI D-19 PHE Funding			0	24. 50
	Total other income (sum of lines 6-24)			4, 474, 593	
	Total (line 5 plus line 25)			1, 581, 623	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscrip			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minu	s line 28)		1, 581, 623	29. 00

Heal th	Financial Systems	PERRY COUNTY	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component (CCN: 15-8516	From 01/01/2023 To 12/31/2023	Date/Time Pre	nared:
			Component	JCIN. 13-0310	10 12/31/2023	5/23/2024 4: 1	
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00			4.00	4)	
	FACILITY HEALTH CARE CTAFE COCTO	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	1 (12 0(0		1 (12 0)	-99, 668	1 510 400	1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	1, 612, 068 0	0	1, 612, 06	0 -99, 668		1.00
3.00	Nurse Practitioner	171, 463		171, 46	-	171, 463	
4. 00	Visiting Nurse	171,403	0	171, 40	0	171, 403	4.00
5. 00	Other Nurse	206, 797	0	206, 79	7	206, 797	5.00
6. 00	Clinical Psychologist	200, 777	0	200, 7 ,	0	200, 777	
7. 00	Clinical Social Worker	0	0			0	1
7. 10	Marriage and Family Therapist		l			Ĭ	7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	0	0		0	0	ı
9. 00	Other Facility Health Care Staff Costs	279, 089	Ö	279, 08	39 0	279, 089	
10.00	Subtotal (sum of lines 1 through 9)	2, 269, 417	0	2, 269, 41			
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	14. 00
15.00	Medical Supplies	0	107, 321	107, 32	21 0	107, 321	15. 00
16.00	Transportation (Health Care Staff)	0	0		0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	0		0	0	1
18. 00	Professional Liability Insurance	0	0		0	0	18. 00
19. 00	Other Health Care Costs	0	0		0	0	19. 00
20. 00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	107, 321			107, 321	21. 00
22. 00	Total Cost of Health Care Services (sum of	2, 269, 417	107, 321	2, 376, 73	-99, 668	2, 277, 070	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
22 00		0	30, 142	30, 14	12 0	20 142	23. 00
23. 00 24. 00	Pharmacy Dental		30, 142	30, 14	0	30, 142	24.00
25. 00	Optometry					0	1
25. 00	Tel eheal th					0	25. 00
25. 01	Chronic Care Management		١			0	25. 02
26. 00	All other nonreimbursable costs	0	١		0 0	l o	26. 00
27. 00	Nonal Lowable GME costs						27. 00
20.00	Total Namesimboursells Costs (some of lines 22		1 00 440	20.4		00 440	20.00

281, 565

281, 565

2, 550, 982

30, 142

666, 524 666, 524

803, 987

30, 142

948, 089

948, 089

3, 354, 969

-83, 824

-83, 824

-183, 492

30, 142

864, 265

864, 265

3, 171, 477

28. 00

29.00

30.00

31.00

32.00

28. 00

through 27)
FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

31)

Total Nonreimbursable Costs (sum of lines 23

31.00 Total Facility Overhead (sum of lines 29 and 30)
32.00 Total facility costs (sum of lines 22, 28 and

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS		Period: Worksheet M-1 From 01/01/2023
	Component CCN: 15-8516	To 12/31/2023 Date/Time Prepared: 5/23/2024 4:14 pm

			Component	CCN: 15-85	16 10	12/31/202	3 Date/IIMe Pr 5/23/2024 4:	
-						RHC I	Cost	тт рііі
		Adjustments	Net Expenses					
			for Allocation	ı				
			(col. 5 + col.					
			6)					
		6.00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	1, 512, 400	1				1. 00
2.00	Physician Assistant	0	0	1				2. 00
3.00	Nurse Practitioner	0	171, 463					3. 00
4.00	Visiting Nurse	0	0	2				4. 00
5.00	Other Nurse	0	206, 797	1				5. 00
6.00	Clinical Psychologist	0	0	2				6. 00
7.00	Clinical Social Worker	U	Ü	7				7. 00
7. 10	Marriage and Family Therapist							7. 10
7. 11	Mental Health Counselor	0	0					7. 11
8. 00 9. 00	Laboratory Technician	0	279. 089					8. 00 9. 00
10.00	Other Facility Health Care Staff Costs	0	2, 169, 749	1				10.00
11. 00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	0	2, 109, 749	1				11. 00
12. 00	Physician Supervision Under Agreement	0	0	1				12.00
13. 00	Other Costs Under Agreement	0	0	1				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	1				14. 00
15. 00	Medical Supplies	0	107, 321	1				15. 00
16. 00	Transportation (Health Care Staff)	0	107, 021	1				16. 00
17. 00	Depreciation-Medical Equipment	0	0	1				17. 00
18. 00	Professional Liability Insurance	o	0					18. 00
19. 00	Other Health Care Costs	0	0					19. 00
20. 00	Allowable GME Costs							20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	107, 321	1				21. 00
22.00	Total Cost of Health Care Services (sum of	0	2, 277, 070	ol				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	30, 142	1				23. 00
24. 00	Dental	0	0	1				24. 00
25. 00	Optometry	0	0)				25. 00
25. 01	Tel eheal th	0	0)				25. 01
25. 02	Chronic Care Management	0	0	1				25. 02
26. 00	All other nonreimbursable costs	0	0	9				26. 00
27. 00	Nonallowable GME costs	_						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	30, 142	2				28. 00
	through 27) FACILITY OVERHEAD							
20 00	Facility Overhead Facility Costs	ol	0					29. 00
30.00	Administrative Costs	-110	864, 155	1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-110 -110	864, 155	1				31. 00
51.00	30)	-110	004, 100					31.00
32. 00	Total facility costs (sum of lines 22, 28 and	-110	3, 171, 367	,				32. 00
	31)		2,, 00,					
	'			•				•

Heal th	Financial Systems	PERRY COUNTY	' HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 01/01/2023 Fo 12/31/2023		narod:
			Component	CCN. 13-0317	10 12/31/2023	5/23/2024 4: 1	4 pm
					RHC II	Cost	
		Compensation	Other Costs		Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	0.00	1. 00	0.00	
1.00	Physi ci an	344, 194	C	344, 19	4 0	344, 194	1. 00
2.00	Physician Assistant	o	0)	0	0	2. 00
3.00	Nurse Practitioner	43, 143	0	43, 14	1, 391	44, 534	3. 00
4.00	Visiting Nurse	0	0	1	0	0	4. 00
5.00	Other Nurse	0	0	1	0	0	5. 00
6.00	Clinical Psychologist	0	0	1	0	0	6. 00
7. 00	Clinical Social Worker	0	0		0	0	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	107, 315	0	107, 31		107, 315	
10.00	Subtotal (sum of lines 1 through 9)	494, 652	0	494, 65	1, 391	496, 043	
11. 00	Physician Services Under Agreement	0	0	1	0	0	11. 00

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84, 916

84, 916

579, 568

494, 652

12.00

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28. 00

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41, 973

41, 973

538, 016

122, 146

122, 146

337, 039

337, 039

997, 201

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22, 000

22, 000

23, 391

41, 973

41, 973

536, 625

122, 146

122, 146

315, 039

315, 039

973, 810

0

0

0

0

41, 973

41, 973

41, 973

122, 146

122, 146

230, 123

230, 123

394, 242

0

0

C

12.00 Physician Supervision Under Agreement

Subtotal (sum of lines 11 through 13)

Subtotal (sum of lines 15 through 20)

COSTS OTHER THAN RHC/FQHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28 and

Transportation (Health Care Staff)

Depreciation-Medical Equipment

Other Health Care Costs

Allowable GME Costs

lines 10, 14, and 21)

Chronic Care Management

Nonallowable GME costs

Administrative Costs

Pharmacy

Optometry

Tel eheal th

through 27)
FACILITY OVERHEAD

29.00 Facility Costs

31)

Dental

Professional Liability Insurance

Other Costs Under Agreement

Medical Supplies

13.00

14 00

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23. 00

24.00

25.00

25.01

25.02

26.00

27.00

28.00

31.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1322	Peri od: Worksheet M-1 From 01/01/2023
	Component CCN: 15-8517	To 12/31/2023 Date/Time Prepared:

			Component	CCIV.	13-6517	10	12/31/2023	5/23/2024 4:	
							RHC II	Cost	
		Adjustments	Net Expenses						
			for Allocatio	n					
			(col. 5 + col	.					
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	344, 19	4					1. 00
2.00	Physician Assistant	0		o					2. 00
3.00	Nurse Practitioner	0	44, 53	4					3. 00
4.00	Visiting Nurse	0		o					4. 00
5.00	Other Nurse	0		ol					5. 00
6.00	Clinical Psychologist	0		ol					6. 00
7.00	Clinical Social Worker	0		ol					7. 00
7. 10	Marriage and Family Therapist			İ					7. 10
7. 11	Mental Health Counselor			İ					7. 11
8.00	Laboratory Techni ci an	0		ol					8. 00
9.00	Other Facility Health Care Staff Costs	0	107, 31	5					9.00
10.00	Subtotal (sum of lines 1 through 9)	0	496, 04						10.00
11. 00	Physician Services Under Agreement	0		ol					11.00
12.00	Physician Supervision Under Agreement	0		ol					12. 00
13.00	Other Costs Under Agreement	0		ol					13. 00
14.00	Subtotal (sum of lines 11 through 13)	0		ol					14. 00
15. 00	Medical Supplies	0	41, 97	3					15. 00
16. 00	Transportation (Health Care Staff)	0		ol					16. 00
17. 00	Depreciation-Medical Equipment	0		ol					17. 00
18. 00	Professional Liability Insurance	0		ol					18. 00
19. 00	Other Health Care Costs	0		o					19. 00
20.00	Allowable GME Costs								20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	41, 97	3					21. 00
22. 00	Total Cost of Health Care Services (sum of	0	538, 01						22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								
23.00	Pharmacy	0	122, 14	6					23. 00
24.00	Dental	0		o					24. 00
25.00	Optometry	0		o					25. 00
25. 01	Tel eheal th	0		o					25. 01
25. 02	Chronic Care Management	0		o					25. 02
26.00	All other nonreimbursable costs	0		o					26. 00
27.00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	122, 14	6					28. 00
	through 27)		•						
	FACILITY OVERHEAD								
29. 00	Facility Costs	0		0					29. 00
30.00	Administrative Costs	0	337, 03	9					30. 00
31.00	Total Facility Overhead (sum of lines 29 and	0	337, 03	9					31. 00
	30)								1
32.00	Total facility costs (sum of lines 22, 28 and	0 t	997, 20	1					32. 00
	31)								1

Heal th	Financial Systems	PERRY COUNTY	/ HOSPLTAL		In lie	eu of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS	. 2	Provider C		Period: From 01/01/2023	Worksheet M-1	
			Component		To 12/31/2023	Date/Time Pre 5/23/2024 4:1	
					RHC III	Cost	
		Compensation	Other Costs	Total (col.	Recl assi fi cati	Reclassi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	1, 775, 646	0	1, 775, 64	6 -173, 322	1, 602, 324	1.00
2.00	Physician Assistant	0	0		0	0	2. 00
3.00	Nurse Practitioner	86, 195	0	86, 19	5 0	86, 195	3. 00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	94, 599	0	94, 59	9 0	94, 599	5. 00
6.00	Clinical Psychologist	0	0		0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	15, 289	Ō	15, 28	9 0	15, 289	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 971, 729	Ō	1, 971, 72	9 -173, 322		
11.00	Physician Services Under Agreement	O	Ō		0	0	11. 00
12.00	Physician Supervision Under Agreement	o	Ō		0	0	12.00
13.00	Other Costs Under Agreement	o	0		0 0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	o	Ō		0	0	14. 00
15.00	Medical Supplies	o	86, 917	86, 91	7 0	86, 917	15. 00
16.00	Transportation (Health Care Staff)	0	. 0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	o	0		0 0	0	17. 00
18.00	Professional Liability Insurance	0	0		0	0	18. 00
19.00	Other Health Care Costs	o	0		0	0	19. 00
20. 00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	o	86, 917	86, 91	7 0	86, 917	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 971, 729	86, 917				•
	lines 10, 14, and 21)	.,,		_,, .	,	.,,	
	COSTS OTHER THAN RHC/FQHC SERVICES	'			•	•	İ
23.00	Pharmacy	0	130, 475	130, 47	5 0	130, 475	23. 00
24.00	Dental	o	. 0		0	0	24.00
	Optometry	O	0		0	0	•
25. 01	Tel eheal th	l	0		o o	Ō	
25. 02	Chronic Care Management	l	0		o o	Ō	25. 02
26. 00	All other nonreimbursable costs	l	0		ol o	Ō	26. 00
27. 00	Nonallowable GME costs	1					27. 00
20.00	T		400 475	1 400 47		400 475	00.00

92, 893

92, 893

2, 064, 622

130, 475

305, 627

305, 627

523, 019

130, 475

398, 520

398, 520

2, 587, 641

-4, 980

-4, 980

-178, 302

130, 475

393, 540

393, 540

2, 409, 339

28. 00

0 29.00

30.00

31.00

32.00

28.00

through 27)
FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

31)

Total Nonreimbursable Costs (sum of lines 23

31.00 Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 01/01/2023
	Component CCN: 15-8560	To 12/31/2023 Date/Time Prepared: 5/23/2024 4:14 pm

			Component	CCN. 13-00	300	10	12/31/2023	5/23/2024 4:	
							RHC III	Cost	
	·	Adjustments	Net Expenses						
		•	for Allocation	ı					
			(col. 5 + col.						
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	1, 602, 324	·					1. 00
2.00	Physician Assistant	0	_	1					2. 00
3.00	Nurse Practitioner	0	86, 195	i					3. 00
4.00	Visiting Nurse	0	C						4. 00
5.00	Other Nurse	0	94, 599						5. 00
6.00	Clinical Psychologist	0	C						6. 00
7.00	Clinical Social Worker	0	C						7. 00
7. 10	Marriage and Family Therapist								7. 10
7. 11	Mental Health Counselor								7. 11
8.00	Laboratory Techni ci an	0	C	1					8. 00
9.00	Other Facility Health Care Staff Costs	0	15, 289						9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 798, 407	'					10. 00
11. 00	Physician Services Under Agreement	0	C						11. 00
12.00	Physician Supervision Under Agreement	0	C						12. 00
13.00	Other Costs Under Agreement	0	C						13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	C	1					14. 00
15. 00	Medical Supplies	0	86, 917	'					15. 00
16. 00	Transportation (Health Care Staff)	0	C	1					16. 00
17. 00	Depreciation-Medical Equipment	0	C	1					17. 00
18. 00	Professional Liability Insurance	0	C	1					18. 00
19. 00	Other Health Care Costs	0	C						19. 00
20. 00	Allowable GME Costs								20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	86, 917						21. 00
22. 00	Total Cost of Health Care Services (sum of	0	1, 885, 324	+					22. 00
	lines 10, 14, and 21)								_
	COSTS OTHER THAN RHC/FQHC SERVICES		400 475	.1					
23. 00	Pharmacy	0	130, 475	1					23. 00
24. 00	Dental	0	C	1					24. 00
25. 00	Optometry	0	C	1					25. 00
25. 01	Tel eheal th	0	C	1					25. 01
25. 02	Chronic Care Management	0	C	1					25. 02
26. 00	All other nonreimbursable costs	0	C	7					26. 00
27. 00	Nonallowable GME costs		400 475						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	130, 475	·					28. 00
	through 27)								_
29. 00	FACILITY OVERHEAD Facility Costs	0	C	1					29. 00
30.00	Administrative Costs	0	393. 540	1					30.00
30.00		0		1					30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	393, 540	'					31.00
32. 00	Total facility costs (sum of lines 22, 28 and	١	2, 409, 339						32. 00
JZ. UU	31)	. 0	2,407,337						32.00
	17		1	1					1

Heal th	Financial Systems	PERRY COUNTY	' HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component (Date/Time Pre 5/23/2024 4:1	
					RHC IV	Cost	
		Compensation	Other Costs	,	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
	1	1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	, , , , , , , , , , , , , , , , , , , ,					
1. 00	Physi ci an	457, 986	0	457, 98	6 85, 335		1.00
2.00	Physician Assistant	0	0	(0	0	2. 00
3.00	Nurse Practitioner	39, 688	0	39, 68	8 0	39, 688	3. 00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	103, 765	0	103, 76	5 0	103, 765	5. 00
6.00	Clinical Psychologist	0	0		0	0	6. 00
7.00	Clinical Social Worker	0	0		0	0	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	601, 439	0	601, 43	9 85, 335	686, 774	10. 00
11. 00	Physician Services Under Agreement	0	0		0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	35, 943	35, 94	3 0	35, 943	15. 00
16.00	Transportation (Health Care Staff)	o	0		0	0	16. 00
17.00	Depreciation-Medical Equipment	o	0		0	0	17. 00
18.00	Professional Liability Insurance	o	0		0	0	18. 00
19. 00	Other Health Care Costs	o	0		0	0	19. 00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	o	35, 943	35, 94	3 0	35, 943	21.00
22. 00	, , , , , , , , , , , , , , , , , , , ,	601, 439	35, 943				
	lines 10, 14, and 21)		,		1		
	COSTS OTHER THAN RHC/FQHC SERVICES						
22 00	Dharmacy		27 057	27.05	7	27 057	22 00

59, 392

59, 392

660, 831

37, 057

37, 057

188, 192

188, 192

261, 192

0

0

C

37, 057

37, 057

247, 584

247, 584

922, 023

0

0

0

37, 057

37, 057

247, 584

247, 584

1, 007, 358

0

85, 335

0

0

0

23.00

24.00

25.00

25.01

0 25.02

26.00

27.00

28. 00

0 29.00

30.00

31.00

32.00

Pharmacy

Optometry

29.00 Facility Costs

31)

Tel eheal th

Chronic Care Management

Nonallowable GME costs

through 27)
FACILITY OVERHEAD

30.00 Administrative Costs

All other nonreimbursable costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28 and

Dental

23.00

24.00

25.00

25.01

25. 02

26.00

27.00

28. 00

31.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1322	Peri od: Worksheet M-1 From 01/01/2023
	Component CCN: 15-8562	To 12/31/2023 Date/Time Prepared: 5/23/2024 4:14 pm

			33			12, 71, 272	5/23/2024 4: 1	4 pm
						RHC IV	Cost	
		Adjustments	Net Expe	nses				
			for Alloc	ati on				
			(col. 5 +	col.				
			6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	54	3, 321				1. 00
2.00	Physician Assistant	0		0				2. 00
3.00	Nurse Practitioner	0	3	9, 688				3.00
4.00	Visiting Nurse	0		0				4. 00
5.00	Other Nurse	0	10	3, 765				5. 00
6.00	Clinical Psychologist	0		. 0	i			6.00
7.00	Clinical Social Worker	0		0				7.00
7. 10	Marriage and Family Therapist							7. 10
7. 11	Mental Health Counselor							7. 11
8.00	Laboratory Techni ci an	0		0				8.00
9. 00	Other Facility Health Care Staff Costs	0		0				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	68	5, 774				10.00
11. 00	Physician Services Under Agreement	0		0	ı			11. 00
12. 00	Physician Supervision Under Agreement	0		0				12.00
13. 00	Other Costs Under Agreement	0		0				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0		0				14. 00
15. 00	Medical Supplies	0	3	5, 943				15. 00
16. 00	Transportation (Health Care Staff)	0		0, 7,10	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
20. 00	Allowable GME Costs	Ü		Ü				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	٦ ء	5, 943				21. 00
22. 00	Total Cost of Health Care Services (sum of	0		2, 717	•			22. 00
22.00	lines 10, 14, and 21)	O	/ -	۷, , , , ,				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	3	7, 057				23. 00
24. 00	Dental	0		0	1			24. 00
25. 00	Optometry	0		0				25. 00
25. 01	Tel eheal th	0		0				25. 01
25. 02	Chronic Care Management	0		0				25. 02
26. 00	All other nonreimbursable costs	0		0				26. 00
27. 00	Nonallowable GME costs	ŭ		Ü				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	٦ ء	7, 057				28. 00
20.00	through 27)	Ü		, 007				20.00
	FACILITY OVERHEAD		1					1
29. 00	Facility Costs	n		0				29. 00
30.00	Administrative Costs	0	24	7, 584				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	n		7, 584	1			31. 00
550	30)	Ü	-	, 551				353
32. 00	Total facility costs (sum of lines 22, 28 and	0 1	1, 00	7, 358				32. 00
	31)	3		,				
	• •							•

	Financial Systems	PERRY COUNT				u of Form CMS-2	
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SI	ERVI CES	Provi der CO		Peri od: From 01/01/2023	Worksheet M-2	
			Component (To 12/31/2023	Date/Time Pre	pared:
			·			5/23/2024 4: 1	4 pm
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	2.00	3.00	3) 4. 00	<u>4</u> 5. 00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	3.00	
	Posi ti ons						
1.00	Physi ci an	1. 42	6, 758	4, 20	5, 964		1.00
2. 00	Physi ci an Assi stant	0. 00	0	2, 10	0 0		2.00
3. 00	Nurse Practitioner	2. 88	9, 155	2, 10	6, 048		3.00
1. 00	Subtotal (sum of lines 1 through 3)	4. 30	15, 913		12, 012	15, 913	4.00
5. 00	Visiting Nurse	0. 00	0			0	5.00
. 00	Clinical Psychologist	0. 00				0	6.00
. 00	Clinical Social Worker	0. 12	59			59	7.00
. 01	Medical Nutrition Therapist (FQHC only)	0. 00	0			0	7.01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
3. 00	Total FTEs and Visits (sum of lines 4 through	1 4.42	15, 972			15, 972	8.00
	7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
0.00	Total costs of health care services (from Wks	st. M-1, col. 7	', line 22)			2, 277, 070	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			30, 142	11. 00
2.00	Cost of all services (excluding overhead) (su	um of lines 10	and 11)			2, 307, 212	12.00
3.00	Ratio of hospital-based RHC/FQHC services (li	ne 10 di vi ded	by line 12)			0. 986936	13.00
4. 00	Total hospital-based RHC/FQHC overhead - (fro	om Worksheet. N	1-1, col. 7, li	ne 31)		864, 155	14.00
5.00	Parent provider overhead allocated to facilit	y (see instruc	ctions)			1, 212, 022	15.00
6. 00						2, 076, 177	16.00
7. 00	Allowable GME overhead (see instructions)					0	17.00
8. 00						2, 076, 177	
	Overhead applicable to hospital-based RHC/FQF					2, 049, 054	
20.00	Total allowable cost of hospital-based RHC/FC	MC services (s	sum of lines 10	and 19)		4, 326, 124	20.00

Heal th	Financial Systems	PERRY COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component (From 01/01/2023 To 12/31/2023	Date/Time Pre	narad:
			Component	JUN. 13-0317	10 12/31/2023	5/23/2024 4: 1	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4	
		1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 91	2, 234				1. 00
2.00	Physician Assistant	0. 00		2, 10			2. 00
3.00	Nurse Practitioner	0. 78					3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 69			5, 460	5, 460	4.00
5.00	Visiting Nurse	0. 00				0	5. 00
6.00	Clinical Psychologist	0. 00				0	6.00
7.00	Clinical Social Worker	0. 00				0	7. 00
7.01	Medical Nutrition Therapist (FQHC only)	0. 00				0	7. 01
7.02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
7.03	Marriage and Family Therapist						7. 03
7.04	Mental Health Counselor						7. 04
8.00	Total FTEs and Visits (sum of lines 4 through	1. 69	3, 782			5, 460	8. 00
9. 00	// Physician Services Under Agreements		0			0	9. 00
9.00	Physician services under Agreements					U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wks					538, 016	
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			122, 146	11. 00
12.00	Cost of all services (excluding overhead) (su					660, 162	
13.00	Ratio of hospital-based RHC/FQHC services (Li					0. 814976	
14.00	Total hospital-based RHC/FQHC overhead - (fro			ne 31)		337, 039	
15.00	Parent provider overhead allocated to facilit	ty (see instruc	ctions)			331, 668	
16. 00	Total overhead (sum of lines 14 and 15)					668, 707	16. 00
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					668, 707	18. 00
	Overhead applicable to hospital-based RHC/FQH					544, 980	
20. 00	Total allowable cost of hospital-based RHC/FC	DHC services (s	sum of lines 10	and 19)		1, 082, 996	20.00

	Financial Systems	PERRY COUNT				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 15-8560	From 01/01/2023 To 12/31/2023	Date/Time Pre	nared:
			Component	0014. 10 0000	10 12/01/2020	5/23/2024 4: 1	
					RHC III	Cost	
		Number of FTE	Total Visits		/ Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
			0.00		3)	4	
	NA OLITO AND DECRUCTANA TV	1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	1.05	2 557	4 20	0 100		1 00
1.00	Physician	1. 95					1.00
2.00	Physician Assistant	0.00		_,			2.00
3.00	Nurse Practitioner	0. 52				0 202	3.00
4. 00 5. 00	Subtotal (sum of lines 1 through 3)	2. 47 0. 00		1	9, 282		4. 00 5. 00
6. 00	Visiting Nurse Clinical Psychologist	0.00		1		0	6.00
7. 00	Clinical Psychologist Clinical Social Worker	0.00				0	7.00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 00
7. 01 7. 02	Diabetes Self Management Training (FQHC only)					0	7.01
7. 02 7. 03	Marriage and Family Therapist	0.00	·	1		U	7.02
7. 03 7. 04	Mental Health Counselor						7.03
8. 00	Total FTEs and Visits (sum of lines 4 through	n 2. 47	4, 536			9, 282	8.00
0.00	7)	2.47	4, 330			7, 202	0.00
9. 00	Physician Services Under Agreements			,		0	9. 00
			_				
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10. 00	Total costs of health care services (from Wks	st. M-1, col. 7	7, line 22)			1, 885, 324	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			130, 475	11.00
12. 00	Cost of all services (excluding overhead) (su	um of lines 10	and 11)			2, 015, 799	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (li					0. 935274	13.00
14. 00	Total hospital-based RHC/FQHC overhead - (fro	om Worksheet. N	M-1, col. 7, li	ne 31)		393, 540	14.00
15. 00	Parent provider overhead allocated to facilit	y (see instruc	ctions)			928, 353	
16. 00	Total overhead (sum of lines 14 and 15)					1, 321, 893	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					1, 321, 893	
	Overhead applicable to hospital-based RHC/FQH					1, 236, 332	
20.00	Total allowable cost of hospital-based RHC/FC	NHC services (s	sum of lines 10	and 19)		3, 121, 656	20.00

	Financial Systems	PERRY COUNT				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der C	CN: 15-1322	Peri od:	Worksheet M-2	
			Component	CCN: 15-8562	From 01/01/2023 To 12/31/2023	Date/Time Pre	nared·
			Component	0014. 10 0002	10 12/01/2020	5/23/2024 4: 1	
					RHC IV	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
	VICITO AND DEODUCTIVITY	1.00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1. 00	Posi ti ons Physi ci an	1. 26	4, 708	3 4, 20	5, 292		1.00
2. 00	Physician Assistant	0.00		1			2.00
3.00	Nurse Practitioner	0. 00					3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 88			6, 594	6, 594	4.00
5. 00	Visiting Nurse	0.00			0, 394	0, 594	5.00
6. 00	Clinical Psychologist	0.00	l .			0	6.00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7.00
7. 02	Diabetes Self Management Training (FQHC only)		_			0	7. 02
7. 02	Marriage and Family Therapist	0.00		ή		U	7. 02
7. 04	Mental Health Counselor						7. 04
8. 00	Total FTEs and Visits (sum of lines 4 through	1.88	5, 444			6, 594	8.00
0.00	7)]			0,07.	0.00
9.00	Physician Services Under Agreements					0	9. 00
				•			
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			RVICES			
10.00	Total costs of health care services (from Wks					722, 717	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					37, 057	
12.00	Cost of all services (excluding overhead) (su					759, 774	
13.00	Ratio of hospital-based RHC/FQHC services (li					0. 951226	
14. 00	Total hospital-based RHC/FQHC overhead - (fro			ne 31)		247, 584	
15. 00	Parent provider overhead allocated to facilit	ty (see instrud	ctions)			376, 533	
16. 00	Total overhead (sum of lines 14 and 15)					624, 117	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16		40 11			624, 117	
	Overhead applicable to hospital-based RHC/FQH					593, 676	
20.00	Total allowable cost of hospital-based RHC/FC	JHU services (s	sum of lines 10	and 19)		1, 316, 393	J 20. 00

ealth Financial Systems PERRY COUNTY F			u of Form CMS-2	
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1322	Peri od: From 01/01/2023	Worksheet M-3	
ERVI CES	Component CCN: 15-8516	To 12/31/2023	Date/Time Pre	pared
			5/23/2024 4:1	4 pm
	Title XVIII	RHC I	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		4, 326, 124	1.0
.00 Cost of injections/infusions and their administration (from W	/kst. M-4, line 15)		27, 649	2.
.00 Total allowable cost excluding injections/infusions (line 1 m	ninus line 2)		4, 298, 475	3.
.00 Total Visits (from Wkst. M-2, column 5, line 8)			15, 972	1
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
Total adjusted visits (line 4 plus line 5)			15, 972	
.00 Adjusted cost per visit (line 3 divided by line 6)		Cal aul ati an	269. 13	7.
		Cal cul ati on	OF LIMIT (I)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
		4.00	12/31/2023)	
00 Day visit normant limit (from CMC Dub. 100 04 shanton 0. 500) (or your contractor)	1.00	2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 .00 Rate for Program covered visits (see instructions)	o. 6 or your contractor)	0. 00 0. 00	233. 88 233. 88	
CALCULATION OF SETTLEMENT		0.00	233.00	7.
0.00 Program covered visits excluding mental health services (from	contractor records)	0	2, 393	10.
1.00 Program cost excluding costs for mental health services (line		0	559, 675	1
2.00 Program covered visits for mental health services (from contr	ractor records)	0	0	12.
3.00 Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.
4.00 Limit adjustment for mental health services (see instructions	•	0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instruction			FF0 /7F	15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	559, 675	1
6.01 Total program charges (see instructions)(from contractor's re 6.02 Total program preventive charges (see instructions)(from prov	•		651, 867 72, 644	1
6.03 Total program preventive charges (see Histractions)(Home prov 6.03 Total program preventive costs ((line 16.02/line 16.01) times	•		62, 370	1
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0		tLes	355, 742	1
V and XIX see instructions.)			000,7.12	
6.05 Total program cost (see instructions)		0	418, 112	16.
7.00 Primary payer amounts			0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions)	•	s)	52, 627	1
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		105, 140	19.
records) D.OO Net program cost excluding injections/infusions (see instruct	i one)		418, 112	20.
1.00 Program cost of vaccines and their administration (from Wkst.	•		5, 886	1
1.50 Total program IOP OPPS payments (see instructions)	m 1, 11116 10)		0,000	21.
1.55 Total program IOP Costs (see instructions)				21.
1.60 Program IOP deductible and coinsurance (see instructions)				21.
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		423, 998	22.
3.00 Allowable bad debts (see instructions)			0	1
3.01 Adjusted reimbursable bad debts (see instructions)			0	
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ne)		0	1
5.50 Pioneer ACO demonstration payment adjustment (see instruction 5.99 Demonstration payment adjustment amount before sequestration	13 <i>)</i>		0	
6.00 Net reimbursable amount (see instructions)			423, 998	
6.01 Sequestration adjustment (see instructions)			8, 480	1
6.02 Demonstration payment adjustment amount after sequestration			0	26.
7.00 Interim payments			407, 962	27.
8.00 Tentative settlement (for contractor use only)			0	28.
9.00 Balance due component/program (line 26 minus lines 26.01, 26.			7, 556	
0.00 Protested amounts (nonallowable cost report items) in accorda	ince with CMS Pub 15-II	1	0	30.

	Financial Systems PERRY COUNTY H			u of Form CMS-2	
CALCUL SERVI (ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1322	Peri od: From 01/01/2023	Worksheet M-3	
SEKAIC	LJ	Component CCN: 15-8517	To 12/31/2023	Date/Time Pre	
		Title XVIII	RHC II	5/23/2024 4: 1 Cost	4 pm
		I tre will	KHC I I	COST	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			1, 082, 996	1
2.00	Cost of injections/infusions and their administration (from WI			36, 676	
. 00 . 00	Total allowable cost excluding injections/infusions (line 1 mi Total Visits (from Wkst. M-2, column 5, line 8)	Tilus Title 2)		1, 046, 320 5, 460	1
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0, 100	1
. 00	Total adjusted visits (line 4 plus line 5)			5, 460	1
7. 00	Adjusted cost per visit (line 3 divided by line 6)			191. 63	7. (
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
			1.00	12/31/2023)	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	1.00	2. 00 168. 76	8. (
00	Rate for Program covered visits (see instructions)	. o or your contractor)	0.00		1
	CALCULATION OF SETTLEMENT				
0. 00	Program covered visits excluding mental health services (from	•	0	163	
1. 00	Program cost excluding costs for mental health services (line	*	0	27, 508	1
2.00	Program covered visits for mental health services (from contra	•	0	0 0	1
3. 00 4. 00	Program covered cost from mental health services (line 9 x lin Limit adjustment for mental health services (see instructions)	•	0	0	
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	27, 508	1
6. 01	Total program charges (see instructions)(from contractor's red	•		43, 676	1
6. 02	Total program preventive charges (see instructions) (from provi	•		15, 643	1
6. 03 6. 04	Total program preventive costs ((line 16.02/line 16.01) times	•	+1.00	9, 852	1
10. 04	Total Program non-preventive costs ((line 16 minus lines 16.0) V and XIX see instructions.)	s and 16) times .80) (11	lies	11, 280	10.
6. 05	Total program cost (see instructions)		0	21, 132	16.
17. 00	Pri mary payer amounts			0	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	•	s)	3, 556	1
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		4, 896	19.
20. 00	records) Net program cost excluding injections/infusions (see instructi	i ons)		21, 132	20.
21. 00	Program cost of vaccines and their administration (from Wkst.	*		170	
1. 50	Total program IOP OPPS payments (see instructions)	•			21.
1. 55	Total program IOP Costs (see instructions)				21.
1. 60	Program IOP deductible and coinsurance (see instructions)				21.
2.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, r	minus line 21.60)		21, 302	1
3. 00 3. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	1
	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	
5. 00		· · · · · · · · · · · · · · · · · · ·		0	1
5. 50		s)		0	
5. 99	Demonstration payment adjustment amount before sequestration			0	
26.00	Net reimbursable amount (see instructions)			21, 302	1
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			426 0	
7. 00				20, 086	1
28. 00	Tentative settlement (for contractor use only)			0	1
	,	02. 27. and 28)		_	29.
29. 00	paranee due componenti program (Trite 20 militas Trites 20:01, 20:0				

	HOSPI TAL		u of Form CMS-2	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1322	Peri od: From 01/01/2023	Worksheet M-3	
SERVI CES	Component CCN: 15-8560	To 12/31/2023	Date/Time Pre	pared:
	•		5/23/2024 4:1	
	Title XVIII	RHC III	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro			3, 121, 656	
2.00 Cost of injections/infusions and their administration (from VB.00 Total allowable cost excluding injections/infusions (line 1 m			35, 875	
B.OO Total allowable cost excluding injections/infusions (line 1 m H.OO Total Visits (from Wkst. M-2, column 5, line 8)	iii iius Title 2)		3, 085, 781 9, 282	3. 0 4. 0
5.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	1
5.00 Total adjusted visits (line 4 plus line 5)			9, 282	6.0
7.00 Adjusted cost per visit (line 3 divided by line 6)		0 1 1 1:	332. 45	7.0
		Cal cul ati on	of Limit (1)	
		Rate Peri od	Rate Period 1	
		N/A	(01/01/2023	
			through	
		1. 00	12/31/2023) 2. 00	
3.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	126. 00	8. 0
P.00 Rate for Program covered visits (see instructions)		0.00	126. 00	
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from	•	0		1
1.00 Program cost excluding costs for mental health services (line 2.00 Program covered visits for mental health services (from contr	*	0	63, 882 0	1
3.00 Program covered cost from mental health services (line 9 x li	•	0	0	1
4.00 Limit adjustment for mental health services (see instructions	•	0	0	1
15.00 Graduate Medical Education Pass Through Cost (see instruction				15. C
16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	63, 882	1
16.01 Total program charges (see instructions)(from contractor's relations) Total program preventive charges (see instructions)(from proventions)	•		139, 063 5, 145	1
16.03 Total program preventive costs ((line 16.02/line 16.01) times	•		2, 364	ı
16.04 Total Program non-preventive costs ((line 16 minus lines 16.0		tles	41, 534	1
V and XIX see instructions.)				
16.05 Total program cost (see instructions)		0	43, 898	
17.00 Primary payer amounts 18.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor record	6)	0 9, 601	17. 0 18. 0
19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions)	,	5)	24, 863	1
records)	31.3) (1. 3 33.11. 43.31		2.7,000	.,,,
20.00 Net program cost excluding injections/infusions (see instruct	*		43, 898	
21.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		2, 898	
21.50 Total program IOP OPPS payments (see instructions) 21.55 Total program IOP Costs (see instructions)				21. 5
21.60 Program IOP deductible and coinsurance (see instructions)				21.6
22.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		46, 796	1
3.00 Allowable bad debts (see instructions)	,		0	1
23.01 Adjusted reimbursable bad debts (see instructions)			0	
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	1
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)5.50 Pioneer ACO demonstration payment adjustment (see instruction)	ne)		0	
15.99 Demonstration payment adjustment amount before sequestration	13)		0	25. 9
26.00 Net reimbursable amount (see instructions)			46, 796	1
26.01 Sequestration adjustment (see instructions)			936	1
26.02 Demonstration payment adjustment amount after sequestration			0	1
27.00 Interim payments			42, 369	1
28.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		0 3, 491	28. 0 29. 0
80.00 Protested amounts (nonallowable cost report items) in accorda			3, 491	1
chapter I, §115.2				1 - 5. 0

	Financial Systems PERRY COUNTY H			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1322	Peri od: From 01/01/2023	Worksheet M-3	
SERVI (ES	Component CCN: 15-8562	To 12/31/2023	Date/Time Pre	pared:
				5/23/2024 4:1	
	<u> </u>	Title XVIII	RHC I V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			1, 316, 393	•
2. 00 3. 00	Cost of injections/infusions and their administration (from WI Total allowable cost excluding injections/infusions (line 1 mi			76, 514	1
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	Thus Time 2)		1, 239, 879 6, 594	1
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6. 00	Total adjusted visits (line 4 plus line 5)			6, 594	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		0.1.1.1.	188. 03	7.00
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through 12/31/2023)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	.6 or your contractor)	0.00	126. 00	8.00
9. 00	Rate for Program covered visits (see instructions)		0.00	126. 00	9.00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	0	956	10.00
11.00	Program cost excluding costs for mental health services (line	*	0		
2. 00	Program covered visits for mental health services (from contra		0	0	1
13.00	Program covered cost from mental health services (line 9 x li	*	0	0	
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	120, 456	1
16. 01	Total program charges (see instructions) (from contractor's red			240, 783	
16. 02	Total program preventive charges (see instructions)(from provi	ider's records)		3, 039	16. 0
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			1, 520	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0) V and XIX see instructions.)	3 and 18) times .80) (II	ties	71, 920	16. 04
16. 05	Total program cost (see instructions)		0	73, 440	16. 0!
17. 00	Pri mary payer amounts			0	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	,	s)	29, 036	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		41, 743	19.00
20. 00	Net program cost excluding injections/infusions (see instructi	i ons)		73, 440	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		21, 164	21.00
21. 50	Total program IOP OPPS payments (see instructions)				21. 50
21. 55 21. 60	Total program IOP Costs (see instructions) Program IOP deductible and coinsurance (see instructions)				21. 5!
22. 00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1	minus line 21.60)		94, 604	1
23. 00	Allowable bad debts (see instructions)			0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration	~ <i>,</i>		0	
26. 00	Net reimbursable amount (see instructions)			94, 604	1
26. 01	Sequestration adjustment (see instructions)			1, 892	
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 69, 817	
28.00	Tentative settlement (for contractor use only)			09,817	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		22, 895	
30. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-II,		0	30.00

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO	CN: 15-1322	Peri od:	Worksheet M-4	
		Component (CCN: 15-8516	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 4:14	
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
. 00 . 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	2, 169, 749 0. 000354				1. 2.
. 00 . 00	Injection/infusion health care staff cost (line 1 x line 2) Injections/infusions and related medical supplies costs (from your records)	768 4, 663	- '		0	3. 4.
. 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)	5, 431 2, 277, 070			0 2, 277, 070	5. 6.
. 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)	2, 049, 054 t 0. 002385				7. 8.
. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4, 887 10, 318			0	9. 10.
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	19 543. 05 4	112.	54 0.00 54 0.00 33 0	0 0. 00 0	11. 12. 13.
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees	d		0	0	13.
1. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2, 172	3, 7	14 0	0	14.
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
. 00	Total cost of injections/infusions and their administration		columns 1,	2,	27, 649	15.
- 00	2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, Total Program cost of injections/infusions and their adminis				5, 886	۱.,

	Financial Systems PERRY COUNTY ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-1322	Peri od:	worksheet M-4	
		Component (CCN: 15-8517	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 4:14	
			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	496, 043 0. 001944				
3. 00 4. 00	Injection/infusion health care staff cost (line 1 x line 2) Injections/infusions and related medical supplies costs (from your records)	964 10, 061	3, 9 3, 1		0	3. 00 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)	11, 025 538, 016			0 538, 016	5. 00 6. 00
7. 00	Total overhead (from Wkst. M-2, line 19)	544, 980				7.00
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)				0.000000	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)	11, 168 22, 193			0	9. 00 10. 00
1. 00	Total number of injections/infusions (from your records)	41		70 0	0	11.0
2. 00 3. 00	Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	541. 29 0	85.	19 0.00 2 0	0.00	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	d		0	0	13. 0
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1	70 0	0	14. 0
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3,		columns 1,	2,	36, 676	15. 0
6.00	Total Program cost of injections/infusions and their adminis	stration costs	(sum of col	umns	170	16.0

	Financial Systems PERRY COUNTY ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO	CN: 15-1322	Peri od:	worksheet M-4	
		Component (CCN: 15-8560	From 01/01/2023 To 12/31/2023		
		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, 798, 407 0. 001622				1. 00 2. 00
3. 00 4. 00	Injection/infusion health care staff cost (line 1 x line 2) Injections/infusions and related medical supplies costs (from your records)	2, 917 12, 270			0	3. 00 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)	15, 187 1, 885, 324			0 1, 885, 324	5. 00 6. 00
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 236, 332 t 0. 008055				
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)	9, 959 25, 146			1	
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	50 502. 92 5		84 0 73 0.00 3 0	0 0.00 0	12. 0
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	d		0	0	13. 0
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2, 515	3	83 0	0	14.0
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3,		columns 1,	2,	35, 875	15. C
6 00	Total Program cost of injections/infusions and their adminis		(sum of colu	umns	2, 898	16 (

	Financial Systems PERRY COUNTY ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-1322	Peri od:	worksheet M-4	
		Component (CCN: 15-8562	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/23/2024 4:14	
			XVIII	RHC I V	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	686, 774 0. 004049				
3. 00 1. 00	Injection/infusion health care staff cost (line 1 x line 2) Injections/infusions and related medical supplies costs (from your records)	2, 781 23, 313	, ,		0	3. C 4. C
5. 00 5. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	26, 094 722, 717			0 722, 717	5. 0 6. 0
7. 00	Total overhead (from Wkst. M-2, line 19)	593, 676	593, 6	76 593, 676	593, 676	7.0
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	t 0. 036105	0. 0220	0. 000000	0. 000000	8. 0
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	21, 435			0	9. (
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	47, 529			0	
1.00	Total number of injections/infusions (from your records)	95		31 0	0	
2. 00 3. 00	Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	500. 31 29		57 0.00 76 0	0.00	1
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	d		0	0	13. (
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	14, 509	6, 6	55 0	0	14. (
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3,		columns 1,	2,	76, 514	15. (
6.00	Total Program cost of injections/infusions and their adminis	stration costs	(sum of colu	umns	21, 164	16.

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F	RHC/FQHC PROVIDER FOR SERVICE\$Provider CCN: 15-1322	
RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2023

KENDEN	TO THOUSENIN DENET FORMING ES	Component CCN: 15-8516	To	12/31/2023	Date/Time Prep 5/23/2024 4:14	
				RHC I	Cost	
					t B	
				mm/dd/yyyy	Amount	
				1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC				407, 962	1. 00
2.00	Interim payments payable on individual bills, either submit				0	2.00
	contractor for services rendered in the cost reporting peri	od. If none, write "NONE	" or			
	enter a zero					
3.00	List separately each retroactive lump sum adjustment amount					3.00
	of the interim rate for the cost reporting period. Also sho	w date of each payment. I	f			
	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.				0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans TO BE COMPLETED BY CONTRACTOR	fer to Worksheet M-3, lin	e 27)	407, 962	4. 00
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)					
	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	•			7, 556	6. 01
6.02	SETTLEMENT TO PROGRAM				0	6. 02
7.00	Total Medicare program liability (see instructions)				415, 518	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		0		1. 00	2. 00	
8.00	Name of Contractor					8.00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL	-BASED RHC/FQHC PROVIDER FOR SERVICE\$Provider CCN: 15-1322	Peri od: Worksheet M-5

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES Provider CCN: 15-1322 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/23/2024 4:14 pm

		Component Cont. 10 Cont	127 017 2020	5/23/2024 4: 14	
			RHC II	Cost	•
	·		Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			20, 086	1. 00
2.00	Interim payments payable on individual bills, either submit contractor for services rendered in the cost reporting perienter a zero	od. If none, write "NONE"	or	0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount of the interim rate for the cost reporting period. Also sho none, write "NONE" or enter a zero. (1) Program to Provider				3. 00
2 01	Program to Provider				2 01
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
2 50	Provider to Program			0	2 50
3.50				1 - 1	3. 50
3.51				0	3. 51
3. 52				0	3. 52
3. 53				0	3. 53
3.54		00)		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.		0.73	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans TO BE COMPLETED BY CONTRACTOR	ter to Worksheet M-3, line	2/)	20, 086	4. 00
5.00	List separately each tentative settlement payment after des	k review. Also show date o	f		5. 00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5. 01
5.02				0	5. 02
5.03				0	5. 03
	Provider to Program				
5.50				0	5.50
5.51				0	5. 51
5.52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	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	•		790	6. 01
6.02	SETTLEMENT TO PROGRAM			0	6. 02
7.00	Total Medicare program liability (see instructions)			20, 876	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	Number 1.00	(Mo/Day/Yr) 2.00	

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL	-BASED RHC/FQHC PROVIDER FOR SERVICE\$Provider CCN: 15-1322	Peri od: Worksheet M-5

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES Provider CCN: 15-1322 | Period: Worksheet M-5 | RENDERED TO PROGRAM BENEFICIARIES | Component CCN: 15-8560 | To 12/31/2023 | Date/Time Prepared: 5/23/2024 4:14 pm

		Component CCN: 15-8560	10 12/31/2023	5/23/2024 4:14	
			RHC III	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			42, 369	1.00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to	the	0	2.00
	contractor for services rendered in the cost reporting peri	od. If none, write "NONE"	or		
	enter a zero				
3.00	List separately each retroactive lump sum adjustment amount		on		3. 00
	of the interim rate for the cost reporting period. Also sho	w 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	27)	42, 369	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5. 00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5. 01
5.02				0	5. 02
5.03				0	5. 03
	Provider to Program				
5.50				0	5. 50
5.51				0	5. 51
5.52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5. 99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6. 00
6. 01	SETTLEMENT TO PROVI DER			3, 491	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7.00	Total Medicare program liability (see instructions)			45, 860	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	0	1. 00	2. 00	8. 00

Health Financial Systems	PERRY COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVIDER FOR SERVICE\$ Provider CCN: 15-1322	
DENDEDED TO DEOCRAM DENEET CLADIES		From 01/01/2023

Component CCN: 15-8562 From 01/01/2023 Date/Time Prepared: RENDERED TO PROGRAM BENEFICIARIES

		·		5/23/2024 4: 1	4 pm
			RHC IV	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			69, 817	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to t	he	0	2.00
	contractor for services rendered in the cost reporting period. If none, write "NONE" of				
	enter a zero				
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision		on		3.00
	of the interim rate for the cost reporting period. Also sho	w date of each payment. If			
	none, write "NONE" or enter a zero. (1)				
	Program to Provider			1	
3. 01				0	3. 0
3. 02				0	3. 02
3. 03				0	3. 0
3. 04				0	3. 04
3. 05				0	3. 0!
0 50	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 5
3. 52				0	3. 52
3. 53 3. 54				_	3. 5. 3. 5.
3. 54	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	00)		0	3. 54
4.00			27)	69, 817	4.00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) 69,817 TO BE COMPLETED BY CONTRACTOR				4.00
5. 00	List separately each tentative settlement payment after desk review. Also show date of				5.00
3.00	each payment. If none, write "NONE" or enter a zero. (1)				3.00
	Program to Provider				
5. 01				0	5.0°
5. 02				0	5. 0
5. 03				0	5. 03
	Provider to Program				
5.50	<u>.</u>			0	5. 50
5. 51				0	5. 5 ⁻
5.52				0	5. 5.
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			22, 895	6. 0°
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			92, 712	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8. 00	Name of Contractor				8. 0