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: 15-0061 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 6/12/2023 11:56 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 6/12/2023 Time: 11:56 am ] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(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.

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 DAVIESS COMMUNITY HOSPITAL (15-0061) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1	2	SI GNATURE STATEMENT	
1			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			2
3	Signatory Title			3
4	Date			4

		Title XVIII				
	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
HOSPI TAL	0	265, 005	-30, 761	0	688, 696	1.00
SUBPROVI DER - I PF	0	19, 508	0		117, 854	2.00
SUBPROVI DER - I RF	0	34, 334	0		0	3.00
SWING BED - SNF	0	0	0		0	5.00
SWING BED - NF	0				0	6.00
HOME HEALTH AGENCY I	0	0	0		0	9.00
RURAL HEALTH CLINIC I	0		14, 323		0	10.00
RURAL HEALTH CLINIC II	0		10, 470		0	10.01
RURAL HEALTH CLINIC III	0		-25, 282		0	10.02
RURAL HEALTH CLINIC V	0		0		0	10.04
RURAL HEALTH CLINIC VI	0		10, 267		0	10.05
TOTAL	0	318, 847	-20, 983	0	806, 550	200.00
	HOSPITAL SUBPROVIDER - IPF SUBPROVIDER - IRF SWING BED - SNF SWING BED - NF HOME HEALTH AGENCY I RURAL HEALTH CLINIC I RURAL HEALTH CLINIC III RURAL HEALTH CLINIC III RURAL HEALTH CLINIC V RURAL HEALTH CLINIC V RURAL HEALTH CLINIC VI	1.00	Title V	Title V	Title V	Title V

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

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

Health Financial Systems DAVIESS COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0061 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 6/12/2023 11:56 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: P0 Box: 760 1.00 Street: 1314 E. WALNUT STREET 1.00 Zi p Code: 47501 2.00 City: WASHINGTON State: IN County: DAVIESS 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 DAVIESS COMMUNITY 150061 99915 07/01/1966 Ν Р 0 3.00 1 HOSPI TAI Subprovi der - IPF 99915 4.00 DCH - PSYCH 15S061 4 01/01/2003 Ν Р 0 4.00 Subprovi der - IRF DCH - REHAB 15T061 99915 01/01/2000 Ρ 5.00 5 0 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF DAVIESS COMMUNITY 15U061 99915 11/10/1999 Р N N 7.00 7 00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce HELPING HEART HOSPICE 151553 99915 07/11/1996 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC DAVIESS COMMUNITY 158500 99915 12/17/2003 Ν 0 N 15.00 HOSPITAL MC NORTH DAVIESS MEDICAL Hospital-Based Health Clinic - RHC 153999 99915 12/17/2003 Ν 0 Ν 15.01 15.01 CENTER Hospital -Based Health Clinic - RHC DCH HEALTH PAVILION 158501 99915 03/30/2004 0 15.02 15.02 N N 1111 Hospital-Based Health Clinic - RHC 15.03 15.03 15.04 Hospital-Based Health Clinic - RHC VGRAND AVENUE PEDIATRICS 158503 99915 01/27/2005 Ν 0 Ν 15.04 Hospital-Based Health Clinic - RHC MARTIN MEDICAL CLINIC 15.05 158506 99915 10/31/2006 Ν 0 Ν 15.05 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 8 21.00 1. 00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Health Financial Systems DAVIESS COMM	IUNI TY I	HOSPI TAL				In Lie	eu of	Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Fr		Per Fro To		01/2022 31/2022	Wor Par Dat	ksheet S-2	pared:
			1 00			00			
22.04 Did this hospital receive a geographic reclassification frural as a result of the revised OMB delineations for state adopted by CMS in FY 2021? Enter in column 1, "Y" for year for the portion of the cost reporting period prior to Oct in column 2, "Y" for yes or "N" for no for the portion of reporting period occurring on or after October 1. (see in Does this hospital contain at least 100 but not more than counted in accordance with 42 CFR 412.105)? Enter in colyes or "N" for no.	atistic s or "N tober 1 f the c nstruct n 499 b	al areas " for no . Enter ost i ons) eds (as	1.00		2.	00		3.00	22.04
23.00 Which method is used to determine Medicaid days on lines below? In column 1, enter 1 if date of admission, 2 if ce if date of discharge. Is the method of identifying the dareporting period different from the method used in the preporting period? In column 2, enter "Y" for yes or "N"	ensus d ays in rior co for no	ays, or 3 this cost st		2		N			23. 00
Medi pai d	State i cai d d days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	St Med elig un	t-of ate i cai d gi bl e pai d	Medic HMO d	lays	Other Medicaid days	
24.00 If this provider is an IPPS hospital, enter the	. 00	2. 00	3.00		. 00	5.0	919	6. 00 78	24. 00
in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	51	0		0		71	o of Coope	25. 00
					1.		bat	e of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) cost reporting period. Enter "1" for urban or "2" for rur 27.00 Enter your standard geographic classification (not wage) reporting period. Enter in column 1, "1" for urban or "2"	ral. status	at the en	d of the co			:	2		26. 00 27. 00
enter the effective date of the geographic reclassificati 35.00 If this is a sole community hospital (SCH), enter the num effect in the cost reporting period.	on in	column 2.		n		(	0		35. 00
					Begi n			Endi ng: 2. 00	
36.00 Enter applicable beginning and ending dates of SCH status of periods in excess of one and enter subsequent dates.	s. Subs	cript line	36 for num	ber		00		2.00	36.00
37.00   If this is a Medicare dependent hospital (MDH), enter the is in effect in the cost reporting period.	e numbe	r of perio	ds MDH stat	us		(	0		37. 00
37.01 Is this hospital a former MDH that is eligible for the MD accordance with FY 2016 OPPS final rule? Enter "Y" for ye instructions)									37. 01
38.00 If line 37 is 1, enter the beginning and ending dates of greater than 1, subscript this line for the number of per enter subsequent dates.				•					38.00
onter subsequent dates.						/N		Y/N	
39.00 Does this facility qualify for the inpatient hospital pay hospitals in accordance with 42 CFR §412.101(b)(2)(i), (i 1 "Y" for yes or "N" for no. Does the facility meet the m accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? or "N" for no. (see instructions)	i), or mileage	(iii)? En	ter in colu nts in	ımn		<u>00</u> ⁄		2. 00 Y	39.00
40.00 Is this hospital subject to the HAC program reduction adj "N" for no in column 1, for discharges prior to October 1 no in column 2, for discharges on or after October 1. (se	1. Ente	r "Y" for			`	(		N	40.00

	complete Wkst. D, Parts III & IV and D-2, Pt. II, IT beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete line 56 is yes, did this facility elect cost reimble defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	R 413.7 on dut ete col ourseme comple	7(e)(1)(iv) a y, if the resp umn 2, and com nt for physici te Wkst. D-5.	nd (v), regard onse to line 5 plete Workshee ans' services	less of 6 is "Y" t E-4. as		58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes	s, comp	lete WKST. D-2	, Pt. I. NAHE 413.85	Worksheet A	Pass-Through	59.00
				Y/N	Li ne #	Qualification Criterion Code	
60.00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent (adjustment? Enter "Y" for yes or "N" for no in column	85? ( umn 1. CR) NAH	see If column 1 E MA payment	1. 00 N	2. 00	3.00	60.00
		Y/N	I ME	Direct GME	IME	Direct GME	
/ / 00	Della de la constanta de la co	1.00	2. 00	3. 00	4. 00	5. 00	// 00
61. 01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care	N			0. (	0.00	61. 01
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.05
	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

Health Financial Systems DAVIESS COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0061 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 6/12/2023 11:56 am Unwei ghted Program Name Unwei ghted Program Code IME FTE Count Direct GME FTE Count 2.00 3. 00 1.00 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 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 'Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs FTEs in Nonprovi der Hospi tal 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. 0.000000 64.00 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0 00 0 00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs 3/ (col. 3 + FTEs in Nonprovi der Hospi tal col. 4)) Si te 1.00 2.00 3.00 4. 00 5.00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 0.00 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)

Health Financial Systems	DAVI ESS	COMMUNITY HOSPITAL		In Lie	u of Form	CMS-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eri od:	Workshee		
			F To	rom 01/01/2022 o 12/31/2022	Part I Date/Tim		
			Unwei ghted	Unweighted	6/12/202 Ratio (		6 am
			FTEs	FTEs in	1/ (col .		
			Nonprovi der	Hospi tal	col. 2	2))	
			Si te 1.00	2. 00	3.00	1	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settir					
beginning on or after July 1, 2			0.00			200000	
66.00 Enter in column 1 the number of FTEs attributable to rotations			0.00	0. 00	0.0	000000	66.00
Enter in column 2 the number of	unweighted non-primar	ry care resident					
FTEs that trained in your hospi (column 1 divided by (column 1							
(cordillir r dr vr ded by (cordillir r	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (	col .	
	, and the second		FTEs	FTEs in	3/ (col.		
			Nonprovi der Si te	Hospi tal	col. 4	4))	
	1. 00	2.00	3. 00	4. 00	5. 00		
67.00 Enter in column 1, the program			0.00			000000	67. 00
name associated with each of							
your primary care programs in which you trained residents.							
Enter in column 2, the program							
code. Enter in column 3, the							
number of unweighted primary care FTE residents attributable							
to rotations occurring in all							
non-provider settings. Enter in							
column 4, the number of unweighted primary care							
resident FTEs that trained in							
your hospital. Enter in column							
5, the ratio of (column 3 divided by (column 3 + column							
4)). (see instructions)							
					1.00		
Direct GME in Accordance with t							
68.00 For a cost reporting period beg MAC to apply the new DGME formu					N		68. 00
(August 10, 2022)?	a ili accordance wrth	the FT 2023 IPPS FI	ilai kuie, o/ FK	49005-49072			
				1.00	0 2.00	3 00	
Inpatient Psychiatric Facility	PPS			1.00	3   2.00	3.00	
70.00 Is this facility an Inpatient P		IPF), or does it con	tain an IPF sub	provi der? Y			70.00
Enter "Y" for yes or "N" for no 71.00 If line 70 is yes: Column 1: Die		n annroved GME teach	ing program in	the most N	l N	0	71.00
recent cost report filed on or						١ ١	71.00
42 CFR 412.424(d)(1)(iii)(c)) C	olumn 2: Did this faci	ility train resident	s in a new teac	hi ng			
program in accordance with 42 C Column 3: If column 2 is Y, ind	-к 412.424 (d)(1)(iii)  cate_which_program_v	)(צ) ל Enter "Y" for ear began during thi	yes or "N" for s cost reportin	no. a period			
(see instructions)				J F = 1.7 Ga.			
Inpatient Rehabilitation Facili		v (LDE) on deep !!	contain as IDS	l v			75 00
75.00 Is this facility an Inpatient R subprovider? Enter "Y" for yes	and "N" for no	y (IKF), OF does It	CONTAIN AN IRF	Y			75. 00
76.00 If line 75 is yes: Column 1: Die	d the facility have a				N	0	76.00
recent cost reporting period en							
no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ent							
indicate which program year beg							
					1.00		
Long Term Care Hospital PPS					1.00		
80.00 Is this a long term care hospita					N		80.00
81.00 Is this a LTCH co-located within "Y" for yes and "N" for no.	n another hospital fo	r part or all of the	cost reporting	peri od? Enter	N		81.00
TEFRA Provi ders							
85.00 Is this a new hospital under 42					N		85.00
86.00 Did this facility establish a no §413.40(f)(1)(ii)? Enter "Y" for	ew Other subprovider	(excluded unit) unde	r 42 CFR Sectio	n			86. 00
87.00 Is this hospital an extended ne			under section		N		87. 00
1886(d)(1)(B)(vi)? Enter "Y" fo							

Health Financial Systems DAVIESS COMMUNIT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Pre 6/12/2023 11:	pared:	
			Approved for Permanent Adjustment (Y/N) 1.00	Number of Approved Permanent Adjustments 2.00		
88.00 Column 1: Is this hospital approved for a permanent adjustmen amount per discharge? Enter "Y" for yes or "N" for no. If yes 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	s, complete c		ne	0	88.00	
		Wkst. A Line	Date	Approved Permanent Adjustment Amount Per Discharge		
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A li on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA tarper discharge.  Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	based. period get amount	1.00	2.00	3.00	89.00	
This earget amount per discordinger			V	XIX		
Title V and XIX Services			1. 00	2. 00		
90.00 Does this facility have title V and/or XIX inpatient hospital	servi ces? E	nter "Y" for	N	Y	90.00	
	yes or "N" for no in the applicable column.  91.00 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.					
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dua		N	92.00			
93.00 Does this facility operate an ICF/IID facility for purposes on "Y" for yes or "N" for no in the applicable column.	N	N	93. 00			
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the				N	94.00	
applicable column. 95.00   If line 94 is "Y", enter the reduction percentage in the appl 96.00   Does title V or XIX reduce operating cost? Enter "Y" for yes	0. 00 N	0. 00 N	95. 00 96. 00			
applicable column. 97.00   If line 96 is "Y", enter the reduction percentage in the appl 98.00   Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo column 1 for title V, and in column 2 for title XIX.	erns and res	idents post	0. 00 Y	0. 00 Y	97. 00 98. 00	
98.01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. 01	
98.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			Y	Y	98. 02	
for title V, and in column 2 for title XIX.  98.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98. 03	
for title V, and in column 2 for title XIX.  98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in	eimbursed 10 column 1 for	1% of title V, and	N N	N	98. 04	
98.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Υ	98. 05	
98.06 Does title VIX.  98.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Υ	98. 06	
Rural Providers  105.00 Does this hospital qualify as a CAH?			N		105.00	
106.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)		. ,	nt N		106. 00	
107.00 Column 1: If line 105 is Y, is this facility eligible for cos training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instruction	1. (see ins you train I&R and/or IRF	tructions) s in an	N		107.00	
108.00 Is this a rural hospital qualifying for an exception to the CCFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	. N		108. 00	

Health Financial Systems DAVIESS COMMUNI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		TY HOSPITAL Provider CCN: 15-0061 Pe		ieu of Form CMS. Worksheet S	
STITAL AND HOSTITAL HEALTH GARL COMMERN TENTH TO BATA	Trovider o	ON. 13 0001	From 01/01/20 To 12/31/20	22 Part I	repare
	Physi cal 1.00	Occupati on	Speech 3.00	Respiratory	
9.00  f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	2. 00 N	N N	4.00 N	109.
				1.00	
0.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work applicable.	" for yes o	r "N" for no.	If yes,	N	110.
			1.00	2.00	
1.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting umn 1 is Y, cicipating in	period? Ente enter the n column 2.			111.
		1.00	2.00	3.00	-
2.00 Did this hospital participate in the Pennsylvania Rural Healt (PARHM) demonstration for any portion of the current cost repperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participademonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable.	porting umn 1 is ating in the sed	N			112.
3. OODid this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current of reporting period? Enter "Y" for yes or "N" for no.					113
Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (ipsychiatric, rehabilitation and long term hospitals providers	or E only) 3" percent ncludes	N			0115
the definition in CMS Pub.15-1, chapter 22, §2208.1. 5.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	for yes or	N			116
7.00 s this facility legally-required to carry malpractice insura	nce? Enter	Y			117
"Y" for yes or "N" for no. 3.00 s the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre			2		118
		Premi ums	Losses	Insurance	
		1.00	2. 00	3.00	
B.01 List amounts of malpractice premiums and paid losses:		213, 2		0	0118
			1.00	2.00	
3.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			N		118
0.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "' alifies for	Y" for yes or the Outpatier	,	N	119
.00 Did this facility incur and report costs for high cost implan	ntable devic	es charged to	Y		121
patients? Enter "Y" for yes or "N" for no.  .00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1					122
the Worksheet A line number where these taxes are included.  ODDid the facility and/or its subproviders (if applicable) purc services, e.g., legal, accounting, tax preparation, bookkeepi management/consulting services, from an unrelated organization for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e.,	ng, payroll on? In colum	, and/or n 1, enter "\			123
professional services expenses, for services purchased from u	inrelated or	gani zati ons			
located in a CBSA outside of the main hospital CBSA? In colum "N" for no.					
located in a CBSA outside of the main hospital CBSA? In colum		"Y" for ves	N		125

Health Financial Systems	DAVIESS COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-:	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATION DATA	Provi der CC	CN: 15-0061	Peri od:	Worksheet S-2			
				From 01/01/2022 To 12/31/2022		pared:		
					6/12/2023 11:	56 am		
				1.00	2.00	-		
127.00 If this is a Medicare-certified heart transp			fication date		2.00	127. 00		
in column 1 and termination date, if applicable, in column 2.  128.00   f this is a Medicare-certified liver transplant program, enter the certification date								
in column 1 and termination date, if applicable, in column 2.  129.00 f this is a Medicare-certified lung transplant program, enter the certification date								
in column 1 and termination date, if applica 130.00 If this is a Medicare-certified pancreas tra	insplant program,	enter the ce	rti fi cati on			130. 00		
date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare-certified intestinal transplant program, enter the certification								
date in column 1 and termination date, if and 132.00 lf this is a Medicare-certified islet transp	lant program, en	ter the certi	fication date	e		132. 00		
in column 1 and termination date, if applica			ha ODO numba			133.00		
134.00  f this is a hospital-based organ procuremer in column 1 and termination date, if applications			ne upu numbei			134. 00		
All Providers  140.00 Are there any related organization or home of				N		140. 00		
chapter 10? Enter "Y" for yes or "N" for no are claimed, enter in column 2 the home offi	ce chain number.	(see instruc						
1.00	2.00		ugh 142 tho	3.00	s of the home			
If this facility is part of a chain organize office and enter the home office contractor	name and contrac				s or the nome			
141.00 Name:   Contr 142.00 Street:   P0 Bo	actor's Name:		Contract	or's Number:		141. 00 142. 00		
143. 00 Ci ty: State			Zi p Code	:		143. 00		
1.00 144.00 Are provider based physicians' costs included in Worksheet A?  Y								
144. OOM e provider based priysrcrans costs frictude	d III WOLKSHEEL A	<b>. :</b>			'	144. 00		
				1. 00	2. 00	1.15.00		
145.00 of costs for renal services are claimed on Winpatient services only? Enter "Y" for yes on no, does the dialysis facility include Medic period? Enter "Y" for yes or "N" for no in 146.00 Has the cost allocation methodology changed Enter "Y" for yes or "N" for no in column 1.	or "N" for no in care utilization column 2. from the previou (See CMS Pub. 1	column 1. If for this cost asly filed cos	column 1 is reporting t report?	N		145. 00 146. 00		
yes, enter the approval date (mm/dd/yyyy) ir	1 COLUMN 2.							
147.00 Was there a change in the statistical basis?	P Enter "V" for v	wes or "N" for	no		1. 00 N	147. 00		
148.00Was there a change in the order of allocation					N	148. 00		
149.00 Was there a change to the simplified cost fi	nding method? En				N	149. 00		
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	-		
Does this facility contain a provider that or charges? Enter "Y" for yes or "N" for no			m the applic	ation of the lo	wer of costs			
155.00Hospital 156.00Subprovider - IPF		N	N	N	N	155.00		
156. 00 Subprovider - TPF 157. 00 Subprovider - TRF		N N	N N	N N	N N	156. 00 157. 00		
158. 00 SUBPROVI DER						158. 00		
159. 00 SNF		N	N	N	N	159.00		
160.00HOME HEALTH AGENCY 161.00CMHC		N	N N	N N	N N	160. 00 161. 00		
161. 10 CORF			N N	N	N	161. 10		
1					1.00			
Multicampus  165.00 s this hospital part of a Multicampus hospi Enter "Y" for yes or "N" for no.	tal that has one	or more camp	uses in diffe	erent CBSAs?	N	165. 00		
Na		County		p Code CBSA	FTE/Campus			
166.00  f   line 165 is yes, for each	J	1. 00	2.00	3.00 4.00	5.00	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)					3.00	100.00		

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPI TAL	In Lie	of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	From 01/01/2022 F To 12/31/2022 F				-2 repared: 1:56 am
				07 127 2020 .	
				1. 00	
Health Information Technology (HIT) in	centive in the American	Recovery and Reinvestme	nt Act		
167.00 Is this provider a meaningful user under	er §1886(n)? Enter "Y"	for yes or "N" for no.		Υ	167. 00
168.00 If this provider is a CAH (line 105 is reasonable cost incurred for the HIT as	), enter the		168. 00		
168.01 If this provider is a CAH and is not a		168. 01			
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)  169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					99169. 00
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beging period respectively (mm/dd/yyyy)	ning date and ending da	te for the reporting			170. 00
			1. 00	2.00	
171.00  f   line 167 is "Y", does this provider section 1876 Medicare cost plans reporting "Y" for yes and "N" for no in column 1, 1876 Medicare days in column 2. (see in	ted on Wkst. S-3, Pt. I If column 1 is yes, e	, line 2, col. 6? Enter	N on		0171.00

Heal th	Financial Systems DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre	epared:
				Y/N	6/12/2023 11: Date	56 am
	DADT II. JOSPITAL AND JOSPITAL JIFATIJADE COMPLEY DELMBIJDS	EMENT OUECTLON	MALDE	1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURS General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
	Provider Organization and Operation		The second			1
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N		1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare	Program? If	1.00 N	2. 00	3. 00	2.00
3. 00	yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary. Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	mn 3, "V" for ng management offices, drug der or its of the board	N			3. 00
	rotations, por (eee their detroile)		Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A		4.00
5. 00	Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5.00
	Y/N	Legal Oper.				
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	s the provide	r N		6. 00
the legal operator of the program?  7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions.  8.00 Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.						7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructio		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.00
	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N	)	11.00
					Y/N 1. 00	
	Bad Debts					10.00
12.00	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection	policy change of	tions. during this co	ost reporting	Y N	12. 00 13. 00
	<pre>period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsur instructions.</pre>	ance amounts wa	aived? If yes,	, see	N	14. 00
	Bed Complement Did total beds available change from the prior cost report	ing period? If	yes, see ins	tructions.	N	15. 00
		Par	t A	Par	t B	
		1. 00	2.00	Y/N 3. 00	Date 4.00	
	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16. 00
17. 00	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 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/31/2023	Y	03/31/2022	17. 00
	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Y		N		19. 00

Heal th	Financial Systems DAVIESS COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0061		Worksheet S-2 Part II Date/Time Pre 6/12/2023 11:	epared:		
					Y/N			
20.00	If I are 1/ are 17 in the property and to DCOD		0	1.00	3. 00 N	20.00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	IN	20.00		
		Y/N	Date	Y/N	Date			
04.00	III	1.00	2. 00	3.00	4. 00	01.00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)					
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se	a instructions				22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense			ing the cost		23. 00		
	reporting period? If yes, see instructions.							
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	· ·				24.00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period:	'If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost report	ing period? I	f yes, see		26. 00		
27. 00	Has the provider's capitalization policy changed during th copy.	e cost reporti	ng period? If	yes, submit		27. 00		
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e		28. 00					
20.00	period? If yes, see instructions.  29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
29.00	treated as a funded depreciation account? If yes, see inst		ebt Service r	(eserve rund)		29. 00		
30.00	Has existing debt been replaced prior to its scheduled mat	urity with new	debt? If yes	s, see		30.00		
31. 00	instructions.  1.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.							
32. 00	Purchased Services							
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If		33.00		
	no, see instructions.					-		
34. 00	Provider-Based Physicians Were services furnished at the provider facility under an	arrangement wi	th provider-b	pased physicians?		34.00		
	If yes, see instructions.	· ·	·	. ,				
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provi der-based		35.00		
	This addring the dost reporting period. It yes, see t	nstructions.		Y/N	Date			
	lu san s			1. 00	2. 00			
36 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00		
	If line 36 is yes, has a home office cost statement been p lf yes, see instructions.	repared by the	home office?			37. 00		
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			=		38. 00		
39. 00				5,		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00		
		1	00		00			
	Cost Report Preparer Contact Information	1.	00	2.	00			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	NI CHOLAS		EI CHELMAN		41.00		
42. 00	respectively. Enter the employer/company name of the cost report	FORVI S				42.00		
43. 00	preparer. Enter the telephone number and email address of the cost	317-383-4000		NI CHOLAS. EI CHEI	MAN@FORVIS CO	43.00		
.0.00	report preparer in columns 1 and 2, respectively.			M		.5. 50		

Health Financial Systems DAVIESS COMMU	JNITY HOSPITAL	In Lie	u of Form CMS-2552-10	0
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0061	Peri od: From 01/01/2022	Worksheet S-2 Part II	_
			Date/Time Prepared: 6/12/2023 11:56 am	_
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	PARTNER		41.00	)
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the cost report			42.00	)
preparer.				
43.00 Enter the telephone number and email address of the cost			43.00	)
report preparer in columns 1 and 2, respectively.				

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: Health Financial Systems DAVIESS OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0061

				Τ̈́	o 12/31/2022	Date/Time Pre 6/12/2023 11:	
						I/P Days / O/P Visits / Trips	JO dill
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00	2. 00	3.00	4. 00	5. 00	
4 00	PART I - STATISTICAL DATA	00.00		10 505	0.00		
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)	30. 00	,	13, 505	0.00	0	2.00
2. 00 3. 00 4. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						3. 00 4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		;	13, 505	0. 00	0	
8. 00 9. 00	INTENSI VE CARE UNIT	31.00		5 1, 825	0.00	0	8. 00 9. 00
10. 00 11. 00 12. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						10.00 11.00 12.00
13.00	NURSERY	43. 00	ŀ			0	13.00
14.00	Total (see instructions)		4	15, 330	0.00	0	14.00
15. 00 16. 00	CAH visits SUBPROVIDER - IPF	40. 00	,	7, 300		0	15. 00 16. 00
17. 00	SUBPROVIDER - IPF	41. 00	•	12 4, 380		0	17.00
18. 00	SUBPROVI DER	41.00		4, 500			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	101.00				0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	116. 00		0 0	)		24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	00.40					25.00
25. 10	CMHC - CORF	99. 10	•			0	25. 10 26. 00
26. 00 26. 01	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	88. 00 88. 01				0	26.00
26. 01	RURAL HEALTH CLINIC III	88. 02				0	26.01
26. 04	RURAL HEALTH CLINIC V	88. 04				0	26.04
26. 05	RURAL HEALTH CLINIC VI	88. 05				Ö	26.05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	<b>l</b>			0	26. 25
27.00	Total (sum of lines 14-26)		-	74			27.00
28.00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)			0 0	'		32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days						33.00
33. 00	LTCH site neutral days and discharges						33.00
34. 00	3	30.00		o c		0	

Health Financial Systems DAVIESS OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0061

				'	0 12/31/2022	6/12/2023 11:	
		I/P Davs	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
						1	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
<u>-</u>	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	760	112	2, 427			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)	467	981				2.00
3.00	HMO IPF Subprovider	136	43				3.00
4.00	HMO IRF Subprovider	72	122				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	760	112	2, 427			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	267	22	646			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		66	815			13.00
14.00	Total (see instructions)	1, 027	200	3, 888	0.00	298. 95	14.00
15.00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF	2, 821	525	3, 845		27. 60	16. 00
17.00	SUBPROVI DER - I RF	1, 016	0	1, 400	0.00	11. 38	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	0	0	0	0. 00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00		3, 046	3	3, 933	0.00	3. 72	24.00
24. 10	HOSPICE (non-distinct part)			8			24. 10
25.00	CMHC - CMHC						25.00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	1, 076	1, 157	5, 970	0.00	7. 14	26.00
26. 01	RURAL HEALTH CLINIC II	1, 135	529	4, 273	0.00	6. 77	26. 01
26. 02	RURAL HEALTH CLINIC III	1, 711	5, 353	18, 266	0.00	16. 07	26. 02
26. 04	RURAL HEALTH CLINIC V	o	3, 415	6, 050	0.00	7. 51	26. 04
26. 05	RURAL HEALTH CLINIC VI	1, 142	509	5, 109	0.00	7. 08	26. 05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00					0.00	386. 22	27.00
28. 00			353	1, 597			28. 00
29.00	Ambul ance Trips	o					29. 00
30.00	•			68			30.00
31.00				0			31.00
32.00	1 1 3	О	78	161			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)			]			
33.00		О					33.00
33. 01	1	O					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	o	0	0			34.00

Provi der CCN: 15-0061

				10	5 12/31/2022	6/12/2023 11:	
		Full Time		Di sch	arges	07 127 2020 111.	oo aiii
	C	Equi val ents	T: ±1 = \/	T: +1 - W// 1 1	T: +1 - VIV	T-+-1 All	
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA	11.00	12.00	13.00	14.00	13.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		(	0 358	274	1, 117	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)			152	0		2. 00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO I RF Subprovi der				0		4.00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00 6. 00
7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						7. 00
7.00	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	(	0 358	274	1, 117	14.00
15. 00	CAH visits						15.00
16. 00	SUBPROVIDER - I PF	0.00		0 159	37	232	16. 00
17.00	SUBPROVIDER - IRF	0. 00	(	0 81	3	98	17.00
18.00	SUBPROVI DER						18.00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						19. 00 20. 00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0.00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					23. 00
24. 00	HOSPI CE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
25. 10	CMHC - CORF	0.00					25. 10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26. 04	RURAL HEALTH CLINIC V	0.00					26. 04
26. 05	RURAL HEALTH CLINIC VI	0. 00 0. 00					26. 05
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25 27. 00
28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00					28.00
29. 00							29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00							32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	1			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

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0061

					Ť	o 12/31/2022	Date/Time Pre 6/12/2023 11:	pared: 56 am
		Wkst. A Line	Amount	Reclassi fi cat	Adj usted	Paid Hours	Average	
		Number	Reported	i on of Sal ari es	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2. 00	A-6) 3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200.00	29, 288, 402	266, 349	29, 554, 751	962, 337. 00	30. 71	1.00
2 00	instructions)		0			0.00	0.00	2 00
2. 00	Non-physician anesthetist Part A		0	0	C	0. 00	0. 00	2.00
3.00	Non-physician anesthetist Part		0	0	C	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		27, 000	0	27, 000	161. 87	166. 80	4.00
4. 01	Physicians - Part A - Teaching		0	0		0.00		
5. 00	Physician and Non Physician-Part B		1, 359, 239	0	1, 359, 239	9, 644. 63	140. 93	5.00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		2, 673, 664	0	2, 673, 664	83, 564. 34	32. 00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	o d	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0		0. 00	0. 00	7. 01
7.01	residents (in an approved programs)		0			0.00	0.00	7.01
8. 00	Home office and/or related organization personnel		0	0	C	0. 00	0. 00	8. 00
9. 00	SNF	44. 00	0	0	О	0. 00	0. 00	
10. 00	Excluded area salaries (see instructions)		7, 307, 365	113, 667	7, 421, 032	246, 323. 00	30. 13	10.00
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		968, 761	0	968, 761	7, 259. 00	133. 46	11.00
12. 00	Care Contract Labor: Top Level		591, 115	0	591, 115	4, 160. 00	142. 09	12.00
12.00	management and other management and administrative		341, 113	0	371, 113	4, 100.00	142.09	12.00
13. 00	services Contract Labor: Physician-Part		30, 000	0	30, 000	31. 25	960. 00	13. 00
14. 00	A - Administrative Home office and/or related		0	0	C	0. 00	0. 00	14.00
	organization salaries and							
14. 01	wage-related costs Home office salaries		0	0	C	0. 00	0. 00	14. 01
14. 02	Related organization salaries		0	0	O	0.00		
15. 00	Home office: Physician Part A - Administrative		0	0	C	0. 00	0. 00	15. 00
16.00	Home office and Contract		0	0	C	0. 00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	l o	0. 00	0. 00	16. 01
1/ 00	- Teachi ng		0			0.00		
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		3, 652, 144	0	3, 652, 144			]   17. 00
17.00	instructions)		3, 032, 144		3, 032, 144			17.00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00	Excluded areas		1, 484, 819	0	1, 484, 819			19. 00
20.00	Non-physician anesthetist Part A Non-physician anesthetist Part		0	0	0			20.00
	В		0					
22. 00	Physician Part A - Administrative		3, 015	0	3, 015			22.00
22. 01	Physician Part A - Teaching		0	0	o			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		156, 596 516, 840		156, 596 516, 840			23. 00 24. 00
25. 00	Interns & residents (in an		0 10, 640	ő	0 0			25. 00
25. 50	approved program) Home office wage-related		0	0	C			25. 50
	(core)		_					
25. 51	Related organization wage-related (core)		0	0	C			25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0	C			25. 52
	wage-related (core)			I	I			I

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0061 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 6/12/2023 11:56 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 195, 069 195, 069 5, 991. 00 32. 56 26.00 27.00 Administrative & General 5.00 3, 098, 561 -17, 177 3, 081, 384 102, 552. 00 30.05 27.00 28.00 218, 930 218, 930 964.00 227. 11 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 68, 634 68, 634 2, 160. 00 31. 78 29.00 30.00 Operation of Plant 7.00 0.00 0.00 30.00 0 0 Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 0 15. 92 32.00 34, 346. 00 Housekeepi ng 9.00 546, 669 Ω 546, 669 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 354, 267 -251, 610 102, 657 22, 893. 00 4. 48 34.00 35.00 Dietary under contract (see 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 168, 722 168, 722 9, 776. 00 17. 26 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 34. 02 19, 060. 00 38.00 38.00 13.00 648, 501 Ω 648, 501 39.00 Central Services and Supply 14.00 295, 384 0 295, 384 13, 264. 00 22. 27 39.00 40.00 Pharmacy 15.00 510, 230 0 510, 230 15, 866.00 32. 16 40.00 Medical Records & Medical Records Library 23, 779. 00 41.00 16.00 539, 159 0 539, 159 22. 67 41.00

0

0

266, 349

17.00

18.00

8, 879. 00

0.00

30.00 42.00

0.00 43.00

266, 349

42.00

Social Service

43.00 Other General Service

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0061	Period: Worksheet S-3

						rom 01/01/2022 o 12/31/2022		
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		25, 474, 429	266, 349	25, 740, 778	870, 092. 03	29. 58	1.00
	instructions)							
2.00	Excluded area salaries (see		7, 307, 365	113, 667	7, 421, 032	246, 323. 00	30. 13	2.00
	instructions)							
3.00	Subtotal salaries (line 1		18, 167, 064	152, 682	18, 319, 746	623, 769. 03	29. 37	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 589, 876	0	1, 589, 876	11, 450. 25	138. 85	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		3, 655, 159	0	3, 655, 159	0.00	19. 95	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		23, 412, 099	152, 682	23, 564, 781	635, 219. 28	37. 10	6.00
7.00	Total overhead cost (see		6, 475, 404	166, 284	6, 641, 688	259, 530. 00	25. 59	7.00
	instructions)							
	,			•	•		•	

DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
Provi der CCN: 15-0061	Peri od: Worksheet S-3
	From 01/01/2022 Part IV

	10 12/31/2022	Date/lime Pre   6/12/2023 11:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	515, 068	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	11, 915	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	2, 946, 931	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00		25, 827	11.00
12.00		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	28, 576	
14.00		0	14.00
15.00		130, 427	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
	FICA-Employers Portion Only	0	
18.00	Medicare Taxes - Employers Portion Only	2, 132, 998	
19. 00		0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER COLUMN TO DO THE TO THE TOTAL		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
00.00	instructions))		00.00
	Day Care Cost and Allowances	0	
	Tuition Reimbursement	21, 672	23.00
24.00	Total Wage Related cost (Sum of Lines 1 -23)	5, 813, 414	24. 00
25 00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	JUINER WAGE RELATED COSTS (SPECIFT)	1	25.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0061	Peri od:	Worksheet S-3

1103111	AL CONTRACT EADOR AND BENEFIT COST	Trovider con. 13-0001	From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
				6/12/2023 11:	56 am
	Cost Center Description		Contract	Benefit Cost	
			Labor	0.00	
	DART W. Control Laborator I Brand Cit Cont		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
4 00	Hospital and Hospital-Based Component Identification:		0/0.7/4	F 040 444	1 00
1.00	Total facility's contract labor and benefit cost		968, 761	5, 813, 414	1.00
2.00	Hospi tal		968, 761	5, 813, 414	1
3.00	SUBPROVI DER - I PF		0	0	3.00
4.00	SUBPROVI DER - I RF		0	0	4.00
5. 00	Subprovi der - (0ther)		0	0	5.00
6. 00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7.00
8. 00	SKILLED NURSING FACILITY				8. 00
9. 00	NURSING FACILITY				9. 00
	OTHER LONG TERM CARE I				10.00
	Hospi tal -Based HHA		0	0	11. 00
	AMBULATORY SURGICAL CENTER (D. P. ) I				12.00
	Hospi tal -Based Hospi ce		0	0	
	Hospital-Based Health Clinic RHC		0	0	14.00
	Hospital-Based Health Clinic RHC 1		0	0	14. 01
	Hospital-Based Health Clinic RHC 2		0	0	14. 02
	Hospital-Based Health Clinic RHC 3		0	0	14.03
14. 04	Hospital-Based Health Clinic RHC 4		0	0	14. 04
14. 05	Hospital-Based Health Clinic RHC 5		0	0	14.05
15. 00	Hospital-Based Health Clinic FQHC				15.00
16. 00	Hospi tal -Based-CMHC				16. 00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17.00	RENAL DIALYSIS I				17.00
18. 00	Other		0	0	18. 00

yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)    Sunday	Heal th	Financial Systems	DAVIESS COMMUNI	ITY HOSPITAL		In Lie	eu of Form CMS	S-25	552-10
Component CON; 15-8500   To 12/31/2002   Patr PTIRE Property 2023 11:5   Cost	HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0061			-8	
City   State   ZiP Code   City   State   ZiP Code   Z				Component	CCN: 15-8500		Date/Time Pr		
1.00						RHC I			o alli
Clinic Address and Identification   1402 GRAND AVENUE   1.00   2.00   3.00				<u>'</u>					
1,00   Street						1.	00		
City   State   71P Code						1402 GRAND AVE	NUE	-	1. 00
2.00   City, State, ZIP Code, County	1.00	Street		Ci	ty				1.00
1.00					00				
NoSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rural or "U" for urban   O	2. 00	City, State, ZIP Code, County		WASHI NGTON		IN	47501		2. 00
1.00   HoSPITAL-BASED FORCS ONLY: Designation - Enter "R" for rural or "U" for urban   O   Cantum Award   Date							1 00	+	
Source of Federal Funds   1.00   2.00	3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for	urban			0	3.00
Source of Federal Funds		, , , , , , , , , , , , , , , , , , ,			Grai	nt Award	Date		
Community Health Center (Section 330(d), PHS Act)						1. 00	2. 00		
Migrant Health Center (Section 329(d), PHS Act)	4 00		Ac+)		I		T		4. 00
Heal th Servi ces for the Homeless (Section 340(d), PHS Act)									5. 00
Look-Alikes   9.00   OTHER (SPECIFY)									6. 00
9.00   OTHER (SPECIFY)									7.00
1.00   2.00   3.00   4.00   5.00   2.00									8.00
10.00   Does this facility operate as other than a hospital-based RRC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)    Sunday	9. 00	OTHER (SPECIFY)						_	9. 00
10.00   Does this facility operate as other than a hospital-based RRC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)    Sunday						1 00	2 00	+	
2 (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)   Sunday	10. 00	Does this facility operate as other than a h	ospi tal -based R	RHC or FQHC? E	nter "Y" for			0	10.00
Nours.   Nours.   Nounday   Nounday   Tuesday   From   to   From									
From   to   from   from   to   from		` 1	other operati	on(s) and the	operatring				
1.00   2.00   3.00   4.00   5.00			Sund	day	N	londay	Tuesday		
Facility hours of operations (1)								_	
11.00   CLINIC		Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	+	
1.00 2.00  12.00 Have you received an approval for an exception to the productivity standard?  13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30. 8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.  Provider name CCN  1.00 2.00  14.00 RHC/FOHC name, CCN  Y/N V XVIII XIX Total Visits  1.00 2.00 3.00 4.00 5.00  15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  County  4.00  City, State, ZIP Code, County  Tuesday  Wednesday  Thursday  Tuesday  Wednesday  Thursday  Thursday  Total Visits  Thursday  Thursday  Thursday  Thursday  Thursday  Total Visits  Thursday  Thursday  Thursday  Thursday  Thursday  Thursday  Thursday  Thursday  Total Visits  Thursday					08: 00	17: 00	08: 00		11. 00
12.00 Have you received an approval for an exception to the productivity standard? 13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.    Provider name   CCN   1.00   2.00		<del></del>	· · · · · · · · · · · · · · · · · · ·						
13.00							2. 00		
30. 8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.    Provider name   CCN   1.00   2.00									12.00
number of providers included in this report. List the names of all providers and numbers below.  Provider name CCN 1.00 2.00  14.00 RHC/FOHC name, CCN  TY/N V XVIII XIX Total Visits to 1.00 2.00 3.00 4.00 5.00  15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  County 4.00  2.00 City, State, ZIP Code, County  Tuesday Wednesday Thursday  to from to from to from to From to From to Facility hours of operations (1)	13.00					IN		ال	13.00
Provider name   CCN     1.00   2.00									
1.00   2.00		numbers below.		·				$\perp$	
14.00   RHC/FOHC name, CCN								+	
Y/N   V   XVIII   XIX   Total Visits	14 00	PHC/FOHC name CCN				1. 00	2.00	+	14. 00
1.00 2.00 3.00 4.00 5.00  15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  County  4.00  2.00 City, State, ZIP Code, County  Tuesday  Wednesday  Thursday  to from to from to 6.00 7.00 8.00 9.00 10.00	14.00	Kilo/ Laile Halle, Colv	Y/N	V	XVIII	XIX	Total Visits		14.00
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  County 4.00  2.00 City, State, ZIP Code, County  DAVIESS  Tuesday  Wednesday  Thursday  to from to from to 6.00 7.00 8.00 9.00 10.00				2. 00					
column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)    County   4.00	15. 00								15.00
4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  County 4.00  2.00 City, State, ZIP Code, County  DAVIESS  Tuesday  Wednesday  Thursday  to from to from to 6.00 7.00 8.00 9.00 10.00									
Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  County 4.00  2.00 City, State, ZIP Code, County  Tuesday  To from from to from to from to from from to from to from to from from to from from to from from to from from from from from from from fro									
XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  County 4.00  2.00 City, State, ZIP Code, County  Tuesday  to from from to from to from to from from to from to from to from from from from from from from fro									
(see instructions)		XIX, as applicable. Enter in column 5 the							
County   4.00		•							
A.00		(see instructions)		Co	Int.			-	
Z. 00         City, State, ZIP Code, County         DAVIESS           Facility hours of operations (1)         Tuesday Wednesday Thursday         Thursday           to         from         to         from         to           6.00         7.00         8.00         9.00         10.00									
Tuesday   Wednesday   Thursday   to   from	2. 00	City, State, ZIP Code, County							2. 00
6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)					esday	Thur	sday		
Facility hours of operations (1)									
		F:   : t., b-, (1)	6. 00	7. 00	8.00	9. 00	10.00		
11. 00   CLINIC   17: 00   08: 00   17: 00   08: 00   17: 00			17:00	08:00	17:00	08: 00	17:00		11. 00

Health Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od: From 01/01/2022	Worksheet S-8	
		Component		To 12/31/2022		
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00   CLI NI C	08: 00	17: 00				11. 00

Heal th	Financial Systems	DAVIESS COMMUNI	TY HOSPITAL		In Lie	eu of Form CN	/S-2	552-10
HOSPI T	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CCN: 15-0061	Peri od:	Worksheet	S-8	
			Component	CCN: 15-3999	From 01/01/2022 To 12/31/2022	Date/Time		
					RHC II	6/12/2023 Cos		oo alii
					1010 11			
	Clinic Address and Identification				1.	00		
1. 00	Street				202 NORTH WEST	STREET		1. 00
	1000		Ci	ty	State	ZIP Code		
			1.	00	2.00	3. 00		
2.00	City, State, ZIP Code, County	(0	DDON		IN	47562		2.00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rura	l or "II" for	urhan		1.00	0	3. 00
3.00	HOSPITAL-BASED FUNCS ONLY. DESIGNATION - EITE	er k TOLTULA	11 01 0 101		nt Award	Date	U	3.00
					1. 00	2.00		
	Source of Federal Funds			•				
4.00	Community Health Center (Section 330(d), PHS							4.00
5.00	Migrant Health Center (Section 329(d), PHS A							5.00
6.00	Health Services for the Homeless (Section 34	O(d), PHS Act)						6.00
7. 00 8. 00	Appal achi an Regional Commission Look-Alikes							7. 00 8. 00
9. 00	OTHER (SPECIFY)							9. 00
71.00	To make (or corn t)							7.00
					1.00	2.00		
10. 00	Does this facility operate as other than a h	•			N		0	10.00
	yes or "N" for no in column 1. If yes, indic							
	2. (Enter in subscripts of line 11 the type o hours.)	r other operati	on(s) and the	operating				
	Tiour S. )	Suno	lav	T M	onday	Tuesday		
		from	to	from	to	from		
		1. 00	2.00	3.00	4. 00	5. 00		
	Facility hours of operations (1)							
11. 00	CLINIC			08: 00	17: 00	08: 00	_	11. 00
					1.00	2.00	-	
12. 00	Have you received an approval for an excepti	on to the produ	ictivity stand	lard?	1. 00 Y	2. 00		12. 00
13. 00	Is this a consolidated cost report as define				N N		o	13.00
	30.8? Enter "Y" for yes or "N" for no in col						-	
	number of providers included in this report.	List the names	of all provi	ders and				
	numbers below.			1 5 .		2011	_	
					der name 1.00	2. 00		
14 00	RHC/FQHC name, CCN				1. 00	2.00		14.00
	Transfer Tamer, Son	Y/N	V	XVIII	XIX	Total Visi	ts	
		1. 00	2. 00	3.00	4.00	5. 00		
15.00	Have you provided all or substantially all							15.00
	GME cost? Enter "Y" for yes or "N" for no in							
	column 1. If yes, enter in columns 2, 3 and							
	A the number of program visits performed by							
	4 the number of program visits performed by						- 1	
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the							
	Intern & Residents for titles V, XVIII, and							
	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.			unty				
2.00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	-	4.	unty 00				2 00
2.00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		A. DAVI ESS	00	Thur	rsdav		2. 00
2.00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday	4. DAVI ESS Wedn	esday		rsday to		2.00
2.00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		A. DAVI ESS	00	Thur from 9.00	sday to 10.00		2.00
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  City, State, ZIP Code, County  Facility hours of operations (1)	Tuesday to 6.00	4. DAVIESS Wedn from	esday to	from 9.00	to		2. 00

Health Financial Systems	DAVIESS COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (	CCN: 15-0061	Peri od:	Worksheet S-8	
		Component	CCN: 15-3999	From 01/01/2022 To 12/31/2022		
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

Heal th	Financial Systems	DAVIESS COMMUNI	ITY HOSPITAL		In Lie	eu of Form CMS	S-25!	52-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0061	Peri od:	Worksheet S	-8	
			Component	CCN: 15-8501	From 01/01/2022 To 12/31/2022	Date/Time Pi		
					RHC III	6/12/2023 17 Cost		am
					INIO III	1 0031		
					1.	00		
1. 00	Clinic Address and Identification Street				1805 S. STATE	PD 57	-	1. 00
1.00	Street		Ci	ty	State	ZIP Code		1.00
				00	2. 00	3. 00		
2. 00	City, State, ZIP Code, County	N	WASHI NGTON		IN	47501		2.00
						1.00		
2 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rure	d or "II" for	urhan		1. 00	0	3. 00
3. 00	HUSPITAL-BASED FUNCS UNLY: Designation - Ent	er k for fura	11 01 0 101		nt Award	Date	U	3.00
					1. 00	2.00		
	Source of Federal Funds			1				
4.00	Community Health Center (Section 330(d), PHS							4.00
5. 00	Migrant Health Center (Section 329(d), PHS A							5.00
6.00	Health Services for the Homeless (Section 34	O(d), PHS Act)						6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes							7. 00 8. 00
9. 00	OTHER (SPECIFY)							9.00
7. 00	orner (or corn r)							71.00
					1. 00	2. 00		
10.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of c	other operatio	ns in column	N		0 1	10. 00
	nours. )	Sund	day	l w	londay	Tuesday		
		from	to	from	to	from		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	Facility hours of operations (1)							
11. 00	CLINIC			08: 00	17: 00	08: 00	_   1	11. 00
					1. 00	2.00		
12. 00	Have you received an approval for an excepti	on to the produ	ıcti vi tv. stand	ard?	1.00 Y	2.00	1	12.00
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the				13. 00
				Provi	ider name	CCN		
					1. 00	2. 00		
14. 00	RHC/FQHC name, CCN	V (N)	.,	20011	VIV	<b>-</b>		14.00
		Y/N 1. 00	V 2.00	XVIII	XIX	Total Visits	<u> </u>	
15 00	Have you provided all or substantially all	1.00	2. 00	3. 00	4. 00	5. 00	1	15. 00
13.00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.							13.00
	(see instructions)			L				
				unty 00				
2. 00	City, State, ZIP Code, County		DAVI ESS	00				2. 00
50	o. c., state, zir sode, county	Tuesday		esday	Thur	rsday		2.00
		to	from	to	from	to		
		6. 00	7. 00	8. 00	9. 00	10.00		
	Facility hours of operations (1)							
11. 00	CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	1	11.

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FOHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
				From 01/01/2022		
		Component	CCN: 15-8501	To 12/31/2022		
					6/12/2023 11:	56 am_
				RHC III	Cost	
	Fri	day	Sa <sup>-</sup>	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

Health Financial Systems	DAVIESS COMMUN	ILTY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0061	Peri od:	Worksheet S-8	
		Component	CCN: 15-8503	From 01/01/2022 To 12/31/2022		
-				RHC V	6/12/2023 11: Cost	30 alli
				1.	00	
Clinic Address and Identification				1400 CDAND AVE		1 00
1.00   Street		Ci	ty	1400 GRAND AVE State	ZIP Code	1.00
			00	2. 00	3. 00	
2.00 City, State, ZIP Code, County		WASHI NGTON			47501	2.00
O OO HOODITAL BACED FOLIO ONLY DOLLAR STORE			. I		1.00	2 00
3.00   HOSPITAL-BASED FOHCS ONLY: Designation - En	ter "R" for rur	al or "U" for		nt Award	O Date	3.00
				1. 00	2. 00	
Source of Federal Funds			1	1.00	2.00	
4.00 Community Health Center (Section 330(d), PH	S Act)					4.00
5.00 Migrant Health Center (Section 329(d), PHS						5.00
6.00 Health Services for the Homeless (Section 3	40(d), PHS Act)					6.00
7.00 Appalachian Regional Commission 8.00 Look-Alikes						7.00
9. 00 OTHER (SPECIFY)						9.00
	_					
				1. 00	2. 00	
10.00 Does this facility operate as other than a yes or "N" for no in column 1. If yes, indicate (Enter in subscripts of line 11 the type hours.)	cate number of o	other operatio	ns in column		0	10.00
mour 3. )	Sun	day	l N	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2.00	3. 00	4. 00	5. 00	
Facility hours of operations (1)		I	loo oo	17.00	00.00	11 00
11. 00   CLI NI C			08: 00	17: 00	08: 00	11.00
				1.00	2. 00	
12.00 Have you received an approval for an except	ion to the prod	uctivity stand	ard?	Y	2.00	12.00
13.00 Is this a consolidated cost report as defin 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report	ed in CMS Pub. lumn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	O	13.00
numbers below.						
			Prov	ider name	CCN	
44.00   DUO /50110   0011	_			1. 00	2. 00	11.00
14.00 RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14.00
	1. 00	2.00	3. 00	4.00	5. 00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	n		5. 55		3, 33	15.00
number of total visits for this provider. (see instructions)			ınty			
2.00 City, State, ZIP Code, County		DAVI ESS	00			2.00
2. 33   Striy, State, 211 Sode, County	Tuesday		esday	Thur	sday	2.00
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)	47.00	laa aa	l	100.00		
11. 00   CLINI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0061	Peri od:	Worksheet S-8	
				From 01/01/2022		
		Component	CCN: 15-8503	To 12/31/2022		
		· ·			6/12/2023 11:	56 am_
			_	RHC V	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11.00

Health Financial Systems	DAVIESS COMMUN	JITY HOSPITAL		In Lie	u of Form CMS-	-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0061	Peri od:	Worksheet S-8	
			0011 45 0507	From 01/01/2022		
		Component	CCN: 15-8506	To 12/31/2022	Date/Time Pro 6/12/2023 11:	
				RHC VI	Cost	. 50 aiii
				1.	00	
Clinic Address and Identification						
1.00 Street				12546 E US HWY		1.00
			ty	State	ZIP Code	
2 00 0: to 0 0: to 0			00	2.00	3. 00 47553	2.00
2.00 City, State, ZIP Code, County		L00G00TEE		IN	4/553	2.00
					1. 00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for run	al or "U" for	urban			3.00
The most time brock that beer great on the		<u> </u>		nt Award	Date	0.00
				1. 00	2.00	
Source of Federal Funds						
4.00 Community Health Center (Section 330(d), PHS						4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5. 00
6.00 Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7.00 Appalachian Regional Commission						7.00
8. 00 Look-Alikes						8.00
9. 00 OTHER (SPECIFY)						9.00
				1. 00	2. 00	
10.00 Does this facility operate as other than a h	ospi tal -based	RHC or FOHC? E	nter "Y" for			10.00
yes or "N" for no in column 1. If yes, indic						10.00
2. (Enter in subscripts of line 11 the type o						
hours.)						
		iday		londay	Tuesday	
	from	to	from	to	from	
Facility bours of energtions (1)	1. 00	2. 00	3. 00	4. 00	5. 00	_
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	08: 00	11.00
TT. 00   CETNIC			00.00	17.00	00.00	11.00
				1.00	2. 00	
12.00 Have you received an approval for an excepti	on to the prod	uctivity stand	ard?	Y	2100	12.00
13.00 Is this a consolidated cost report as define				N	C	13.00
30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu	mn 2 the			
number of providers included in this report.	List the name	s of all provi	ders and			
numbers below.			D		000	
			Prov	ider name	2. 00	
14.00 RHC/FQHC name, CCN				1. 00	2.00	14.00
14. 00 pitro/1 terro frame, con	Y/N	V	XVIII	XIX	Total Visits	14.00
	1. 00	2.00	3. 00	4.00	5. 00	
15.00 Have you provided all or substantially all			3.00	00	2.00	15.00
GME cost? Enter "Y" for yes or "N" for no in						
column 1. If yes, enter in columns 2, 3 and						
4 the number of program visits performed by						
Intern & Residents for titles V, XVIII, and						
XIX, as applicable. Enter in column 5 the						
number of total visits for this provider. (see instructions)						
Lace Histi detions)		Col	l inty			
			00			
2.00 City, State, ZIP Code, County		DAVI ESS				2.00
	Tuesday		esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)		1				
11. 00   CLINI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (	CCN: 15-0061	Peri od:	Worksheet S-8	
				From 01/01/2022		
		Component	CCN: 15-8506	To 12/31/2022	Date/Time Pre	pared:
		·			6/12/2023 11:	56 am_
				RHC VI	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11.00

Heal th	Financial Systems		DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
	FAL-BASED HOSPICE IDENTIFICATION	I DATA		Provider C	CN: 15-0061 N: 15-1553	Peri od: From 01/01/2022 To 12/31/2022		GH IV
				<u>'</u>			6/12/2023 11:	56 am_
						Hospi ce I		
		Unduplicated						
		Days Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
		II LIE AVIII	II LIE XIX	Skilled	Nursing	All Other	cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			٥,	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING	PERIODS BEGINN	ING BEFORE OCT	OBER 1, 2015			
1.00	Hospice Continuous Home Care							1.00
2. 00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days	DEDODTI NO DED	LODG BEGLAINLING	DEFODE OCTOBE	D 1 2015			5. 00
6. 00	Part II - CENSUS DATA FOR COST Number of patients receiving	REPORTING PER	LODS REGINNING	BEFORE OCTOBE	R 1, 2015			6. 00
0.00	hospi ce care							0.00
7. 00	Total number of unduplicated							7. 00
,, 00	Continuous Care hours billable							7.00
	to Medicare							
8.00	Average Length of Stay (line 5							8.00
	/ line 6)							
9. 00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
				1.00	0.00	0.00	through 3)	
	PART III - ENROLLMENT DAYS FOR	COCT DEDODTIN	C DEDLODE DECL	1. 00	2.00	3. 00	4. 00	
10. 00	Hospice Continuous Home Care	COST REPORTIN	G PERIODS BEGI	NNING ON OR AF	TER OCTOBER I	0 0	0	10.00
11. 00	Hospice Routine Home Care			3, 033		0 521	-	11.00
12.00	Hospice Inpatient Respite Care			3,033	i	0 0	3, 334	12.00
13. 00	Hospice General Inpatient Care			13	1	0 0	13	
	Total Hospice Days			3, 046	1	0 521	-	14. 00
50	PART IV - CONTRACTED STATISTICA	AL DATA FOR CO	ST REPORTING P				· · · · · · · · · · · · · · · · · · ·	55
15.00	Hospice Inpatient Respite Care			О		0 0		15. 00
16.00	Hospice General Inpatient Care			0		0 0	0	16.00

	Financial Systems DAVIESS COMMUNITY HOSPITAL	2011 45 00/4		u of Form CMS-2				
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 15-0061	Period: From 01/01/2022	Worksheet S-1	0			
			To 12/31/2022	Date/Time Pre	pared:			
				6/12/2023 11:				
				1. 00				
	Uncompensated and indigent care cost computation							
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	ine 202 colu	mn 8)	0. 386356	1.00			
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid			1 OOF 404	2 00			
2. 00 3. 00	Did you receive DSH or supplemental payments from Medicaid?			1, 085, 686 Y	2. 00 3. 00			
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment	nts from Medi	cai d?	Ϋ́	4.00			
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medica			0	1			
6. 00	Medi cai d charges			30, 687, 192				
7.00	Medicaid cost (line 1 times line 6)			11, 856, 181 10, 770, 495	7. 00 8. 00			
8. 00								
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for each li</pre>	ne)						
9. 00	Net revenue from stand-alone CHIP	ne)		0	9.00			
10.00	Stand-al one CHIP charges			0				
11. 00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00				
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 i	ninus line 9;	if < zero then	0	12.00			
	enter zero)	6 l:	- )					
13. 00	Other state or local government indigent care program (see instructions Net revenue from state or local indigent care program (Not included on local)			0	l 13. 00			
14. 00	Charges for patients covered under state or local indigent care program			0				
	10)							
15.00	State or local indigent care program cost (line 1 times line 14)			0				
16. 00	Difference between net revenue and costs for state or local indigent can	re program (I	ne 15 minus line	0	16. 00			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and sta	te/Local indi	gent care progra	ms (saa				
	instructions for each line)	rte/Tocal Thui	gent care progra	illis (see				
17.00	Private grants, donations, or endowment income restricted to funding cha			0				
18.00	Government grants, appropriations or transfers for support of hospital			0	18.00			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigen 8, 12 and 16)	care prograi	ns (sum of fines	10, 770, 495				
		1	Insured		19.00			
		Uni nsured	T HSGI CG	Total (col. 1	19.00			
		pati ents	pati ents	+ col . 2)	19.00			
	Uncompanyated Care (see instructions for each line)				19.00			
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	patients 1.00	pati ents 2.00	+ col . 2) 3.00				
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions)	pati ents	pati ents 2.00	+ col. 2) 3.00				
	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see	patients 1.00	pati ents 2.00 89 68,306	+ col . 2) 3.00	20. 00			
21. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions)	patients 1.00	pati ents 2.00  89 68,306  68,306	+ col . 2) 3.00 191, 395 115, 862	20. 00			
21. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	patients 1.00	pati ents 2.00 89 68,306	+ col . 2) 3.00	20. 00			
21. 00 22. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	patients 1.00 123,0 47,5	pati ents 2.00  89 68,306 68,306 0 0	+ col . 2) 3. 00 191, 395 115, 862	20.00 21.00 22.00			
21. 00 22. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	patients 1.00	pati ents 2.00  89 68,306 68,306 0 0	+ col . 2) 3.00 191, 395 115, 862	20.00 21.00 22.00			
21. 00 22. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	patients 1.00 123,0 47,5	pati ents 2.00  89 68,306  66,306  0 0  56 68,306	+ col . 2) 3. 00 191, 395 115, 862	20.00 21.00 22.00			
21. 00 22. 00 23. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days be	patients 1.00 123,0 47,5	pati ents 2.00  89 68,306  66,306  0 0  56 68,306	+ col . 2) 3.00 191, 395 115, 862 0 115, 862	20. 00 21. 00 22. 00 23. 00			
21. 00 22. 00 23. 00 24. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program?	patients 1.00 123, 0 47, 5 47, 5	patients 2.00  89 68,306 56 68,306 0 0 56 68,306	+ col. 2) 3.00  191, 395  115, 862  0  115, 862  1.00  N	20. 00 21. 00 22. 00 23. 00			
21. 00 22. 00 23. 00 24. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days be	patients 1.00 123, 0 47, 5 47, 5	patients 2.00  89 68,306 56 68,306 0 0 56 68,306	+ col. 2) 3.00  191, 395  115, 862  0  115, 862	20. 00 21. 00 22. 00 23. 00			
21. 00 22. 00 23. 00 24. 00 25. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigen	patients 1.00  123,0 47,5  47,5  eyond a Length	patients 2.00  89 68,306 56 68,306 0 0 56 68,306	+ col. 2) 3.00  191, 395  115, 862  0  115, 862  1.00  N	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00			
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see	patients 1.00  123,0 47,5  47,5  eyond a length at care programs structions)	patients 2.00  89 68,306 56 68,306 0 0 56 68,306	+ col. 2) 3.00  191, 395  115, 862  0 115, 862  1.00  N  0 3, 275, 728 98, 301	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00			
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instructions Medicare reimbursable bad debts for the entire hospital complex (see instructions)	patients 1.00  123,0 47,5  47,5  eyond a length at care programs structions)	patients 2.00  89 68,306 56 68,306 0 0 56 68,306	+ col. 2) 3.00  191, 395  115, 862  0  115, 862  1.00  N  0  3, 275, 728 98, 301 151, 233	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01			
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program?  If line 24 is yes, enter the charges for patient days beyond the indiger stay limit  Total bad debt expense for the entire hospital complex (see instructions Medicare allowable bad debts for the entire hospital complex (see instructions)	patients 1.00  123,0 47,5  47,5  eyond a Length at care programs structions)	patients 2.00  89 68,306  56 68,306  0 0  56 68,306  n of stay limit am's length of	+ col. 2) 3.00  191, 395  115, 862  0  115, 862  1.00  N  0  3, 275, 728 98, 301 151, 233 3, 124, 495	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00			
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00	Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program?  If line 24 is yes, enter the charges for patient days beyond the indiger stay limit  Total bad debt expense for the entire hospital complex (see instructions Medicare reimbursable bad debts for the entire hospital complex (see instructions)  Medicare bad debt expense (see instructions)  Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see	patients 1.00  123,0 47,5  47,5  eyond a Length at care programs structions)	patients 2.00  89 68,306  56 68,306  0 0  56 68,306  n of stay limit am's length of	+ col. 2) 3.00  191, 395  115, 862  0  115, 862  1.00  N  0  3, 275, 728 98, 301 151, 233 3, 124, 495 1, 260, 099	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 01 28. 00 29. 00			
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00	Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program?  If line 24 is yes, enter the charges for patient days beyond the indiger stay limit  Total bad debt expense for the entire hospital complex (see instructions Medicare allowable bad debts for the entire hospital complex (see instructions)	patients 1.00  123,0 47,5  47,5  eyond a Length at care programs structions)	patients 2.00  89 68,306  56 68,306  0 0  56 68,306  n of stay limit am's length of	+ col. 2) 3.00  191, 395  115, 862  0  115, 862  1.00  N  0  3, 275, 728 98, 301 151, 233 3, 124, 495	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01 28. 00 29. 00 30. 00			

		DAVIESS COMMUNIT			In Lie	u of Form CMS-:	<u> 2552-10</u>
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	nared:
					10 12/31/2022	6/12/2023 11:	
	Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
	·			+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT		2, 367, 554			2, 539, 735	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		1, 476, 147	1, 476, 14	7 4, 314	1, 480, 461	2.00
3. 00	00300 OTHER CAP REL COSTS		0		0 0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	195, 069	5, 901, 944				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 098, 561	12, 081, 662			14, 034, 758	
6.00	00600 MAINTENANCE & REPAIRS	68, 634	2, 176, 318			2, 244, 952	
7.00	00700 OPERATION OF PLANT	0	898, 446	1			
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	546, 669	125, 966 107, 443	1		125, 966 654, 112	
10.00	01000 DI ETARY	354, 267	320, 393			195, 499	
11. 00	01100 CAFETERI A	354, 267	32U, 393	1	0 321, 311	321, 311	
13. 00	01300 NURSING ADMINISTRATION	648, 501	55, 407			703, 908	
14. 00	01400 CENTRAL SERVICES & SUPPLY	295, 384	149, 255	1		444, 639	
15. 00	01500 PHARMACY	510, 230	208, 903			719, 133	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	539, 159	103, 896	1		643, 055	
	01700 SOCI AL SERVI CE	337, 137	76	1	6 266, 349		
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	,,,	'	200,017	200, 120	17.00
30. 00	03000 ADULTS & PEDIATRICS	2, 543, 869	469, 432	3, 013, 30	-88, 079	2, 925, 222	30.00
31. 00	03100 I NTENSI VE CARE UNI T	749, 438	334, 269				1
40. 00	04000 SUBPROVI DER - I PF	1, 813, 629	247, 774				
41. 00	04100 SUBPROVI DER - I RF	720, 029	230, 313		·		1
43.00	04300 NURSERY	0	11, 236				1
	ANCILLARY SERVICE COST CENTERS	·					1
50.00	05000 OPERATING ROOM	1, 606, 195	1, 421, 661	3, 027, 85	6 -46	3, 027, 810	50.00
51.00	05100 RECOVERY ROOM	O	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	117, 375	0	117, 37	5 359, 134	476, 509	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	739, 865	328, 089	1, 067, 95	4 0	1, 067, 954	54.00
56.00	05600 RADI OI SOTOPE	182, 964	545, 110	728, 07	4 0	728, 074	56.00
60.00	06000 LABORATORY	920, 592	1, 685, 048	2, 605, 64	.0	2, 605, 640	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	9, 606	9, 60	0 0	9, 606	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	1	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	524, 651	167, 156				
66. 00	06600 PHYSI CAL THERAPY	1, 087, 359	65, 234			1, 152, 593	
67. 00	06700 OCCUPATI ONAL THERAPY	396, 145	2, 266			398, 411	
68. 00	06800 SPEECH PATHOLOGY	205, 635	2, 153	1		207, 788	
69. 00	06900 ELECTROCARDI OLOGY	64, 473	12, 402	1		76, 875	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 848, 477	1			
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 272, 005	272, 005	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 054, 800			3, 054, 800	
76.00	03020 CARDI AC REHAB	103, 384	3, 459	1			
76. 01	03030 ADDICTION SERVICES OUTPATIENT SERVICE COST CENTERS	204, 143	36, 255	240, 39	8 0	240, 398	76. 01
88. 00		671, 601	85, 736	757, 33	7 0	757, 337	00 00
88. 01	08801 RURAL HEALTH CLINIC II	567, 520	70, 395			637, 915	
88. 02	08802 RURAL HEALTH CLINIC III	1, 232, 206	215, 981			1, 448, 187	
88. 03	08805 RURAL HEALTH CLINIC IV	0	210, 701		0 0	0	1
88. 04	08803 RURAL HEALTH CLINIC V	939, 011	141, 737	1	-1	1, 080, 748	
88. 05	08804 RURAL HEALTH CLINIC VI	545, 922	56, 250			602, 172	
90.00	09000 CLI NI C	216, 002	95, 469			311, 471	
90. 01	09001 ONCOLOGY	278, 760	11, 015			289, 775	1
90. 02	09002 PAIN MANAGEMENT	0	0		0 0	0	90. 02
91.00	09100 EMERGENCY	1, 295, 505	3, 231, 683	4, 527, 18	8 -21, 170	4, 506, 018	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,		,	.,	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	531, 948	379, 433	911, 38	-112, 733	798, 648	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	2, 241, 406	402, 216	2, 643, 62	2 0	2, 643, 622	95.00
99. 10	09910 CORF	o	0	1	0 0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		241, 084			241, 084	
	11600 HOSPI CE	236, 949	181, 130	1			
118.00		26, 993, 050	41, 560, 279	68, 553, 32	-398, 957	68, 154, 372	118.00
	NONREI MBURSABLE COST CENTERS			ı	_1		
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0		l .	0 0		192. 00
	007951 OTHER NONREIMBURSABLE AND PHYSICIAN	2, 295, 352	1, 221, 468				
200.00	TOTAL (SUM OF LINES 118 through 199)	29, 288, 402	42, 781, 747	72, 070, 14	9 0	72, 070, 149	200.00

Provi der CCN: 15-0061

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 6/12/2023 11:56 am

				6/12/2023 11:	<u>56 am</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		/ 00	Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00	00100 CAP REL COSTS-BLDG & FIXT	0	2, 539, 735		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	0	1, 480, 461		2.00
3. 00	00300 OTHER CAP REL COSTS	0	0		3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-117, 429	5, 921, 646	1	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-5, 015, 542	9, 019, 216		5.00
6. 00	00600 MAINTENANCE & REPAIRS	0	2, 244, 952	•	6.00
7. 00	00700 OPERATION OF PLANT	0	898, 446	•	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	125, 966	•	8.00
9.00	00900 HOUSEKEEPI NG	0	654, 112	•	9.00
10.00	01000 DI ETARY	0	195, 499		10.00
11.00	01100 CAFETERI A	-142, 190	179, 121		11.00
13.00	01300 NURSING ADMINISTRATION	0	703, 908		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-750	443, 889		14.00
15.00	01500 PHARMACY	-1, 800	717, 333		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-10, 299	632, 756		16.00
17.00	01700 SOCI AL SERVI CE	0	266, 425		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDIATRICS	-839, 050			30.00
31.00	03100 INTENSIVE CARE UNIT	0	,	•	31.00
40. 00	04000 SUBPROVI DER - I PF	-508, 436	1, 469, 731		40.00
41. 00	04100 SUBPROVI DER - I RF	-174, 714	782, 385	•	41.00
43. 00	04300 NURSERY	0	548, 460		43.00
F0 00	ANCILLARY SERVICE COST CENTERS	4 445 004	4 040 547	T	
50.00	05000 OPERATING ROOM	-1, 115, 294		•	50.00
51.00	05100 RECOVERY ROOM	0	0	l .	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	110.750	476, 509	•	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-110, 750			54.00
56. 00 60. 00	05600 RADI OI SOTOPE 06000 LABORATORY	-741 0	727, 333 2, 605, 640		56. 00 60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	9, 606	•	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	9, 606	•	64.00
65. 00	06500 RESPIRATORY THERAPY	-58, 073	633, 734	l .	65.00
66. 00	06600 PHYSI CAL THERAPY	0	1, 152, 593		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	398, 411		67.00
68. 00	06800 SPEECH PATHOLOGY	0	207, 788		68.00
69. 00	06900 ELECTROCARDI OLOGY	-3, 841	73, 034		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 576, 472	•	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	272, 005		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 054, 800	1	73.00
76.00	03020 CARDI AC REHAB	0	106, 843	1	76.00
76. 01	03030 ADDICTION SERVICES	0		1	76. 01
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	757, 337		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	637, 915		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	1, 448, 187		88. 02
88. 03	08805 RURAL HEALTH CLINIC IV	0	0		88. 03
88. 04	08803 RURAL HEALTH CLINIC V	0	1, 080, 748		88. 04
88. 05	08804 RURAL HEALTH CLINIC VI	0	602, 172		88. 05
90.00	09000 CLI NI C	-2, 500	308, 971	•	90.00
90. 01	09001 ONCOLOGY	0	289, 775	l .	90. 01
90. 02	09002 PAIN MANAGEMENT	0	0	l .	90.02
91.00	09100 EMERGENCY	-7, 784	4, 498, 234		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	-339, 995	458, 653		93.00
05.00	OTHER REIMBURSABLE COST CENTERS	1 0	0 / 40 / 00	I	05.00
95.00	09500 AMBULANCE SERVI CES	0	2, 643, 622	l .	95.00
	09910 CORF	0	0	l .	99. 10
101.00	10100 HOME HEALTH AGENCY	0	0	1	101.00
112 0	SPECIAL PURPOSE COST CENTERS	241 004	0		112 00
	11300 INTEREST EXPENSE 11600 HOSPICE	-241, 084 0	417, 999		113. 00 116. 00
118.00		-8, 690, 272			118.00
110.00	NONREI MBURSABLE COST CENTERS	-0,090,272	37, 404, 100		1 10.00
102 0	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
	07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0	3, 915, 777	•	194.00
200.00		-8, 690, 272			200.00
				•	

					To 12/31/202	2 Date/Time Prepared: 6/12/2023 11:56 am
		Increases				9, 12, 2020 111 00 0
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3.00	4. 00	5. 00		
	A - DIETARY					
1.00	CAFETERI A	11. 00	168, 722	152, 589		1.00
2.00	OTHER NONREIMBURSABLE AND	194. 00	82, 888	74, 962		2.00
	PHYSI CI AN					
	TOTALS		251, 610	227, 551		
	C - BILLING COSTS			·		
1.00	OTHER NONREIMBURSABLE AND	194. 00	17, 177	25, 758		1.00
	PHYSI CI AN					
	TOTALS		17, 177	25, 758		
	D - OBSTETRI CS					
1.00	NURSERY	43. 00	467, 946	69, 278		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	312, 822	46, 312		2.00
	TOTALS		780, 768	115, 590		
	E - INSURANCE RECLASS			·		
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	172, 181		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	4, 314		2.00
3.00	OTHER NONREIMBURSABLE AND	194. 00	o	199, 028		3.00
	PHYSI CI AN					
	TOTALS		0	375, 523		
	F - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	272, 005		1.00
	PATI ENTS					
	TOTALS		0	272, 005		
	G - SOCIAL SERVICES RECLASS					
1.00	SOCI AL SERVI CE	17. 00	266, 349	О		1.00
2.00		0. 00	0	0		2.00
3.00		0. 00	0	0		3.00
4.00		0. 00	0	0		4.00
5.00		0. 00	0	0		5.00
6.00		0. 00	0	О		6.00
7.00		0. 00	0	О		7.00
8.00		0. 00	0	0		8.00
9.00		0. 00	0	0		9.00
10.00		0.00	0	0		10.00
	TOTALS		266, 349	0		
	H - OTHER					
1.00	ADULTS & PEDIATRICS	30. 00	61, 209	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	61, 209	0		2.00
3.00	SUBPROVI DER - I PF	40. 00	6, 801	0		3.00
4.00	SUBPROVI DER I RF	4100	<u>6, 8</u> 01	0		4.00
	TOTALS		136, 020			
	I - HOSPITALIST RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	750, 400		1.00
	TOTALS			750, 400		
	J - BENEFIT RECLASS					
1 00	ADMINICEDATIVE & CENEDAL	E 00		E7 020		1 00

5. 00

5<u>7, 9</u>38 57, 938

1, 824, 765

1.00

500.00

\_\_\_\_0

1, 451, 924

1. 00 ADMINISTRATIVE & GENERAL TOTALS
500. 00 Grand Total: Increases

Peri od: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Ti me Prepared:

						6/12/2023 11	:56 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - DIETARY						
1.00	DI ETARY	10. 00	251, 610	227, 551	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		251, 610	227, 551			
	C - BILLING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	17, 177	25, 758	0		1.00
	TOTALS	T	17, 177	25, 758	3 7		1
	D - OBSTETRI CS						1
1.00	ADULTS & PEDIATRICS	30.00	780, 768	115, 590	0		1.00
2.00		0.00	0	0	ol		2.00
	TOTALS		780, 768	115, 590			1
	E - INSURANCE RECLASS	•					1
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	375, 523	12		1.00
2.00		0.00	O	. 0			2.00
3.00		0.00	0	0	12		3.00
	TOTALS			375, 523			
	F - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	272, 005	0		1.00
	PATI ENT						
	TOTALS			272, 005	<u> </u>		1
	G - SOCIAL SERVICES RECLASS				'		1
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	34, 545	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3, 330	ol		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	3, 508	ol ol		3.00
4.00	SUBPROVI DER - I PF	40.00	0	90, 037	ol		4.00
5.00	SUBPROVI DER - I RF	41.00	o	44	ıl ol		5.00
6. 00	OPERATING ROOM	50.00	o	46			6.00
7. 00	EMERGENCY	91.00	o	21, 170			7. 00
8. 00	OTHER OUTPATIENT SERVICE	93, 00	o	112, 733			8.00
	COST CENTE			•			
9.00	HOSPI CE	116. 00	0	80	ol		9.00
10.00	OTHER NONREI MBURSABLE AND	194. 00	0	856	ol ol		10.00
	PHYSI CI AN						
	TOTALS			266, 349			
	H - OTHER						
1.00	INTENSIVE CARE UNIT	31. 00	136, 020	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	O	0	o		3.00
4.00		0.00	O	0	ol		4.00
	TOTALS		136, 020				1
	I - HOSPITALIST RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	750, 400	0		1.00
	TOTALS			750, 400			
	J - BENEFIT RECLASS		1				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	57, 938	0		1.00
	TOTALS			57, 938	3		
500.00	Grand Total: Decreases		1, 185, 575	2, 091, 114			500.00

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

				10	12/31/2022	Date/lime Pre   6/12/2023 11:	
				Acqui si ti ons		07 127 2020 111	00 4
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	1, 280, 955	0	0	0	0	1.00
2.00	Land Improvements	687, 865	0	0	0	0	2.00
3.00	Buildings and Fixtures	43, 627, 507	123, 646	0	123, 646	0	3.00
4.00	Building Improvements	39, 119	0	0	0	0	4.00
5. 00	Fixed Equipment	11, 586, 418	109, 643	0	109, 643		5.00
6. 00	Movable Equipment	32, 363, 542	561, 950	0	561, 950	0	6.00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	89, 585, 406	795, 239	0	795, 239	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	,,,,,
10.00	Total (line 8 minus line 9)	89, 585, 406	795, 239	0	795, 239	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DART I ANNUALO OF GUANGES IN CARLEY AGOS	6. 00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		al				
1.00	Land	1, 280, 955	0				1.00
2.00	Land Improvements	687, 865	0				2.00
3.00	Buildings and Fixtures	43, 751, 153	0				3.00
4.00	Building Improvements	39, 119	0				4.00
5.00	Fi xed Equi pment	11, 696, 061	0				5.00
6.00	Movable Equipment	32, 925, 492	0				6.00
7.00	HIT designated Assets	00 000 (45	0				7.00
8.00	Subtotal (sum of lines 1-7)	90, 380, 645	0				8.00
9.00	Reconciling Items	00 200 (45	0				9.00
10. 00	Total (line 8 minus line 9)	90, 380, 645	0				10.00

Health Financial Systems		DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2022 To 12/31/2022		pared:
			SL	JMMARY OF CAPI	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	RKSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 144, 044	0	223, 51	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 076, 798	321, 712		0	77, 637	2.00
3.00	Total (sum of lines 1-2)	3, 220, 842	321, 712	223, 51	0	77, 637	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 367, 554				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 476, 147				2.00
3. 00	Total (sum of lines 1-2)	0	3, 843, 701				3. 00

Heal th	n Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2022 To 12/31/2022		pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1. 00	2.00	col . 2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1. 00	CAP REL COSTS-BLDG & FIXT	57, 455, 153	1 0	57, 455, 15	3 0. 635702	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	32, 925, 492		32, 925, 49			2.00
3. 00	Total (sum of lines 1-2)	90, 380, 645		90, 380, 64			3. 00
		ALLOCATION OF OTHER CAPITAL			SUMMARY 0	F CAPI TAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	cost center bescription	Taxes	Capi tal -Rel at		Depi eci ati on	Lease	
			ed Costs	through 7)			
		6. 00	7. 00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1. 00	CAP REL COSTS-BLDG & FIXT	0	0		0 2, 144, 044		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	0	1	0 1, 076, 798		2. 00
3. 00	Total (sum of lines 1-2)	0	0	IMMADY OF CADI	0 3, 220, 842	321, 712	3. 00
			St	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
		11 00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	223, 510	172, 181		0 0	2, 539, 735	1. 00
2. 00	CAP REL COSTS-BLDG & FTXT	223, 310	1	1	-	2, 539, 735 1, 480, 461	2. 00
3.00	Total (sum of lines 1-2)	223, 510				4, 020, 196	
5.00	1.010. (00 0. 1.1.00 . 2)	220,010	170, 170	1 77,00	.1	., 520, 170	0.00

105001	INCINIO TO EM ENGES			Trevider sem to see!	From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	
			Т	Expense Classification o p/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00	2. 00	3.00 AP REL COSTS-BLDG & FLXT	4.00	5. 00	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			AP REL COSTS-MVBLE EQUIP	2. 00	0	
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time discounts (chapter 8)	В	-750 C	ENTRAL SERVICES & SUPPLY	14. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7. 00	Telephone services (pay stations excluded) (chapter	Α	-1, 518 A	DMINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	21)   Tel evi si on and radi o servi ce   (chapter 21)	А	-24, 121 A	DMINISTRATIVE & GENERAL	5. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -3, 153, 394		0. 00	0	
11. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	0 -142, 190 C	AFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee and others		0		0.00	0	
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17. 00	patients Sale of drugs to other than patients	В	-1, 800 P	HARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-10, 299 M	EDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of interest, finance or penalty	А	-3, 733 A	DMINISTRATIVE & GENERAL	5. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OR	ESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0 P	HYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review – physicians' compensation		0 *	** Cost Center Deleted ***	* 114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		o C.	AP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP		o C.	AP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0 *	** Cost Center Deleted ***			28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	CCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		OIA	DULTS & PEDIATRICS	30. 00		30. 99
•	i nstructi ons)		1.				

Не	al th	Financial Systems		DAVIESS COMMUN	IITY HOSPITAL	In Lie	u of Form CMS-	2552-10
Αſ	JUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	3
						From 01/01/2022		
						To 12/31/2022	Date/Time Pre 6/12/2023 11:	epared: 56 am
		·			Expense Classification or	Worksheet A	07 127 2023 11.	JO am
					To/From Which the Amount is			
						,		
		Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
			(2)				Ref.	
			1. 00	2. 00	3. 00	4. 00	5. 00	
31	1.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
		pathology costs in excess of						
		limitation (chapter 14)						
32	2. 00	CAH HIT Adjustment for		0		0.00	(	32.00
		Depreciation and Interest						
	3. 00	ADVERTI SI NG EXPENSES	Α	· ·	ADMINISTRATIVE & GENERAL	5. 00		1 00.00
	1. 00	PHYSICIAN RECRUITMENT EXPENSES			ADMINISTRATIVE & GENERAL	5. 00		34.00
	5. 01	NON-ALLOWABLE COSTS	Α	· ·	ADMINISTRATIVE & GENERAL	5. 00		35. 01
	5. 04	PHYSICIAN BENEFITS	Α	· ·	EMPLOYEE BENEFITS DEPARTMEN			35. 04
	5. 00	CPR CLASS INCOME	В	· ·	EMERGENCY	91. 00		36.00
		MISC. INCOME	В	· ·	ADMINISTRATIVE & GENERAL	5. 00		36. 01
		LATERECT EVERNOE OFFICE			L NITEDECT EVDENCE	440 00		1 0/ 00

-241, 084 I NTEREST EXPENSE

-8, 690, 272

-8, 131 ADMINISTRATIVE & GENERAL

21, 245 ADMINISTRATIVE & GENERAL

-4, 384, 214 ADMINISTRATIVE & GENERAL

113.00

5.00

5.00

5.00

36.02

38.00

39.00

40.00

50.00

Α

Α

Α

36.02 | INTEREST EXPENSE OFFSET

LOBBYING EXPENSE

AMORTI ZATI ON

DEBT ISSUANCE COST

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

38.00

39.00

40.00 HAF

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Provider CCN: 15-0061

						To 12/31/2022		
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	839, 050					1. 00
2. 00		SUBPROVI DER - I PF	508, 436					
3. 00		SUBPROVI DER - I RF	174, 714	174, 714				
4. 00	•	OPERATING ROOM	1, 115, 294	1, 115, 294				4.00
5. 00		RADI OLOGY-DI AGNOSTI C	110, 750			,		5.00
6. 00		RADI OI SOTOPE	741	741	0			6.00
7. 00		RESPIRATORY THERAPY	58, 073	58, 073	_	260, 300		7.00
8. 00		ELECTROCARDI OLOGY	3, 841	3, 841				8.00
9. 00		CLI NI C	2, 500			,	•	9.00
10.00		OTHER OUTPATIENT SERVICE	339, 995	339, 995		2,000	•	10.00
10.00	75.00	COST CENTE	337, 773	337, 773		211, 300	0	10.00
200.00		COST CENTE	3, 153, 394	3, 153, 394	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3. 00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	5. 00
6.00	56. 00	RADI OI SOTOPE	0	0	0	0	0	6. 00
7.00	65. 00	RESPIRATORY THERAPY	0	0	0	0	0	7. 00
8. 00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	8. 00
9. 00	90.00	CLINIC	0	0	0	0	0	9. 00
10.00	93. 00	OTHER OUTPATIENT SERVICE	0	0	0	0	0	10.00
		COST CENTE						
200.00			0	0			0	200.00
	Wkst. A Line #	J	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti 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	10.00		839, 050		1.00
2. 00		SUBPROVI DER - I PF	0	ĺ				2.00
3. 00		SUBPROVI DER - I RF		0		·		3.00
4. 00		OPERATING ROOM			_			4.00
5. 00		RADI OLOGY-DI AGNOSTI C			_	.,		5.00
6. 00		RADI OLOGI - DI AGNOSTI C			-	,,,,,,		6.00
7. 00		RESPIRATORY THERAPY			_			7.00
8. 00		ELECTROCARDI OLOGY			_	,		8.00
		1						4
9.00		CLINIC				2, 500		9.00
10. 00	93.00	OTHER OUTPATIENT SERVICE COST CENTE			0	339, 995		10. 00
200.00		COST CLIVIL	0	0	0	3, 153, 394		200. 00
200.00	I	T .	1	١ ٠		1 5, 155, 574	I	200.00

| Period: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0061

						o 12/31/2022		pared:
				CAPI TAL REI	LATED COSTS		6/12/2023 11:	56 am
						54510455	0.1.1.1	
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7) 0	1. 00	2.00	4.00	4A	
	GENER	AL SERVICE COST CENTERS	0	1.00	2.00	4.00	48	
1. 00	00100	CAP REL COSTS-BLDG & FIXT	2, 539, 735	2, 539, 735				1.00
2.00		CAP REL COSTS-MVBLE EQUIP	1, 480, 461	, ,,,	1, 480, 461			2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	5, 921, 646 9, 019, 216	6, 210 139, 223			9, 949, 692	4. 00 5. 00
6. 00		MAINTENANCE & REPAIRS	2, 244, 952	68, 045			2, 331, 213	6.00
7.00		OPERATION OF PLANT	898, 446	490, 724	•		1, 389, 170	7. 00
8.00		LAUNDRY & LINEN SERVICE	125, 966	5, 282		_	131, 248	8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	654, 112 195, 499	17, 486 45, 854			785, 021 270, 407	9. 00 10. 00
11. 00	1	CAFETERI A	179, 121	16, 796			229, 994	11.00
13.00		NURSING ADMINISTRATION	703, 908	33, 740			886, 778	13. 00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	443, 889	50, 728 20, 529			559, 711 847, 417	14. 00 15. 00
16.00		MEDICAL RECORDS & LIBRARY	717, 333 632, 756	20, 529 111, 953			855, 362	16.00
17. 00		SOCIAL SERVICE	266, 425	0			320, 220	17. 00
		TENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	2, 086, 172 1, 005, 388	107, 146			2, 627, 313 1, 187, 662	
40.00		SUBPROVI DER - I PF	1, 469, 731	27, 044 111, 320			1, 167, 002	40.00
41. 00		SUBPROVI DER - I RF	782, 385	98, 109			1, 035, 286	1
43.00		NURSERY	548, 460	10, 768		94, 512	653, 740	43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	1, 912, 516	153, 350	220, 188	324, 406	2, 610, 460	50.00
51.00		RECOVERY ROOM	1, 412, 510	153, 350			2, 010, 400	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	476, 509	111, 478	C	86, 888	674, 875	52.00
54.00		RADI OLOGY-DI AGNOSTI C	957, 204	137, 606			1, 375, 218	•
56. 00 60. 00		RADI OI SOTOPE LABORATORY	727, 333 2, 605, 640	12, 872 38, 524			793, 894 2, 853, 669	56. 00 60. 00
63.00	1	BLOOD STORING, PROCESSING & TRANS.	9, 606	2, 251			11, 857	63.00
64.00	1	INTRAVENOUS THERAPY	0	0			0	64. 00
65.00		RESPI RATORY THERAPY	633, 734	29, 600			827, 290	
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	1, 152, 593 398, 411	76, 291 16, 253			1, 648, 420 537, 688	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	207, 788	11, 514			292, 278	
69. 00		ELECTROCARDI OLOGY	73, 034	7, 013			98, 878	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	1, 576, 472 272, 005	0			1, 577, 464 272, 005	
73.00		DRUGS CHARGED TO PATIENTS	3, 054, 800	3, 631	-	_	3, 058, 431	
76.00	03020	CARDI AC REHAB	106, 843	26, 003	C		153, 727	76. 00
76. 01		ADDICTION SERVICES	240, 398	0	C	41, 231	281, 629	76. 01
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	757, 337	55, 026	958	135, 645	948, 966	88. 00
88. 01		RURAL HEALTH CLINIC II	637, 915	39, 406			793, 057	88. 01
88. 02	08802	RURAL HEALTH CLINIC III	1, 448, 187	60, 569			1, 765, 216	88. 02
88. 03		RURAL HEALTH CLINIC IV	1 000 740	0		_	1 204 125	88. 03
88. 04 88. 05		RURAL HEALTH CLINIC V RURAL HEALTH CLINIC VI	1, 080, 748 602, 172	21, 965 28, 854			1, 294, 125 742, 063	88. 04 88. 05
90.00	1	CLI NI C	308, 971	42, 517			396, 880	
90. 01		ONCOLOGY	289, 775	43, 603	1		389, 680	90. 01
90. 02 91. 00		PAIN MANAGEMENT EMERGENCY	0 4, 498, 234	0 72, 954	E4 014	1	0 4 994 940	90. 02 91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART	4, 490, 234	72, 934	54, 016	201,030	4, 886, 860 0	91.00
93. 00	1	OTHER OUTPATIENT SERVICE COST CENTE	458, 653	65, 987	227	107, 439	632, 306	93.00
05 00		REIMBURSABLE COST CENTERS			1 004 075	450 704	0.000.005	05.00
95. 00 99. 10	09500	AMBULANCE SERVICES	2, 643, 622 0	0			3, 302, 395 0	95. 00 99. 10
		HOME HEALTH AGENCY	0	0				101.00
	SPECI	AL PURPOSE COST CENTERS		-				
	1	I NTEREST EXPENSE	447.000	, ,,,,		47.057	470 470	113.00
116.00		HOSPICE  SUBTOTALS (SUM OF LINES 1 through 117)	417, 999 59, 464, 100			47, 857 5, 446, 039	472, 473 58, 722, 295	
1 10.00		IMBURSABLE COST CENTERS		2, 727, 041	1, 337, 337		00, 122, 270	. 10. 00
	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
194. 00 200. 00		OTHER NONREIMBURSABLE AND PHYSICIAN Cross Foot Adjustments	3, 915, 777	114, 894	143, 104	483, 807	4, 657, 582	194. 00 200. 00
200.00		Negative Cost Centers		n	(	o		200.00
202.00		TOTAL (sum lines 118 through 201)	63, 379, 877	2, 539, 735	1, 480, 461	-	63, 379, 877	
		-				·		

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0061

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

6/12/2023 11:56 am Cost Center Description ADMINISTRATIV MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **REPAIRS PLANT** LINEN SERVICE 5.00 7.00 8.00 9.00 6.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 9, 949, 692 5.00 6.00 00600 MAINTENANCE & REPAIRS 434, 116 2, 765, 329 6.00 7.00 00700 OPERATION OF PLANT 258, 690 583, 345 2, 231, 205 7.00 00800 LAUNDRY & LINEN SERVICE 6, 279 6, 421 168, 389 8 00 8 00 24.441 9.00 00900 HOUSEKEEPI NG 146, 186 20, 787 21, 256 12, 306 985, 556 9.00 01000 DI ETARY 50, 355 55, 738 24, 929 10.00 54, 508 1, 154 10.00 11.00 01100 CAFETERI A 42,829 19, 967 20, 417 0 9, 132 11.00 01300 NURSING ADMINISTRATION 165, 135 41,013 13 00 40, 108 0 18.344 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 104, 229 60, 303 61,664 0 27, 580 14.00 01500 PHARMACY 24, 954 15.00 157, 805 24, 404 0 11, 161 15.00 01600 MEDICAL RECORDS & LIBRARY 159, 285 ol 16, 00 136, 086 16,00 133, 084 60,866 01700 SOCIAL SERVICE 17.00 59, 631 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 489, 256 127, 370 130, 243 40, 369 58, 253 30.00 03100 INTENSIVE CARE UNIT 14, 703 32, 148 32.874 31.00 221, 165 5, 767 31.00 04000 SUBPROVI DER - I PF 40 00 366, 899 132, 331 135, 316 0 60.522 40 00 04100 SUBPROVI DER - I RF 192, 790 119, 258 6,920 53, 339 41.00 116, 627 41.00 04300 NURSERY 43.00 121, 739 12,800 13, 089 5, 854 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 486, 117 182, 295 186, 405 18, 454 83, 373 50.00 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 135, 509 125, 675 52.00 132, 519 0 60,608 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 256, 092 163, 578 167, 269 4, 261 74, 813 54.00 15, 301 05600 RADI OI SOTOPE 147, 838 15, 646 6, 998 56.00 56.00 45, 795 60.00 06000 LABORATORY 531, 407 46, 829 0 20, 945 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 2, 208 2,676 2,736 0 1, 224 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 Ω 64.00 35, 981 65.00 06500 RESPIRATORY THERAPY 154, 057 35, 187 1, 154 16,093 65.00 06600 PHYSI CAL THERAPY 306, 967 92, 736 15, 461 41, 477 66.00 90, 690 66.00 06700 OCCUPATI ONAL THERAPY 19.757 3, 294 67.00 100.128 19.321 8,837 67.00 68.00 06800 SPEECH PATHOLOGY 54, 428 13,688 13, 996 2, 333 6, 260 68.00 06900 ELECTROCARDI OLOGY 18, 413 69.00 8, 336 8,524 0 3, 813 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 293.754 0 71.00 C 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 50,652  $\cap$ Λ 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 569, 538 4, 316 4, 413 0 1,974 73.00 03020 CARDI AC REHAB 76.00 28, 627 30, 911 31,609 0 14, 137 76.00 03030 ADDICTION SERVICES 76 01 76.01 52 445 0 OUTPATIENT SERVICE COST CENTERS 65, 413 66, 888 88.00 08800 RURAL HEALTH CLINIC 176, 715 7, 515 29, 917 88.00 88.01 08801 RURAL HEALTH CLINIC II 147, 682 46, 844 47, 901 21, 424 88.01 0 08802 RURAL HEALTH CLINIC LLI 88 02 328, 717 72, 001 32, 930 88 02 73, 625 0 88.03 08805 RURAL HEALTH CLINIC IV 0 88.03 26, 700 11, 942 88.04 08803 RURAL HEALTH CLINIC V 240, 991 26, 111 488 88.04 08804 RURAL HEALTH CLINIC VI 138, 186 34, 300 35, 073 88.05 15.687 88.05 0 73, 907 09000 CLI NI C 90 00 90 00 50.542 51, 682 1.226 23, 115 90.01 09001 ONCOLOGY 72, 566 51,833 53,002 3, 460 23, 706 90.01 90.02 09002 PAIN MANAGEMENT 90.02 0 09100 EMERGENCY 39, 663 910,002 91 00 86, 724 88, 680 10.380 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTE 93.00 93.00 117, 747 78, 441 80, 211 16, 147 35, 875 OTHER REIMBURSABLE COST CENTERS 95.00 95 00 09500 AMBULANCE SERVICES 614, 969 0 4,613 0 99. 10 09910 CORF 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 87, 983 8,043 3, 597 116. 00 7,866 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 9, 082, 362 2, 628, 749 2, 091, 544 155, 302 923, 091 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192, 00 194.00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 62, 465 194. 00 867, 330 13, 087 136, 580 139, 661 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 0 201, 00 201.00 202.00 TOTAL (sum lines 118 through 201) 9, 949, 692 2, 765, 329 2, 231, 205 168, 389 985, 556 202. 00

Provider CCN: 15-0061

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

				10	5 12/31/2022	Date/IIme Pre 6/12/2023 11:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	Jo alli
		10. 00	11. 00	13. 00	14. 00	15. 00	
	ENERAL SERVICE COST CENTERS						
2. 00 00 4. 00 00 5. 00 00 6. 00 00 7. 00 00	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0600 MAINTENANCE & REPAIRS 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00
	0900 HOUSEKEEPI NG						9. 00
	1000 DI ETARY	457, 091					10.00
11.00 0	1100 CAFETERI A	0	322, 339				11.00
1	1300 NURSING ADMINISTRATION	0	7, 661				13.00
1	1400 CENTRAL SERVICES & SUPPLY	0	5, 332		818, 819		14.00
1	1500 PHARMACY	0	6, 386		1, 058	1, 073, 185	1
1	1600 MEDICAL RECORDS & LIBRARY 1700 SOCIAL SERVICE	0	9, 558 3, 569	0	13 19	0	
	NPATIENT ROUTINE SERVICE COST CENTERS	U U	3, 309	0	19[	U	17.00
	3000 ADULTS & PEDIATRICS	153, 867	25, 841	202, 491	15, 360	0	30.00
	3100 INTENSIVE CARE UNIT	55, 333	8, 348		3, 141	0	1
40.00 0	4000 SUBPROVI DER - I PF	183, 296	23, 072	180, 793	3, 802	0	40. 00
	4100 SUBPROVI DER - I RF	64, 595	9, 517		2, 220	0	
	4300 NURSERY	0	5, 733	44, 925	2, 727	0	43.00
	NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM	O	15, 561	121, 933	21, 459	0	50.00
	5100 RECOVERY ROOM		15, 561	121, 933	21, 439	0	
	5200 DELIVERY ROOM & LABOR ROOM		5, 621	44, 049	o	0	52.00
1	5400 RADI OLOGY-DI AGNOSTI C	O	11, 116		11, 028	0	54.00
56.00 0	5600 RADI OI SOTOPE	o	1, 906	14, 936	5, 147	0	56.00
1	6000 LABORATORY	0	16, 069		259, 926	0	60.00
1	6300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
	6400   NTRAVENOUS THERAPY 6500   RESPI RATORY THERAPY	0	0 6, 528	0	12 210	0	64. 00 65. 00
1	6600 PHYSI CAL THERAPY		14, 009	0	13, 310 557	0	66.00
	6700 OCCUPATI ONAL THERAPY	l ö	4, 862	l ö	0	0	67. 00
1	6800 SPEECH PATHOLOGY	ō	2, 013	Ō	Ō	0	68. 00
69.00 0	6900 ELECTROCARDI OLOGY	0	736	0	1, 881	0	69. 00
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	450, 265	0	71.00
1	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
1	7300 DRUGS CHARGED TO PATIENTS	0	1 147	0 000	0	1, 073, 185	1
1	3020 CARDI AC REHAB 3030 ADDI CTI ON SERVI CES	0	1, 147 3, 894	8, 989 30, 515	525 0	0	
	UTPATIENT SERVICE COST CENTERS	<u> </u>	3,074	30, 313	<u> </u>		70.01
_	8800 RURAL HEALTH CLINIC	0	5, 967	0	380	0	88. 00
1	8801 RURAL HEALTH CLINIC II	0	5, 658	0	1, 208	0	
1	8802 RURAL HEALTH CLINIC III	0	13, 439	0	1, 816	0	
	8805 RURAL HEALTH CLINIC IV	0	0	0	1 043	0	
	8803 RURAL HEALTH CLINIC V 8804 RURAL HEALTH CLINIC VI		6, 277 5, 921	0	1, 042 478	0	
	9000 CLINIC	l ö	2, 796		1, 354	0	90.00
	9001 ONCOLOGY	O	3, 891	O	1, 353	0	90. 01
	9002 PAIN MANAGEMENT	0	0	0	0	0	90. 02
4	9100 EMERGENCY	0	16, 980	133, 055	7, 552	0	91.00
4	9200 OBSERVATION BEDS (NON-DISTINCT PART		4 000		0.4	0	92.00
	4040 OTHER OUTPATIENT SERVICE COST CENTE THER REIMBURSABLE COST CENTERS	0	4, 993	0	86	0	93.00
	9500 AMBULANCE SERVICES	O	33, 678	O	8, 195	0	95. 00
	9910 CORF	Ö	0		0	0	
	0100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	PECIAL PURPOSE COST CENTERS						
	1300 I NTEREST EXPENSE		0.404	0.4.0.4	4 400		113.00
	1600 HOSPI CE	0	3, 106		1, 100		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)  ONREIMBURSABLE COST CENTERS	457, 091	291, 185	1, 159, 039	817, 002	1, 073, 185	1118.00
	9200 PHYSICIANS' PRIVATE OFFICES	O	0	O	ol	O	192. 00
1	7951 OTHER NONREIMBURSABLE AND PHYSICIAN	ال	31, 154		1, 817		194.00
200.00	Cross Foot Adjustments		,		.,,		200. 00
201. 00	Negative Cost Centers	0	0	0	o		201. 00
202. 00	TOTAL (sum lines 118 through 201)	457, 091	322, 339	1, 159, 039	818, 819	1, 073, 185	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCI		eriod: rom 01/01/2022 o 12/31/2022	Worksheet B Part I Date/Time Pre 6/12/2023 11:	pared: 56 am
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	16. 00	17. 00	24. 00	25. 00	26.00	
GENERAL SERVICE COST CENTERS						
1. 00   00100   CAP REL COSTS-BLDG & FIXT   00200   CAP REL COSTS-MVBLE EQUIP   4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT   5. 00   00500   ADMINI STRATI VE & GENERAL   00600   MAI NTENANCE & REPAI RS   00700   OPERATION OF PLANT   00800   LAUNDRY & LINEN SERVICE   00900   HOUSEKEEPING   10. 00   01000   DI ETARY   11. 00   01100   CAFETERIA   13. 00   01300   NURSING ADMINI STRATION   14. 00   01400   CENTRAL SERVICES & SUPPLY   15. 00   01500   PHARMACY   01600   MEDICAL RECORDS & LIBRARY   17. 00   01700   SOCIAL SERVICE	1, 354, 254 0	383, 439				1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF 04300   NURSERY   ANCILLARY SERVICE COST CENTERS	20, 406 14, 376 47, 353 16, 648 7, 203	5, 249 5, 249 133, 954 99 0	3, 896, 018 1, 646, 180 3, 237, 595 1, 691, 873 867, 810	0 0 0 0	3, 896, 018 1, 646, 180 3, 237, 595 1, 691, 873 867, 810	31.00 40.00 41.00
50. 00 05000 OPERATING ROOM	84, 326	99	3, 810, 482	ol	3, 810, 482	50.00
51.00   05100   RECOVERY ROOM	0	0	0	O	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	6, 926	0	1, 185, 782	0	1, 185, 782	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 56. 00   05600   RADI OI SOTOPE	178, 070	0	2, 328, 548	0 0	2, 328, 548	
60. 00   06000   LABORATORY	41, 204 179, 841	o	1, 042, 870 4, 080, 402	0	1, 042, 870 4, 080, 402	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	5, 140	Ö	25, 841	o	25, 841	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	o	0	64.00
65. 00 06500 RESPI RATORY THERAPY	42, 321	0	1, 131, 921	0	1, 131, 921	
66. 00 06600 PHYSI CAL THERAPY	37, 102	0	2, 247, 419	0	2, 247, 419	
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	18, 639 6, 308	0	712, 526 391, 304	0	712, 526 391, 304	
69. 00   06900   ELECTROCARDI OLOGY	7, 707	o	148, 288	ő	148, 288	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	61, 089	0	2, 382, 572	0	2, 382, 572	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 700	0	329, 357	0	329, 357	
73. 00 07300 DRUGS CHARGED TO PATIENTS	125, 108	0	4, 836, 965		4, 836, 965	
76. 00   03020   CARDI AC REHAB 76. 01   03030   ADDI CTI ON SERVI CES	5, 145 0	0	274, 817 368, 483	0	274, 817 368, 483	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	300, 403	<u> </u>	300, 403	70.01
88. 00 08800 RURAL HEALTH CLINIC	9, 061	0	1, 310, 822	0	1, 310, 822	
88. 01   08801   RURAL HEALTH CLINIC II	6, 364	0	1, 070, 138	0	1, 070, 138	
88. 02   08802   RURAL HEALTH CLINIC III 88. 03   08805   RURAL HEALTH CLINIC IV	24, 307	0	2, 312, 051 0	0	2, 312, 051 0	88. 02 88. 03
88. 04 08803 RURAL HEALTH CLINIC V	11, 506	o	1, 619, 182	ő	1, 619, 182	
88. 05 08804 RURAL HEALTH CLINIC VI	4, 482	0	976, 190	O	976, 190	88. 05
90. 00   09000   CLI NI C	11, 471	0	612, 973	0	612, 973	
90. 01   09001   0NCOLOGY 90. 02   09002   PAI N MANAGEMENT	8, 032	0	607, 523	0	607, 523 0	90. 01 90. 02
91. 00   09100   EMERGENCY	299, 601	32, 882	6, 512, 379	0	6, 512, 379	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		52, 552	2, 212, 211	ō	2, 212, 211	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	15, 297	204, 421	1, 185, 524	0	1, 185, 524	93.00
95. 00 OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	45, 523	ol	4, 009, 373	ol	4 000 272	95. 00
99. 10   09910 CORF	45, 523	0	4,009,373	0	4, 009, 373 0	
101.00 10100 HOME HEALTH AGENCY	O	Ö	0	Ö		101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE	4 000	00	/1F /0/		/1F /0/	113.00
116.00   11600   HOSPI CE 118.00   SUBTOTALS (SUM OF LINES 1 through 117)	6, 998 1, 354, 254	99 382, 052	615, 606 57, 468, 814	0	615, 606 57, 468, 814	
NONREI MBURSABLE COST CENTERS	1, 554, 254	302, 032	57, 400, 014	O <sub>I</sub>	57, 400, 014	1
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1, 387	1, 387	0		192. 00
194. 00 07951 OTHER NONREI MBURSABLE AND PHYSI CI AN	0	0	5, 909, 676	0	5, 909, 676	
200.00 Cross Foot Adjustments			0	0		200. 00 201. 00
201.00 Negative Cost Centers	١	U	0	-		
202.00 TOTAL (sum lines 118 through 201)	1, 354, 254	383, 439	63, 379, 877	Ol	63, 379, 877	120) 2 1111

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0061

				To	12/31/2022	Date/Time Pre 6/12/2023 11:	
			CAPI TAL REI	LATED COSTS		0/12/2023 11.	JO alli
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost denter bescription	Assigned New	DEDG & TTXT	WVBLL EQUIT	Subtotal	BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 210	1, 990	8, 200	8, 200	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	139, 223	168, 889	308, 112	872	5. 00
6. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	68, 045		72, 399	19	6.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	0	490, 724 5, 282	1	490, 724 5, 282	0	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	17, 486	1	20, 497	153	9. 00
10.00	01000 DI ETARY	0	45, 854		54, 174	29	10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	0	16, 796 33, 740	1	16, 796 51, 891	47 181	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	50, 728		56, 163	82	14. 00
15.00	01500 PHARMACY	0	20, 529		27, 032		15.00
16. 00 17. 00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE	0	111, 953 0		113, 711 0	150 74	16. 00 17. 00
.,. 00	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30.00	03000 ADULTS & PEDIATRICS	0			172, 681	509	30.00
31. 00 40. 00	03100   INTENSIVE CARE UNIT   04000   SUBPROVI DER -   PF	0	27, 044 111, 320		46, 018 132, 850		31. 00 40. 00
	04100 SUBPROVI DER – I RF	0	98, 109		106, 102		41. 00
43.00	04300 NURSERY	0	10, 768	0	10, 768	131	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	0	153, 350	220, 188	373, 538	448	50.00
51. 00	05100 RECOVERY ROOM	0	0		0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	111, 478		111, 478		52.00
54. 00 56. 00	05400  RADI OLOGY-DI AGNOSTI C   05600  RADI OI SOTOPE	0	137, 606 12, 872		268, 582 29, 607	206 51	54. 00 56. 00
60.00	06000 LABORATORY	0	38, 524		62, 095		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	2, 251	0	2, 251	0	63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0		0 97 E01	0 146	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		29, 600 76, 291		87, 591 276, 211	303	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	16, 253		59, 267	111	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	11, 514		42, 957	57	68.00
69. 00 71. 00	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	7, 013 0		12, 822 992	18 0	69. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 631		3, 631	0	73.00
76. 00 76. 01	03020 CARDI AC REHAB 03030 ADDI CTI ON SERVI CES	0	26, 003 0	1	26, 003 0		76. 00 76. 01
	OUTPATIENT SERVICE COST CENTERS	·	-				
	O8800   RURAL HEALTH CLINIC   O8801   RURAL HEALTH CLINIC II	0		1	55, 984		88.00
	O8801  RURAL HEALTH CLINIC III	0	39, 406 60, 569		40, 519 68, 158	158 344	
88. 03	08805 RURAL HEALTH CLINIC IV	0	0	0	0	0	88. 03
88. 04 88. 05	08803 RURAL HEALTH CLINIC V	0	21, 965		23, 723		88. 04
90.00	O8804   RURAL HEALTH CLINIC VI   O9000   CLINIC		28, 854 42, 517		29, 630 44, 283		88. 05 90. 00
90. 01	09001 ONCOLOGY	0	43, 603		43, 603		90. 01
90. 02	09002 PAIN MANAGEMENT	0	70.054	-	0	0	90. 02
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART	0	72, 954	54, 016	126, 970 0	361	91. 00 92. 00
	04040 OTHER OUTPATIENT SERVICE COST CENTE	0	65, 987	227	66, 214	148	93.00
	OTHER REIMBURSABLE COST CENTERS	_	_				
	09500 AMBULANCE SERVI CES 09910 CORF	0	•		206, 072 0	625 0	1
	10100 HOME HEALTH AGENCY	0			0		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE  11600 HOSPICE	0	6, 617	0	6, 617		113. 00 116. 00
118.00		0	1		3, 762, 198		118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES  07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0	0 114, 894	0 143, 104	0 257, 998		192. 00 194. 00
200.00			114, 094	143, 104	237, 998		200.00
201.00	Negative Cost Centers		0	1	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	2, 539, 735	1, 480, 461	4, 020, 196	8, 200	202. 00

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

					Т	o 12/31/2022	Date/Time Pre 6/12/2023 11:	
		Cost Center Description		MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	
			E & GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENER.	AL SERVICE COST CENTERS	2.22			2.22		
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00	1	ADMINISTRATIVE & GENERAL	308, 984					5.00
6. 00	1	MAINTENANCE & REPAIRS	13, 481	85, 899				6.00
7. 00		OPERATION OF PLANT	8, 034	18, 120				7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	759	195	1, 487	7, 723		8. 00
9. 00	1	HOUSEKEEPI NG	4, 540	646			31, 324	1
10.00		DI ETARY	1, 564	1, 693			l e	
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	1, 330 5, 128	620 1, 246		0		
14. 00		CENTRAL SERVICES & SUPPLY	3, 120	1, 240		0	877	14.00
15. 00		PHARMACY	4, 901	758		0	355	
16.00	01600	MEDICAL RECORDS & LIBRARY	4, 947	4, 134	31, 526	0	1, 935	16.00
17. 00		SOCI AL SERVI CE	1, 852	0	0	0	0	17.00
20.00		I ENT ROUTINE SERVICE COST CENTERS	15 104	2.05/	20 172	1 052	1 051	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	15, 194 6, 868	3, 956 999			l	1
40.00		SUBPROVI DER - I PF	11, 394	4, 111		0	l	
41. 00		SUBPROVIDER - IRF	5, 987	3, 623			1, 695	
43.00	04300	NURSERY	3, 781	398		0	186	1
		LARY SERVICE COST CENTERS			,			
50.00	1	OPERATING ROOM	15, 096	5, 663			2, 650	1
51.00	1	RECOVERY ROOM	0 3, 903	0		-	0	51.00
52. 00 54. 00	1	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	7, 953	4, 116 5, 081			1, 926 2, 378	1
56. 00		RADI OI SOTOPE	4, 591	475			222	1
60.00		LABORATORY	16, 503	1, 423			666	1
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	69	83	634	0	39	63.00
64.00		INTRAVENOUS THERAPY	0	0		_	0	64.00
65.00		RESPI RATORY THERAPY	4, 784	1, 093			l	65.00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	9, 533 3, 109	2, 817 600			1, 318 281	66. 00 67. 00
68.00	1	SPEECH PATHOLOGY	1, 690	425			199	
69. 00		ELECTROCARDI OLOGY	572	259			121	69.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	9, 122	0			0	
72.00		IMPL. DEV. CHARGED TO PATIENTS	1, 573	0	0	0	0	
73. 00		DRUGS CHARGED TO PATIENTS	17, 687	134			63	1
76.00		CARDI AC REHAB	889	960			449	1
76. 01		ADDICTION SERVICES TIENT SERVICE COST CENTERS	1, 629	0	0	U	0	76. 01
88. 00		RURAL HEALTH CLINIC	5, 488	2, 032	15, 495	345	951	88.00
88. 01	08801	RURAL HEALTH CLINIC II	4, 586	1, 455			681	88. 01
88. 02	1	RURAL HEALTH CLINIC III	10, 208	2, 237	17, 056	0	1, 047	1
88. 03		RURAL HEALTH CLINIC IV	0	0			0	1
88. 04		RURAL HEALTH CLINIC V	7, 484	811			380	
88. 05 90. 00		RURAL HEALTH CLINIC VI CLINIC	4, 291 2, 295	1, 065 1, 570		-		88. 05 90. 00
90. 01		ONCOLOGY	2, 254	1, 610				
90. 02	1	PAIN MANAGEMENT	0	0			0	1
91.00	1	EMERGENCY	28, 256	2, 694	20, 544	476	1, 261	1
92.00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 00		OTHER OUTPATIENT SERVICE COST CENTE	3, 657	2, 437	18, 582	741	1, 140	93.00
95. 00		REIMBURSABLE COST CENTERS  AMBULANCE SERVICES	19, 098	0	1 0	212	0	95. 00
	09300		19, 096	0				99. 10
	1	HOME HEALTH AGENCY	ő	0	•			101.00
		AL PURPOSE COST CENTERS	- 1					
		INTEREST EXPENSE						113.00
	1	HOSPI CE	2, 732	244				116.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	282, 049	81, 656	484, 524	7, 123	29, 339	118. 00
192 00		IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES		0	0	0	0	192. 00
		OTHER NONREIMBURSABLE AND PHYSICIAN	26, 935	4, 243	-			194.00
200.00		Cross Foot Adjustments	25, 755	1, 240	02,004	300	1, 703	200.00
201.00	1	Negative Cost Centers	0	0	0	0		201.00
202.00	)	TOTAL (sum lines 118 through 201)	308, 984	85, 899	516, 878	7, 723	31, 324	202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
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					To	12/31/2022	Date/Time Pre 6/12/2023 11:	
		Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	OO diii
					ADMI NI STRATI O N	SERVI CES & SUPPLY		
			10.00	11. 00	13.00	14. 00	15. 00	
1 00		AL SERVICE COST CENTERS			I	T		1 00
1. 00 2. 00		CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00		ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	1	MAINTENANCE & REPAIRS OPERATION OF PLANT						6. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE						8.00
9. 00	00900	HOUSEKEEPI NG						9. 00
10.00		DI ETARY	71, 217	00.010				10.00
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	0	23, 813 566				11. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	Ö	394		76, 911		14.00
15.00	1	PHARMACY	0	472		99	39, 540	
16.00	1	MEDICAL RECORDS & LIBRARY	0	706		1	0	16.00
17. 00		SOCIAL SERVICE     IENT ROUTINE SERVICE COST CENTERS	U	264	<u> </u>	2	0	17. 00
30.00	03000	ADULTS & PEDIATRICS	23, 973	1, 909		1, 443	0	30. 00
31.00		INTENSIVE CARE UNIT	8, 621	617	3, 900	295	0	31.00
40. 00 41. 00		SUBPROVI DER - I PF SUBPROVI DER - I RF	28, 559 10, 064	1, 704 703		357 209	0	40. 00 41. 00
43.00	1	NURSERY	0	424		256	0	43.00
		LARY SERVICE COST CENTERS						
50. 00 51. 00	1	OPERATING ROOM RECOVERY ROOM	0	1, 150 0		2, 016 0	0	50.00 51.00
52.00		DELIVERY ROOM & LABOR ROOM	Ö	415		Ö	0	52.00
54.00		RADI OLOGY-DI AGNOSTI C	0	821	5, 193	1, 036	0	54.00
56. 00 60. 00	1	RADI OI SOTOPE LABORATORY	0	141 1, 187	890 7, 507	483 24, 415	0	56. 00 60. 00
63.00	1	BLOOD STORING, PROCESSING & TRANS.	0	1, 167		24, 415	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	О	0	64.00
65.00	1	RESPI RATORY THERAPY	0	482		1, 250	0	65.00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	1, 035 359		52 0	0	66. 00 67. 00
68.00		SPEECH PATHOLOGY	Ö	149		Ö	0	68.00
69. 00	1	ELECTROCARDI OLOGY	0	54	0	177	0	69. 00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42, 293 0	0	71. 00 72. 00
72.00		DRUGS CHARGED TO PATTENTS	0	0		0	39, 540	
76.00	1	CARDI AC REHAB	0	85	536	49	0	76. 00
76. 01		ADDICTION SERVICES	0	288	1, 819	0	0	76. 01
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	ol	441	0	36	0	88. 00
88. 01	1	RURAL HEALTH CLINIC II	O	418	0	113	0	88. 01
88. 02	1	RURAL HEALTH CLINIC III	0	993		171	0	88. 02
88. 03 88. 04	1	RURAL HEALTH CLINIC IV RURAL HEALTH CLINIC V	0	0 464	1	0 98	0	88. 03 88. 04
88. 05		RURAL HEALTH CLINIC VI	Ö	437		45	0	88. 05
90.00		CLI NI C	0	207	1	127	0	90.00
90. 01 90. 02		ONCOLOGY PAIN MANAGEMENT	0	287 0	0	127 0	0	90. 01 90. 02
91.00		EMERGENCY	Ö	1, 254	·	709	0	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART					_	92.00
93. 00		OTHER OUTPATIENT SERVICE COST CENTE REIMBURSABLE COST CENTERS	0	369	0	8	0	93. 00
95.00		AMBULANCE SERVICES	0	2, 487	0	770	0	95. 00
99. 10			0	0		0	0	
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
113.00		INTEREST EXPENSE						113. 00
		HOSPI CE	0	229		103		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71, 217	21, 511	69, 096	76, 740	39, 540	1118.00
	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 00
	1	OTHER NONREIMBURSABLE AND PHYSICIAN	0	2, 302	0	171	0	194.00
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers	0	0	0	0	0	200. 00 201. 00
202.00		TOTAL (sum lines 118 through 201)	71, 217	23, 813		76, 911	39, 540	

ALLOCATION OF CAPITAL RELATED COSTS				Worksheet B				
						From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
		Coat Contar Decement on	MEDICAL	COCLAI	Cubtatal	Intern 0	6/12/2023 11:	56 am
		Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	Subtotal	Intern & Residents	Total	
			LI BRARY			Cost & Post		
						Stepdown		
			16. 00	17. 00	24. 00	Adjustments 25.00	26. 00	
	GENER.	AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00		ADMINISTRATIVE & GENERAL						5.00
6.00		MAINTENANCE & REPAIRS						6.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPI NG						9.00
10.00	01000	DI ETARY						10.00
11.00	1	CAFETERI A						11.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						13.00
15. 00		PHARMACY						15.00
16. 00	1	MEDICAL RECORDS & LIBRARY	157, 110					16.00
17. 00		SOCIAL SERVICE	0	2, 192				17. 00
30. 00		ADULTS & PEDIATRICS	2, 368	30	268, 01	0 0	268, 010	30.00
31. 00		INTENSIVE CARE UNIT	1, 668	30			77, 550	1
40.00		SUBPROVI DER - I PF	5, 495	766			229, 793	1
41. 00 43. 00	1	SUBPROVI DER - I RF NURSERY	1, 932 836	1 <sub>0</sub>	162, 90 22, 49		162, 909 22, 490	1
43.00		LARY SERVICE COST CENTERS	030	<u> </u>	22,47	<u> </u>	22,470	43.00
50.00		OPERATING ROOM	9, 785	1	461, 64		461, 645	1
51.00	1	RECOVERY ROOM	0 804	0		0 0	154 700	
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	20, 662	0	156, 78 350, 85	-	156, 780 350, 856	1
56.00	1	RADI OI SOTOPE	4, 781	Ö	44, 86		44, 866	1
60.00	1	LABORATORY	20, 868	0	145, 76		145, 769	1
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	596 0	0	- ' -	0 0	3, 672 0	
65.00		RESPI RATORY THERAPY	4, 911	0		-	109, 156	1
66.00		PHYSI CAL THERAPY	4, 305	0	317, 76		317, 766	1
67.00		OCCUPATIONAL THERAPY	2, 163	0	70, 61		70, 618	•
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	732 894	0	49, 55 16, 89	-	49, 558 16, 892	•
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	7, 088	0	59, 49		59, 495	•
72.00		IMPL. DEV. CHARGED TO PATIENTS	777	0	2, 35		2, 350	•
73. 00 76. 00		DRUGS CHARGED TO PATIENTS CARDIAC REHAB	14, 517 597	0			76, 594 36, 919	
76. 01	1	ADDICTION SERVICES	0	Ö			3, 793	1
		TIENT SERVICE COST CENTERS						
		RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	1, 051 738	0	02,01		82, 010 59, 765	88. 00 88. 01
88. 01 88. 02	1	RURAL HEALTH CLINIC III	2, 820	0	103, 03		103, 034	1
88. 03	08805	RURAL HEALTH CLINIC IV	0	0		0	0	1
88. 04		RURAL HEALTH CLINIC V	1, 335	0	40, 76		40, 764	1
88. 05 90. 00		RURAL HEALTH CLINIC VI CLINIC	520 1, 331	0	44, 76 62, 63		44, 764 62, 637	1
90. 01		ONCOLOGY	932	Ö	62, 08		62, 081	
90. 02		PAIN MANAGEMENT	0	0		0	0	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	34, 735	188	225, 38	0 0	225, 380	91.00 92.00
93.00		OTHER OUTPATIENT SERVICE COST CENTE	1, 775	1, 167	96, 23		96, 238	1
	OTHER	REIMBURSABLE COST CENTERS		·				
		AMBULANCE SERVICES	5, 282	0	,		234, 546	1
101.00	09910	HOME HEALTH AGENCY	0	0		0 0	0	99. 10 101. 00
	SPECI	AL PURPOSE COST CENTERS	-	-		_	_	
		INTEREST EXPENSE	212	_	44.00		4.4.000	113.00
116. 00 118. 00	1	HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	812 157, 110	1 2, 184	14, 23 3, 692, 93		14, 232 3, 692, 932	116.00
110.00		IMBURSABLE COST CENTERS	137, 110	2, 104	3, 072, 73	2 0	3, 072, 732	1110.00
	19200	PHYSICIANS' PRIVATE OFFICES	0	8		8 0		192. 00
	1	OTHER NONREIMBURSABLE AND PHYSICIAN	0	0	327, 25		327, 256	
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers	O	n		0 0		200. 00 201. 00
202.00		TOTAL (sum lines 118 through 201)	157, 110	2, 192	4, 020, 19	-		

Provi der CCN: 15-0061

						o 12/31/2022	Date/Time Pre 6/12/2023 11:	
			CAPITAL REI	ATED COSTS			0/12/2023 11.	30 alli
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			1. 00	2.00	SALARI ES) 4. 00	5A	5. 00	
		AL SERVICE COST CENTERS				-		
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	224, 543	1, 393, 559				1.00 2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	549					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12, 309	158, 975	3, 081, 384	-9, 949, 692	53, 430, 185	5.00
6.00		MAINTENANCE & REPAIRS	6, 016	l '			2, 331, 213	6.00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	43, 386 467	0	•		1, 389, 170 131, 248	ı
9. 00		HOUSEKEEPI NG	1, 546	2, 834			785, 021	9. 00
10.00		DI ETARY	4, 054				270, 407	10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMI NI STRATI ON	1, 485 2, 983		,		229, 994 886, 778	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	4, 485				559, 711	14.00
15.00		PHARMACY	1, 815				847, 417	•
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	9, 898				855, 362 320, 220	1
17.00		IENT ROUTINE SERVICE COST CENTERS			200, 347	0	320, 220	17.00
30.00		ADULTS & PEDIATRICS	9, 473				2, 627, 313	
31. 00 40. 00		INTENSIVE CARE UNIT SUBPROVIDER - IPF	2, 391 9, 842	17, 860 20, 266			1, 187, 662 1, 970, 257	31.00 40.00
41.00		SUBPROVIDER - I RF	8, 674				1, 970, 237	•
43.00	04300	NURSERY	952				653, 740	1
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	13, 558	207, 263	1, 606, 195	0	2, 610, 460	50.00
51.00	1	RECOVERY ROOM	13, 556	l ·			2,610,460	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9, 856	ł			674, 875	
54.00	1	RADI OLOGY-DI AGNOSTI C	12, 166	l '			1, 375, 218	1
56. 00 60. 00		RADI OI SOTOPE LABORATORY	1, 138 3, 406	l '			793, 894 2, 853, 669	1
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	199		1		11, 857	63.00
64.00		I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	2, 617 6, 745	54, 587 188, 185			827, 290 1, 648, 420	1
67. 00		OCCUPATI ONAL THERAPY	1, 437	40, 489			537, 688	1
68.00		SPEECH PATHOLOGY	1, 018				292, 278	•
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	620	5, 468 934			98, 878 1, 577, 464	1
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	272, 005	•
73.00		DRUGS CHARGED TO PATIENTS	321	0	102 204		3, 058, 431	1
76. 00 76. 01		CARDIAC REHAB ADDICTION SERVICES	2, 299 0	l e			153, 727 281, 629	76. 00 76. 01
		TIENT SERVICE COST CENTERS		-		_		
88. 00 88. 01		RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	4, 865 3, 484				948, 966 793, 057	88. 00 88. 01
88. 02		RURAL HEALTH CLINIC III	5, 355				1, 765, 216	1
88. 03		RURAL HEALTH CLINIC IV	0	0	C	0	0	88. 03
88. 04 88. 05		RURAL HEALTH CLINIC V RURAL HEALTH CLINIC VI	1, 942	1, 655 730			1, 294, 125	1
90.00		CLINIC	2, 551 3, 759	ł			742, 063 396, 880	1
90. 01	09001	ONCOLOGY	3, 855				389, 680	90. 01
90. 02 91. 00		PAIN MANAGEMENT EMERGENCY	0 6, 450	1	ı	_	0 4, 886, 860	90. 02 91. 00
92.00		OBSERVATION BEDS (NON-DISTINCT PART	0, 430	50, 843	1, 293, 303	0	4, 880, 800	92.00
93. 00		OTHER OUTPATIENT SERVICE COST CENTE	5, 834	214	531, 948	0	632, 306	93. 00
95. 00		REIMBURSABLE COST CENTERS  AMBULANCE SERVICES	0	193, 976	2, 241, 406	0	3, 302, 395	95.00
99. 10	09910		Ö	0			0,002,070	1
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101.00
113.00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
116.00	11600	HOSPI CE	585				472, 473	116. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	214, 385	1, 258, 855	26, 964, 265	-9, 949, 692	48, 772, 603	118. 00
192. 00		PHYSICIANS' PRIVATE OFFICES	0	0	О	0	0	192. 00
		OTHER NONREIMBURSABLE AND PHYSICIAN	10, 158	134, 704	2, 395, 417	0	4, 657, 582	1
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	1	Cost to be allocated (per Wkst. B,	2, 539, 735	1, 480, 461	5, 929, 846		9, 949, 692	•
		Part I)			<u> </u>			<u> </u>

	In Lie	u of Form CMS-2	2552-10
		Date/Time Pre	
EMPLOYEE	Reconciliatio		
	n		
		(ACCUM. COST)	
,			
4. 00	5A	5. 00	
0. 20197:	2	0. 186219	203. 00
8, 20	D	308, 984	204.00
0. 00027	9	0. 005783	205. 00
			206. 00
			207. 00
1			
	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARI ES) 4.00 0.201972 8,200	CCN: 15-0061 Period: From 01/01/2022 To 12/31/2022  EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 4.00 5A	From 01/01/2022   Date/Time Pre 6/12/2023 11:    EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0061

Company   Comp					T	o 12/31/2022	Date/Time Pre 6/12/2023 11:	
SOLIMBE FEET   COLUMBS OF   LAURISMY   SERVED		Cost Center Description					DI ETARY	
Description   Control						(SQUARE FEET)		
Cherent Schwicz COST CENTERS					LAUNDRY)		,	
1.00   1.00		CENEDAL SEDVICE COST CENTEDS	6. 00	7. 00	8.00	9. 00	10.00	
2.00   000000   000000   000000   000000   000000	1. 00							1.00
5.00   DOSCO AMM INSTRUTE & CEMERAL   5.00		I I						1
0.00   0.000   DOCODINA NTENANCE & REPAIR S   205, 669								1
7.00 000000 HOUSENET HOW OF PLANT 1 43, 3816 162, 283 47, 408 0.0 000000 HOUSENEEPH NG 1, 546 1, 546 1, 546 25, 389 1, 467 3, 300 0.0 00000 HOUSENEEPH NG 1, 546 1, 546 1, 546 25, 389 1, 465 28, 673 10.0 0.0 10.0 00000 HOUSENEEPH NG 1, 448 1, 488 1, 488 1, 465 28, 673 10.0 0.0 10.0 0000 HOUSENEEPH NG 1, 485 10.0 1, 546 10.0 10.0 0.0 10.0 0000 HOUSENEEPH NG 1, 485 10.0 1, 485 10.0 1, 540 10.0 10.0 0.0 10.0 000 HOUSENEEPH NG 1, 485 10.0 1, 485 10.0 1, 540 10.0 10.0 0.0 10.0 000 HOUSENEEPH NG 1, 540 10.0 10.0 0.0 10.0 000 HOUSENEEPH NG 1, 540 10.0 10.0 0.0 10.0 000 HOUSENEEPH NG 1, 540 10.0 10.0 0.0 10.0 000 HOUSENEEPH NG 1, 540 10.0 10.0 0.0 10.0 000 HOUSENEEPH NG 1, 540 10.0 10.0 0.0 10.0 000 HOUSENEEPH NG 1, 540 10.0 10.0 0.0 10.0 000 HOUSENEEPH NG 1, 540 10.0 0.0 0.0 000 HOUSENEEPH NG 1, 540 10.0 0.0 0.0 000 HOUSENEEPH NG 1, 540 10.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0			205 660					1
8.00   000000   LAURDRY & LINEN SERVICE   467   467   347, 488   8.0   0								1
10.00   01000   DETARY   4.054   4.055   2.380   1.485   0.11.00   1.10.00   1.10.00   CAFEERIA AMAIN INSTRATION   7.987   7.987   7.988   0.0   2.981   0.11.00   1.10.00   1		00800 LAUNDRY & LINEN SERVICE	467	467	347, 408			1
11.00   0100   CAFETERIA   1,485   1,485   0   1,485   0   1,485   13.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   15.00   1			1				20 472	1
13.00   01300   NIRSHIR ADMINISTRATION   2, 963   2, 983   0   2, 983   0   13.00			1	1				
15.00   01500   PHABMACY   1.815   1.815   0   1.815   0   15.00		i i	1		1			
16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.0			1		1			
17.00   17.0		l l				,		
30.00					1	· ·		1
31.00   03100   INTERSIVE CARE UNIT   2, 391   2, 391   11, 898   2, 391   3, 471   31.00   04.00   04000   SUBPROVIDER - I IF   9, 842   9, 842   0 9, 842   0 9, 842   1, 498   40.00   04.00   04100   SUBPROVIDER - I IF   8, 674   8, 674   4, 672   41.00   04.00   04100   SUBPROVIDER - I IF   8, 674   8, 674   4, 672   41.00   04.00   04.00   04.00   04.00   0500   0500   0500   0500   0500   0500   0500   0500   0500   0500   0500   0500   0500   0500   0500   0510   0500   0510   0500   0510   0500   0510   0500   0510   0500   0510   05								]
0.000   0.000   0.000   SUBPROVIDER - IPF				1			· ·	
41.00   04100   SUBPROVIDER - IRF			1			· ·		
MICHILLARY SERVICE COST CENTRES		04100 SUBPROVI DER - I RF	8, 674	8, 674	14, 277	8, 674		
50.00	43.00		952	952	0	952	0	43.00
51.00   05100   RECOVERY ROOM & LABOR ROOM   0, 0   0   0   0   0   0   0   51.00	50 00		13 558	13 558	38 073	13 558	0	50.00
54. 00			0			·		
56.00   05600   RADIO ISOTOPE   1,138			1	1				
60.00   06000   LABORATORY   0   0   0   0   0   0   0   0   0		I I						1
63.00		l l						1
65.00   06500   0659N RATORY THERAPY   2,617   2,617   2,380   2,617   0   65.00	63.00	06300 BLOOD STORING, PROCESSING & TRANS.		199	0	199		63.00
66.00		l l	-	1	_	_		1
67.00   06700   06700   06700   06700   06700   06700   0670   06800   06800   08900   SPEECH PATHOLOGY   1,018   1,018   1,018   1,018   0,080   0,0900   0,000   0			1					1
69 00   06900   0600   0620   0620   0620   0620   0620   0620   0620   0620   0620   0620   0620   0620   071.00   071.00   071.00   072.00   07							0	
17. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   0   0   0		l l	1			· ·		
17.00   07.00   07.00   07.00   07.00   0   0   0   0   0   0   0   0   0		i i	1					
76. 00			0					
03030   ADDICTION SERVICES   0   0   0   0   0   0   76.01								
OUTPATIENT SERVICE COST CENTERS		l l						
88.01   08801 RIVAL HEALTH CLINIC II   3,484   3,484   0   3,484   0   88.01   88.02   08802 RIVAL HEALTH CLINIC III   5,355   5,355   0   5,355   0   88.03   88.03   08805 RIVAL HEALTH CLINIC IV   0   0   0   0   0   0   88.03   08805 RIVAL HEALTH CLINIC V   1,942   1,942   1,007   1,942   0   88.04   88.05   08804 RIVAL HEALTH CLINIC V   2,551   2,551   0   2,551   0   88.05   88.06   08804 RIVAL HEALTH CLINIC V   2,551   2,551   0   2,551   0   88.05   88.07   08805 RIVAL HEALTH CLINIC V   2,551   2,551   0   2,551   0   88.05   88.08   08806 RIVAL HEALTH CLINIC V   2,551   2,551   0   2,551   0   88.05   88.09   08806 RIVAL HEALTH CLINIC V   2,551   2,551   0   2,551   0   88.05   88.01   08807 RIVAL HEALTH CLINIC V   2,551   2,551   0   2,551   0   88.05   88.02   08808 RIVAL HEALTH CLINIC V   2,551   2,551   0   2,551   0   88.05   88.03   08805 RIVAL HEALTH CLINIC V   2,551   2,551   0   0   2,551   0   88.05   88.04   08806 RIVAL HEALTH CLINIC V   2,551   2,551   0   0   0   0   0   0   99.00   09000 CLINIC   3,759   3,759   2,529   3,759   0,90.00   99.01   09001   00000   0   0   0   0   0   0   0	70.01		0		0	0	0	70.01
88. 02   08802   RURAL HEALTH CLINIC III   5,355   5,355   0   0   0   0   0   0   0   0   0		l l	1	1				1
88.03   08805 RURAL HEALTH CLINIC IV   0   0   0   0   0   88.03   88.04   08803 RURAL HEALTH CLINIC V   1,942   1,942   1,007   1,942   0   88.05   08804 RURAL HEALTH CLINIC V   2,551   2,551   0   2,551   0   90.00   09000 CLINIC   3,759   3,759   2,529   3,759   0   90.01   09001   0NCOLOGY   3,855   3,855   7,139   3,855   0   90.02   09002 PAIN MANAGEMENT   0   0   0   0   0   0   91.00   09100   EMERGENCY   6,450   6,450   21,416   6,450   0   92.00   09200   0SERVATION BEDS (NON-DISTINCT PART   92.00   93.00   04040   OTHER OUTPATIENT SERVICE COST CENTE   5,834   5,834   33,314   5,834   0   95.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   99.10   09910   CORF   0   0   0   0   0   0   101:00   10100   HOME HEALTH AGENCY   0   0   0   0   0   113.00   1300   INTEREST EXPENSE   113.00   116.00   11600   HOSPICE   S85   S85   0   S85   0   116.00   11600   HOSPICE   S85   S85   0   S85   0   117.00   10100   HOSPICE   S85   S85   0   S85   0   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   195,511   152,125   320,408   150,112   28,673   18.00   190.00   Cross Foot Adjustments   NonreimBursAble Rons Physician   S85   S85   0   0   0   200.00   Cross Foot Adjustments   S85   S85   0   10,158   0   201.00   Negative Cost Centers   S85   S85   0   S85   S85   0   S85   S85   0   202.00   Cost to be allocated (per Wkst. B, 2,765,329   2,231,205   168,389   985,556   457,091   202.00   203.00   Unit cost multiplier (Wkst. B, Part I)   13.445531   13.748852   0.484701   6.149348   15.941513   203.00   204.00   Cost to be allocated (per Wkst. B, 85,899   516,878   7,723   31,324   71,217   204.00				1				
88. 04   08803 RURAL HEALTH CLINIC V		1 1	0, 333			·		
90. 00   09000   CLINIC   3,759   3,759   2,529   3,759   0   90. 00   90. 01   09001   ONCOLOGY   3,855   3,855   7,139   3,855   0   90. 01   90. 02   09002   PAIN MANAGEMENT   0   0   0   0   0   0   0   91. 00   09100   EMERGENCY   6,450   6,450   21,416   6,450   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   92. 00   93. 00   O9200   OBSERVATION BEDS (NON-DISTINCT PART   92. 00   93. 00   O9400   OTHER OUTPATIENT SERVICE COST CENTE   5,834   5,834   33,314   5,834   0   93. 00   07HER REIMBURSABLE COST CENTERS   0   0   0   9,518   0   0   95. 00   99. 10   09910   CORF   0   0   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   0   0   118. 00   SPECIAL PURPOSE COST CENTERS   113. 00   113. 00   11300   1100   HOME HEALTH AGENCY   0   0   0   0   0   0   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   195, 511   152, 125   320, 408   150, 112   28,673   118. 00   194. 00   07951   OTHER NONREIMBURSABLE COST CENTERS   0   0   0   0   0   0   194. 00   07951   OTHER NONREIMBURSABLE AND PHYSICIAN   10, 158   10, 158   27, 000   10, 158   0   194. 00   200. 00   Cross Foot Adjustments   201. 00   Negative Cost Centers   201. 00   201. 00   Negative Cost Centers   201. 00   0   0   0   0   0   0   202. 00   Cost to be allocated (per Wkst. B, 2, 765, 329   2, 231, 205   168, 389   985, 556   457, 091   202. 00   203. 00   Unit cost multiplier (Wkst. B, Part I)   13. 445531   13. 748852   0. 484701   6. 149348   15. 941513   203. 00   204. 00   Cost to be allocated (per Wkst. B, 85, 899   516, 878   7, 723   31, 324   71, 217   204. 00   204. 00   Cost to be allocated (per Wkst. B, 85, 899   516, 878   7, 723   31, 324   71, 217   204. 00   205. 00   Cost to be allocated (per Wkst. B, 85, 899   516, 878   7, 723   31, 324   71, 217   204. 00   206. 00   Cost to be allocated (per Wkst. B, 85, 899   516, 878   7, 723   31, 324								
90. 01   09001   0NCOLOGY   3,855   3,855   7,139   3,855   0   90. 01   90. 02   09002   PAI N MANAGEMENT   0   0   0   0   0   0   91. 00   09100   EMERGENCY   6,450   6,450   21,416   6,450   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   92. 00   93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTE   5,834   5,834   33,314   5,834   0   93. 00   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   99. 10   09910   CORF   0   0   0   0   0   0   99. 10   10100   HOME HEALTH AGENCY   0   0   0   0   0   113. 00   11300   INTEREST EXPENSE   113. 00   116. 00   11600   HOSPICE   SERVICES   585   585   0   118. 00   NONREI MBURSABLE COST CENTERS   113. 00   1192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   0   0   0   0   0   194. 00   07951   0716K NONREI MBURSABLE AND PHYSI CI AN   10,158   10,158   27,000   10,158   0194. 00   201. 00   Negative Cost Centers   200. 00   202. 00   Cost to be allocated (per Wkst. B, Part I)   13. 445531   13. 748852   0. 484701   6.149348   15. 941513   203. 00   204. 00   Cost to be allocated (per Wkst. B, 85, 899   516, 878   7,723   31, 324   71, 217   204. 00   204. 00   Cost to be allocated (per Wkst. B, 85, 899   516, 878   7,723   31, 324   71, 217   204. 00   205. 00   00   00   00   00   00   00   0								
90. 02   09002   PAI N MANAGEMENT   0   0   0   0   0   0   90. 02   91. 00   09100   EMERGENCY   6, 450   6, 450   21, 416   6, 450   0   91. 00   92. 00   09200   095ERVATI ON BEDS (NON-DISTINCT PART   92. 00   93. 00   04040   OTHER OUTPATI ENT SERVI CE COST CENTE   5, 834   5, 834   33, 314   5, 834   0   95. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   0   99. 10   09910   CORF   0   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   118. 00   1300   INTEREST EXPENSE   113. 00   118. 01   1300   INTEREST EXPENSE   114. 00   118. 00   192. 00   192. 00   1920   PHYSI CI ANS " PRI VATE OFFI CES   0   0   0   0   194. 00   07951   OTHER NORNEI MBURSABLE AND PHYSI CI AN   10, 158   10, 158   27, 000   10, 158   0   201. 00   Negative Cost Centers   220. 00   202. 00   Cost to be all located (per Wkst. B, Part I)   13. 445531   13. 748852   0. 484701   6. 149348   15. 941513   203. 00   204. 00   Cost to be all located (per Wkst. B, 85, 899   516, 878   7, 723   31, 324   71, 217   204. 00   204. 00   192. 00   10, 10   10   10   10   10   10								
92. 00			_	1	0	0		
93. 00			6, 450	6, 450	21, 416	6, 450	0	1
OTHER REIMBURSABLE COST CENTERS   O   O   O   O   O   O   O   O   O			5, 834	5, 834	33, 314	5. 834	0	
99. 10		OTHER REIMBURSABLE COST CENTERS						
101. 00			-	•				
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   11600   HOSPI CE   116.00   11600   HOSPI CE   116.00   SUBTOTALS (SUM OF LINES 1 through 117)   195, 511   152, 125   320, 408   150, 112   28, 673   118.00   118.00   NONREI MBURSABLE COST CENTERS   0   0   0   0   0   192.00   192.00   194.00   07951   OTHER NONREI MBURSABLE AND PHYSI CI AN   10, 158   10, 158   27, 000   10, 158   0   194.00   200.00   Cross Foot Adjustments   200.00   Cost to be allocated (per Wkst. B, 2, 765, 329   2, 231, 205   168, 389   985, 556   457, 091   202.00   203.00   Unit cost multiplier (Wkst. B, Part I)   13.445531   13.748852   0.484701   6.149348   15.941513   203.00   204.00   Cost to be allocated (per Wkst. B, 85, 899   516, 878   7, 723   31, 324   71, 217   204.00   10.158   10, 158   1	101.00	10100 HOME HEALTH AGENCY						
116. 00		SPECIAL PURPOSE COST CENTERS		-				
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   195,511   152,125   320,408   150,112   28,673   118.00   NONREI MBURSABLE COST CENTERS   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   192.00   194.00   194.00   192.00   194.00   192.00			505	505	0	505	0	
NONREI MBURSABLE COST CENTERS   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   0   192.00			1		1			
194. 00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, 85, 899 516, 878 7, 723 31, 324 71, 217 204. 00		NONREI MBURSABLE COST CENTERS		·				
200. 00     Cross Foot Adjustments     200. 00       201. 00     Negative Cost Centers     201. 00       202. 00     Cost to be allocated (per Wkst. B, Part I)     2, 765, 329     2, 231, 205     168, 389     985, 556     457, 091     202. 00       203. 00     Unit cost multiplier (Wkst. B, Part I)     13. 445531     13. 748852     0. 484701     6. 149348     15. 941513     203. 00       204. 00     Cost to be allocated (per Wkst. B, Part I)     85, 899     516, 878     7, 723     31, 324     71, 217     204. 00			-			_		
201.00   Negative Cost Centers   201.00   Cost to be allocated (per Wkst. B, Part I)   203.00   Unit cost multiplier (Wkst. B, Part I)   13.445531   13.748852   0.484701   6.149348   15.941513   203.00   204.00   Cost to be allocated (per Wkst. B, 85,899   516,878   7,723   31,324   71,217   204.00			10, 158	10, 158	27,000	10, 158	U	
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, 85,899 516,878 7,723 31,324 71,217 204.00	201.00	Negative Cost Centers						201. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 13.445531 13.748852 0.484701 6.149348 15.941513 203.00 204.00 Cost to be allocated (per Wkst. B, 85,899 516,878 7,723 31,324 71,217 204.00	202.00		2, 765, 329	2, 231, 205	168, 389	985, 556	457, 091	202. 00
204.00 Cost to be allocated (per Wkst. B, 85,899 516,878 7,723 31,324 71,217 204.00	203 00		13 445531	13 748852	0 484701	6 149348	15 941513	203 00
			1		1			
		Part II)						

Heal th Fina	ncial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der C		eri od:	Worksheet B-1	
				_	rom 01/01/2022 o 12/31/2022		
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		SERVED)	
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part	0. 417657	3. 185041	0. 022230	0. 195445	2. 483765	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems	DAVIESS COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					rom 01/01/2022 o 12/31/2022		
	Cost Center Description	CAFETERIA (HOURS PAID)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	50 alli
		11. 00	13. 00	14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 17. 00		801, 922 19, 060 13, 264 15, 886 23, 779 8, 879	367, 978 0 0 0	3, 361, 229 4, 344 54 76	100	162, 173, 591	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00 40. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	64, 288 20, 768 57, 399 23, 676 14, 263	20, 768 57, 399 23, 676	12, 894 15, 606	0 0 0 0	1, 721, 468 5, 670, 358 1, 993, 495	31.00 40.00 41.00
50. 00	05000 OPERATING ROOM	38, 712	38, 712	88, 090	0	10, 097, 761	50.00
51. 00 52. 00 54. 00 56. 00 60. 00 63. 00 64. 00 65. 00	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE 06000 LABORATORY 06300 BLOOD STORING, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	13, 985 27, 654 4, 742 39, 978 C C 16, 240	0 13, 985 27, 654 4, 742 39, 978 0 0	( ) 45, 270 21, 130	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		51. 00 52. 00 54. 00 56. 00 60. 00 63. 00 64. 00
66. 00 67. 00 68. 00 69. 00 71. 00	O6600  PHYSI CAL THERAPY   O6700  OCCUPATI ONAL THERAPY   O6800  SPEECH PATHOLOGY   O6900  ELECTROCARDI OLOGY   O7100  MEDI CAL SUPPLIES CHARGED TO PATIENT	34, 851 12, 096 5, 007 1, 832	0 0 0	2, 287 ( ) ( 7, 723 1, 848, 319	0 0 0	4, 442, 777 2, 231, 942 755, 395 922, 925 7, 315, 202	67. 00 68. 00 69. 00
72. 00 73. 00 76. 00 76. 01	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC REHAB 03030 ADDICTION SERVICES OUTPATIENT SERVICE COST CENTERS	2, 854 9, 688	0 0 0 2, 854	2, 157	0 100 7 0	802, 267 14, 981, 253 616, 074	72. 00 73. 00 76. 00
88. 00	08800 RURAL HEALTH CLINIC	14, 844	0	1, 559	0	1, 085, 067	88.00
88. 01 88. 02 88. 03 88. 04 88. 05 90. 00 90. 01 90. 02 91. 00 92. 00	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 08805 RURAL HEALTH CLINIC IV 08803 RURAL HEALTH CLINIC V 08804 RURAL HEALTH CLINIC VI 09000 CLINIC 09001 ONCOLOGY 09002 PAIN MANAGEMENT 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 04040 OTHER OUTPATIENT SERVICE COST CENTE	14, 077 33, 434 C 15, 616 14, 731 6, 957 9, 681 C 42, 243	0 0 0 0 0 0 0 0 0 0 42, 243	4, 959 7, 456 0 4, 276 1, 963 5, 557 5, 555 0 31, 000		762, 016 2, 910, 700 0 1, 377, 845 536, 690 1, 373, 583 961, 800 0 35, 882, 946	88. 01 88. 02 88. 03 88. 04 88. 05 90. 00 90. 01 90. 02 91. 00 92. 00
73.00	OTHER REIMBURSABLE COST CENTERS	12, 421		304		1,031,733	73.00
99. 10	09500 AMBULANCE SERVICES 09910 CORF 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	83, 784 C	0	33, 640 (	0	0	1
	11300   I NTEREST EXPENSE   11600   HOSPI CE	7, 728 724, 417					1
194. 00 200. 00 201. 00	19200 PHYSICIANS' PRIVATE OFFICES 07951 OTHER NONREIMBURSABLE AND PHYSICIAN Cross Foot Adjustments Negative Cost Centers	77, 505		7, 459	0	0	192. 00 194. 00 200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	322, 339	1, 159, 039	818, 819	1, 073, 185	1, 354, 254	202.00
203. 00		0. 401958	3. 149751	0. 243607	10, 731. 850000	0. 008351	203. 00

Heal th Fina	ncial Systems	DAVIESS COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od: From 01/01/2022	Worksheet B-1		
					To 12/31/2022	Date/Time Pre 6/12/2023 11:		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		(HOURS PAID)	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &		
			N	SUPPLY	REQUIS.)	LI BRARY		
			(DI RECT	(COSTED		(GROSS		
			NRSI NG)	REQUIS.)		CHARGES)		
		11. 00	13. 00	14.00	15. 00	16.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	23, 813	69, 096	76, 91	1 39, 540	157, 110	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 029695	0. 187772	0. 02288	395. 400000	0. 000969	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS DAVIESS COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0061

Period: Worksheet B-1
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 6/12/2023 11:56 am

		6/12/2023 11:56 am
Cost Center Description	SOCI AL	
	SERVI CE	
	(TIME SPENT) 17.00	
GENERAL SERVICE COST CENTERS	17.00	
1.00 00100 CAP REL COSTS-BLDG & FLXT		1.00
2. 00   00200   CAP REL COSTS-MVBLE EQUIP		2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT		4.00
5. 00   00500   ADMI NI STRATI VE & GENERAL		5.00
6. 00   00600 MAI NTENANCE & REPAI RS		6.00
7. 00   00700   OPERATION OF PLANT		7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG		8.00
10. 00   01000 DI ETARY		10.00
11. 00   01100   CAFETERI A		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY		14.00
15. 00   01500   PHARMACY		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY		16.00
17. 00 01700 SOCI AL SERVI CE	7, 743	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	10/	20.00
30. 00   03000   ADULTS & PEDI ATRI CS	106	30.00
31. 00   03100   I NTENSI VE CARE UNI T 40. 00   04000   SUBPROVI DER - I PF	106 2, 705	31. 00 40. 00
41. 00   04100   SUBPROVI DER - 1 FF	2, 703	40.00
43. 00   04300   NURSERY	0	43.00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	101 00
50. 00 05000 OPERATING ROOM	2	50.00
51. 00   05100   RECOVERY ROOM	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	54.00
56. 00   05600   RADI 0I SOTOPE	0	56.00
60. 00 06000 LABORATORY	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	63.00
64. 00   06400   I NTRAVENOUS   THERAPY 65. 00   06500   RESPI RATORY   THERAPY	0	64. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY	o	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	o	67.00
68. 00 06800 SPEECH PATHOLOGY	Ö	68.00
69. 00 06900 ELECTROCARDI OLOGY	О	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	73.00
76. 00   03020   CARDI AC   REHAB	0	76.00
76. 01 03030 ADDICTION SERVICES OUTPATIENT SERVICE COST CENTERS	0	76. 01
88. 00   08800 RURAL HEALTH CLINIC	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC II	o	88. 01
88. 02   08802 RURAL HEALTH CLINIC III	o	88.02
88. 03 08805 RURAL HEALTH CLINIC IV	O	88.03
88.04 08803 RURAL HEALTH CLINIC V	o	88.04
88. 05   08804 RURAL HEALTH CLINIC VI	0	88. 05
90. 00   09000   CLI NI C	0	90.00
90. 01   09001   0NCOLOGY	0	90. 01
90. 02   09002   PAI N   MANAGEMENT	0	90.02
91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATION   BEDS (NON-DISTINCT PART	664	91.00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART 93.00   04040   OTHER OUTPATIENT SERVICE COST CENTE	4, 128	92. 00 93. 00
OTHER REIMBURSABLE COST CENTERS	4, 120	73.00
95. 00 09500 AMBULANCE SERVICES	0	95. 00
99. 10   09910   CORF	ō	99.10
101.00 10100 HOME HEALTH AGENCY	O	101.00
SPECIAL PURPOSE COST CENTERS		
113. 00 11300 INTEREST EXPENSE		113.00
116. 00 11600 H0SPI CE	2	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 715	118. 00
NONREI MBURSABLE COST CENTERS	00	400.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	28	192.00
194.00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 200.00  Cross Foot Adjustments	0	194. 00 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B,	383, 439	201.00
Part I)	303, 437	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	49. 520728	203. 00
204.00 Cost to be allocated (per Wkst. B,	2, 192	204.00
Part II)		

Health Financial Systems	DAVIESS COMMUNITY	Y HOSPITAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0061	Peri od: From 01/01/2022	Worksheet B-1
				Date/Time Prepared: 6/12/2023 11:56 am
Cost Center Description	SOCI AL SERVI CE (TI ME SPENT) 17.00			
205.00 Unit cost multiplier (Wkst. B, Pa	o. 283094			205. 00
206.00 NAHE adjustment amount to be allo (per Wkst. B-2)	cated			206. 00
207.00 NAHE unit cost multiplier (Wkst. Parts III and IV)	D,			207. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0061	Peri od: From 01/01/2022	Worksheet C Part I
		To 12/31/2022	Date/Time Prepared:

				Т	o 12/31/2022	Date/Time Pre 6/12/2023 11:	
			Title	XVIII	Hospi tal	PPS	<u> </u>
			11 110	XVIII	Costs	110	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost conten bescription	(from Wkst.	Adj .	10141 00313	Di sal I owance	10101 00313	
		B, Part I,	, .c., .		Di Gai i Gilanos		
		col . 26)					
		1.00	2.00	3.00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	3, 896, 018		3, 896, 018	ol	3, 896, 018	30.00
	03100 INTENSIVE CARE UNIT	1, 646, 180		1, 646, 180		1, 646, 180	1
	04000 SUBPROVI DER – I PF	3, 237, 595		3, 237, 595		3, 237, 595	
	04100 SUBPROVI DER – I RF	1, 691, 873		1, 691, 873		1, 691, 873	•
	04300 NURSERY	867, 810		867, 810		867, 810	•
-	ANCILLARY SERVICE COST CENTERS	007,010		007,010	<u> </u>	007,010	10.00
	D5000 OPERATING ROOM	3, 810, 482		3, 810, 482	0	3, 810, 482	50.00
	D5100 RECOVERY ROOM	0		0,010,102		0	51.00
	D5200 DELIVERY ROOM & LABOR ROOM	1, 185, 782		1, 185, 782	_	1, 185, 782	
	D5400 RADI OLOGY-DI AGNOSTI C	2, 328, 548		2, 328, 548		2, 328, 548	1
	D5600 RADI OI SOTOPE	1, 042, 870		1, 042, 870	l l	1, 042, 870	1
	D6000 LABORATORY	4, 080, 402		4, 080, 402		4, 080, 402	1
	06300 BLOOD STORING, PROCESSING & TRANS.	25, 841		25, 841		25, 841	63.00
	06400 I NTRAVENOUS THERAPY	23, 041		23, 041		25, 041	64.00
	06500 RESPIRATORY THERAPY	1, 131, 921	0	_	-	1, 131, 921	65.00
	06600 PHYSI CAL THERAPY	2, 247, 419	0	2, 247, 419		2, 247, 419	66.00
	06700 OCCUPATI ONAL THERAPY	712, 526	0	712, 526		712, 526	ł
	06800 SPEECH PATHOLOGY	1	0				1
	06900 ELECTROCARDI OLOGY	391, 304 148, 288	U	391, 304 148, 288		391, 304 148, 288	
		1				·	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 382, 572		2, 382, 572		2, 382, 572	
	07200 IMPL. DEV. CHARGED TO PATIENTS	329, 357		329, 357		329, 357	72.00
	07300 DRUGS CHARGED TO PATIENTS	4, 836, 965		4, 836, 965		4, 836, 965	
	03020 CARDI AC REHAB	274, 817		274, 817		274, 817	76.00
	03030 ADDI CTI ON SERVI CES	368, 483		368, 483	ı U	368, 483	76. 01
	DUTPATIENT SERVICE COST CENTERS D8800 RURAL HEALTH CLINIC	1 210 022		1 210 022	O	1 210 022	00 00
	D8801 RURAL HEALTH CLINIC	1, 310, 822		1, 310, 822		1, 310, 822	88.00
		1, 070, 138		1, 070, 138		1, 070, 138	1
	D8802 RURAL HEALTH CLINIC III	2, 312, 051		2, 312, 051		2, 312, 051	
	D8805 RURAL HEALTH CLINIC IV	0		1 /10 103		1 (10 102	88. 03
	D8803 RURAL HEALTH CLINIC V	1, 619, 182		1, 619, 182		1, 619, 182	
	D8804 RURAL HEALTH CLINIC VI	976, 190		976, 190		976, 190	
	09000 CLI NI C	612, 973		612, 973		612, 973	
	09001 ONCOLOGY	607, 523		607, 523		607, 523	
	D9002 PAIN MANAGEMENT	0		C		0	90.02
	D9100 EMERGENCY	6, 512, 379		6, 512, 379		6, 512, 379	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 546, 215		1, 546, 215		1, 546, 215	
	04040 OTHER OUTPATIENT SERVICE COST CENTE	1, 185, 524		1, 185, 524	0	1, 185, 524	93.00
	OTHER REIMBURSABLE COST CENTERS					4 000 070	
	D9500 AMBULANCE SERVICES	4, 009, 373		4, 009, 373		4, 009, 373	
	09910 CORF	0		C		0	
	10100 HOME HEALTH AGENCY	0		C		0	101.00
	SPECIAL PURPOSE COST CENTERS	1					110 00
	11300 INTEREST EXPENSE	/15 /0/		/15 /0/		/15 /0/	113.00
	11600 HOSPI CE	615, 606	_	615, 606		615, 606	1
200.00	Subtotal (see instructions)	59, 015, 029	0			59, 015, 029	1
201.00	Less Observation Beds	1, 546, 215	_	1, 546, 215		1, 546, 215	
202. 00	Total (see instructions)	57, 468, 814	0	57, 468, 814	0	57, 468, 814	J2U2. UU

			Т	o 12/31/2022	Date/Time Pre 6/12/2023 11:	epared:
		Title	xVIII	Hospi tal	PPS	30 alli
		Charges	AVIII	Hospi tai	113	
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
oost center bescription	ripatront	outpatrent	+ col . 7)	Ratio	I npati ent	
			' 001. '/)	Nati o	Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	2, 443, 506		2, 443, 506			30.00
31. 00 03100 INTENSIVE CARE UNIT	1, 721, 468		1, 721, 468			31.00
40. 00   04000   SUBPROVI DER -   1 PF	5, 670, 358		5, 670, 358	1		40.00
41. 00   04100   SUBPROVI DER -   RF	1, 993, 495		1, 993, 495			41.00
43. 00   04300   NURSERY	862, 496		862, 496			43.00
ANCI LLARY SERVI CE COST CENTERS	002, 170		002, 170	'		10.00
50. 00 05000 OPERATI NG ROOM	1, 624, 273	8, 808, 430	10, 432, 703	0. 365244	0.000000	50.00
51. 00   05100   RECOVERY ROOM	1, 02 1, 2, 0	0,000,100		0.000000	0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	766, 563	62, 806			0. 000000	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 559, 223	18, 763, 973	21, 323, 196	I	0. 000000	
56. 00   05600   RADI 01 SOTOPE	426, 755	4, 507, 280			0. 000000	
60. 00   06000   LABORATORY	4, 848, 977	16, 686, 292	21, 535, 269		0. 000000	
					0. 000000	
	317, 223	298, 317 0	615, 540			
64. 00 06400 I NTRAVENOUS THERAPY	2 002 244	-	F 0/7 70F	0.000000	0.000000	
65. 00 06500 RESPI RATORY THERAPY	3, 002, 244	2, 065, 481	5, 067, 725		0.000000	
66. 00 06600 PHYSI CAL THERAPY	781, 740	3, 661, 037	4, 442, 777	I	0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	694, 510	1, 537, 432			0. 000000	
68. 00 06800 SPEECH PATHOLOGY	200, 965	554, 430			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	205, 424	717, 501	922, 925	1	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 192, 048	5, 123, 154		1	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	116, 748	685, 519			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 715, 882	11, 265, 371	14, 981, 253	1	0. 000000	
76. 00   03020   CARDI AC   REHAB	347	615, 727		1	0. 000000	1
76. 01 03030 ADDICTION SERVICES	3, 195	51, 871	55, 066	6. 691661	0. 000000	76. 01
OUTPATIENT SERVICE COST CENTERS			T			
88.00 08800 RURAL HEALTH CLINIC	0	1, 085, 067		1		88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	762, 016		I		88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0	2, 910, 700	2, 910, 700			88. 02
88.03 08805 RURAL HEALTH CLINIC IV	0	0	C			88. 03
88.04 08803 RURAL HEALTH CLINIC V	151	1, 275, 771	1, 275, 922	1		88. 04
88.05 08804 RURAL HEALTH CLINIC VI	0	865, 397	865, 397			88. 05
90. 00  09000   CLI NI C	0	957, 605	957, 605	I	0. 000000	
90. 01  09001  ONCOLOGY	3, 230	1, 045, 841	1, 049, 071		0. 000000	
90. 02   09002   PAI N   MANAGEMENT	0	0	C	0. 000000	0. 000000	90. 02
91. 00   09100   EMERGENCY	2, 082, 616	17, 215, 734	19, 298, 350	0. 337458	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	362, 883	3, 596, 986	3, 959, 869	0. 390471	0.000000	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	5, 265	753, 858	759, 123	1. 561702	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	5, 451, 158	5, 451, 158	0. 735508	0.000000	95.00
99. 10   09910   CORF	0	0	C			99. 10
101.00 10100 HOME HEALTH AGENCY	o	0	l c			101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	819, 280	819, 280	)		116.00
200.00 Subtotal (see instructions)	36, 601, 585	112, 144, 034	148, 745, 619			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	36, 601, 585	112, 144, 034	148, 745, 619	)		202.00
				,		

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	_	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der		From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared:

				6/12/2023 11:56 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31.00  03100 INTENSIVE CARE UNIT				31.00
40. 00   04000   SUBPROVI DER - 1 PF				40.00
41. 00  04100  SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATING ROOM	0. 365244			50.00
51. 00  05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 429740			52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 109203			54.00
56. 00   05600   RADI 0I SOTOPE	0. 211363			56.00
60. 00  06000   LABORATORY	0. 189475			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 041981			63.00
64.00  06400   I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00   06500   RESPI RATORY THERAPY	0. 223359			65.00
66. 00  06600 PHYSI CAL THERAPY	0. 505859			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 319240			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 518012			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 160672			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 325701			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 410533			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 322868			73.00
76. 00   03020   CARDI AC   REHAB	0. 446078			76.00
76. 01 03030 ADDICTION SERVICES	6. 691661			76. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00   08800   RURAL HEALTH CLINIC				88.00
88.01 08801 RURAL HEALTH CLINIC II				88. 01
88.02 08802 RURAL HEALTH CLINIC III				88. 02
88.03   08805   RURAL HEALTH CLINIC IV				88. 03
88. 04   08803   RURAL HEALTH CLINIC V				88. 04
88. 05   08804   RURAL HEALTH CLINIC VI				88. 05
90. 00  09000  CLI NI C	0. 640110			90.00
90. 01  09001 0NC0L0GY	0. 579106			90. 01
90. 02   09002   PAIN MANAGEMENT	0. 000000			90. 02
91. 00  09100   EMERGENCY	0. 337458			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 390471			92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	1. 561702			93.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 735508			95.00
99. 10  09910 CORF				99. 10
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0061	Peri od: From 01/01/2022	Worksheet C Part I
		To 12/31/2022	Date/Time Prepared:

				Т	o 12/31/2022	Date/Time Pre 6/12/2023 11:	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	<b>'</b>	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	,				
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3, 896, 018		3, 896, 018	0	3, 896, 018	30.00
31.00 03100	INTENSIVE CARE UNIT	1, 646, 180		1, 646, 180	0	1, 646, 180	31.00
40.00 04000	SUBPROVI DER - I PF	3, 237, 595		3, 237, 595	0	3, 237, 595	40.00
41.00 04100	SUBPROVI DER - I RF	1, 691, 873		1, 691, 873	0	1, 691, 873	41.00
43.00 04300	NURSERY	867, 810		867, 810	0	867, 810	43.00
ANCI L	LARY SERVICE COST CENTERS						
	OPERATING ROOM	3, 810, 482		3, 810, 482	0	3, 810, 482	50.00
	RECOVERY ROOM	0		0	0	0	51.00
	DELIVERY ROOM & LABOR ROOM	1, 185, 782		1, 185, 782	0	1, 185, 782	52.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	2, 328, 548		2, 328, 548	0	2, 328, 548	54.00
56. 00 05600	RADI OI SOTOPE	1, 042, 870		1, 042, 870	0	1, 042, 870	56.00
60.00 06000	LABORATORY	4, 080, 402		4, 080, 402	0	4, 080, 402	60.00
	BLOOD STORING, PROCESSING & TRANS.	25, 841		25, 841	0	25, 841	63.00
64. 00 06400	I NTRAVENOUS THERAPY	0		0	0	0	64.00
65.00 06500	RESPI RATORY THERAPY	1, 131, 921	0	1, 131, 921	0	1, 131, 921	65.00
66. 00 06600	PHYSI CAL THERAPY	2, 247, 419	0	2, 247, 419	0	2, 247, 419	66.00
67. 00 06700	OCCUPATI ONAL THERAPY	712, 526	0	712, 526	0	712, 526	67.00
68. 00 06800	SPEECH PATHOLOGY	391, 304	0	391, 304	o	391, 304	68.00
69. 00 06900	ELECTROCARDI OLOGY	148, 288		148, 288	O	148, 288	69.00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2, 382, 572		2, 382, 572	o	2, 382, 572	71.00
	IMPL. DEV. CHARGED TO PATIENTS	329, 357		329, 357	o	329, 357	72.00
	DRUGS CHARGED TO PATIENTS	4, 836, 965		4, 836, 965		4, 836, 965	73.00
76. 00 03020	CARDI AC REHAB	274, 817		274, 817	O	274, 817	76.00
76. 01 03030	ADDICTION SERVICES	368, 483		368, 483	0	368, 483	76. 01
OUTPA	TIENT SERVICE COST CENTERS						
88. 00 08800	RURAL HEALTH CLINIC	1, 310, 822		1, 310, 822	0	1, 310, 822	88. 00
88. 01 08801	RURAL HEALTH CLINIC II	1, 070, 138		1, 070, 138	0	1, 070, 138	88. 01
	RURAL HEALTH CLINIC III	2, 312, 051		2, 312, 051	0	2, 312, 051	88. 02
88. 03 08805	RURAL HEALTH CLINIC IV	0			0	0	88. 03
	RURAL HEALTH CLINIC V	1, 619, 182		1, 619, 182	0	1, 619, 182	88. 04
88. 05 08804	RURAL HEALTH CLINIC VI	976, 190		976, 190	o	976, 190	88. 05
90.00 09000	CLINIC	612, 973		612, 973	o	612, 973	90.00
90. 01 09001	ONCOLOGY	607, 523		607, 523	o	607, 523	90. 01
90. 02 09002	PAIN MANAGEMENT	0		0	0	0	90.02
	EMERGENCY	6, 512, 379		6, 512, 379	o	6, 512, 379	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	1, 546, 215		1, 546, 215		1, 546, 215	92.00
93. 00 04040	OTHER OUTPATIENT SERVICE COST CENTE	1, 185, 524		1, 185, 524	O	1, 185, 524	93.00
OTHER	REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	4, 009, 373		4, 009, 373	0	4, 009, 373	95.00
99. 10 09910	CORF	0		0		0	99. 10
101. 00 10100	HOME HEALTH AGENCY	0		0		0	101.00
	AL PURPOSE COST CENTERS						
	INTEREST EXPENSE						113. 00
116. 00 11600		615, 606		615, 606		615, 606	
200. 00	Subtotal (see instructions)	59, 015, 029	0			59, 015, 029	
201.00	Less Observation Beds	1, 546, 215		1, 546, 215		1, 546, 215	
202.00	Total (see instructions)	57, 468, 814	0	57, 468, 814	0	57, 468, 814	202. 00

			1	o 12/31/2022	Date/Time Pre 6/12/2023 11:	
		Ti +I	e XIX	Hospi tal	Cost	JU alli
		Charges	CAIA	nospi tui	0031	
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
5552 5511tol. 55551.1 pt. 511	patront	output. o	+ col . 7)	Ratio	Inpatient	
			' ' ' ' ' ' '		Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	'			'		
30. 00 03000 ADULTS & PEDIATRICS	2, 443, 506		2, 443, 506			30.00
31.00 03100 INTENSIVE CARE UNIT	1, 721, 468		1, 721, 468	3		31.00
40. 00   04000   SUBPROVI DER - I PF	5, 670, 358		5, 670, 358	3		40.00
41. 00   04100   SUBPROVI DER - I RF	1, 993, 495		1, 993, 495	5		41.00
43. 00   04300   NURSERY	862, 496		862, 496			43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 624, 273	8, 808, 430	10, 432, 703	0. 365244	0.000000	50.00
51.00   05100   RECOVERY ROOM	0	0	C	0.000000	0.000000	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	766, 563	62, 806	829, 369	1. 429740	0.000000	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 559, 223	18, 763, 973	21, 323, 196	0. 109203	0.000000	54.00
56. 00   05600   RADI 0I SOTOPE	426, 755	4, 507, 280	4, 934, 035	0. 211363	0.000000	56.00
60. 00   06000   LABORATORY	4, 848, 977	16, 686, 292	21, 535, 269	0. 189475	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	317, 223	298, 317	615, 540	0. 041981	0.000000	63.00
64. 00   06400   I NTRAVENOUS THERAPY	0	0	C	0. 000000	0.000000	64.00
65. 00 06500 RESPIRATORY THERAPY	3, 002, 244	2, 065, 481	5, 067, 725	0. 223359	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	781, 740	3, 661, 037	4, 442, 777	0. 505859	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	694, 510	1, 537, 432	2, 231, 942	0. 319240	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	200, 965	554, 430	755, 395	0. 518012	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	205, 424	717, 501	922, 925	0. 160672	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 192, 048	5, 123, 154	7, 315, 202	0. 325701	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	116, 748	685, 519	802, 267	0. 410533	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 715, 882	11, 265, 371	14, 981, 253	0. 322868	0.000000	73.00
76. 00   03020   CARDI AC REHAB	347	615, 727	616, 074	0. 446078	0.000000	1
76. 01 03030 ADDICTION SERVICES	3, 195	51, 871	55, 066	6. 691661	0.000000	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	1, 085, 067		1	0. 000000	1
88.01 08801 RURAL HEALTH CLINIC II	0	762, 016		I	0. 000000	
88.02 08802 RURAL HEALTH CLINIC III	0	2, 910, 700	2, 910, 700		0. 000000	
88. 03   08805   RURAL HEALTH CLINIC IV	0	0	C	0.000000	0. 000000	1
88. 04   08803   RURAL HEALTH CLINIC V	151	1, 275, 771	1, 275, 922	I	0. 000000	1
88. 05 08804 RURAL HEALTH CLINIC VI	0	865, 397	865, 397	I	0. 000000	
90. 00   09000   CLI NI C	0	957, 605	957, 605	I	0. 000000	1
90. 01   09001   0NCOLOGY	3, 230	1, 045, 841	1, 049, 071		0. 000000	1
90. 02   09002   PAI N MANAGEMENT	0	0	C		0. 000000	
91. 00   09100   EMERGENCY	2, 082, 616	17, 215, 734			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	362, 883	3, 596, 986			0. 000000	1
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	5, 265	753, 858	759, 123	1. 561702	0. 000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	5, 451, 158		1	0. 000000	
99. 10   09910   CORF	0	0				99. 10
101. 00 10100 HOME HEALTH AGENCY	0	0	C	)		101.00
SPECIAL PURPOSE COST CENTERS			1			
113. 00 11300   NTEREST EXPENSE		040 5==				113.00
116. 00 11600 HOSPI CE	0	819, 280		1		116.00
200.00 Subtotal (see instructions)	36, 601, 585	112, 144, 034	148, 745, 619	'		200.00
201.00 Less Observation Beds	27 701 505	110 111 001	140 745 (40			201.00
202.00   Total (see instructions)	36, 601, 585	112, 144, 034	148, 745, 619	'I I		202. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	_	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der		From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared:

				6/12/2023 11:56 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31.00  03100   INTENSIVE CARE UNIT				31.00
40. 00   04000   SUBPROVI DER - 1 PF				40.00
41. 00   04100   SUBPROVI DER - 1 RF				41.00
43. 00   04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51.00   05100   RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
56. 00   05600   RADI 0I SOTOPE	0. 000000			56.00
60. 00 06000 LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00   03020   CARDI AC   REHAB	0. 000000			76.00
76. 01   03030   ADDI CTI ON   SERVI CES	0. 000000			76. 01
OUTPATIENT SERVICE COST CENTERS	0.00000			70.01
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
88. 01   08801 RURAL HEALTH CLINIC II	0. 000000			88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0. 000000			88. 02
88. 03   08805   RURAL HEALTH CLINIC IV	0. 000000			88. 03
88. 04   08803 RURAL HEALTH CLINIC V	0. 000000			88. 04
88. 05   08804 RURAL HEALTH CLINIC VI	0. 000000			88.05
90. 00   09000   CLINI C	0. 000000			90.00
90. 01   09001   0NC0L0GY	0. 000000			90. 01
90. 02   09002   PAI N   MANAGEMENT	0. 000000			90.02
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0. 000000			93. 00
OTHER REIMBURSABLE COST CENTERS	0. 000000			70.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
99. 10   09910 CORF	0.00000			99. 10
101. 00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				101.00
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
202.00   10tal (000 1115t) 40t1 0115)	1			1202.00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2022	Worksheet D Part I	
				Γο 12/31/2022	Date/Time Pre	pared:
		T: +1 -	WILL	Hanni kal	6/12/2023 11: PPS	<u>56 am</u>
Cook Cooker December 1	C==: +=1		Reduced	Hospi tal	Per Diem	
Cost Center Description	Capi tal Related Cost	Swing Bed Adjustment	Capi tal	Total Patient Days	(col. 3 /	
	(from Wkst.	Aujustillerit	Related Cost		col . 4)	
	B, Part II,		(col. 1 -		(01.4)	
	col . 26)		col . 2)			
	1, 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11.55				0.00	
30. 00 ADULTS & PEDIATRICS	268, 010	0	268, 010	4, 024	66. 60	30.00
31.00 INTENSIVE CARE UNIT	77, 550		77, 550	646	120. 05	31.00
40. 00 SUBPROVI DER - I PF	229, 793	0	229, 793	3, 845	59. 76	40.00
41. 00 SUBPROVI DER - I RF	162, 909	0	162, 909	1, 400	116. 36	41.00
43. 00 NURSERY	22, 490		22, 490	815	27. 60	43.00
200.00 Total (lines 30 through 199)	760, 752		760, 752	10, 730		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col . 6)				
LNDATLENT DOUTLNE CEDIA OF COCT CENTERS	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	7.0	FO (4)	I			20.00
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT	760					30. 00 31. 00
31. 00   I NTENSI VE CARE UNI T 40. 00   SUBPROVI DER - I PF	267	32, 053 168, 583				40.00
41. 00   SUBPROVIDER - TPF	2, 821 1, 016					40.00
43. 00   NURSERY	1,016	118, 222	1			41.00
200.00 Total (lines 30 through 199)	4, 864	-	I .			200.00
200. 00 Total (Titles 30 till ough 177)	4, 004	JU7, 4/4	I			200.00

Health Financial Systems	DAVIESS COMMUN	IITY HOSPITAI		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT		Provider C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part II	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		,	•			
50.00   05000   OPERATING ROOM	461, 645		0. 04425	· ·	15, 882	
51.00   05100   RECOVERY ROOM	0		0. 00000		0	51.00
52.00  05200   DELIVERY ROOM & LABOR ROOM	156, 780		0. 18903	· ·	<b>l</b>	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	350, 856		0. 01645			
56. 00   05600   RADI 0I SOTOPE	44, 866					
60. 00   06000   LABORATORY	145, 769				10, 944	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 672	615, 540		· ·	541	63.00
64. 00   06400   I NTRAVENOUS THERAPY	0	0	0. 00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	109, 156		0. 02153			
66. 00   06600   PHYSI CAL THERAPY	317, 766	4, 442, 777	0. 07152	4 91, 752	6, 562	66.00
67. 00   06700   OCCUPATI ONAL THERAPY	70, 618	2, 231, 942	0. 03164	0 36, 270	1, 148	
68. 00   06800   SPEECH PATHOLOGY	49, 558					
69. 00   06900   ELECTROCARDI OLOGY	16, 892	922, 925	0. 01830	3 79, 088	1, 448	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	59, 495	7, 315, 202	0. 00813	3 525, 139	4, 271	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 350	802, 267	0. 00292	9 89, 716	263	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	76, 594	14, 981, 253	0. 00511	3 815, 512	4, 170	73.00
76. 00   03020   CARDI AC   REHAB	36, 919	616, 074	0. 05992	6 326	20	76.00
76.01 03030 ADDICTION SERVICES	3, 793	55, 066	0. 06888	1 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	82, 010	1, 085, 067	0. 07558	1 0	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC II	59, 765	762, 016	0. 07843	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	103, 034	2, 910, 700	0. 03539	8 0	0	88. 02
88.03 08805 RURAL HEALTH CLINIC IV	0	0	0. 00000	0 0	0	88. 03
88.04 08803 RURAL HEALTH CLINIC V	40, 764	1, 275, 922	0. 03194	9 0	0	88. 04
88.05 08804 RURAL HEALTH CLINIC VI	44, 764	865, 397	0. 05172	7 0	0	88. 05
90. 00   09000   CLI NI C	62, 637	957, 605	0. 06541	0 0	0	90.00
90 01 09001 0NCOLOGY	62 081	1 0/0 071	0 05017	7 2 650	157	00 01

62, 081

225, 380

106, 366

96, 238

2, 789, 768

1, 049, 071

19, 298, 350 3, 959, 869 759, 123

129, 783, 858

2, 659

871, 830

171, 357

6, 944, 308

0.059177

0.000000

0.011679

0. 026861

0. 126775

157

10, 182

4, 603

0

15

100, 699 200. 00

90.01

90.02

91.00

92.00

93.00

95.00

90.01

90.02

200.00

09001 ONCOLOGY

91. 00 09100 EMERGENCY

09002 PAIN MANAGEMENT

95. 00 09500 AMBULANCE SERVICES

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.		TS Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 6/12/2023 11:	epared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Program	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF 41. 00   04100   SUBPROVIDER - IRF	0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	31. 00 40. 00 41. 00
43. 00   04300   NURSERY	0	0	1	0	0	1 .0.00
200.00   Total (lines 30 through 199)	0	Total Costs	Total Patien	0 0 t Per Diem		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	(sum of cols. 1 through 3, minus col. 4)	Days	(col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF 41. 00   04100   SUBPROVIDER - IRF 43. 00   04300   NURSERY	0 0	0 0 0 0	3, 84 1, 40 81	6 0. 00 5 0. 00 0 0. 00 5 0. 00	267 2, 821 1, 016 0	31. 00 40. 00 41. 00 43. 00
200.00 Total (lines 30 through 199)  Cost Center Description	Inpatient	0	10, 73	0	4, 864	200.00
	Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF 41. 00   04100   SUBPROVIDER - IRF	0 0					30. 00 31. 00 40. 00 41. 00
43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0					43. 00 200. 00

Health Financial Systems	DAVIESS COMMUNITY	Y HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-0061	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared:

				10 12/31/2022	Date/lime Pre   6/12/2023 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	1	0	0	
51.00   05100   RECOVERY ROOM	0	0	1	0	0	
52.00   O5200   DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	1	0	0	
56. 00   05600   RADI 0I SOTOPE	0	0	1	0	0	56.00
60. 00   06000   LABORATORY	0	0	1	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0	0	
64.00   06400   I NTRAVENOUS THERAPY	0	0	1	0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1	0	0	
69. 00   06900   ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	
76. 00   03020   CARDI AC REHAB	0	0	1	0	0	
76. 01 03030 ADDICTION SERVICES	0	0		0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS			T			
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	
88. 01   08801 RURAL HEALTH CLINIC II	0	0	1	0	0	
88. 02   08802   RURAL HEALTH CLINIC III	0	0	1	0	0	88. 02
88. 03   08805   RURAL HEALTH CLINIC IV	0	0	1	0	0	
88. 04   08803 RURAL HEALTH CLINIC V	0	0	1	0	0	
88. 05   08804   RURAL HEALTH CLINIC VI	0	0	1	0	0	
90. 00   09000   CLI NI C	0	0	1	0	0	
90. 01   09001   0NCOLOGY	0	0	1	0	0	
90. 02   09002   PAI N   MANAGEMENT	0	0	1	0	0	
91. 00   09100   EMERGENCY	0	0	1	0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_	1	0	0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0		0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 09500 AMBULANCE SERVI CES		_			_	95.00
200.00   Total (lines 50 through 199)	0	0	1	0	0	200.00

Health Financial Systems	DAVIESS COMMUNITY	Y HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0061	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared:

THROUGH COSTS			1	o 12/31/2022	Date/Time Pre 6/12/2023 11:	
		Title	Title XVIII		PPS	
Cost Center Description	All Other	Total Cost	Total	Hospi tal Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				10 100 700	2 22222	
50. 00 05000 OPERATING ROOM	0	0				
51. 00   05100   RECOVERY ROOM	0	0	·	-	0.00000	1
52.00   05200   DELI VERY ROOM & LABOR ROOM	0	0	· ·			
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	`	,,		
56. 00   05600   RADI 01 SOTOPE	0	0	`	., ,		
60. 00   06000   LABORATORY	0	0	(	,,		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	615, 540		
64. 00 06400 I NTRAVENOUS THERAPY	0	0		-	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		-,,		
66. 00   06600   PHYSI CAL THERAPY	0	0		.,		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		_, _,		
68. 00 06800 SPEECH PATHOLOGY	0	0		755, 395		
69. 00 06900 ELECTROCARDI OLOGY	0	0		, , , , , , , , , , , , , , ,		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	·	.,		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	`	,		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	`	, ,		
76. 00   03020   CARDI AC   REHAB	0	0				
76. 01 03030 ADDI CTI ON SERVI CES	0	0	(	55, 066	0. 000000	76. 01
OUTPATIENT SERVICE COST CENTERS				1 005 077	0.00000	00.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		· · ·		
88. 01   08801 RURAL HEALTH CLINIC II	0	0	· ·			
88. 02 08802 RURAL HEALTH CLINIC III	0	0	· ·	_,		
88. 03 08805 RURAL HEALTH CLINIC IV	0	0	· ·	-	0.00000	
88. 04   08803 RURAL HEALTH CLINIC V	0	0	· ·	1,2,0,,22	0. 000000	
88. 05   08804 RURAL HEALTH CLINIC VI	0	0	· `	865, 397		
90. 00   09000   CLI NI C	0	0	· ·	,		
90. 01   09001   0NCOLOGY	0	0	(	1, 049, 071	0. 000000	
90. 02   09002   PAI N MANAGEMENT	0	0	(	0	0. 000000	90. 02
91. 00   09100   EMERGENCY	0	0		, , , , , , , , , , , , , , , , , , , ,		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		-, ,		
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0		759, 123	0. 000000	93.00
OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 09500 AMBULANCE SERVI CES		_		100 700 050		95.00
200.00   Total (lines 50 through 199)	0	0	(	129, 783, 858	1	200. 00

Heal th	Financial Systems	DAVIESS COMMUNIT	ΓΥ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS	RVICE OTHER PASS	Provi der Co		Period: From 01/01/2022 To 12/31/2022		
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
		col . 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	358, 917		0 1, 521, 743	i e	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0	1	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	4, 240	l .	0	0	52.00
54.00	05400   RADI OLOGY-DI AGNOSTI C	0. 000000	1, 154, 519		0 3, 974, 926	•	54.00
56.00	05600 RADI OI SOTOPE	0. 000000	194, 955		0 1, 400, 010	•	56.00
60.00	06000 LABORATORY	0. 000000	1, 616, 711		0 1, 751, 083	•	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	90, 640	(	0 124, 297	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	(	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	822, 009		0 517, 595	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	91, 752		0 14, 147	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	36, 270	(	0 170	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	18, 546		0 5, 064	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	79, 088		0 194, 823	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	525, 139		0 1, 001, 902	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	89, 716		0 209, 780	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	815, 512		0 5, 080, 254	0	73.00
76.00	03020 CARDI AC REHAB	0. 000000	326		0 346, 212	0	76.00
76. 01	03030 ADDICTION SERVICES	0. 000000	0		0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS			•			1
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
00 01	00001 DUDAL HEALTH CLINIC LI	0.000000	0	1 .			00 01

0.000000

0. 000000

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0

2,659

871, 830

171, 357

6, 944, 308

122

0 0

0

ol

385, 101

154, 932

2, 765, 598 1, 200, 679 313, 382

20, 961, 698

88.01

88.02

88.03 0

88. 05

90.00

90.02

91.00

95.00

0 200.00

0

0 88.04

0

0

0 90.01

0

0

0 92.00

0 93.00

88. 01

88.02

88.03

88. 04

88. 05

90.00

90.01

90.02

91.00

92.00

93.00

200.00

08801 RURAL HEALTH CLINIC II

08802 RURAL HEALTH CLINIC III

08805 RURAL HEALTH CLINIC IV

08803 RURAL HEALTH CLINIC V

08804 RURAL HEALTH CLINIC VI

OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART 04040 OTHER OUTPATIENT SERVICE COST CENTE

Total (lines 50 through 199)

09000 CLI NI C

09001 ONCOLOGY

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

09002 PAIN MANAGEMENT

Date/Time Prepared: 12/31/2022 6/12/2023 11:56 am Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 365244 1, 521, 743 555, 808 50.00 05100 RECOVERY ROOM 0 0 0.000000 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 1. 429740 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.109203 3, 974, 926 0 0 434,074 54.00 56.00 05600 RADI OI SOTOPE 0. 211363 1, 400, 010 0 0 295, 910 56.00 0 06000 LABORATORY 0. 189475 0 331, 786 60. nn 1, 751, 083 60 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 0.041981 124, 297 5, 218 63.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 0 64.00 0 0 06500 RESPIRATORY THERAPY 0. 223359 517, 595 115, 610 65.00 65.00 0 06600 PHYSI CAL THERAPY 66.00 0.505859 14, 147 7, 156 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.319240 170 54 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0.518012 5,064 2,623 68.00 0 06900 ELECTROCARDI OLOGY 194, 823 0 69 00 0 160672 31 303 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.325701 1,001,902 326, 320 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.410533 209, 780 0 0 86, 122 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 322868 5, 080, 254 0 5,030 1, 640, 251 73.00 03020 CARDI AC REHAB 0 76 00 0. 446078 346, 212 154, 438 76 00 0 03030 ADDICTION SERVICES 76.01 6.691661 0 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88.01 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 08805 RURAL HEALTH CLINIC IV 88.03 88.03 08803 RURAL HEALTH CLINIC V 88.04 88.04 08804 RURAL HEALTH CLINIC VI 88.05 88.05 90.00 09000 CLI NI C 0.640110 385, 101 246, 507 90.00 09001 ONCOLOGY 90.01 0.579106 154, 932 0 ol 89, 722 90.01 09002 PAIN MANAGEMENT 0 90.02 0.000000 90 02 0 0 0 91.00 09100 EMERGENCY 0. 337458 2, 765, 598 378 933, 273 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.390471 1, 200, 679 0 468, 830 92.00 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTE OTHER REIMBURSABLE COST CENTERS 93.00 1.561702 313, 382 0 489, 409 93.00 95. 00 09500 AMBULANCE SERVICES 0.735508 0 95.00 200.00 Subtotal (see instructions) 20, 961, 698 0 5, 408 6, 214, 414 200. 00 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00 Only Charges

0

5, 408

6, 214, 414 202. 00

20, 961, 698

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	DAVI ESS COMMUN	TY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0061	Period: Worksheet D From 01/01/2022 Part V To 12/31/2022 Date/Time Prepared:

				To 12/31/2022	Date/Time Prepared: 6/12/2023 11:56 am
		Title	: XVIII	Hospi tal	PPS
	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 OPERATING ROOM	0	0	1		50.00
51.00   O5100   RECOVERY ROOM	0	0			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0			52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0			54.00
56. 00   05600   RADI 01 SOTOPE	0	0			56.00
60. 00   06000   LABORATORY	0	0			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00 06400 INTRAVENOUS THERAPY	0	0			64.00
65. 00 06500 RESPIRATORY THERAPY	0	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			67.00
68.00 06800 SPEECH PATHOLOGY	0	0			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 624			73.00
76. 00   03020   CARDI AC   REHAB	0	0			76.00
76. 01 03030 ADDICTION SERVICES	0	0			76. 01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88.00
88.01   08801   RURAL HEALTH CLINIC II					88. 01
88.02 08802 RURAL HEALTH CLINIC III					88. 02
88.03   08805   RURAL HEALTH CLINIC IV					88. 03
88. 04   08803   RURAL HEALTH CLINIC V					88. 04
88. 05   08804   RURAL HEALTH CLINIC VI					88. 05
90. 00  09000  CLI NI C	0	0			90.00
90. 01   09001   0NCOLOGY	0	0			90. 01
90.02 09002 PAIN MANAGEMENT	0	0			90. 02
91. 00   09100   EMERGENCY	0	128			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0			93.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0				95.00
200.00 Subtotal (see instructions)	0	1, 752			200.00
201.00 Less PBP Clinic Lab. Services-Program	0				201.00
Only Charges					
202.00   Net Charges (line 200 - line 201)	0	1, 752			202. 00

Health Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0061	Period: From 01/01/2022	Worksheet D Part II	
		· ·	CCN: 15-S061	To 12/31/2022	Date/Time Pre 6/12/2023 11:	pared: 56 am
		Title	e XVIII	Subprovi der  - I PF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)	0.00		4.00		
ANOLILIADIV OFRIMOF, COST, OFFITFRO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1/4 /45	10 100 700	0.04405			50.00
50. 00   05000   OPERATING ROOM	461, 645				0	
51. 00 05100 RECOVERY ROOM	0	_			0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	156, 780		1		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	350, 856				3, 202	1
56. 00 05600 RADI 0I SOTOPE	44, 866				93	56.00
60. 00 06000 LABORATORY	145, 769				4, 197	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 672				0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	109, 156				6, 113	
66. 00   06600   PHYSI CAL THERAPY	317, 766				4, 140	1
67. 00 06700 OCCUPATI ONAL THERAPY	70, 618		1		176	
68.00 06800 SPEECH PATHOLOGY	49, 558				1, 205	1
69. 00 06900 ELECTROCARDI OLOGY	16, 892				606	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	59, 495				662	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 350				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	76, 594				4, 640	1
76. 00   03020   CARDI AC   REHAB	36, 919				0	
76. 01 03030 ADDICTION SERVICES	3, 793	55, 066	0. 06888	1 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	82, 010				0	1
88. 01 08801 RURAL HEALTH CLINIC II	59, 765				0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	103, 034				0	
88. 03 08805 RURAL HEALTH CLINIC IV	0	_	0.0000		0	
88. 04 08803 RURAL HEALTH CLINIC V	40, 764		1		0	
88. 05 08804 RURAL HEALTH CLINIC VI	44, 764		1		0	
90. 00 09000 CLINIC	62, 637		1		0	
90. 01   09001   0NC0L0GY	62, 081		1		0	
90. 02   09002   PAI N MANAGEMENT	0	_			0	
91. 00   09100   EMERGENCY	225, 380				2, 808	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-, ,			0	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	96, 238	759, 123	0. 12677	5 0	0	93.00
OTHER REIMBURSABLE COST CENTERS		1	1			
95. 00 09500 AMBULANCE SERVICES		100 === :==				95.00
200.00   Total (lines 50 through 199)	2, 683, 402	129, 783, 858	I	2, 452, 938	27, 842	J200. 00

	Financial Systems	DAVIESS COMMUNI		ON 45 00/4	I 5		u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider Co	JN: 15-0061	Peri	oa: n 01/01/2022	Worksheet D Part IV	
THROUG	in Custs		Component	CCN: 15-S061	To	12/31/2022	Date/Time Pre 6/12/2023 11:	
			Title	XVIII	Sul	oprovi der  - I PF	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
		Anesthetist	Program	Program		st-Stepdown		
		Cost	Post-Stepdown		Α Α	djustments		
		1.00	Adjustments 2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00		SA	3.00	
50. 00	05000 OPERATING ROOM	O	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM		0		0	o	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0		0	0	0	
56.00	05600 RADI OI SOTOPE		0		0	0	0	1
60.00	06000 LABORATORY		0		0	Ö	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0	Ö	0	
64.00	06400 I NTRAVENOUS THERAPY	o	0		Ö	o	0	
65. 00	06500 RESPI RATORY THERAPY	o	0		Ö	o	0	1
66.00	06600 PHYSI CAL THERAPY	O	0		O	o	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	O	0		0	o	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	o	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	o	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	o	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
76.00	03020 CARDI AC REHAB	0	0		0	0	0	
76. 01	03030 ADDICTION SERVICES	0	0		0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS	T						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0	0	0	
88. 02	08802 RURAL HEALTH CLINIC III	0	0		0	0	0	88. 02
88. 03	08805 RURAL HEALTH CLINIC IV	0	0		0	0	0	
88. 04 88. 05	08803 RURAL HEALTH CLINIC V	0	0		0	0	0	88. 04 88. 05
90.00	08804 RURAL HEALTH CLINIC VI 09000 CLINIC		0		0	0	0	90.00
90.00	09001 ONCOLOGY		0		0	0	0	
90. 01	09002 PALN MANAGEMENT		0		0	0	0	90.01
91. 00	109100 EMERGENCY		0		0	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		U		0	٩	0	
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE		0		0	0	0	
, 0. 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>				<u> </u>		1 75.50
95. 00	09500 AMBULANCE SERVICES							95.00
	[	1			1			1

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	DAVIESS COMMUN		CN. 1E 00/1	Peri od:	u of Form CMS-2 Worksheet D	2552-10
	TUNMENT OF INPATTENT/OUTPATTENT ANCILLARY SEF H COSTS	WICE UTHER PAS	S Provider C	CN: 15-0061	From 01/01/2022	Part IV	
TTROOG	11 60313		Component	CCN: 15-S061	To 12/31/2022	Date/Time Pre	epared:
			Ti +l c	· XVIII	Subprovi der -	6/12/2023 11: PPS	56 am_
			11116	; AVIII	I PF	FF3	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	f C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	0	0		0 10, 432, 703	0. 000000	
51.00	05100 RECOVERY ROOM	0	0		0 0	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 829, 369	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 21, 323, 196	0. 000000	
56.00	05600 RADI OI SOTOPE	0	0		0 4, 934, 035	0. 000000	1
60.00	06000 LABORATORY	0	0		0 21, 535, 269	0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 615, 540	0.000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 5, 067, 725	0.000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 4, 442, 777	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 231, 942	0.000000	
68.00	06800 SPEECH PATHOLOGY	0	0	1	0 755, 395	0.000000	
69. 00 71. 00	06900 ELECTROCARDI OLOGY	0	0	1	0 922, 925	0.000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 7, 315, 202 0 802, 267	0. 000000 0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 14, 981, 253	0. 000000	1
76.00	03020 CARDI AC REHAB	0	0		0 14, 961, 253	0. 000000	
	03030 ADDICTION SERVICES	0	0	1	0 55, 066	0. 000000	
70.01	OUTPATIENT SERVICE COST CENTERS	0	0		0 55,000	0.000000	70.01
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 1, 085, 067	0. 000000	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	1	0 762, 016	0. 000000	
88. 02	08802 RURAL HEALTH CLINIC III	0	0		0 2, 910, 700	0. 000000	
88. 03	08805 RURAL HEALTH CLINIC IV	0	0	•	0 0	0. 000000	
88. 04	08803 RURAL HEALTH CLINIC V	0	0		0 1, 275, 922	0. 000000	
88. 05	08804 RURAL HEALTH CLINIC VI	0	0		0 865, 397	0. 000000	
90.00	09000 CLI NI C	0	0		0 957, 605	0.000000	
90.01	09001 ONCOLOGY	0	0		0 1, 049, 071	0. 000000	
90.02	09002 PAIN MANAGEMENT	0	0		0 0	0.000000	
91.00	09100 EMERGENCY	0	0		0 19, 298, 350	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 3, 959, 869	0. 000000	
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0		0 759, 123	0. 000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
	Total (lines 50 through 199)	0	0	I .	0 129, 783, 858		200.00

Health Financial Systems	DAVIESS COMMUNIT	_			u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C	CN: 15-0061	Peri od:	Worksheet D	
THROUGH COSTS		Component CCN: 15-S061		From 01/01/2022 Part IV To 12/31/2022 Date/Time 6/12/2023		pared: 56 am
		Title	· XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00   05000   OPERATING ROOM	0. 000000	0		0 0	0	
51. 00   05100   RECOVERY ROOM	0. 000000	0	1	0 0	0	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	194, 579		0	0	54.00
56. 00   05600   RADI OI SOTOPE	0. 000000	10, 250		0	0	56. 00
60. 00   06000   LABORATORY	0. 000000	620, 092		0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	283, 804		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	57, 881		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	5, 571		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	18, 363		0	0	68. 00
69. 00  06900   ELECTROCARDI OLOGY	0. 000000	33, 123		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	81, 360		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	l .	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	907, 509		0	0	73.00
76. 00   03020   CARDI AC   REHAB	0. 000000	0		0	0	76. 00
76. 01 03030 ADDICTION SERVICES	0. 000000	0		0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RURAL HEALTH CLINIC	0. 000000	0		0	0	88. 00
88.01   08801   RURAL HEALTH CLINIC II	0. 000000	0		0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0		0	0	88. 02
88.03 08805 RURAL HEALTH CLINIC IV	0. 000000	0		0	0	88. 03
88.04 08803 RURAL HEALTH CLINIC V	0. 000000	0		0	0	88. 04
88.05   08804 RURAL HEALTH CLINIC VI	0. 000000	0		0	0	88. 05
90. 00  09000  CLI NI C	0. 000000	0		0	0	90.00
90. 01  09001 0NC0L0GY	0. 000000	0		0	0	90. 01
90. 02   09002   PAIN MANAGEMENT	0. 000000	0		0	0	90. 02
91. 00   09100   EMERGENCY	0. 000000	240, 406		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0. 000000	0		0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)		2, 452, 938	l	0 0	0	200. 00

Health Financial Systems	DAVIESS COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		Provider CCN: 15-0061		Worksheet D Part II	
		·	CCN: 15-T061	From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	pared: 56 am
		Title	· XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1	,				
50. 00   05000   OPERATI NG ROOM	461, 645				1, 295	
51. 00   05100   RECOVERY ROOM	0	1			0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	156, 780		l .		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	350, 856				1, 327	
56. 00   05600   RADI 0I SOTOPE	44, 866	1 '			119	
60. 00   06000   LABORATORY	145, 769				1, 250	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 672				66	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	1			0	64.00
65. 00 06500 RESPI RATORY THERAPY	109, 156				7, 801	65.00
66. 00   06600 PHYSI CAL THERAPY	317, 766				28, 608	
67. 00 06700 OCCUPATI ONAL THERAPY	70, 618				14, 643	
68. 00 06800 SPEECH PATHOLOGY	49, 558				3, 921	68. 00
69. 00 06900 ELECTROCARDI OLOGY	16, 892				82	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	59, 495				1, 035	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 350				59	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	76, 594			·	972	1
76. 00   03020   CARDI AC   REHAB	36, 919				0	
76. 01 03030 ADDICTION SERVICES	3, 793	55, 066	0. 06888	1 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	82, 010				0	
88.01 08801 RURAL HEALTH CLINIC II	59, 765				0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	103, 034				0	
88. 03   08805   RURAL HEALTH CLINIC IV	0	1	0.0000		0	
88. 04   08803 RURAL HEALTH CLINIC V	40, 764		l .		0	
88. 05 08804 RURAL HEALTH CLINIC VI	44, 764		•		0	
90. 00 09000 CLINIC	62, 637		•		0	
90. 01   09001   0NCOLOGY	62, 081		•		0	
90. 02   09002   PAI N   MANAGEMENT	0	1			0	
91. 00   09100   EMERGENCY	225, 380				691	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-, ,			0	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	96, 238	759, 123	0. 12677	5 0	0	93.00
OTHER REIMBURSABLE COST CENTERS	T	T	T			
95. 00 09500 AMBULANCE SERVICES	0 (00 :00	100 700 050		0.004.707	(4.000	95.00
200.00   Total (lines 50 through 199)	2, 683, 402	129, 783, 858	I	2, 004, 787	61, 869	J200.00

Health Financial Systems	DAVIESS COMMUNIT	TV HOSPITAI		Inlie	ı of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA		Provi der CCN	l: 15-0061	Peri od:	Worksheet D	1002 10
THROUGH COSTS		Component CC	N: 15-T061	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 6/12/2023 11:	pared: 56 am
		Title >	XVI I I	Subprovi der - I RF	PPS	<u> </u>
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
· ·	Anesthetist	Program	Program	Post-Stepdown		
		ost-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS		-1				
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51. 00   05100   RECOVERY ROOM	0	0		0 0	0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56. 00   05600   RADI OI SOTOPE	0	0		0 0	0	56.00
60. 00   06000   LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS	.   0	0		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0			0	66.00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY		0			0	67. 00 68. 00
69. 00   06900   SPEECH PATHOLOGY		0			0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NT O	0			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0			0	73.00
76. 00 03020 CARDI AC REHAB		o			0	76.00
76. 01   03030   ADDI CTI ON   SERVI CES		0			0	76.00
OUTPATIENT SERVICE COST CENTERS		9		0  0	0	70.01
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC II	ol ol	ol		o o	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	l ol	ol		o o	0	88. 02
88. 03 08805 RURAL HEALTH CLINIC IV	o	o		0 0	0	88. 03
88. 04 08803 RURAL HEALTH CLINIC V	o	o		0 0	0	88. 04
88. 05 08804 RURAL HEALTH CLINIC VI	o	O		0 0	0	88. 05
90. 00   09000   CLI NI C	o	O		0 0	0	90.00
90. 01 09001 ONCOLOGY	o	0		0 0	0	90. 01
90. 02 09002 PAIN MANAGEMENT	o	0		0 0	0	90. 02
91. 00 09100 EMERGENCY	o	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	RT O			0	0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CEN	TE 0	0		0 0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00   09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0		200.00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	DAVIESS COMMUN		CN. 1E 00/1	Peri od:	u of Form CMS-2 Worksheet D	2552-10
	H COSTS	WICE UTHER PAS	S Provider C	CN: 15-0061	From 01/01/2022	Part IV	
TTIKOUG	11 60313		Component	CCN: 15-T061	To 12/31/2022		pared:
			Title	xVIII	Subprovi der -	PPS	30 aiii
					I RF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
				and 4)		(see	
		4.00	F 00	/ 00	7.00	instructions)	
	ANOLILIADY CEDVICE COCT CENTEDS	4. 00	5. 00	6. 00	7. 00	8. 00	
50. 00	ANCI LLARY SERVI CE COST CENTERS    05000   OPERATI NG ROOM	0	0	I	0 10, 432, 703	0.000000	50.00
51.00		0	0			0.000000	
51.00	05100 RECOVERY ROOM   05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0. 000000 0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 829, 369 0 21, 323, 196		
56.00	05600 RADI OLOGY - DI AGNOSTI C	0	0		0 21, 323, 196 0 4, 934, 035	0. 000000 0. 000000	
		0	_				1
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		,,	0. 000000 0. 000000	
	06400 INTRAVENOUS THERAPY	0	0				
64. 00 65. 00	06500 RESPIRATORY THERAPY	0	0		-	0. 000000 0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 4, 442, 777 0 2, 231, 942	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 755, 395	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0 755, 375	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 7, 315, 202	0. 000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 802, 267	0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 14, 981, 253	0. 000000	1
76.00	03020 CARDI AC REHAB	0	0		0 616, 074	0. 000000	
76. 01	03030 ADDICTION SERVICES	0	0	1	0 55, 066	0. 000000	
, 0. 0 .	OUTPATIENT SERVICE COST CENTERS				00,000	0.00000	1 / 0 . 0 .
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 1, 085, 067	0. 000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 762, 016	0.000000	
88. 02	08802 RURAL HEALTH CLINIC III	0	0		0 2, 910, 700	0.000000	88. 02
88. 03	08805 RURAL HEALTH CLINIC IV	0	0		0 0	0.000000	88. 03
88. 04	08803 RURAL HEALTH CLINIC V	0	0		0 1, 275, 922	0.000000	88. 04
88. 05	08804 RURAL HEALTH CLINIC VI	0	0		0 865, 397	0.000000	88. 05
90.00	09000 CLI NI C	0	0		0 957, 605	0.000000	90.00
90.01	09001 ONCOLOGY	0	0		0 1, 049, 071	0.000000	90. 01
90.02	09002 PAIN MANAGEMENT	0	0		0 0	0. 000000	
91.00	09100 EMERGENCY	0	0		0 19, 298, 350	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 3, 959, 869	0. 000000	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0		0 759, 123	0. 000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
	Total (lines 50 through 199)	0	0	I .	0 129, 783, 858		200.00

	Financial Systems ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI COSTS	DAVIESS COMMUNIT RVICE OTHER PASS	Provi der Co	CN: 15-0061 CCN: 15-T061	Peri od: From 01/01/2022 To 12/31/2022	w of Form CMS-2 Worksheet D Part IV Date/Time Pre 6/12/2023 11:	pared:
			Title	XVIII	Subprovi der - I RF	PPS	30 alli
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	
Δ.	NCLLLADY SEDVICE COST CENTEDS	9.00	10.00	11.00	12.00	13.00	
50. 00	INCILLARY SERVICE COST CENTERS  J5000 OPERATI NG ROOM  D5100 RECOVERY ROOM  D5200 DELIVERY ROOM & LABOR ROOM  J5400 RADI OLOGY-DI AGNOSTI C  D5600 RADI OLOGY-DI AGNOSTI C  D6000 LABORATORY  D6400 I NTRAVENOUS THERAPY  D6500 RESPIRATORY THERAPY  D6600 PHYSI CAL THERAPY  D6700 OCCUPATI ONAL THERAPY  D6800 SPEECH PATHOLOGY  D6900 ELECTROCARDI OLOGY  J17100 MEDI CAL SUPPLIES CHARGED TO PATI ENT  D7200 DRUGS CHARGED TO PATI ENTS  D3300 DRUGS CHARGED TO PATI ENTS  D3030 ADDI CTI ON SERVICES	0. 000000 0. 000000	29, 272 0 0 80, 644 13, 040 184, 704 11, 130 0 362, 170 399, 982 462, 806 59, 771 4, 499 127, 287 20, 115 190, 178		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 52. 00 54. 00 56. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 00
88. 00 0 88. 01 0 88. 02 0 88. 03 0 88. 05 0 90. 00 0 90. 01 0 90. 02 0 91. 00 0 92. 00 0 93. 00 0	DUTPATIENT SERVICE COST CENTERS  D8800 RURAL HEALTH CLINIC II  D8801 RURAL HEALTH CLINIC III  D8802 RURAL HEALTH CLINIC III  D8803 RURAL HEALTH CLINIC IV  D8803 RURAL HEALTH CLINIC V  D8804 RURAL HEALTH CLINIC VI  D9000 CLINIC  D9001 ONCOLOGY  D9002 PAIN MANAGEMENT  D9100 EMERGENCY  D9200 OTHER OUTPATIENT SERVICE COST CENTE	0. 000000 0. 000000	0 0 0 0 0 0 0 0 0 59, 189 0		0 0 0 0 0 0	0 0 0 0 0 0 0 0	88. 01 88. 02 88. 03 88. 04 88. 05 90. 00 90. 01 90. 02 91. 00 92. 00
	09500 AMBULANCE SERVICES Total (lines 50 through 199)		2, 004, 787		0 0	0	95. 00 200. 00

					10 12/31/2022	6/12/2023 11:	
			Ti tl	e XIX	Hospi tal	Cost	<u> </u>
			11 (1	Charges	nospi tui	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	oost center bescription	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see		Servi ces Not	(300 11131.)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3.00	4. 00	5. 00	
ANCI LL	ARY SERVICE COST CENTERS						
	OPERATI NG ROOM	0. 365244	0	211, 54	1 0	0	50.00
	RECOVERY ROOM	0. 000000	0		0	0	
	DELIVERY ROOM & LABOR ROOM	1. 429740	0	1, 50		0	
1 1	RADI OLOGY-DI AGNOSTI C	0. 109203	0	450, 63		0	
	RADI OI SOTOPE	0. 211363	0	108, 24		0	56.00
	LABORATORY	0. 189475	0	400, 73		0	60.00
	BLOOD STORING, PROCESSING & TRANS.	0. 041981	0	7, 16		0	63.00
	INTRAVENOUS THERAPY	0. 000000	0	1	0	0	64.00
	RESPI RATORY THERAPY	0. 223359	0	49, 60	ا ا	0	65.00
	PHYSI CAL THERAPY	0. 223359	0			0	66.00
		1	0	87, 92		0	67.00
	OCCUPATI ONAL THERAPY	0. 319240	ŭ	00,72		_	
	SPEECH PATHOLOGY	0. 518012	0			0	
	ELECTROCARDI OLOGY	0. 160672	0	,		0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 325701	0			0	
	I MPL. DEV. CHARGED TO PATIENTS	0. 410533	0			0	
	DRUGS CHARGED TO PATIENTS	0. 322868	0			0	
1 1	CARDI AC REHAB	0. 446078	0			0	
	ADDICTION SERVICES	6. 691661	0	1, 24	5 0	0	76. 01
	TIENT SERVICE COST CENTERS	1		ı			
	RURAL HEALTH CLINIC						88. 00
	RURAL HEALTH CLINIC II						88. 01
	RURAL HEALTH CLINIC III						88. 02
	RURAL HEALTH CLINIC IV						88. 03
	RURAL HEALTH CLINIC V						88. 04
	RURAL HEALTH CLINIC VI						88. 05
90.00 09000	CLINIC	0. 640110	0	22, 99	8 0	0	90.00
90. 01 09001	ONCOLOGY	0. 579106	0	25, 11	7 0	0	90. 01
90. 02 09002	PAIN MANAGEMENT	0. 000000	0		0	0	90. 02
91.00 09100	EMERGENCY	0. 337458	0	413, 45	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0. 390471	0	86, 38	4 0	0	92.00
93. 00 04040	OTHER OUTPATIENT SERVICE COST CENTE	1. 561702	0	18, 10	5 0	0	93.00
OTHER	REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	0. 735508	0		0		95.00
	Subtotal (see instructions)		0	2, 376, 95	6 0	0	200.00
	Less PBP Clinic Lab. Services-Program		_		o o		201.00
	Only Charges						
	Net Charges (line 200 - line 201)		0	2, 376, 95	6 0	0	202.00
- (	• • • • • • • • • • • • • • • • • • • •				-		

Health Financial Systems	DAVIESS COMMUNIT	Y HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0061	Peri od: From 01/01/2022	

				To 12/31/2022	Date/Time Prepared: 6/12/2023 11:56 am
		Ti tl e	e XIX	Hospi tal	Cost
	Cos	sts			
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 OPERATING ROOM	77, 264	0			50.00
51.00   05100   RECOVERY ROOM	0	0			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	2, 156	0			52.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	49, 210	0			54.00
56. 00   05600   RADI 0I SOTOPE	22, 879	0			56.00
60. 00   06000   LABORATORY	75, 929	o			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	301	o			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	ol			64.00
65. 00 06500 RESPIRATORY THERAPY	11, 079	l ol			65.00
66. 00 06600 PHYSI CAL THERAPY	44, 477	o			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	11, 787	o			67. 00
68. 00 06800 SPEECH PATHOLOGY	6, 897	o			68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 769				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40, 073				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 759				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	87, 351	l ol			73.00
76. 00 03020 CARDI AC REHAB	6, 597				76.00
76. 01   03030   ADDI CTI ON   SERVI CES	8, 331				76.00
OUTPATIENT SERVICE COST CENTERS	0, 331	<u> </u>			70.01
88. 00 08800 RURAL HEALTH CLINIC					88.00
88. 01   08801 RURAL HEALTH CLINIC II					88. 01
88. 02   08802 RURAL HEALTH CLINIC III					88. 02
88. 03   08805 RURAL HEALTH CLINIC IV					88. 03
88. 04   08803 RURAL HEALTH CLINIC V					88. 04
88. 05   08804 RURAL HEALTH CLINIC VI					88. 05
	14, 721	0			90.00
90. 00   09000  CLI NI C 90. 01   09001  0NCOLOGY		1			
	14, 545				90. 01
90. 02   09002   PAI N MANAGEMENT	100 500	0			90. 02
91. 00   09100   EMERGENCY	139, 522				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	33, 730				92.00
93. 00 O4040 OTHER OUTPATIENT SERVICE COST CENTE	28, 275	0			93. 00
OTHER REIMBURSABLE COST CENTERS	-				25
95. 00 09500 AMBULANCE SERVI CES	0				95. 00
200.00 Subtotal (see instructions)	684, 652	1			200.00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges	/04 :==	_			
202.00   Net Charges (line 200 - line 201)	684, 652	0			202.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN	: 15-0061 Peri od: From 01/01/2022	Worksheet D-1	
			Date/Time Pre 6/12/2023 11:	
	Title >	(VIII Hospi tal	PPS	
Cost Center Description				
			1 00	

		Title XVIII	Hospi tal	6/12/2023 11: PPS	<u>56 am</u>
	Cost Center Description	THE AVIII	nospi tui		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			4, 024	1.00
2.00	Inpatient days (including private room days, excluding swing-			4, 024	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	Tvate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		2, 427	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	21 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 of the cost	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m daya) aftar Dagambar (	01 of the cost	0	8.00
6.00	reporting period (if calendar year, enter 0 on this line)	ili days) arter beceiliber s	of the cost	U	8.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	760	9. 00
10.00	newborn days) (see instructions)			0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, e				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	te room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
15. 00 16. 00	Nursery days (title V or XIX only)			0	
.0.00	SWI NG BED ADJUSTMENT			<u> </u>	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	as after December 31 of	the cost	0.00	18.00
10.00	reporting period	es arter becember 51 or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.00
20.00	reporting period	3 arter becomber 31 or 1	ine cost	0.00	20.00
21. 00	,			3, 896, 018	1
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22.00
23. 00		31 of the cost reportir	na period (line 6	0	23.00
	x line 18)	·			
24. 00	] 3	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19)   Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)		, , , , , , , , , , , , , , , , , , , ,	_	
26.00	Total swing-bed cost (see instructions)	(11 01 11 04)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		3, 896, 018	27. 00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
29. 00				0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	11 20)		0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	rtions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li		, tr 0113)	0.00	1
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 di	fferential (line		
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	LISTMENTS			
38 00	Adjusted general inpatient routine service cost per diem (see			968. 20	38.00
39. 00	Program general inpatient routine service cost per diem (see			735, 832	
	Medically necessary private room cost applicable to the Progr	•		0	40.00
	Total Program general inpatient routine service cost (line 39			735, 832	

Health Financial S COMPUTATION OF IN	PATIENT OPERATING COST	DAVIESS COMMUNI	Provider C		<u>In Lie</u> Period: From 01/01/2022	worksheet D-1	
					To 12/31/2022		
Cost	Center Description	Total	Ti tl e	XVIII Average Per	Hospital Program Days	PPS Program Cost	
COST	center bescription	Inpatient	I npati ent	Diem (col. 1		(col. 3 x	
		1.00	2. 00	÷ col . 2) 3.00	4. 00	col . 4) 5.00	
42.00 NURSERY (ti	tle V & XIX only)	0	2.00				42.00
43.00 INTENSIVE (	Care Type Inpatient Hospital Units	1, 646, 180	646	2, 548. 2 <sup>-</sup>	7 267	680, 388	43.00
44.00 CORONARY CA	ARE UNIT	1,010,100	010	2,010.2	,	000, 000	44.00
	SIVE CARE UNIT NTENSIVE CARE UNIT						45. 00 46. 00
N I	AL CARE (SPECIFY)						47.00
Cost	Center Description					1. 00	
48.00 Program in	patient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1, 712, 642	48.00
	patient cellular therapy acquisition ram inpatient costs (sum of lines s				column 1)	2 120 042	
	GH COST ADJUSTMENTS	41 through 48. C	))(See Thstru	CTI OIIS)		3, 128, 862	J 49. 00
· · · · · · · · · · · · · · · · · · ·	gh costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	82, 669	50.00
51.00 Pass through	gh costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	100, 699	51.00
and IV) 52.00 Total Progr	ram excludable cost (sum of lines	50 and 51)				102 260	52.00
	ram inpatient operating cost exclu		elated, non-ph	ysician anesth	netist, and	183, 368 2, 945, 494	
	ucation costs (line 49 minus line I INT AND LIMIT COMPUTATION	52)					-
54. 00 Program di						0	54.00
	unt per discharge					0.00	
N Control of the Cont	adjustment amount per discharge amount per discharge (contractor :	use only)				0. 00 0. 00	1
56.00 Target amou	unt (line 54 x sum of lines 55, 55	. 01, and 55. 02)				0	56.00
	between adjusted inpatient operatent (see instructions)	ing cost and ta	arget amount (	line 56 minus	line 53)	0	57. 00 58. 00
	sts (lesser of line 53 ÷ line 54, )	or line 55 from	n the cost rep	orting period	endi ng 1996,	0.00	
	d compounded by the market basket) osts (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year	cost report i	indated by the	0.00	60.00
market basl	(et)						
55.01, or l 53) are les	<pre>improvement bonus payment (if line ine 59, or line 60, enter the less sthan expected costs (lines 54 x (see instructions)</pre>	ser of 50% of t	the amount by	which operatir	ng costs (line	0	61.00
62.00 Relief payr	ment (see instructions)					0	62.00
	npatient cost plus incentive paymerATIENT ROUTINE SWING BED COST	ent (see instru	ıcti ons)			0	63.00
	wing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
	ns)(title XVIII only) wing-bed SNF inpatient routine cos	ts after Decemb	ner 31 of the	cost reporting	neriod (See	0	65.00
i nstructi o	ns)(title XVIII only)				, , ,		
	care swing-bed SNF inpatient routi nstructions	ne costs (line	64 plus line	65)(title XVII	I only); for	0	66.00
67.00 Title V or	XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost re	eporting period	0	67.00
68.00 Title V or	line 19) XIX swing-bed NF inpatient routine	e costs after D	December 31 of	the cost repo	ortina period	0	68.00
(line 13 x	line 20)			•	a tring part au		
	e V or XIX swing-bed NF inpatient SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00 Skilled nui	rsing facility/other nursing facil	ity/ICF/IID rou	itine service	cost (line 37)			70.00
, ,	eneral inpatient routine service c utine service cost (line 9 x line	,	ine 70 ÷ line	2)			71.00
9	necessary private room cost applications		n (line 14 x l	ine 35)			73.00
	ram general inpatient routine serv ated cost allocated to inpatient			•	Part II column		74. 00 75. 00
26, line 4	•	routine service	2 00313 (110111	WOTKSHEET B, T	art II, corumi		75.00
	apital-related costs (line 75 ÷ li pital-related costs (line 9 x line	. *					76.00
, ,	routine service cost (line 74 minus	,					78.00
	charges to beneficiaries for excess				uo lino 70)		79.00
	ram routine service costs for comp routine service cost per diem limi		ost ilmitatio	n (line /8 mir	ius IINE /9)		80. 00 81. 00
82.00 Inpatient	routine service cost limitation (I	ine 9 x line 81	•				82.00
	inpatient routine service costs (		ns)				83.00
, ,	oatient ancillary services (see in: n review - physician compensation		ons)				84. 00 85. 00
86.00 Total Progr	ram inpatient operating costs (sum	of lines 83 th					86.00
	COMPUTATION OF OBSERVATION BED PASS rvation bed days (see instructions					1, 597	   87. 00
1	eneral inpatient routine cost per	•	- line 2)			968. 20	

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			1, 546, 215	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	268, 010	3, 896, 018	0. 06879	1, 546, 215	106, 366	90.00
91.00 Nursing Program cost	O	3, 896, 018	0. 00000	1, 546, 215	0	91.00
92.00 Allied health cost	O	3, 896, 018	0. 00000	00 1, 546, 215	0	92.00
93.00 All other Medical Education	O	3, 896, 018	0. 00000	1, 546, 215	0	93.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0061	Peri od:	Worksheet D-1
	0	From 01/01/2022	
	Component CCN: 15-S061	10 12/31/2022	
			6/12/2023 11:56 am
	Title XVIII	Subprovi der -	PPS
		I PF	

		I PF		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3, 845	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3, 845	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only	private room days,	0	3.00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3, 845	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through Decem	ber 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after Decembe	r 31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	1 31 01 the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through Decemb	er 31 of the cost	0	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
	reporting period (if calendar year, enter 0 on this line)		0.004	
9. 00	Total inpatient days including private room days applicable to the Program (excluding private room days)	ng swing-bed and	2, 821	9. 00
10.00	<pre>lnewborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private</pre>	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	1 ddiii ddys)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private	room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including priv	ate room days)	0	12.00
40.00	through December 31 of the cost reporting period			40.00
13. 00			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this I Medically necessary private room days applicable to the Program (excluding swing-be		0	14.00
15. 00		a days)	0	15.00
	Nursery days (title V or XIX only)		0	
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31	of the cost	0. 00	17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 o	f the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31	of the cost	0.00	19. 00
17.00	reporting period	of the cost	0.00	19.00
20.00	1 31	the cost	0. 00	20.00
	reporting period			
21.00			3, 237, 595	1
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost repo	rting period (line	0	22. 00
22.00	5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost report	ing ported (line	0	22.00
23. 00	x line 18)	ing perrou (inte o	U	23. 00
24. 00		ting period (line	0	24.00
	7 x line 19)	9		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporti	ng period (line 8	0	25. 00
	x line 20)			
26. 00		,	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	)	3, 237, 595	27. 00
28 00	General inpatient routine service charges (excluding swing-bed and observation bed	charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	criai ges)	0	1
30.00	Semi -pri vate room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00	1
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instr	uctions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	1
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost	differential (line	0 3 227 505	36.00
37.00	27 minus line 36)	urrerentiai (IINe	3, 237, 595	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		842. 03	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		2, 375, 367	39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	l	2, 375, 367	41.00

			0011 45 00/4	From 01/01/2022		
		component	CCN: 15-S061	To 12/31/2022		
		Title	e XVIII	Subprovi der -	6/12/2023 11: PPS	30 alli
Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
cost center bescription	Inpati ent Cost	I npati ent Days	Diem (col. ÷ col. 2)		(col. 3 x col. 4)	
NUDCEDY (+:+1 - V 0 VIV1.)	1. 00	2.00	3.00	4.00	5. 00	12.0
			. U.	<u>J0</u>   0	0	42.0
	0	C	0.	00 0	0	43.0
CORONARY CARE UNIT						44.0
						45. 0 46. 0
						47.0
Cost Center Description			-			
Program inpatient ancillary service cost (Wh	et D-3 col '	3 line 200)				48.0
Program inpatient cellular therapy acquisiti	on cost (Worksh	neet D-6, Part	III, line 10	), column 1)	030, 021	
Total Program inpatient costs (sum of lines				<u> </u>	3, 026, 188	49.0
			Wi+ D		1/0 502	
5 11 5 1	batient routine	services (Tro	m wkst. D, St	um or Parts I and	168, 583	50.0
,	oatient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	27, 842	51.0
Total Program excludable cost (sum of lines					196, 425	
		elated, non-ph	ysician anest	:hetist, and	2, 829, 763	53.0
	52)					1
Program di scharges					0	
						55.0
	use only)					
		)			0.00	1
			line 56 minus	s line 53)	0	57.
Bonus payment (see instructions)					0	
		m the cost rep	orting period	ending 1996,	0.00	59. (
Expected costs (lesser of line 53 ÷ line 54,		om prior year	cost report,	updated by the	0.00	60.0
Continuous improvement bonus payment (if lin $55.01$ , or line $59$ , or line $60$ , enter the les $53$ ) are less than expected costs (lines $54$ x	sser of 50% of	the amount by	which operati	ng costs (line	0	61.0
					0	62.0
Allowable Inpatient cost plus incentive paym	ment (see instru	uctions)			0	63.0
Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of th	e cost report	ting period (See	0	64.0
	sts after Decemb	per 31 of the	cost reportir	ng period (See	0	65.0
instructions)(title XVIII only) Total Modicare swing had SNE inpatient routi	no costs (lino	64 plus lino	65) (+i +l o VVI	II only): for	0	66. (
CAH, see instructions				3,		
(line 12 x line 19)						
(line 13 x line 20)				nor cring period		
PART III - SKILLED NURSING FACILITY, OTHER N	JURSING FACILITY	, AND ICF/IID	ONLY	7)	0	
				7		70. (
•		70 . 11116	-/			72.
Medically necessary private room cost applic	cable to Progran	•	,			73.0
Capital-related cost allocated to inpatient	•		•	Part II, column		74. (
	ne 2)					76.
•						77.
Inpatient routine service cost (line 74 minu	us line 77)					78.
				nue line 70)		79.
		JUST TIMITATIO	ıı (ııne /8 mi	nus iine 79)		80.
·		1)				82.
Reasonable inpatient routine service costs (	(see instruction					83.
						84.
Utilization review - physician compensation Total Program inpatient operating costs (sum	•	,				85.
PART IV - COMPUTATION OF OBSERVATION BED PAS		Jugii UJ)				1 30.
	INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  Program inpatient ancillary service cost (Wipprogram inpatient cellular therapy acquisitional program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatient costs (sum of lines Total Program excludable cost (sum of lines Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges  Target amount per discharge Permanent adjustment amount per discharge Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55)  Difference between adjusted inpatient operations payment (see instructions)  Trended costs (lesser of line 53 + line 54, updated and compounded by the market basket)  Continuous improvement bonus payment (if lines 55, 01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)  Allowable Inpatient cost plus incentive paymendedicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine cost instructions) (title V or XIX swing-bed NF inpatient routine cost instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine cost instructions) (title V or XIX swing-bed NF inpatient routine cost instructions) (title V or XIX swing-bed NF inpatient routine cost instructions) (title V or XIX swing-bed NF inpatient routine cost instructions)  Total Program general inpatient routine service cost (line 75 + line program capital -related cost	INDESERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description  Program inpatient ancillary service cost (Wkst. D-3, col.: Program inpatient cellular therapy acquisition cost (Worksl Total Program inpatient cellular therapy acquisition cost (Worksl Total Program inpatient costs (sum of lines 41 through 48.0 PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine III) Pass through costs applicable to Program inpatient ancillar and IV) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital remedical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Permanent adjustment amount per discharge Adjustment amount per discharge (contractor use only) Target amount (line 54 x sum of lines 55, 55.01, and 55.02; Difference between adjusted inpatient operating cost and to Bonus payment (see instructions) Trended costs (lesser of line 53 + line 54, or line 55 from updated and compounded by the market basket) Expected costs (lesser of line 53 + line 54, or line 55 from and sheet) Expected costs (lesser of line 53 + line 54, or line 55 from an expected costs (lines 54 x 60), or 1 % of enter the lesser of 50% of 53) are less than expected costs (lines 54 x 60), or 1 % of enter zero. (see instructions) Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs through Deceinstructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs after December of the payment (see instructions) Title V or XIX swing-bed NF inpatient routine costs after (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs after (line 13 x line 20) Total title V or XIX swing-bed NF in	INTERSITY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description  Program Inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Program inpatient collular therapy acquisition cost (Worksheet D-6, Part Total Program inpatient costs (sum of lines 41 through 48.01) (see instru PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatient routine services (frou 11) Total Program excludable cost (sum of lines 50 and 51) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-ph medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges  Target amount per discharge Permanent adjustment amount per discharge Adjustment amount per discharge (contractor use only) Target amount (line 54 x sum of lines 55, 55.01, and 55.02) Difference between adjusted inpatient operating cost and target amount (Bonus payment (see instructions) Trended costs (lesser of line 53 + line 54, or line 55 from the cost repupdated and compounded by the market basket) Continuous improvement bonus payment (if line 53 + line 54 is less than 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by 33) are less than expected costs (lesser of line 53) are less than expected costs (lines 54 x 60), or 1 % of the target an enter zero. (see instructions)  Real ef payment (see instructions) Allowable Inpatient cost plus Incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the instructions (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the instructions (title XVIII only)  Total Medicare	INDESERY (1110 V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description  Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Program inpatient costs (sum of lines 41 through 48.01) (see instructions) PASS THROUGH COST ADJUSTMENTS PASS THROUGH COST ADJUSTMENTS PASS through costs applicable to Program inpatient routine services (from Wkst. D, su lil) And IV) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anest medical education costs (line 40 min us line 52) TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Permanent adjustment amount per discharge Adjustment amount per discharge (contractor use only) Target amount (line 54 x sum of lines 55, 55, 01, and 55, 02) DI Tference between adjusted inpatient operating cost and target amount (line 56 mirus Bonus payment (see instructions) Trended costs (lesser of line 53 + line 54, or line 55 from prior year cost report, market basket) Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, market basket) Expected costs (lesser of line 53 + line 54, or line 55 ins from prior year cost report, market basket) Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, market basket) Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, market basket) Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, market basket) Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, market basket)  Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, market basket)  Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, ma	NURSERY (LITTLE V. & XIX only)  Intensive Care Type Inpatient liospital Units  INTENSIVE CARE UNIT  BURN INTENSIVE CARE UNIT  Cost Center Description  Program inpatient ancillary service cost (West. D-3, col. 3, line 200)  Program inpatient ancillary service cost (West. D-3, col. 3, line 200)  Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)  Total Program inpatient costs (sum of lines 41 through 48, 01)(see instructions)  Pass THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I ancillar)  Pass Through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II ancillar)  Pass Through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II ancillar)  Pass Through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II ancillar)  Pass Through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II ancillar)  Pass Through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II ancillar)  Pass Through costs applicable to program inpatient ancillary services (from Wkst. D, sum of Parts II ancillar)  Pass Through costs applicable to program inpatient ancillary services (from Wkst. D, sum of Parts II ancillar)  Pass Through costs applicable to program inpatient ancillary services (from Wkst. D, sum of Parts II ancillar)  Pass Through costs applicable to program inpatient ancillary services (from Wkst. D, sum of Parts II ancillary services (from Wkst. D, sum of Parts II ancillary services (from Wkst. D, sum of Parts II ancillary services (from Wkst. D, sum of Parts II ancillary services (from Wkst. D, sum of Parts II ancillary services (from Wkst. D, sum of Parts II ancillary services (from Wkst. D, sum of Parts II ancillary services (from par	INDESTRY (1 till e V & XIX Only)

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2022 To 12/31/2022		pared: 56 am_
		Title	XVIII	Subprovi der  - I PF	PPS	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	: line 2)			0. 00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)	)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	229, 793	3, 237, 595	0. 07097	76 0	0	90.00
91.00 Nursing Program cost	0	3, 237, 595	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 237, 595	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 237, 595	0. 00000	00	0	93.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061	Peri od:	Worksheet D-1
	Component CCN: 15-T061	From 01/01/2022	
	Component Con. 13-1001	10 12/31/2022	6/12/2023 11: 56 am
	Title XVIII	Subprovi der -	PPS
		IRF	

		I RF		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1, 400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1, 400	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only	private room days,	0	3. 00
	do not complete this line.		4 400	
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	h 21 -6 +h4	1, 400	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through Decem reporting period	ber 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after Decembe	r 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)			
7.00	Total swing-bed NF type inpatient days (including private room days) through Decemb	er 31 of the cost	0	7. 00
0.00	reporting period	04 . 6 . 11	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December reporting period (if calendar year, enter 0 on this line)	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excludi	ng swing-bed and	1, 016	9. 00
7. 00	newborn days) (see instructions)	ing oming boar and	., 0.0	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private	room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private	room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including priv	ato room days)	0	12. 00
12.00	through December 31 of the cost reporting period	ate room days)	O	12.00
13.00		ate room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this I			
14. 00	Medically necessary private room days applicable to the Program (excluding swing-be	d days)	0	14.00
15.00	1		0	15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		0	16. 00
17. 00		of the cost	0.00	17. 00
00	reporting period	0. 1.10 0001	0.00	17100
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 o	f the cost	0.00	18. 00
40.00	reporting period			40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 reporting period	or the cost	0.00	19. 00
20. 00	1 31	the cost	0. 00	20.00
	reporting period			
21.00			1, 691, 873	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost repo	rting period (line	0	22. 00
23. 00	5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost report	ing period (line A	0	23. 00
23.00	x line 18)	riig perroa (irrie o	· ·	25.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost repor	ting period (line	0	24.00
	7 x line 19)			
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting line 20)	ng period (line 8	0	25. 00
26. 00			0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26	)	1, 691, 873	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
	General inpatient routine service charges (excluding swing-bed and observation bed	charges)		28. 00
	Private room charges (excluding swing-bed charges)		0	
30.00	Semi-private room charges (excluding swing-bed charges)   General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instr	uctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	,	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost	differential (line	1, 691, 873	37. 00
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)		1, 208. 48	38, 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		1, 227, 816	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)		1, 227, 816	41.00

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	27.17.200 00	Provider C	CN: 15-0061	Peri od:	u of Form CMS-2 Worksheet D-1	
				CCN: 15-T061	From 01/01/2022 To 12/31/2022	Date/Time Pre	epared
			Title	e XVIII	Subprovi der -	6/12/2023 11: PPS	oo all
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	5550 53.115. 5353. <b>, p</b> . 13.	Inpatient Cost	Inpatient Days	Diem (col. + col. 2)		(col. 3 x col. 4)	
12.00	NUDCEDY (+:+ c V 0 VIV cm v)	1. 00	2. 00	3.00	4.00	5.00	12.0
12.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0	42.0
13. 00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.0
14. 00	CORONARY CARE UNIT						44.0
15. 00 16. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 0 46. 0
	OTHER SPECIAL CARE (SPECIFY)						47. (
	Cost Center Description					4.00	
8. 00	Program inpatient ancillary service cost (W	kst D-3 col :	3 Line 200)			1. 00 651, 469	48.0
8. 01	Program inpatient cellular therapy acquisit	ion cost (Works	heet D-6, Part	III, line 10	), column 1)	0	1
9. 00	Total Program inpatient costs (sum of lines				·	1, 879, 285	49.
0. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program in	nationt routing	corul cos (fro	m Wks+ D si	um of Dorte L and	118, 222	50.
0.00	[111]	patrent routine	services (110	III WKSt. D, St	III OI PAILS I AIR	110, 222	30.
1. 00	Pass through costs applicable to Program in	patient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	61, 869	51.
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				180, 091	52.
3. 00	Total Program inpatient operating cost excl		elated, non-ph	ysician anest	thetist, and	1, 699, 194	1
	medical education costs (line 49 minus line	52)					
4. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.
	Target amount per discharge					0.00	
5. 01	Permanent adjustment amount per discharge					0.00	
5. 02	Adjustment amount per discharge (contractor		`			0.00	
5. 00 7. 00	Target amount (line 54 x sum of lines 55, 5 Difference between adjusted inpatient opera			line 56 minus	s Line 53)	0	
3. 00	Bonus payment (see instructions)	tring obot and th	ar got amount (		, , , , , , , , , , , , , , , , , , , ,	Ö	1
9. 00	Trended costs (lesser of line 53 ÷ line 54,		m the cost rep	orting period	d ending 1996,	0.00	59.
0. 00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54		om prior vear	cost renort	undated by the	0.00	60
0. 00	market basket)	, or time 55 fix	om prior year	cost report,	apaarea by the	0.00	00.
1. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54 paters are (coe instructions)	sser of 50% of	the amount by	which operati	ng costs (line	0	61.
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.
3. 00	Allowable Inpatient cost plus incentive pay	ment (see instr	uctions)			0	63.
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Dec	ember 31 of th	e cost report	ting period (See	0	64.
5 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decemb	har 21 of the	cost roporti	na ported (Soc	0	65.
3. 00	instructions)(title XVIII only)	sts after beceili	bei 31 01 the	cost reportir	ig period (see	0	05.
6. 00	Total Medicare swing-bed SNF inpatient rout CAH, see instructions	ine costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66.
7. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	h December 31	of the cost i	reporting period	0	67.
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after l	December 31 of	the cost rep	porting period	0	68.
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routi ne costs	<u>(line</u> 67 + lin	e 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER I	NURSING FACILITY	, AND ICF/IID	ONLY	7)		
0. 00 1. 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service				")		70. 71.
2. 00	Program routine service cost (line 9 x line		70 . 11110	2)			72.
3. 00	Medically necessary private room cost appli	5	•	,			73.
4. 00 5. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient	•		•	Part II, column		74. 75.
5. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76.
7. 00	Program capital -related costs (line 9 x line						77.
	Inpatient routine service cost (line 74 min		amand deservice	do)			78.
9. 00 0. 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)		79. 80.
1. 00	Inpatient routine service costs for com	•		( 70 IIII			81.
2. 00	Inpatient routine service cost limitation (						82.
3. 00 4. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	ns)				83. 84.
	Utilization review - physician compensation		ons)				85.
	Total Program inpatient operating costs (su	m of lines 83 tl					86.
	PART IV - COMPUTATION OF OBSERVATION BED PAS	TODOLICH COCT					

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	pared: 56 am_
		Title	XVIII	Subprovi der  - I RF	PPS	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	: line 2)			0. 00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)	)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	162, 909	1, 691, 873	0. 09628	0	0	90.00
91.00 Nursing Program cost	0	1, 691, 873	0.00000	0 0	0	91.00
92.00 Allied health cost	0	1, 691, 873	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 691, 873	0.00000	00	0	93.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061	Period: From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 6/12/2023 11:	
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	

		Title XIX	Hospi tal		00 alli
	1.00 private radys (including private room days, excluding swing-bed and newborn days) 2.01 private room days (excluding swing-bed and observation bed days). If you have only private room days. 3.02 onto complete this line. 3.03 onto complete this line. 3.04 onto complete this line. 3.06 onto complete this line. 3.07 onto semi-private room days (excluding swing-bed and observation bed days). 3.08 onto complete this line. 3.09 onto complete this line. 3.00 onto semi-private room days (excluding private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 3.00 onto line ground (if calendar year, enter 0 on this line) 3.00 onto line ground (if calendar year, enter 0 on this line) 3.00 onto line ground (if calendar year, enter 0 on this line) 3.00 onto line ground (if calendar year, enter 0 on this line) 3.00 onto line ground (if calendar year, enter 0 on this line) 3.00 onewborn days) (see instructions) 3.00 onewborn days) 3.00 onewborn days (see instructions) 3.00 onewborn days) 3.00 onewborn days (see instructions) 3.00 onewborn days) 3.00 onewborn days (see instructions) 3.00 onewborn days (see instructions) 3.00 onewborn days (see instructions) 3.00 o				
	DART I - ALL PROVIDER COMPONENTS			1. 00	
1.00				· ·	
2.00				· ·	
3.00		ys). If you have only pr	ivate room days,	0	3.00
4.00	· '	ed days)		2, 427	4.00
5.00		om days) through Decembe	r 31 of the cost	0	5.00
4 00		om days) after December	21 of the cost	0	4 00
0.00		on days) at ter becember	31 OF THE COST	0	0.00
7.00		m days) through December	31 of the cost	0	7.00
0.00	1 91		4 . 6 . 11		0.00
8.00		m days) after December 3	or the cost	0	8.00
9. 00		o the Program (excluding	swing-bed and	112	9. 00
				_	
10. 00			oom days)	0	10. 00
11. 00			oom davs) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	,		
12. 00		X only (including privat	e room days)	0	12.00
13 00		Y only (including privat	e room days)	0	13 00
10.00				o l	10.00
14. 00		am (excluding swing-bed	days)		
16.00				00	16.00
17. 00		es through December 31 o	f the cost	0.00	17.00
40.00	1 3 1	6. 5			40.00
18.00		es after December 31 of	the cost	0.00	18.00
19. 00		s through December 31 of	the cost	0. 00	19.00
		_			
20. 00		s after December 31 of t	he cost	0.00	20. 00
21. 00	, , , , , , , , , , , , , , , , , , , ,	s)		3, 896, 018	21. 00
22. 00			ing period (line		
22.00		21 of the cost reportin	a ported (line (	0	22.00
23.00		31 of the cost reportin	ig period (iine d	0	23.00
24.00		r 31 of the cost reporti	ng period (line	0	24.00
05 00		21 . 6 . 11			05.00
25.00		31 of the cost reporting	period (line 8	0	25.00
26.00				0	26.00
27. 00		(line 21 minus line 26)		3, 896, 018	27.00
28 00		d and observation had ch	arnes)	0	28 00
29. 00		a and observation bed ch	lai ges)	0	
30.00				0	
31.00	,	÷ line 28)			
34.00		nus line 33)(see instruc	tions)		
35. 00	, , , , , , , , , , , , , , , , , , , ,	, ,	,		
36.00	1				
37.00	,	and private room cost di	TTERENTIAL (line	3, 896, 018	37.00
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	, , , , , , , , , , , , , , , , , , , ,	•			
	, ,	•			
	, , , , , , , , , , , , , , , , , , , ,	•			
		•	'		

PUTATION OF INPATIENT OPERATING COST		Provi der Co	F	eriod: rom 01/01/2022	Worksheet D-1	
				o 12/31/2022	Date/Time Pre 6/12/2023 11:	
Cost Center Description	Total Inpatient Cost	Ti tl Total Inpati ent Days	e XIX  Average Per Diem (col. 1  ÷ col. 2)	Hospi tal Program Days	Program Cost (col. 3 x col. 4)	
	1. 00	2. 00	3. 00	4.00	5. 00	
00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	867, 810	815	1, 064. 80	66	70, 277	42
00 INTENSIVE CARE UNIT	1, 646, 180	646	2, 548. 27	22	56, 062	43
OO CORONARY CARE UNIT					·	44
OO BURN INTENSIVE CARE UNIT			1			45
OO SURGICAL INTENSIVE CARE UNIT			1			46
00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47
·					1. 00	
00 Program inpatient ancillary service cost (Wks					456, 016	
On Program inpatient cellular therapy acquisition				column 1)	400.703	
OO Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	+1 through 48.C	n)(see mstruc	iti ons)		690, 793	49
00 Pass through costs applicable to Program inpa	atient routine	services (from		of Parts I and	0	50
[111]		·				
OO Pass through costs applicable to Program inpa	atient ancillar	y services (fi	om Wkst. D, s	um of Parts II	0	51
and IV) 00 Total Program excludable cost (sum of lines 5	50 and 51)				0	52
00 Total Program inpatient operating cost excluded		elated, non-phy	ysician anesth	etist, and	0	53
medical education costs (line 49 minus line 5		,				
TARGET AMOUNT AND LIMIT COMPUTATION						ļ
00   Program di scharges 00   Target amount per di scharge					0 0. 00	
00   Target amount per discharge 01   Permanent adjustment amount per discharge					0.00	
02 Adjustment amount per discharge (contractor u	use onl v)				0.00	
OD Target amount (line 54 x sum of lines 55, 55.					0	56
00 Difference between adjusted inpatient operati	ng cost and ta	irget amount (I	ine 56 minus	line 53)	0	57
00 Bonus payment (see instructions)					0	58
OD Trended costs (lesser of line 53 ÷ line 54, of updated and compounded by the market basket)	or line 55 from	the cost repo	orting period	ending 1996,	0. 00	59
00 Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior vear o	ost report. u	odated by the	0. 00	60
market basket)			, .,			
OO Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by w	which operating	g costs (line	0	61
00 Relief payment (see instructions)					0	62
OO Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	63
PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cost	ts through Doos	umbor 21 of the		ag pariod (Saa	0	64
instructions)(title XVIII only)	is through bece	iliber 31 OF the	; cost reportir	ig period (see	U	04
00 Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the o	cost reporting	period (See	0	65
<pre>instructions)(title XVIII only)</pre>						
OO Total Medicare swing-bed SNF inpatient routing CAH, see instructions	ne costs (line	64 plus line 6	55)(title XVIII	only); for	0	66
00 Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	of the cost re	porting period	0	67
(line 12 x line 19)				3		
OD Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	rting period	0	68
(line 13 x line 20) 00 Total title V or XIX swing-bed NF inpatient r	routine costs (	line 67 + line	÷ 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHER NU					-	
OO Skilled nursing facility/other nursing facili						70
00 Adjusted general inpatient routine service co 00 Program routine service cost (line 9 x line 7		ine /U ÷ line	2)			71
00 Medically necessary private room cost applica	•	ı (line 14 x li	ne 35)			73
On Total Program general inpatient routine servi		•	,			74
00 Capital-related cost allocated to inpatient r				art II, column		75
26, line 45)	2)					_,
00   Per diem capital-related costs (line 75 ÷ lir 00   Program capital-related costs (line 9 x line						7 <i>6</i>   77
00 Inpatient routine service cost (line 74 minus						78
00 Aggregate charges to beneficiaries for excess		rovi der record	ls)			79
OO Total Program routine service costs for compa		ost limitation	າ (line 78 min	us line 79)		80
00 Inpatient routine service cost per diem limit		`				81
00   Inpatient routine service cost limitation (li 00   Reasonable inpatient routine service costs (s		•				82
00 Program inpatient ancillary services (see ins		13)				84
00 Utilization review - physician compensation (		ns)				85
00 Total Program inpatient operating costs (sum	of lines 83 th					86
PART IV - COMPUTATION OF OBSERVATION BED PASS					. =	
00   Total observation bed days (see instructions)	)				1, 597	87

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 56 am_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions	)			1, 546, 215	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	268, 010	3, 896, 018	0. 06879	1, 546, 215	106, 366	90.00
91.00 Nursing Program cost	0	3, 896, 018	0. 00000	0 1, 546, 215	0	91.00
92.00 Allied health cost	0	3, 896, 018	0. 00000	0 1, 546, 215	0	92.00
93.00 All other Medical Education	0	3, 896, 018	0. 00000	0 1, 546, 215	0	93.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061	Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 15-S061		
	Title XIX	Subprovi der -	Cost
		IPF	

		IPF		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)	3, 845	1.00
2.00	Inpatient days (including private room days, excluding swing-be		3, 845	2.00
3.00	Private room days (excluding swing-bed and observation bed days	). If you have only private room days,	0	3.00
	do not complete this line.			
4. 00	Semi-private room days (excluding swing-bed and observation bed		3, 845	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room	days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) after beceinder 51 of the cost	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	davs) through December 31 of the cost	0	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
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding swing-bed and	525	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructi		O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		0	11.00
	December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)		
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		0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program		0	14. 00
15. 00	Total nursery days (title V or XIX only)	(excluding swing-bed days)	815	
16. 00	Nursery days (title V or XIX only)		66	
	SWI NG BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of the cost	0.00	17.00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of the cost	0. 00	18. 00
19. 00	reporting period	through December 21 of the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	through becember 31 of the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of the cost	0.00	20. 00
	reporting period			
21.00	Total general inpatient routine service cost (see instructions)		3, 237, 595	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporting period (line	0	22.00
22.00	5 x line 17)	1 -6 -1	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	or the cost reporting period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporting period (line	0	24. 00
21.00	7 x line 19)	or or the door roper tring period (irine	Ü	21100
25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting period (line 8	0	25.00
	x line 20)			
26. 00	Total swing-bed cost (see instructions)		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)	3, 237, 595	27.00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed	and observation had charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34.00	Average per diem private room charge differential (line 32 minu		0.00	
35. 00	Average per diem private room cost differential (line 34 x line	31)	0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	d private room cost differential (line	2 227 505	36.00
37.00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	u private room cost differential (fine	3, 237, 595	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see i		842. 03	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	8)	442, 066	
40.00	Medically necessary private room cost applicable to the Program	` /	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)	442, 066	41.00

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	2 LOO COMMON	Provider C	CN: 15-0061	Peri od:	u of Form CMS-2 Worksheet D-1	
			Component	CCN: 15-S061	From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	
			Ti tl	e XIX	Subprovider -	Cost	00 4111
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0	42. C
43. 00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.0
44. 00	CORONARY CARE UNIT						44.0
45.00	BURN INTENSIVE CARE UNIT						45.0
16.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. C
+7.00	Cost Center Description						47.0
9 00	Program inpatient ancillary service cost (W	ket D 2 col 1	2 Line 200)			1.00	48.0
18. 00 18. 01	Program inpatient cellular therapy acquisit	ion cost (Works)	s, rine 200) heet D-6. Part	III. line 10	). column 1)	31, 593 0	1
	Total Program inpatient costs (sum of lines					473, 659	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program in	patient routine	services (fro	m WKST. D, SI	um of Parts I and	0	50.0
1. 00	Pass through costs applicable to Program in	patient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	0	51.0
-0.00	and IV)	EQ. (1.51)	·			_	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		alated non-ph	veician ange	thatist and	0	
3. 00	medical education costs (line 49 minus line		cratea, non pri	ysi ci aii aiics	inctist, and	Ĭ	33. 0
	TARGET AMOUNT AND LIMIT COMPUTATION					_	ļ
	Program discharges Target amount per discharge					0	54. ( 55. (
5. 01	Permanent adjustment amount per discharge					0.00	1
5. 02	Adjustment amount per discharge (contractor					0. 00	1
6.00	Target amount (line 54 x sum of lines 55, 5			ltEZt.		0	
7. 00 8. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	ting cost and to	arget amount (	line 56 minus	s line 53)	0	
9. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	m the cost rep	orting period	d ending 1996,	0.00	
	updated and compounded by the market basket	)		0 .			
0. 00	Expected costs (lesser of line 53 ÷ line 54 market basket)	, or line 55 fro	om prior year	cost report,	updated by the	0.00	60.0
51. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54 enter zero. (see instructions)	sser of 50% of	the amount by	which operati	ng costs (line	0	61. (
2. 00	Relief payment (see instructions)					0	62.
3. 00	Allowable Inpatient cost plus incentive pay	ment (see instr	uctions)			0	63.0
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of th	e cost report	ting period (See	0	64.0
	instructions)(title XVIII only)	-		·		_	
5.00	Medicare swing-bed SNF inpatient routine co- instructions)(title XVIII only)	sts after Decemb	ber 31 of the	cost reporti	ng period (See	0	65.
6. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66.0
7. 00	CAH, see instructions  Title V or XIX swing-bed NF inpatient routi	ne costs through	h December 31	of the cost i	reporting period	0	67.
	(line 12 x line 19)	_					
8. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after l	December 31 of	the cost rep	porting period	0	68.0
9. 00	Total title V or XIX swing-bed NF inpatient					0	69. (
0.00	PART III - SKILLED NURSING FACILITY, OTHER I				7)		70
0. 00 1. 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service				")		70. 71.
2.00	Program routine service cost (line 9 x line			-/			72.
73.00	Medically necessary private room cost appli	5	•	,			73.
4. 00 5. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient 26, line 45)	•		•	Part II, column		74. 75.
	Per diem capital-related costs (line 75 ÷ l						76.
	Program capital-related costs (line 9 x line						77. 78.
9. 00 9. 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce		provi den inecon	ds)			79.
0.00	Total Program routine service costs for com				nus line 79)		80.
1.00	Inpatient routine service cost per diem lim		• >		•		81.
2.00	Inpatient routine service cost limitation (						82.
3. 00 4. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	115)				83. 84.
	Utilization review - physician compensation		ons)				85.
6.00	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA		hrough 85)				86.

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	pared: 56 am_
		Ti tl	e XIX	Subprovi der  - I PF	Cost	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)	)			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	229, 793	3, 237, 595	0. 07097	76 0	0	90.00
91.00 Nursing Program cost	0	3, 237, 595	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 237, 595	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 237, 595	0. 00000	00	0	93.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0061	Peri od:	Worksheet D-1
	Component CCN: 15-T061	From 01/01/2022 To 12/31/2022	Date/Time Prepared: 6/12/2023 11:56 am
	Title XIX	Subprovi der -	Cost

			I RF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 400 1, 400	1. 00 2. 00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed da		ivate room days	1, 400	3.00
0.00	do not complete this line.	ye, yeu nave ey p.	. varo i com dayo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation b			1, 400	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through Dosombor	21 of the cost	0	7. 00
7.00	reporting period	iii days) trii odgir beceiiber	31 Of the Cost	O	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	0	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		oom days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar y			0	44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 815	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			66	
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 o	t the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	3 thi ough becember 31 of	the cost	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	he cost	0. 00	20. 00
21.00	Total general inpatient routine service cost (see instruction	s)		1, 691, 873	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	a period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 691, 873	
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				00.00
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	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	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li		=/	0.00	35.00
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 di	fferential (line		
200	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		Ţ	1 200 40	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 208. 48 0	38. 00 39. 00
	Medically necessary private room cost applicable to the Progr	•		0	40.00
	Total Program general inpatient routine service cost (line 39			0	
00	1.2.2 23. a.m. 35.15. a			O	

COMPUTA	Financial Systems ATION OF INPATIENT OPERATING COST	DAVIESS COMMUN		CN: 15-0061	Peri od:	u of Form CMS-2 Worksheet D-1	
			Component	CCN: 15-T061	From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	
			Ti tl	e XIX	Subprovi der -	Cost	30 dii
	Cost Center Description	Total I npati ent	Total I npati ent	Average Per Diem (col.	0	Program Cost (col. 3 x	
		1.00	Days 2.00	÷ col. 2)	4. 00	col . 4) 5.00	
	NURSERY (title V & XIX only)	0					42.0
	Intensive Care Type Inpatient Hospital Unit				00		40.6
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(	0.	00 0	0	43.0
	BURN INTENSIVE CARE UNIT						45.0
	SURGICAL INTENSIVE CARE UNIT						46.0
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (W	kst. D-3, col.	3, line 200)			0	
	Program inpatient cellular therapy acquisit				D, column 1)	0	
19.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	JI)(see Instru	CTI ONS)		0	49.0
50.00	Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D, sı	um of Parts I and	0	50.0
	111)						
51. 00	Pass through costs applicable to Program in and IV)	patient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	0	51.0
52. 00	Total Program excludable cost (sum of lines					0	1 .
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		elated, non-ph	ysician anest	thetist, and	0	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
	Program di scharges					0	1
5. 00 5. 01	Target amount per discharge Permanent adjustment amount per discharge					0.00	55. 55.
	Adjustment amount per discharge (contractor	use onl v)				0.00	
	Target amount (line 54 x sum of lines 55, 5		)			0	1
	Difference between adjusted inpatient opera	ting cost and to	arget amount (	line 56 minus	s line 53)	0	1 -
8. 00 9. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	m the cost ren	orting period	d anding 1006	0.00	
77. 00	updated and compounded by the market basket		ii the cost rep	or tring period	a charing 1770,	0.00	] 37.
0.00	Expected costs (lesser of line 53 ÷ line 54	, or line 55 fro	om prior year	cost report,	updated by the	0.00	60.
51. 00	market basket) Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54	sser of 50% of	the amount by	which operati	ng costs (line	0	61. (
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. (
3. 00	Allowable Inpatient cost plus incentive pay	ment (see instr	uctions)			0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Dec	ember 31 of th	e cost report	ting period (See	0	64.0
	instructions)(title XVIII only)	-		·			
5.00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts after Decemi	per 31 of the	cost reporti	ng perioa (See	0	65.
6. 00	Total Medicare swing-bed SNF inpatient rout CAH, see instructions	ine costs (line	64 plus line	65)(title XVI	II only); for	0	66.
7. 00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	h December 31	of the cost i	reporting period	О	67.
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after l	December 31 of	the cost rep	porting period	0	68. (
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. (
	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci				7)		70.
	Adjusted general inpatient routine service						70.
2. 00	Program routine service cost (line 9 x line	71)		•			72.
3. 00   4. 00	Medically necessary private room cost appli Total Program general inpatient routine ser	9	•	,			73. 74.
75.00	Capital-related cost allocated to inpatient	•		•	Part II, column		75.
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76.
7. 00	Program capital -related costs (line 9 x lin						77.
	Inpatient routine service cost (line 74 min		nend deservice	do)			78.
9. 00 0. 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)		79. 80.
	Inpatient routine service costs for com	•	Jose Timi tati U	(11110 70 1111			81.
2. 00	Inpatient routine service cost limitation (	line 9 x line 8					82.
	Reasonable inpatient routine service costs	•	ns)				83.
	Program inpatient ancillary services (see i Utilization review - physician compensation		ons)				84. 85.
	. ,	•					86.
	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA:		iii ougii oo)				

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2022 To 12/31/2022		pared: 56 am_
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	: line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	ee instructions	)			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		,		(from line	(col. 3 x	
				89)	col. 4) (see	
				· ·	instructions)	
	1. 00	2.00	3. 00	4.00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	162, 909	1, 691, 873	0. 09628	39 0	0	90.00
91.00 Nursing Program cost	0	1, 691, 873	0.00000	00	0	91.00
92.00 Allied health cost	0	1, 691, 873	0. 00000	00	0	92.00
93.00 All other Medical Education	0	1, 691, 873		00	0	93. 00
•		•		•	'	

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre 6/12/2023 11:	pared:
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			636, 364		30.00
31. 00	03100 INTENSIVE CARE UNIT			754, 305		31.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 36524		131, 092	
51.00	05100 RECOVERY ROOM		0.00000		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1. 42974		6, 062	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 10920		126, 077	54.00
56.00	05600 RADI OI SOTOPE		0. 21136		41, 206	
60.00	06000 LABORATORY		0. 18947		306, 326	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 04198		3, 805	
64.00	06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65.00	06500 RESPIRATORY THERAPY		0. 22335		183, 603	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY		0. 50585		46, 414	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		0. 31924	·	11, 579	
68. 00 69. 00	06900 ELECTROCARDI OLOGY		0. 51801		9, 607	68. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 16067 0. 32570		12, 707 171, 038	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 32570	·	36, 831	72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 41033		263, 303	
76.00	03020 CARDI AC REHAB		0. 32280		203, 303	
76. 01	03030 ADDI CTI ON SERVI CES		6. 69166		0	
70.01	OUTPATIENT SERVICE COST CENTERS		0.07100	0	0	70.01
88. 00	08800 RURAL HEALTH CLINIC		0.00000	10	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		0.00000		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III		0.00000		0	88. 02
88. 03	08805 RURAL HEALTH CLINIC IV		0.00000		0	88. 03
88. 04	08803 RURAL HEALTH CLINIC V		0. 00000		0	88. 04
88. 05	08804 RURAL HEALTH CLINIC VI		0. 00000		Ö	88. 05
90.00	09000 CLI NI C		0. 64011		0	90.00
90. 01	09001 ONCOLOGY		0. 57910		1, 540	90. 01
90. 02	09002 PAIN MANAGEMENT		0.00000		0	90.02
91.00	09100 EMERGENCY		0. 33745		294, 206	
02 00	OOGOO ORCEDVATION REDC (MON DICTINCT DART		0 20047	171 257	44 010	

0. 390471

1. 561702

171, 357

6, 944, 308

6, 944, 308

122

92.00

93.00

95.00

201. 00 202. 00

66, 910

191

1, 712, 642 200. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE OTHER REIMBURSABLE COST CENTERS

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

95. 00 09500 AMBULANCE SERVICES

200.00

201.00 202. 00

	Financial Systems DAVIESS ( ENT ANCILLARY SERVICE COST APPORTIONMENT	COMMUNITY HOSPITAL Provider C	CN: 15-0061	Peri od:	eu of Form CMS- Worksheet D-3	
		Component	CCN: 15-S061	From 01/01/202 To 12/31/202	2 2 Date/Time Pre 6/12/2023 11:	
		Title	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	· ·	Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS					30.
1.00	03100 I NTENSI VE CARE UNI T			4 745 (0		31.
	04000 SUBPROVI DER - I PF			4, 715, 60	3	40.
	04100 SUBPROVI DER - I RF					41.
3. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.
0.00	05000 OPERATING ROOM		0. 3652	44	ol o	50.
1. 00	05100 RECOVERY ROOM		0. 0000			
	05200 DELIVERY ROOM & LABOR ROOM		1. 4297		ol ö	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1092			
6. 00	05600 RADI OI SOTOPE		0. 2113			
0.00	06000 LABORATORY		0. 1894			
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 0419		0 0	
4. 00	06400 I NTRAVENOUS THERAPY		0.0000		ol o	
5. 00	06500 RESPIRATORY THERAPY		0. 2233		4 63, 390	65.
6. 00	06600 PHYSI CAL THERAPY		0. 5058	57, 88	1 29, 280	66.
7. 00	06700 OCCUPATI ONAL THERAPY		0. 3192	40 5, 57	1 1, 778	67.
8. 00	06800 SPEECH PATHOLOGY		0. 5180	12 18, 36	3 9, 512	68.
9. 00	06900 ELECTROCARDI OLOGY		0. 1606	72 33, 12	3 5, 322	69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3257	01 81, 36	0 26, 499	71.
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4105		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 3228			
	03020 CARDI AC REHAB		0. 4460		0	
5. 01	03030 ADDI CTI ON SERVI CES		6. 6916	61	0 0	76.
0.00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC		0.0000	00	1 0	
8. 00 8. 01	08801 RURAL HEALTH CLINIC		0. 0000 0. 0000			
	08802 RURAL HEALTH CLINIC III		0.0000			
8. 03	08805 RURAL HEALTH CLINIC IV		0.0000			
8. 04	08803 RURAL HEALTH CLINIC V		0.0000			
	08804 RURAL HEALTH CLINIC VI		0.0000			
0. 00	09000 CLI NI C		0. 6401		ol ö	
0. 01	09001 ONCOLOGY		0. 5791		ol ö	
	09002 PAIN MANAGEMENT		0.0000		ol o	
	09100 EMERGENCY		0. 3374			
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3904		0 0	1
3. 00	04040 OTHER OUTPATIENT SERVICE COST CENTE		1. 5617	02	0 0	93.
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95.
00.00		h 98)		2, 452, 93	8 650, 821	1
01.00		y charges (line 61)	1		0	201.
02.00	Net charges (line 200 minus line 201)		1	2, 452, 93	QΙ	202.

	Financial Systems DAVIESS COMMI ENT ANCILLARY SERVICE COST APPORTIONMENT	UNITY HOSPITAL  Provider C	CN: 15-0061	Peri od:	u of Form CMS-: Worksheet D-3	
		Component	CCN: 15-T061	From 01/01/2022 To 12/31/2022		
		Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
	INDATIENT DOUTINE CEDVICE COCT CENTEDS		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000 ADULTS & PEDIATRICS		I			30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
	04000 SUBPROVI DER - I PF					40.00
41. 00	04100 SUBPROVI DER - I RF			1, 516, 918		41.00
	04300 NURSERY			1, 2.2,		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 3652	44 29, 272	10, 691	50.00
51.00	05100 RECOVERY ROOM		0.00000			
	05200 DELIVERY ROOM & LABOR ROOM		1. 4297		1	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 10920		8, 807	
56.00	05600 RADI OI SOTOPE		0. 2113			
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.		0. 1894 0. 04198			
64. 00	06400   NTRAVENOUS THERAPY		0.0000		0	
65.00	06500 RESPI RATORY THERAPY		0. 2233!		<b>l</b>	
66. 00	06600 PHYSI CAL THERAPY		0. 5058		202, 334	
67.00	06700 OCCUPATI ONAL THERAPY		0. 3192		147, 746	
68.00	06800 SPEECH PATHOLOGY		0. 5180°	12 59, 771	30, 962	68.00
	06900 ELECTROCARDI OLOGY		0. 1606	72 4, 499	723	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 32570	· ·	41, 458	
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4105			
	07300 DRUGS CHARGED TO PATIENTS		0. 3228	· ·		
	03020 CARDI AC REHAB		0. 4460		1	
76.01	O3O3O ADDI CTI ON SERVI CES OUTPATI ENT SERVI CE COST CENTERS		6. 6916	61 0	0	76. 01
88. 00	08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II		0. 00000		l ő	
	08802 RURAL HEALTH CLINIC III		0.0000		0	
88. 03	08805 RURAL HEALTH CLINIC IV		0. 00000		0	88. 03
88. 04	08803 RURAL HEALTH CLINIC V		0.0000	00	0	88. 04
88. 05	08804 RURAL HEALTH CLINIC VI		0.0000	00	0	88. 05
90.00	09000 CLI NI C		0. 6401		0	
90. 01	09001 ONCOLOGY		0. 57910		· -	
	09002 PAI N MANAGEMENT		0.0000		1	
91. 00 92. 00	09100 EMERGENCY		0. 3374! 0. 3904		19, 974 0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART 04040 OTHER OUTPATIENT SERVICE COST CENTE		1. 56170			
73. UU	OTHER REIMBURSABLE COST CENTERS		1. 30170	UZ <sub>1</sub> U	<u> </u>	J 73.00
95. 00	09500 AMBULANCE SERVICES		1			95.00
200.00	l l	)		2, 004, 787	651, 469	
201.00		arges (line 61)		0		201.00
202.00		- , ,	1	2, 004, 787		202.00

Heal th	Financial Systems	DAVIESS COMMUNITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (	CCN: 15-0061	Peri od:	Worksheet D-3	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	
		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			156, 300		30.00
	03100   NTENSI VE CARE UNI T 04000   SUBPROVI DER -   PF			110, 114		31.00
40. 00 41. 00	04100 SUBPROVI DER - TPF			366, 691 127, 515		40.00
				55, 170		43.00
43.00	ANCILLARY SERVICE COST CENTERS			33, 170		1 43.00
50.00	05000 OPERATING ROOM		0. 36524	14 103, 897	37, 948	50.00
51.00	05100 RECOVERY ROOM		0.00000	00	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1. 42974	49, 034	70, 106	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 10920	163, 702	17, 877	54.00
56. 00	05600  RADI 0I SOTOPE		0. 21136	· ·	5, 770	1
60.00	06000 LABORATORY		0. 1894	· ·	58, 769	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 04198	· ·	852	1
64.00	06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 22335 0. 50585		42, 894 25, 295	
67.00	06700 OCCUPATI ONAL THERAPY		0. 31924		25, 295 14, 182	1
			0. 5180		6, 659	1
69. 00	06900 ELECTROCARDI OLOGY		0. 1606		2, 111	
			0. 32570		45, 668	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 41053	· ·	2, 840	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 32286		76, 742	73.00
76.00	03020 CARDI AC REHAB		0. 4460	78 21	9	76.00
76. 01	03030 ADDICTION SERVICES		6. 69166	51 204	1, 365	76. 01
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		1. 2080		0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		1. 4043		0	
88. 02	08802 RURAL HEALTH CLINIC III		0. 79432		0	88. 02
88. 03	08805 RURAL HEALTH CLINIC IV		0.00000		0	
88. 04	08803 RURAL HEALTH CLINIC V		1. 26902		-6, 925	1
88. 05 90. 00	08804 RURAL HEALTH CLINIC VI 09000 CLINIC		1. 12802 0. 6401		0	88. 05 90. 00
90.00	09000 CET NI C		0. 6401		120	
90.01	00000 DALN MANACEMENT		0.57710		120	

0.000000

0. 337458

0. 390471

1. 561702

133, 215

1, 522, 893

1, 522, 893

23, 212

-182

0

44, 954

9,064

-284

456, 016 200. 00 201. 00 202. 00

0

90.02

91.00

92.00

93.00

95.00

90. 02 09002 PAIN MANAGEMENT

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

04040 OTHER OUTPATIENT SERVICE COST CENTE OTHER REIMBURSABLE COST CENTERS

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

91.00

93.00

200.00

201.00 202.00

	nancial Systems DAVIESS COMM ANCILLARY SERVICE COST APPORTIONMENT	MUNITY HOSPITAL  Provider C	CN: 15-0061	Peri od:	u of Form CMS-2 Worksheet D-3	
			CCN: 15-S061	From 01/01/2022 To 12/31/2022		enared:
-		<u>'</u>			6/12/2023 11:	
		Ti tl	e XIX	Subprovi der  - I PF	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
	<b>'</b>		To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1.00	0.00	col . 2)	
I ND	PATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	DOO ADULTS & PEDIATRICS		I			30.00
	100 INTENSIVE CARE UNIT					31.00
	000 SUBPROVI DER - I PF			248, 344		40.00
41.00 041	100 SUBPROVI DER - I RF					41.00
	300 NURSERY					43.00
	CILLARY SERVICE COST CENTERS					1
	OOO OPERATI NG ROOM		0. 36524			
	IOO RECOVERY ROOM		0.00000		1	
	200 DELIVERY ROOM & LABOR ROOM		1. 42974			
	100  RADI OLOGY-DI AGNOSTI C 500  RADI OI SOTOPE		0. 10920 0. 21130		85	1
	000 LABORATORY		0. 1894		5, 051	
	BOO BLOOD STORING, PROCESSING & TRANS.		0. 04198			
	100 I NTRAVENOUS THERAPY		0. 00000		o o	
	500 RESPI RATORY THERAPY		0. 2233!		3, 826	65.00
66. 00 066	600 PHYSI CAL THERAPY		0. 5058	59 2, 516	1, 273	66.00
	700 OCCUPATIONAL THERAPY		0. 31924		86	
	BOO SPEECH PATHOLOGY		0. 5180		487	
	900 ELECTROCARDI OLOGY		0. 1606	· ·	•	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 32570		l .	
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS		0. 41053 0. 32286		1	
	D20 CARDI AC REHAB		0. 32260			1
	030 ADDICTION SERVICES		6. 69166		1	
	TPATIENT SERVICE COST CENTERS		0.07100	511 0		70.01
	300 RURAL HEALTH CLINIC		1. 2080	56 0	0	88. 00
88. 01 088	BO1 RURAL HEALTH CLINIC II		1. 4043	51 0	0	88. 01
	302 RURAL HEALTH CLINIC III		0. 79432			
	305 RURAL HEALTH CLINIC IV		0. 00000			
	303 RURAL HEALTH CLINIC V		1. 26902		1	
	804 RURAL HEALTH CLINIC VI		1. 12802			
	000  CLI NI C 001  0NC0L0GY		0. 6401° 0. 57910			
4	DOZ PALN MANAGEMENT		0.0000			
	100 EMERGENCY		0. 3374		5, 697	
	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3904		0,077	1
	040 OTHER OUTPATIENT SERVICE COST CENTE		1. 56170			1
	HER REIMBURSABLE COST CENTERS					
[0111	TOO AMBUU ANCE CERVI CEC					95.00
95. 00 095	500 AMBULANCE SERVICES				l	
95. 00 095 200. 00	Total (sum of lines 50 through 94 and 96 through 98	3)		117, 854	31, 593	200.00
95. 00 095		8) harges (line 61)		117, 854 0 117, 854	·	

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 6/12/2023 11:56 am

	1	Γitle XVIII	Hospi tal	6/12/2023 11: PPS	<u>56 am</u>
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring pri instructions)	or to October 1 (	(see	0 1, 920, 401	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on instructions)	or after October	1 (see	538, 896	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for disc 1 (see instructions)	0		0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for disc October 1 (see instructions)	harges occurring	on or after	0	1.04
2. 00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see in			0	2. 03
2. 04 3. 00	Outlier payments for discharges occurring on or after October 1 (see Managed Care Simulated Payments	ŕ		0 1, 041, 457	3.00
4. 00	Bed days available divided by number of days in the cost reporting p Indirect Medical Education Adjustment			37. 60	
5. 00	FTE count for allopathic and osteopathic programs for the most recen or before 12/31/1996. (see instructions)				
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 202 FTE count for allopathic and osteopathic programs that meet the crit new programs in accordance with 42 CFR 413.79(e)			0.00	5. 01 6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-buil the CAA 2021 (see instructions)	ding window close	ed under §127 of	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 4 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR cost report straddles July 1, 2011 then see instructions.			0. 00 0. 00	7. 00 7. 01
7. 02	Adjustment (increase or decrease) to the hospital's rural track prog track programs with a rural track for Medicare GME affiliated progra and 87 FR 49075 (August 10, 2022) (see instructions)			0. 00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic an affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2 1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots und report straddles July 1, 2011, see instructions.	er § 5503 of the	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots frounder § 5506 of ACA. (see instructions)	m a closed teachi	ng hospi tal	0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots und instructions) $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$		,	0. 00	
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (se	e instructions)		0.00	
11. 00	FTE count for allopathic and osteopathic programs in the current yea FTE count for residents in dental and podiatric programs.	r from your recor	rds		11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.				12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ende otherwise enter zero.	d on or after Sep	otember 30, 1997,	0. 00	14.00
	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instru	ctions)			15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count			0. 00 0. 00	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)  IME payment adjustment (see instructions)			0.000000	1
22. 01	IME payment adjustment - Managed Care (see instructions)			0	
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the Number of additional allopathic and osteopathic IME FTE resident cap		CFR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C).  IME FTE Resident Count Over Cap (see instructions)	£ 11 20 11	24 (	0.00	1
25. 00	If the amount on line 24 is greater than -0-, then enter the lower o instructions)	Tilne 23 or line	e 24 (see	0.00	
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
	IME add-on adjustment amount (see instructions)			0	28. 00
	IME add-on adjustment amount - Managed Care (see instructions)			0	•
29. 00 29. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed tree (sum of lines 22.01 and 28.01)			0	29. 00 29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient	days (see instruc	ctions)	2. 63	30.00
31.00	Percentage of Medicaid patient days (see instructions)			30. 58	
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			33. 21 12. 00	32. 00 33. 00
	printendario di apriopor ti onato andi o percentage (acc i ilati dottolia)			12.00	

	Financial Systems DAVIESS COMMUNI ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061	Peri od: From 01/01/2022 To 12/31/2022	w of Form CMS-2 Worksheet E Part A Date/Time Pre 6/12/2023 11:	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
34. 00	Disproportionate share adjustment (see instructions)		D 1 10/1	73, 779	34.00
			Pri or to 10/1 1.00	2.00	
	Uncompensated Care Payment Adjustment				
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		7, 192, 008, 710 0. 000054055	6, 874, 403, 459 0. 000066664	
35. 02	Hospital UCP, including supplemental UCP (If line 34 is zer	o, enter zero on this line		458, 274	
35. 03	(see instructions) Pro rata share of the hospital UCP, including supplemental	IICD (soo instructions)	290, 773	115, 510	35. 03
	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	,	406, 283	115, 510	36.00
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throu			
40. 00 41. 00	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0		40.00
41. 01	Total ESRD Medicare covered and paid discharges (see instru	ctions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qua	lify for adjustment)	0.00		42.00
43. 00 44. 00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0. 000000		43. 00 44. 00
	days)	`			45.00
45. 00 46. 00	Average weekly cost for dialysis treatments (see instructio Total additional payment (line 45 times line 44 times line	•	0.00		45. 00 46. 00
47. 00	Subtotal (see instructions)		2, 939, 359		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	0		48. 00
	only. (see Tristructions)			Amount	
				1. 00	
49. 00 50. 00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L. Pt. I.		,	2, 939, 359 181, 302	1
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	52.00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 33, 574	53. 00 54. 00
54. 01	Islet isolation add-on payment			0	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	1
55. 01 56. 00	Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see in	tructions)		0	55. 01 56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30 f	through 35).	0	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58)	. IV, col. 11 line 200)		2 154 225	58. 00 59. 00
60.00	,			3, 154, 235 0	60.00
61. 00	Total amount payable for program beneficiaries (line 59 min	us line 60)		3, 154, 235	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			382, 128 12, 059	
	Allowable bad debts (see instructions)			41, 939	
65. 00	, ,			27, 260	
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)	structi ons)		14, 850 2, 787, 308	
68. 00	Credits received from manufacturers for replaced devices fo	r applicable to MS-DRGs (s	see instructions)	2, 767, 306	
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96	11	1	0	69.00
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon	stration) adjustment (see	instructions)	0	70.00
70. 75	N95 respirator payment adjustment amount (see instructions)		THISTI UCTIONS)	0	70. 30
70. 87	Demonstration payment adjustment amount before sequestration	n		0	70. 87
70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in			0	70.88 70.89
	HSP bonus payment HVBP adjustment amount (see instructions)	ati ucti uliaj		0	
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
	Bundled Model 1 discount amount (see instructions)			0	
70. 92	UVPD paymont adjustment amount (see instructions)			^	
70. 92 70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0 -606	1

Heal th Financial Systems DAVIESS COMMUNI		ON 45 00/4		u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	UN: 15-0061	Peri od: From 01/01/2022		
			To 12/31/2022	Date/Time Pre 6/12/2023 11:	
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
70 0/ Law and the state of fortunal file and the state of fort			0	1. 00	70.07
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1			2022	451, 882	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter	in column 0		2023	170, 783	70. 97
the corresponding federal year for the period ending on or	after 10/1)			0	70.00
70.98 Low Volume Payment-3 70.99 HAC adjustment amount (see instructions)				0 27, 889	
71.00 Amount due provider (line 67 minus lines 68 plus/minus line	es 69 & 70)			3, 381, 478	
71.01 Sequestration adjustment (see instructions)	,5 07 u 70)			42, 607	•
71.02 Demonstration payment adjustment amount after sequestration	1			0	•
71.03   Sequestration adjustment-PARHM or CHART pass-throughs					71.03
72.00 Interim payments				3, 073, 866	72.00
72.01   Interim payments-PARHM or CHART					72. 01
73.00 Tentative settlement (for contractor use only)				0	
73.01 Tentative settlement-PARHM or CHART (for contractor use on					73. 01
74.00 Balance due provider/program (line 71 minus lines 71.01, 71 73)	. 02, 72, and			265, 005	74.00
74.01 Balance due provider/program-PARHM or CHART (see instruction	ons)				74. 01
75.00 Protested amounts (nonallowable cost report items) in accor	dance with			0	75. 00
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				0	00.00
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or su plus 2.04 (see instructions)	IM OT 2.03			0	90.00
91.00   Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see ins	structions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instr	,			Ö	93.00
94.00 The rate used to calculate the time value of money (see ins				0. 00	
95.00 Time value of money for operating expenses (see instruction				0	95.00
96.00 Time value of money for capital related expenses (see instr	ructions)			0	96.00
			Prior to 10/1		
HSP Bonus Payment Amount			1. 00	2. 00	
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment				J	100.00
101.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.00
					102.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructi	ons)		0		
	ons)		0	- O	
102.00 HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions)	,		0.0000	0. 0000	103. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions)	ons)			0. 0000	
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demon	ons) stration) Adju		0. 0000	0. 0000 0	103. 00 104. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) 200.00 Is this the first year of the current 5-year demonstration	ons) stration) Adju		0. 0000	0. 0000 0	103. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonstration Century Cures Act? Enter "Y" for yes or "N" for no.	ons) stration) Adju		0. 0000	0. 0000 0	103. 00 104. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ons) estration) Adju period under		0. 0000	0.0000	103. 00 104. 00 200. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I	ons) estration) Adju period under		0. 0000	0.0000	103. 00 104. 00 200. 00 201. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I 202.00 Medicare discharges (see instructions)	ons) estration) Adju period under		0. 0000	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A)	ons) istration) Adju period under ine 49)	the 21st	0.0000	0.0000	103. 00 104. 00 200. 00 201. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demon 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period)	ons) istration) Adju period under ine 49)	the 21st	0.0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demon 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 204.00 Medicare target amount	ons) istration) Adju period under ine 49)	the 21st	0.0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Cost in this the first year of the current 5-year demonstration Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204)	ine 49)	the 21st	0.0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonstration Contury Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 206)	ine 49)	the 21st	0.0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Community Rural Community Hospital Demonstration Project (§410A Demonstration Community Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I Rural Community Rural Rural Rural Community Rural Rural Community Rural	ine 49) in first year	the 21st	0.0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonstration (See instructions) Program reimbursement Under HSP Bonus Payment (See instructions) Program Project (§410A Demonstration Project (§4	ine 49) in first year	the 21st	0.0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration (§410A Demonstration (§410A Demonstration Program reimbursement Under He §410A Demonstration (\$410A Demonstration (\$410A Demonstration Project Part A Inpatient Project (§410A Demonstration (\$410A Demonstration Project (§410A Demonstration P	ine 49) in first year	the 21st	0.0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonstration Project P	ine 49) in first year	the 21st	0.0000	0. 0000 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00

211. 00

212. 00 213. 00 218. 00

211.00 Total adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

Comparision of PPS versus Cost Reimbursement

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

213.00 Low-volume adjustment (see instructions)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2022 Part A Exhi bit 4 To 12/31/2022 Date/Time Prepared: 6/12/2023 11:56 am Provider CCN: 15-0061

					10	7 12/31/2022	6/12/2023 11:	
	,				XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After	Total (Col 2 through 4)	
		Title	E, Part A)	EIITI ti eilleiit	10 10/01	10/01	tili ough 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
4 04	payments	4.04	4 000 404		4 000 404		4 000 404	4 04
1. 01	DRG amounts other than outlier payments for discharges	1. 01	1, 920, 401	0	1, 920, 401		1, 920, 401	1. 01
	occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	538, 896	0		538, 896	538, 896	1. 02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	0	0	0		0	1.03
	operating payment for Model 4							
	BPCI occurring prior to							
1. 04	October 1 DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.01	operating payment for Model 4	1.01	Ö	J		Ö		1.01
	BPCI occurring on or after							
2. 00	October 1 Outlier payments for	2. 00						2.00
2.00	discharges (see instructions)	2.00						2.00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
2 02	discharges for Model 4 BPCI	2.02	0	0	0			2 02
2. 02	Outlier payments for discharges occurring prior to	2. 03	0	0	0		0	2. 02
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	0	0		0	0	2. 03
	discharges occurring on or after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	0	0	0	0	0	3.00
4 00	reconciliation	2.00	1 041 457	0	(22.045	440 540	1 041 457	4 00
4. 00	Managed care simulated payments	3. 00	1, 041, 457	0	622, 945	418, 512	1, 041, 457	4.00
	Indirect Medical Education Adj	ustment			L			
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
0.00	instructions)	22.00	O	J	J	O	0	0.00
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see instructions)							
	Indirect Medical Education Adj	ustment for the	e Add-on for Se	ection 422 of 1	the MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0.000000	0. 000000		7.00
0.00	(see instructions)	00.00			0			0.00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
	for managed care (see							
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
7. 00	lines 6 and 8)	27.00	O	J	J	O	0	7.00
9. 01	Total IME payment for managed	29. 01	0	0	0	o	0	9. 01
	care (sum of lines 6.01 and 8.01)							
	Disproportionate Share Adjustm	ent			L.			
10.00	Allowable disproportionate	33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10.00
	share percentage (see							
11. 00	instructions) Disproportionate share	34. 00	73, 779	0	57, 612	16, 167	73 779	11.00
	adjustment (see instructions)	01.00	, 6, , , ,	J	07,012	.0, .0,		
11. 01	Uncompensated care payments	36.00	406, 283	0	290, 773	115, 510	406, 283	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment	rcentage of ESI 46.00	עט beneficiary	di scharges 0	0	O	0	12.00
12.00	(see instructions)	40.00		U	U			12.00
13. 00	Subtotal (see instructions)	47. 00	2, 939, 359	0	2, 268, 786	670, 573	2, 939, 359	
14.00	Hospital specific payments	48. 00	0	0	0	0	0	14.00
	(completed by SCH and MDH, small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	2, 939, 359	0	2, 268, 786	670, 573	2, 939, 359	15.00
	operating costs (see instructions)							
	THE HUCH OHS)				ı	'	ı	ı

					-	-rom 01/01/2022 Го 12/31/2022	6/12/2023 11:56 ar		
				Title	XVIII	Hospi tal	PPS		
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)		
		0	1. 00	2. 00	3.00	4. 00	5. 00		
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	181, 302	0	-39, 520	220, 822	181, 302	16.00	
17. 00 17. 01	Special add-on payments for new technologies Net organ aquisition cost	54. 00	33, 574	0	33, 57	1 O	33, 574	17. 00 17. 01	
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	(	0	0		
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0	0		
19. 00	SUBTOTAL			0	2, 262, 840	891, 395	3, 154, 235	19.00	
		W/S L, line	(Amounts from L)						
		0	1. 00	2. 00	3.00	4. 00	5. 00		
20. 00	Capital DRG other than outlier	1. 00	181, 302	0			181, 302	20.00	
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0		0	0	20. 01	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	0	0		0	0	21. 00 21. 01	
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0.0000		22. 00	
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0			0		
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.00	
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	(	0	0	25. 00	
26. 00	Total prospective capital payments (see instructions)	12. 00	181, 302	0	-39, 520	220, 822	181, 302	26. 00	
		W/S E, Part A	(Amounts to						
		line	E, Part A)						
07.00		0	1. 00	2. 00	3.00	4.00	5. 00	07.00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 19969 451, 88		451, 882	27. 00 28. 00	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				170, 783	170, 783	29. 00	
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00	

Provider CCN: 15-0061

Peri od:

From 01/01/2022

12/31/2022

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 6/12/2023 11:56 am Hospi tal Title XVIII Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 1, 920, 401 1, 920, 401 1, 920, 401 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 538.896 538, 896 538, 896 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 2.02 2.02 Outlier payments for discharges occurring 2.03 0 0 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 2.03 0 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 1, 041, 457 622, 945 418, 512 1, 041, 457 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 0 6.00 0 6.01 IME payment adjustment for managed care (see 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 0 8.00 0 IME payment adjustment add on for managed 0 28 01 r 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 9.00 0 Total IME payment for managed care (sum of 9.01 29.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 10.00 Allowable disproportionate share percentage 33.00 0.1200 0.1200 0.1200 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 73, 779 57, 612 16, 167 73, 779 11.00 instructions) Uncompensa<u>ted care payments</u> 11.01 36 00 406, 283 290, 774 115, 510 406, 284 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 46.00 12.00 instructions) 47.00 13.00 Subtotal (see instructions) 2, 939, 359 2, 268, 786 670, 573 2, 939, 359 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15 00 49 00 2 939 359 2 268 786 670 573 2, 939, 359 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 181, 302 -39, 520 220, 822 181, 302 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 33, 574 33, 574 33, 574 17.00 0 Net organ acquisition cost 17.01 17.01 17.02 Credits received from manufacturers for 68.00 0 Λ 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 19.00 SUBTOTAL 891, 395 3, 154, 235 19.00 2, 262, 840

World Street A. Corton	DAVI ECC. COMMUN	U.T.V. 1100D1.TA1			S F ONG	2550 40
Health Financial Systems HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUI	DAVIESS COMMUN ATION EXHIBIT 5	Provider CO	F	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	t 5 pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1. 00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1. 00	181, 302	-39, 520	220, 822	181, 302	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	0	(	0	0	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	(	0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0. 0000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0	(	0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	181, 302	-39, 520	220, 822	181, 302	26. 00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
	0	1.00	2.00	3.00	4. 00	
27. 00						27.00
28.00 Low volume adjustment prior to October 1	70. 96	451, 882	451, 882	2	451, 882	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	170, 783		170, 783	170, 783	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	0	(	0	0	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(	0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-606	-39	-215	-606	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
					(Am+ +a	

0 70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

1.00

Ν

(Amt. to Wkst. E, Pt.

2. 00 27, 143

3.00

A) 4. 00 27, 143

32.00

100.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 6/12/2023 11:56 am

Medical and other services for inbursed under OPPS (see instructions)			Title XVIII	Hospi tal	6/12/2023 11: PPS	50 alli
MART B - MEDICAL AND CHIER HEALTH SENVICES					1 00	
Medical and other services riel abursed under GPS (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
0.000   10PS payments   0.000   3.00		, , , , , , , , , , , , , , , , , , ,				1.00
0.011 in repayment (see Instructions)   18, 954   4.00   0.011 in reconcilitation amount (see Instructions)   0.001   5.00   5		, ,	ons)			1
0.00000   1.0000000   1.00000000   1.0000000   1.0000000   1.0000000   1.0000000   1.00000000   1.00000000   1.00000000   1.000000000   1.0000000000						4.00
Line 2 times line 5						1
2.00   Sum of Ilnes 3, 4, and 4.01, divided by Ilne 6   0.00   7-row is instructions   0.00   7-row   0.00   7-row   0.00   7-row   0.00   0			i ons)			1
1.00   Continued					-	1
0,00   Ancil lary service other pass through costs from West. D. Pt. IV, col. 13. Iline 200   0,00   0,00   11.00   10.00   00   10.						1
1.00   Total cost (sum of lines 1 and 10) (see instructions)		, , , , , , , , , , , , , , , , , , , ,	, col. 13, line 200		0	ł
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   Reasonable charges   S. 400   12.00   Ancillary service charges   S. 400   12.00   13.00   Organ acquisition charges (from Wist. D-4, Pt. 111, col. 4, line 69)   S. 400   13.00   Organ acquisition charges (from Wist. D-4, Pt. 111, col. 4, line 69)   S. 400   13.00   Organ acquisition charges (from Wist. D-4, Pt. 111, col. 4, line 69)   S. 400   13.00   Organ acquisition charges (sum of lines 12 and 13)   S. 400   14.00   Organization charges (sum of lines 12 and 13)   Organization charges (sum of lines 14)   Organization charges (sum of lines 25)   Organization of Charges (sum of lines 26)   Organization charges (sum of lines 26)   Organization charges (sum of lines 26)   Organization charges (sum of lines 27)   Organization charges (sum of lines 27)   Organization charges (sum of lines 28)   Organization charges (sum of lines 27)   Organization charges (sum of lines 28)   Organization charges (sum of lines 28)					-	10.00
Reasonable charges	11. 00				1, 752	11.00
12.00   Ancil lary service charges   5, 408   12.00   10tal reasonable charges (from West, D-4, Pt. III, col. 4, line 69)   5, 408   14.00   10tal reasonable charges (sum of lines 12 and 13)   5, 408   14.00   10tal reasonable charges (sum of lines 12 and 13)   5, 408   14.00   10tal reasonable charges (sum of lines 12 and 13)   5, 408   14.00   10tal reasonable charges (sum of lines 12 and 13)   5, 408   14.00   10tal reasonable charges (sum of lines 12 and 13)   5, 408   14.00   10tal charges (sum of lines 12 and 13)   16.00						
14. 00   Total reasonable charges (sum of lines 12 and 13)	12.00				5, 408	12.00
Customary charges   Cust			e 69)		-	
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00	14.00				5, 408	14.00
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00	15. 00		vment for services on	a charge basis	0	15.00
17. 00					0	16.00
18. 00   Total customary charges (see instructions)   5, 408   18. 00	47.00					47.00
19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   19.00   19.00   18.00   18.00   19.00   18.00   18.00   18.00   18.00   18.00   18.00   19.00   18.00   18.00   18.00   18.00   19.00   18.00   18.00   19.00   18.00   19.00   18.00   19.00   18.00   19.00   18.00   19.00   1						ı
instructions		, , , , , , , , , , , , , , , , , , , ,	if line 18 exceeds li	ne 11) (see		1
Instructions    1,752   21.00   1.0		instructions)		, ,		
21.00   Lesser of cost or charges (see instructions)   0.22.00   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0.22.00   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0.23.00   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0.24.00   Computation of REIMBURSEMENT SETTLEMENT   0.00	20. 00		if line 11 exceeds li	ne 18) (see	0	20.00
22.00   Interns and residents \( \tilde{\text{See} instructions} \)   0   22.00   23.00   23.00   25.00   7   7   7   7   7   7   7   7   7	21 00				1 752	21 00
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   24.00   COMPUTATION OF RET HUBURSEMENT SETTLEMENT						22.00
COMPUTATION OF REIMBURSEMENT SETILEMENT   SETILEMENT   SETILEMENT   SECULUTION   SUbstitution   Seculutible sand coinsurance amounts (for CAH, see instructions)   901, 176   26,00   27.00   Subtotal [(I ines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   901, 176   26,00   27.00   Subtotal [(I ines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   901, 176   26,00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28,00   30.00   Subtotal (sum of lines 27 through 29)   3,760,030   30,300   30.100   Primary payer payments   802   31,300   31.00   Primary payer payments   802   31,300   32.00   Subtotal (line 30 minus line 31)   0   37,759,228   32,00   33.00   Allowable bad debts (see instructions)   80,016   34,00   34.00   Allowable bad debts (see instructions)   80,016   34,00   35.00   Adjusted reimbursable bad debts (see instructions)   52,273   36,00   37.00   Subtotal (see instructions)   38,11,238   37,00   38.00   MSP-LCC reconciliation amount from PS&R   38,11,238   37,00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39,00   39,55   Pioneer ACO demonstration payment adjustment (see instructions)   39,57   39,97   Demonstration payment adjustment amount (see instructions)   39,99   39,99   RECOVERY OF ACCELERATED DEPRECIATION   39,99   40,00   Subtotal (see instructions)   48,022   40,01   40,01   Sequestration adjustment (see instructions)   48,022   40,01   40,02   Demonstration payment adjustment amount after sequestration   40,02   40,03   Sequestration adjustment (for contractors use only)   42,00   41,00   Tentative settlement-PARHM or CHART (for contractor use only)   42,00   43,00   Balance due provider/program (see instructions)   1,00   44,00   Potested amounts (nonality with case instructions)   43,00   44,00   Forested amounts (nonality work)   42,00   45,00   Balance due provider/program (see instructions)   43,00   44,00   Forested amounts	23.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   0.25.00	24. 00				4, 659, 454	24. 00
26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   901,176   26.00	25 00				0	25 00
instructions			24 (for CAH, see instr	ructions)	-	1
28. 00	27. 00		us the sum of lines 22	and 23] (see	3, 760, 030	27. 00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   3, 00   29.00   3, 00   Subtotal (sum of lines 27 through 29)   3, 760, 030   30.00   30.100   Primary payer payments   802   31.00   3.759, 228   32.00   Subtotal (line 30 minus line 31)   3, 759, 228   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   33.00   33.00   Allowable bad debts (see instructions)   80, 016   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   80, 016   34.00   35.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   52, 378   36.00   37.00   Subtotal (see instructions)   38.00   MSP-LCC reconciliation amount from PS&R   38.00   39.00   MSP-LCC reconciliation amount from PS&R   38.00   39.00   MSP-LCC reconciliation amount from PS&R   38.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   99.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97   99.97   Pomonstration payment adjustment amount before sequestration   39.97   99.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.98   39.99   RECOVERY OF ACCELERAFIED DEPRECIATION   39.98   39.99   RECOVERY OF ACCELERAFIED DEPRECIATION   48.02   40.01   49.00	20.00		o FO)		0	20.00
30.00   Subtotal (sum of lines 27 through 29)   3,760,030   30.00   20.00   Primary payer payments   802   31.00   31.00   31.00   Primary payer payments   802   31.00   31.00   32.00   Subtotal (line 30 minus line 31)   3,759,228   32.00   Adjustal E BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   80.016   34.00   35.00   Adjustal end lebts (see instructions)   80,016   34.00   35.00   Adjustal end lebts (see instructions)   52,010   35.00   Adjustal end lebts for dual eligible beneficiaries (see instructions)   52,378   36.00   37.00   Subtotal (see instructions)   52,378   36.00   39.00   39.50   39.50   59.			e 30)		-	1
32.00   Subtotal (ine 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   37.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   80,016   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   52,010   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   52,378   36.00   37.00   Subtotal (see instructions)   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   97.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.97   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.97   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   39.90   39.		, , , , , , , , , , , , , , , , , , ,			3, 760, 030	•
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00						•
33.00   Composite rate ESRD (from Wkst. I - 5, line 11)	32.00		3)		3, 759, 228	32.00
34.00	33. 00		3)		0	33.00
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 NSF respirator payment adjustment amount before sequestration 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Sequestration adjustment (see instructions) 39.99 Sequestration adjustment (see instructions) 39.99 Look of the payment adjustment amount before sequestration 39.99 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 40.03 Sequestration adjustment (see instructions) 40.04 Sequestration adjustment (see instructions) 40.02 Sequestration adjustment (see instructions) 40.02 Sequestration adjustment (see instructions) 40.03 Sequestration adjustment (see instructions) 40.04 Sequestration adjustment (see instructions) 40.02 Sequestration adjustment (see instructions) 40.03 Sequestration adjustment (see instructions) 40.04 Sequestration adjustment (see instructions) 40.02 Sequestration adjustment (see instructions) 40.03 Sequestration adjustment (see instructions) 40.04 Sequestration adjustment (see instructions) 40.05 Sequestration adjustment (see instructions) 40.06 Sequestration adjustment (see instructions) 40.07 Sequestration adjustment amount after sequestration 40.08 Sequestration adjustment amount after sequestration 40.09 Sequestration adjustment amount after sequestration 40.00 Sequestration adjustmen	34.00	Allowable bad debts (see instructions)			80, 016	•
37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 75 N95 respirator payment adjustment amount before sequestration 39. 97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 AU. 00 Subtotal (see instructions) 39. 99 AU. 01 Sequestration adjustment (see instructions) 39. 99 Demonstration payment adjustment amount after sequestration 39. 99 AU. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment (see instructions) 40. 04 Demonstration payment adjustment amount after sequestration 40. 02 Interim payments 41. 00 Interim payments 41. 01 Interim payments-PARHM or CHART 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR		· · · · · · · · · · · · · · · · · · ·	. 12			•
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.51 N95 respirator payment adjustment amount (see instructions) 39.52 Demonstration payment adjustment amount before sequestration 39.97 Demonstration payment adjustment amount before sequestration 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 39.99 Sequestration adjustment (see instructions) 39			ctions)			1
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM or CHART pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM or CHART 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 70 BE COMPLETED BY CONTRACTOR						1
39. 75 39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions)  Demonstration payment adjustment amount before sequestration  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount before sequestration  39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION  Subtotal (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Sequestration adjustment (see instructions)  1 Interim payments  Interim payments  Interim payments-PARHM or CHART Tentative settlement (for contractors use only)  Tentative settlement-PARHM or CHART (for contractor use only)  Balance due provider/program (see instructions)  Balance due provider/program (see instructions)  Balance due provider/program-PARHM (see instructions)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 5115. 2  TO BE COMPLETED BY CONTRACTOR					0	ł
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment amount after sequestration 40. 02 Homonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment (see instructions) 41. 00 Interim payments Interim payments Interim payments-PARHM or CHART 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 44. 00 Frotested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  10 39. 97 39. 98 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 39. 90 39. 99 39. 90 30. 00 39. 90 39. 90 39. 90 39. 90 30. 00 39. 90 39. 90 39. 90 39. 90 30. 00 40. 00 40. 00 40. 00 41. 00 41. 00 41. 00 42. 00 42. 00 42. 00 4						
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39.99 RECOVERY OF ACCELERATED DEPRECIATION  40.00 Subtotal (see instructions)  39.99 Sequestration adjustment (see instructions)  40.01 Demonstration payment adjustment amount after sequestration  40.02 Demonstration adjustment-PARHM or CHART pass-throughs  41.00 Interim payments  41.01 Interim payments-PARHM or CHART  42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM or CHART (for contractor use only)  43.00 Bal ance due provider/program (see instructions)  43.01 Bal ance due provider/program-PARHM (see instructions)  47.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  81.52 TO BE COMPLETED BY CONTRACTOR		, , , , , , , , , , , , , , , , , , , ,				
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM or CHART pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM or CHART 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  TO BE COMPLETED BY CONTRACTOR			d devices (see instruc	ti ons)		39. 98
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM or CHART pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM or CHART 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  TO BE COMPLETED BY CONTRACTOR	39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.02 Demonstration payment adjustment amount after sequestration  40.03 Sequestration adjustment-PARHM or CHART pass-throughs  41.00 Interim payments  41.01 Interim payments-PARHM or CHART  Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM or CHART (for contractor use only)  43.00 Ballance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50 Value of 40.02 Value of 40.03						
40. 03 Sequestration adjustment-PARHM or CHART pass-throughs  Interim payments  Interim payments-PARHM or CHART  Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM or CHART (for contractor use only)  Balance due provider/program (see instructions)  43. 01 Balance due provider/program-PARHM (see instructions)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  10 Silb. 2  10 BE COMPLETED BY CONTRACTOR						
41.00 Interim payments Interim payments-PARHM or CHART 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  TO BE COMPLETED BY CONTRACTOR					0	
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 47.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 00 §115.2  TO BE COMPLETED BY CONTRACTOR					3, 793, 977	41.00
42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{1}{5}115.2\$  TO BE COMPLETED BY CONTRACTOR						l
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  §115.2  TO BE COMPLETED BY CONTRACTOR		· · · · · · · · · · · · · · · · · · ·			0	1
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  §115.2  TO BE COMPLETED BY CONTRACTOR		,			-30, 761	1
§115. 2 TO BE COMPLETED BY CONTRACTOR		Balance due provider/program-PARHM (see instructions)				43. 01
TO BE COMPLETED BY CONTRACTOR	44. 00		e with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00 Original outlier amount (see instructions)	90.00				0	90.00
91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00	91.00	Outlier reconciliation adjustment amount (see instructions)			-	91.00
						•
					-	
3171130	55	1 1				

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pr	epared:
				6/12/2023 11	:56 am_
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

| Period: | Worksheet E-1 | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: 6/12/2023 | 11:56 am

					6/12/2023 11:	56 am
			XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	rt 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, 073, 86	6	3, 793, 977	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER		I		1 0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER			0		3. 01 3. 02
3. 02				0		3. 02
3. 03				0		3.03
3. 05				0		3.04
3.05	Provider to Program			U	- 0	3.05
3. 50	ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51	ADSOSTMENTS TO TROOKAW			Ö	0	3. 51
3. 52				o	0	3. 52
3. 53				o	0	3. 53
3. 54				Ö	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 073, 86	6	3, 793, 977	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider		1	ol		F 01
5. 01 5. 02	TENTATI VE TO PROVI DER			0	0	5. 01 5. 02
5. 02				0		5. 02
5.03	Provider to Program			U <sub>I</sub>	0	5.03
5. 50	TENTATI VE TO PROGRAM		l	ol	0	5. 50
5. 51	TENTATI VE TO TROGIVIM			Ö	0	5. 51
5. 52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
0. ,,	5. 50-5. 98)					0.77
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		265, 00	5	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			o	30, 761	6. 02
7.00	Total Medicare program liability (see instructions)		3, 338, 87	1	3, 763, 216	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor					8.00

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVICES RENDERED	Provi der (	CCN: 15-0061	Peri od:	Worksheet E-1
		C		From 01/01/2022	
		component	CCN: 15-5061	10 12/31/2022	Date/Time Prepared: 6/12/2023 11:56 am
		Titl	e XVIII	Subprovi der -	PPS

		Title XVIII		Subprovi der - I PF	PPS	
		I npati en	t Part A		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, 856, 817	1	0	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		C		0	2.00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER		C	)	0	3.01
3. 02				)	0	3.02
3. 03				)	0	3.03
3. 04			Ċ	)	0	3.04
3. 05			C	)	0	3.05
	Provider to Program			•		1
3.50	ADJUSTMENTS TO PROGRAM		C	)	0	3.50
3. 51			C	)	0	3. 51
3. 52			C	)	0	3. 52
3.53			C	)	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)		C	)	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		2, 856, 817	,	0	4.00
	appropriate) TO BE COMPLETED BY CONTRACTOR					-
5. 00	List separately each tentative settlement payment after				I	5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
- 04	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	
5. 02			(		0	
5. 03	Dravi dan ta Dragnam			)	0	5.03
5. 50	Provider to Program TENTATIVE TO PROGRAM		C	1	0	5. 50
5. 50 5. 51	ILIVIATIVE TO FROURAM					5.50
5. 51					0	
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		19, 508		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		C		0	
7. 00	Total Medicare program liability (see instructions)		2, 876, 325		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financial Systems	DAVIESS COMMUNITY	' HOSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	R SERVICES RENDERED	Provider CCN: 15	-0061	Peri od: From 01/01/2022	Worksheet E-1 Part I
		Component CCN: 1	5-T061	To 12/31/2022	Date/Time Prepared: 6/12/2023 11:56 am
•		T1 11 1000		0 1 1 1	550

				I RF		
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 805, 87		0	
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			0	T 0	3.01
3. 02	ADJUSTIMENTS TO TROVIDER			0		3. 02
3. 03				Ö	0	
3.04				o	0	3. 04
3. 05				0	0	3. 05
0.50	Provider to Program				1	
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0	0 0	
3. 52				0		3.52
3. 53				o	o o	
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)				_	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 805, 87	6	0	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR				1	
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5.01
5. 02	TENTATI VE TO TROVIDER			0		
5. 03				Ö	0	
	Provider to Program			_		
5. 50	TENTATIVE TO PROGRAM			0	0	
5. 51 5. 52				0	0 0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
3. 77	5. 50-5. 98)					3. 77
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		34, 33		0	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM  Total Modicaro program Liability (see instructions)		1, 840, 21	0	0	6. 02 7. 00
7.00	Total Medicare program liability (see instructions)		1,040,21	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems	DAVIESS COMMUNITY	/ HOSPITAL	In Lie	u of Form CMS-	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der CCN: 15-0061	Peri od: From 01/01/2022	Worksheet E-	1
				To 12/31/2022		
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTI					
1.00	Total hospital discharges as defined in AAF	RA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	2.00   Medicare days (see instructions)					2.00
3.00	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,					5. 00
6.00	Total hospital charity care charges from Wk	st. 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 (s	see instructions)				8. 00
9.00	9.00   Sequestration adjustment amount (see instructions)					9. 00
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see	e instructions)				30.00
31.00	Other Adjustment (specify)					31.00
32. 00	Balance due provider (line 8 (or line 10) m	ninus line 30 and l	ine 31) (see instruction	ns)		32.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061		Worksheet E-3
		From 01/01/2022	
	Component CCN: 15-S061	To 12/31/2022	Date/Time Prepared:
			6/12/2023 11:56 am
	Title XVIII	Subprovi der -	PPS
		LDE	

	I PF	113	
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	11.00	
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	3, 114, 771	1
00	Net IPF PPS Outlier Payments	7, 456	2
0	Net IPF PPS ECT Payments	0	3
0	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4
	15, 2004. (see instructions)		
1	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
0	New Teaching program adjustment. (see instructions)	0. 00	{
0	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	(
_	teaching program" (see instuctions)	0.00	١.
0	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	7
_	teaching program" (see instuctions)	0.00	١.
0	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	
0 00	Average Daily Census (see instructions)	10. 534247 0. 000000	10
	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.		1
00	Teaching Adjustment (line 1 multiplied by line 10).	2 122 227	12
)O	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	3, 122, 227	ı
)O	Nursing and Allied Health Managed Care payment (see instruction) Organ acquisition (DO NOT USE THIS LINE)	0	1.
)O	Cost of physicians' services in a teaching hospital (see instructions)	0	ı
00	Subtotal (see instructions)	3, 122, 227	
0C	Primary payer payments	3, 122, 227	
00	Subtotal (line 16 less line 17).	3, 122, 227	
0C		155, 096	
00	Subtotal (line 18 minus line 19)	2, 967, 131	
00	Coi nsurance	73, 132	
00	Subtotal (line 20 minus line 21)	2, 893, 999	
00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29, 278	
00	Adjusted reimbursable bad debts (see instructions)	19, 031	2
00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16, 892	
00	Subtotal (sum of lines 22 and 24)	2, 913, 030	
	Direct graduate medical education payments (see instructions)	0	2
00	Other pass through costs (see instructions)	0	2
00	Outlier payments reconciliation	0	2
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	3
50	Pioneer ACO demonstration payment adjustment (see instructions)	0	3
98	Recovery of accelerated depreciation.	0	3
99	Demonstration payment adjustment amount before sequestration	0	3
00	Total amount payable to the provider (see instructions)	2, 913, 030	3
21	Sequestration adjustment (see instructions)	36, 705	3
)2	Demonstration payment adjustment amount after sequestration	0	3
00	Interim payments	2, 856, 817	3:
00	Tentative settlement (for contractor use only)	0	3
00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	19, 508	3
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	3
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Worksheet E-3, Part II, line 2	7, 456	
	Outlier reconciliation adjustment amount (see instructions)	0	5
00	The rate used to calculate the Time Value of Money	0. 00	
00	Time Value of Money (see instructions)	0	5
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1		
00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	
17	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	190

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061		Worksheet E-3
	Component CCN: 15-T061	From 01/01/2022 To 12/31/2022	Date/Time Prepared:   6/12/2023 11:56 am
	Title XVIII	Subprovi der -	PPS
		IRF	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
. 00	Net Federal PPS Payment (see instructions)	1, 812, 725	1. (
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2. (
. 00	Inpatient Rehabilitation LIP Payments (see instructions)	48, 762	3. (
. 00	Outlier Payments	36, 365	4. (
. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5. (
. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. (
. 00	New Teaching program adjustment. (see instructions)	0. 00	6. (
00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7.
00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8.
00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9.
0.00	Average Daily Census (see instructions)	3. 835616	10.
1.00	Teaching Adjustment Factor (see instructions)	0.000000	11.
2. 00	Teaching Adjustment (see instructions)	o	12.
3. 00	Total PPS Payment (see instructions)	1, 897, 852	13.
1. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.
5. 00	Organ acquisition (DO NOT USE THIS LINE)		15.
5. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.
. 00	Subtotal (see instructions)	1, 897, 852	17.
. 00	Pri mary payer payments	0	18.
. 00	Subtotal (line 17 less line 18).	1, 897, 852	
. 00	Deducti bl es	29, 492	
. 00	, ,	1, 868, 360	
. 00	Coi nsurance	4, 668	
. 00	Subtotal (line 21 minus line 22)	1, 863, 692	
. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.
. 00	Adjusted reimbursable bad debts (see instructions)	0	25.
. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.
. 00	Subtotal (sum of lines 23 and 25)	1, 863, 692	27.
. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.
. 00	Other pass through costs (see instructions)	0	29
.00	Outlier payments reconciliation	0	30.
.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.
. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.
. 98 . 99	Recovery of accelerated depreciation.	0	31. 31.
. 00	Demonstration payment adjustment amount before sequestration  Total amount payable to the provider (see instructions)	1, 863, 692	
. 01	Sequestration adjustment (see instructions)	23, 482	32.
. 02		23, 462	32.
. 02	Interim payments	1, 805, 876	33.
. 00	Tentative settlement (for contractor use only)	0	34.
. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	34, 334	35.
. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.
ΩΩ	TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4	36, 365	50.
. 00	Outlier reconciliation adjustment amount (see instructions)	30, 303	51.
. 00	The rate used to calculate the Time Value of Money	0. 00	
. 00	Time Value of Money (see instructions)	0.00	53.
. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1		55.
. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	

Health Financial Systems	DAVIESS COMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 15-0061	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 6/12/2023 11:56 am
		Ti +Lo VIV	Hospi tal	Cost

PART_VII - CALCULATION_OF_REINBURSENENT - ALL_OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			'	0 12/31/2022	6/12/2023 11:	
PART VII - CALCULATION OF RETINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V.OR XIX SERVICES			Title XIX	Hospi tal		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES   509, 793   684, 652   2.00						
COMPUTATION OF NET COST OF COVERED SERVICES   509, 793   684, 652   2.00		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI	X SERVICES		
2.00   Medical and other services   684,652   2.00   2.0						1
3.00   Organ acquisition (certified transplant programs only)   690,793   684,652   4.00	1.00	Inpatient hospital/SNF/NF services		690, 793		1.00
4.00   Subtotal (sum of lines 1, 2 and 3)   690,793   684,652   6.00   0   0   0   0   0   0   0   0   0	2.00	Medical and other services			684, 652	2.00
Subtotal (sum of lines 1, 2 and 3)	3.00	Organ acquisition (certified transplant programs only)		0		3.00
5.00	4.00			690, 793	684, 652	4.00
0.00   Outpatient primary payer payments	5.00			0		5.00
3.00   COMPUTATION OF LESSER OF COST OF CHARGES   Reasonable Cost of coverages   Charges   Cha	6.00				0	6.00
Reasonable Charges	7.00	Subtotal (line 4 less sum of lines 5 and 6)		690, 793	684, 652	7.00
Routine service charges		COMPUTATION OF LESSER OF COST OR CHARGES				
9.00   Ancillary service charges   1,522,893   2,376,956   9.00   10		Reasonabl e Charges				
10.00   Organ acquisition charges, net of revenue   10.00   11.00	8.00	Routi ne servi ce charges		0		8.00
11.00   Incentive from target amount computation   1.00   1.522,893   2.376,956   12.00   1.502   1.522,893   2.376,956   12.00   1.502   1.502,895	9.00	Ancillary service charges		1, 522, 893	2, 376, 956	9.00
12.00   Total reasonable charges (sum of lines 8 through 11)   1,522,893   2,376,956   12.00	10.00	Organ acquisition charges, net of revenue		0		10.00
CUSTOMARY CHARGES   Amount actually collected from patients   I able for payment for services on a charge basis	11.00	Incentive from target amount computation		0		11. 00
13.00   Amount actually collected from patients liable for payment for services on a charge basis   14.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   0.000000   1.500   15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   0.000000   1.500	12.00	Total reasonable charges (sum of lines 8 through 11)		1, 522, 893	2, 376, 956	12.00
basis   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   16.00   101						
14.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   0.000000   1.500	13.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 13 to line 14 (not to exceed 1.000000) 15.00 Rotio of line 13 to line 14 (not to exceed 1.000000) 17.00 Excess of customary charges (see instructions) 18.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 4) (see instructions) 19.00 Interns and Residents (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of physicians' services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services only be completed for PPS providers.  10.00 Cost of covered services only be completed for PPS providers.  10.00 Cost of covered services only be completed for PPS providers.  10.00 Cost of covered services only be completed for PPS providers.  10.00 Cost of covered services only be completed for PPS providers.  10.00 Cost of covered services only be completed for PPS providers.  10.00 Cost of covered services only be completed for PPS providers.  10.00 Cost of covered services only be completed for PPS providers.  10.00 Cost of covered services only be completed for PPS providers.  10.00 Cost of covered services only						
15. 00	14. 00	l '	1 3	0	0	14. 00
16.00   Total customary charges (see instructions)   1,522,893   2,376,956   16.00   17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   11.692,304   17.00   17.00   17.00   18.00			42 CFR §413.13(e)			
17. 00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   11 ne 4) (see instructions)   1,692,304   17. 00						ł
line 4   (see instructions)						
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   0   18.00	17. 00		ly if line 16 exceeds	832, 100	1, 692, 304	17. 00
16) (see instructions)	10.00				0	10.00
19.00   Interns and Residents' (see instructions)	18.00		Ty IT Tine 4 exceeds Tine	0	0	18.00
20. 00       Cost of physicians' services in a teaching hospital (see instructions)       0       0       20. 00         21. 00       Cost of covered services (enter the lesser of line 4 or line 16)       690, 793       684, 652       21. 00         PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.       0       0       22. 00         22. 00       Outlier payments       0       0       23. 00         24. 00       Program capital payments       0       24. 00         25. 00       Capital exception payments (see instructions)       0       24. 00         26. 00       Routine and Ancillary service other pass through costs       0       0       26. 00         27. 00       Subtotal (sum of lines 22 through 26)       0       0       27. 00         28. 00       Customary charges (title V or XIX PPS covered services only)       0       0       28. 00         29. 00       Titles V or XIX (sum of lines 21 and 27)       690,793       684,652       29. 00         31. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       690,793       684,652       31. 00         32. 00       Deductibles       0       0       0       32. 00         33. 00       Coinsurance       0       0       0 <td>10.00</td> <td></td> <td></td> <td>0</td> <td>0</td> <td>10.00</td>	10.00			0	0	10.00
21.00   Cost of covered services (enter the lesser of line 4 or line 16)   ROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.   O			ruoti ana)		_	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				0		
22. 00       Other than outlier payments       0       0       22. 00         23. 00       Outlier payments       0       0       23. 00         24. 00       Program capital payments       0       0       24. 00         25. 00       Capital exception payments (see instructions)       0       25. 00         26. 00       Routine and Ancillary service other pass through costs       0       0       0       25. 00         28. 00       Customary charges (title V or XIX PPS covered services only)       0       0       0       27. 00         28. 00       Customary charges (title V or XIX PPS covered services only)       0       0       0       28. 00         29. 00       Titles V or XIX (sum of lines 21 and 27)       690, 793       684, 652       29. 00         20. 00       Excess of reasonable cost (from line 18)       0       0       0       30. 00         31. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       690, 793       684, 652       31. 00         32. 00       Deductibles       0       0       0       32. 00         33. 00       Coinsurance       0       0       0       33. 00         35. 00       Utilization review       0       0       0	21.00				004, 032	21.00
23.00	22 00		compreted for FF3 provid		0	22 00
24. 00       Program capital payments       0       24. 00         25. 00       Capital exception payments (see instructions)       0       25. 00         26. 00       Routine and Ancillary service other pass through costs       0       0       0         27. 00       Subtotal (sum of lines 22 through 26)       0       0       0       27. 00         28. 00       Customary charges (title V or XIX PPS covered services only)       0       0       0       28. 00         29. 00       Titles V or XIX (sum of lines 21 and 27)       690, 793       684, 652       29. 00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       690, 793       684, 652       31. 00         32. 00       Deductibles       0       0       32. 00         33. 00       Coinsurance       0       0       33. 00         34. 00       Allowable bad debts (see instructions)       0       0       34. 00         35. 00       Utilization review       0       0       35. 00         36. 00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       690, 793       684, 652       36. 00         37. 00       ZERO OUT MEDICALD       0 <t< td=""><td></td><td> </td><td></td><td>-</td><td></td><td></td></t<>				-		
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 0 0 0 26. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 1 Titles V or XIX (sum of lines 21 and 27) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				_	U	
26. 00 Routine and Ancillary service other pass through costs  27. 00 Subtotal (sum of lines 22 through 26)  28. 00 Customary charges (title V or XIX PPS covered services only)  29. 00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18)  31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32. 00 Deductibles  30. 00 Coinsurance  31. 00 Allowable bad debts (see instructions)  31. 00 Allowable bad debts (see instructions)  32. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  33. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  36. 00 Subtotal (line 36 ± line 37)  37. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  50 Costomary charges (title V or XIX PPS covered services only)  50 Costomary charges (title V or XIX PPS covered services only)  50 Costomary charges (title V or XIX PPS covered services only)  690, 793  684, 652  690, 793  684, 652  690, 793  684, 652  690, 793  684, 652  690, 793  684, 652  690, 793  684, 652  690, 793  684, 652  690, 793  684, 652  690, 793  684, 652  690, 793  684, 652  690, 793				-		
27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 30. 00 Coinsurance 31. 00 Ocinsurance 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 ZERO OUT MEDICALD 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39)  0 0 27. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 0 30. 00 0 0 0 30. 00 0 0 0 30. 00 0 0 0 32. 00 0 0 0 32. 00 0 0 0 32. 00 0 0 0 33. 00 0 0 0 34. 00 0 0 0 34. 00 0 0 0 35. 00 0 0 0 36. 00 0 0 0 36. 00 0 0 0 36. 00 0 0 0 0 36. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	
28. 00 Customary charges (title V or XIX PPS covered services only)  7				0		
29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 ZERO OUT MEDICALD 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39)  690, 793 684, 652 99. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36, 00 36, 00 36, 00 36, 00 36, 00 37. 00 38. 00 38. 00 39. 00		,		0		ı
COMPUTATION OF REIMBURSEMENT SETTLEMENT   30.00   Excess of reasonable cost (from line 18)   0   0   30.00   31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   690,793   684,652   31.00   32.00   33.00   Coinsurance   0   0   0   33.00   33.00   Coinsurance   0   0   0   0   34.00   35.00   Utilization review   0   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   690,793   684,652   36.00   37.00   ZERO OUT MEDICALD   0   -686,749   37.00   39.00   Subtotal (line 36 ± line 37)   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   39.00   Total amount payable to the provider (sum of lines 38 and 39)   690,793   -2,097   40.00				690, 793	684, 652	1
30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 30. 00 Coi nsurance 30. 01 lowable bad debts (see instructions) 31. 00 Utilization review 32. 00 Utilization review 33. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 34. 00 ZERO OUT MEDICALD 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39)  0 0 0 0 0 30. 00 0 0 0 32. 00 0 0 0 33. 00 0 0 0 33. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32.00 Deductibles  33.00 Coinsurance  34.00 Allowable bad debts (see instructions)  35.00 Utilization review  36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 ZERO OUT MEDICALD  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  690,793 684,652 36.00  39.00 690,793 -2,097 40.00	30.00			0	0	30.00
32.00   Deductibles   0   0   32.00   33.00   Coinsurance   0   0   33.00   33.00   34.00   Allowable bad debts (see instructions)   0   34.00   35.00   Utilization review   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   690, 793   684, 652   36.00   37.00   ZERO OUT MEDICALD   0   -686, 749   37.00   CERO OUT MEDICALD   0   -686, 749   37.00   0   -686, 749			)	690, 793	684, 652	31.00
34.00 Allowable bad debts (see instructions)  35.00 Utilization review  36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 ZERO OUT MEDICALD  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  0 34.00 35.	32. 00		,		·	•
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 ZERO OUT MEDICALD 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39)  0	33.00	Coi nsurance		0	0	33.00
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 ZERO OUT MEDICALD 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39)  0	34.00	Allowable bad debts (see instructions)		0	0	34.00
37.00 ZERO OUT MEDICALD 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39)  0 -686, 749 37.00 690, 793 -2, 097 38.00 39.00 690, 793 -2, 097 40.00	35.00			0		35.00
37.00       ZERO OUT MEDICALD       0       -686, 749       37.00         38.00       Subtotal (line 36 ± line 37)       690, 793       -2, 097       38.00         39.00       Direct graduate medical education payments (from Wkst. E-4)       0       39.00         40.00       Total amount payable to the provider (sum of lines 38 and 39)       690, 793       -2, 097       40.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	690, 793	684, 652	36.00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39)  0 39.00 690,793 -2,097 40.00			,	0	-686, 749	37.00
40.00 Total amount payable to the provider (sum of lines 38 and 39) 690,793 -2,097 40.00	38.00	Subtotal (line 36 ± line 37)		690, 793	-2, 097	38.00
40.00 Total amount payable to the provider (sum of lines 38 and 39) 690,793 -2,097 40.00	39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
41 00 Interim normante				690, 793	-2, 097	40.00
41. 00   Internii payiients   0  0  41. 00	41.00	Interim payments		0	0	41.00
42.00 Balance due provider/program (line 40 minus line 41) 690,793 -2,097 42.00	42.00	Balance due provider/program (line 40 minus line 41)		690, 793	-2, 097	42.00
	43.00	,	nce with CMS Pub 15-2,	0	0	43.00
chapter 1, §115.2		chapter 1, §115.2				

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061	Peri od: From 01/01/2022	Worksheet E-3
	Component CCN: 15-S061		
	Title XIX	Subprovi der -	Cost
		I PF	

	···	tio xix	I PF	0001	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FO	R TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		473, 659		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		473, 659	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		473, 659	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		117, 854	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		117, 854	0	12.00
	CUSTOMARY CHARGES		-		
13. 00	Amount actually collected from patients liable for payment for service	s on a charge	0	0	13.00
44.00	basis	6			
14. 00	Amounts that would have been realized from patients liable for payment		0	0	14.00
45.00	a charge basis had such payment been made in accordance with 42 CFR §4	13. 13(e)	0.000000	0.000000	45 00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	15.00
16.00	Total customary charges (see instructions)	- 1/	117, 854	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if lin	e 16 exceeds	U	U	17. 00
18. 00	lline 4) (see instructions) Excess of reasonable cost over customary charges (complete only if lin	o 4 ovecode Line	355, 805	0	18. 00
10.00	16) (see instructions)	e 4 exceeus iiile	333, 603	U	16.00
19. 00	Interns and Residents (see instructions)			0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		117, 854	0	21.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete	d for PPS provid		0	21.00
22. 00	Other than outlier payments	a for fra provid	0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	o .	24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		o	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		117, 854	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		355, 805	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		117, 854	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		117, 854	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38. 00	Subtotal (line 36 ± line 37)		117, 854	0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		117, 854	0	40.00
41. 00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0110 5 1 := -	117, 854	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance with	CMS Pub 15-2,		0	43.00
	chapter 1, §115.2		1		

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061	Peri od:	Worksheet E-3
	Component CCN: 15-T061	From 01/01/2022 To 12/31/2022	
	Title XIX	Subprovi der -	Cost
		IRF	

		C ALA	IRF	0031	
		-	Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR	TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services	on a charge	0	0	13. 00
	basis				
14.00	Amounts that would have been realized from patients liable for payment f	for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413	. 13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		0	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if line	16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if line	4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed	for PPS provid			
	Other than outlier payments		0	0	
			0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30.00	Excess of reasonable cost (from line 18)		0	0	1
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
32.00	Deductibles		0	0	
33.00	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	Ü	
35.00	Utilization review		0	0	35.00
36. 00 37. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	
			0	0	
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		0	U	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41.00	, , , , , , , , , , , , , , , , , , , ,		0	0	1
42.00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance with CM	IS Dub 15_2	0	0	1
43.00	chapter 1, §115. 2	13 T UD 13-2,		U	75.00
	Onaptor 1, 3110.2		1 1		I

Health Financial Systems DAVIESS COMMUNITY HOSPITAL In Lieu			u of Form CMS-2	552-10	
			Worksheet E-5		
			From 01/01/2022 To 12/31/2022	Date/Time Prep 6/12/2023 11:5	oared: 56 am
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00 Time value of money for operating expenses (see instructions)				0	6.00
7.00 Time value of money for capital related expenses (see instructions)				0	7.00

Health Financial Systems

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

Provi der CCN: 15-0061

Peri od: Worksheet G
From 01/01/2022
To 12/31/2022 Date/Ti me Prepared: 6/12/2023 11:56 am

OIII y)					6/12/2023 11:	56 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	19, 254, 908	0	0	0	1.00
2.00	Temporary investments	0	0	0		
3.00	Notes recei vabl e	0	0	0	0	
4.00	Accounts recei vable	19, 209, 226	1	0	0	1
5.00	Other receivable	910, 012		0	0	
6.00	Allowances for uncollectible notes and accounts receivable		1	0	0	1
7. 00 8. 00	Inventory Prepai d expenses	1, 987, 994 447, 653	1	0	0	
9. 00	Other current assets	447,053		0	0	
10.00	Due from other funds		o o	0	Ö	
11. 00	Total current assets (sum of lines 1-10)	31, 702, 110	o	0	l	
	FIXED ASSETS		'			1
12.00	Land	1, 280, 955	0	0	0	12.00
13.00	Land improvements	687, 865	1	0		
14. 00	Accumulated depreciation	-686, 530		0	1	1
15.00	Buildings	65, 807, 369	1	0	ı	
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-49, 321, 930		0	0	1
18.00	Accumulated depreciation	39, 119 -37, 162		0		
19. 00	Fi xed equipment	11, 899, 728		0	0	
20.00	Accumulated depreciation	-7, 751, 913		0	Ö	1
21. 00	Automobiles and trucks	0	o	0	Ō	
22. 00	Accumulated depreciation	0	0	0	0	22.00
23. 00	Maj or movable equipment	32, 925, 492	0	0	0	23.00
24.00	Accumulated depreciation	-29, 480, 324	0	0	0	
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	
26. 00	Accumul ated depreciation	0	0	0	0	1
27. 00	HIT designated Assets	0	0	0	0	
28. 00 29. 00	Accumul ated depreciation Minor equipment-nondepreciable	0	0	0	0	
30.00	Total fixed assets (sum of lines 12-29)	25, 362, 669		0	1	
30. 00	OTHER ASSETS	25, 302, 007	<u> </u>			30.00
31.00	Investments	4, 807, 040	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	
34.00	Other assets	2, 132, 786	1	0	0	1
35.00	Total other assets (sum of lines 31-34)	6, 939, 826	1	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	64, 004, 605	0	0	0	36.00
37. 00	Accounts payable	1, 928, 400	O	0	0	37.00
38. 00	Salaries, wages, and fees payable	-18	1	0	l	
39. 00	Payrol I taxes payable	621, 483		0	Ō	
40.00	Notes and Loans payable (short term)	1, 976, 498	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	
44.00	Other current liabilities	-636, 003	·	0	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	3, 890, 360	0	0	0	45.00
46. 00	Mortgage payable		O	0	0	46. 00
47. 00	Notes payable			0	·	
48. 00	Unsecured Loans		Ö	0	l	1
49.00	Other long term liabilities	10, 316, 431	0	0	l	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	10, 316, 431	1	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14, 206, 791	0	0	0	51.00
	CAPITAL ACCOUNTS		1		ı	
52.00	General fund balance	49, 797, 814	1			52.00
53.00	Specific purpose fund		0			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted			0		54. 00 55. 00
56.00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			Ü	0	
58. 00	Plant fund balance - reserve for plant improvement,				ő	
	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	49, 797, 814	0	0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	64, 004, 605	0	0	0	60.00
	[59]	I	l l		I	I

Peri od: Worksheet G-1 From 01/01/2022 Provi der CCN: 15-0061

					То	12/31/2022	Date/Time Pr 6/12/2023 11	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2.00	2.00		4.00	F 00	
1. 00	Fund balances at beginning of period	1. 00	2. 00 44, 610, 942	3. 00		4.00	5. 00	1, 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		-8, 394, 806			o o		2.00
3. 00	Total (sum of line 1 and line 2)		36, 216, 136			o		3.00
4.00	Additions (credit adjustments) (specify)	o			0		(	4.00
5.00	TRANSFER TO LTC OPERATIONS	13, 581, 678			0		(	5.00
6.00		0			0			6.00
7. 00		0			0			7.00
8. 00		0			0			8.00
9.00	Talal a 1818 and (a a a 6 18 a a 4 0)	0	40 504 (70		0		(	9.00
10.00	Total additions (sum of line 4-9)		13, 581, 678			0		10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		49, 797, 814		0	U	,	11.00
13. 00	beductions (debit adjustments) (specify)	0			0			13.00
14. 00					0			14.00
15. 00		ő			0			15.00
16. 00		o			0			16.00
17.00		O			0		(	17.00
18.00	Total deductions (sum of lines 12-17)		0			0		18. 00
19.00	Fund balance at end of period per balance		49, 797, 814			0		19. 00
	sheet (line 11 minus line 18)		51	L				
		Endowment Fund	PI ant	Funa				
		i unu						
		6. 00	7. 00	8. 00				
1. 00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0			3.00
4. 00 5. 00	TRANSFER TO LTC OPERATIONS		0					4. 00 5. 00
6. 00	TRANSIER TO ETC OPERATIONS		0					6.00
7. 00			0					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	Subtotal (line 3 plus line 10)	o			0			11.00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14.00			0					14.00
15.00			0					15.00
16.00			0					16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		O		0			17. 00 18. 00
19.00	Fund balance at end of period per balance				0			19.00
17.00	sheet (line 11 minus line 18)							17.00
	1	ı I		1	- 1			1

Health Financial Systems DASTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0061

				o 12/31/2022	Date/lime Pre   6/12/2023 11:	
	Cost Center Description		Inpati ent	Outpati ent	Total	oo alli
	cost center bescription		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES		1.00	2.00	3. 00	
	General Inpatient Routine Services					
1.00	Hospi tal		7, 292, 138		7, 292, 138	1. 00
2. 00	SUBPROVI DER - I PF		7, 385, 231		7, 385, 231	2.00
3.00	SUBPROVI DER - I RF		2, 259, 918		2, 259, 918	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			i i	0	5.00
6.00	Swing bed - NF		(	i i	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		16, 937, 287		16, 937, 287	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT		2, 539, 283		2, 539, 283	11. 00
12. 00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				0 500 000	15.00
16. 00	Total intensive care type inpatient hospital services (sum of	lines	2, 539, 283		2, 539, 283	16. 00
17 00	11-15)	`	10 474 576		10 474 570	17. 00
17. 00 18. 00	Total inpatient routine care services (sum of lines 10 and 16 Ancillary services	)	19, 476, 570 24, 871, 804		19, 476, 570 137, 377, 811	17.00
19.00	Outpatient services		24, 671, 602		1, 651, 360	19.00
20.00	RURAL HEALTH CLINIC			.,,	1, 085, 067	20.00
20. 00	RURAL HEALTH CLINIC II				762, 016	
20. 01	RURAL HEALTH CLINIC III				2, 910, 700	
20. 02	RURAL HEALTH CLINIC IV				2, 710, 700	20. 02
20. 04	RURAL HEALTH CLINIC V				1, 230, 689	20.03
20. 05	RURAL HEALTH CLINIC VI			,	865, 397	20. 05
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			,	0	21. 00
22. 00	HOME HEALTH AGENCY			o	0	22. 00
23. 00	AMBULANCE SERVICES		(	o	0	23.00
24.00	CMHC					24.00
24. 10	CORF			o	0	24. 10
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE		(	819, 280	819, 280	26.00
27. 00	OTHER (SPECIFY)		(	-,,	5, 306, 514	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	44, 348, 374	127, 137, 030	171, 485, 404	28. 00
	G-3, line 1)					
00.00	PART II - OPERATING EXPENSES			70 070 440		00.00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200)		(	72, 070, 149		29. 00 30. 00
31.00	ADD (SPECIFY)			1		30.00
31.00				1		31.00
33. 00				1		33. 00
34.00						34. 00
35. 00						35. 00
36. 00	Total additions (sum of lines 30-35)		· ·	0		36. 00
37. 00	DEDUCT (SPECIFY)					37. 00
38. 00						38. 00
39. 00			ď	ı		39. 00
40.00			Ċ			40.00
41.00			C			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		72, 070, 149		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10		
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-006		Worksheet G-3			
			From 01/01/2022		narad.		
			To 12/31/2022	Date/Time Pre 6/12/2023 11:			
				07 127 2020 11.	OO diii		
				1. 00			
1. 00	Total patient revenues (from Wkst. G-2, Par	t I, column 3, line 28)		171, 485, 404	1.00		
2.00	Less contractual allowances and discounts of	n patients' accounts		110, 111, 350	2.00		
3.00	Net patient revenues (line 1 minus line 2)			61, 374, 054	3.00		
4.00	Less total operating expenses (from Wkst. G	-2, Part II, line 43)		72, 070, 149	4.00		
5.00	Net income from service to patients (line 3	minus line 4)		-10, 696, 095	5. 00		
	OTHER INCOME						
6.00							
	7.00   Income from investments						
	8.00 Revenues from telephone and other miscellaneous communication services						
9. 00	Revenue from television and radio service			0	9. 00		
	Purchase di scounts			750			
	Rebates and refunds of expenses			0	11. 00		
	Parking Lot receipts			0	12.00		
	Revenue from Laundry and Linen service			0	13.00		
	Revenue from meals sold to employees and gu	ests		142, 190			
	Revenue from rental of living quarters			0			
	Revenue from sale of medical and surgical si			0	16. 00		
	Revenue from sale of drugs to other than pa			266, 574			
	Revenue from sale of medical records and about			10, 299			
	Tuition (fees, sale of textbooks, uniforms,			0	19. 00		
	Revenue from gifts, flowers, coffee shops,	and canteen		0	20.00		
	Rental of vending machines			0	21.00		
	Rental of hospital space			144, 726			
	Governmental appropriations			0	23.00		
24. 00	OTHER - INCLUDES EHR REVENUE	904, 744	24.00				

696, 266 2, 301, 289 -8, 394, 806 2, 301, 289 25. 00 0

0 28.00 -8,394,806 29.00

27.00

24.00 OTHER - INCLUDES EHR REVENUE
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

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68.00

RESIDENTIAL CARE\*

TELEHEALTH/TELEMONI TORI NG\*

71.00 OTHER NONREIMBURSABLE (SPECIFY)\*

NURSING FACILITY ROOM & BOARD\*

ADVERTI SI NG\*

THRIFT STORE\*

66.00

67 00

68.00

69 00

70.00

100.00 TOTAL

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

 $<sup>^{**}</sup>$  See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

				Hospi d	ce I	
		ADJUSTMENTS	TOTAL (col. 5			
			± col . 6)			
	GENERAL SERVICE COST CENTERS	6. 00	7. 00			
1. 00	CAP REL COSTS-BLDG & FIXT*	0	0			1.00
2. 00	CAP REL COSTS-BEDG & TTXT	0	0			2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0			3.00
4. 00	ADMINISTRATIVE & GENERAL*	0	107, 392			4. 00
5. 00	PLANT OPERATION & MAINTENANCE*	0	0			5. 00
6. 00	LAUNDRY & LINEN SERVICE*	0	ő			6.00
7. 00	HOUSEKEEPI NG*	0	0			7.00
8. 00	DI ETARY*	0	0			8.00
9. 00	NURSI NG ADMI NI STRATI ON*	0	Ö			9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	o			10.00
11. 00	MEDI CAL RECORDS*	0	o			11.00
12. 00	STAFF TRANSPORTATION*	0	4, 267			12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	0			13.00
14.00	PHARMACY*	0	270			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	o			15.00
16.00	OTHER GENERAL SERVICE*	0	o			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	I NPATI ENT CARE-CONTRACTED**	0	0			25. 00
26.00	PHYSI CI AN SERVI CES**	0	40, 596			26.00
27.00	NURSE PRACTITIONER**	0	0			27.00
28.00	REGI STERED NURSE**	0	214, 483			28. 00
29. 00	LPN/LVN**	0	0			29. 00
30.00	PHYSI CAL THERAPY**	0	0			30.00
31.00	OCCUPATIONAL THERAPY**	0	0			31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0			32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0			33.00
34.00	SPIRITUAL COUNSELING**	0	0			34.00
35.00	DI ETARY COUNSELI NG**	0	0			35. 00
36. 00	COUNSELING - OTHER**	0	0			36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	-80	50, 911			37.00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0			38. 00
39. 00	PATI ENT TRANSPORTATI ON**	0	0			39.00
40.00	I MAGING SERVI CES**	0	0			40.00
41. 00	LABS & DI AGNOSTI CS**	0	80			41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0			42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0			42.50
43.00	OUTPATIENT SERVICES**	0	0			43.00
44.00	PALLIATIVE CHEMOTHERAPY**	0	0			44.00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	0			45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	U			46. 00
60. 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM *	0	0			60.00
61.00	VOLUNTEER PROGRAM *	0	0			61.00
62. 00	FUNDRAI SI NG*	0	0			62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0			63.00
64. 00	PALLIATIVE CARE PROGRAM*	0	0			64.00
65. 00	OTHER PHYSICIAN SERVICES*	0	0			65.00
66. 00	RESIDENTIAL CARE*	0	0			66.00
67. 00	ADVERTI SI NG*	0	0			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0			68.00
69. 00	THRIFT STORE*	0	0			69.00
70. 00	NURSING FACILITY ROOM & BOARD*	0	0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	n			71.00
100.00		-80	417, 999			100.00
	1					

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

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304, 997 100. 00

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OUTPATIENT SERVICES

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

PALLIATIVE CHEMOTHERAPY

43.00

44.00

45.00

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATI ENT CARE-CONTRACTED			25. 00
26. 00	PHYSI CI AN SERVI CES	0	40, 443	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28. 00	REGI STERED NURSE	0	213, 675	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	-80	50, 719	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	80	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	-80	304, 917	100.00

Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

<sup>100. 00</sup> TOTAL 148, 700 \* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

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PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

PALLIATIVE CHEMOTHERAPY

		ADJUSTMENTS	TOTAL (col. 5		
		6. 00	± col . 6) 7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00		
25. 00	I NPATI ENT CARE-CONTRACTED	0	0		25. 00
26. 00	PHYSI CI AN SERVI CES	0	153	l	26.00
27. 00	NURSE PRACTITIONER		0		27.00
28. 00	REGI STERED NURSE	0	808		28. 00
29. 00	LPN/LVN	0	0		29. 00
30.00	PHYSI CAL THERAPY	0	o		30.00
31. 00	OCCUPATI ONAL THERAPY	0	0		31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	o		33.00
34.00	SPIRITUAL COUNSELING	0	o		34.00
35.00	DI ETARY COUNSELING	0	o		35.00
36.00	COUNSELING - OTHER	0	o		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	192		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1, 153		100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

44.00

45.00

<sup>100. 00</sup> TOTAL \* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Health Financial Systems	DAVIESS COMMUNI	TY HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - DETERMINATION OF HOSPITAL-BAS	SED HOSPICE NET	Provi der C		Peri od:	Worksheet 0-5	
EXPENSES FOR ALLOCATION		Hospi ce CCI		From 01/01/2022 To 12/31/2022	Date/Time Prep 6/12/2023 11:	oared: 56 am
				Hospi ce I		
Descriptions			HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES (see	EXPENSES FROM	of cols. 1 +	
			instructions)	WKST B PART I	2)	
				(see		
				instructions)		
			1.00	2. 00	3. 00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT				0 6, 617	6, 617	1.00
2.00 CAP REL COSTS-MVBLE EQUIP				0	0	2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT				0 47, 857	47, 857	3.00
4 OO ADMINI CEDATI VE 0 CENEDAL			107.00	01 000	100 401	4 00

						6/12/2023 11:	56 am
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1. 00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6, 617	6, 617				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	47, 857	0		47, 857		3.00
4.00	ADMINISTRATIVE & GENERAL	198, 481	0	ı c	17, 710	216, 191	4.00
5.00	PLANT OPERATION & MAINTENANCE	15, 909	0		0	15, 909	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	l c	0	0	6.00
7.00	HOUSEKEEPI NG	3, 597	0	(	o	3, 597	7. 00
8.00	DI ETARY	0	0	(	o	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	24, 341	0	(	o	24, 341	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	1, 100	0	l c	o	1, 100	10.00
11.00	MEDI CAL RECORDS	6, 998	0	ıl c	o	6, 998	11.00
12.00	STAFF TRANSPORTATION	4, 267	0	ıl c	o	4, 267	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		ol	0	13.00
14. 00	PHARMACY	270	0		ol	270	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		ol	0	15.00
16. 00	OTHER GENERAL SERVICE	0	0		ol	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0			99	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	304, 917			30, 033	334, 950	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	d c	o	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 153	0	(	114	1, 267	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	ı c	0	0	61.00
62.00	FUNDRAI SI NG	0	0	C	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	C	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	ı c	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	ı c	0	0	65.00
66.00	RESI DENTI AL CARE	0	0	ı c	0	0	66.00
67.00	ADVERTI SI NG	0	0	l c	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0	l c	0	0	68.00
69.00	THRIFT STORE	0	0	l c	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	6, 617	(	o o	6, 617	71.00
99.00	NEGATI VE COST CENTER	0	0	(	0		99. 00
100.00	TOTAL	615, 606	6, 617	(	47, 857	615, 606	100.00

			nospi ce cc	N. 15-1555	10 12/31/2022	6/12/2023 11	
					Hospi ce I		
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	r. r.	E & GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	'		•	<u>'</u>		
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	216, 191					4.00
5.00	PLANT OPERATION & MAINTENANCE	8, 611	24, 520				5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0				6.00
7. 00	HOUSEKEEPI NG	1, 947	0		5, 544		7. 00
8. 00	DI ETARY	0	0		0		0 8.00
9. 00	NURSI NG ADMI NI STRATI ON	13, 175	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	595	0		0		10.00
11. 00	MEDI CAL RECORDS	3, 788	0		0		11.00
12. 00	STAFF TRANSPORTATION	2, 310	0		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	2,010	0		0		13.00
14. 00	PHARMACY	146	0		0		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	140	0		0		15.00
16. 00	OTHER GENERAL SERVICE		0		0		16.00
	PATIENT/RESIDENTIAL CARE SERVICES	54	0		0		17. 00
17.00	LEVEL OF CARE	34		<u>'</u>	١		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00	HOSPICE ROUTINE HOME CARE	181, 297					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	101, 277	0		o		0 52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	686	0				0 53.00
00.00	NONREI MBURSABLE COST CENTERS	000		'	٥,		00.00
60.00	BEREAVEMENT PROGRAM	0	0	ol	0		60.00
61. 00	VOLUNTEER PROGRAM	0	0	1	0		61.00
62. 00	FUNDRAI SI NG	0	0		0		62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64. 00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65. 00	OTHER PHYSICIAN SERVICES		0		0		65.00
66.00	RESI DENTI AL CARE		0		ol ő		0 66.00
67. 00	ADVERTI SI NG		0				67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		0		0		68.00
69. 00	THRIFT STORE		0		0		69.00
70. 00	NURSING FACILITY ROOM & BOARD		O				70.00
	OTHER NONREIMBURSABLE (SPECIFY)	3, 582	24, 520		5, 544		0 71.00
99. 00		3, 302	24, 320		) 3, 344 )		0 99.00
	TOTAL	216, 191	24, 520	1	5, 544		0 100.00
100.00	7.02	210, 171	21, 320	Ή '	0, 044		01.00.00

Heal th Financial	Systems	ms DAVIESS COMMUNITY					In Lieu	of Form CMS-2552-10
COST ALLOCATION	- HOSPI TAL-BASEI	HOSPICE GEN	IERAL SERVICI	COSTS	Provi der	CCN: 15-0061	Peri od: From 01/01/2022	Worksheet 0-6 Part I

Hospi ce CCN: 15-1553 To 12/31/2022 Date/Time Prepared: 6/12/2023 11:56 am Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL **RECORDS** TRANSPORTATI O SERVI CE COORDI NATI ON SUPPLI ES Ν N 9.00 10.00 11.00 12.00 13.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 37, 516 9.00 9.00 ROUTINE MEDICAL SUPPLIES 1, 695 10.00 10.00 11.00 MEDICAL RECORDS 0 10,786 11.00 0 12.00 STAFF TRANSPORTATION 6, 577 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 0 0 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 16.00 0 0 16.00 0 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 0 HOSPICE ROUTINE HOME CARE 10, 747 6, 577 37, 516 1, 689 51.00 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 0 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 39 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 0 0 0 0 0 0 0 61.00 62.00 FUNDRAI SI NG 62.00 0 0 0 0 0 0 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 PALLIATIVE CARE PROGRAM 64.00 64.00 0 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71 00 OTHER NONREIMBURSABLE (SPECIFY) 0 Ω 71.00 0 99.00 NEGATIVE COST CENTER

0

1, 695

10, 786

6, 577

37, 516

0 99.00

0 100.00

100.00 TOTAL

Provi der CCN: 15-0061

			nospi ce co	10. 13-1333	0 12/31/2022	6/12/2023 11	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL		TOTAL	
			ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES		CARE SERVICES		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS			•	-		
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	1					3.00
4.00	ADMINISTRATIVE & GENERAL	1					4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11.00
12. 00	STAFF TRANSPORTATION						12.00
13. 00	VOLUNTEER SERVICE COORDINATION						13.00
14. 00	PHARMACY	416					14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	410	0				15.00
16. 00	OTHER GENERAL SERVICE		0				16.00
	PATIENT/RESIDENTIAL CARE SERVICES				153		17. 00
17.00	LEVEL OF CARE				155		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	(		(	50.00
51. 00	HOSPICE ROUTINE HOME CARE	416	0	1		573, 192	
52. 00	HOSPICE INPATIENT RESPITE CARE	410	0			373, 172	
	HOSPICE GENERAL INPATIENT CARE		0	1		2, 151	
33.00	NONREI MBURSABLE COST CENTERS	J 9			, 199	2, 13	33.00
60.00	BEREAVEMENT PROGRAM	0				(	60.00
61. 00	VOLUNTEER PROGRAM	0				(	
62. 00	FUNDRAI SI NG	0				(	•
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				(	•
64. 00	PALLIATIVE CARE PROGRAM	0				(	•
65. 00	OTHER PHYSICIAN SERVICES	0				(	•
66. 00	RESI DENTI AL CARE	0	0		o	(	
67. 00	ADVERTI SI NG	0	· ·			(	
68. 00	TELEHEALTH/TELEMONI TORI NG	0				(	
69. 00	THRI FT STORE			1		(	
70. 00	NURSING FACILITY ROOM & BOARD						•
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	1	ol	40, 263	
99.00			0			40, 200	1
100.00		416	0		153		100.00
100.00	1.0	1 410	0	1	1 133	0.0,000	

Health Financial Systems	DAVIESS COMMUNI	TY HOSPITAL		In Lieu	u of Form CMS-2552-1	0
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der CCI		Peri od: From 01/01/2022	Worksheet 0-6	_
STATISTICAL BASIS		Hospi ce CCN			Date/Time Prepared: 6/12/2023 11:56 am	
				Hospi ce I		
Cost Center Descriptions	CAP REL BLDG		EMPLOYEE	RECONCI LI ATI O		
	l & FIX	FOULP	BENEFLTS	N	F & GENERAL	

COST Center Descriptions							6/12/2023 11:	56 am
COST CENTER DESCRIPTIONS						Hospi ce I		
COULAR FEET		Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI O	ADMI NI STRATI V	
VALUE   SCALARIES   COSTS   COSTS		·	& FIX	EQUI P	BENEFITS	N	E & GENERAL	
VALUE   SCALARIES   COSTS   COSTS			(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
CENERAL SERVICE COST CENTERS			,	VALUE)	(GROSS		COSTS)	
1.00   2.00   3.00   4A   4.00								
CENTRAL SERVICE COST CENTERS			1. 00	2.00		4A	4.00	
1. 00		GENERAL SERVICE COST CENTERS						
2.00	1 00		585		I			1 00
3.00   EMPLOYEE BENEFITS DEPARTMENT   0   0   236, 949     3.00   4.00   ADMIN ISTRATI VE & GENERAL   0   0   0   0   0   0   0   15, 909   5.00   0   0   0   0   0   0   0   0   0				1				
4. 00 ADMINISTRATIVE & GENERAL 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	236 040			
5.00   PLANT OPERATION & MAINTENANCE   0 0 0 0 0 0 0 15,909   5.00		I control of the cont					200 /15	
6. 00 LAUNDRY & LINEN SERVICE				0	07,007	-210, 191	l .	1
7. 00 HOUSEKEEPING 8. 00 DI ETARY 9. 00 NURSING ADMINISTRATION 9. 00 NURSING ADMINISTRATION 9. 00 NURSING ADMINISTRATION 10. 00 ROUTINE MEDICAL SUPPLIES 0 0 0 0 0 0 0 1.1.00 11. 00 ROUTINE MEDICAL SUPPLIES 0 0 0 0 0 0 0 0 1.1.00 12. 00 STAFF TRANSPORTATION 0 0 0 0 0 0 0 0 4. 267 12. 00 12. 00 STAFF TRANSPORTATION 0 0 0 0 0 0 0 4. 267 12. 00 13. 00 VOLUNITEER SERVICE COORDINATION 0 0 0 0 0 0 0 4. 267 12. 00 14. 00 PHARMACY 0 0 0 0 0 0 0 0 0 0 13. 00 14. 00 PHARMACY 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 0 0 0 0 0 0 0 15. 00 16. 00 OTHER GENERAL SERVICE 0 0 0 0 0 0 0 0 0 0 15. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 15. 00 18. 00 19. 01 15. 00 15. 00		All control of the co	0	0				
8. 00 DI ETARY 0 0 0 0 0 0 0 0 0 8. 00 9 0 0 10 10 10 10 10 10 10 10 10 10 10 10		All controls and the control of the	0	0				
9.00 NURSING ADMINISTRATION 0 0 0 0 24,341 9,00 10.00 ROUTINE MEDICAL SUPPLIES 0 0 0 0 0 0 0 1,100 10.00 11.00 MEDICAL SUPPLIES 0 0 0 0 0 0 0 1,100 10.00 11.00 MEDICAL RECORDS 0 0 0 0 0 0 0 6,998 11.00 11.00 MEDICAL RECORDS 0 0 0 0 0 0 0 4,267 12.00 11.00 MEDICAL RECORDS 0 0 0 0 0 0 0 4,267 12.00 11.00 11.00 MEDICAL RECORDS 0 0 0 0 0 0 0 0 13.00 11.00			0	0		0		1
10. 00   ROUTI NE MEDI CAL SUPPLIES   0   0   0   0   0   1, 100   10. 00		l control of the cont	0	0		0		
11.00   MEDICAL RECORDS   0   0   0   0   6,998   11.00     12.00   STAFF TRANSPORTATION   0   0   0   0   0   4,267   12.00     13.00   VOLUNTEER SERVI CE COORDINATION   0   0   0   0   0   0   13.00     14.00   PHARMACY   0   0   0   0   0   0   270   14.00     15.00   PHYSICIAN ADMINISTRATI VE SERVI CES   0   0   0   0   0   0   16.00     17.00   OTHER GENERAL SERVI CE   0   0   0   0   0   0   16.00     17.00   PATIENT/RESIDENTI AL CARE SERVI CES   0   0   0   0   0   0   16.00     17.00   PATIENT/RESIDENTI AL CARE SERVI CES   0   0   0   0   0   0   0     16.00   OTHER GENERAL SERVI CE   0   0   0   0   0   0   0   0     17.00   PATIENT/RESIDENTI AL CARE SERVI CES   0   0   0   0   0   0   0   0     18.00   HOSPI CE CONTI NUOUS HOME CARE   0   0   0   0   0   0   0   0   0     19.00   HOSPI CE ROUTI IN EHOME CARE   0   0   0   0   0   0   0   0   0			0	0		0	l	1
12.00   STAFF TRANSPORTATION		l control of the cont	0	0	C	0		1
13. 00   VOLUNTEER SERVICE COORDINATION   0   0   0   0   0   0   13. 00     14. 00   PHARMACY   0   0   0   0   0   0   0     15. 00   PHYSICIAN ADMINISTRATIVE SERVICES   0   0   0   0   0   0     16. 00   OTHER GENERAL SERVICE   0   0   0   0   0   0     17. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0   0     18. 00   OTHER GENERAL SERVICE   0   0   0   0   0     19. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0     19. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0     19. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0     19. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0     19. 00   PATIENT/RESIDENTIAL CARE   0   0   0   0   0     10. 00   HOSPICE CONTINUOUS HOME CARE   0   0   0   0   0   0     12. 00   HOSPICE CRUTINE HOME CARE   0   0   0   0   0   0     148,700   0   334,950   51.00     15. 00   HOSPICE GENERAL INPATIENT CARE   0   0   562   0   1,267   53.00     18. 00   HOSPICE GENERAL INPATIENT CARE   0   0   562   0   1,267   53.00     19. 00   POSTICE GENERAL INPATIENT CARE   0   0   0   0   0   0     10. 00   OTHER GENERAL SERVICES   0   0   0   0   0   0     10. 00   OTHER GENERAL SERVICES   0   0   0   0   0   0     10. 00   OTHER GENERAL SERVICES   0   0   0   0   0   0     10. 00   PALLIATIVE CARE PROGRAM   0   0   0   0   0   0     10. 00   OTHER PHYSICIAN SERVICES   0   0   0   0   0   0     10. 00   OTHER PHYSICIAN SERVICES   0   0   0   0   0   0     10. 00   OTHER PHYSICIAN SERVICES   0   0   0   0   0   0     10. 00   OTHER PHYSICIAN SERVICES   0   0   0   0   0   0     10. 00   OTHER MORREI MBURSABLE (SPECIFY)   585   0   0   0   0   0   0     10. 00   OTHER MORREI MBURSABLE (SPECIFY)   585   0   0   0   0   0   0     10. 00   OTHER MORREI MBURSABLE (SPECIFY)   585   0   0   0   0   0   0     10. 00   OTHER MORREI MBURSABLE (SPECIFY)   585   0   0   0   0   0   0     10. 00   OTHER MORREI MBURSABLE (SPECIFY)   585   0   0   0   0   0   0     10. 00   OTHER MORREI MBURSABLE (SPECIFY)   585   0   0   0   0   0   0     10. 00   OTHER MORREI M		l e e e e e e e e e e e e e e e e e e e	0	0	C	0	l .	
14. 00 PHARMACY 15. 00 PHYSICI AN ADMINISTRATIVE SERVICES 0 0 0 0 0 0 0 0 15. 00 17. 00 THER GENERAL SERVICE 0 0 0 0 0 0 0 0 16. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 0 99 17. 00  LEVEL OF CARE  50. 00 HOSPICE CONTINUOUS HOME CARE 51. 00 HOSPICE CONTINUOUS HOME CARE 52. 00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 0 0 0 55. 00 148, 700 0 334, 950 51. 00 15. 00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 0 0 52. 00 15. 00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 0 0 562  NONREI MBURSABLE COST CENTERS  60. 00 BEREAVEMENT PROGRAM 0 0 0 0 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG 63. 00 HOSPICE PROGRAM 0 0 0 0 0 0 0 62. 00 63. 00 HOSPICE PROGRAM 0 0 0 0 0 0 0 64. 00 64. 00 PALLI ATIVE CARE PROGRAM 0 0 0 0 0 0 0 63. 00 65. 00 OTHER PHYSI CIAN SERVICES 0 0 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CIAN SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 0 0 0 0 0 0 0 0 0 68. 00 TELEHEALTH/TELEMONI TORI NG 0		STAFF TRANSPORTATION	0	0	C	0	4, 267	12.00
15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 0 0 0 15. 00 16. 00 OTHER GENERAL SERVICE 0 0 0 0 0 0 16. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 0 16. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13.00	VOLUNTEER SERVICE COORDINATION	0	0	C	0	0	13.00
16.00   OTHER GENERAL SERVICE   O O O O O O O O O O O O O O O O O O	14.00	PHARMACY	0	0	C	0	270	14.00
17. 00   PATI ENT/RESI DENTI AL CARE SERVICES   0   0   0   99   17. 00	15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	C	0	0	15.00
LEVEL OF CARE     0   0   0   50.00	16.00	OTHER GENERAL SERVICE	0	0	l c	0	0	16. 00
Description	17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	99	17. 00
Description					•			
S1. 00	50.00					0	0	50.00
100   100						1		
NONNEI MBURSABLE COST CENTERS   0   0   562   0   1, 267   53.00			0	1	1			1
NONREI MBURSABLE COST CENTERS   O			4	ł				
60. 00 BEREAVEMENT PROGRAM 61. 00 VOLUNTEER PROGRAM 61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAI SI NG 62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THEI F STORE 69. 00 THER FORMA BOARD 70. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 79. 00 NEGATI VE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 70. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 70. 00 THER NONREI MBURSABLE (SPECI FY) 70. 00 OCOST TO BE ALLOCATED (per Wkst. 0-6, Part I) 70. 00 THER NONREI MBURSABLE (SPECI FY) 70. 00 THER NONREI MBURSABLE (SPECI FY) 70. 00 TO THE ROOM BEALLOCATED (per Wkst. 0-6, Part I) 70. 00 THER NONREI MBURSABLE (SPECI FY) 70. 00 THER NONREI MBURSABLE (SPECI FY) 70. 00 THER NONREI MBURSABLE (SPECI FY) 70. 00 TO THE NONREI MBURSABLE (SPECI FY) 70. 00 THER NONREI MBURSABLE (SPECI FY)	33.00				J 302	0	1, 207	33.00
61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAI SI NG 62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE 70. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 61. 00 62. 00 60.	60 00					0	0	60.00
62. 00 FUNDRAI SING 0 0 0 0 0 0 62. 00 63. 00 HOSPICE/PALLIATI VE MEDICINE FELLOWS 0 0 0 0 0 0 0 63. 00 64. 00 PALLIATI VE CARE PROGRAM 0 0 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 0 0 65. 00 66. 00 0 0 0 0 0 0 0 0 65. 00 66. 00 0 0 0 0 0 0 0 0 0 0 0 65. 00 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 0 0 0 0 68. 00 69. 00 THRIFT STORE 0 0 0 0 0 0 0 0 0 0 0 68. 00 69. 00 NURSI NG FACILITY ROOM & BOARD 70. 00 NURSI NG FACILITY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 585 0 0 0 0 6, 617 71. 00 99. 00 NEGATI VE COST CENTER 99. 00 100. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	1	1	_	1	
63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 64. 00 PALLIATIVE CARE PROGRAM 0 0 0 0 0 0 0 63. 00 64. 00 PALLIATIVE CARE PROGRAM 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 0 0 0 0 0 0 65. 00 67. 00 ADVERTI SI NG 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 0 0 0 68. 00 69. 00 THRIFT STORE 0 0 0 0 0 0 0 69. 00 70. 00 NURSI NG FACILITY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 63. 00 0 0 0 0 0 0 63. 00 0 0 0 0 0 65. 00 0 0 0 0 0 0 66. 00 0 0 0 0 0 0 0 67. 00 0 0 0 0 0 0 0 68. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				1
64. 00 PALLIATIVE CARE PROGRAM 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 0 0 0 0 65. 00 66. 00 RESIDENTIAL CARE 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTISING 0 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING 0 0 0 0 0 0 0 68. 00 69. 00 THRIFT STORE 0 0 0 0 0 0 0 0 68. 00 70. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 99. 00 NEGATIVE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 64. 00 0 0 0 0 0 0 65. 00 0 0 0 0 0 0 66. 00 0 0 0 0 0 0 0 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				1
65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 0 0 65. 00 66. 00 66. 00 66. 00 66. 00 0 0 0 0			0	0			-	
66. 00 RESI DENTI AL CARE 0 0 0 0 0 0 0 66. 00 67. 00 68. 00 67. 00 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE 0 0 0 0 0 0 0 69. 00 71. 00 NURSI NG FACI LI TY ROOM & BOARD 0 0 0 0 0 69. 00 0 0 69. 00 0 0 0 66. 617 71. 00 0 THER NONREI MBURSABLE (SPECI FY) 585 0 0 0 66. 617 71. 00 99. 00 NEGATI VE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 6, 617 0 47, 857 216, 191 100. 00			0	0		0		
67. 00   ADVERTISING   0   0   0   0   67. 00   68. 00   TELEHEALTH/TELEMONITORING   0   0   0   0   68. 00   69. 00   THRIFT STORE   0   0   0   0   69. 00   70. 00   NURSING FACILITY ROOM & BOARD   0   70. 00   71. 00   OTHER NONREIMBURSABLE (SPECIFY)   585   0   0   6,617   70. 00   NEGATIVE COST CENTER   99. 00   100. 00   COST TO BE ALLOCATED (per Wkst. 0-6, Part I)   6,617   0   47,857   216,191   100. 00		I control of the cont	0	0		0		
68. 00   TELEHEALTH/TELEMONI TORI NG   0 0 0 0 0 0 68. 00 69. 00   THRI FT STORE   0 0 0 0 0 0 0 69. 00 70. 00   NURSI NG FACI LI TY ROOM & BOARD   0 0 0 0 0 0 6, 617 71. 00   OTHER NONREI MBURSABLE (SPECI FY)   585   0 0 0 0 0 6, 617 71. 00 99. 00   NEGATI VE COST CENTER   99. 00 100. 00   COST TO BE ALLOCATED (per Wkst. 0-6, Part I)   6, 617   0 47, 857   216, 191 100. 00		All control of the co	0	0		0		
69. 00 THRIFT STORE 0 0 0 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 0 0 0 0 0 6, 617 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 585 0 0 0 0 6, 617 71. 00 99. 00 NEGATIVE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 6, 617 0 47, 857 216, 191 100. 00			0	0	C	0		
70.00   NURSING FACILITY ROOM & BOARD   70.00   71.00   OTHER NONREIMBURSABLE (SPECIFY)   585   0   0   0   6,617   71.00   99.00   NEGATIVE COST CENTER   99.00   100.00   COST TO BE ALLOCATED (per Wkst. 0-6, Part I)   6,617   0   47,857   216,191   100.00   100.0		All control of the co	0	0	C	0		
71. 00 OTHER NONREIMBURSABLE (SPECIFY) 585 0 0 0 6,617 71. 00 99. 00 NEGATI VE COST CENTER 99. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 6,617 0 47,857 216,191 100. 00			0	0	C	0	0	1
99.00 NEGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 6,617 0 47,857 216,191 100.00	70.00					0		70.00
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 6,617 0 47,857 216,191 100.00	71.00		585	0	( C	0	6, 617	71.00
								99.00
	100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	6, 617	0	47, 857	'	216, 191	100.00
			11. 311111	0. 000000	0. 201972	2	0. 541269	101.00

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED STATISTICAL BASIS	HOSPI CE GENERAL SERVI CE COSTS	Provi der CCN: Hospi ce CCN:	From 01/01/2022	Worksheet 0-6 Part II Date/Time Prepared: 6/12/2023 11:56 am

			Hospi ce CC	N: 15-1553 T	o 12/31/2022	Date/Time Pre 6/12/2023 11:	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	·	OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMINISTRATIO	
		MAI NTENANCE	(IN-FACILITY	,	DAYS)	N	
		(SQUARE FEET)	DAYS)		571107	(DI RECT NURS.	
		(040/1112 / 221)	57.1.07			HRS. )	
		5. 00	6. 00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMI NI STRATI VE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE	585					5.00
6. 00	LAUNDRY & LINEN SERVICE	0					6.00
	1						
7.00	HOUSEKEEPI NG	0		585			7.00
8.00	DI ETARY	0		0	U		8.00
9. 00	NURSI NG ADMI NI STRATI ON	0		0		7, 728	9.00
10. 00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11. 00	MEDI CAL RECORDS	0		0		0	11. 00
12. 00	STAFF TRANSPORTATION	0		0		0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					7, 728	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0		0	0	53.00
00.00	NONREI MBURSABLE COST CENTERS	ı		·	· ·		00.00
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61. 00	VOLUNTEER PROGRAM	0		0		Ö	61.00
62. 00	FUNDRAI SI NG	0				Ö	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	63.00
64. 00	PALLIATIVE CARE PROGRAM					0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0				0	65.00
	4	0			0	-	
66.00	RESI DENTI AL CARE	0	0		U	0	66.00
67.00	ADVERTI SI NG	0		0		-	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	68.00
69. 00	THRI FT STORE	0		0		0	69.00
70. 00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	585	0	585	0	0	
99. 00	NEGATI VE COST CENTER	]					99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			5, 544			100.00
101.00	UNIT COST MULTIPLIER	41. 914530	0. 000000	9. 476923	0. 000000	4. 854555	101.00

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	SERVI CE COSTS	Provi der C		Peri od: From 01/01/2022	Worksheet 0-6 Part II	
INITIONE BASIS		Hospi ce CC	:N: 15-1553	To 12/31/2022	Date/Time Pre 6/12/2023 11:	
				Hospi ce I		
Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	MEDI CAL	RECORDS	TRANSPORTATIO	SERVI CE	(CHARGES)	
	SUPPLI ES	(PATI ENT	N	COORDI NATI ON		
	(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
	DAYS)		,	SERVICE)		
	10.00	11 00	12.00	12 00	14.00	

					поѕргсе г		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATIO	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON	( , , , , , , , , , , , , , , , , , , ,	
		(PATIENT	DAYS)	(MI LEAGE)	(HOURS OF		
		· ·	DATS)	(WII LLAGE)			
		DAYS)	44.00	10.00	SERVICE)	44.00	
	CENEDAL CEDALCE COCT CENTEDO	10. 00	11. 00	12.00	13. 00	14. 00	
1 00	GENERAL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT			I			1 00
1.00							1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION						9.00
		2 5/7					
10.00	ROUTINE MEDICAL SUPPLIES	3, 567	0 5/7				10.00
11. 00	MEDI CAL RECORDS		3, 567				11.00
12. 00	STAFF TRANSPORTATION			4, 267			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	270	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	o	0	15.00
16. 00	OTHER GENERAL SERVICE			0	0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			Ĭ	Ĭ	Ü	17. 00
17.00	LEVEL OF CARE			l			17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	3, 554	3, 554	_	0	270	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0,001	0,001		o	0	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	13	13		0	0	53.00
33.00	NONREI MBURSABLE COST CENTERS	13	13	1 0	υ	U	33.00
60.00	BEREAVEMENT PROGRAM			0	O	0	60.00
					- 1		61.00
61.00	VOLUNTEER PROGRAM			0	0	0	
62.00	FUNDRAI SI NG			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESI DENTI AL CARE			0	0	0	66.00
67.00	ADVERTI SI NG			0	o	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	0	68.00
69. 00	THRI FT STORE			1 0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				Ŭ	Ü	70.00
71. 00	OTHER NONREI MBURSABLE (SPECIFY)				_	0	71.00
	1				U	Ü	
	NEGATIVE COST CENTER	4 (05	40 707	,			99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1, 695	10, 786		0		100.00
101.00	UNIT COST MULTIPLIER	0. 475189	3. 023830	1. 541364	0. 000000	1. 540741	101.00

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL		In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED H STATISTICAL BASIS	IOSPI CE GENERAL SERVI CE COSTS	Provi der CCN: Hospi ce CCN:	15-0061 15-1553	From 01/01/2022 To 12/31/2022	Worksheet 0-6 Part II Date/Time Prepared: 6/12/2023 11:56 am

						6/12/2023 11:56 am
					Hospi ce I	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERA	AL PATIENT/		
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
		E SERVICES	(SPECI FY	CARE SERVICE	S	
		(PATI ENT	BASIS)	(IN-FACILIT	1	
		DAYS)	,	DAYS)		
		15. 00	16. 00	17. 00		
	GENERAL SERVICE COST CENTERS					
1. 00	CAP REL COSTS-BLDG & FIXT					1.00
2. 00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4. 00	ADMINISTRATIVE & GENERAL					
						4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6. 00	LAUNDRY & LINEN SERVICE					6.00
7. 00	HOUSEKEEPI NG					7.00
8. 00	DI ETARY					8.00
9. 00	NURSI NG ADMI NI STRATI ON					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11. 00	MEDI CAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13. 00	VOLUNTEER SERVICE COORDINATION					13.00
14. 00	PHARMACY					14.00
	PHYSICIAN ADMINISTRATIVE SERVICES					15.00
16. 00	OTHER GENERAL SERVICE		1	0		16.00
17. 00					1.2	
17.00	PATIENT/RESIDENTIAL CARE SERVICES				13	17. 00
F0 00	LEVEL OF CARE					50.00
	HOSPICE CONTINUOUS HOME CARE	C	1	0		50.00
	HOSPICE ROUTINE HOME CARE	C	l l	0		51.00
	HOSPICE INPATIENT RESPITE CARE	C	l .	0	0	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	C	)	0	13	53.00
	NONREI MBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM			0		60.00
61.00	VOLUNTEER PROGRAM			0		61.00
62.00	FUNDRAI SI NG			o		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			o		63.00
64.00	PALLIATIVE CARE PROGRAM		•	0		64.00
	OTHER PHYSICIAN SERVICES			0		65.00
66. 00	RESI DENTI AL CARE				0	66.00
67. 00	ADVERTI SI NG		1			67.00
68. 00				0		68.00
	TELEHEALTH/TELEMONI TORI NG	1				
69.00	THRIFT STORE	1		٧		69.00
	NURSING FACILITY ROOM & BOARD					70.00
	OTHER NONREIMBURSABLE (SPECIFY)	C	)	O	0	71.00
	NEGATI VE COST CENTER					99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		)	0 15		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 0000	00 11. 76923	31	101.00
	•	•		•	*	•

Health Financial Systems	DAVIESS COMMUNITY	Y HOSPITAL		In Lieu	of Form CMS-2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE	SHARED SERVICE COSTS BY	Provider CCN: 15-0		Peri od: From 01/01/2022	Worksheet 0-7
22722 01 0/11/2		Hospi ce CCN: 15-	-1553		Date/Time Prepared: 6/12/2023 11:56 am
				Hospi so I	

LLVLL	OT OTHE		Hospi ce CC	N: 15-1553	Γο 12/31/2022	Date/Time Pre 6/12/2023 11:	
					Hospi ce I	07 127 2020 111.	<u>00 um</u>
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to	HCHC	HRHC	HI RC	
		Part I, Col. 9 line	Charge Ratio				
		0	1.00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66.00			0	0	
2.00	OCCUPATI ONAL THERAPY	67.00			٥ -	0	2. 00
3.00	SPEECH PATHOLOGY	68. 00			٥ -	0	
4.00	DRUGS CHARGED TO PATIENTS	73. 00		(	0	0	
5.00	DURABLE MEDI CAL EQUI P-RENTED	96. 00				_	5.00
6. 00	LABORATORY	60.00		1	1	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00		(	1	0	
8.00	OTHER OUTPATIENT SERVICE COST CENTE	93.00		(	0	0	0.00
9. 00 10. 00	RADI OLOGY-THERAPEUTI C CARDI AC REHAB	55. 00 76. 00		(		_	9. 00 10. 00
	ADDICTION SERVICES	76.00	6. 691661		1	0	1
11. 00		76.01	0.091001			0	11.00
11.00	Total's (suil of Times 1-11)	Charges by		Shared Service	ce Costs by LOC		11.00
		LOC (from		0.10.00	29 200		
		Provi der					
		Records)					
	Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
			x col. 2)	x col. 3)	x col. 4)	x col. 5)	
	T	5. 00	6. 00	7. 00	8. 00	9. 00	
4 00	ANCILLARY SERVICE COST CENTERS	_		1			
1.00	PHYSI CAL THERAPY	0	0		-	0	
2. 00 3. 00	OCCUPATIONAL THERAPY	0	0		0	0	
	SPEECH PATHOLOGY DRUGS CHARGED TO PATIENTS	0	0	,		0	
4. 00 5. 00	DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	4. 00 5. 00
6. 00	LABORATORY	0	0		0	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT		0	`		0	1
8. 00	OTHER OUTPATIENT SERVICE COST CENTE		0	`			
9. 00	RADI OLOGY-THERAPEUTI C		١				9.00
10.00	CARDI AC REHAB	0	0		0	0	
10. 01	ADDICTION SERVICES	0	ĺ		-	ő	1
	Totals (sum of lines 1-11)	1	Ō		0		

Health Financial Systems	DAVIESS COMMUNITY	' HOSPI TAL		In Lieu	of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE F	PER DIEM COST	Provi der CCN:	15-0061	Peri od: From 01/01/2022	Worksheet 0-8
		Hospi ce CCN:	15-1553	To 12/31/2022	Date/Time Prepared:

					6/12/2023 11:	56 am
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7,	col . 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0. 00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)	0	0		4.00
5.00	Program cost (line 3 times line 4)		0	0		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7,	col . 7,			573, 192	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				3, 554	7.00
8.00	Total average cost per diem (line 6 divided by line 7)				161. 28	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	9 11)	3, 033	0		9.00
10.00	Program cost (line 8 times line 9)		489, 162	0		10.00
	HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7,	col . 8,			0	11.00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)		0	0		15.00
	HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7,	col . 9,			2, 151	16.00
	line 11)					
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				13	
18. 00	Total average cost per diem (line 16 divided by line 17)				165. 46	
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 13)	13	0		19.00
20.00	Program cost (line 18 times line 19)		2, 151	0		20.00
	TOTAL HOSPICE CARE					
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				575, 343	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				3, 567	
23. 00	Average cost per diem (line 21 divided by line 22)				161. 30	23.00

CALCIN	Financial Systems DAVIESS COMMUNI			u of Form CMS-2 Worksheet L	2552-10			
CALCUI	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0061	Peri od: From 01/01/2022 To 12/31/2022	Parts I-III Date/Time Pre				
		Title XVIII	Hospi tal	6/12/2023 11: PPS	<u>56 am</u>			
		11 (10 /////	noop. ta.					
	DADT I FULLY PROOPERTING METURE			1. 00				
	PART I - FULLY PROSPECTIVE METHOD  CAPITAL FEDERAL AMOUNT							
1. 00	Capital DRG other than outlier			181, 302	1.00			
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.00			
2. 00	Capital DRG outlier payments		0	2.00				
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0			
3. 00	Total inpatient days divided by number of days in the cost	reporting period (see ins	structions)	9. 05	3.0			
4. 00	Number of interns & residents (see instructions)	,	0. 00	4.0				
5. 00	Indirect medical education percentage (see instructions)	0. 00	5.00					
6. 00	Indirect medical education adjustment (multiply line 5 by t	he sum of lines 1 and 1.0	1, columns 1 and	0	6.0			
	1.01) (see instructions)							
7. 00								
8. 00								
9. 00								
10. 00								
11. 00								
12. 00	Total prospective capital payments (see instructions)			181, 302	12.0			
				1. 00				
	PART II - PAYMENT UNDER REASONABLE COST							
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00			
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.0			
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00			
4. 00	Capital cost payment factor (see instructions)			0	4.00			
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 0			
				1. 00				
	PART III - COMPUTATION OF EXCEPTION PAYMENTS							
	Program inpatient capital costs (see instructions)			0	1.0			
	Program inpatient capital costs for extraordinary circumsta	nces (see instructions)		0	2. 00 3. 00			
2. 00								
2. 00 3. 00			Applicable exception percentage (see instructions)					
2. 00 3. 00 4. 00	Applicable exception percentage (see instructions)			0. 00	ı			
2. 00 3. 00 4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	:		0				
2. 00 3. 00 4. 00 5. 00 6. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see		v line ()	0 0. 00	6.0			
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina		x line 6)	0 0. 00 0	6. 0 7. 0			
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7)	ry circumstances (line 2	x line 6)	0 0. 00 0 0	6. 00 7. 00 8. 00			
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app	ry circumstances (line 2 licable)	ŕ	0.00 0.00 0	6. 00 7. 00 8. 00 9. 00			
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7)	ry circumstances (line 2 licable) capital payments (line 8	less line 9)	0 0. 00 0 0	6. 00 7. 00 8. 00 9. 00 10. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	ry circumstances (line 2 licable) capital payments (line 8 capital payment (from pr	Bless line 9) Tior year	0. 00 0. 00 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00			
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	ry circumstances (line 2 licable) capital payments (line 8 capital payment (from pr payments (line 10 plus li	Bless line 9) Fior year ne 11)	0.00 0.00 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00			
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	ry circumstances (line 2 licable) capital payments (line 8 capital payment (from pr payments (line 10 plus li er the amount on this lir	Bless line 9) Tior year The 11)	0.00 0.00 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00			
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over	ry circumstances (line 2 licable) capital payments (line 8 capital payment (from pr payments (line 10 plus li er the amount on this lir capital payment for the	Bless line 9) Tior year The 11)	0.00 0.00 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00			
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	ry circumstances (line 2 licable) capital payments (line 8 capital payment (from pr payments (line 10 plus lier the amount on this lir capital payment for the nstructions)	Bless line 9) Tior year The 11)	0.00 0.00 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00			

Heal th	Financial Systems	DAVI ESS COMMUNI	ITY HOSPITAL		In lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS	DAVIESS COMMON	Provi der C	CN: 15-0061	Peri od:	Worksheet M-1	
711071213	TO OF HOSELTHE BUSED WHOLE THE COOLS		Trovider o	014. 10 0001	From 01/01/2022	Mor Rondoc III 1	
			Component	CCN: 15-8500	To 12/31/2022	6/12/2023 11:	
					RHC I	Cost	
		Compensation	Other Costs		1 Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	EAGLE TV HEATTL CARE CTAFF COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	0.4.7.40.7			ST	244 274	
1.00	Physi ci an	317, 487	0			316, 376	1
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	132, 660	0	132, 66	-464	132, 196	1
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	0	0		0	0	
6.00	Clinical Psychologist	0	0		0	0	
7.00	Clinical Social Worker	0	0		0 0	0	1
8.00	Laboratory Technician	0	0	147 /	0	0	
9.00	Other Facility Health Care Staff Costs	147, 684	0	,		147, 167	9.00
10. 00 11. 00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	597, 831 0	0 1, 925			595, 739	
12.00			1, 925	1, 92	0 0	1, 925 0	12.00
12.00	Physician Supervision Under Agreement Other Costs Under Agreement		0			0	13.00
14. 00	•	0	1, 925	1, 92	0		1
15. 00	Subtotal (sum of lines 11 through 13)		16, 299			1, 925 16, 299	
16. 00	Medical Supplies Transportation (Health Care Staff)		10, 299		0 0	10, 299	1
17. 00	1 '		0			0	1
18.00	Professional Liability Insurance		0			0	18.00
19. 00			0			0	19.00
20.00	Allowable GME Costs	o <sub>l</sub>	0			O	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	16, 299	16, 29	00	16, 299	
22. 00	Total Cost of Health Care Services (sum of	597, 831	18, 224			613, 963	
22.00	lines 10, 14, and 21)	077,001	10, 221	010,00	2,072	010, 700	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23.00		0	0		0 0	0	23.00
24.00	Dental	o	0		0 0	0	24.00
25.00	Optometry	O	0		0	0	25.00
25. 01	Tel eheal th	O	0		0 2, 586	2, 586	25. 01
25.02	Chronic Care Management	O	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 2, 586	2, 586	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	67, 512			67, 276	
30.00	Administrative Costs	73, 770	0			73, 512	
31.00	Total Facility Overhead (sum of lines 29 and	73, 770	67, 512	141, 28	-494	140, 788	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	671, 601	85, 736	757, 33	87 O	757, 337	32.00

85, 736

757, 337

0

757, 337

32.00

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

Health Financial Systems	DAVIESS COMMUN	NITY H	IOSPI TAL			In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Р	rovi der	CCN: 15-0061	Peri od From (	d: 01/01/2022	Worksheet M-1	
		С	omponent	CCN: 15-8500	То	12/31/2022	Date/Time Pre 6/12/2023 11:	pared: 56 am
						RHC I	Cost	
	Adjustments	Net	Expenses					
			ocation					
	( 00	C	ol. 6)	_				

		Adjustments	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
	FACILITY HEALTH CARE CTAFE COCTO	6. 00	7. 00		
1. 00	FACILITY HEALTH CARE STAFF COSTS Physician	0	316, 376		1.00
2.00	Physician Assistant	0	310, 370	1	2.00
3. 00	Nurse Practitioner	0	132, 196		3.00
4. 00	Visiting Nurse	0	132, 170		4.00
5. 00	Other Nurse	0	0		5.00
6. 00	Clinical Psychologist	0	0		6.00
7. 00	Clinical Social Worker	0	l o		7.00
8.00	Laboratory Techni ci an	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	147, 167	,	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	595, 739		10.00
11.00	Physician Services Under Agreement	0	1, 925		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	1, 925		14.00
15.00	Medical Supplies	0	16, 299		15.00
16.00		0	0		16. 00
	Depreciation-Medical Equipment	0	0		17.00
	Professional Liability Insurance	0	0		18. 00
	Other Health Care Costs	0	0		19. 00
20. 00					20.00
21. 00	, , ,	0	16, 299		21.00
22. 00		0	613, 963		22. 00
	lines 10, 14, and 21)				
23. 00	COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy	0	0		23. 00
24. 00	1 3	0			24.00
25. 00		0		•	25. 00
25. 00	Tel eheal th	0	2, 586		25. 00
25. 02	4	0	2, 300		25. 02
26. 00	3	0	0		26.00
27. 00		· ·			27. 00
28. 00	1	0	2, 586		28.00
	through 27)		,		
	FACILITY OVERHEAD		<u>'</u>		
29.00	Facility Costs	0	0.,2.0		29. 00
30.00	Administrative Costs	0	73, 512		30.00
31.00		0	140, 788		31.00
	30)				
32. 00		0	757, 337		32.00
	and 31)		l		

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-0061	Peri od:	Worksheet M-1	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	pared: 56 am
					RHC II	Cost	
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS		_		.		
1.00	Physi ci an	272, 996	0	272, 99		272, 996	
2.00	Physician Assistant	0	0		0	0	
3.00	Nurse Practitioner	87, 413	0	87, 41	3 0	87, 413	
4.00	Visiting Nurse	0	0		0	0	1
5.00	Other Nurse	0	0		0	0	1 0.00
6.00	Clinical Psychologist	0	0		0	0	
7.00	Clinical Social Worker	0	0			0	7.00
8. 00 9. 00	Laboratory Technician	100, 739	0	100, 73	0 0	100 730	
10.00	Other Facility Health Care Staff Costs					100, 739	1
	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	461, 148	0	461, 14	0 0	461, 148 0	1
11. 00 12. 00	Physician Supervision Under Agreement	0	0		0 0	0	
13. 00	Other Costs Under Agreement	0	0			0	•
14. 00	Subtotal (sum of lines 11 through 13)	0	0			0	
15. 00	Medical Supplies	0	29, 820	29, 82	۰ <sub>ا</sub>	29, 820	
16. 00	Transportation (Health Care Staff)	0	27,020			27, 020	1
17. 00	Depreciation-Medical Equipment	0	l o			0	1
18. 00	Professional Liability Insurance	0	0			0	
19. 00	,	0	0			0	1
20. 00	Allowable GME Costs	· ·	Ĭ		Ĭ	Ü	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	29. 820	29. 82	ol	29, 820	
22. 00	Total Cost of Health Care Services (sum of	461, 148		490, 96		490, 968	
	lines 10, 14, and 21)	,					
	COSTS OTHER THAN RHC/FQHC SERVICES		•		'		
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		o o	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25. 01	Tel eheal th	0	0		0 0	0	25. 01
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0		40, 57			29. 00
30 00	Administrative Costs	106 372	l o	106.37	2  0	106 372	1 30 00

106, 372

567, 520

40, 575

70, 395

106, 372

146, 947

637, 915

40, 575 106, 372

146, 947

637, 915

0

0

30.00

31.00

32.00

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-0061	Peri od: From 01/01/2022	Worksheet M-1	
		Component	CCN: 15-3999	To 12/31/2022		
				RHC II	Cost	
	Adjustments	Net Expenses				

Adj ustments   Net Expenses   For   All ocation   (col. 5 + col. 6)
FACILITY HEALTH CARE STAFF COSTS
Allocation (col. 5 + col. 6)
Col . 5 + col . 6)   Col . 6   Col . 7   Col . 6   Col
Col . 5 + col . 6)   Col . 6   Col . 7   Col . 6   Col
FACILITY HEALTH CARE STAFF COSTS
FACILITY HEALTH CARE STAFF COSTS   1.00   Physician   0   272,996   1.00   2.00   Physician Assistant   0   0   0   2.00   3.00   Nurse Practitioner   0   87,413   3.00   4.00   Visiting Nurse   0   0   0   4.00   5.00   Other Nurse   0   0   0   5.00   Other Nurse   0   0   0   0   6.00   Clinical Psychologist   0   0   0   0   6.00   7.00   Clinical Social Worker   0   0   0   0   8.00   Laboratory Technician   0   0   0   0   0   0   0   0   0
FACILITY HEALTH CARE STAFF COSTS   1.00   Physician
1.00     Physician     0     272,996     1.00       2.00     Physician Assistant     0     0     2.00       3.00     Nurse Practitioner     0     87,413     3.00       4.00     Visiting Nurse     0     0     4.00       5.00     Other Nurse     0     0     5.00       6.00     Clinical Psychologist     0     0     6.00       7.00     Clinical Social Worker     0     0     7.00       8.00     Laboratory Technician     0     0     8.00       9.00     Other Facility Health Care Staff Costs     0     100,739     9.00
2. 00       Physician Assistant       0       0       3. 00         3. 00       Nurse Practitioner       0       87, 413       3. 00         4. 00       Visiting Nurse       0       0       4. 00         5. 00       Other Nurse       0       0       5. 00         6. 00       Clinical Psychologist       0       0       6. 00         7. 00       Clinical Social Worker       0       0       7. 00         8. 00       Laboratory Technician       0       0       8. 00         9. 00       Other Facility Health Care Staff Costs       0       100, 739       9. 00
3.00   Nurse Practitioner   0   87,413   3.00   4.00   Visiting Nurse   0   0   0   0   0   0   0   0   0
4.00       Visiting Nurse       0       0       4.00         5.00       Other Nurse       0       0       5.00         6.00       Clinical Psychologist       0       0       6.00         7.00       Clinical Social Worker       0       0       7.00         8.00       Laboratory Technician       0       0       8.00         9.00       Other Facility Health Care Staff Costs       0       100,739       9.00
5.00     Other Nurse     0     0       6.00     Clinical Psychologist     0     0       7.00     Clinical Social Worker     0     0       8.00     Laboratory Technician     0     0       9.00     Other Facility Health Care Staff Costs     0     100,739       5.00     5.00       6.00       7.00       8.00       9.00
6.00   Clinical Psychologist   0   0   0   7.00     Clinical Social Worker   0   0   0   7.00     8.00   Laboratory Technician   0   0   0   8.00   9.00   Other Facility Health Care Staff Costs   0   100,739   9.00
7.00         Clinical Social Worker         0         0         7.00           8.00         Laboratory Technician         0         0         8.00           9.00         Other Facility Health Care Staff Costs         0         100,739         9.00
8.00       Laboratory Technician       0       0       8.00         9.00       Other Facility Health Care Staff Costs       0       100,739       9.00
9.00 Other Facility Health Care Staff Costs 0 100,739 9.00
10.00   Subtotal (sum of lines 1 through 9)   0   461,148   10.00
11.00 Physician Services Under Agreement 0 0 11.00
12.00 Physician Supervision Under Agreement 0 0 12.00
13.00 Other Costs Under Agreement 0 0 13.00
14.00 Subtotal (sum of lines 11 through 13) 0 0 14.00
15.00 Medical Supplies 0 29,820 15.00
16. 00 Transportation (Health Care Staff) 0 0 16. 00
17. 00 Depreciation-Medical Equipment 0 0 17. 00
18.00 Professional Liability Insurance 0 0 18.00
19.00 Other Health Care Costs 0 0 19.00
20.00   Allowable GME Costs   20.00
21.00   Subtotal (sum of lines 15 through 20)   0   29,820   21.00
22.00   Total Cost of Health Care Services (sum of   0   490,968   22.00
li nes 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES
23.00   Pharmacy   0   0   23.00
24. 00   Dental   0   0   24. 00
25.00 Optometry 0 0 25.00
25. 01 Tel eheal th 0 0 0 25. 01
25.02 Chronic Care Management 0 0 0 25.02
26.00 All other nonrei mbursable costs 0 0 26.00
27.00 Nonallowable GME costs
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00
through 27)
FACILITY OVERHEAD
29. 00 Facility Costs 0 40, 575 29. 00
30. 00   Administrative Costs   0   106, 372   30. 00
30.00   Administrative costs   0   106, 372   30.00   31.00   Total Facility Overhead (sum of lines 29 and   0   146, 947   31.00
30) 32 00 Tatal facility costs (sum of lines 22 20 )
32.00 Total facility costs (sum of lines 22, 28 0 637,915 32.00
and 31)

Heal th	Financial Systems	DAVIESS COMMUN	ITV HOSDITAI		In lie	u of Form CMS-2	2552_10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS	DAVIESS COMMON	Provi der C	CN: 15-0061	Peri od:	Worksheet M-1	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	
					RHC III	Cost	30 alli
		Compensation	Other Costs	Total (col.	1 Reclassificat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	3, 000	0	3, 00	0 0	3, 000	1.00
2.00	Physi ci an Assi stant	0	0		0	0	2.00
3.00	Nurse Practitioner	766, 564	0	766, 56	4 0	766, 564	3.00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	0	0		0	0	0.00
6. 00	Clinical Psychologist	0	0		0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	1
8.00	Laboratory Techni ci an	0	0		0	0	8.00
9. 00	Other Facility Health Care Staff Costs	313, 715	0	313, 71		313, 715	1
10. 00	Subtotal (sum of lines 1 through 9)	1, 083, 279	0	1, 083, 27		1, 083, 279	1
11. 00	Physician Services Under Agreement	0	116, 566	116, 56		116, 566	1
12. 00	Physician Supervision Under Agreement	0	0		0	0	12.00
13. 00	Other Costs Under Agreement	0	0		0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	116, 566	•		116, 566	
15. 00	Medical Supplies	0	24, 968	24, 96	8 0	24, 968	1
16.00	Transportation (Health Care Staff)	0	0		0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	
18.00	Professional Liability Insurance	0	0		0	0	18.00
	Other Health Care Costs	U	U		U U	0	19.00
20.00	Allowable GME Costs	0	24.060	24.04	0	24.040	20.00
21. 00 22. 00	Subtotal (sum of lines 15 through 20) Total Cost of Health Care Services (sum of	1, 083, 279	24, 968 141, 534			24, 968	•
22.00	lines 10, 14, and 21)	1,083,279	141, 534	1, 224, 81	3	1, 224, 813	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00		0	0		0 0	0	23.00
24. 00	Dental	0	0		0 0	0	24.00
25. 00	Optometry	0	0		0 0	0	25.00
25. 01	Tel eheal th	0	0		0 0	0	25. 01
25. 02		0	0		0 0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26.00
27. 00	Nonal Lowable GME costs	Ĭ					27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	o	0		0 0	0	
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	74, 447	74, 44	7 0	74, 447	29. 00
30.00	1	148, 927	0				
21 00	Total Facility Overhead (sum of lines 20 and	1/12 027	7/ //7	222 27	4	222 27/	1 31 00

148, 927

1, 232, 206

Total Facility Overhead (sum of lines 29 and

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

74, 447 148, 927 223, 374

1, 448, 187

0

0

31.00

32.00

223, 374

1, 448, 187

74, 447

215, 981

Health Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CC	CN: 15-0061	Peri od: From 01/01/2022	Worksheet M-1	
		Component (	CCN: 15-8501	To 12/31/2022		
				RHC III	Cost	
	Adjustments	Net Expenses				

			Component	CCN. 13-6501	10 12/31/202	6/12/2023 11	
					RHC III	Cost	
		Adjustments	Net Expenses		•		
		,	for				
			All ocation				
			(col. 5 +				
			col. 6)				
		6. 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	3, 000				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	766, 564				3.00
4.00	Visiting Nurse	0	0				4. 00
5.00	Other Nurse	0	0				5. 00
6.00	Clinical Psychologist	0	0				6. 00
7.00	Clinical Social Worker	0	0				7. 00
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	313, 715				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 083, 279				10.00
11. 00	Physician Services Under Agreement	0	116, 566				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	116, 566				14.00
15. 00	Medical Supplies	0	24, 968				15. 00
16. 00	Transportation (Health Care Staff)	0	0				16. 00
	Depreciation-Medical Equipment	0	0				17. 00
18. 00	1	0	0				18. 00
	Other Health Care Costs	0	0				19. 00
20.00	Allowable GME Costs						20.00
21. 00		0	24, 968				21.00
22. 00	Total Cost of Health Care Services (sum of	0	1, 224, 813				22. 00
	lines 10, 14, and 21)						
00.00	COSTS OTHER THAN RHC/FQHC SERVICES	ام	0				
23. 00	1 -	0	0	•			23.00
24. 00	Dental	U	0				24.00
25. 00	Optometry	U O	0				25. 00
25. 01 25. 02	Telehealth Chronic Care Management	U O	0				25. 01 25. 02
26. 00	,	O O	0				26.00
27.00	Nonallowable GME costs	٩	U				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
20.00	through 27)	٩	U				20.00
	FACILITY OVERHEAD						-
29 00	Facility Costs	ol	74, 447				29. 00
30.00	Administrative Costs	0	148, 927				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	223, 374	1			31.00
51.50	30)	٩	220,014				31.00
32.00	1 /	o	1, 448, 187				32.00
	and 31)	[	,				
	,	·		•			•

		DAVIESS COMMUN		ON 15 00/1		u of Form CMS-1	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	JN: 15-0061	Period: From 01/01/2022	Worksheet M-1	
			Component (		To 12/31/2022	Date/Time Pre 6/12/2023 11:	
					RHC V	Cost	
		Compensation	Other Costs		Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	FACULTY WENT THE CARE OTATE COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	101 050		104.05		101 050	
1.00	Physi ci an	481, 858	0	481, 85		481, 858	
2.00	Physician Assistant	0	0	0.4 50	0	0	2.00
3.00	Nurse Practitioner	241, 524	0	241, 52	4 0	241, 524	
4.00	Visiting Nurse	0	0		0	0	
5.00	Other Nurse	U	0		0	0	
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0	0		0	0	
7. 00 8. 00	Laboratory Technician	0	0		0	0	
9. 00	Other Facility Health Care Staff Costs	155. 896	0	155. 89	0	155, 896	
10.00	Subtotal (sum of lines 1 through 9)	879, 278	0	879, 27		879, 278	
11. 00	Physician Services Under Agreement	0/9, 2/0	9, 544	9, 54		9, 544	
12. 00	Physician Supervision Under Agreement	0	7, 344 N	7, 54	0	9, 544	12.00
13. 00		0	0		0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	9, 544	9.54	4 0	9, 544	
15. 00	Medical Supplies	0	102, 582	102, 58		102, 582	1
16. 00	Transportation (Health Care Staff)	0	0.002		0 0	0	1
17. 00	Depreciation-Medical Equipment	0	0		0 0	o o	
18. 00	Professional Liability Insurance	0	0		0	0	
	Other Health Care Costs	Ö	0		o o	Ō	
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	102, 582	102, 58	2 0	102, 582	21.00
22.00	Total Cost of Health Care Services (sum of	879, 278	112, 126	991, 40	4 0	991, 404	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0	0	
24. 00	Dental	0	0		0	0	
25.00	Optometry	0	0		0	0	20.00
25. 01	Tel eheal th	0	0		0	0	
25. 02		0	0		0	0	
26. 00	All other nonreimbursable costs	0	0		0	0	
27. 00	Nonallowable GME costs					_	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		0 0	0	28. 00
	FACILITY OVERHEAD						
	Facility Costs	0	29, 611	29, 61		29, 611	
	Administrative Costs	59, 733	0	,		59, 733	
31 00	Total Facility Overhead (sum of lines 29 and	59 733	29 611	89 34	4 0	1 89 344	31 00

59, 733

939, 011

Total Facility Overhead (sum of lines 29 and

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

29, 611 59, 733 89, 344

1, 080, 748

0

0

31.00

32.00

89, 344

1, 080, 748

29, 611

141, 737

31.00

Hart H. El accel at Contact	DAV4 FCC .004###	II TV 1100D1 TA1		1 . 11 .	. C. E OHC. /	0550 40
Health Financial Systems	DAVI ESS COMMUN	IIIY HUSPITAL		In Lieu	u of Form CMS-2	<u> 2552-10</u>
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-0061	Peri od:	Worksheet M-1	
				From 01/01/2022		
		Component	CCN: 15-8503	To 12/31/2022	Date/Time Pre 6/12/2023 11:	
				RHC V	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				
		(col E :				

				RHC V Cost	
		Adjustments	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7.00		
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00		
1.00	Physi ci an	0	481, 858		1.00
2. 00		0			2.00
	Physician Assistant	0			
3.00	Nurse Practitioner	0	241, 524	l e e e e e e e e e e e e e e e e e e e	3.00
4.00	Visiting Nurse	0	0	1	4.00
5.00	Other Nurse	0	0		5. 00
6.00	Clinical Psychologist	0	0		6. 00
7.00	Clinical Social Worker	0	0		7. 00
8.00	Laboratory Techni ci an	0	0		8. 00
9.00	Other Facility Health Care Staff Costs	0	155, 896		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	879, 278		10.00
11.00	Physician Services Under Agreement	0	9, 544		11.00
12. 00	Physician Supervision Under Agreement	0	0		12.00
13. 00	Other Costs Under Agreement	0	0		13. 00
14. 00		0	9. 544		14.00
	Subtotal (sum of lines 11 through 13)	0			
15.00	Medical Supplies	0	102, 582	l e e e e e e e e e e e e e e e e e e e	15.00
16. 00	Transportation (Health Care Staff)	0	0		16. 00
17. 00	Depreciation-Medical Equipment	0	0	I and the second	17. 00
18. 00	Professional Liability Insurance	0	0		18. 00
19.00	Other Health Care Costs	0	0		19. 00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	102, 582		21.00
22.00	Total Cost of Health Care Services (sum of	0	991, 404		22. 00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICES				1
23.00	Pharmacy	0	0		23. 00
24. 00	Dental	0	Ō	•	24.00
25. 00	Optometry	0	0	•	25.00
25. 01	Tel eheal th	0	0	The state of the s	25. 00
25. 01	Chronic Care Management	0	0		25. 01
		0	_	1	
26.00	All other nonreimbursable costs	Ü	0		26.00
27. 00	Nonallowable GME costs	_	_		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
	through 27)				
	FACILITY OVERHEAD				
29. 00	Facility Costs	0			29. 00
30.00	Administrative Costs	0	59, 733		30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	89, 344		31.00
	30)				1
32.00	Total facility costs (sum of lines 22, 28	0	1, 080, 748		32.00
	and 31)				
	1 /		•	1	

	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	DAVIESS COMMUN		CN: 15-0061	Peri od:	u of Form CMS- Worksheet M-1	
			Component	CCN: 15-8506	From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
					RHC VI	6/12/2023 11: Cost	56 am
		Compensation	Other Costs	Total (col	1 Reclassificat	Recl assi fi ed	
		oomponoa er on	011101 00010	+ col . 2)	ions	Tri al 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	207, 255	C	207, 25	55 0	207, 255	1.00
2.00	Physician Assistant	o	C		0 0	0	2.00
3.00	Nurse Practitioner	109, 339	C	109, 33	39 0	109, 339	3.00
4.00	Visiting Nurse	0	C		0 0	0	4.00
5.00	Other Nurse	0	C		0 0	0	5.00
6.00	Clinical Psychologist	0	C		0 0	0	6.00
7.00	Clinical Social Worker	0	C		0 0	0	7.00
8.00	Laboratory Techni ci an	0	C	)	0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	154, 781	C	154, 78	31 0	154, 781	9. 00
10.00	Subtotal (sum of lines 1 through 9)	471, 375	C	471, 37	75 0	471, 375	10.00
11. 00	Physician Services Under Agreement	0	C		0	0	11.00
12.00	Physician Supervision Under Agreement	0	C		0	0	12.00
13.00	Other Costs Under Agreement	0	C	)	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	C	)	0	0	
15.00	Medical Supplies	0	19, 689	19, 68	39 0	19, 689	
16.00	Transportation (Health Care Staff)	0	C	)	0	0	16.00
17. 00	1 '	0	C	)	0	0	1
18. 00		0	C	)	0	0	1 .0.00
	Other Health Care Costs	0	C		0	0	1
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	19, 689			19, 689	
22. 00	Total Cost of Health Care Services (sum of	471, 375	19, 689	491, 06	54 0	491, 064	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		0	C	1	0	0	
24. 00	Dental	0	C	)	0	0	
25. 00	Optometry	0	C	)	0	0	
25. 01	Tel eheal th	0	C	)	0	0	
25. 02	9	0	C	)	0	0	
26.00	All other nonreimbursable costs	0	C	)	0	0	0.00
27. 00	Nonallowable GME costs	_	_			_	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	이	C	ין	0	0	28. 00
	through 27)						-
20.00	FACILITY OVERHEAD		0/ 5/4	24.5	1 ^	2/ 5/4	20.00
	Facility Costs Administrative Costs	0 74 547	36, 561				29.00
K() ()()	TAUMENI STEATI VE LOSTS	1 /4 54/1	(	л /4.54	↓/  ()	1 /4 54/	1 .50 ()()

74, 547

545, 922

36, 561 74, 547 111, 108

602, 172

0

74, 547

111, 108

602, 172

36, 561

56, 250

29. 00 30. 00

31.00

32.00

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPITAL	In Lieu	u of Form CMS-25	552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-0061	Peri od: From 01/01/2022	Worksheet M-1	
		Component CCN: 15-8506	To 12/31/2022	Date/Time Prepa 6/12/2023 11:50	
			RHC VI	Cost	
	A 12 . 1				

					6/12/2023 11:	56 am_
				RHC VI	Cost	
		Adjustments	Net Expenses			
		•	for			
			Allocation			
			(col. 5 +			
			col. 6)			
		6. 00	7.00			
	FACILITY HEALTH CARE STAFF COSTS					
1. 00	Physi ci an	0	207, 255			1.00
2. 00	Physician Assistant	0	0			2.00
3. 00	Nurse Practitioner	0	109, 339			3.00
4. 00	Vi si ti ng Nurse	0	107, 337			4.00
		0	١			
5.00	Other Nurse	0	0			5.00
6.00	Clinical Psychologist	0	0			6.00
7. 00	Clinical Social Worker	0	0			7.00
8.00	Laboratory Techni ci an	0	0			8. 00
9. 00	Other Facility Health Care Staff Costs	0	154, 781			9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	471, 375			10.00
11. 00	Physician Services Under Agreement	0	0			11.00
12.00	Physician Supervision Under Agreement	0	0			12.00
13.00	Other Costs Under Agreement	0	0			13.00
14.00	Subtotal (sum of lines 11 through 13)	0	l ol			14.00
15.00	Medical Supplies	0	19, 689			15.00
16. 00	Transportation (Health Care Staff)	0	0			16.00
17. 00	Depreciation-Medical Equipment	0	0			17. 00
18. 00	Professional Liability Insurance	0				18.00
19. 00	Other Health Care Costs	0				19.00
20.00	Allowable GME Costs	0				20.00
		0	19, 689			
21.00	Subtotal (sum of lines 15 through 20)	0				21.00
22. 00	Total Cost of Health Care Services (sum of	0	491, 064			22. 00
	lines 10, 14, and 21)					1
00.00	COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0				23.00
24. 00	Dental	0	0			24.00
25.00	Optometry	0	0			25. 00
25. 01	Tel eheal th	0	0			25. 01
25. 02	Chronic Care Management	0	0			25. 02
26.00	All other nonreimbursable costs	0	0			26.00
27.00	Nonallowable GME costs					27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0			28. 00
	through 27)					
	FACILITY OVERHEAD		•			1
29.00	Facility Costs	0	36, 561			29. 00
30.00	Administrative Costs	0				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	111, 108			31.00
220	30)	· ·	,			
32. 00	Total facility costs (sum of lines 22, 28	n	602, 172			32.00
02. 00	and 31)	Ü	332, 172			32.00
	1		1			1

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre	pared.
			ooporrorre	33.11 13 3333		6/12/2023 11:	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1.00	0.00	2.00	1 x col . 3)	col . 4	
	VICITE AND DRODUCTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY Positions						1
1. 00	Physi ci an	1. 29	3, 952	1	1 1		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3. 00	Nurse Practitioner	0.00			1 1		3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 24			'  '2	5. 970	
5. 00	Visiting Nurse	0.00				0,770	
6. 00	Clinical Psychologist	0.00	l e			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	2. 24	5, 970			5, 970	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL -BASE	ED RHC/EOHC SEI	RVICES		1.00	
	Total costs of health care services (from Wk					613, 963	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,						11.00
12.00	Cost of all services (excluding overhead) (s					616, 549	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 995806	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. I	M-1, col. 7, I	ine 31)		140, 788	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			553, 485	
16.00	Total overhead (sum of lines 14 and 15)					694, 273	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					694, 273	
	Overhead applicable to hospital-based RHC/FC					691, 361	
∠0. 00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (	sum of lines 1	u and 19)	I	1, 305, 324	J 20.00

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre	narod:
			Component	CCN. 13-3777	10 12/31/2022	6/12/2023 11:	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						_
4 00	Posi ti ons	1 0 00	0 (40	ı	a a		4 00
1.00	Physician	0. 88 0. 00		1			1.00
2. 00 3. 00	Physician Assistant Nurse Practitioner				1 0		2. 00 3. 00
3. 00 4. 00		0. 80 1. 68				4. 273	
5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	0.00			2	4, 2/3	
6. 00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0.00				0	7.00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00				0	7.00
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7.02
7.02	only)	0.00	Ĭ			O	7.02
8. 00	Total FTEs and Visits (sum of lines 4	1. 68	4, 273			4, 273	8.00
	through 7)		,				
9.00	Physician Services Under Agreements		0			0	9. 00
	-						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					490, 968	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (s					490, 968	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		146, 947	
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			432, 223	
16.00	Total overhead (sum of lines 14 and 15)					579, 170	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	)UC (I	! 10   !	10)		579, 170 570, 170	
	Overhead applicable to hospital-based RHC/FC Total allowable cost of hospital-based RHC/F					579, 170 1, 070, 138	
∠∪. ∪∪	Tiorai arrowabie cost of Hospital-Dased RHC/F	unc services (	Sum Of FITTES I	o anu 19)	l	1,070,138	<sub>1</sub> 20.00

	Financial Systems	DAVIESS COMMUN				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Peri od: From 01/01/2022	Worksheet M-2	
			Component		To 12/31/2022	Date/Time Pre	pared:
						6/12/2023 11:	
					RHC III	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1.00		0.00	1 x col . 3)	col . 4	
	WICHTO AND DEODUCTIVIETY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						1
1 00	Posi ti ons Physi ci an	0. 15	658	ol .	1 0		1.00
1. 00 2. 00	Physician Assistant	0. 15		1	1 0		2.00
3. 00	Nurse Practitioner	5. 65			1 6		3.00
4. 00	Subtotal (sum of lines 1 through 3)	5. 80			6	18, 266	
5. 00	Visiting Nurse	0.00		1	J	10, 200	5.00
6. 00	Clinical Psychologist	0.00	l .			0	6.00
7. 00	Clinical Social Worker	0.00	l .	á		0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7. 01
7. 02	Di abetes Self Management Training (FQHC	0.00	l .			0	7. 02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	5. 80	18, 266			18, 266	8.00
	through 7)						
9. 00	Physician Services Under Agreements		(			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
10.00	Total costs of health care services (from Wk					1, 224, 813	
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (s					1, 224, 813	
13.00	Ratio of hospital -based RHC/FQHC services (I			01)		1.000000	
14.00	Total hospital -based RHC/FQHC overhead - (fr			ine 31)		223, 374	
15.00	Parent provider overhead allocated to facili	ty (see Instru	Ctions)			863, 864	
16. 00 17. 00	Total overhead (sum of lines 14 and 15) Allowable GME overhead (see instructions)					1, 087, 238 0	
	Enter the amount from line 16					1, 087, 238	
	Overhead applicable to hospital-based RHC/FC	NHC sarvices (1	ine 13 v line	10)		1, 087, 238	
	Total allowable cost of hospital-based RHC/F					2, 312, 051	
20.00	Tiotal allowable cost of hospital-based kilc/l	unc services (	Juli Di Titles I	0 and 17)		2,312,031	<sub>1</sub> 20.00

Heal th	Financial Systems	DAVI ESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre	narod:
			Component	CON. 13 0303	10 12/31/2022	6/12/2023 11:	
					RHC V	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col . 3)	col . 4	
	MICLES AND PROPRIOTIVITY	1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1. 00	Posi ti ons Physi ci an	1. 04	1, 716	I	1 1		1.00
2. 00	Physician Assistant	0.00			1 0		2.00
3. 00	Nurse Practitioner	1.06			1 1		3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 10			'  '2	6, 050	
5. 00	Visiting Nurse	0.00		1		0, 030	
6. 00	Clinical Psychologist	0.00				0	
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	0.00	0			0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	2. 10	6, 050			6, 050	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
						4 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOCDITAL DACI	ED DUC/EQUE CEI	חעו פרכ		1. 00	
	Total costs of health care services (from Wk			KVICES		991, 404	10 00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					991, 404	1
12. 00	Cost of all services (excluding overhead) (s					991, 404	
13. 00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital -based RHC/FQHC overhead - (fr			ine 31)		89, 344	
15. 00	Parent provider overhead allocated to facili					538, 434	
16.00	Total overhead (sum of lines 14 and 15)	<i>,</i>	,			627, 778	16.00
17.00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					627, 778	18.00
	Overhead applicable to hospital-based RHC/FC					627, 778	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (	sum of lines 1	0 and 19)		1, 619, 182	20.00

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 6/12/2023 11:	
					RHC VI	Cost	
	·	Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	1.06	,		1 1		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	1. 02			1 1		3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 08			2	5, 109	4.00
5. 00	Visiting Nurse	0.00				0	
6. 00	Clinical Psychologist	0.00				0	6. 00
7. 00	Clinical Social Worker	0.00	l .			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
8. 00	only) Total FTEs and Visits (sum of lines 4	2. 08	5, 109			5, 109	8.00
0.00	through 7)	2.00	3, 109			3, 109	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	Thysreran services under Agreements					0	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	0 HOSPI TAL-BASI	ED RHC/FQHC SEI	RVICES			
	Total costs of health care services (from Wk					491, 064	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	1
12.00	Cost of all services (excluding overhead) (s					491, 064	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, l	ine 31)		111, 108	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)	ŕ		374, 018	15.00
16.00	Total overhead (sum of lines 14 and 15)					485, 126	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					485, 126	18. 00
	Overhead applicable to hospital-based RHC/FC					485, 126	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (	sum of lines 1	o and 19)		976, 190	20.00

	Financial Systems  DAVIESS COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0061	Peri od:	Worksheet M-3	2552-10
SERVI (		Provider CCN. 15-0081	From 01/01/2022	WOLKSHEET M-3	
J		Component CCN: 15-8500	To 12/31/2022	Date/Time Pre	
		Title XVIII	RHC I	6/12/2023 11: Cost	56 am
		TI LIE XVIII	KIIC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 305, 324	
2. 00	Cost of injections/infusions and their administration (from W			17, 504	
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	irnus irne 2)		1, 287, 820 5, 970	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		3, 470	5.00
6. 00	Total adjusted visits (line 4 plus line 5)	1111e 7)		5, 970	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			215. 72	7.00
			Cal cul ati on	of Limit (1)	
			Data Dani ad	Data Dari ad 1	
			Rate Period N/A	Rate Period 1 (01/01/2022	
			IV/A	through	
				12/31/2022)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	219. 35	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	215. 72	9.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	ol	1, 076	10 00
11. 00	Program cost excluding costs for mental health services (line		o	232, 115	
12. 00	Program covered visits for mental health services (from contr	•	o	0	12.00
13. 00	Program covered cost from mental health services (line 9 x li		0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions	,	0	0	
15.00	Graduate Medical Education Pass Through Cost (see instruction	•		000 445	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re		0	232, 115 211, 447	
16. 01	Total program preventive charges (see instructions)(from prov	•		17, 190	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		18, 870	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	•		149, 387	
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	168, 257	
17. 00 18. 00	Primary payer amounts	(from contractor		0 24 511	17. 00 18. 00
16.00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Troil Contractor		26, 511	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		33, 550	19.00
	records)			·	
20. 00	Net Medicare cost excluding vaccines (see instructions)			168, 257	
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		9, 284	
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			177, 541	1
23. 00	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99	, , , , , , , , , , , , , , , , , , , ,				25. 9
26. 00	Net reimbursable amount (see instructions)			177, 541	
26. 01	Sequestration adjustment (see instructions)			2, 237	
26. 02	Demonstration payment adjustment amount after sequestration Interim payments			0 160, 981	
	Tentative settlement (for contractor use only)			100, 781 N	28.00
28. UU	,	00 07   00)		14 222	
28. 00 29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)	J	14, 323	Z7. U

	Financial Systems  DAVIESS COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (		FIOVIDE CCN. 15-0001	From 01/01/2022	WOLKSHEET M-3	
02		Component CCN: 15-3999	To 12/31/2022	Date/Time Pre	
		Title XVIII	RHC II	6/12/2023 11: Cost	56 am
	<u> </u>	THE AVIII	ICIO TT	0031	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 070, 138	
2. 00	Cost of injections/infusions and their administration (from W			17, 058	
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	irius iriie 2)		1, 053, 080 4, 273	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		4, 2, 3	1
6. 00	Total adjusted visits (line 4 plus line 5)			4, 273	1
7. 00	Adjusted cost per visit (line 3 divided by line 6)			246. 45	7.0
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2022	
			1.,,,,	through	
				12/31/2022)	
			1.00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	204. 01	8.00
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	204. 01	9.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	0	1, 135	10.0
11. 00	Program cost excluding costs for mental health services (line		O	231, 551	
12. 00	Program covered visits for mental health services (from contr	actor records)	0	0	12.0
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	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	231, 551	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's re	•		242, 241	
16. 02	Total program preventive charges (see instructions) (from prov	•		850	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		813	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		150, 254	16.0
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	151, 067	
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		42, 921	17. 00 18. 00
10.00	records)	(11 oiii coitti actoi		42, 721	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		39, 695	19.00
	records)				
20.00	Net Medicare cost excluding vaccines (see instructions)			151, 067	
21. 00 22. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		4, 048 155, 115	
23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			155, 115	
23. 00	Adjusted reimbursable bad debts (see instructions)			0	ı
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.0
	Pioneer ACO demonstration payment adjustment (see instruction	ıs)		0	
25. 99	, , , , , , , , , , , , , , , , , , , ,				25. 9
26.00	Net reimbursable amount (see instructions)			155, 115	
26. 01 26. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			1, 955 0	
	Interim payments			142, 690	
28. 00	Tentative settlement (for contractor use only)			0	28.0
29. 00	,	02, 27, and 28)		10, 470	
27.00		ince with CMS Pub. 15-II	1	0	30.00

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Y HOSPITAL Provider CCN: 15-0061	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVICES		From 01/01/2022		
	Component CCN: 15-8501	To 12/31/2022	Date/Time Pre	
	Title XVIII	RHC III	6/12/2023 11: Cost	oo aiii
		1	3331	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES	W	1	0.010.051	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro			2, 312, 051	1.0
2.00   Cost of injections/infusions and their administration (from No.00   Total allowable cost excluding injections/infusions (line 1 m			9, 440 2, 302, 611	2. 0 3. 0
.00 Total Visits (from Wkst. M-2, column 5, line 8)	milius iiile 2)		18, 266	ı
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.0
.00 Total adjusted visits (line 4 plus line 5)	•		18, 266	6.0
.00 Adjusted cost per visit (line 3 divided by line 6)			126. 06	7.0
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2022	
			through	
			12/31/2022)	
		1.00	2. 00	
2.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	156. 85	1
Rate for Program covered visits (see instructions)		0.00	126. 06	9.0
CALCULATION OF SETTLEMENT  0.00 Program covered visits excluding mental health services (from	m contractor records)	0	1, 711	10 0
1.00 Program cost excluding costs for mental health services (line	· · · · · · · · · · · · · · · · · · ·	o	215, 689	
2.00 Program covered visits for mental health services (from conti	*	0		12.0
3.00 Program covered cost from mental health services (line 9 x li	ine 12)	0	0	13.0
4.00 Limit adjustment for mental health services (see instructions	s)	0	0	14.0
5.00 Graduate Medical Education Pass Through Cost (see instruction	•			15.0
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 1		0	215, 689	
<ul><li>6.01   Total program charges (see instructions)(from contractor's reference.</li><li>6.02   Total program preventive charges (see instructions)(from program preventive charges.</li></ul>	•		314, 689 7, 857	1
6.03 Total program preventive costs ((line 16.02/line 16.01) times			5, 385	
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0	•		133, 202	
(Titles V and XIX see instructions.)	,			
6.05 Total program cost (see instructions)		0	138, 587	
7.00 Primary payer amounts			0	17.0
8.00 Less: Beneficiary deductible for RHC only (see instructions)	) (from contractor		43, 801	18.0
records) 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		52, 607	10 0
records)	ons) (11 on contractor		32,007	17.0
0.00 Net Medicare cost excluding vaccines (see instructions)			138, 587	20.0
1.00 Program cost of vaccines and their administration (from Wkst.	. M-4, line 16)		6, 163	
2.00 Total reimbursable Program cost (line 20 plus line 21)			144, 750	
3.00 Allowable bad debts (see instructions)			0	
3.01 Adjusted reimbursable bad debts (see instructions)	++!>		0	1
4.00 Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	
<ul><li>5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li><li>5.50 Pioneer ACO demonstration payment adjustment (see instruction)</li></ul>	ns)		0	
5.99 Demonstration payment adjustment amount before sequestration			-	25. 9
6.00 Net reimbursable amount (see instructions)			144, 750	
6.01 Sequestration adjustment (see instructions)			1, 824	26.0
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			168, 208	1
8.00   Tentative settlement (for contractor use only)	02 27 20		0	
9.00   Balance due component/program (line 26 minus lines 26.01, 26.0.00   Protested amounts (nonallowable cost report items) in accorda			-25, 282	
o. oo jriotesteu amounts (nonarrowable cost report rtems) IN accord	ance with two Pub. 15-11	,	0	30.0

ealth Financial Systems DAVIESS COMMUNIT			u of Form CMS-2	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0061	Peri od: From 01/01/2022	Worksheet M-3	
SERVI CES	Component CCN: 15-8503	To 12/31/2022	Date/Time Pre	pared:
	·		6/12/2023 11:	
	Title XVIII	RHC V	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	· · · · · · · · · · · · · · · · · · ·		1, 619, 182	1.00
2.00   Cost of injections/infusions and their administration (from N			0	2.00
B.OO   Total allowable cost excluding injections/infusions (line 1 mark). B.OO   Total Visits (from Wkst. M-2, column 5, line 8)	minus line 2)		1, 619, 182 6, 050	3. 00 4. 00
			0, 030	5.00
5.00 Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	1111c 7)		6, 050	6.00
7.00 Adjusted cost per visit (line 3 divided by line 6)			267. 63	7.00
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2022	
			through	
		1.00	12/31/2022)	
8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	1 6 or vour contractor)	1.00	2. 00 335. 83	8.00
2.00   Rate for Program covered visits (see instructions)	5.6 or your contractor)	0.00	267. 63	ı
CALCULATION OF SETTLEMENT		0.00	2071.00	/ // 00
0.00 Program covered visits excluding mental health services (from	n contractor records)	0	0	10.00
1.00 Program cost excluding costs for mental health services (line		0	0	11.00
2.00 Program covered visits for mental health services (from conti	,	0	0	12.00
3.00 Program covered cost from mental health services (line 9 x li 4.00 Limit adjustment for mental health services (see instructions	*	0	0	13.00 14.00
5.00 Graduate Medical Education Pass Through Cost (see instruction	•	U	U	15.00
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1,	•	0	0	16.00
6.01 Total program charges (see instructions) (from contractor's re	ecords)		0	16. 01
6.02 Total program preventive charges (see instructions)(from pro	•		0	16. 02
6.03 Total program preventive costs ((line 16.02/line 16.01) times			0	16.03
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	03 and 18) times .80)		0	16.04
6.05 Total program cost (see instructions)		0	0	16. 0
7.00 Primary payer amounts			0	17.00
8.00 Less: Beneficiary deductible for RHC only (see instructions)	) (from contractor		0	18.00
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		0	19.00
10.00 Net Medicare cost excluding vaccines (see instructions)			0	20.00
11.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	21.00
22.00 Total reimbursable Program cost (line 20 plus line 21)			0	22.00
3.00 Allowable bad debts (see instructions)			0	23.00
23.01  Adjusted reimbursable bad debts (see instructions) 24.00  Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	23. 0° 24. 00
24.00   Allowable bad debts for dual eligible beneficiaries (see ins 25.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tructrons)		0	25.00
15.50 Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	
9 Demonstration payment adjustment amount before sequestration		0		
6.00 Net reimbursable amount (see instructions)			0	
6.01 Sequestration adjustment (see instructions)			0	
16.02 Demonstration payment adjustment amount after sequestration			0	26. 0
17.00 Interim payments			0	27.00
18.00   Tentative settlement (for contractor use only) 19.00   Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		0	28. 00 29. 00
10.00 Protested amounts (nonallowable cost report items) in accordance		,	0	30.00
chapter I, §115.2			· ·	

Health Financia				u of Form CMS-2	
	REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0061	Peri od: From 01/01/2022	Worksheet M-3	
SERVI CES		Component CCN: 15-8506	To 12/31/2022	Date/Time Pre	pared:
		·		6/12/2023 11:	
		Title XVIII	RHC VI	Cost	
				1. 00	
DETERMIN	ATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
	Iowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		976, 190	1.00
1	injections/infusions and their administration (from W			22, 515	2. 00
3.00 Total al	lowable cost excluding injections/infusions (line 1 m	inus line 2)		953, 675	3.00
	sits (from Wkst. M-2, column 5, line 8)			5, 109	
	ans visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
1	djusted visits (line 4 plus line 5)			5, 109	
7.00  Adjuste	d cost per visit (line 3 divided by line 6)		Cal cul ati on	186.67	7.00
			Carcuration	OI LIMIT (I)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2022	
				through	
			1 00	12/31/2022)	
8.00 Per visi	t payment limit (from CMS Pub. 100-04, chapter 9, §20	1 6 or vour contractor)	1.00	2. 00 198. 37	8.00
1	Program covered visits (see instructions)	. o or your contractor)	0.00	186. 67	
	TON OF SETTLEMENT		0.00	100.07	7.00
	covered visits excluding mental health services (from	contractor records)	0	1, 142	10.00
11.00 Program	cost excluding costs for mental health services (line	9 x line 10)	0	213, 177	11.00
	covered visits for mental health services (from contr	*	0	0	
	covered cost from mental health services (line 9 x li	•	0	0	
1	djustment for mental health services (see instructions e Medical Education Pass Through Cost (see instruction	•	0	0	14. 00 15. 00
1	rogram cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	213, 177	
1	rogram charges (see instructions)(from contractor's re	*	J	211, 498	1
	rogram preventive charges (see instructions)(from prov			607	1
16.03 Total p	rogram preventive costs ((line 16.02/line 16.01) times	line 16)		612	16. 03
	rogram non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		143, 484	16. 04
	V and XIX see instructions.)		0	144.007	1, 0
1	rogram cost (see instructions)		0	144, 096 0	1
,	payer amounts Beneficiary deductible for RHC only (see instructions)	(from contractor		33, 210	
records	,	(11 om contractor		33, 210	10.00
	ary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		35, 537	19.00
records)					
1	care cost excluding vaccines (see instructions)			144, 096	1
	cost of vaccines and their administration (from Wkst.	M-4, line 16)		14, 151	
	eimbursable Program cost (line 20 plus line 21) e bad debts (see instructions)			158, 247 0	1
	d reimbursable bad debts (see instructions)			0	1
,	e bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
25. 00 OTHER AI	DJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		Ö	
25. 50 Pi oneer	ACO demonstration payment adjustment (see instruction	is)		0	25. 50
	ration payment adjustment amount before sequestration			0	
1	nbursable amount (see instructions)			158, 247	1
	ration adjustment (see instructions)			1, 994	1
1	ration payment adjustment amount after sequestration payments			0 145, 986	
1	re settlement (for contractor use only)			143, 960	
1	due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		10, 267	
	ed amounts (nonallowable cost report items) in accorda		,	0	1
	I, §115. 2				

COMPLIT	Financial Systems DAVIESS COMMUN ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	NITY HOSPITAL Provider CO	N: 15-0061	Peri od:	u of Form CMS-2 Worksheet M-4	
COMI O I	ATTON OF HOSELTAL-BASED KHO/TQHC VACCINE COST	Trovider co		From 01/01/2022	WOLKSHEET W-4	
		Component (		To 12/31/2022	Date/Time Pre 6/12/2023 11:	
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCINES	ANTI BODY	
					PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	595, 739	595, 73	· ·	595, 739	
2. 00	Ratio of injection/infusion staff time to total health	0. 000185	0. 00146	0. 000000	0. 000000	2.00
	care staff time				_	
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	110	87	/3 0	0	3. 00
4.00	Injections/infusions and related medical supplies costs	2, 838	4, 41	12 0	0	4.00
	(from your records)					
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	2, 948	5, 28		0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	613, 963	613, 96	613, 963	613, 963	6. 00
7. 00	Total overhead (from Wkst. M-2, line 19)	691, 361	691, 36	691, 361	691, 361	7.00
8. 00	Ratio of injection/infusion direct cost to total direct	0. 004802	0. 00860	· ·	0.000000	
0.00	cost (line 5 divided by line 6)	0.001002	0.0000	0.00000	0.00000	0.00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	3, 320	5, 95	51 0	o	9.00
10.00	Total injection/infusion costs and their administration	6, 268	11, 23		0	1
	costs (sum of lines 5 and 9)	,	,			
11. 00	Total number of injections/infusions (from your records)	11	8	37 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	569. 82	129. 1	0. 00	0.00	12.00
13.00	Number of injection/infusion administered to Program	7	4	11 0	0	13.00
	benefi ci ari es					
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
	administered to MA enrollees					
14.00	Program cost of injections/infusions and their	3, 989	5, 29	95 0	0	14.00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)					
					COST OF	
					INJECTIONS /	
					I NFUSI ONS AND	
					ADMI NI STRATI O	
				1.00	N	
1E 00	Total cost of injections/infusions and their administration	un costs (sum of	f columns 1	1. 00	2. 00 17, 504	15. 00
13.00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		17,504	15.00
16 00	z, z.or, and z.oz, fine for (transfer this amount to wkst.  Total Program cost of injections/infusions and their admin		c (sum of		9, 284	16.00
	riviai rivulaii lust vi riitelii015/11114510115 aliu t1181 [auiii]11	11 3 LI A LI OII COS LS	s count of	1	7.∠84	1 10.00

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od:	Worksheet M-4	
		Component (		From 01/01/2022 To 12/31/2022	Date/Time Pre	nared
		· ·			6/12/2023 11:	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2.02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	461, 148	461, 14			1.0
. 00	Ratio of injection/infusion staff time to total health	0. 000337	0. 00083			
	care staff time					
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	155	38	5 0	0	3.0
. 00	Injections/infusions and related medical supplies costs (from your records)	4, 902	2, 38	0	0	4. C
. 00	Direct cost of injections/infusions (line 3 plus line 4)	5, 057	2, 76	9 0	o	5. C
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	490, 968	490, 96	490, 968	490, 968	6.0
. 00	Total overhead (from Wkst. M-2, line 19)	579, 170	579, 17	0 579, 170	579, 170	7. (
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 010300	0. 00564	0. 000000	0.000000	8.0
. 00	Overhead cost - injection/infusion (line 7 x line 8)	5, 965	3, 26	7 0	0	9. (
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	11, 022	6, 03	0	0	10.0
1. 00	Total number of injections/infusions (from your records)	19		.7	0	
2. 00	Cost per injection/infusion (line 10/line 11)	580. 11	128. 4			
3. 00	Number of injection/infusion administered to Program beneficiaries	1	2	7 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. (
4. 00	Program cost of injections/infusions and their	580	3, 46	.8	0	14. (
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)					
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMINISTRATIO   N	
				1. 00	2.00	
5. 00	Total cost of injections/infusions and their administratio	n costs (sum of	f columns 1	1.00	17, 058	15.
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		23. 4 17		, 000	
6. 00	Total Program cost of injections/infusions and their admin		c (sum of		4, 048	16

	Financial Systems DAVIESS COMMUNITION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od:	Worksheet M-4	
		Component (		From 01/01/2022 To 12/31/2022	Date/Time Pre	narod:
		Component	CIN. 15-6501	10 12/31/2022	6/12/2023 11:	
			XVIII	RHC III	Cost	
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
		1.00	2. 00	2. 01	PRODUCTS 2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 083, 279	1, 083, 27			1.0
	Ratio of injection/infusion staff time to total health	0. 000015	0. 00056		0.000000	
	care staff time	0.000013	0.00030	0.00000	0.000000	2.0
	Injection/infusion health care staff cost (line 1 x line	16	61	15 0	0	3.0
	2)					
	Injections/infusions and related medical supplies costs	516	3, 85	54 0	0	4.0
	(from your records)					
	Direct cost of injections/infusions (line 3 plus line 4)	532	4, 46		0	5.0
	Total direct cost of the hospital-based RHC/FQHC (from	1, 224, 813	1, 224, 81	1, 224, 813	1, 224, 813	6.0
	Worksheet M-1, col. 7, line 22) Total overhead (from Wkst. M-2, line 19)	1, 087, 238	1, 087, 23	1, 087, 238	1, 087, 238	7.0
	Ratio of injection/infusion direct cost to total direct	0. 000434	0. 00364		0. 000000	
	cost (line 5 divided by line 6)	0.000434	0.0030-	0.00000	0.000000	0.0
	Overhead cost - injection/infusion (line 7 x line 8)	472	3, 96	67 0	0	9.0
	Total injection/infusion costs and their administration	1, 004	8, 43	36	0	10.0
	costs (sum of lines 5 and 9)					
	Total number of injections/infusions (from your records)	2		76 0	0	
	Cost per injection/infusion (line 10/line 11)	502.00	111. (			12.0
	Number of injection/infusion administered to Program	1	5	51 0	0	13.0
	beneficiaries Number of COVID-19 vaccine injections/infusions			0	o	   13.0
	administered to MA enrollees			0	U	13.0
	Program cost of injections/infusions and their	502	5, 66	51 0	0	14.0
	administration costs (line 12 times the sum of lines 13	002	0, 00		, and the second se	0
	and 13.01, as applicable)					
					COST OF	
					INJECTIONS /	
					I NFUSI ONS AND	
					ADMI NI STRATI O	
				1. 00	N 2. 00	
5. 00	Total cost of injections/infusions and their administratio	n costs (sum of	columns 1	1.00	9, 440	15. C
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		551 dilii 15 1,		,, 440	''''
6. 00	Total Program cost of injections/infusions and their admin	istration costs	s (sum of		6, 163	16.0
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou					

Heal th	Financial Systems DAVIESS COMMUI	NITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider Co		Period: From 01/01/2022		
		Component	CCN: 15-8506	To 12/31/2022	Date/Time Pre 6/12/2023 11:	
		Title	XVIII	RHC VI	Cost	
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
					PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	471, 375	471, 3	75 471, 375	471, 375	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000221	0. 0022	0. 000000	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	104	1, 0	72 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	3, 354	6, 7	96 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3, 458	7, 80	58 0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from	491, 064			491, 064	6.00
	Worksheet M-1, col. 7, line 22)		,	,	,	
7.00	Total overhead (from Wkst. M-2, line 19)	485, 126	485, 12	485, 126	485, 126	7.00
8. 00	Ratio of injection/infusion direct cost to total direct	0.007042				
	cost (line 5 divided by line 6)					
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3, 416	7, 7	73 0	0	9.00
10.00	Total injection/infusion costs and their administration	6, 874	15, 6	41 0	0	10.00
	costs (sum of lines 5 and 9)					
11.00	Total number of injections/infusions (from your records)	13	1;	34 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	528. 77	116.	72 0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program	8		35 0	0	13.00
	benefi ci ari es					
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
	administered to MA enrollees					
14.00	Program cost of injections/infusions and their	4, 230	9, 9:	21 0	0	14.00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)					
					COST OF	
					I NJECTIONS /	
					I NFUSIONS AND	
					ADMINISTRATIO N	
				1. 00	2.00	
15 00	Total cost of injections/infusions and their administration	in costs (sum of	f columns 1	1.00	22, 515	15. 00
15.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		i corumns I,		22, 313	13.00
16. 00	Total Program cost of injections/infusions and their admir		s (sum of		14, 151	16 00
10.00	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				14, 151	10.00
	1 2, 2, 01, and 2, 02, 11110 11) (transfer this amou	to mat. w	5, 21)	ı	ı	ı

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provi der CCN: 15-0061 Component CCN: 15-8500	From 01/01/2022 To 12/31/2022	

		Component Con. 13-8300	10 12/31/2022	6/12/2023 11:	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
00	Total interim payments paid to hospital-based RHC/FQHC			160, 981	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		o	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	3
02				0	3
03				0	3
)4				0	3
)5				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
3				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		160, 981	4
	27)				
	TO BE COMPLETED BY CONTRACTOR			I	
00	List separately each tentative settlement payment after des	k review. Also show date c	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
)1	Program to Provider			0	 
)2				0	
)3					5
	Provider to Program			U	-
0	Frovider to Frogram			0	
51				0	5
52				l ől	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
0	Determined net settlement amount (balance due) based on the				ì
1	SETTLEMENT TO PROVIDER	3332 . opor c. (1)		14, 323	
)2	SETTLEMENT TO PROGRAM			11, 323	1
00	Total Medicare program liability (see instructions)			175, 304	7
	indicate program readility (300 mate detroils)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provi der CCN: 15-0061 Component CCN: 15-3999	Peri od: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 6/12/2023 11:56 am

				6/12/2023 11:	56 am
			RHC II	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			142, 690	1.00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.0
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3.0
3.02				0	3.0
3. 03				o	3.0
3. 04				0	3.0
3. 05				0	3.0
	Provider to Program				
3. 50				0	3.5
3. 51				o	3. 5
3. 52				0	3.5
3. 53				o	3.5
3. 54				o	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		o	3. 9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		142, 690	4. C
	27)	•		·	
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	k review. Also show date of	,		5.0
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		*		
5. 01	-			0	5.0
5. 02				o	5.0
5. 03				0	5.0
	Provider to Program				
5. 50				0	5. 5
5. 51				0	5. 5
5. 52				o	5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		o	5. 9
5. 00	Determined net settlement amount (balance due) based on the				6.0
5. 01	SETTLEMENT TO PROVIDER			10, 470	6.0
5. 02	SETTLEMENT TO PROGRAM			0	6.0
7. 00	Total Medicare program liability (see instructions)			153, 160	7.0
	The second of th		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-0061 Component CCN: 15-8501	From 01/01/2022 To 12/31/2022	
				_

		Component Con. 13-0301	10 12/31/2022	6/12/2023 11:	
			RHC III	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			168, 208	1.
00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero	•			
0	List separately each retroactive lump sum adjustment amount	t based on subsequent			3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				1
1				0	] 3
2				0	3
3				0	3
4				0	3
5				0	3
	Provider to Program			•	ĺ
0	<u>.</u>			0	3
1				0	3
2				0	3
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	e	168, 208	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				1
0	List separately each tentative settlement payment after des	sk review. Also show date o	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
1				0	5
2				0	5
3				0	5
	Provider to Program				
0				0	5
1				0	5
2				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (1)			6
1	SETTLEMENT TO PROVIDER			0	6
2	SETTLEMENT TO PROGRAM			25, 282	
0	Total Medicare program liability (see instructions)			142, 926	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
00	Name of Contractor				8

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15 Component CCN: 1	 From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 6/12/2023 11:56 am
-			B	

				6/12/2023 11:	56 a
			RHC VI	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			145, 986	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
00	List separately each retroactive lump sum adjustment amount			3.	
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
02				0	3.
03				0	3
04				o	3
)5				o	3
	Provider to Program		<u>'</u>		
50				0	3
51				o	3
52				0	3
53				0	3
54				o	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			145, 986	4
	27)	ore. to her hencet in e, it he		1.07,700	
	TO BE COMPLETED BY CONTRACTOR		-	•	
00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		-	•	
01				0	5
)2				0	5
)3				0	5
	Provider to Program				
0				0	5
51				0	5
52				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)				6
)1	SETTLEMENT TO PROVIDER			10, 267	6
02	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			156, 253	7
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	