DAVIESS COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

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 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: То 5/31/2024 9:20 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/31/2024 Time: 9:20 am]Manually prepared cost report use only 2. []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. 3 0 Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 [1] As Submitted
 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:

 (10) In the status
 11. Contractor's Vendor Code:

 (2) Settled without Audit
 9.

 [N] Final Report for this Provider CCN
 12.

 [0] If line 5, column 1 is 4:
 Enter number of times reopened = 0-9.

 Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S) 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 DAVLESS COMMUNITY HOSPITAL (15-0061) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were

SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR CHECKBOX ELECTRONI C SIGNATURE STATEMENT 2 1 I have read and agree with the above certification 1 statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature. 2 Signatory Printed Name 3 Signatory Title 3 4 Date 4

provided in compliance with such laws and regulations.

			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						
1.00	HOSPI TAL	0	253, 207	1, 132	0	0	1.00
2.00	SUBPROVIDER - IPF	0	6,004	0		0	2.00
3.00	SUBPROVIDER - IRF	0	34, 728	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		1, 812		0	10.00
10.01	RURAL HEALTH CLINIC II	0		693		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-16, 082		0	10.02
10.04	RURAL HEALTH CLINIC V	0		100		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		2, 937		0	10.05
200.00	TOTAL	0	293, 939	-9, 408	0	0	200.00

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

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

	TAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provio	der CCN: 1		Period: From 01/01/ To 12/31/	2023 2023	Workshe Part I Date/Ti 5/31/20	me Pre	pare
	1.00	2.00		3.00		4	4.00			
	Hospital and Hospital Health Care Co									
00	Street: 1314 E. WALNUT STREET	P0 Box: 760								1.
00	City: WASHINGTON	State: IN		e: 47501		y: DAVIESS				2.
		Component Name	CCN	CBSA	Provi der	Date	Paymer	nt Syst	em (P,	
			Number	Number	Туре	Certified		0, or		
							V	XVIII		4
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer			1						4
0	Hospi tal	DAVIESS COMMUNITY	150061	99915	1	07/01/1966	N	P	0	3
_		HOSPI TAL								
0	Subprovider - IPF	DCH - PSYCH	15S061	99915	4	01/01/2003	N	P	0	4
0	Subprovider - IRF	DCH – REHAB	15T061	99915	5	01/01/2000	N	P	0	5
0	Subprovider - (Other)									6
0	Swing Beds - SNF	DAVIESS COMMUNITY	150061	99915		11/10/1999	N	P	N	7
~		HOSPI TAL								
0	Swing Beds - NF									8
0	Hospital-Based SNF									9
00										10
00	Hospital-Based OLTC									11
00	Hospital-Based HHA									12
00										13
00	Hospi tal -Based Hospi ce	HELPING HEART HOSPICE	151553	99915		07/11/1996				14
00	Hospital-Based Health Clinic - RHC	DAVIESS COMMUNITY	158500	99915		12/17/2003	N	0	N	15
~		HOSPITAL MC	450000	00015		10/17/0000				
01	Hospital-Based Health Clinic - RHC	NORTH DAVIESS MEDICAL	153999	99915		12/17/2003	Ν	0	N	15
02	Hospital-Based Health Clinic - RHC	CENTER DCH HEALTH PAVILION	158501 99915 03/30/2004		03/30/2004	Ν	0	N	15	
03										15
04	Hospital-Based Health Clinic - RHC V	CRAND AVENUE PEDLATRICS	158503	99915		01/27/2005	N	0	N	15
04		MARTIN MEDICAL CLINIC	158506	99915		10/31/2006	N	0	N	15
05	VI	MARTIN MEDICAL CLINIC	136300	99915		10/ 31/ 2000	IN	0		15
00										16
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00						1.00		2.0		
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00 00 00 01	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on co instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. Ps, including supplement column 1, "Y" for yes o g period occurring prior "N" for no for the port r after October 1. (see requires a final UCP to ? (see instructions) Ent e portion of the cost re column 2, "Y" for yes or g period on or after Oct ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe	th 42 CF this endment tal UCPs, or "N" for to Octo tion of t o be ter in co eporting - "N" for tober 1. m urban t stical a "N" for er 1. Ent	R for r no ber he I umn no, o reas no	Y Y N	1.00 01/01/20 8 2.00 N Y		2. (12/31/ 3. (00	21 22 22 22
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00 00 00 01	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. Ps, including supplement column 1, "Y" for yes of g period occurring prior "N" for no for the port r after October 1. (see requires a final UCP to ? (see instructions) Ent e portion of the cost ro column 2, "Y" for yes or g period on or after Oct ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr	th 42 CF this endment tal UCPs, or "N" for to Octo tion of t o be ter in co eporting - "N" for tober 1. m urban t stical a "N" for er 1. Ent he cost ructions)	R for r no ber he I umn no, o reas no er	Y Y N	1.00 01/01/20 8 2.00 N Y		2. (12/31/ 3. (00	20 21 22 22 22 22 22
00 00 00 00 00 00 00 00 00 00 00 00 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section 5 hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportir 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportir Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. Ps, including supplement column 1, "Y" for yes of g period occurring prior "N" for no for the port r after October 1. (see requires a final UCP to ? (see instructions) Ent e portion of the cost re column 2, "Y" for yes or g period on or after Oct ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	th 42 CF this endment tal UCPs, or "N" for to Octo tion of t obe ter in co eporting "N" for tober 1. n urban t stical a "N" for er 1. Ent the cost "uctions) 29 beds (R for r no ber he I umn no, o reas no er as	Y Y N	1.00 01/01/20 8 2.00 N Y		2. (12/31/ 3. (00	21 22 22 22

	Financial Systems DAVIESS TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D/	ATA	Provider CC	CN: 15-0061	Peri od:		Wor	Form CMS- cksheet S-2	
					From 01 To 12	/01/2023		rt ∣ te∕Time Pre	narod
						./ 51/ 2020		31/2024 9:2	
				1.00		2. 00	+	3.00	-
2.04	Did this hospital receive a geographic reclassificat	ion from ur	-ban to	1.00		2.00	-	3.00	22.0
	rural as a result of the revised OMB delineations fo adopted by CMS in FY 2021? Enter in column 1, "Y" fo for the portion of the cost reporting period prior t in column 2, "Y" for yes or "N" for no for the porti reporting period occurring on or after October 1. (s Does this hospital contain at least 100 but not more counted in accordance with 42 CFR 412.105)? Enter i	r yes or "N o October 1 on of the c ee instruct than 499 b	N" for no L. Enter cost tions) peds (as						
3. 00	yes or "N" for no. Which method is used to determine Medicaid days on I below? In column 1, enter 1 if date of admission, 2 if date of discharge. Is the method of identifying t reporting period different from the method used in t reporting period? In column 2, enter "Y" for yes or	if census c he days in he prior co	days, or 3 this cost ost		2	N			23.0
		In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible			Other Medi cai d days	
			days		unpaid				
4 00		1.00 191	2.00	3.00	4.00	5.0		6.00	04.5
4.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		45	. 0		0	891	/6	5 24.0
5.00	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	17	0	United	0	80		25.0
						7.00	5 Dat	e of Geogr 2.00	
6. 00	Enter your standard geographic classification (not w		s at the be	gi nni ng of			2	2.00	26.0
	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th	age) status r "2" for r ication in	rural. If a column 2.	ppl i cabl e,			2		27.0
	effect in the cost reporting period.								
						<u>nni ng:</u> 1. 00	_	Endi ng: 2. 00	-
6.00	Enter applicable beginning and ending dates of SCH s		script line	36 for num					36.0
7.00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente		er of perio	ds MDH stat	us		0		37.0
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f								37.0
8. 00	instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.0
						Y/N 1.00		Y/N 2.00	-
9.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i), (ii), or the mileage	r (iii)? En e requireme	ter in colu nts in	ume mn	Y		Y	39.0
		II): LIILEI							1

Health Financial Systems DAVIESS	COMMUNI	TY HOSPITAL		١r	Lieu	ı of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC		eriod: rom 01/01/	2022	Workshe Part I	et S-2	
				o 12/31/		Date/Ti		
					V	5/31/20 XVIII	24 9:20 XIX	<u>) am</u>
					1.00		3.00	
45.00 Does this facility qualify and receive Capital payme	nt for (di sproporti opa	te share in ac	cordance	N	N	N	45.00
with 42 CFR Section §412.320? (see instructions)							, N	40.00
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00
 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen Teaching Hospitals 					N N	N N	N N	47.00 48.00
56.00 Is this a hospital involved in training residents in					N			56.00
periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to c involved in training residents in approved GME progr	er 27, 20 column 1 rams in r	020, under 42 is "Y", or if the prior year	CFR 413.78(b)(this hospital or penultimat	(2), see was te year,				
and are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2	2.	•			N			57.00
7.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes is this the first cost reporting period during which residents in approved GME programs train at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless o which month(s) of the cost report the residents were on duty, if the response to line 56 is "for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.								57.00
	ete coli	umn 2, and com	plete Workshee	et E-4.	N			58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	comple ⁻	te Wkst. D-5.						
59.00 Are costs claimed on line 100 of Worksheet A? If ye	es, comp	lete Wkst. D-2	, Pt. I. NAHE 413.85	Workshee	N t A	Pass-Th	rouah	59.00
			Y/N	Line		Qualific Criter	cation	
						Cod		
60.00 Are you claiming nursing and allied health education	(NAHE)	costs for	1.00 N	2.00		3.0	0	60.00
any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent	8.85? (9 01 umn 1. CR) NAHI	see If column 1						
adjustment? Enter "Y" for yes or "N" for no in colu	Y/N	I ME	Direct GME	IME		Di rect	GME	
	1.00	2.00	3.00	4.00		E O	0	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N	2.00	3.00	4.00	0.00	5.0		61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)								61. 01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)	•							61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the 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 61.04 minus line 61.03). (see instructions)	è							61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)								61.06

MCRI F32 - 22. 2. 178. 3

SPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA		Fi		5/31/2024 9:2	pared
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 .10 Of the FTEs in line 61.05, special ty, if any, and the number for each new program. (see instrucol umn 1, the program name. Enter program code. Enter in col umn 3, unweighted count. Enter in col umn FTE unweighted count. .20 Of the FTEs in line 61.05, special ty, if any, and the residents for each expanded program structions) Enter in col umn 1, Enter in col umn 2, the program cod 3, the IME FTE unweighted count. 	of FTE residents actions) Enter in in column 2, the the IME FTE 4, the direct GME by each expanded are number of FTE ram. (see the program name. de. Enter in column Enter in column 4,			0.00		61.
					1.00	
ACA Provisions Affecting the Heal						
.00 Enter the number of FTE residents your hospital received HRSA PCRE			τ reporting per	iod for which	0.00	62.
01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	that rotated from a iod of HRSA THC pro	a Teaching Health Ce gram. (see instructi		your hospital	0.00	62.
00 Has your facility trained residen "Y" for yes or "N" for no in colu	its in nonprovider se	ettings during this			Ν	63.
			Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year			-This base year	is your cost	reporti ng	
period that begins on or after Ju .00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facili per of unweighted non ations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00	0. 000000	64.(
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63 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			0.00	0.00	0. 000000	

	Financial Systems		COMMUNI TY				n Lieu	ı of For		
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION D	ΑΤΑ	Provider C	CN: 15-0061	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/31/20	me Pre	pared:
					Unweighted FTEs	FTES i	n	Ratio 1/ (col	. 1 +	
					Nonprovide Site	· ·		col .	2))	
	Section 5504 of the ACA Current	Vear FTF Residents i	n Nonnrov	der Settin	1.00	2.00		3.0 ing peri		
	beginning on or after July 1, 20	010	•				·	0.		
66.00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in	rovider se ry care re 3 the rati <u>struction</u> s	ettings. esident oof s)		00	0.00			66.00
		Program Name	Progr	am Code	Unwei ghted FTEs Nonprovi den Si te	FTES i	n	Ratio 3/ (col col.	. 3 +	
		1.00	2	. 00	3.00	4.00		5.0		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.		0.00	0.		67.00
							-	1.0	0	-
68.00	Direct GME in Accordance with the For a cost reporting period begi MAC to apply the new DGME formul (August 10, 2022)?	nning prior to Octob	er 1, 2022	2, did you o	obtain permis	sion from y				68.00
	[[August 10, 2022]:								2.00	
	Inpatient Psychiatric Facility F	PPS					1.00	2.00	3.00	
70.00	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		IPF), or (does it cont	tain an IPF s	ubprovi der?	Y			70.00
71.00	If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilia	I the facility have a before November 15, 2 Jumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	004? Ente ility trai)(D)? Ente	er "Y" for y n residents er "Y" for y	yes or "N" fo s in a new te yes or "N" fo	r no. (see achi ng r no.	N	N	0	71.00
75.00	Is this facility an Inpatient Re	habilitation Facilit	y (IRF), d	or does it o	contain an IR	F	Y			75.00
76.00	subprovider? Enter "Y" for yes If line 75 is yes: Column 1: Dic recent cost reporting period enc no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	I the facility have a ling on or before Nov train residents in a er "Y" for yes or "N"	ember 15, new teach for no. (2004? Enter ning progran Column 3: If	r "Y" for yes n in accordan f column 2 is	or "N" for ce with 42 Y,	N	N	0	76.00
								1. 0	0	-
80.00	Long Term Care Hospital PPS Is this a long term care hospita	1 (ITCH)2 Enter "V"	for yes '	and "N" for	no			N		80.00
	Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					ng period?	Enter	N		81.00
	Is this a new hospital under 42 Did this facility establish a new						r no.	N		85.00 86.00
	\$413.40(f)(1)(ii)? Enter "Y" fo Is this hospital an extended neo	or yes and "N" for no		ŗ				N		87.00
07.00	1886(d)(1)(B)(vi)? Enter "Y" for	yes or "N" for no.	nospi tal	Ci dəsi i i eu				IN		07.00

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT.	A Provider CO		eriod:	u of Form CMS- Worksheet S-	
		F	rom 01/01/2023 o 12/31/2023	Part I Date/Time Pr 5/31/2024 9:	epare 20 am
	I		Approved for	Number of	
			Permanent	Approved	
			Adjustment	Permanent	
			(Y/N) 1.00	Adjustments	-
. 00 Column 1: Is this hospital approved for a permanent ad	livetmont to the TEE	DA target	1.00 N	2.00	0 88.
amount per discharge? Enter "Y" for yes or "N" for no. 89. (see instructions)	If yes, complete c				0 00.
Column 2: Enter the number of approved permanent adjus	stillents.	Wkst. A Line	Effecti ve	Approved	
		No.	Date	Permanent	
				Adjustment	
				Amount Per	
				Di scharge	
		1.00	2.00	3.00	
00 Column 1: If line 88, column 1 is Y, enter the Workshe		0.00			0 89
on which the per discharge permanent adjustment approv					
Column 2: Enter the effective date (i.e., the cost rep					
beginning date) for the permanent adjustment to the TE	EFRA target amount				
per discharge.	divictment to the				
Column 3: Enter the amount of the approved permanent a TEFRA target amount per discharge.	adjustment to the				
		1	V	XI X	
			1.00	2.00	-
Title V and XIX Services					
00 Does this facility have title V and/or XIX inpatient h	nospital services? E	nter "Y" for	N	Y	90
yes or "N" for no in the applicable column.					
00 Is this hospital reimbursed for title V and/or XIX thr			N	Y	91
full or in part? Enter "Y" for yes or "N" for no in th					
00 Are title XIX NF patients occupying title XVIII SNF be		ion)? (see		N	92
instructions) Enter "Y" for yes or "N" for no in the a	applicable_column.			•	
00 Does this facility operate an ICF/IID facility for pur	rposes of title V an	d XIX? Enter	N	N	93
"Y" for yes or "N" for no in the applicable column. .00 Does title V or XIX reduce capital cost? Enter "Y" for	was and "N" for n	o in the	N	Ν	94
applicable column.	yes, and is ror i		IN IN	IN	74
.00 If line 94 is "Y", enter the reduction percentage in t	the applicable colum	n	0.00	0.00	95
00 Does title V or XIX reduce operating cost? Enter "Y" f			N	N	96
applicable column.	3				
.00 If line 96 is "Y", enter the reduction percentage in t	the applicable colum	n.	0.00	0.00	97
00 Does title V or XIX follow Medicare (title XVIII) for			Y	Y	98
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter	~ "Y" for yes or "N"	for no in			
column 1 for title V, and in column 2 for title XIX.					
01 Does title V or XIX follow Medicare (title XVIII) for			Y	Y	98
C, Pt. I? Enter "Y" for yes or "N" for no in column 1	for title V, and in	column 2 for			
title XIX. 02 Does title V or XIX follow Medicare (title XVIII) for	the calculation of	obconvotion	Y	Y	00
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for			ř	ř	98
for title V, and in column 2 for title XIX.	yes of in tor no				
03 Does title V or XIX follow Medicare (title XVIII) for	a critical access h	ospital (CAH)	N	N	98
reimbursed 101% of inpatient services cost? Enter "Y"					
for title V, and in column 2 for title XIX.	5				
04 Does title V or XIX follow Medicare (title XVIII) for			N	N	98
outpatient services cost? Enter "Y" for yes or "N" for	no in column 1 for	title V, and			
in column 2 for title XIX.					
05 Does title V or XIX follow Medicare (title XVIII) and			Y	Y	98
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for n	no in column 1 for t	itle V, and in			
column 2 for title XIX. 06 Does title V or XIX follow Medicare (title XVIII) when	cost roimbursod fo	r Wkst D	Y	Y	98
Pts. I through IV? Enter "Y" for yes or "N" for no in			· ·	1	70
column 2 for title XIX.		v, and m			
Rural Providers					
5.00Does this hospital qualify as a CAH?			N		105
b.00 If this facility qualifies as a CAH, has it elected th	ne all-inclusive met	hod of payment	N		106
for outpatient services? (see instructions)					
7.00 Column 1: If line 105 is Y, is this facility eligible			N		107
training programs? Enter "Y" for yes or "N" for no in					
Column 2: If column 1 is Y and line 70 or line 75 is					
approved medical education program in the CAH's exclud Enter "Y" for yes or "N" for no in column 2. (see ins		unit(S)?			
7.01 If this facility is a REH (line 3, column 4, is "12"),	-	cost			107
reimbursement for I&R training programs? Enter "Y" for					,
instructions)	, <u>, , , , , , , , , , , , , , , , , , </u>	、			
	to the CRNA fee sche	dule? See 42	N		108
3.00 Is this a rural hospital qualifying for an exception t	LU LIE UNINA LEE SUIE				

	Provider C		eriod: rom 01/01/2023	Worksheet S- Part I	2
			o 12/31/2023	Date/Time Pr	
	Physi cal	Occupati onal	Speech	5/31/2024 9: Respi ratory	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1.00 N	2.00 N	3. 00 N	4.00 N	109. (
for yes or "N" for no for each therapy.					
10 000 d this best to east signate in the Dural Committee User it			104	1.00	110
10.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes o	r "N" for no. I	f yes,	N	110. (
			1.00	2.00	-
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this cc "Y" for yes or "N" for no in column 1. If the response to cc integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the n column 2.	N		111.
		1.00	2.00	3.00	_
12.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital ceap participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	eporting blumn 1 is bating in the	N			112.0
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, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes	N			0115.
6.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116.
"N" for no. 7.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Y			117.
"Y" for yes or "N" for no. 18.00 s the malpractice insurance a claims-made or occurrence pol			2		118.
if the policy is claim-made. Enter 2 if the policy is occurr					110.
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	-
8.01 List amounts of malpractice premiums and paid losses:		215, 583			0118.
		215, 583	3 0 1.00		_
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schec and amounts contained therein.		215, 583	3 0		118.
8. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein. 9. 00 D0 NOT USE THIS LINE	dule listing d Harmless pro n column 1, "" ualifies for	215,58 than the cost centers ovision in ACA (" for yes or the Outpatient	3 0 1.00		0118. 118. 119. 120.
 8. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schect and amounts contained therein. 9. 00 D0 NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment for no. 1. 00 Did this facility incur and report costs for high cost impla 	dule listing d Harmless pro n column 1, "" ualifies for nts? (see ins	215,58: than the cost centers ovision in ACA (" for yes or the Outpatient tructions)	3 0 1.00 N	2.00	118. 119. 120.
 3. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schect and amounts contained therein. 3. 00 D0 NOT USE THIS LINE 3. 00 D1 USE THIS LINE 4. 00 D1 USE THIS LINE 5. 00 Lis this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 1. 00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 	dule listing d Harmless pro- n column 1, "" ualifies for nts? (see ins antable device fined in §190	215,58 than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the	3 0 1.00 N	2.00	118. 119. 120. 121.
 8. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schece and amounts contained therein. 9. 00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment for no. 1. 00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 3. 00 Did the facility and/or its subproviders (if applicable) pur services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizati for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In colum 	dule listing d Harmless pro- n column 1, "' ualifies for " nts? (see ins antable device fined in §190 1 is "Y", ent rchase profess ping, payroll on? In colum greater than unrelated or	215,58: than the cost centers ovision in ACA ("for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 sional and/or h 1, enter "Y" h 50% of total ganizations	3 0 1.00 N N	2.00	118. 119. 120. 121. 122.
 8. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schec and amounts contained therein. 9. 00 D0 NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1. 00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 3. 00 Did the facility and/or its subproviders (if applicable) pur services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizati for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In colu "N" for no. 	dule listing d Harmless pro- n column 1, " ualifies for nts? (see ins antable device fined in §190 1 is "Y", enter chase profess bing, payroll on? In column greater that unrelated or umn 2, enter	215,58: than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 sional , and/or n 1, enter "Y" n 50% of total ganizations 'Y" for yes or	3 0 1.00 N N Y N Y N Y	2. 00 N	118. 119. 120. 121. 122. 123.
 8. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9. 00 D0 NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1. 00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 3. 00 Did the facility and/or its subproviders (if applicable) pur services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizati for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In colu "N" for no. 	dule listing d Harmless pro- column 1, " ualifies for nts? (see ins antable device fined in §190 1 is "Y", ent chase profess bing, payroll on? In column greater that unrelated or unn 2, enter center? Enter	215,58: than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 sional , and/or n 1, enter "Y" n 50% of total ganizations 'Y" for yes or	3 0 1.00 N N Y N	2. 00 N	118. 119. 120. 121. 122.
 and amounts contained therein. 9.00 D0 NOT USE THIS LINE 9.00 D1s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 11.00 D1d this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 12.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 12.00 D1d the facility and/or its subproviders (if applicable) pur services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizati for yes or "N" for no. 11f column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In colu "N" for no. 15.00 Does this facility operate a Medicare-certified transplant center Information 	dule listing d Harmless pro- n column 1, "' ualifies for ts? (see ins antable device fined in §190 1 is "Y", ent chase profess oing, payroll on? In column greater than unrelated or umn 2, enter center? Enter yyyy) below. enter the cer	215,58: than the cost centers ovision in ACA ("for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 sional and/or n 1, enter "Y" n 50% of total ganizations 'Y" for yes or	3 0 1.00 N N Y N Y N	2. 00 N	118. 119. 120. 121. 122. 123.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provider CCI	N: 15-0061		1/01/2023 2/31/2023	Worksheet S- Part I Date/Time Pi 5/31/2024 9:	repared:
					1.00	2.00	-
128.00 If this is a Medicare-certified liver t	ransplant program, (enter the certif	Fication d	ate	1.00	2.00	128.00
in column 1 and termination date, if ap 129.00 If this is a Medicare-certified lung tr in column 1 and termination date, if ap	ansplant program, ei	nter the certifi	cation da	te			129.00
130.00 If this is a Medicare-certified pancrea date in column 1 and termination date,	s transplant progra	m, enter the cer	rti fi cati o	n			130.00
I31.00 If this is a Medicare-certified intesti date in column 1 and termination date,	nal transplant prog	ram, enter the c	certi fi cat	i on			131.00
132.00 If this is a Medicare-certified islet t in column 1 and termination date, if ap	ransplant program, 🤅	enter the certif	fication d	ate			132.00
133.00Removed and reserved 134.00If this is a hospital-based organ procu	rement organization	(OPO) enter th	ne OPO num	ber			133.00
in column 1 and termination date, if an All Providers							
40.00 Are there any related organization or h chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home	r no in column 1. In	f yes, and home	office co		N		140.00
1.00	2. (3.00		_
If this facility is part of a chain orgoing office and enter the home office contra	ctor name and contr					of the home	
	Contractor's Name: PO Box:		Contra	ictor's Nu	mber:		141.00
	State:		Zip Co	de:			143.0
						1.00	-
44.00 Are provider based physicians' costs in	cluded in Worksheet	Α?				Y	144.0
					1.00	2.00	-
no, does the dialysis facility include period? Enter "Y" for yes or "N" for r 46.00 Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu yes, enter the approval date (mm/dd/yyy	o in column 2. nged from the previo mn 1. (See CMS Pub.	ously filed cost	t report?		N		146. 0
47.00Was there a change in the statistical b	asis2 Enter "V" for	ves or "N" for	no			1.00 N	147.0
48.00 Was there a change in the order of allo	cation? Enter "Y" fo	or yes or "N" fo	or no.			N	148.0
49.00 Was there a change to the simplified co	st finding method?	Enter "Y" for ye Part A	<u>es or "N"</u> Part E		itle V	N Title XIX	149.0
		1.00	2.00		3.00	4.00	_
Does this facility contain a provider t or charges? Enter "Y" for yes or "N" fo							
55.00Hospi tal		N	N		N	N	155.0
56.00 Subprovi der – IPF 57.00 Subprovi der – IRF		N N	N N		N N	N N	156.0 157.0
58. 00 SUBPROVI DER							158.0
59. 00 SNF 60. 00 HOME HEALTH AGENCY		N	N N		N N	N	159.0 160.0
61. OO CMHC		N	N		N	N N	161. 0
61. 10 CORF			N		N	N	161.1
						1.00	_
Multicampus 65.00[s this hospital part of a Multicampus	hospital that has o	ne or more campu	uses in di	fferent C	BSAs?	N	165.0
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each					1	0. (

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lie	u of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	CATION DATA	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023		
			10 12/01/2020	5/31/2024	
				1.00	
Health Information Technology (HIT) incenti			ent Act		
167.00 Is this provider a meaningful user under §1				Y	167.00
168.00 f this provider is a CAH (line 105 is "Y") reasonable cost incurred for the HIT assets), enter the		168.00
168.01 If this provider is a CAH and is not a mean exception under §413.70(a)(6)(ii)? Enter "Y					168.01
169.00 If this provider is a meaningful user (line transition factor. (see instructions)	167 is "Y") and is	s not a CAH (line 105 is	"N"), enter the	9	. 99169. 00
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 f line 167 is "Y", does this provider have section 1876 Medicare cost plans reported o "Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instru	n Wǩst. S-3, Pt. I, column 1 is yes, er	line 2, col. 6? Enter	on		0 171.00

SPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0061	Period:	Worksheet S-	2
				From 01/01/2023 To 12/31/2023	Date/Time Pr	epared
				Y/N	5/31/2024 9: Date	20 am
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSI				·	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	N for all NO r	esponses. Ente	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation Has the provider changed ownership immediately prior to the	o bogi ppi pg of	the cost	N	1	1.
50	reporting period? If yes, enter the date of the change in					1.
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare	Dragram? If	1.00 N	2.00	3.00	2.
50	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and other	offices, drug der or its of the board	N			3.
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports				. <u></u>	
	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	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit re-		N			5.
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If ves i	s the provider	~ N		6.
	the legal operator of the program?	2. 11 303, 1				0.
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during the	e N		7.
00	Are costs claimed for Interns and Residents in an approved		cal education	Ν		9.
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	Ν		10.
00	Are GME cost directly assigned to cost centers other than	I & R in an Ap	proved	N		11.
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	_
					1.00	-
	Bad Debts	·			I	_
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection			ost reporting	Y N	12. 13.
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura	ance amounts w	aived? If ves.	see	N	14.
	instructions.					
	Bed Complement Did total beds available change from the prior cost report	ing period2 [f	ves see inst	tructions	N	15.
00	bru total beus available change from the piror cost report	1 2 1	rt A		T B	10.
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16.
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/04/2024	Y	04/04/2024	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	Ν		Ν		18.
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	Y		Ν		19.

Heal th	Fi nanci al	Systems

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE				Period: From 01/01/2023 Fo 12/31/2023	Worksheet S-2 Part II Date/Time Pro 5/31/2024 9:2	epared:		
		Descri	ption	Y/N	Y/N			
		()	1.00	3.00			
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00		
		Y/N	Date	Y/N	Date			
21 00		1.00 N	2.00	3.00 N	4.00	21.00		
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 Capital Related Cost	EPT CHILDRENS H	HOSPI TALS)			-		
	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		sals made duri	ng the cost		22.00 23.00		
24.00	If yes, see instructions							
	5.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.							
	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.		- ·	-		26.00		
27.00	Has the provider's capitalization policy changed during th copy. Interest Expense	e cost reporti	ng period? If	yes, submit		27.00		
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	ntered into du	ring the cost	reporti ng		28.00		
29.00								
30.00	Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes,	see		30.00		
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes,	see		31.00		
32.00	Purchased Services Have changes or new agreements occurred in patient care se		ed through con	tractual		32.00		
33.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competit	ive bidding? If	-	33.00		
	Provi der-Based Physi ci ans							
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-ba	sed physicians?		34.00		
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		nts with the p	rovi der-based		35.00		
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date			
				1.00	2.00			
	Home Office Costs							
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	roparod by the	homo offico?	Ν		36.00 37.00		
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	1 5				38.00		
	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth	d of the home of	offi ce.			39.00		
	see instructions. If line 36 is yes, did the provider render services to the		5			40.00		
	instructions.							
		1.	00	2.	00	-		
	Cost Report Preparer Contact Information							
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY		BEJARANO		41.00		
42.00	Enter the employer/company name of the cost report preparer.	FORVIS, LLP				42.00		
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 383. 4000		KERRY. BEJARANO	@FORVIS.COM	43.00		

Health Financial Systems DAVIESS	COMMUNITY HOSPITAL	In Lieu	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAI	RE Provi der CCN: 15-0061	Period: From 01/01/2023	Worksheet S-2	
			Part II Date/Time Pre 5/31/2024 9:2	pared: 0 am
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/positi	on DI RECTOR			41.00
held by the cost report preparer in columns 1, 2, an	d 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.				

HOSPI -	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0061	Period: From 01/01/2023 To 12/31/2023		pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	37	13, 50	0.00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	57	13, 50	0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		37	13, 50	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	5	1, 82	25 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY) NURSERY	42.00				0	12.00
13.00 14.00		43.00	10	15 2	30 0.00	0	
14.00	Total (see instructions) CAH visits		42	15, 33	0.00	0	1
15.00	REH hours and visits				0.00	0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7, 30		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12			0	17.00
18.00	SUBPROVIDER			.,		-	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						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.04	RURAL HEALTH CLINIC V	88.04 88.05				0	26.04
26.05 26.25	RURAL HEALTH CLINIC VI FEDERALLY QUALIFIED HEALTH CENTER	88.05				0	26.05 26.25
20.25	Total (sum of Lines 14-26)	87.00	74			0	27.00
28.00			7 4			0	
29.00	Ambul ance Trips					0	29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges						33.01
34 00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	34.00

0SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 01/01/2023	Worksheet S-3 Part I	3
					To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epare
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		(00	7.00	Patients	& Residents	Payrol I	
	PART I – STATISTICAL DATA	6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	590	89	1, 86	9		1 1.
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)	358	936				2.
00	HMO IPF Subprovider	112	0				3.
00	HMO IRF Subprovider	61	97				4.
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5
00	Hospital Adults & Peds. Swing Bed NF		0		0		6
. 00	Total Adults and Peds. (exclude observation	590	89	1, 86	9		7
	beds) (see instructions)						
00	INTENSIVE CARE UNIT	238	24	57	4		8
00	CORONARY CARE UNIT						9
0. 00	BURN INTENSIVE CARE UNIT						10
I. 00	SURGICAL INTENSIVE CARE UNIT						11
2.00	OTHER SPECIAL CARE (SPECIFY)						12
3.00	NURSERY		78	88	6		13
4.00	Total (see instructions)	828	191	3, 32	9 0.00	372.67	14
5.00	CAH visits	0	0		0		15
5.10	REH hours and visits	0	0		0		15
6.00	SUBPROVIDER - IPF	3, 064	0	3, 86	4 0.00	27.68	16
7.00	SUBPROVIDER - IRF	1, 119	0	1, 34	4 0.00	12.41	17
3. 00	SUBPROVI DER						18
9.00	SKILLED NURSING FACILITY						19
0. 00	NURSING FACILITY						20
1.00	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY	0	0		0.00	0.00	22
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23
4.00	HOSPICE	2, 984	9	3, 81	2 0.00	3.34	24
4.10	HOSPICE (non-distinct part)				5		24
5.00	CMHC - CMHC						25
5. 10	CMHC - CORF	0	0		0.00	0.00	25
5.00	RURAL HEALTH CLINIC	938	0	6, 10		7.80	26
5. 01	RURAL HEALTH CLINIC II	483	0	2,80		6. 17	26
5. 02	RURAL HEALTH CLINIC III	1, 312	0	14, 93		13.90	
5.04	RURAL HEALTH CLINIC V	6	0	6, 18		11.53	
5. 05	RURAL HEALTH CLINIC VI	971	0	4, 70		6. 73	
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
7.00	Total (sum of lines 14-26)		-		0.00	462.23	
3.00			293	1, 48			28
9.00	Ambulance Trips	О	270	.,			29
). 00	Employee discount days (see instruction)			4	8		30
1.00	Employee discount days - IRF				0		31
2.00	Labor & delivery days (see instructions)	o	76		-		32
2.01	Total ancillary labor & delivery room	0	70		Ó		32
2.01	outpatient days (see instructions)				ĭ		52
3. 00	LTCH non-covered days	o					33
	LTCH site neutral days and discharges	o					33
		U		1	1		1 00.

OSPI T <i>i</i>	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider (CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023		pare
		Full Time		Di	scharges	10/01/2021 //2	
	Component	Equi val ents Nonpai d	Title V	Title XVII	I Title XIX	Total All	
		Workers	12.00	12.00	14.00	Patients	
I	PART I – STATISTICAL DATA	11.00	12.00	13.00	14.00	15.00	
	Hospital Adults & Peds. (columns 5, 6, 7 and				285 22	950	1 1.
	8 exclude Swing Bed, Observation Bed and		,	2	205 22	730	···
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
	HMO and other (see instructions)				117 232		2.
	HMO I PF Subprovi der				0		3.
	HMO IRF Subprovider				0		4.
	Hospital Adults & Peds. Swing Bed SNF				0		5.
	Hospital Adults & Peds. Swing Bed NF						6.
	Total Adults and Peds. (exclude observation						7
	beds) (see instructions)						''
	INTENSI VE CARE UNI T						8
	CORONARY CARE UNIT						9
	BURN INTENSIVE CARE UNIT						10
	SURGI CAL I NTENSI VE CARE UNI T						11
	OTHER SPECIAL CARE (SPECIFY)						12
	NURSERY						13
	Total (see instructions)	0.00	(2	285 22	950	
	CAH visits						15
5. 10	REH hours and visits						15
	SUBPROVIDER - IPF	0.00	(c c	143 13	183	
7.00	SUBPROVIDER - IRF	0.00	(b	86 0	104	17
3. 00	SUBPROVI DER						18
9.00	SKILLED NURSING FACILITY						19
0. 00	NURSING FACILITY						20
1.00	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY	0.00					22
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23
1.00	HOSPI CE	0.00					24
I. 10	HOSPICE (non-distinct part)						24
5.00	CMHC - CMHC						25
5. 10	CMHC - CORF	0.00					25
5.00	RURAL HEALTH CLINIC	0.00					26
5. 01	RURAL HEALTH CLINIC II	0.00					26
5. 02	RURAL HEALTH CLINIC III	0.00					26
5.04	RURAL HEALTH CLINIC V	0.00					26
5. 05	RURAL HEALTH CLINIC VI	0.00					26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
. 00	Total (sum of lines 14-26)	0.00					27
3.00	Observation Bed Days						28
. 00	Ambulance Trips						29
	Employee discount days (see instruction)						30
	Employee discount days - IRF						31
	Labor & delivery days (see instructions)						32
	Total ancillary labor & delivery room						32
	outpatient days (see instructions)						
	LTCH non-covered days				0		33
	LTCH site neutral days and discharges				0		33
00	Temporary Expansion COVID-19 PHE Acute Care			1	1		34

SPI T	Financial Systems AL WAGE INDEX INFORMATION			II TY HOSPI TAL Provi der C	F T	eriod: rom 01/01/2023 o 12/31/2023	u of Form CMS-2 Worksheet S-3 Part II Date/Time Pre 5/31/2024 9:2	par
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II – WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
00	Total salaries (see instructions)	200.00	31, 453, 265	0	31, 453, 265	962, 781. 00	32.67	1
0	Non-physician anesthetist Part		0	0	0	0.00	0.00	
0	A Non-physician anesthetist Part		0	0	0	0.00	0.00	
0	B Physician-Part A -		30, 000	0	30, 000	185.00	162.16	
0	Administrative		30,000		30,000	185.00	102.10	, í
)1)0	Physicians - Part A - Teaching Physician and Non		0 1, 774, 542	-		0. 00 11, 239. 00		
	Physician-Part B							
00	Non-physician-Part B for hospital-based RHC and FQHC services		2, 325, 503	0	2, 325, 503	85, 572. 00	27.18	
0	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	
)1	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	
00	programs) Home office and/or related organization personnel		0	0	0	0.00	0.00	3
)0 00	SNĚ	44.00	0 8, 234, 532	0 -14, 058	0 8, 220, 474	0. 00 255, 548. 00		
00	Excluded area salaries (see instructions)		8, 234, 532	-14, 058	8, 220, 474	255, 548. 00	32.17	
00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		968, 761	0	968, 761	7, 259. 00	133. 46	1
00	Care Contract Labor: Top Level		591, 115	0	591, 115	4, 160. 00	142.09	1:
00	management and other management and administrative		0,1,110			1, 100.00	112.07	
00	services Contract Labor: Physician-Part		0	0	o	0.00	0.00	1:
00	A - Administrative Home office and/or related organization salaries and		0	0	0	0.00	0.00	14
01	wage-related costs Home office salaries		0	0	0	0.00	0.00	1
02	Related organization salaries		0	0	0	0.00	0.00	14
00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15
00	Home office and Contract		0	0	0	0.00	0.00	10
01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0.00	0.00	1
02	- Teaching Home office contract		0	0		0.00	0.00	1
02	Physicians Part A - Teaching WAGE-RELATED COSTS					0.00	0.00	<u> </u> ''
00	Wage-related costs (core) (see		3, 972, 818	0	3, 972, 818			11
00	instructions) Wage-related costs (other)							18
	(see instructions)		1 (02 000		1 (02 000			
00 00	Excluded areas Non-physician anesthetist Part A		1, 683, 820 0	0	1, 683, 820 0			20
00	Non-physician anesthetist Part B		0	0	0			2
00	Physician Part A - Administrative		3, 412	0	3, 412			22
01 00	Physician Part A - Teaching Physician Part B		0 202, 842	0	0 202, 842			22
00	Wage-related costs (RHC/FQHC)		202, 842 524, 904		524, 904			24
00	Interns & residents (in an approved program)		0	0	0			25
50	Home office wage-related (core)		0	0	0			25
51	Related organization		0	0	o			25
52	wage-related (core) Home office: Physician Part A		0	о	0			25
	- Administrative - wage-related (core)							

	Financial Systems		DAVIESS COMMUN				u of Form CMS-2	
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2023 To 12/31/2023		pared:
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.5
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26.00	Employee Benefits Department	4.00	208, 016					
27.00	Administrative & General	5.00	2, 290, 235					
28.00	Administrative & General under		259, 705	0	259, 70	5 1, 086. 00	239.14	28.0
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	69, 152	0	69, 15			
30.00	Operation of Plant	7.00	0	0		0 0.00		
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		
32.00	Housekeepi ng	9.00	648, 520	0	648, 52			
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0. 00	33. C
34.00	Dietary	10.00	381, 556	-266, 273	115, 28	3 6, 797. 00	16. 96	
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0. 00	35. C
36.00	Cafeteri a	11.00	0	219, 724	219, 72	4 12, 954. 00	16. 96	36.0
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.0
38.00	Nursing Administration	13.00	647, 279	0	647, 27	9 19, 070. 00	33. 94	38.0
39.00	Central Services and Supply	14.00	315, 594	0	315, 59	4 12, 669. 00	24. 91	39.0
40.00	Pharmacy	15.00	533, 822	0	533, 82	2 14, 672. 00	36.38	40.0
41.00	Medi cal Records & Medi cal Records Li brary	16.00	537, 735	0	537, 73	5 22, 556. 00	23.84	41.C
42.00	Social Service	17.00	0	261,060	261,06	0 8, 730. 00	29.90	42.0
43 00	Other General Service	18.00	0	0		0 0.00		43.0

Heal th	Financial Systems		DAVIESS COMMUN	ITY HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2023 To 12/31/2023		pared:	
		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		27, 612, 925	0	27, 612, 92	5 867, 056. 00	31.85	1.00	
	instructions)								
2.00	Excluded area salaries (see		8, 234, 532	-14, 058	8, 220, 47	4 255, 548. 00	32.17	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		19, 378, 393	14,058	19, 392, 45	1 611, 508. 00	31.71	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		1, 559, 876	0	1, 559, 87	6 11, 419. 00	136.60	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		3, 976, 230	0	3, 976, 23	0.00	20.50	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		24, 914, 499	14, 058	24, 928, 55	7 622, 927. 00	40.02	6.00	
7.00	Total overhead cost (see		5, 891, 614						
	instructions)		5, 671, 611		3,000,20	200, 100.00	20.00		
			I	1	I	1	I	I	

Heal th	Financial Systems	DAVIESS COMMUNIT	Y HOSPI TAL	In Lieu	」of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provider CCN: 15-0061	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part IV Date/Time Pre 5/31/2024 9:2	pared:
					Amount Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contri				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see	instructions)			536, 912	3.00
4.00	Qualified Defined Benefit Plan Cost (see in				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension PI				13, 254	6.00
7.00	Employee Managed Care Program Administration	n Fees			0	7.00
	HEALTH AND INSURANCE COST			1		
8.00	Health Insurance (Purchased or Self Funded)				0	8.00
8.01	Health Insurance (Self Funded without a Thi				0	
8.02	Health Insurance (Self Funded with a Third	Party Administrate	or)		3, 369, 378	
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	Life Insurance (If employee is owner or ben				16, 764	
12.00	Accident Insurance (If employee is owner or				0	
13.00	Disability Insurance (If employee is owner				54, 067	
14.00 15.00	Long-Term Care Insurance (If employee is ow	ner or benericiary	<i>Y</i>)		0	
16.00	'Workers' Compensation Insurance Retirement Health Care Cost (Only current y	oor not the over	and party accrual require	od by EASP 104	117, 491 0	
16.00	Noncumulative portion)	ear, not the extra	aordinary accruai requir	ed by FASB 106.	0	16.00
	TAXES					
17 00	FICA-Employers Portion Only				0	17.00
18.00	Medicare Taxes - Employers Portion Only				2, 259, 055	
19.00	Unemployment Insurance				2, 207, 000	
	State or Federal Unemployment Taxes				0	
201.00	OTHER					20100
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost P	Reported on lines 1 thro	ugh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement				20, 875	
24.00	Total Wage Related cost (Sum of lines 1 -23	5)			6, 387, 796	24.00
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00

Heal th	Financial Systems	DAVIESS COMMUNITY H	OSPI TAL	In Lieu	u of Form CMS-2	2552-10
HOSPI 1	AL CONTRACT LABOR AND BENEFIT COST	Pi	rovider CCN: 15-0061	Peri od:	Worksheet S-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/31/2024 9:20	
	Cost Center Description			Contract	Benefit Cost	
				Labor	201101111 00001	
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Ident	i fi cati on:				
1.00	Total facility's contract labor and benefit	cost		0	0	1.00
2.00	Hospi tal			0	0	2.00
3.00	SUBPROVIDER - IPF			0	0	3.00
4.00	SUBPROVIDER - IRF			0	0	4.00
5.00	Subprovider - (Other)			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
10.00	OTHER LONG TERM CARE I					10.00
11.00	Hospital-Based HHA			0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I					12.00
13.00	Hospi tal -Based Hospi ce			0	0	13.00
14.00	Hospital-Based Health Clinic RHC			0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1			0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2			0	0	14.02
14.03	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	Hospital-Based-CMHC					16.00
16. 10	Hospital-Based-CMHC 10			0	0	16.10
17.00	RENAL DIALYSIS I					17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems	DAVIESS COMMUN	I TY HOSPI TAL		In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-	3
			Component		rom 01/01/202 o 12/31/202		
					RHC I	Cost	
	Clinic Address and Identification				1	. 00	-
1.00	Clinic Address and Identification Street				1402 GRAND AV	FNUE	1.00
1.00			Ci	ty	State	ZIP Code	1.00
	1			00	2.00	3.00	
2.00	City, State, ZIP Code, County		WASHI NGTON			N 47501	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for	urban		1.00	3.00
				Grant	Award	Date	
				1.	00	2.00	_
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)					4.00
4.00 5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	(10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o hours.)	i other operati	on(s) and the	operating			
		Sund	day	Mor	nday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	-
11 00	Facility hours of operations (1) CLINIC			08: 00	17:00	08: 00	11.00
11100				00100		00100	
					1.00	2.00	
	Have you received an approval for an excepti				Y		12.00
13.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				N	0	13.00
	number of providers included in this report.						
	numbers below.						
13.01	If line 13, column 1, is "Y", are you report				N	(13.01
	in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli						
	separate Worksheet S-8 for each consolidated						
	are comprised exclusively of grandfathered c			ping or			
	comprised exclusively of new consolidated RH	Cs in the group	bing.	Brovid	er name	CCN	
					00	2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
15.00	GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						

Health Financial Systems	DAVIESS COMMUN	ITY 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	3
		Component	CCN: 15-8500	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epared: 20 am
		_		RHC I	Cost	
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County	DAVI ESS					2.00
	Tuesday	Wednesday		Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	17:00	08: 00	17:00	08: 00	17:00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)			·			
11. 00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems	DAVIESS COMMUNI	TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0061	Period:	Worksheet S-8	3
			Component (CCN: 15-3999	From 01/01/2023 To 12/31/2023		
					RHC II	Cost	
					1	00	-
	Clinic Address and Identification					00	
1.00	Street				202 NORTH WEST	STREET	1.00
			Ci		State	ZIP Code	
0.00			1.	00	2.00	3.00	0.00
2.00	City, State, ZIP Code, County	C	DON			47562	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	l or "U" for u	urban		C	3.00
					nt Award	Date	
	Courses of Fodowell Funda				1.00	2.00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)				1	4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
9.00	UTIER (SFECTIT)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	C	10.00
	yes or "N" for no in column 1. If yes, indic 2.(Enter in subscripts of line 11 the type o						
	hours.)	i other operation	un(s) and the	operating			
		Sund	lay	Μ	londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC			08: 00	17:00	08: 00	11.00
11.00				00.00	17.00	00.00	11.00
					1.00	2.00	
	Have you received an approval for an excepti				Y	_	12.00
13.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				N	C	13.00
	number of providers included in this report.						
	numbers below.						
13.01	If line 13, column 1, is "Y", are you report					C	13.01
	in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli						
	separate Worksheet S-8 for each consolidated				as		
	are comprised exclusively of grandfathered c	onsolidated RHC	s in the group	bing or '			
	comprised exclusively of new consolidated RH	<u>Cs in the group</u>	i ng.	Direct		CON	
					der name	CCN 2.00	
14.00	RHC/FQHC name, CCN				1.00	2.00	14.00
		Y/N	V	XVIII	XIX	Total Visits	
45.00		1.00	2.00	3.00	4.00	5.00	45.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider. (see instructions)						
		1 I			I	1	1

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		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	3
		Component	CCN: 15-3999	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epared: 20 am
				RHC II	Cost	
		Col	inty			
		4.	00			
2.00 City, State, ZIP Code, County		DAVI ESS				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	17:00	08: 00	17:00	08: 00	17:00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)	·	•	·			
11. 00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems	DAVIESS COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0061	Period:	Worksheet S-8	3
			Component (CCN: 15-8501	From 01/01/2023 To 12/31/2023	3 Date/Time Pre	epared:
					RHC III	5/31/2024 9:2 Cost	20 am
					RHCITI	COST	
					1	. 00	
1 00	Clinic Address and Identification				1005 6 67475		1 00
1.00	Street		Ci	tv	1805 S. STATE State	ZIP Code	1.00
			1.		2.00	3.00	
2.00	City, State, ZIP Code, County		WASHI NGTON		11	47501	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for u	urban		0	3.00
				Gran	nt Award	Date	
	Courses of Foderal Funda				1.00	2.00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)				1	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
9.00	OTHER (SPECIFY)						9.00
10.00	Deep this facility energies as other then a h	anital based F		ator "V" for	1.00	2.00	10.00
10.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic				N	0	10.00
	2. (Enter in subscripts of line 11 the type o						
	hours.)						
		Sunc	to	from M	onday to	Tuesday 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	uctivity standa	ard?	Y		12.00
13.00	Is this a consolidated cost report as define				Ν	0	13.00
	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.						
	numbers below.						
13.01	If line 13, column 1, is "Y", are you report	ing multiple co	onsolidated RH	Cs (as define	ed N	0	13.01
	in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli						
	separate Worksheet S-8 for each consolidated				gs		
	are comprised exclusively of grandfathered c			bing or	-		
	comprised exclusively of new consolidated RH	<u>Cs in the group</u>	or ng.	Provi	der name	CCN	
					1.00	2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N 1.00	V 2.00	XVIII 3.00	XI X 4.00	Total Visits 5.00	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	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)						

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0061	Period:	Worksheet S-8	3
		Component	CCN: 15-8501	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epared: 20 am
		_		RHC III	Cost	
		Col	inty			
		4.	00			
2.00 City, State, ZIP Code, County		DAVI ESS				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)		•				
11.00 CLINIC	17:00	08: 00	17:00	08: 00	17:00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)		•	·			
11. 00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems	DAVIESS COMMUN	I TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPI 1	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0061	Period:	Worksheet S-8	3
			Component (CCN: 15-8503	From 01/01/2023 To 12/31/2023		epared:
						5/31/2024 9:2	20 am
					RHC V	Cost	
					1.	00	
	Clinic Address and Identification					-	
1.00	Street		Ci	+	1400 GRAND AVE	ZIP Code	1.00
		-	<u> </u>			3.00	
2.00	City, State, ZIP Code, County		WASHI NGTON			47501	2.00
2 00	HOSPITAL PASED FOLICE ONLY: Decimpation Ent	or "D" for rur	a or "II" for i	urban		1.00	3.00
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent				nt Award	Date	3.00
					1.00	2.00	
	Source of Federal Funds					1	
4.00	Community Health Center (Section 330(d), PHS						4.00 5.00
5.00 6.00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34						6.00
7.00	Appal achi an Regi onal Commi ssi on						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h	ospital-based F	RHC or FQHC? E	nter "Y" for	N	C	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o hours.)	f other operati	on(s) and the	operating			
		Sun	dav	Μ	londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC			08: 00	17:00	08: 00	11.00
11.00				08.00	17.00	08.00	11.00
					1.00	2.00	
12.00	Have you received an approval for an excepti				Y		12.00
13.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				N	C	13.00
	number of providers included in this report.						
	numbers below.		· · · · · · · · · · ·				
13.01	If line 13, column 1, is "Y", are you report					C	13.01
	in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli						
	separate Worksheet S-8 for each consolidated				gs		
	are comprised exclusively of grandfathered c	onsolidated RHC	Cs in the group	oing or	-		
	comprised exclusively of new consolidated RH	Cs in the group	bing.	Brow	der name	CCN	
					1.00	2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVI I I	XIX	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
15.00	GME cost? Enter "Y" for yes or "N" for no in						13.00
	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)						

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0061	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8503	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epared: 20 am
				RHC V	Cost	
		Col	inty			
		4.	00			
2.00 City, State, ZIP Code, County		DAVI ESS				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	17:00	08: 00	17:00	08: 00	17:00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0061	Period:	Worksheet S-8	3
			Component	CCN: 15-8506	From 01/01/202 To 12/31/202		epared:
					RHC VI	5/31/2024 9:2	20 am
	· · · · · · · · · · · · · · · · · · ·				KHC VI	Cost	
					1	. 00	
	Clinic Address and Identification						
1.00	Street		Ci	ty	12546 E US HW State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		LOOGOOTEE			N 47553	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for i	urban		1.00	3.00
3.00	THOSPITAL-DASED FUNCS UNLT. Designation - Entr				nt Award	Date	3.00
					1.00	2.00	
	Source of Federal Funds			1		1	
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4.00 5.00
5.00 6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appal achi an Regi onal Commissi on	-(-);)					7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	C	10.00
	yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type o hours.)						
		Sun	day	N	londay	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC			08: 00	17:00	08: 00	11.00
					1.00	2.00	
12.00 13.00	Have you received an approval for an exception Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colo number of providers included in this report.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y N	C	12.00 13.00
13. 01	numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered co)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC	for yes or "N" pings and comp Consolidated Cs in the grou	for no. If lete a RHC grouping		C	13.01
	comprised exclusively of new consolidated RH	us in the group	ung.	Provi	ider name	CCN	
					1.00	2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N 1.00	V 2.00	XVIII	XI X	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	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)						

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		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	3
		Component	CCN: 15-8506	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epared: 20 am
				RHC VI	Cost	
		Col	inty			
		4.	00			
2.00 City, State, ZIP Code, County		DAVI ESS				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	17:00	08: 00	17:00	08: 00	17:00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)	·	•	·			
11. 00 CLINIC	08: 00	17:00				11.00

HOSPI T	Financial Systems AL-BASED HOSPICE IDENTIFICATION		DAVIESS COMMUN	Provider CO	CN: 15-0061 N: 15-1553	Period: From 01/01/2023 To 12/31/2023		GH IV pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	AII Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING F	PERIODS BEGINN	ING BEFORE OCTO	DBER 1, 2015			
1.00 2.00 3.00 4.00 5.00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care Total Hospice Days							1.00 2.00 3.00 4.00 5.00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015	-		
5.00 7.00	Number of patients receiving hospice care Total number of unduplicated Continuous Care hours billable to Medicare							6.00 7.00
3. 00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00
	Parts I and II, columns 1 and 2	al so include	the days repor	ted in columns	3 and 4.			,,,,,,
				Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI	NNING ON OR AFT	ER OCTOBER 1			1
10.00 11.00 12.00 13.00 14.00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care Total Hospice Days			0 2, 971 0 22 2, 993		0 0 0 0 0 0 0 0 0 0 0 0	2, 971 0 22	11.00 12.00
	PART IV - CONTRACTED STATISTIC	AL DATA FOR COS	ST REPORTING P		IG ON OR AFTE	-		1
15 00	Hospice Inpatient Respite Care			0		0 0		15.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0061	Peri od:	Worksheet S-10

Perio		worksneet	
From	01/01/2023	Parts I &	11
То	12/31/2023	Date/Time	Prepared:

12/31/2023	Date/lime	Prepared:
	5/31/2024	9.20 am

				0/31/2024 9.2	
				1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA	<u>.</u>		1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1
. 00	Cost to charge ratio (see instructions)			0. 373829	1.0
	Medicaid (see instructions for each line)				1
. 00	Net revenue from Medicaid			1, 806, 315	2.0
. 00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment	ts from Medicai	d?	Y	4.
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medical	i d		0	5.
00	Medicaid charges			45, 239, 183	6.
00	Medicaid cost (line 1 times line 6)			16, 911, 719	7.
. 00	Difference between net revenue and costs for Medicaid program (see instru			15, 105, 404	8.
~~	Children's Health Insurance Program (CHIP) (see instructions for each lin	ne)			
00	Net revenue from stand-al one CHIP			0	9.
0.00	Stand-alone CHIP charges			0	10. 11.
1.00 2.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (see instru	uctions)		0	
2.00	Other state or local government indigent care program (see instructions t			0	12.
3. 00	Net revenue from state or local indigent care program (Not included on li			0	13.
1.00	Charges for patients covered under state or local indigent care program			0	-
1. 00	10)			Ű	
5.00	State or local indigent care program cost (line 1 times line 14)			0	15.
. 00	Difference between net revenue and costs for state or local indigent card	e program (see	instructions)	0	16.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and sta	te/local indige	ent care progra	ams (see	1
	instructions for each line)				
. 00	Private grants, donations, or endowment income restricted to funding chan	5		0	
3.00	Government grants, appropriations or transfers for support of hospital of			0	18.
9.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent	care programs	(sum of lines	15, 105, 404	19.
	8, 12 and 16)	Unincured	Incurred	Tatal (asl 1	
		Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)	1.00	2.00	0.00	
. 00	Charity care charges and uninsured discounts (see instructions)	1, 025, 672	59, 242	1, 084, 914	20.
. 00	Cost of patients approved for charity care and uninsured discounts (see	383, 426	59, 242	442, 668	21.
	instructions)				
2.00	Payments received from patients for amounts previously written off as	0	0	0	22.
	charity care				
. 00	Cost of charity care (see instructions)	383, 426	59, 242	442, 668	23.
				1.00	
. 00	Does the amount on line 20 col. 2, include charges for patient days beyon	nd a longth of	otov limit	1.00 N	24.
. 00	imposed on patients covered by Medicaid or other indigent care program?	nd a rength of	Stay IImit	IN	24.
. 00	If line 24 is yes, enter the charges for patient days beyond the indigen	t care program'	s length of	0	25.
. 00	stav limit		3 Tength Of	0	25.
. 01	Charges for insured patients' liability (see instructions)			0	25.
. 00	Bad debt amount (see instructions)			4, 357, 681	
	Medicare reimbursable bad debts (see instructions)			96, 042	
00				147, 756	
	Medicare allowable bad debts (see instructions)				
7. 01	Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)			4, 209, 925	28.
7.01 3.00		instructions)		4, 209, 925 1, 625, 506	
8.00 9.00	Non-Medicare bad debt amount (see instructions)	instructions)			29.

Health Financial Systems	DAVIESS COMMUNITY HOSPI	TAL	In Lieu	In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi		From 01/01/2023	Worksheet S-10 Parts I & II Date/Time Prepared:	

	5/31/2024	<u>9:20 am</u>
2/31/2023	Date/Time	Prepared
	Parts I &	
1 /01 /0000		

				373172024 7.2	
				1.00	
I	PART II - HOSPITAL DATA				
ī	Jncompensated and Indigent Care Cost-to-Charge Ratio				
00	Cost to charge ratio (see instructions)			0. 322540	1.
Ν	Medicaid (see instructions for each line)				
00	Net revenue from Medicaid				2.
0	Did you receive DSH or supplemental payments from Medicaid?				3.
	If line 3 is yes, does line 2 include all DSH and/or supplemental paymen		d?		4
	If line 4 is no, then enter DSH and/or supplemental payments from Medical	i d			5
	Medicaid charges				6
	Medicaid cost (line 1 times line 6)				7
-	Difference between net revenue and costs for Medicaid program (see instru	/			8
	Children's Health Insurance Program (CHIP) (see instructions for each lin	ne)			
	Net revenue from stand-alone CHLP				9 10
	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				11
	Difference between net revenue and costs for stand-alone CHIP (see instru	uctions)			12
· · ·	Other state or local government indigent care program (see instructions i	/			12
	Net revenue from state or local indigent care program (Not included on li				13
	Charges for patients covered under state or local indigent care program				14
	10)				
00	State or local indigent care program cost (line 1 times line 14)				15
00	Difference between net revenue and costs for state or local indigent care program (see instructions)				16
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and sta	te/local indige	ent care progra	ams (see	
	nstructions for each line)				
	Private grants, donations, or endowment income restricted to funding cha	2			17.
	Government grants, appropriations or transfers for support of hospital o				18.
	Total unreimbursed cost for Medicaid , CHIP and state and local indigent 8, 12 and 16)	care programs	(sum of lines		19.
		Uni nsured	Insured	Total (col. 1	
		patients	patients	+ col. 2)	
		1.00	2.00	3.00	
l	Jncompensated care cost (see instructions for each line)				
00 [Charity care charges and uninsured discounts (see instructions)	1, 025, 672	59, 242	1, 084, 914	20.
00	Cost of patients approved for charity care and uninsured discounts (see	330, 820	59, 242	390, 062	21
	instructions)				
	Payments received from patients for amounts previously written off as	0	0	0	22.
	charity care		50.040	200 0/0	
00	Cost of charity care (see instructions)	330, 820	59, 242	390, 062	23
				1.00	
00	Does the amount on line 20 col. 2, include charges for patient days beyon	nd a length of	stav limit	N 1.00	24
	imposed on patients covered by Medicaid or other indigent care program?	na a rength of	Stuy IIIII t		2.0
00	If line 24 is yes, enter the charges for patient days beyond the indigen	t care program'	s length of	0	25
	stay limit	i i i i i i i i i i i i i i i i i i i	5		
01	Charges for insured patients' liability (see instructions)			0	25
00	Bad debt amount (see instructions)			4, 357, 681	26
	Medicare reimbursable bad debts (see instructions)			85, 232	27
00				131, 126	
01	Medicare allowable bad debts (see instructions)				28
01 00	Non-Medicare bad debt amount (see instructions)			4, 226, 555	
01 00 00	Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		1, 409, 127	29
01 00 00 00	Non-Medicare bad debt amount (see instructions)	instructions)			29. 30.

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		eriod: rom 01/01/2023	Worksheet A	
					o 12/31/2023	Date/Time Pre 5/31/2024 9:2	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
	-	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS						
00	00100 CAP REL COSTS-BLDG & FIXT		2, 294, 081	2, 294, 081		2, 477, 256	1.0
00 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		1, 414, 398	1, 414, 398		1, 426, 359 0	2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT	208, 016	6, 478, 781	6, 686, 797		6, 625, 448	4.0
00	00500 ADMI NI STRATI VE & GENERAL	2, 290, 235	14, 229, 641	16, 519, 876		15, 354, 260	
00	00600 MAINTENANCE & REPAIRS	69, 152	2, 285, 058			2, 354, 210	
00	00700 OPERATION OF PLANT	0	813, 890			813, 890	7. 8.
00 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	648, 520	125, 274 127, 005			125, 274 775, 525	8. 9.
. 00	01000 DI ETARY	381, 556	347, 134			220, 167	
. 00	01100 CAFETERI A	0	0	C		419, 625	
. 00	01300 NURSING ADMINISTRATION	647, 279	36, 305	683, 584		683, 584	13.
. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	315, 594	88, 133			403, 727	14.
. 00 . 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	533, 822 537, 735	166, 214 134, 347	700, 036 672, 082		700, 036 672, 082	15. 16.
	01700 SOCIAL SERVICE	0	135, 347	135		261, 195	
	INPATIENT ROUTINE SERVICE COST CENTERS						
. 00	03000 ADULTS & PEDIATRICS	2, 535, 142	324, 195			2, 754, 957	30.
. 00	03100 I NTENSI VE CARE UNI T	863, 469	32, 829			816, 246	
. 00 . 00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 982, 747 843, 661	176, 304 106, 590			2, 078, 386 957, 237	40. 41.
. 00	04300 NURSERY	043,001	35, 762			562, 659	43.
	ANCILLARY SERVICE COST CENTERS						1
. 00	05000 OPERATING ROOM	2, 124, 970	1, 605, 847	3, 730, 817		3, 730, 817	50.
. 00 . 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 140 775	0	140 775	0	0	51. 52.
00	05400 RADI OLOGY-DI AGNOSTI C	168, 775 946, 110	370, 711	168, 775 1, 316, 821		557, 076 1, 316, 821	52.
00	05600 RADI OI SOTOPE	267, 978	664, 099			932, 077	56.
00	06000 LABORATORY	961, 936	1, 496, 271	2, 458, 207	0	2, 458, 207	60.
. 00	06300 BLOOD STORING PROCESSING & TRANS.	0	3, 599	3, 599		3, 599	63.
. 00	06400 INTRAVENOUS THERAPY		150 744	740.260	0	740.260	64. 65.
00 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	590, 505 1, 107, 797	158, 764 61, 470	749, 269 1, 169, 267		749, 269 1, 169, 267	66.
00	06700 OCCUPATI ONAL THERAPY	425, 059	3, 646	428, 705		428, 705	67.
00	06800 SPEECH PATHOLOGY	193, 317	66			193, 383	68.
00	06900 ELECTROCARDI OLOGY	64, 610	14, 398			79, 008	
00 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 869, 904 0	2, 869, 904		2, 311, 301	71.
00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	4, 135, 306	-	,	558, 603 4, 135, 306	
	03020 CARDI AC REHAB	118, 917	14, 195			133, 112	
01	03030 ADDI CTI ON SERVI CES	235, 638	62, 527			298, 165	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	
00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	78
00	08800 RURAL HEALTH CLINIC	745, 107	79, 750	824, 857	0	824, 857	88
01	08801 RURAL HEALTH CLINIC II	558, 723	70, 941	629, 664		629, 664	88
02	08802 RURAL HEALTH CLINIC III	1, 047, 579	181, 021	1, 228, 600	0	1, 228, 600	88.
03	08805 RURAL HEALTH CLINIC IV	0	0	0	0	0	88
04 05	08803 RURAL HEALTH CLINIC V 08804 RURAL HEALTH CLINIC VI	1, 641, 569 550, 161	190, 905 53, 918	1, 832, 474 604, 079		1, 832, 474 604, 079	88. 88.
00	09000 CLINIC	219, 102	263, 134			482, 236	
01	09001 ONCOLOGY	297, 088	14, 651	311, 739		311, 739	90.
02	09002 PAIN MANAGEMENT	0	0	C	0	0	90.
00	09100 EMERGENCY	1, 434, 578	3, 370, 761	4, 805, 339	-21, 747	4, 783, 592	91.
00	09200 OBSERVATION BEDS (NON-DISTINCT PART	488, 694	241 251	720 045	112 000	(17.0/5	92.
00	04040 OTHER OUTPATIENT SERVICE COST CENTE OTHER REIMBURSABLE COST CENTERS	400, 094	241, 351	730, 045	-112, 980	617, 065	93.
00	09500 AMBULANCE SERVICES	2, 335, 202	505, 193	2, 840, 395	0	2, 840, 395	95.
	09910 CORF	0	0	C	0	0	99.
	10100 HOME HEALTH AGENCY	0	0	C			101.
2. 00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102.
2 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		173, 893	173, 893	0	173, 893	112
	11600 HOSPI CE	239, 061	169, 090			408, 151	
8.00		28, 619, 404	45, 991, 487			74, 273, 584	
	NONREIMBURSABLE COST CENTERS	· · · · ·					
2.00	19200 PHYSICIANS PRIVATE OFFICES 07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0 2, 833, 861	0 1, 273, 723	0	0 337, 307	0 4, 444, 891	192.
				4, 107, 584	TOC TCC	4 444 001	

LASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 15-0061	Period: From 01/01/2023	Worksheet A
			To 12/31/2023	Date/Time Prepare
Cost Center Description	Adjustments	Net Expenses		5/31/2024 9:20 an
cost center bescription	(See A-8)	For		
	(000000)	Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS				
0 00100 CAP REL COSTS-BLDG & FIXT	0			1
0 00200 CAP REL COSTS-MVBLE EQUIP	0			2
0 00300 OTHER CAP REL COSTS	104 550	0		3
0 00400 EMPLOYEE BENEFITS DEPARTMENT	-134, 552	6, 490, 896		4
0 00500 ADMINISTRATIVE & GENERAL 0 00600 MAINTENANCE & REPAIRS	-7, 470, 628	7,883,632		5
0 00700 OPERATION OF PLANT	0	2, 354, 210 813, 890		7
0 00800 LAUNDRY & LI NEN SERVI CE	0	125, 274		8
0 00900 HOUSEKEEPI NG	0	775, 525		9
00 01000 DI ETARY	0	220, 167		10
00 01100 CAFETERI A	-162, 974	256, 651		11
00 01300 NURSI NG ADMI NI STRATI ON	0	683, 584		13
00 01400 CENTRAL SERVICES & SUPPLY	-4, 736			14
00 01500 PHARMACY	-5, 445	694, 591		15
00 01600 MEDICAL RECORDS & LIBRARY	-5, 880	666, 202		16
00 01700 SOCI AL SERVI CE	0	261, 195		
INPATIENT ROUTINE SERVICE COST CENTERS				
00 03000 ADULTS & PEDIATRICS	-850, 050			30
00 03100 INTENSIVE CARE UNIT	0	816, 246		31
00 04000 SUBPROVIDER - IPF	-390, 800			40
00 04100 SUBPROVIDER - IRF	-169, 858	787, 379		41
00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	562, 659		43
OO 05000 OPERATING ROOM	1 222 454	2 407 161		50
00 05100 RECOVERY ROOM	-1, 233, 656	2, 497, 161 0		51
00 05200 DELIVERY ROOM & LABOR ROOM	0	557, 076		52
00 05400 RADI OLOGY-DI AGNOSTI C	-172, 642	1, 144, 179		54
00 05600 RADI 0I SOTOPE	-440	931, 637		56
00 06000 LABORATORY	-30,000	2, 428, 207		60
00 06300 BLOOD STORING PROCESSING & TRANS.	0	3, 599		63
00 06400 I NTRAVENOUS THERAPY	0	0		64
00 06500 RESPI RATORY THERAPY	-60, 336	688, 933		65
00 06600 PHYSI CAL THERAPY	0	1, 169, 267		66
00 06700 OCCUPATI ONAL THERAPY	0	428, 705		67
00 06800 SPEECH PATHOLOGY	0	193, 383		68
00 06900 ELECTROCARDI OLOGY	-11,076			69
00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	2, 311, 301		71
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	558, 603		72
00 07300 DRUGS CHARGED TO PATIENTS	0	4, 135, 306		73
00 03020 CARDI AC REHAB	0	133, 112		76
01 03030 ADDICTION SERVICES 00 07700 ALLOGENEIC HSCT ACQUISITION	0			76
00 07800 CAR T-CELL IMMUNOTHERAPY	0	U U		78
OUTPATIENT SERVICE COST CENTERS	0			//
00 08800 RURAL HEALTH CLINIC	0	824, 857		88
01 08801 RURAL HEALTH CLINIC II	0	629, 664		88
02 08802 RURAL HEALTH CLINIC III	0	1, 228, 600		88
03 08805 RURAL HEALTH CLINIC IV	0	0		88
04 08803 RURAL HEALTH CLINIC V	0	1, 832, 474		88
05 08804 RURAL HEALTH CLINIC VI	0	604, 079		88
00 09000 CLINIC	-2, 250	479, 986		90
01 09001 0NC0L0GY	0	311, 739		90
02 09002 PAIN MANAGEMENT	0	0		90
00 09100 EMERGENCY	-8, 608	4, 774, 984		91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	214 500	102 147		92
OTHER REIMBURSABLE COST CENTERS	-214, 598	402, 467		93
00 09500 AMBULANCE SERVICES	0	2, 840, 395		95
10 09910 CORF	0	2, 840, 395		93
. 00 10100 HOME HEALTH AGENCY	0	0		101
. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		101
SPECIAL PURPOSE COST CENTERS				102
. 00 11300 I NTEREST EXPENSE	-173, 893	0		113
. 00 11600 HOSPI CE	0	408, 151		116
. 00 SUBTOTALS (SUM OF LINES 1 through 117)	-11, 102, 422			118
NONREI MBURSABLE COST CENTERS				
. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0		192
. 00 07951 OTHER NONREI MBURSABLE AND PHYSI CLAN	0	1		194
.00 TOTAL (SUM OF LINES 118 through 199)	-11, 102, 422			200

Health Financial Sys	tems	[DAVIESS COMMUNI	TY HOSPI TAL		In Lieu	of Form CM	S-2552-10
RECLASSI FI CATI ONS				Provider C	CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time P	Prepared:
		Increases					5/31/2024 9	7:20 am
Cost	Center	Li ne #	Salary	Other				
		3.00	4,00	5.00				
A - DIETARY		0.00	1.00	0.00		· · · · · ·		
1.00 CAFETERIA		11.00	219, 724	199, 901				1.00
2.00 OTHER NONREIM	BURSABLE AND	194,00	46, 549	42, 349				2.00
PHYSI CI AN		.,	107017	12/01/				2.00
TOTALS		+	266, 273	242, 250				
C - BILLING C	OSTS	I		,				
1.00 OTHER NONRELM		194,00	13,072	19, 754				1.00
PHYSI CI AN								
TOTALS			13,072	19, 754				
D - OBSTETRIC	S	I						
1.00 NURSERY	-	43.00	489, 076	37, 821				1.00
	& LABOR ROOM	52.00	360, 429	27, 872				2.00
TOTALS			849, 505	65, 693				
E - INSURANCE	RECLASS	1						
1.00 CAP REL COSTS		1.00	0	183, 175				1.00
2.00 CAP REL COSTS	-MVBLE EQUIP	2.00	О	11, 961				2.00
3.00 OTHER NONREIM	BURSABLE AND	194.00	0	215, 583				3.00
PHYSI CI AN								
TOTALS			0	410, 719				
F - IMPLANTAB	LE DEVICES							
1.00 IMPL. DEV. CH	ARGED TO	72.00	0	558, 603				1.00
PATI ENTS								
TOTALS			0	558, 603				
	RVICES RECLASS							
1.00 SOCIAL SERVIC	E	17.00	261, 060	0				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
TOTALS			261, 060	0				
H - OTHER								
1.00 ADULTS & PEDI		30. 00	62, 875	0				1.00
2.00 SUBPROVI DER -		40.00	6, 986	0				2.00
3.00 SUBPROVI DER -	<u>IRF</u>		<u>6, 9</u> 86	0				3.00
TOTALS			76, 847	ō				
I - HOSPITALI								
1.00 ADULTS & PEDI			0	75 <u>0, 6</u> 00				1.00
TOTALS			0	750, 600				
J - BENEFIT R			- 1					_
1.00 ADMI NI STRATI V	E & GENERAL	5.00	0	<u>61, 349</u>				1.00
TOTALS			0	61, 349				500.55
500.00 Grand Total:	Increases		1, 466, 757	2, 108, 968				500.00

LASS	SEFECATIONS			Provi der	CCN: 15-0061	Peri od:	Worksheet A-6
						From 01/01/202 To 12/31/202	3 Date/Time Prepared
		Decreases					5/31/2024 9:20 am
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Re	f.	
	6.00	7.00	8.00	9.00	10.00		
	A – DIETARY						
0	DI ETARY	10.00	266, 273	242, 250)	0	1.
0	\square $_$ $_$ $_$ $_$ $_$ $_$ $_$	0.00	0	0)	0	2.
	TOTALS		266, 273	242, 250)		
	C - BILLING COSTS						
0	ADMI NI STRATI VE & GENERAL	5.00	1 <u>3,0</u> 72	1 <u>9, 7</u> 54		0	1.
	TOTALS		13, 072	19, 754	ł		
_	D - OBSTETRICS		- ·		. [-1	
0	ADULTS & PEDIATRICS	30.00	849, 505	65, 693	8	0	1.
0		0.00	0	()	Q	2.
	TOTALS		849, 505	65, 693	3		
~	E - INSURANCE RECLASS	5 00		440 740		10	
0	ADMI NI STRATI VE & GENERAL	5.00	0	410, 719		12	1.
0 0		0.00 0.00	0	0		12	2.
0			<u>0</u>	410, 719		12	3.
	F - IMPLANTABLE DEVICES		<u> </u>	410, 719	<u> </u>		
0	MEDICAL SUPPLIES CHARGED TO	71.00	0	558, 603		0	1.
0	PATIENT	71.00	0	556, 603		0	1.
	TOTALS	+		558, 603			
	G - SOCIAL SERVICES RECLASS		<u> </u>	330,000	,		
0	ADMI NI STRATI VE & GENERAL	5.00	32, 820	(0	1.
0	ADULTS & PEDIATRICS	30,00	2, 657	(0	2.
0	INTENSIVE CARE UNIT	31.00	3, 205	C)	0	3.
0	SUBPROVIDER - IPF	40.00	87, 651	C)	0	4.
0	EMERGENCY	91.00	21, 747	C)	0	5.
0	OTHER OUTPATIENT SERVICE	93.00	112, 980	C)	0	6.
	COST CENTE						
	TOTALS		261,060	c)		
	H – OTHER						
0	INTENSIVE CARE UNIT	31.00	76, 847	C)	0	1.
0		0.00	0	C)	0	2.
0	L	0.00	0	0)	Q	3.
	TOTALS		76, 847	0)		
	I - HOSPITALIST RECLASS		1		T	-1	
0	ADMI NI STRATI VE & GENERAL	5.00		75 <u>0,6</u> 00		<u>0</u>	1.
	TOTALS		0	750, 600			
~	J - BENEFIT RECLASS	!	-1				
0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6 <u>1,3</u> 49		<u> </u>	1.
	TOTALS Grand Total: Decreases		0	61, 349	3		

2.00 Land Improvements 687,865 0 0 0 0 2.00 3.00 Buildings and Fixtures 43,751,153 1,757,920 0 1,757,920 0 3.00 4.00 Building Improvements 39,119 0 0 0 0 40 5.00 Fixed Equipment 11,696,061 1,069,135 0 1,069,135 0 5.00 6.00 Movable Equipment 32,925,492 0 0 0 0 0 7.00 7.00 HIT designated Assets 0	Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL			In Lie	u of Form CMS-2	2552-10
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES - Analysis -	RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0061	Fro	om 01/01/2023	Part I Date/Time Pre	pared:
Beginning Balances Purchases Donation Total Retirements Disposals and Retirements PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 0 0 0 0 1.00 Land 1,280,955 0 0 0 0 2.00 3.00 Building provements 687,865 0 0 0 2.00 3.00 Building provements 39,119 0 0 0 4.00 5.00 Fixed Equipment 11,696,061 1,069,135 0 1.00 6.00 6.00 Movable Equipment 32,925,492 0 0 0 7.00 11 designated Assets 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 90,380,645 2,827,055 0 2,827,055 402,750 8.00 0.00 Total I ine 8 minus line 9 90,380,645 2,827,055 0 2,827,055 402,750 8.00 1.00 Land Land I.con 1,280,955 0					Acquisition	IS		J73172024 9.2	
Bai ances Retirements 1.00 2.00 3.00 4.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.280,955 0 0 0 0 1.00 2.00 Land Improvements 687,865 0 0 0 0 2.00 3.00 Buil dii ng sand Fixtures 43,751,153 1,757,920 0 1,069,135 0 0 0 0 4.00 5.00 Fixed Equipment 11,696,051 1,069,135 0 1,069,135 0 5.00 6.00 6.00 Movable Equipment 32,925,492 0 0 0 0 7.00 7.00 HT designated Assets 0 0 0 0 0 7.00 9.00 Reconciling Items 0			Begi nni ng	Purchases			Total	Disposals and	
PART I - ANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES 0 0 0 1.00 1.00 Land 1, 280, 955 0 0 0 0 1.00 2.00 Land Improvements 687, 865 0 0 0 2.00 3.00 Buil dings and Fixtures 43, 751, 153 1, 757, 920 0 3.00 4.00 Buil ding Improvements 39, 119 0 0 0 4.00 5.00 Fixed Equipment 11, 696, 061 1, 069, 135 0 1, 069, 135 0 5.00 6.00 7.00 402, 750 6.00 7.00 0			Bal ances						
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 Buil dings and Fixtures 43,751,153 1,757,920 0 1,757,920 0 3.00 4.00 Buil ding Improvements 39,119 0 0 0 0 0 4.00 5.00 Fixed Equipment 11,696,061 1.069,135 0 0 0 4.00 6.00 Movable Equipment 32,925,492 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 90,380,645 2,827,055 0 2,827,055 402,750 8.00 9.00 Reconcil ing I tems 0 0 0 0 0 9.00 0 0 0 0 0 0 0 9.00 8.00 2,827,055 0 2,827,055 402,750 10.00 10.00 Total (line 8 minus line 9) 90,380,645 2,827,055 0 2,827,055 402,750 10.00 2,			1.00	2.00	3.00		4.00	5.00	
2.00 Land Improvements 687,865 0 0 0 0 2.00 3.00 Buildings and Fixtures 43,751,153 1,757,920 0 1,757,920 0 3.00 4.00 Building Improvements 39,119 0 0 0 0 4.00 5.00 Fixed Equipment 11,696,061 1,069,135 0 1,069,135 0 5.00 6.00 Movable Equipment 32,925,492 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 90,380,645 2,827,055 0 2,827,055 402,750 8.00 9.00 Reconciling Items 0 0 0 0 9.00 10.00 Total (line 8 minus line 9) 90,380,645 2,827,055 0 2,827,055 402,750 10.00 10.00 Land Inprovements 6.00 7.00 2.00 2.827,055 0 2,827,055 402,750 10.00 2.00 Land	-	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
3.00 Buildings and Fixtures 43,751,153 1,757,920 0 1,757,920 0 3.00 4.00 Building Improvements 39,119 0 0 0 4.00 5.00 Fixed Equipment 11,696,061 1,069,135 0 1,069,135 0 4.00 6.00 Movable Equipment 32,925,492 0 0 0 402,750 6.00 7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 90,380,645 2,827,055 0 2,827,055 402,750 8.00 9.00 Reconciling Items 0 0 0 0 0 9.00 0 0 0 9.00 0 0 0 9.00 0 0 0 9.00 0 0 0 0 0 9.00 0 <t< td=""><td>1.00</td><td>Land</td><td>1, 280, 955</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>1.00</td></t<>	1.00	Land	1, 280, 955	0		0	0	0	1.00
4.00 Building Improvements 39, 119 0 0 0 0 4.00 5.00 Fixed Equipment 11, 696, 061 1, 069, 135 0 1, 069, 135 0 5.00 6.00 Movable Equipment 32, 925, 492 0 0 0 0 402, 750 6.00 7.00 HIT designated Assets 0	2.00	Land Improvements	687, 865	0		0	0	0	2.00
5.00 Fixed Equipment 11,696,061 1,069,135 0 1,069,135 0 5.00 6.00 Movable Equipment 32,925,492 0<	3.00	Buildings and Fixtures	43, 751, 153	1, 757, 920		0	1, 757, 920	0	3.00
6.00 Movable Equipment 32,925,492 0 0 0 402,750 6.00 7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 90,380,645 2,827,055 0 2,827,055 402,750 8.00 9.00 Reconciling Items 0 0 0 0 0 9.00 9.00 Total (line 8 minus line 9) 90,380,645 2,827,055 0 2,827,055 402,750 10.00 10.00 Total (line 8 minus line 9) 90,380,645 2,827,055 0 2,827,055 402,750 10.00 Ending Fully Balance Depreciated Assets 6.00 7.00 1.00 2.00 Land 1,280,955 0 2.00 2.00 2.00 2.00 3.00 3.00 Buildings and Fixtures 45,509,073 0 3.00 3.00 3.00 4.00 Building Improvements 39,119 0 5.00 5.00 6.00 5.00 Fixed Equipment	4.00	Building Improvements	39, 119	0		0	0	0	4.00
7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 90, 380, 645 2, 827, 055 0 2, 827, 055 402, 750 8.00 9.00 Reconciling Items 0 0 0 0 0 0 0 9.00 10.00 Total (line 8 minus line 9) 90, 380, 645 2, 827, 055 0 2, 827, 055 402, 750 10.00 10.00 Total (line 8 minus line 9) 90, 380, 645 2, 827, 055 0 2, 827, 055 402, 750 10.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 7.00 1.00 2.00 Land 1, 280, 955 0 2.00 2.00 2.00 2.00 3.00 Buil dings and Fixtures 45, 509, 073 0 3.00 3.00 3.00 3.00 5.00 Fixed Equipment 12, 765, 196 0 5.00 6.00 5.00 6.00 7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00	5.00	Fixed Equipment	11, 696, 061	1, 069, 135		0	1, 069, 135		5.00
8.00 Subtotal (sum of lines 1-7) 90, 380, 645 2, 827, 055 0 2, 827, 055 402, 750 8.00 9.00 Total (line 8 minus line 9) 90, 380, 645 2, 827, 055 0 2, 827, 055 402, 750 8.00 10.00 Total (line 8 minus line 9) 90, 380, 645 2, 827, 055 0 2, 827, 055 402, 750 8.00 Part 1 Analysis Ending Fully Bal ance Depreciated 4 6 6 6 6 6 6 6 6 6 6 6 6 6	6.00	Movable Equipment	32, 925, 492	0		0	0	402, 750	6.00
9.00 Reconciling Items 0 0 0 0 0 0 0 0 9.00 10.00 Total (line 8 minus line 9) 90,380,645 2,827,055 0 2,827,055 402,750 10.00 Interview Ending Fully Depreciated Assets 402,750 10.00 Interview 6.00 7.00 7.00 1.00 1.00 1.00 1.00 Interview 6.00 7.00 1.00	7.00		0	0		0	0	0	7.00
10.00 Total (line 8 minus line 9) 90, 380, 645 2, 827, 055 0 2, 827, 055 402, 750 10.00 Ending Balance Fully Depreciated Assets Fully Depreciated	8.00	Subtotal (sum of lines 1-7)	90, 380, 645	2,827,055		0	2, 827, 055	402, 750	8.00
Ending Balance Fully Depreciated Assets PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 Land 1,280,955 0 1.00 2.00 Land Improvements 687,865 0 2.00 3.00 Buildings and Fixtures 45,509,073 0 3.00 4.00 Building Improvements 39,119 0 4.00 5.00 Fixed Equipment 12,765,196 0 5.00 6.00 Movable Equipment 32,522,742 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 92,804,950 0 7.00	9.00	Reconciling Items	0	0		0	0	0	9.00
Bal ance Depreciated Assets 6.00 7.00 PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 Land 1,280,955 0 1.00 2.00 Land Improvements 687,865 0 2.00 3.00 Buildings and Fixtures 45,509,073 0 3.00 4.00 Building Improvements 39,119 0 4.00 5.00 Fixed Equipment 12,765,196 0 5.00 6.00 Movable Equipment 32,522,742 0 6.00 7.00 HIT designated Assets 0 0 7.00 7.00 9.00 Reconciling Items -7) 92,804,950 0 7.00	10.00	Total (line 8 minus line 9)	90, 380, 645	2,827,055		0	2, 827, 055	402, 750	10.00
PART I - ANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES 0 7.00 1.00 Land 1, 280, 955 0 1.00 2.00 Land Improvements 687, 865 0 2.00 3.00 Buildings and Fixtures 45, 509, 073 0 3.00 4.00 Building Improvements 39, 119 0 4.00 5.00 Fixed Equipment 12, 765, 196 0 5.00 6.00 Movable Equipment 32, 522, 742 0 6.00 8.00 Subtotal (sum of lines 1-7) 92, 804, 950 0 8.00 8.00 9.00 Reconciling Items 0 0 0 9.00									
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 280, 955 0 1.00 2.00 Land Improvements 687, 865 0 2.00 3.00 Buildings and Fixtures 45, 509, 073 0 3.00 4.00 Building Improvements 39, 119 0 4.00 5.00 Fixed Equipment 12, 765, 196 0 5.00 6.00 Movable Equipment 32, 522, 742 0 6.00 8.00 Subtotal (sum of lines 1-7) 92, 804, 950 0 7.00 9.00 Reconciling Items 0 0 0 9.00			Bal ance						
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 280, 955 0 1.00 2.00 Land Improvements 687, 865 0 2.00 3.00 Buildings and Fixtures 45, 509, 073 0 3.00 4.00 Building Improvements 39, 119 0 4.00 5.00 Fixed Equipment 12, 765, 196 0 5.00 6.00 Movable Equipment 32, 522, 742 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 92, 804, 950 0 8.00 9.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00									
1.00 Land 1,280,955 0 1.00 2.00 Land Improvements 687,865 0 2.00 3.00 Buildings and Fixtures 45,509,073 0 3.00 4.00 Building Improvements 39,119 0 4.00 5.00 Fixed Equipment 12,765,196 0 5.00 6.00 Movable Equipment 32,522,742 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 92,804,950 0 8.00 9.00 Reconciling Items 0 0 9.00				7.00					
2.00 Land Improvements 687,865 0 2.00 3.00 Buildings and Fixtures 45,509,073 0 3.00 4.00 Building Improvements 39,119 0 4.00 5.00 Fixed Equipment 12,765,196 0 5.00 6.00 Movable Equipment 32,522,742 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 92,804,950 0 8.00 9.00 Reconciling Items 0 0 9.00									
3.00 Buildings and Fixtures 45,509,073 0 3.00 4.00 Building Improvements 39,119 0 4.00 5.00 Fixed Equipment 12,765,196 0 5.00 6.00 Movable Equipment 32,522,742 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 92,804,950 0 8.00 9.00 Reconciling Items 0 0 9.00				0					
4.00 Building Improvements 39,119 0 4.00 5.00 Fixed Equipment 12,765,196 0 5.00 6.00 Movable Equipment 32,522,742 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 92,804,950 0 8.00 9.00 Reconciling Items 0 0 9.00				0					
5.00 Fixed Equipment 12,765,196 0 5.00 6.00 Movable Equipment 32,522,742 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 92,804,950 0 8.00 9.00 Reconciling Items 0 0 9.00				0					3.00
6.00 Movable Equipment 32,522,742 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 92,804,950 0 8.00 9.00 Reconciling Items 0 0 9.00				0					
7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 92,804,950 0 8.00 9.00 Reconciling Items 0 0 9.00				0					5.00
8.00 Subtotal (sum of lines 1-7) 92,804,950 0 8.00 8.00 9.00			32, 522, 742	0					6.00
9.00 Reconciling Items 0 0 9.00			0	0					7.00
			92, 804, 950	0					
10.00 Total (line 8 minus line 9) 92,804,950 0 10.00			0	0					9.00
	10.00	Total (line 8 minus line 9)	92, 804, 950	0					10.00

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
				JMMARY OF CAPI		5/31/2024 9:2	0 am
			50	JIVIIVIARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1				
1.00	CAP REL COSTS-BLDG & FIXT	2, 070, 571		223, 51	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 015, 049	321, 712		0 0	77,637	2.00
3.00	Total (sum of lines 1-2)	3, 085, 620		223, 51	0 0	77,637	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	Other	Total (1)	1			
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU					
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 294, 081	1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 414, 398				2.00
3.00	Total (sum of lines 1-2)	0	3, 708, 479				3.00

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2023 Fo 12/31/2023	Worksheet A-7 Part III Date/Time Prep 5/31/2024 9:20	
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col. 2)			
	1.00	2.00	3,00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2100	0100		0100	
1.00 CAP REL COSTS-BLDG & FIXT	60, 282, 208	0	60, 282, 208	0. 649558	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	32, 522, 742		32, 522, 742			2.00
3.00 Total (sum of lines 1-2)	92, 804, 950		92, 804, 950			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT	ENTERS 0			2,070,571	0	1.00
2.00 CAP REL COSTS-BLDG & FIXT	0			1, 015, 049	Ű	2.00
3.00 Total (sum of lines 1-2)	0			3, 085, 620		2.00 3.00
	0	SI SI	IMMARY OF CAPIT		521,712	3.00
		00				
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see	9 through 14)	
	11.00	10.00	10.00	instructions)	15.00	
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	183, 175	C		2, 477, 256	1.00
2.00 CAP REL COSTS-MUBLE EQUIP	223, 310				1, 426, 359	2.00
3.00 Total (sum of lines 1-2)	223, 510				3, 903, 615	3.00
		1		1		

Health Financial Systems

In Lieu of Form CMS-2552-10

			To	rom 01/01/2023 0 12/31/2023	Date/Time Pre 5/31/2024 9:2	pare 0 an
			Expense Classification on To/From Which the Amount is			
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2) 1.00	2.00	3.00	4.00	Ref. 5.00	
0 Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1
COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2
COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3
(chapter 2)	_	_				
0 Trade, quantity, and time discounts (chapter 8)	В	-4, 736	CENTRAL SERVICES & SUPPLY	14.00	0	4
0 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5
0 Rental of provider space by		0		0. 00	0	6
suppliers (chapter 8) 0 Telephone services (pay	А	-1 725	ADMI NI STRATI VE & GENERAL	5.00	0	7
stations excluded) (chapter		1,723		5.00	0	'
21) 0 Television and radio service	А	-23, 760	ADMI NI STRATI VE & GENERAL	5.00	0	8
(chapter 21)					0	9
0 Parking lot (chapter 21) 00 Provider-based physician	A-8-2	-3, 135, 706		0.00	0 0	
adjustment 00 Sale of scrap, waste, etc.		0		0.00	0	11
(chapter 23)		_		0.00		
00 Related organization transactions (chapter 10)	A-8-1	0			0	12
00 Laundry and linen service 00 Cafeteria-employees and guests	В	162 074	CAFETERI A	0.00 11.00	0	13 14
00 Rental of quarters to employee		- 102, 974	CAFEIERIA	0.00	0	
and others 00 Sale of medical and surgical		0		0. 00	0	16
supplies to other than		-				
patients 00 Sale of drugs to other than	В	-5, 445	PHARMACY	15.00	0	17
patients 00 Sale of medical records and	В	-5.880	MEDI CAL RECORDS & LI BRARY	16.00	0	18
abstracts						
00 Nursing and allied health education (tuition, fees,		0		0. 00	0	19
books, etc.) 00 Vending machines		0		0.00	0	20
00 Income from imposition of	А	-	ADMI NI STRATI VE & GENERAL	5.00	0	
interest, finance or penalty charges (chapter 21)						
00 Interest expense on Medicare		0		0.00	0	22
overpayments and borrowings to repay Medicare overpayments						
00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
limitation (chapter 14)		_				
00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24
limitation (chapter 14) 00 Utilization review -			*** Cost Center Deleted ***	114.00		25
physicians' compensation			cost center bereted	114.00		20
(chapter 21) 00 Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26
COSTS-BLDG & FIXT						
00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27
00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	0	28 29
00 Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	30
therapy costs in excess of limitation (chapter 14)						
99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30
instructions)	I	l				1

Health Fi	inancial Systems		DAVIESS COMMUN	I TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTME	NTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
				Expense Classification or	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)				Ref.	
		1.00	2.00	3.00	4.00	5.00	
	djustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	athology costs in excess of						
	imitation (chapter 14)						
	AH HIT Adjustment for		0		0.00	0	32.00
	epreciation and Interest DVERTISING EXPENSES	٨	210 440		5.00	0	33.00
	HYSICIAN RECRUITMENT EXPENSES	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00	0	34.00
	ON-ALLOWABLE COSTS	A		ADMINISTRATIVE & GENERAL	5.00	0	35.01
	HYSICIAN BENEFITS	Δ		EMPLOYEE BENEFITS DEPARTMEN		0	35.04
	PR CLASS I NCOME	В		EMERGENCY	91.00	0	36.00
	I SC. I NCOME	B		ADMI NI STRATI VE & GENERAL	5.00	0	36.01
	NTEREST EXPENSE OFFSET	A		INTEREST EXPENSE	113.00	0	36.02
1		^			F 00	0	

38.00 0 0 39.00 40.00 0

50.00

36.01	MISC. INCOME	В	-482, 404	ADMINISTRATIVE & GENERAL	5.00
36.02	INTEREST EXPENSE OFFSET	А	-173, 893	INTEREST EXPENSE	113.00
38.00	LOBBYING EXPENSE	A	-9, 728	ADMINISTRATIVE & GENERAL	5.00
39.00	DEBT I SSUANCE COST	A	21, 245	ADMINISTRATIVE & GENERAL	5.00
	AMORTI ZATI ON				
40.00	HAF	A	-6, 353, 552	ADMINISTRATIVE & GENERAL	5.00
50.00	TOTAL (sum of lines 1 thru 49)		-11, 102, 422		
	(Transfer to Worksheet A,				
	column 6, line 200.)				

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

(2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

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

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

Heal th	Financial Syste	ems	DAVIESS COMML	INI TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	ER BASED PHYSIC				CCN: 15-0061	Peri od:	Worksheet A-8	
	_			_		From 01/01/2023 To 12/31/2023		
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	850, 050			211,500	0	1.00
2.00	40.00	SUBPROVIDER – IPF	390, 800	390, 800	(181, 300	0	2.00
3.00	41.00	SUBPROVIDER - IRF	169, 858	169, 858	(211,500	0	3.00
4.00	50.00	OPERATING ROOM	1, 233, 656	1, 233, 656	(246,400	0	4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	172, 642	172, 642	(271,900	0	5.00
6.00	56.00	RADI OI SOTOPE	440	440	(271,900	0	6.00
7.00		LABORATORY	30,000	30,000	(260, 300	0	7.00
8.00	65.00	RESPI RATORY THERAPY	60, 336	60, 336	(260, 300	0	8.00
9.00	69.00	ELECTROCARDI OLOGY	11,076		(211, 500	0	9.00
10.00	90.00	CLINIC	2, 250	2, 250	(211, 500	0	10.00
11.00	93.00	OTHER OUTPATIENT SERVICE	214, 598	214, 598	(211,500	0	11.00
		COST CENTE						
200.00			3, 135, 706	3, 135, 706	(b	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	0		0 0	0	
2.00		SUBPROVIDER – IPF	0	0		0 0	0	2.00
3.00		SUBPROVI DER – I RF	0	0		0 0	0	3.00
4.00		OPERATING ROOM	0	0		0 0	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	5.00
6.00		RADI OI SOTOPE	0	0		0 0	0	6.00
7.00		LABORATORY	0	0		0 0	0	7.00
8.00		RESPI RATORY THERAPY	0	0		0 0	0	8.00
9.00		ELECTROCARDI OLOGY	0	0		0 0	0	9.00
10.00		CLINIC	0	0		0 0	0	10.00
11.00		OTHER OUTPATIENT SERVICE COST CENTE	C	0	(0 0	0	
200.00			0	0	(0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
	1.00	2.00	15, 00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	13.00			850,050		1.00
2.00		SUBPROVIDER - IPF		-		390, 800		2.00
3.00		SUBPROVIDER - IRF		-		169,858		3.00
4.00		OPERATI NG ROOM		-		1, 233, 656		4.00
5.00		RADI OLOGY-DI AGNOSTI C		, s		172,642		5.00
6.00		RADI OI SOTOPE	0	0		440		6.00
7.00		LABORATORY		° °		30,000		7.00
8.00		RESPI RATORY THERAPY		° °		60, 336		8.00
9.00		ELECTROCARDI OLOGY		, s		11,076		9.00
10.00		CLINIC		-		2, 250		10.00
11.00		OTHER OUTPATIENT SERVICE		0		214, 598		11.00
		COST CENTE						
200.00			C	0	(3, 135, 706		200.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	DAVIESS COMMUN	ITY HOSPITAL Provider CO	1	In Lie Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
			CAPI TAL REL	ATED COSTS		5/31/2024 9:2	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	2, 477, 256	2, 477, 256				1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT	1, 426, 359		1, 426, 35	9		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 490, 896					4.00
5.00	00500 ADMINI STRATI VE & GENERAL	7, 883, 632					
6.00	00600 MAINTENANCE & REPAIRS	2, 354, 210		8, 86			
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	813, 890 125, 274	478, 654 5, 152		0 0 0 0	1, 292, 544 130, 426	
9.00	00900 HOUSEKEEPI NG	775, 525	17, 056			929, 312	
10.00	01000 DI ETARY	220, 167	44, 725				
11.00	01100 CAFETERI A	256, 651	16, 383		0 45, 692		
13.00	01300 NURSI NG ADMI NI STRATI ON	683, 584	32, 910				
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	398, 991 694, 591	49, 480 20, 024				
16.00	01600 MEDI CAL RECORDS & LI BRARY	666, 202	109, 199				
	01700 SOCI AL SERVI CE	261, 195	0		0 54, 288		
	INPATIENT ROUTINE SERVICE COST CENTERS				-	l	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 904, 907	104, 510				1
40.00	04000 SUBPROVI DER – I PF	816, 246 1, 687, 586	26, 379 108, 581	18, 63			1
41.00	04100 SUBPROVI DER – I RF	787, 379					
43.00	04300 NURSERY	562, 659	10, 503		0 101, 704		
50.00	ANCI LLARY SERVICE COST CENTERS	0 407 4 44	140 570	010 10	0 444 000	0.007.0/0	1 50 00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	2, 497, 161	149, 578 0		8 441, 892 0 0	3, 307, 069	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	557, 076	108, 736		0 110, 049	775, 861	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 144, 179	134, 221	108, 58			
56.00	05600 RADI OI SOTOPE	931, 637	12, 555			1, 049, 306	
60.00	06000 LABORATORY	2, 428, 207	37, 576				
63.00 64.00	06300 BLOOD STORI NG PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	3, 599	2, 195 0		0 0 0 0	5, 794 0	
65.00	06500 RESPI RATORY THERAPY	688, 933	28, 872			911, 945	
66.00	06600 PHYSI CAL THERAPY	1, 169, 267	74, 414				
67.00	06700 OCCUPATI ONAL THERAPY	428, 705	15, 854	18, 64			
68.00		193, 383	11, 231			258, 371	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	67, 932 2, 311, 301	6, 840 0				
	07200 I MPL. DEV. CHARGED TO PATIENTS	558, 603	0		0 0		
	07300 DRUGS CHARGED TO PATIENTS	4, 135, 306			0 0	.,	73.00
76.00	03020 CARDI AC REHAB	133, 112	25, 364		0 24, 729		
76.01 77.00	03030 ADDICTION SERVICES 07700 ALLOGENEIC HSCT ACQUISITION	298, 165 0	0		0 49,001 0 0	347, 166 0	
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	824, 857	53, 673				1
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	629, 664 1, 228, 600	38, 437 59, 079				1
88.02	08805 RURAL HEALTH CLINIC IV	1, 228, 000	39, 079 0		0 217, 840 0 0	0	1
88.04	08803 RURAL HEALTH CLINIC V	1, 832, 474	21, 425	4, 56	8 341, 368	2, 199, 835	
88.05	08804 RURAL HEALTH CLINIC VI	604, 079	28, 144	67		747, 301	
90. 00 90. 01	09000 CLINIC 09001 0NC0L0GY	479, 986 311, 739	41, 471 42, 530				
90. 01 90. 02	09002 PALN MANAGEMENT	311,739	42, 530		0 61,780 0 0	410,049	
91.00	09100 EMERGENCY	4, 774, 984	71, 159	52, 55		5, 192, 500	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			_		0	12.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE OTHER REIMBURSABLE COST CENTERS	402, 467	64, 363	9	1 78, 130	545, 051	93.00
95.00	09500 AMBULANCE SERVICES	2, 840, 395	0	188, 50	5 485, 610	3, 514, 510	95.00
	09910 CORF	0	0		0 0	0	99.10
	10100 HOME HEALTH AGENCY	0	0		0 0		101.00
102.00	10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0		0 0	0	102.00
113.00	11300 INTEREST EXPENSE						113.00
	11600 H0SPI CE	408, 151	6, 454		0 49, 713		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	63, 171, 162	2, 365, 189	1, 360, 21	5 5, 895, 807	62, 391, 249	1118.00
192.00	19200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	0	192.00
194.00	07951 OTHER NONREIMBURSABLE AND PHYSICIAN	4, 444, 891	112, 067		-	5, 224, 804	194.00
200.00	Cross Foot Adjustments					0	200.00

Health Financial Systems	DAVIESS COMMUN	ILTY HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B Part I	
				From 01/01/2023 Fo 12/31/2023		pared: 0 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
201.00 Negative Cost Centers		0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	67, 616, 053	2, 477, 256	1, 426, 359	6, 497, 509	67, 616, 053	202.00

Heal th	Financial Systems	DAVIESS COMMUNIT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2023	Worksheet B Part I	
				T			epared:
	Cost Center Description	ADMI NI STRATI V MA	AINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	·	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS	8, 637, 708 357, 914	2, 801, 744				5.00
7.00	00700 OPERATION OF PLANT	189, 301	591, 029	2, 072, 874			7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE	19, 102	6, 362	5, 965	161, 855		8.00
9.00	00900 HOUSEKEEPI NG	136, 103	21,061	19, 747	42, 861	1, 149, 084	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	43, 447 46, 679	55, 226 20, 230	51, 783 18, 968	879 0	29, 066 10, 647	
13.00	01300 NURSI NG ADMI NI STRATI ON	127, 152	40, 636	38, 102	0	21, 387	
14.00	01400 CENTRAL SERVICES & SUPPLY	82, 154	61, 097	57, 288	0	32, 156	
15.00	01500 PHARMACY	122, 960	24, 725	23, 183	0	13, 013	
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	130, 442 46, 204	134, 836 0	126, 429 0	0	70, 965 0	
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	40, 204	V	0	0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	362, 094	129, 047	121, 001	30, 776	67, 918	
31.00	03100 I NTENSI VE CARE UNI T	150, 831	32, 572	30, 541	4, 396	17, 143	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	323, 718 156, 332	134, 074 118, 162	125, 714 110, 795	0 5, 276	70, 564 62, 190	
41.00	04300 NURSERY	98, 838	12, 969	12, 160	5,270	6, 826	
	ANCILLARY SERVICE COST CENTERS		,	,	-	-,	
50.00	05000 OPERATING ROOM	484, 340	184, 695	173, 179	14, 068	97, 207	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 113, 629	0 134, 264	0 125, 893	0	0 70, 664	
52.00	05400 RADI OLOGY-DI AGNOSTI C	231, 947	165, 732	125, 893	3, 250	87, 226	
56.00	05600 RADI OI SOTOPE	153, 677	15, 503	14, 536	0	8, 159	1
60.00	06000 LABORATORY	409, 060	46, 399	43, 506	0	24, 420	
63.00	06300 BLOOD STORING PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	849	2, 711	2, 542 0	0	1, 427	
64.00 65.00	06500 RESPIRATORY THERAPY	133, 560	0 35, 650	33, 427	879	0 18, 763	
66.00	06600 PHYSI CAL THERAPY	228, 820	91, 884	86, 155	11, 787	48, 359	
67.00	06700 OCCUPATI ONAL THERAPY	80, 784	19, 576	18, 355	2, 511	10, 303	
68.00	06800 SPEECH PATHOLOGY	37, 840	13, 868	13,003	1, 779	7, 299	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	13, 305 338, 579	8, 446 0	7, 919 0	0	4, 445 0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	81, 811	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	606, 159	4, 373	4, 100	0	2, 301	
76.00	03020 CARDI AC REHAB	26, 831	31, 318	29, 366	0	16, 483	
76. 01 77. 00	03030 ADDI CTI ON SERVI CES 07700 ALLOGENEI C HSCT ACQUI SI TI ON	50, 845 0	0	0	0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	151, 861	66, 274	62, 142	5, 729	34, 880	
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	115, 007 221, 476	47, 461 72, 949	44, 502 68, 401	0	24, 979 38, 394	
88.03	08805 RURAL HEALTH CLINIC IV	0	0	00,401	0	0	
88.04	08803 RURAL HEALTH CLINIC V	322, 179	26, 455	24, 806	372	13, 924	
88.05	08804 RURAL HEALTH CLINIC VI	109, 447	34, 751	32, 584	0	18, 290	
90. 00 90. 01	09000 CLINIC 09001 0NC0L0GY	83, 298 60, 933	51, 207 52, 515	48, 014 49, 241	934 2, 638	26, 951 27, 639	
90.01 90.02	09002 PALN MANAGEMENT	00, 933	52, 515	49,241	2,030	27,039	
91.00	09100 EMERGENCY	760, 473	87, 866	82, 387	7, 914	46, 244	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	70.00/	70 47	74 540	10 044	44 000	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE OTHER REIMBURSABLE COST CENTERS	79, 826	79, 474	74, 519	12, 311	41, 828	93.00
95.00	09500 AMBULANCE SERVICES	514, 721	0	0	3, 517	0	95.00
99.10	09910 CORF	0	0	0	0	0	99.10
	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102.00	10200 OPIOLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	68, 002	7, 969		0		116.00
118.00		7, 872, 530	2, 663, 366	1, 943, 124	151, 877	1, 076, 254	118.00
192 00	NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
	07951 OTHER NONREL MBURSABLE AND PHYSICIAN	765, 178	138, 378		-		192.00
200.00	Cross Foot Adjustments			,	.,		200.00
201.00	U U U U U U U U U U U U U U U U U U U	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	8, 637, 708	2, 801, 744	2, 072, 874	161, 855	1, 149, 084	202.00

	1 Financial Systems ALLOCATION - GENERAL SERVICE COSTS	DAVIESS COMMUNI	Provi der C		eriod: rom 01/01/2023	u of Form CMS-2 Worksheet B Part I	
					o 12/31/2023		pared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00 4.00 5.00 6.00 7.00 8.00 9.00	00200 CAP REL COSTS-NVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						2.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00	01000 DI ETARY	477, 055					10.00
11.00	01100 CAFETERI A	0	415, 250				11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	9, 856 6, 548				13.00
15.00	01500 PHARMACY	0	7, 583			1, 031, 790	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	11, 658			0	16.00
17.00		0	4, 512	0	17	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	163, 209	29, 948	174,016	11, 166	0	30.00
31.00		55, 596	11, 106			0	31.00
40.00		191, 898	29, 754			0	40.00
41.00 43.00		66, 352 0	13, 339 6, 555			0	•
43.00	ANCI LLARY SERVI CE COST CENTERS	UU	0, 555	38, 091	0,200	0	43.00
50.00		0	23, 390	135, 911	18, 941	0	50.00
51.00		0	0	-	-	0	51.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	9, 133 13, 059		0 7, 297	0	52.00 54.00
56.00	05600 RADI OL SOTOPE	0	3, 046			0	56.00
60.00	06000 LABORATORY	0	20, 418	118, 643	219, 277	0	60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0	0		-	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 8, 499	0	0 9, 565	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	17, 401	0		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	6, 285		0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	2, 274 893		1 490	0	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	075			0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	О	0	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATI ENTS	0	0	0	-	1,031,790	
76.00 76.01	03020 CARDI AC REHAB 03030 ADDI CTI ON SERVI CES	0	1, 554 4, 706			0	76.00
77.00		0	4, 700 0			0	
78.00		0	0	0	0	0	78.00
88.00	OUTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLINIC		8, 390	0	400	0	 88. OC
88.00	08800 RURAL HEALTH CLINIC II	0	6, 633	1		0	88.00
88.02		0	14, 939		1, 552	0	88.02
88.03	08805 RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88. 04 88. 05	08803 RURAL HEALTH CLINIC V 08804 RURAL HEALTH CLINIC VI	0	12, 397 7, 239		1, 056 429	0	88.04 88.05
90.00	09000 CLINIC	0	3, 426		1, 171	0	90.00
90. 01	09001 ONCOLOGY	0	5,090	0	968	0	90.01
90.02		0	0		0 E 224	0	90.02
91.00 92.00		0	20, 626	119, 847	5, 226	0	91.00 92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0	6, 014	0	41	0	•
	OTHER REIMBURSABLE COST CENTERS		40.017		E 0/7		
95.00 99.10	09500 AMBULANCE SERVICES 09910 CORF	0	42, 967 0	0		0	95.00 99.10
	D 10100 HOME HEALTH AGENCY	0	0	0	-		101.00
	0 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0	0	0		102.00
113.00	D 11300 I NTEREST EXPENSE						113.00
116.00	D 11600 HOSPI CE	0	3, 591				116.00
118.00		477, 055	372, 829	1, 105, 327	798, 939	1, 031, 790	118.00
192 01	NONREI MBURSABLE COST CENTERS D 19200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	0	0	192.00
	07951 OTHER NONREL MBURSABLE AND PHYSICIAN	0	42, 421				194.00
200.00	0 Cross Foot Adjustments						200.00
201.00	S S	477 000	0	0	0	0 1, 031, 790	201.00
202.00	" I HINA ASUM LIDOS LIV THROUGH (101)	477, 055	415, 250	1, 105, 327	800, 188	1 031 790	1202 00

		DAVIESS COMMUNI				of Form CMS-2	2552-10
COST AL	LOCATION - GENERAL SERVICE COSTS		Provider CCN		om 01/01/2023	Worksheet B Part I	
				To	12/31/2023	Date/Time Pre 5/31/2024 9:2	pared: 0 am
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	Subtotal	Intern & Residents	Total	
		LI BRARY	SERVICE		Cost & Post		
					Stepdown Adjustments		
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						1.00
	DO200 CAP REL COSTS-BEDG & FIXT						2.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	DO500 ADMINI STRATI VE & GENERAL DO600 MAI NTENANCE & REPAI RS						5.00 6.00
	DO700 OPERATION OF PLANT						7.00
	DO800 LAUNDRY & LINEN SERVICE						8.00
	D0900 HOUSEKEEPI NG D1000 DI ETARY						9.00 10.00
	D1100 CAFETERI A						11.00
	D1300 NURSI NG ADMI NI STRATI ON						13.00
	D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY						14.00 15.00
	D1600 MEDI CAL RECORDS & LI BRARY	1, 364, 993					16.00
	D1700 SOCIAL SERVICE	0	366, 216				17.00
	NPATIENT ROUTINE SERVICE COST CENTERS	51, 998	4, 350	3, 617, 894	0	3, 617, 894	30.00
	D3100 I NTENSI VE CARE UNI T	10, 644	5, 019	1, 414, 289	Ő	1, 414, 289	
	04000 SUBPROVIDER - IPF	53, 552	124, 526	3, 439, 710	0	3, 439, 710	
	04100 SUBPROVI DER – I RF 04300 NURSERY	16, 676 9, 707	0	1, 695, 408 866, 218	0	1, 695, 408 866, 218	
ŀ	ANCILLARY SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Y	000,210		000,210	10.00
	D5000 OPERATING ROOM	115, 482	0	4, 554, 282	0	4, 554, 282	50.00
	D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM	0 9, 815	0	0 1, 292, 330	0	0 1, 292, 330	51.00 52.00
	D5400 RADI OLOGY-DI AGNOSTI C	195, 620	Ő	2, 519, 145	Ő	2, 519, 145	
	05600 RADI OI SOTOPE	50, 821	0	1, 315, 530	0	1, 315, 530	
	D6000 LABORATORY D6300 BLOOD STORI NG PROCESSI NG & TRANS.	166, 155 4, 854	0	3, 840, 935 18, 177	0	3, 840, 935 18, 177	60.00 63.00
	D6400 I NTRAVENOUS THERAPY	0	Ő	0	Ő	0	64.00
	06500 RESPI RATORY THERAPY	38, 907	0	1, 191, 195	0	1, 191, 195	
	D6600 PHYSI CAL THERAPY D6700 OCCUPATI ONAL THERAPY	54, 297 26, 594	0	2, 101, 495 715, 999	0	2, 101, 495 715, 999	66.00 67.00
	D6800 SPEECH PATHOLOGY	7, 234	Ő	341, 669	Ő	341, 669	68.00
	06900 ELECTROCARDI OLOGY	8, 679	0	135, 026	0	135, 026	1
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENT D7200 IMPL. DEV. CHARGED TO PATIENTS	71, 642 14, 935	0	3, 123, 192 752, 303	0	3, 123, 192 752, 303	
	D7300 DRUGS CHARGED TO PATIENTS	150, 576	Ő	5, 938, 146	Ö	5, 938, 146	
	D3020 CARDI AC REHAB	4,086	0	302, 403	0	302, 403	76.00
	D3030 ADDICTION SERVICES D7700 ALLOGENEIC HSCT ACQUISITION	676 0	0	430, 739 0	0	430, 739 0	
	D7800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	
	DUTPATIENT SERVICE COST CENTERS	0.000		1 274 470		1 27/ 470	
	D8800 RURAL HEALTH CLINIC D8801 RURAL HEALTH CLINIC II	9, 889 4, 209	0	1, 376, 470 1, 028, 539	0	1, 376, 470 1, 028, 539	88.00 88.01
88.02 0	08802 RURAL HEALTH CLINIC III	20, 481	0	1, 950, 426	0	1, 950, 426	
	D8805 RURAL HEALTH CLINIC IV D8803 RURAL HEALTH CLINIC V	17 404	0	0 2, 618, 428	0	0 2, 618, 428	88.03
	D8803 RURAL HEALTH CLINIC V	17, 404 6, 596	0	2, 618, 428 956, 637	0	2, 618, 428 956, 637	88. 04 88. 05
90.00	09000 CLINIC	17, 859	0	801, 620	0	801, 620	90.00
	09001 ONCOLOGY 09002 PALN MANAGEMENT	9, 486	0	624, 559	0	624, 559	
	D9100 EMERGENCY	160, 408	31, 406	6, 514, 897	0	0 6, 514, 897	90.02 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	D4040 OTHER OUTPATIENT SERVICE COST CENTE	7, 473	200, 915	1, 047, 452	0	1,047,452	93.00
	09500 AMBULANCE SERVICES	41, 425	0	4, 122, 207	0	4, 122, 207	95.00
	09910 CORF	0	0	0	0	0	
	10100 HOME HEALTH AGENCY 10200 OPI OI D TREATMENT PROGRAM	0	0	0 0	0		101.00 102.00
	SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
	11300 INTEREST EXPENSE		-		-		113.00
116.00 ⁷ 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	6, 813 1, 364, 993	0 366, 216	584, 145 61, 231, 465	0	584, 145 61, 231, 465	
-	NONREIMBURSABLE COST CENTERS	1, 304, 773	300, 210	01, 231, 403	U	01, 231, 403	110.00
192.00	19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0		192.00
101 000	07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0	0	6, 384, 588	0	6, 384, 588	
	Cross Foot Adjustments		I	0		<u>^</u>	200 00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0 0	0 0		200. 00 201. 00

	I Financial Systems ATION OF CAPITAL RELATED COSTS	DAVIESS COMMUN	ITY HOSPITAL Provider CC		Peri od:	u of Form CMS-: Worksheet B	2552-10
					From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 5/31/2024 9:2	epared: 20 am
			CAPI TAL REL	ATED COSTS		0,01,2021,12	
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						1
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 057	550	6 6, 613	6, 613	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	135, 798	151, 56	2 287, 360	476	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	66, 371	8, 86		15	1
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	478, 654 5, 152		0 478,654 0 5,152	0	7.00
9.00	00900 HOUSEKEEPI NG	0	17,056	1, 870		137	9.00
10.00	01000 DI ETARY	0	44, 725	7, 78		24	10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	16, 383 32, 910	(17, 09 ⁻	0 16, 383 7 50, 007	47 137	11.00
13.00	01400 CENTRAL SERVICES & SUPPLY	0	32, 910 49, 480	46, 84		67	14.00
15.00	01500 PHARMACY	0	20, 024	13, 94		113	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	109, 199	3, 43		114	
17.00	01700 SOCIAL SERVICE	0	0	(0 0	55	17.00
30.00	03000 ADULTS & PEDIATRICS	0	104, 510	99, 90	204, 410	370	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	26, 379	24, 33	2 50, 711	166	
40.00	04000 SUBPROVIDER - IPF	0	108, 581	18, 63		403	1
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	0	95, 695 10, 503	7,46	2 103, 157 0 10, 503	180 104	1
45.00	ANCI LLARY SERVICE COST CENTERS	0	10, 303		10, 303	104	45.00
50.00	05000 OPERATING ROOM	0		218, 43		450	1
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0 108, 736		0 0 0 108, 736	0 112	51.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	134, 221	108, 58		201	54.00
56.00	05600 RADI OI SOTOPE	0	12, 555	49, 38		57	56.00
60.00	06000 LABORATORY	0	37, 576	127, 23		204	60.00
63.00 64.00	06300 BLOOD STORING PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	2, 195 0		2,195 0 0	0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY	0	28, 872	71, 34	-	125	1
66.00	06600 PHYSI CAL THERAPY	0	74, 414	88, 33		235	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	15, 854	18, 64		90	1
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	11, 231 6, 840	13, 550 2, 64		41 14	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0,010	51		0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC REHAB	0	3, 541 25, 364		0 3, 541 0 25, 364	0	73.00 76.00
76.00	03030 ADDI CTI ON SERVI CES	0	25, 364		25,364 0 0	25 50	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	
78.00	07800 CAR T-CELL I MMUNOTHERAPY	0	0	(0 0	0	78.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	53, 673	3, 42	9 57, 102	158	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	38, 437	978		118	1
88.02	08802 RURAL HEALTH CLINIC III	0	59, 079	6, 70		222	
88. 03 88. 04	08805 RURAL HEALTH CLINIC IV 08803 RURAL HEALTH CLINIC V	0	0 21, 425	4, 56	0 0 8 25,993	0 348	
88.05	08804 RURAL HEALTH CLINIC VI	0	28, 144	4, 50		117	88.05
90.00	09000 CLI NI C	0	41, 471	1, 740		46	
90.01	09001 ONCOLOGY	0	42, 530	(42, 530	63	
90.02 91.00	09002 PALN MANAGEMENT 09100 EMERGENCY	0	0 71, 159	52, 55	5 0 6 123, 715	0 300	90.02 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	, , , , , , , , , , , , , , , , , , , ,	02,00	0		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0	64, 363	9	1 64, 454	80	93.00
95 00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	0	0	188, 50	5 188, 505	495	95.00
	09910 CORF	0	0		0	495 0	1
101.00	10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(0 0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS						113.00
	11600 HOSPI CE	0	6, 454	(0 6, 454	51	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 365, 189	1, 360, 21			118.00
100.04	NONREI MBURSABLE COST CENTERS						102.00
	0 19200 PHYSICIANS PRIVATE OFFICES 0 07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0	0 112, 067	66, 14	0 0 4 178, 211		192.00 194.00
200.00				30, 14	0		200.00
	Negative Cost Centers	T	0	,	o o	0	201.00

Health Financial Systems	DAVIESS COMMUN	I TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period:	Worksheet B	
				From 01/01/2023 To 12/31/2023		pared: 0 am
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
202.00 TOTAL (sum lines 118 through 201)	0	2, 477, 256	1, 426, 35	3, 903, 615	6, 613	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	DAVIESS COMMUN	ITY HOSPITAL Provider C	CN: 15-0061 P	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
ALL007	THOR OF WATTINE RELATED GUITS				rom 01/01/2023	Part II	pared:
	Cost Center Description	ADMI NI STRATI V			LAUNDRY &	HOUSEKEEPI NG	
		E & GENERAL 5.00	REPAI RS 6.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL	287, 836					4.00 5.00
5.00 6.00	00600 MAINTENANCE & REPAIRS	11, 926	87, 181				6.00
7.00	00700 OPERATI ON OF PLANT	6, 308	18, 392				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	636	198	1, 448	7,434		8.00
9.00	00900 HOUSEKEEPI NG	4, 535	655				
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	1, 448 1, 555	1, 718 629				
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 237	1, 264				
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 737	1, 901	13, 911	0		
	01500 PHARMACY	4, 097	769				
	01600 MEDI CAL RECORDS & LI BRARY	4, 346	4, 196		0		
17.00	01700 SOCIAL SERVICE	1, 540	0	0	0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	12,065	4, 016	29, 382	1, 414	1, 833	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 026	1, 014				
40.00	04000 SUBPROVI DER – I PF	10, 786	4, 172		0		
41.00	04100 SUBPROVI DER – I RF	5, 209	3, 677				
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 293	404	2, 953	0	184	43.00
50.00	05000 OPERATING ROOM	16, 138	5, 747	42,056	646	2,625	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 786	4, 178				1
54.00	05400 RADI OLOGY-DI AGNOSTI C	7,729	5, 157				1
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY	5, 121 13, 630	482 1, 444		0	-	
63.00	06300 BLOOD STORING PROCESSING & TRANS.	28	84		0		
64.00	06400 INTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPI RATORY THERAPY	4, 450	1, 109				
66.00	06600 PHYSI CAL THERAPY	7,624	2,859		541		
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2, 692 1, 261	609 432		115 82		
69.00	06900 ELECTROCARDI OLOGY	443	263				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 282	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 726	0		-		
73.00 76.00	07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC REHAB	20, 198 894	136 975		0		
76.01	03030 ADDI CTI ON SERVI CES	1, 694	0		-		
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	
78.00	07800 CAR T-CELL I MMUNOTHERAPY	0	0	0	0	0	78.00
00 00	OUTPATIENT SERVICE COST CENTERS	E O(O	2.0(2	15 000	2(2	042	
88. 00 88. 01	08801 RURAL HEALTH CLINIC	5, 060 3, 832	2, 062 1, 477			942	
88.02	08802 RURAL HEALTH CLINIC III	7, 380	2, 270				
88.03	08805 RURAL HEALTH CLINIC IV	0	0	-	-	0	
88.04	08803 RURAL HEALTH CLINIC V	10, 735	823		17		
88.05 90.00	08804 RURAL HEALTH CLINIC VI 09000 CLINIC	3, 647 2, 776	1, 081 1, 593	7, 912 11, 659	0 43		
90.00 90.01	09001 ONCOLOGY	2,030	1, 634		121	746	
90.02	09002 PAIN MANAGEMENT	0	0		0		1
91.00	09100 EMERGENCY	25, 339	2, 734	20, 006	364	1, 248	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.440	0 470	10.005	E/E	1 100	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE OTHER REIMBURSABLE COST CENTERS	2,660	2, 473	18, 095	565	1, 129	93.00
95.00	09500 AMBULANCE SERVICES	17, 151	0	0	162	0	95.00
99.10	09910 CORF	0	0				99.10
	10100 HOME HEALTH AGENCY	0	0				101.00
102.00	10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	102.00
113 00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	2, 266	248	1, 814	0	113	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	262, 316	82, 875	471, 847	6, 976	29, 052	118.00
100 0	NONREI MBURSABLE COST CENTERS			-	-	-	100.00
	19200 PHYSICIANS PRIVATE OFFICES 07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0 25, 520	0 4, 306		-		192.00 194.00
200.00		25, 520	4, 306	31, 507	438	1, 900	200.00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	287, 836	87, 181	503, 354	7, 434	31, 018	202.00

Health Financial Systems	DAVI ESS COMMUNI	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0061 F	Period: From 01/01/2023	Worksheet B Part II	
				To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	
			N	SUPPLY		
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	69, 103	22 507				10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	23, 507 558		2		11.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	371	C	0 116, 181		14.00
15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY	0	429 660		-	45, 466 0	
17. 00 01700 SOCIAL SERVICE	0	255			0	
INPATIENT ROUTINE SERVICE COST CENTERS				-	-	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	23, 641 8, 053	1, 695 629			0	
40. 00 04000 SUBPROVI DER - I PF	27, 798	1, 684			0	
41.00 04100 SUBPROVIDER - IRF	9, 611	755			0	
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	371	2,276	901	0	43.00
50. 00 05000 OPERATI NG ROOM	0	1, 324	8, 119	2, 750	0	
51.00 05100 RECOVERY ROOM	0	0		-	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0	517 739			0	
56. 00 05600 RADI OI SOTOPE	0	172	1, 057	404	0	
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORI NG PROCESSI NG & TRANS.	0	1, 156 0			0	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		-	0	
65. 00 06500 RESPI RATORY THERAPY	0	481		.,	0	
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	985 356			0	
68. 00 06800 SPEECH PATHOLOGY	0	129		-	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	51			0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			45, 466	
76.00 03020 CARDI AC REHAB	0	88			0	
76. 01 03030 ADDI CTI ON SERVI CES 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	266 0			0	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	475	i c	58	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	376				
88. 02 08802 RURAL HEALTH CLINIC III	0	846				
88.03 08805 RURAL HEALTH CLINIC IV 88.04 08803 RURAL HEALTH CLINIC V	0	0 702		-		
88. 05 08804 RURAL HEALTH CLINIC VI	0	410		62	0	
90. 00 09000 CLINIC	0	194		170		90.00
90. 01 09001 0NCOLOGY 90. 02 09002 PALN MANAGEMENT	0	288 0) 140) 0	0	90.01 90.02
91. 00 09100 EMERGENCY	0	1, 168			-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		240				92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE OTHER REIMBURSABLE COST CENTERS	0	340) () 6	0	93.00
95.00 09500 AMBULANCE SERVICES	0	2, 433	C	736		
99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY	0	0			0	99.10 101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		-		102.00
SPECIAL PURPOSE COST CENTERS				-		
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE	0	203	1, 246	5 134	0	113.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1		203				118.00
NONREI MBURSABLE COST CENTERS			1			
192.00 19200 PHYSICIANS PRIVATE OFFICES 194.00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0	0 2, 401				192.00 194.00
200. 00 Cross Foot Adjustments		2,401				200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	69, 103	23, 507	66, 032	2 116, 181	45,466	202.00

Heal th	Financial Systems	DAVIESS COMMUNI	TY HOSPI TAL		In Lieu	of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2023	Worksheet B Part II	
				Ť	o 12/31/2023	Date/Time Pre 5/31/2024 9:2	
	Cost Center Description	MEDI CAL	SOCI AL	Subtotal	Intern &	Total	
		RECORDS & LI BRARY	SERVI CE		Residents Cost & Post		
		LI DKAKT			Stepdown		
		1/ 00	17.00		Adjustments		
	GENERAL SERVICE COST CENTERS	16.00	17.00	24.00	25.00	26.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						13.00 14.00
	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	154, 567					16.00
17.00	01700 SOCIAL SERVICE	0	1, 852				17.00
30.00	03000 ADULTS & PEDIATRICS	5, 890	22	296, 756	0	296, 756	30,00
31.00	03100 I NTENSI VE CARE UNI T	1, 206	25	79, 062	0	79, 062	
	04000 SUBPROVIDER - IPF	6, 066	630	221, 901	0	221, 901	1
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	1, 889 1, 100	0 0	158, 129 22, 089	0	158, 129 22, 089	•
10.00	ANCI LLARY SERVICE COST CENTERS	1,100		22,007		22,007	10.00
50.00	05000 OPERATING ROOM	13, 081	0	460, 952	0	460, 952	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 1, 112	0	0 154, 088	0	0 154, 088	51.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	22, 108	0	324, 574	0	324, 574	•
56.00	05600 RADI OI SOTOPE	5, 757	0	78, 742	0	78, 742	•
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING PROCESSING & TRANS.	18, 821 550	0	250, 216 3, 513	0	250, 216 3, 513	•
64.00	06400 I NTRAVENOUS THERAPY	0	0	0,010	0	0,010	64.00
65.00	06500 RESPI RATORY THERAPY	4, 407	0	120, 839	0	120, 839	•
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 150 3, 012	0 0	203, 426 46, 103	0	203, 426 46, 103	
68.00	06800 SPEECH PATHOLOGY	819	0	30, 906	0	30, 906	
	06900 ELECTROCARDI OLOGY	983	0	13, 349	0	13, 349	•
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 115 1, 692	0 0	78, 158 18, 495	0	78, 158 18, 495	•
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 056	0	87, 455	0	87, 455	
76.00	03020 CARDI AC REHAB	463	0	36, 001	0	36, 001	
	03030 ADDICTION SERVICES 07700 ALLOGENEIC HSCT ACQUISITION	77 0	0	3, 721	0	3, 721 0	76.01 77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	•
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	1, 120	0	82, 330	0	82, 330	•
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	477 2, 320	0	57, 245 96, 697	0	57, 245 96, 697	
	08805 RURAL HEALTH CLINIC IV	0	0	0	0	0	1
88.04	08803 RURAL HEALTH CLINIC V	1, 971	0	47, 142	0	47, 142	88.04
88. 05 90. 00	08804 RURAL HEALTH CLINIC VI 09000 CLINIC	747 2, 023	0	43, 285 62, 443	0	43, 285 62, 443	•
90.01	09001 ONCOLOGY	1, 075	0	60, 584	0	60, 584	
90.02	09002 PAIN MANAGEMENT	0	0	0	0	0	90.02
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	18, 170	159	201, 122	0	201, 122	91.00 92.00
	04040 OTHER OUTPATIENT SERVICE COST CENTE	846	1, 016	91, 664	0	91, 664	•
	OTHER REIMBURSABLE COST CENTERS		-				
	09500 AMBULANCE SERVI CES 09910 CORF	4, 692	0	214, 174	0	214, 174 0	
	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	772	0	13, 301	0	13, 301	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	154, 567	1, 852	3, 658, 462		3, 658, 462	
100.00	NONREI MBURSABLE COST CENTERS						102.00
	19200 PHYSICIANS PRIVATE OFFICES 07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0	0	0 245, 153	0	0 245, 153	192.00 194.00
200.00	Cross Foot Adjustments	0	5	0	o	0	200.00
201.00			0	2 002 (15	0		201.00
202.00	TOTAL (sum lines 118 through 201)	154, 567	1, 852	3, 903, 615	0	3, 903, 615	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	DAVIESS COMMUN	ITY HOSPITAL Provider C		Period:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre	
		CAPI TAL REL	ATED COSTS			5/31/2024 9:2	0 am
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR	EMPLOYEE BENEFITS	Reconciliatio n	ADMI NI STRATI V E & GENERAL	
			VALUE)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	2.00	SALARIES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	54	5.00	
	00100 CAP REL COSTS-BLDG & FIXT	224, 543					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	549	1, 476, 741 576				2.00 4.00
5.00	00500 ADMINI STRATI VE & GENERAL	12, 309	156, 915			58, 978, 345	5.00
	00600 MAI NTENANCE & REPAI RS	6, 016	9, 182			2, 443, 830	
	00700 OPERATION OF PLANT	43, 386	0			1, 292, 544	7.00
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	467 1, 546	0 1, 936	-	-	130, 426 929, 312	•
	01000 DI ETARY	4, 054	8, 064			296, 654	•
	01100 CAFETERI A	1, 485	0	,			•
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 983 4, 485	17, 701 48, 501			868, 194 560, 945	•
	01500 PHARMACY	1, 815	14, 435			839, 567	•
	01600 MEDI CAL RECORDS & LI BRARY	9, 898	3, 555				
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	261,060	0 0	315, 483	17.00
30.00	03000 ADULTS & PEDI ATRI CS	9, 473	103, 429	1, 745, 855	0	2, 472, 371	30.00
	03100 I NTENSI VE CARE UNI T	2, 391	25, 191			1, 029, 870	1
	04000 SUBPROVIDER - IPF	9,842	19, 290				1
	04100 SUBPROVI DER – I RF 04300 NURSERY	8, 674 952	7, 726			1, 067, 430 674, 866	•
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	13, 558	226, 157			3, 307, 069	•
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 9, 856	0			0 775, 861	51.00 52.00
	05400 RADI OLOGY-DI AGNOSTI C	12, 166	112, 424			1, 583, 733	•
	05600 RADI OI SOTOPE	1, 138	51, 131			1, 049, 306	
	06000 LABORATORY 06300 BLOOD STORI NG PROCESSI NG & TRANS.	3, 406 199	131, 731 0			2, 793, 057 5, 794	•
	06400 I NTRAVENOUS THERAPY	0	0		, v	0	
	06500 RESPI RATORY THERAPY	2, 617	73, 863			911, 945	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 745 1, 437	91, 453 19, 298			1, 562, 383 551, 591	•
	06800 SPEECH PATHOLOGY	1, 437	14, 035			258, 371	•
69.00	06900 ELECTROCARDI OLOGY	620	2, 734	64, 610	0 0	90, 849	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	531			2, 311, 814	•
	07200 TMPL. DEV. CHARGED TO PATTENTS 07300 DRUGS CHARGED TO PATTENTS	0 321	0				•
76.00	03020 CARDI AC REHAB	2, 299	0	118, 917	0	183, 205	
	03030 ADDI CTI ON SERVI CES	0	0			347, 166	•
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0		-	0	
	OUTPATIENT SERVICE COST CENTERS		0				/0.00
	08800 RURAL HEALTH CLINIC	4, 865	3, 550			1	1
	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	3, 484 5, 355	1, 013 6, 946			785, 267 1, 512, 234	88.01 88.02
	08805 RURAL HEALTH CLINIC IV	0	0, 740		0	0	88.03
88.04	08803 RURAL HEALTH CLINIC V	1, 942	4, 729			2, 199, 835	88.04
	08804 RURAL HEALTH CLINIC VI 09000 CLINIC	2, 551 3, 759	695 1, 801			747, 301 568, 760	88.05 90.00
	09001 ONCOLOGY	3, 759	0			416, 049	•
90.02	09002 PAIN MANAGEMENT	0	0	C	0	0	90.02
	09100 EMERGENCY	6, 450	54, 412	1, 412, 831	0	5, 192, 500	91.00 92.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART 04040 OTHER OUTPATIENT SERVICE COST CENTE	5, 834	94	375, 714	0	545, 051	•
	OTHER REIMBURSABLE COST CENTERS	1					
	09500 AMBULANCE SERVI CES 09910 CORF	0	195, 163			3, 514, 510 0	
	10100 HOME HEALTH AGENCY	0	0		-		99.10 101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C			102.00
	SPECIAL PURPOSE COST CENTERS						112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	585	0	239, 061	0	464, 318	113.00 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	214, 385	1, 408, 261				
100.0-	NONREI MBURSABLE COST CENTERS]
	19200 PHYSICIANS PRIVATE OFFICES 07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0 10, 158	0 68, 480	-			192.00
200.00	Cross Foot Adjustments	10, 158	00, 480	2,073,482	0		200.00
			•	•	•		

Heal th F	inancial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023		
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers	o (77 of (1 101 050	/ /07 50			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 477, 256	1, 426, 359	6, 497, 50	9	8, 637, 708	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.032435	0. 965883	0. 20795	2	0. 146456	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			6, 61	3	287, 836	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0. 00021	2	0. 004880	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 - STATISTIC		DAVIESS COMMUN	ITY HOSPITAL Provider CO	CN: 15-0061 P	In Lie	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
Cost Center De	scription	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	5/31/2024 9:2 DI ETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST 1.00 00100 CAP REL COSTS-I							1.00
2.00 00200 CAP REL COSTS-I 4.00 00400 EMPLOYEE BENEF 5.00 00500 ADMI NI STRATI VE 6.00 00600 MAI NTENANCE & I 7.00 00700 OPERATI ON OF PI 8.00 00800 LAUNDRY & LI NEI 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY	IVBLE EQUI P TS DEPARTMENT & GENERAL REPAI RS _ANT	205, 669 43, 386 467 1, 546 4, 054	162, 283 467 1, 546 4, 054	239, 335 63, 375 1, 300	160, 270 4, 054	28, 917	2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMINIS 14.00 01400 CENTRAL SERVICI 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS	ES & SUPPLY	1, 485 2, 983 4, 485 1, 815 9, 898	1, 485 2, 983 4, 485 1, 815 9, 898	0 0 0 0	2, 983 4, 485 1, 815 9, 898	0 0 0 0 0	11.00 13.00 14.00 15.00 16.00
17.00 01700 SOCIAL SERVICE		0	0	0	0	0	17.00
30.00 03000 ADULTS PEDIA 31.00 03100 INTENSI VE CARE 40.00 04000 SUBPROVI DER - 41.00 04100 SUBPROVI DER - 43.00 04300 NURSERY -	FRI CS UNI T PF RF	9, 473 2, 391 9, 842 8, 674 952	9, 473 2, 391 9, 842 8, 674 952	6, 500 0 7, 802	2, 391 9, 842 8, 674	9, 893 3, 370 11, 632 4, 022 0	
ANCILLARY SERVICE CO 50.00 05000 0PERATING ROOM	ST CENTERS	13, 558	13, 558	20, 803	13, 558	0	50.00
72.00 07200 I MPL. DEV. CHAI 73.00 07300 DRUGS CHARGED	NOSTI C PROCESSI NG & TRANS. ERAPY ERAPY HERAPY GY GY ES CHARGED TO PATI ENT RGED TO PATI ENTS	0 9, 856 12, 166 1, 138 3, 406 199 0 2, 617 6, 745 1, 437 1, 018 620 0 0 321	0 9, 856 12, 166 1, 138 3, 406 199 0 2, 617 6, 745 1, 437 1, 018 620 0 0 0	0 4,806 0 0 0 1,300 17,430 3,713 2,631 0 0 0 0 0 0 0 0 0 0 0 0	9, 856 12, 166 1, 138 3, 406 199 0 2, 617 6, 745 1, 437 1, 018 620 0 0 0 321	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.00\\ 52.00\\ 54.00\\ 56.00\\ 60.00\\ 63.00\\ 64.00\\ 65.00\\ 65.00\\ 66.00\\ 67.00\\ 68.00\\ 69.00\\ 71.00\\ 72.00\\ 73.00\\ \end{array}$
76.00 03020 CARDIAC REHAB 76.01 03030 ADDICTION SERV 77.00 07700 ALLOGENEIC HSC 78.00 07800 CAR T-CELL IMM	F ACQUI SI TI ON	2, 299 0 0 0	2, 299 0 0 0	0	0	0 0 0 0	76.00 76.01 77.00 78.00
OUTPATIENT SERVICE C	OST CENTERS	-					
	LINIC II LINIC III LINIC IV LINIC V LINIC VI T DS (NON-DISTINCT PART	4, 865 3, 484 5, 355 0 1, 942 2, 551 3, 759 3, 855 0 6, 450	4, 865 3, 484 5, 355 0 1, 942 2, 551 3, 759 3, 855 0 6, 450	0 0 550 0 1, 381 3, 901 0 11, 703	5, 355 0 1, 942 2, 551 3, 759 3, 855 0 6, 450		88.00 88.01 88.02 88.03 88.04 88.05 90.00 90.01 90.02 91.00 92.00
93.00 04040 OTHER OUTPATIE	NT SERVICE COST CENTE	5, 834	5, 834	18, 204	5, 834	0	93.00
95. 00 09500 AMBULANCE SERV 99. 10 09910 CORF 101. 00 10100 HOME HEALTH AG 102. 00 10200 0PI 0I D TREATMEI SPECI AL PURPOSE COST	CES ENCY NT PROGRAM	0 0 0 0	0 0 0 0	0			95.00 99.10 101.00 102.00
113.0011300 I NTEREST EXPEN 116.0011600 H0SPI CE	SE OF LINES 1 through 117)	585 195, 511	585 152, 125		585 150, 112	0 28, 917	113. 00 116. 00 118. 00
192. 00 19200 PHYSI CI ANS PRI 194. 00 07951 OTHER NONREI MBI 200. 00 Cross Foot Adj	/ATE OFFICES JRSABLE AND PHYSICIAN Jstments	0 10, 158	0 10, 158		0 10, 158		192.00 194.00 200.00
201.00Negative Cost (202.00Cost to be all (Part I)	Centers ocated (per Wkst. B,	2, 801, 744	2, 072, 874	161, 855	1, 149, 084	477, 055	201. 00 202. 00

Heal th Fi	nancial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLC	CATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2023	Worksheet B-1	
					o 12/31/2023	Date/Time Pre 5/31/2024 9:2	
	Cost Center Description	MAINTENANCE &		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	
203.00	Unit cost multiplier (Wkst. B, Part I)	13. 622588	12. 773205	0. 676270	7. 169676	16. 497389	203.00
204.00	Cost to be allocated (per Wkst. B,	87, 181	503, 354	7,434	31, 018	69, 103	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 423890	3. 101705	0. 031061	0. 193536	2.389702	205.00
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)						

	inancial Systems LOCATION - STATISTICAL BASIS	DAVIESS COMMUN	IITY HOSPITAL Provider CO	CN: 15-0061 F	In Lieu Period:	ı of Form CMS-2 Worksheet B-1	
0001 7122				F	From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/31/2024 9:2	pared:
	Cost Center Description	CAFETERI A (HOURS PAI D)	NURSI NG ADMI NI STRATI O N (DI RECT NRS	CENTRAL SERVICES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS	
		11.00	I NG) 13.00	REQUIS.) 14.00	15.00	CHARGES) 16.00	
G	ENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUI P 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0600 MAINTENANCE & REPAIRS 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DI ETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY 1700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	803, 461 19, 070 12, 669 14, 672 22, 556 8, 730	368, 063 0 0 0	4, 610, 312 4, 372 27 97	2 100 7 0	163, 795, 258 0	1
30.00 0	3000 ADULTS & PEDI ATRI CS	57, 945		64, 333		6, 239, 243	1
		21, 489		11, 740		1, 277, 225	1
	4000 SUBPROVI DER – I PF 4100 SUBPROVI DER – I RF	57, 571 25, 809		15, 432 7, 773		6, 425, 771 2, 000, 932	•
	4300 NURSERY	12, 684		35, 754		1, 164, 751	
	NCI LLARY SERVICE COST CENTERS	45.057	45.057	100.100		40.057.770	
	5000 OPERATING ROOM 5100 RECOVERY ROOM	45, 257 0		109, 128 (13, 856, 778 0	50.00
	5200 DELIVERY ROOM & LABOR ROOM	17,672		(1, 177, 754	•
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	25, 268	25, 268	42, 040		23, 481, 565	54.00
	5600 RADI OI SOTOPE	5, 893		16, 046		6, 098, 034	
	6000 LABORATORY 6300 BLOOD STORI NG PROCESSI NG & TRANS.	39, 507 0		1, 263, 371 (19, 936, 999 582, 479	•
	6400 I NTRAVENOUS THERAPY	0		(0	64.00
	6500 RESPI RATORY THERAPY	16, 444	0	55, 108	3 0	4, 668, 430	65.00
	6600 PHYSI CAL THERAPY	33, 669		2, 354		6, 515, 110	
	6700 OCCUPATI ONAL THERAPY 6800 SPEECH PATHOLOGY	12, 161 4, 400		6		3, 190, 992 868, 070	•
	6900 ELECTROCARDI OLOGY	1, 727		2, 822		1, 041, 396	•
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		2, 311, 300		8, 596, 341	
	7200 IMPL. DEV. CHARGED TO PATIENTS	0		558, 603		1, 792, 000	
	7300 DRUGS CHARGED TO PATIENTS 3020 CARDIAC REHAB	0 3, 006	-	(3, 070		18, 067, 724 490, 266	
	3030 ADDI CTI ON SERVI CES	9, 106		0,070		81, 092	
77.00 0	7700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	77.00
	7800 CAR T-CELL IMMUNOTHERAPY UTPATIENT SERVICE COST CENTERS	0	0	(0 0	0	78.00
	8800 RURAL HEALTH CLINIC	16, 233	0	2, 303	3 0	1, 186, 590	88.00
	8801 RURAL HEALTH CLINIC II	12, 835	0	2, 769		504, 987	88.01
	8802 RURAL HEALTH CLINIC III	28, 906		8, 940		2, 457, 559	
	8805 RURAL HEALTH CLINIC IV 8803 RURAL HEALTH CLINIC V	0 23, 986	-	0 6, 086	-	0 2, 088, 347	88.03 88.04
	8804 RURAL HEALTH CLINIC VI	14,006		2, 473		791, 460	
	9000 CLINIC	6, 629		6, 746		2, 142, 852	
	9001 ONCOLOGY	9, 848	1	5, 575		1, 138, 274	
	9002 PALN MANAGEMENT 9100 EMERGENCY	39, 908	-	(30, 112		0 19, 247, 416	90.02 91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART		077700	007112		.,,,,	92.00
	4040 OTHER OUTPATIENT SERVICE COST CENTE	11, 636	0	234	4 0	896, 680	93.00
	THER REI MBURSABLE COST CENTERS 9500 AMBULANCE SERVI CES	83, 141	0	29, 191	1 0	4, 970, 621	95.00
	9910 CORF	03, 141		27, 17		4, 770, 021	1
101.001	0100 HOME HEALTH AGENCY	0		C			101.00
	0200 OPI OI D TREATMENT PROGRAM	0	0	(0 0	0	102.00
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE						113.00
	1600 HOSPI CE	6, 948	6, 948	5, 307	7 0	817, 520	
116.00 1	SUBTOTALS (SUM OF LINES 1 through 117)	721, 381				163, 795, 258	
118.00							
118.00	ONREIMBURSABLE COST CENTERS	-		-	-1	-	100 00
118.00 N 192.00	ONREI MBURSABLE COST CENTERS 9200 PHYSI CLANS PRI VATE OFFICES	0 82_080		(7 198			192.00 194.00
118.00 N 192.00	ONREIMBURSABLE COST CENTERS	0 82, 080		(7, 198			192. 00 194. 00 200. 00

Heal th I	- inancial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS				Peri od:	Worksheet B-1	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/31/2024 9:2	pared: 0 am
	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 NRS	(COSTED		(GROSS	
			I NG)	REQUIS.)		CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	415, 250	1, 105, 327	800, 188	3 1, 031, 790	1, 364, 993	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 516827	3. 003092	0. 173565	5 10, 317. 900000	0. 008334	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	23, 507	66, 032	116, 181	45, 466	154, 567	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 029257	0. 179404	0. 025200	454.660000	0. 000944	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

-	Financial Systems LLLOCATION - STATISTICAL BASIS	DAVIESS COMMUNI	Provi der CCN: 15-0061	Peri od:	u of Form CMS-2552-1 Worksheet B-1
				From 01/01/2023 To 12/31/2023	
	Cost Center Description	SOCI AL			5/31/2024 9:20 am
		SERVI CE			
		(TIME SPENT) 17.00			
	GENERAL SERVICE COST CENTERS	17.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.0
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS				5.0
7.00	00700 OPERATION OF PLANT				7.0
8.00	00800 LAUNDRY & LINEN SERVICE				8.0
9.00	00900 HOUSEKEEPI NG				9.0
10.00	01000 DI ETARY				10.0
	01100 CAFETERIA 01300 NURSING ADMINISTRATION				11.0
	01400 CENTRAL SERVICES & SUPPLY				14.0
	01500 PHARMACY				15.0
16.00	01600 MEDI CAL RECORDS & LI BRARY				16.0
17.00	01700 SOCIAL SERVICE	7, 661			17.0
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	91			20.0
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	105			30. 0 31. 0
	04000 SUBPROVI DER – I PF	2,605			40.0
	04100 SUBPROVI DER – I RF	0			41.0
43.00	04300 NURSERY	0			43.0
	ANCI LLARY SERVICE COST CENTERS	0			
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0			50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			52.0
	05400 RADI OLOGY-DI AGNOSTI C	0			54.0
56.00	05600 RADI OI SOTOPE	0			56.0
	06000 LABORATORY	0			60.0
	06300 BLOOD STORI NG PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0			63. 0 64. 0
	06500 RESPIRATORY THERAPY	0			65.0
66.00	06600 PHYSI CAL THERAPY	o			66.0
67.00	06700 OCCUPATI ONAL THERAPY	О			67.0
68.00	06800 SPEECH PATHOLOGY	0			68.0
	06900 ELECTROCARDI OLOGY	0			69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0			71.0
	07300 DRUGS CHARGED TO PATIENTS	0			73.0
76.00	03020 CARDI AC REHAB	0			76.0
	03030 ADDI CTI ON SERVI CES	0			76.0
	07700 ALLOGENEIC HSCT ACQUISITION	0			77.0
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0			78.0
88.00	08800 RURAL HEALTH CLINIC	0			88.0
88. 01	08801 RURAL HEALTH CLINIC II	0			88.0
	08802 RURAL HEALTH CLINIC III	0			88.0
	08805 RURAL HEALTH CLINIC IV	0			88.0
88. 04 88. 05	08803 RURAL HEALTH CLINIC V 08804 RURAL HEALTH CLINIC VI	0			88. 0 88. 0
90.00	09000 CLINIC	0			90.0
90.01	09001 ONCOLOGY	О			90.0
	09002 PAIN MANAGEMENT	0			90.0
	09100 EMERGENCY	657			91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART 04040 OTHER OUTPATIENT SERVICE COST CENTE	4, 203			92. 0 93. 0
, 5. 00	OTHER REIMBURSABLE COST CENTERS	+, 203			75.0
	09500 AMBULANCE SERVI CES	0			95.0
	09910 CORF	0			99.1
	10100 HOME HEALTH AGENCY	0			101.0
102.00	10200 0PI0ID_TREATMENT_PROGRAM SPECIAL_PURPOSE_COST_CENTERS	0			102.0
113.00	11300 INTEREST EXPENSE				113.0
	11600 HOSPI CE	0			116.0
118.00		7, 661			118.0
	NONREI MBURSABLE COST CENTERS				
	19200 PHYSI CLANS PRI VATE OFFICES	0			192.0
194.00 200.00	07951 OTHER NONREIMBURSABLE AND PHYSICIAN Cross Foot Adjustments	0			194. 0 200. 0
200.00					200.0
202.00		366, 216			202.0
	Part I)				
203.00	Unit cost multiplier (Wkst. B, Part I)	47.802637			203.0

Heal th Fi	nancial Systems	DAVIESS COMMUNITY	Y HOSPI TAL	In Lieu	of Form CMS-2552-10
COST ALLC	CATION - STATISTICAL BASIS		Provider CCN: 15-0061	Period: From 01/01/2023	Worksheet B-1
				To 12/31/2023	Date/Time Prepared: 5/31/2024 9:20 am
	Cost Center Description	SOCI AL			
		SERVICE (TIME SPENT)			
		17.00			
204.00	Cost to be allocated (per Wkst. B,	1, 852			204.00
201100	Part II)	1,002			2011 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 241744			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)	1			

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/31/2024 9:2	epared: 0 am
		Title	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 617, 894		3, 617, 89			
31.00 03100 INTENSIVE CARE UNIT	1, 414, 289		1, 414, 28			•
40. 00 04000 SUBPROVI DER – I PF	3, 439, 710		3, 439, 71			
41.00 04100 SUBPROVI DER – I RF	1, 695, 408		1, 695, 40			•
43.00 04300 NURSERY	866, 218		866, 21	18 0	866, 218	43.00
ANCI LLARY SERVICE COST CENTERS		1	1	1		
50. 00 05000 OPERATI NG ROOM	4, 554, 282		4, 554, 28			•
51.00 05100 RECOVERY ROOM	0			0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 292, 330		1, 292, 33			•
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 519, 145		2, 519, 14			•
56. 00 05600 RADI OI SOTOPE	1, 315, 530		1, 315, 53			•
60.00 06000 LABORATORY	3, 840, 935		3, 840, 93			•
63. 00 06300 BLOOD STORING PROCESSING & TRANS.	18, 177		18, 17		- 1	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0			0 0		64.00
65. 00 06500 RESPIRATORY THERAPY	1, 191, 195					•
66.00 06600 PHYSI CAL THERAPY	2, 101, 495					
67. 00 06700 OCCUPATI ONAL THERAPY	715, 999					
68. 00 06800 SPEECH PATHOLOGY	341, 669					•
69. 00 06900 ELECTROCARDI OLOGY	135, 026		135, 02			•
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	3, 123, 192		3, 123, 19			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	752, 303		752, 30			•
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 938, 146		5, 938, 14			•
76. 00 03020 CARDI AC REHAB	302, 403		302, 40			•
76. 01 03030 ADDI CTI ON SERVI CES	430, 739		430, 73			
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			0 0		77.00
78.00 07800 CAR T-CELL I MMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		1		0 0	0	78.00
88.00 08800 RURAL HEALTH CLINIC	1, 376, 470		1, 376, 47	70 0	1, 376, 470	88.00
88. 01 08800 RURAL HEALTH CLINIC	1, 028, 539		1, 028, 53			
88.02 08802 RURAL HEALTH CLINIC III	1, 950, 426		1, 950, 42			
88. 03 08805 RURAL HEALTH CLINIC IV	1, 950, 420		1, 930, 42	0 0		88.02
88. 04 08803 RURAL HEALTH CLINIC V	2, 618, 428		2, 618, 42		-	
88. 05 08804 RURAL HEALTH CLINIC VI	956, 637		956, 63			•
90. 00 09000 CLINIC	801, 620		801, 62			
90. 01 09001 0NC0L0GY	624, 559		624, 55			•
90. 02 09002 PALN MANAGEMENT	024, 337		024, 30	0 0		
91. 00 09100 EMERGENCY	6, 514, 897		6, 514, 89			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 602, 443		1, 602, 44		1, 602, 443	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	1,047,452		1, 047, 45			
OTHER REIMBURSABLE COST CENTERS	1,047,432		1,047,40	02	1,047,432	/0.00
95. 00 09500 AMBULANCE SERVICES	4, 122, 207		4, 122, 20	07 0	4, 122, 207	95.00
99. 10 09910 CORF	0		1, 122, 20	0	0	
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0			0		102.00
SPECIAL PURPOSE COST CENTERS		1	1	<u> </u>	. 0	1.02.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 H0SPI CE	584, 145		584, 14	15	584, 145	•
200.00 Subtotal (see instructions)	62, 833, 908					
201.00 Less Observation Beds	1, 602, 443		1, 602, 44		1, 602, 443	
202.00 Total (see instructions)	61, 231, 465		1			
	, , , , , , , , , , , , , , , , , ,		, , , == , , , ,		, ,,,	

Heal th Fi	inancial Systems	DAVIESS COMMUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2023	Worksheet C Part I	
					To 12/31/2023	Date/Time Pre 5/31/2024 9:2	pared: 0 am
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	IPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDI ATRI CS	2, 494, 487		2, 494, 487			30.00
	3100 INTENSIVE CARE UNIT	1, 277, 225		1, 277, 225			31.00
	4000 SUBPROVIDER - IPF	6, 425, 771		6, 425, 771			40.00
	4100 SUBPROVIDER - IRF	2,000,932		2,000,932			41.00
	4300 NURSERY ICI LLARY SERVI CE COST CENTERS	1, 164, 751		1, 164, 751			43.00
	5000 OPERATING ROOM	1, 873, 664	11, 983, 114	13, 856, 778	0. 328668	0.000000	50.00
	5100 RECOVERY ROOM	1, 873, 004	0			0.000000	51.00
	5200 DELIVERY ROOM & LABOR ROOM	868, 246	309, 508			0.000000	52.00
	5400 RADI OLOGY-DI AGNOSTI C	2, 412, 907	21,068,658			0.000000	54.00
	5600 RADI OI SOTOPE	480, 598	5, 617, 436			0.000000	
	5000 LABORATORY	3, 843, 442	16,093,557			0,000000	60.00
	5300 BLOOD STORING PROCESSING & TRANS.	337, 931	244, 548			0.000000	
	5400 I NTRAVENOUS THERAPY	0	0	(0.000000	64.00
	5500 RESPIRATORY THERAPY	2, 493, 071	2, 175, 359	4, 668, 430		0.000000	65.00
	5600 PHYSI CAL THERAPY	1, 070, 083	5, 445, 027	6, 515, 110		0.000000	66.00
	5700 OCCUPATI ONAL THERAPY	875, 548	2, 315, 444			0.000000	67.00
	5800 SPEECH PATHOLOGY	236, 804	631, 266			0.000000	68.00
69.00 06	5900 ELECTROCARDI OLOGY	206, 483	834, 913	1, 041, 396	0. 129659	0.000000	69.00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 210, 548	6, 385, 793	8, 596, 341	0. 363316	0.00000	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	273, 867	1, 518, 133	1, 792, 000	0. 419812	0.00000	72.00
	7300 DRUGS CHARGED TO PATIENTS	3, 333, 661	14, 734, 063	18, 067, 724		0.00000	
	3020 CARDI AC REHAB	0	490, 266			0.00000	
	3030 ADDI CTI ON SERVI CES	1, 125	79, 967	81, 092		0.00000	76.01
	7700 ALLOGENEIC HSCT ACQUISITION	0	0	(0.000000	77.00
	7800 CAR T-CELL IMMUNOTHERAPY	0	0	(0.000000	0.00000	78.00
	JTPATI ENT SERVICE COST CENTERS		1 10/ 500	1 10/ 50			
	8800 RURAL HEALTH CLINIC	0	1, 186, 590				88.00 88.01
	3801 RURAL HEALTH CLINIC II 3802 RURAL HEALTH CLINIC III	0	504, 987 2, 457, 559				88.01
	3805 RURAL HEALTH CLINIC IV	0	2,457,559	2,457,559			88.02
	3803 RURAL HEALTH CLINIC V	0	2,088,347	2, 088, 347			88.04
	3804 RURAL HEALTH CLINIC VI	0	791, 460				88.05
	2000 CLINIC	0	2, 142, 852			0.000000	
	POOT ONCOLOGY	250	1, 138, 024			0.000000	90.01
	POO2 PAIN MANAGEMENT	0	1, 130, 024	1, 130, 27		0.000000	
	P100 EMERGENCY	1, 675, 266	17, 572, 150	-		0.000000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART	368, 150	3, 376, 606			0.000000	92.00
	4040 OTHER OUTPATIENT SERVICE COST CENTE	204	896, 476			0.000000	
ТО	THER REIMBURSABLE COST CENTERS			•			1
95.00 09	9500 AMBULANCE SERVICES	0	4, 970, 621	4, 970, 621	0. 829314	0.000000	95.00
99.10 09		0	0	0			99.10
	D100 HOME HEALTH AGENCY	0	0	C			101.00
	0200 OPI OI D TREATMENT PROGRAM	0	0	(102.00
	PECIAL PURPOSE COST CENTERS	1		l .	1		
	1300 INTEREST EXPENSE						113.00
	1600 HOSPI CE	0	817, 520				116.00
	Subtotal (see instructions)	35, 925, 014	127, 870, 244	163, 795, 258	5		200.00
200.00					1		001 00
200.00 201.00 202.00	Less Observation Beds Total (see instructions)	35, 925, 014	127, 870, 244	163, 795, 258			201.00 202.00

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	DAVIESS COMMUNI	Provi der CCN: 15-0061	Peri od:	u of Form CMS-2552- Worksheet C
				From 01/01/2023 To 12/31/2023	Part I Date/Time Prepare
			Title XVIII	Hospi tal	5/31/2024 9:20 am PPS
	Cost Center Description	PPS Inpatient		10301 tai	113
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30.
	03100 INTENSIVE CARE UNIT				31.
	04000 SUBPROVIDER - IPF				40.
	04100 SUBPROVIDER - IRF				41.
43.00	04300 NURSERY				43.
	ANCI LLARY SERVICE COST CENTERS	0.000((0			
	05000 OPERATING ROOM	0. 328668			50.
	05100 RECOVERY ROOM	0. 000000			51.
	05200 DELIVERY ROOM & LABOR ROOM	1. 097283			52.
	05400 RADI OLOGY-DI AGNOSTI C	0. 107282			54.
	05600 RADI OI SOTOPE 06000 LABORATORY	0. 215730			56. 60.
		0. 192654			
	06300 BLOOD STORING PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0. 031206 0. 000000			63. 64.
	06500 RESPI RATORY THERAPY	0. 255160			65.
	06600 PHYSI CAL THERAPY	0. 322557			66.
	06700 OCCUPATI ONAL THERAPY	0. 224381			67.
	06800 SPEECH PATHOLOGY	0. 393596			68.
	06900 ELECTROCARDI OLOGY	0. 129659			69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 363316			71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 419812			72.
	07300 DRUGS CHARGED TO PATIENTS	0. 328660			73.
	03020 CARDI AC REHAB	0. 616814			76.
	03030 ADDI CTI ON SERVI CES	5. 311732			76.
	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC				88.
88. 01	08801 RURAL HEALTH CLINIC II				88.
88. 02	08802 RURAL HEALTH CLINIC III				88.
	08805 RURAL HEALTH CLINIC IV				88.
	08803 RURAL HEALTH CLINIC V				88.
	08804 RURAL HEALTH CLINIC VI				88.
	09000 CLINIC	0. 374090			90.
	09001 ONCOLOGY	0. 548690			90.
	09002 PAIN MANAGEMENT	0. 000000			90.
	09100 EMERGENCY	0. 338482			91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 427917			92.
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	1. 168145			93.
05 00	OTHER REIMBURSABLE COST CENTERS	0.00001.1			
	09500 AMBULANCE SERVICES	0. 829314			95.
	09910 CORF				99.
	10100 HOME HEALTH AGENCY 10200 OPI OI D TREATMENT PROGRAM				101. 102.
102.00					102.
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE				113.
	11600 HOSPI CE				113.
200. 00					200.
<u>د</u> 00.00					
201.00	Less Observation Beds				201.

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/31/2024 9:2	epared:
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 617, 894		3, 617, 89			
31.00 03100 INTENSIVE CARE UNIT	1, 414, 289		1, 414, 28			•
40. 00 04000 SUBPROVI DER – I PF	3, 439, 710		3, 439, 71			
41.00 04100 SUBPROVI DER – I RF	1, 695, 408		1, 695, 40			
43.00 04300 NURSERY	866, 218		866, 21	8 0	866, 218	43.00
ANCI LLARY SERVICE COST CENTERS		1			4 55 4 000	
50. 00 05000 OPERATING ROOM	4, 554, 282		4, 554, 28			•
51.00 05100 RECOVERY ROOM	0		1 000 00	0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 292, 330		1, 292, 33			•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 519, 145		2, 519, 14			•
56. 00 05600 RADI OI SOTOPE	1, 315, 530		1, 315, 53			•
	3, 840, 935		3, 840, 93			•
63. 00 06300 BLOOD STORING PROCESSING & TRANS.	18, 177		18, 17		- 1	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	1 101 105		1 101 10	0 0		64.00
	1, 191, 195 2, 101, 495					•
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	2, 101, 495					
68. 00 06800 SPEECH PATHOLOGY	341, 669					
69. 00 06900 ELECTROCARDI OLOGY	135, 026		135, 02			•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 123, 192		3, 123, 19			•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	752, 303		752, 30			
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 938, 146		5, 938, 14			•
76. 00 03020 CARDI AC REHAB	302, 403		302, 40			•
76. 01 03030 ADDI CTI ON SERVI CES	430, 739		430, 73			•
77.00 07700 ALLOGENEIC HSCT ACQUISITION	430,737		400,70	0 0		77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			0 0		•
OUTPATIENT SERVICE COST CENTERS				0 0		/0.00
88.00 08800 RURAL HEALTH CLINIC	1, 376, 470		1, 376, 47	0 0	1, 376, 470	88.00
88.01 08801 RURAL HEALTH CLINIC II	1, 028, 539		1, 028, 53			
88. 02 08802 RURAL HEALTH CLINIC III	1, 950, 426		1, 950, 42			
88. 03 08805 RURAL HEALTH CLINIC IV	0		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0		88.03
88.04 08803 RURAL HEALTH CLINIC V	2, 618, 428		2, 618, 42		-	
88.05 08804 RURAL HEALTH CLINIC VI	956, 637		956, 63			•
90. 00 09000 CLINIC	801, 620		801, 62			
90. 01 09001 ONCOLOGY	624, 559		624, 55			•
90. 02 09002 PALN MANAGEMENT	0			0 0		
91.00 09100 EMERGENCY	6, 514, 897		6, 514, 89	07 0	6, 514, 897	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 602, 443		1, 602, 44	3	1, 602, 443	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	1,047,452		1, 047, 45	0	1, 047, 452	93.00
OTHER REIMBURSABLE COST CENTERS			•		•	1
95.00 09500 AMBULANCE SERVICES	4, 122, 207		4, 122, 20	07 0	4, 122, 207	95.00
99. 10 09910 CORF	0			0	0	99.10
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0			0	0	102.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	584, 145		584, 14	5	584, 145	116.00
200.00 Subtotal (see instructions)	62, 833, 908	0	62, 833, 90	0 8	62, 833, 908	200.00
201.00 Less Observation Beds	1, 602, 443		1, 602, 44		1, 602, 443	
202.00 Total (see instructions)	61, 231, 465	0	61, 231, 46	5 0	61, 231, 465	202.00

	Financial Systems	DAVIESS COMMUN				u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 494, 487		2, 494, 48	7		30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 277, 225		1, 277, 22	5		31.00
40.00	04000 SUBPROVI DER – I PF	6, 425, 771		6, 425, 77			40.00
41.00	04100 SUBPROVI DER – I RF	2,000,932		2, 000, 93	2		41.00
43.00	04300 NURSERY	1, 164, 751		1, 164, 75	1		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 873, 664	11, 983, 114	13, 856, 77	8 0. 328668	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0.000000	0.00000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	868, 246	309, 508	1, 177, 75	4 1. 097283	0.00000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 412, 907	21, 068, 658	23, 481, 56	5 0. 107282	0. 000000	54.00
56.00	05600 RADI OI SOTOPE	480, 598	5, 617, 436	6, 098, 03	4 0. 215730	0.000000	56.00
60.00	06000 LABORATORY	3, 843, 442	16, 093, 557	19, 936, 99	9 0. 192654	0.000000	60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	337, 931	244, 548	582, 47	9 0. 031206	0. 000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0		0. 000000	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	2, 493, 071	2, 175, 359	4, 668, 43	0 0. 255160	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	1,070,083	5, 445, 027	6, 515, 11	0 0. 322557	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	875, 548	2, 315, 444			0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	236, 804	631, 266			0.000000	
69.00	06900 ELECTROCARDI OLOGY	206, 483	834, 913			0.000000	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 210, 548	6, 385, 793				
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	273, 867	1, 518, 133			0.000000	•
	07300 DRUGS CHARGED TO PATIENTS	3, 333, 661	14, 734, 063			0.000000	
76.00	03020 CARDI AC REHAB	0	490, 266			0.000000	
76.01	03030 ADDICTION SERVICES	1, 125	79, 967			0.000000	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0.000000	
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0.000000	0.000000	•
	OUTPATIENT SERVICE COST CENTERS	· · · · ·					
88.00	08800 RURAL HEALTH CLINIC	0	1, 186, 590	1, 186, 59	0 1. 160022	0.00000	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	504, 987			0.000000	
88.02	08802 RURAL HEALTH CLINIC III	0	2, 457, 559			0.000000	
88.03	08805 RURAL HEALTH CLINIC IV	0	0		0. 000000	0.000000	
88.04	08803 RURAL HEALTH CLINIC V	0	2,088,347	2, 088, 34		0.000000	
88.05	08804 RURAL HEALTH CLINIC VI	0	791, 460			0.000000	
90.00	09000 CLI NI C	0	2, 142, 852			0.000000	
90.01	09001 ONCOLOGY	250	1, 138, 024			0.000000	•
90.02	09002 PALN MANAGEMENT	0	0		0. 000000	0.000000	
91.00	09100 EMERGENCY	1, 675, 266	17, 572, 150			0. 000000	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	368, 150	3, 376, 606			0. 000000	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	204	896, 476			0. 000000	
701.00	OTHER REIMBURSABLE COST CENTERS	201	0,0,110	0,0,00		0.000000	/01.00
95 00	09500 AMBULANCE SERVICES	0	4, 970, 621	4, 970, 62	0. 829314	0.00000	95.00
	09910 CORF	0	4, 770, 021		0.027314	0.00000	99.10
	10100 HOME HEALTH AGENCY	0	0		0		101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
102.00	SPECIAL PURPOSE COST CENTERS	U U	0	1			102.00
112 00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	817, 520	817, 52	n		116.00
200.00		35, 925, 014	127, 870, 244				200.00
200.00		33, 723, 014	127,070,244	103, 773, 23			200.00
201.00		35, 925, 014	127, 870, 244	163, 795, 25	8		201.00
202.00		1 00,720,014	.2., 0, 0, 244	1	-1	I Contraction of the second	

	Financial Systems	DAVIESS COMMUNI			u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0061	Period: From 01/01/2023	Worksheet C Part I	
				To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epared: 20 am
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
	INDATIENT DOUTINE CEDVICE COCT CENTERS	11.00				
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
40.00	04000 SUBPROVI DER – I PF					40.00
41.00	04100 SUBPROVI DER – I RF					41.00
43.00	04300 NURSERY					43.00
	ANCI LLARY 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 OI 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 I NTRAVENOUS THERAPY	0. 000000				64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 69.00		0. 000000				68.00 69.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 000000				71.00
71.00 72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000 0. 000000				72.00
	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
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78.00
	OUTPATIENT SERVICE COST CENTERS					
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 CLINIC	0. 000000				90.00
90.01	09001 ONCOLOGY	0. 000000				90.01
90.02		0. 000000				90.02
91.00 92.00	09100 EMERGENCY	0. 000000				91.00
92.00 93.00	09200 OBSERVATION BEDS (NON-DISTINCT PART 04040 OTHER OUTPATIENT SERVICE COST CENTE	0. 000000 0. 000000				92.00
93.00	OTHER REIMBURSABLE COST CENTERS	0.000000				93.00
95.00	09500 AMBULANCE SERVICES	0. 000000				95.00
	09910 CORF	0.000000				99.10
	10100 HOME HEALTH AGENCY					101.00
	10200 OPI OI D TREATMENT PROGRAM					102.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300 I NTEREST EXPENSE					113.00
	11600 HOSPI CE					116.00
200.00	Subtotal (see instructions)					200.00
201.00						201.00
	Total (see instructions)					202.00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider (Period: From 01/01/2023 To 12/31/2023		epared: 20 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	296, 756		296, 75	6 3, 355	88.45	30.00
31.00 INTENSIVE CARE UNIT	79, 062		79, 06			
40. 00 SUBPROVIDER - IPF	221, 901	(221,90	3, 864	57.43	40.00
41.00 SUBPROVIDER - IRF	158, 129	(0 158, 12	1, 344	117.66	41.00
43.00 NURSERY	22, 089		22, 08	886 886	24.93	43.00
200.00 Total (lines 30 through 199)	777, 937		777, 93	10, 023		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30.00 ADULTS & PEDIATRICS	590					30.00
31.00 INTENSIVE CARE UNIT	238					31.00
40.00 SUBPROVIDER - IPF	3, 064					40.00
41.00 SUBPROVIDER - IRF	1, 119	131, 662	2			41.00
43.00 NURSERY	0	(43.00
200.00 Total (lines 30 through 199)	5, 011	392, 596	6			200.00

	Financial Systems		ITY HOSPITAL	CN 15 00/1		u of Form CMS-	2002-1
PPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL CUSIS	Provider C	UN: 15-0061	Period: From 01/01/2023	Worksheet D Part II	
					To 12/31/2023	Date/Time Pre	nared.
					10 12/31/2023	5/31/2024 9:2	0 am
			Title	XVIII	Hospi tal	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)	J		
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS		````				
	05000 OPERATI NG ROOM	460, 952	13, 856, 778	0.03326	5 576, 982	19, 193	50.0
	05100 RECOVERY ROOM	0					
	05200 DELIVERY ROOM & LABOR ROOM	154,088				0	
	05400 RADI OLOGY-DI AGNOSTI C	324, 574				13, 755	
	05600 RADI OI SOTOPE	78, 742					
	06000 LABORATORY	250, 216					
	06300 BLOOD STORING PROCESSING & TRANS.	3, 513					
	06400 I NTRAVENOUS THERAPY	3, 515				0	
	06500 RESPIRATORY THERAPY	120, 839	0			12, 666	
	06600 PHYSI CAL THERAPY	203, 426				3, 491	
	06700 OCCUPATI ONAL THERAPY	46, 103					
	06800 SPEECH PATHOLOGY	30, 906					
	06900 ELECTROCARDI OLOGY	13, 349					
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78, 158		0.00909			
	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 495					
	07300 DRUGS CHARGED TO PATIENTS	87, 455				2, 909	
	03020 CARDI AC REHAB	36, 001	490, 266			0	
	03030 ADDICTION SERVICES	3, 721	81, 092			0	
	07700 ALLOGENEIC HSCT ACQUISITION	0	-			0	1
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78.0
	OUTPATIENT SERVICE COST CENTERS	1		r			
	08800 RURAL HEALTH CLINIC	82, 330					
	08801 RURAL HEALTH CLINIC II	57, 245				-	
	08802 RURAL HEALTH CLINIC III	96, 697	2, 457, 559			0	88.0
	08805 RURAL HEALTH CLINIC IV	0	0	0,00000		0	1
	08803 RURAL HEALTH CLINIC V	47, 142	2, 088, 347	0. 02257	4 0	0	88.0
	08804 RURAL HEALTH CLINIC VI	43, 285	791, 460	0. 05469	0 0	0	88.0
0. 00	09000 CLINIC	62, 443	2, 142, 852	0. 02914	0 0	0	90.0
0. 01	09001 ONCOLOGY	60, 584	1, 138, 274	0. 05322	4 210	11	90.0
0. 02	09002 PALN MANAGEMENT	0	0	0. 00000	0 0	0	90.0
1.00	09100 EMERGENCY	201, 122	19, 247, 416	0. 01044	9 675, 913	7,063	91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART	131, 440					
	04040 OTHER OUTPATIENT SERVICE COST CENTE	91, 664					
	OTHER REIMBURSABLE COST CENTERS	, 301	, 500				1
	09500 AMBULANCE SERVICES						95.0
	Total (lines 50 through 199)	2, 784, 490	144, 643, 951	1	5, 979, 696	92, 657	

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COS			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
40.00 04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
43.00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem	Inpatient	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)	0 9	
	instructions)	minus col. 4)		,		
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	3, 35	5 0.00	590	30.00
31.00 03100 INTENSIVE CARE UNIT		0	57	4 0.00	238	31.00
40. 00 04000 SUBPROVI DER - I PF	0	0	3,86	4 0.00	3, 064	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	1, 34	4 0.00	1, 119	41.00
43.00 04300 NURSERY		0	88	6 0.00	0	43.00
200.00 Total (lines 30 through 199)		0	10, 02	3	5, 011	200.00
Cost Center Description	I npati ent		• · · ·		. ·	
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					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	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

ealth Financial Systems	DAVI ESS COMMUN				u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANC	LLARY SERVICE OTHER PAS	SS Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet D B Part IV	
THROUGH COSTS				To 12/31/2023		pared.
				10 12/01/2020	5/31/2024 9:2	20 am
		Title	e 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 0		0 0	0 0	50.00
51.00 05100 RECOVERY ROOM	0	0 0		0 0	0 0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0 0		0 0	0 0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0 0		0 0	0 0	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0 0	56.00
50. 00 06000 LABORATORY	0			0 0	0 0	60.00
53.00 06300 BLOOD STORING PROCESSING & T	RANS. C			0 0	0 0	63.00
54.00 06400 INTRAVENOUS THERAPY	C			0 0	0 0	64. OC
55. 00 06500 RESPI RATORY THERAPY	C	ol o		0 0	o o	65.00
66. 00 06600 PHYSI CAL THERAPY	C	ol o		0 0	o o	66.00
57.00 06700 OCCUPATI ONAL THERAPY	0	ol o		0 0	o o	67.00
58.00 06800 SPEECH PATHOLOGY	0	ol o		0 0	ol o	68.00
59. 00 06900 ELECTROCARDI OLOGY	0	ol o		0 0	ol o	69.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO P	ATLENT C			0 0	0	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENT				0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	(0 0	0	73.00
76. 00 03020 CARDI AC REHAB				0 0		
76. 01 03030 ADDI CTI ON SERVI CES				0 0		76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION				0 0	o o	
78.00 07800 CAR T-CELL IMMUNOTHERAPY				0 0		
OUTPATIENT SERVICE COST CENTERS		<u>, </u>	1	0	<u> </u>	1 101 00
38. 00 08800 RURAL HEALTH CLINIC	0			0 0	0 0	88.00
38. 01 08801 RURAL HEALTH CLINIC II				0 0		
38. 02 08802 RURAL HEALTH CLINIC III				0 0		
38. 03 08805 RURAL HEALTH CLINIC IV				0 0	ol o	
38.04 08803 RURAL HEALTH CLINIC V				0		
38. 05 08804 RURAL HEALTH CLINIC VI				0 0	ol o	
20. 00 09000 CLINIC				0	ol o	
20. 01 09001 ONCOLOGY	()			0 0		
PO. 02 09002 PALN MANAGEMENT	()			0 0		
21. 00 09100 EMERGENCY	(0 0		
22.00 09200 OBSERVATION BEDS (NON-DISTINC	T PART C	-		0		
23. 00 04040 OTHER OUTPATIENT SERVICE COST				0 0		
OTHER REIMBURSABLE COST CENTERS			1	с ₁ С	[']	1 / 3.00
25. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0			0 0		200.00
	1	1 0	I	~C	1 0	

Health Financial Systems	DAVIESS COMMUN			In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2023	Worksheet D Part IV	
				To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	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	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0			0 13, 856, 778	0. 000000	
51.00 05100 RECOVERY ROOM	0	0		0 0	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 177, 754	0.000000	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 23, 481, 565	0.000000	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 6, 098, 034		
60. 00 06000 LABORATORY	0	-		0 19, 936, 999		
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0	0		0 582, 479		
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0.000000	
65.00 06500 RESPI RATORY THERAPY	0	0		0 4, 668, 430		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 6, 515, 110		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 190, 992		
68.00 06800 SPEECH PATHOLOGY	0	0		0 868, 070		
69.00 06900 ELECTROCARDI OLOGY	0	0		0 1, 041, 396		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 8, 596, 341		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 792, 000		•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 18, 067, 724		
76. 00 03020 CARDI AC REHAB	0	0		0 490, 266		•
76. 01 03030 ADDI CTI ON SERVI CES	0	0		0 81, 092		•
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0		•
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0.00000	78.00
OUTPATIENT SERVICE COST CENTERS				0 1 10/ 500	0.00000	00.00
88. 00 08800 RURAL HEALTH CLINIC	0			0 1, 186, 590		
88. 01 08801 RURAL HEALTH CLINIC II	0	-		0 504, 987		
88. 02 08802 RURAL HEALTH CLINIC III	0	-		0 2, 457, 559		
88. 03 08805 RURAL HEALTH CLINIC IV	0	-		0 0	0.000000	
88. 04 08803 RURAL HEALTH CLINIC V	0	0		0 2,088,347		
88. 05 08804 RURAL HEALTH CLINIC VI	0	0		0 791, 460		
90. 00 09000 CLINIC	0	0		0 2, 142, 852		
90. 01 09001 ONCOLOGY	0	0		0 1, 138, 274		
90. 02 09002 PALN MANAGEMENT	0	0		0		
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-				
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0					
071 OTHER REIMBURSABLE COST CENTERS	0	0	1	0 896, 680	0.00000	43.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 144, 643, 951		200.00
200.00 Total (Thes by through 199)	0	1 0	1	144, 045, 951	I	l≥00.00

Health Financial Systems	DAVIESS COMMUNI	TY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0061	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	
			XVIII	Hospi tal	5/31/2024 9:2 PPS	
Cost Conton Description	Outpati ent	Inpatient		Outpati ent	Outpatient	
Cost Center Description	Ratio of Cost	Program	Inpatient Program	Program	Program	
			Pass-Through		Pass-Through	
	to Charges (col. 6 ÷	Charges	Costs (col.		Costs (col. 9	
	col. 7)		x col. 10)	0	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0. 000000	576, 982	1	0 1, 776, 377	0	50.00
	0. 000000				-	
		0		0 0		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 81, 433		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	995, 103		0 4, 512, 107	0	
56. 00 05600 RADI OI SOTOPE	0. 000000	192, 896		0 1, 655, 826	0	56.00
60. 00 06000 LABORATORY	0. 000000	1, 233, 995		0 1, 767, 498		
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0. 000000	98, 070		0 63, 750		63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	, s	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	489, 348		0 345, 374	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	111, 819		0 8, 538		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	46, 652		0 126	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	27, 303		0 5, 917	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	81, 645		0 210, 962	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	519, 914		0 1, 240, 354	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	160, 182		0 472,041	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	601, 007		0 6, 754, 763	0	73.00
76. 00 03020 CARDI AC REHAB	0. 000000	0		0 237, 183	0	76.00
76.01 03030 ADDICTION SERVICES	0. 000000	0		0 0	0	76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	l o	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000	0		0 0		1
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0		0 0		
88. 03 08805 RURAL HEALTH CLINIC IV	0. 000000	0		0 0		1
88. 04 08803 RURAL HEALTH CLINIC V	0. 000000	0		0 0	-	
88. 05 08804 RURAL HEALTH CLINIC VI	0. 000000	0		0 0		
90. 00 09000 CLINIC	0. 000000	0		0 1, 105, 181	0	
90. 01 09001 0NC0L0GY	0. 000000	210		0 602, 719		90.01
90. 02 09002 PALN MANAGEMENT	0. 000000	210		0 002, 717	0	
91. 00 09100 EMERGENCY	0. 000000	675, 913		0 2,855,038		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	168, 552		0 1, 142, 112	-	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0. 000000	108, 552		0 1, 142, 112		
OTHER REIMBURSABLE COST CENTERS	0.000000	105	I	<u>- 70, 900</u>	0	73.00
95. 00 09500 AMBULANCE SERVICES	1					95.00
200.00 Total (lines 50 through 199)		5, 979, 696		0 24, 936, 267	0	200.00
	1 1	5, 717, 070	I	24, 750, 207	0	l <u>∼</u> 00.00

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 01/01/2023 To 12/31/2023	u of Form CMS-: Worksheet D Part V Date/Time Pre 5/31/2024 9:2	epared:
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1	-		
50. 00 05000 OPERATI NG ROOM	0. 328668			0 0	583, 838	1
51.00 05100 RECOVERY ROOM	0. 000000			0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 097283			0 0	89, 355	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 107282			0 0	484, 068	
56. 00 05600 RADI OI SOTOPE	0. 215730			0 0	357, 211	
60. 00 06000 LABORATORY	0. 192654			0 0	340, 516	
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0. 031206			0 0	1, 989	1
64.00 06400 INTRAVENOUS THERAPY	0. 000000			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 255160		1	0 0	88, 126	
66. 00 06600 PHYSI CAL THERAPY	0. 322557			0 0	2, 754	
67.00 06700 OCCUPATI ONAL THERAPY	0. 224381	126		0 0	28	
68.00 06800 SPEECH PATHOLOGY	0. 393596			0 0	2, 329	
69. 00 06900 ELECTROCARDI OLOGY	0. 129659			0 0	27, 353	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 363316			0 0	450, 640	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 419812			0 0	198, 168	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 328660			0 4, 797	2, 220, 020	
76. 00 03020 CARDI AC REHAB	0. 616814		1	0 0	146, 298	
76. 01 03030 ADDI CTI ON SERVI CES	5. 311732		1	0 0	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000		1	0 0	0	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS		1				
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 CLINIC	0. 374090		1	0 0	413, 437	1
90. 01 09001 ONCOLOGY	0. 548690			0 0	330, 706	1
90. 02 09002 PALN MANAGEMENT	0. 000000			0 0	0	
91.00 09100 EMERGENCY	0. 338482			0 252	966, 379	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 427917			0 0	488, 729	
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	1. 168145	98, 968		0 0	115, 609	93.00
OTHER REIMBURSABLE COST CENTERS		1	1			
95.00 09500 AMBULANCE SERVICES	0. 829314			0		95.00
200.00 Subtotal (see instructions)		24, 936, 267		0 5,049	7, 307, 553	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		04.004.01-			7 007 5	000.05
202.00 Net Charges (line 200 - line 201)		24, 936, 267	1	0 5, 049	7, 307, 553	202.00

Health Financial Systems	DAVIESS COMMUNI	TY HOSPI TAL		In Lie	u of Form CMS-2552	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CO	CN: 15-0061	Peri od: From 01/01/2023	Worksheet D Part V	!
				To 12/31/2023	Date/Time Prepare 5/31/2024 9:20 a	
		Title	XVIII	Hospi tal	PPS	
	Cost					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins. [Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0	0				0. 00
51.00 05100 RECOVERY ROOM	0	0				1.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				2.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				4.00
56. 00 05600 RADI OI SOTOPE	0	0				6.00
60. 00 06000 LABORATORY	0	0				0. 00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0	0				3.00
64.00 06400 INTRAVENOUS THERAPY	0	0				4.00
65. 00 06500 RESPI RATORY THERAPY	0	0			65	5.00
66. 00 06600 PHYSI CAL THERAPY	0	0			66	6.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0			67	7.00
68.00 06800 SPEECH PATHOLOGY	0	0			68	8.00
69. 00 06900 ELECTROCARDI OLOGY	0	0			69	9.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71	1.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 577				3.00
76. 00 03020 CARDI AC REHAB	0	0				6.00
76. 01 03030 ADDI CTI ON SERVI CES	0	0				6. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				7.OC
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0			78	8.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						8. OC
88.01 08801 RURAL HEALTH CLINIC II						8. 01
88.02 08802 RURAL HEALTH CLINIC III						8. 02
88.03 08805 RURAL HEALTH CLINIC IV						8. 03
88.04 08803 RURAL HEALTH CLINIC V						8.04
88.05 08804 RURAL HEALTH CLINIC VI						8. 05
90. 00 09000 CLINIC	0	0				0.00
90. 01 09001 ONCOLOGY	0	0				0. 01
90. 02 09002 PALN MANAGEMENT	0	0				0. 02
91.00 09100 EMERGENCY	0	85				1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				2.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0			93	3.00
OTHER REIMBURSABLE COST CENTERS	1 1					
95. 00 09500 AMBULANCE SERVICES	0					5.00
200.00 Subtotal (see instructions)	0	1, 662				0.00
201.00 Less PBP Clinic Lab. Services-Program	0				201	1.00
Only Charges		4				
202.00 Net Charges (line 200 - line 201)	0	1, 662			202	2.00

Health Financial Systems	DAVIESS COMMUN				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provider C	CN: 15-0061	Period:	Worksheet D	
		Component	CCN: 15-S061	From 01/01/2023 To 12/31/2023		narod
		component	CCN. 15-5001	10 12/31/2023	5/31/2024 9:2	
		Title	XVIII	Subprovider -	PPS	o un
				IPF		
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	
ANCI LLARY SERVICE COST CENTERS	-			-		
50. 00 05000 OPERATI NG ROOM	460, 952				0	50.00
51.00 05100 RECOVERY ROOM	0	-	010000		-	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	154, 088				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	324, 574	23, 481, 565				54.00
56. 00 05600 RADI OI SOTOPE	78, 742	6, 098, 034			273	56.00
60. 00 06000 LABORATORY	250, 216				7, 591	60.00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	3, 513	582, 479			0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	-	0,0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	120, 839				10, 275	65.00
66. 00 06600 PHYSI CAL THERAPY	203, 426	6, 515, 110	0. 0312	24 80, 078	2, 500	66.00
67.00 06700 OCCUPATI ONAL THERAPY	46, 103	3, 190, 992	0. 0144	48 7, 179	104	67.00
68.00 06800 SPEECH PATHOLOGY	30, 906				1, 329	
69. 00 06900 ELECTROCARDI OLOGY	13, 349				498	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78, 158				646	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 495				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	87, 455	18, 067, 724	0. 00484	40 1, 146, 251	5, 548	73.00
76. 00 03020 CARDI AC REHAB	36, 001	490, 266			0	76.00
76. 01 03030 ADDI CTI ON SERVI CES	3, 721	81, 092			0	76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0				0	77.00
78.00 07800 CAR T-CELL I MMUNOTHERAPY	0	0	0.0000	0 00	0	78.00
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	82, 330					
88.01 08801 RURAL HEALTH CLINIC II	57, 245					88.01
88.02 08802 RURAL HEALTH CLINIC III	96, 697	2, 457, 559			-	88.02
88.03 08805 RURAL HEALTH CLINIC IV	0	-	010000		-	88.03
88.04 08803 RURAL HEALTH CLINIC V	47, 142		0. 0225		0	88.04
88.05 08804 RURAL HEALTH CLINIC VI	43, 285				0	88.05
90. 00 09000 CLINIC	62, 443				0	90.00
90. 01 09001 0NC0L0GY	60, 584	1, 138, 274			0	90.01
90. 02 09002 PALN MANAGEMENT	0	-	010000		0	90.02
91. 00 09100 EMERGENCY	201, 122				2, 466	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	91, 664	896, 680	0. 1022	26 0	0	93.00
OTHER REIMBURSABLE COST CENTERS			1			
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 653, 050	144, 643, 951		2, 869, 777	34, 411	200.00

51.00 651.00 652.00 00 0 0 0 0 51.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 0 54.00 52.00 05400 RADIOLOCY-DIAGNOSTIC 0 0 0 0 54.00 56.00 05600 RADIOLOCY-DIAGNOSTIC 0 0 0 0 56.00 06000 LABORATORY 0 0 0 0 66.00 66.00 06300 INTRAVENDUS THERAPY 0 0 0 66.00 66.00 06400 OHOU CULAPTIANAL THERAPY 0 0 0 66.00 66.00 06600 PHYSICAL THERAPY 0 0 0 0 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00	Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Li	eu of Form CMS-	2552-10
Number 2001 Component CON: 15-5061 To 12/31/2023 Date/Time Prepared: 5/31/2024 9:20 and 2/31/2024 9:20 and 2/31/		RVICE OTHER PAS	S Provider C	CN: 15-0061			
Cost Center Description Non Physician Anesthetist Cost Nursing Program Adjustments 0 <t< td=""><td>THROUGH COSTS</td><td></td><td>Component</td><td>CCN: 15-SO61</td><td></td><td>B Date/Time Pre</td><td></td></t<>	THROUGH COSTS		Component	CCN: 15-SO61		B Date/Time Pre	
Anesthet ist Cost Program Post-Stepdown Adjustments Program Adjustments Program Adjustments Program Adjustments NCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 NCILLARY SERVICE COST CENTERS 0			Title	× XVIII		PPS	
Cost Post-Stepdom Adj ustments Adj ustments 1.00 2A 2.00 3A 3.00 50.00 05000 0PERATING ROOM 0 0 0 0 0 0 50.00 51.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 56.00	Cost Center Description		Nursi ng	Nursi ng			
Adj ustments Adj ustments Adj ustments 1.00 2A 2.00 3A 3.00 50.00 05000 QPERATING ROOM 0 0 0 0 0 0 0 0 0 50.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00				Program			
Includer		Cost			Adjustments		
ANCILLARY SERVICE COST CENTERS 0 <th< td=""><td></td><td>1 00</td><td></td><td>2.00</td><td>31</td><td>3 00</td><td></td></th<>		1 00		2.00	31	3 00	
50.00 65000 0FECOVERY ROOM 0	ANCILLARY SERVICE COST CENTERS	1.00	20	2.00	54	3.00	
52.00 052200 DELLVERY ROM & LABOR ROM 0 0 0 52.00 0 0 0 54.00 0 0 0 0 0 54.00 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>50.00</td>		0	0		0		50.00
54.00 0 0 0 0 54.00 0 0 0 0 54.00 <	51.00 05100 RECOVERY ROOM	0	0		0		51.00
56.00 OS600 RAD IO SOTOPE O	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	o c	52.00
60.00 0 <td>54.00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>54.00</td>	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
63.00 06300 BLOOD STORI NC PROCESSI NG & TRANS. 0 0 0 0 63.00 64.00 06400 INTRAVENUUS THERAPY 0 0 0 0 64.00 66.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06500 RESPI RATORY THERAPY 0 0 0 0 66.00 66.00 00 0 0 0 0 0 66.00 66.00 00 0 0 0 0 0 0 66.00 66.00 00 0 0 0 0 0 66.00 67.00 0700 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 71.00 07100 MEL DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.	56. 00 05600 RADI 0I SOTOPE	0	0		0	o c	56.00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 66.00 67.00 0 0 0 0 0 0 0 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 67.00 0 0 0 68.00 69.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 74.01 74.01<	60. 00 06000 LABORATORY	0	0		0	o c	60.00
65.00 06500 RESPIRATORY THERAPY 0 0 0 0 66.00 0 0 0 0 66.00 0	63.00 06300 BLOOD STORING PROCESSING & TRANS.	0	0		0) (63.00
66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 66.00 66.00 <	64.00 06400 INTRAVENOUS THERAPY	0	0		0) (64.00
67.00 06700 0CCUPATIONAL THERAPY 0 <td< td=""><td>65. 00 06500 RESPI RATORY THERAPY</td><td>0</td><td>0</td><td></td><td>0</td><td>) (</td><td>65.00</td></td<>	65. 00 06500 RESPI RATORY THERAPY	0	0		0) (65.00
68.00 06800 SPEECH PATHOLOGY 0 </td <td>66. 00 06600 PHYSI CAL THERAPY</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>) (</td> <td>66.00</td>	66. 00 06600 PHYSI CAL THERAPY	0	0		0) (66.00
69:00 06900 ELECTROCARDIOLOGY 0<	67.00 06700 OCCUPATI ONAL THERAPY	0	0		0) (67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 03020 CARDIAC REHAB 0 0 0 0 74.00 76.01 03030 ADDI CTI ON SERVI CES 0 0 0 0 77.00 71.00 07800 CARCI ACQUISITION 0 0 0 0 77.00 78.00 07800 CRRAL HEALTH CLINIC TION 0 0 0 0 78.00 0810 RURAL HEALTH CLINIC TI I 0 0 0 0 0 88.00 88.01 08807 RURAL HEALTH CLINIC TI I 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC VI 0 0 0		0	0		0) C	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.00 03020 CARDIAC REHAB 0 0 0 0 76.00 70.00 03030 ADDI CTI ON SERVI CES 0 0 0 0 76.00 77.00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 77.00 78.00 07800 CART - CELL IMMUNOTHERAPY 0 0 0 0 77.00 07800 CART - CEL IMMUNOTHERAPY 0 0 0 0 78.00 07800 CART - CELL IMMUNOTHERAPY 0 0 0 0 88.00 08801 RURAL HEALTH CLINIC II 0 0 0 0 88.00 88.01 08802 RURAL HEALTH CLINIC III 0 0 0 88.00 88.02 08803 RURAL HEALTH CLINIC V 0 0 0 0 88.00 90.00 09000	69. 00 06900 ELECTROCARDI OLOGY	0	0		0) C	69.00
73.00 OR300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 76.00 03020 CARDIAC REHAB 0 0 0 0 76.00 77.00 77.00 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.00 77.00 77.00 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78.00 07800 CART - CELL IMMUNOTHERAPY 0 0 0 0 78.00 07800 RURAL HEALTH CLINIC 0 0 0 0 88.00 88.01 08807 RURAL HEALTH CLINIC II 0 0 0 88.00 88.01 08805 RURAL HEALTH CLINIC II 0 0 0 88.02 88.02 08805 RURAL HEALTH CLINIC V 0 0 0 88.02 88.03 08805 RURAL HEALTH CLINIC V 0 0 0 88.03 88.03 88.04 08803 RURAL HEALTH CLINIC VI 0 0 0 0 0 0 0		0	0		0	-	
76.00 03020 CARDI AC REHAB 0 0 0 0 0 76.00 76.01 03030 ADDI CTI ON SERVI CES 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>12.00</td>		0	0		0		12.00
76.01 0303 ADDICTION SERVICES 0 0 0 0 76.01 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78.00 78.00 0800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 0 0 88.00 88.02 08802 RURAL HEALTH CLINIC IV 0 0 0 0 88.00 88.03 08805 RURAL HEALTH CLINIC V 0 0 0 0 88.00 88.04 08803 RURAL HEALTH CLINIC V 0 0 0 0 88.00 88.05 08804 RURAL HEALTH CLINIC V 0 0 0 0 0 88.00 90.00 090000 CLINIC 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>-</td> <td></td>		0	0		0	-	
77.00 0700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 88.00 0800 RURAL HEALTH CLINIC II 0 0 0 0 88.01 88.01 08802 RURAL HEALTH CLINIC III 0 0 0 88.02 88.02 08803 RURAL HEALTH CLINIC IV 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC VI 0 0 0 88.03 88.04 08803 RURAL HEALTH CLINIC VI 0 0 0 88.04 88.05 08804 RURAL HEALTH CLINIC VI 0 0 0 0 88.05 90.00 09000 CLINIC 0 0 0 0 0 0 0 0 0 90.00 09000 CLINIC 0 0 0 0 0 0 0<		0	0		0		1 1 01 00
78.00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0 0 0 78.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 88.00 08800 RURAL HEALTH CLINIC II 0 0 0 0 88.00 08801 RURAL HEALTH CLINIC II 0 0 0 0 0 88.00 88.01 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 88.01 88.02 88.02 88.02 88.02 88.02 RURAL HEALTH CLINIC III 0 0 0 0 0 88.01 88.02 88.02 88.02 88.02 88.02 88.05 88.05 88.05 88.04 08803 RURAL HEALTH CLINIC IV 0 0 0 0 88.04 88.		0	0		0	-	
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0		0	0		0		
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC 0		0	0		0) (78.00
88.01 08801 RURAL HEALTH CLINICIII 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINICIII 0 0 0 0 0 88.02 88.03 08805 RURAL HEALTH CLINICIV 0 0 0 0 0 88.03 88.04 08803 RURAL HEALTH CLINICIV 0 0 0 0 88.03 88.04 08803 RURAL HEALTH CLINICV 0 0 0 0 88.03 88.05 08804 RURAL HEALTH CLINICV 0 0 0 0 88.04 88.05 08804 RURAL HEALTH CLINICV 0 0 0 0 88.03 88.05 08804 RURAL HEALTH CLINICV 0 0 0 0 88.04 88.05 08804 RURAL HEALTH CLINICV 0 0 0 0 88.04 90.00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""><td></td><td></td><td></td><td>1</td><td></td><td></td><td></td></td<>				1			
88.02 08802 RURAL HEALTH CLINICIIII 0 0 0 0 0 88.02 88.03 08805 RURAL HEALTH CLINICIV 0 0 0 0 0 88.03 88.04 08803 RURAL HEALTH CLINICIV 0 0 0 0 88.04 88.05 08804 RURAL HEALTH CLINICV 0 0 0 0 88.04 88.05 08804 RURAL HEALTH CLINICVI 0 0 0 0 88.04 90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 09001 NCOLOGY 0 0 0 0 90.00 90.02 PAIN MANAGEMENT 0 0 0 0 90.00 91.00 OP100 EMERGENCY 0 0 0 91.00 92.00 08SERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 93.00 04040 OTHER NET MEURSABLE COST CENTERS 0 0 0 93.00 95.00		0	0		0		
88.03 08805 RURAL HEALTH CLINICIV 0 0 0 0 88.03 88.04 08803 RURAL HEALTH CLINIC V 0 0 0 0 88.04 88.05 08804 RURAL HEALTH CLINIC VI 0 0 0 0 88.04 90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 09001 NCOLOGY 0 0 0 0 90.01 90.02 09002 PAIN MANAGEMENT 0 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 0 90.02 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 91.00 92.00 93.00 04040 OTHER REIMBURSABLE COST CENTER 0 0 0 93.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00		0	0		0	-	
88.04 08803 RURAL HEALTH CLINIC V 0 0 0 0 88.04 88.05 08804 RURAL HEALTH CLINIC VI 0 0 0 0 88.05 90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 09001 0NCOLOGY 0 0 0 0 90.01 90.02 09002 PAIN MANAGEMENT 0 0 0 90.02 90.02 91.00 09100 EMERGENCY 0 0 0 0 90.02 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 91.00 93.00 04040 OTHER REIMBURSABLE COST CENTE 0 0 0 93.00 04040 OTHER REI MBURSABLE COST CENTERS 95.00 95.00 95.00 95.00 95.00		0	0		0		
88.05 08804 RURAL HEALTH CLINIC VI 0 0 0 0 88.05 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 0NCOLOGY 0 0 0 0 90.01 90.02 09002 PAIN MANAGEMENT 0 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 91.00 92.00 0 0 0 92.00 93.00 0 93.00 0 0 0 0 93.00 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>-</td><td></td></td<>		0	0		0	-	
90.00 09000 CLINIC 0		0	0		0		
90.01 09001 0NCOLOGY 0		0	0		0		
90.02 09002 PAIN MANAGEMENT 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td>		0	0		0		
91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 93.00 04040 0THER OUTPATI ENT SERVICE COST CENTE 0 0 0 0 93.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00		0	0		0	-	
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE 0 0 0 0 93.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00			0		0	-	
93. 00 04040 OTHER OUTPATI ENT SERVICE COST CENTE 0 0 0 0 93. 00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00		0	0		0	-	
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0	0		0	-	
95.00 09500 AMBULANCE SERVICES 95.00		<u> </u>	0	1	<u> </u>		
							95.00
		0	0		0		

lealth Financial Systems		ITY HOSPITAL	1		u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PAS	S Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-S061	To 12/31/2023	Date/Time Pre	
				C 1	5/31/2024 9:2	20 am
		IIIIE	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				0 40 05 (770	0.00000	50.00
50. 00 05000 OPERATING ROOM	0	0		0 13, 856, 778		
51.00 05100 RECOVERY ROOM	0	0		0 0 0		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 1, 177, 754	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 23, 481, 565	0.00000	
56. 00 05600 RADI 0I SOTOPE	0	0		0 6, 098, 034	0.00000	
60. 00 06000 LABORATORY	0	0		0 19, 936, 999		
63. 00 06300 BLOOD STORING PROCESSING & TRANS.	0	0		0 582, 479		
54. 00 06400 INTRAVENOUS THERAPY	0	0		0 0	0.00000	
	0	0		0 4, 668, 430		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 6, 515, 110		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 190, 992		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 868,070		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 1,041,396		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0		0 8, 596, 341	0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 1, 792, 000		
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CARDIAC REHAB	0			0 18,067,724	0.000000	
76. 01 03020 CARDIAC REHAB 76. 01 03030 ADDI CTI ON SERVI CES	0			0 490, 266 0 81, 092		
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0 0		
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			0 0		
OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0	0.00000	/ /8.00
88. 00 08800 RURAL HEALTH CLINIC	0	C		0 1, 186, 590	0.00000	88.00
88. 01 08801 RURAL HEALTH CLINIC II	0			0 1, 188, 390	0. 000000	
88. 02 08802 RURAL HEALTH CLINIC III	0 0			0 2, 457, 559		
88. 03 08805 RURAL HEALTH CLINIC IV	0			0 2,437,337		
88. 04 08803 RURAL HEALTH CLINIC V				0 2, 088, 347	0.000000	
88. 05 08804 RURAL HEALTH CLINIC VI	0			0 791, 460		
90. 00 09000 CLINIC	0			0 2, 142, 852		
90. 01 09001 0NCOLOGY	0	0		0 1, 138, 274	0.000000	
90. 02 09002 PAIN MANAGEMENT	0	0		0 0	0.000000	
91. 00 09100 EMERGENCY	0	0		0 19, 247, 416		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 3, 744, 756		
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0		0 896, 680		
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
			1	1		

	inancial Systems DNMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	DAVIESS COMMUNI	Provider C	CN: 15-0061	Peri od:	u of Form CMS-2 Worksheet D	LUUL
THROUGH		KWICE OTHER TASS		CN. 13-0001	From 01/01/2023	Part IV	
			•	CCN: 15-S061	To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
			Title	e XVIII	Subprovider -	PPS	
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug	5	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	
	NCI LLARY SERVICE COST CENTERS	0.000000					1 50 0
	5000 OPERATING ROOM	0.000000	0		0 0	0	50.0
	5100 RECOVERY ROOM	0.000000	0		0 0	0	51.0
	5200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	0	52.0
	5400 RADI OLOGY-DI AGNOSTI C	0.000000	230, 146		0 0	0	54.
	5600 RADI OI SOTOPE	0.000000	21, 121		0 0	0	56.
	6000 LABORATORY	0. 000000	604, 824	1	0 0	0	60.
	6300 BLOOD STORING PROCESSING & TRANS.	0. 000000	0		0 0	0	63.
	6400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.
	6500 RESPI RATORY THERAPY	0. 000000	396, 968		0 0	0	65.
	6600 PHYSI CAL THERAPY	0. 000000	80, 078		0 0	0	66.
	6700 OCCUPATI ONAL THERAPY	0. 000000	7, 179		0 0	0	67.
	6800 SPEECH PATHOLOGY	0. 000000	37, 334		0 0	0	68.
	6900 ELECTROCARDI OLOGY	0. 000000	38, 826		0 0	0	69.
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	71, 006	1	0 0	0	71.
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.
	7300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 146, 251		0 0	0	73.
	3020 CARDI AC REHAB	0. 000000	0		0 0	0	76.
	3030 ADDICTION SERVICES	0. 000000	0		0 0	0	76.
	7700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.
	7800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78.
	UTPATIENT SERVICE COST CENTERS	· · ·					
	8800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.
	8801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.
	8802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88.
	8805 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	0	88.
	8803 RURAL HEALTH CLINIC V	0. 000000	0		0 0	0	88.
	8804 RURAL HEALTH CLINIC VI	0. 000000	0		0 0	0	88.
	9000 CLINIC	0. 000000	0		0 0	0	90.
	9001 ONCOLOGY	0. 000000	0		0 0	0	90.
	9002 PAIN MANAGEMENT	0. 000000	0		0 0	0	90.
	9100 EMERGENCY	0. 000000	236, 044		0 0	0	91.
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.
	4040 OTHER OUTPATIENT SERVICE COST CENTE	0. 000000	0		0 0	0	93.
	THER REIMBURSABLE COST CENTERS			-			
	9500 AMBULANCE SERVICES						95.
00.00	Total (lines 50 through 199)		2,869,777	1	0 0	0	200.

Health Financial Systems	DAVIESS COMMUN				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0061	Period:	Worksheet D	
		Component	CCN: 15-T061	From 01/01/2023 To 12/31/2023		narad
		component	CCN. 15-1001	10 12/31/2023	5/31/2024 9:2	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges		(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	
ANCI LLARY SERVICE COST CENTERS	440.050	40.054.770	0.0000	(F) (10		
50. 00 05000 OPERATI NG ROOM	460, 952	13, 856, 778			14	50.00
51.00 O5100 RECOVERY ROOM	0	0	010000		0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	154,088	1, 177, 754			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	324, 574	23, 481, 565			1, 159	54.00
56. 00 05600 RADI OI SOTOPE	78, 742	6, 098, 034				56.00
60. 00 06000 LABORATORY	250, 216	19, 936, 999			1,905	60.00
63. 00 06300 BLOOD STORING PROCESSING & TRANS.	3, 513	582, 479			87	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0,0000		0	64.00
65. 00 06500 RESPIRATORY THERAPY	120, 839	4, 668, 430			14, 952	65.00
66. 00 06600 PHYSI CAL THERAPY	203, 426	6, 515, 110			19, 803	66.00
67. 00 06700 OCCUPATIONAL THERAPY	46, 103	3, 190, 992				•
68. 00 06800 SPEECH PATHOLOGY	30, 906	868, 070				•
69. 00 06900 ELECTROCARDI OLOGY	13, 349	1,041,396			92	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	78, 158	8, 596, 341				•
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	18, 495	1, 792, 000			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	87, 455	18,067,724				
76. 00 03020 CARDI AC REHAB	36,001	490, 266			0	76.00
76. 01 03030 ADDI CTI ON SERVI CES	3, 721	81, 092			0	76.01
77. 00 07700 ALLOGENEI CHSCT ACQUI SI TI ON	0	0				77.00
78. 00 07800 CAR T-CELL I MMUNOTHERAPY OUTPATI ENT SERVICE COST CENTERS	0	0	0.0000	0	0	78.00
88. 00 08800 RURAL HEALTH CLINIC	82, 330	1, 186, 590	0.0693	34 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	57, 245	504, 987				88.00
88. 02 08802 RURAL HEALTH CLINIC III	96, 697	2, 457, 559				88.02
88. 03 08805 RURAL HEALTH CLINIC IV	90, 097	2,457,559				88.03
88. 04 08803 RURAL HEALTH CLINIC V	47, 142	2, 088, 347	0. 0225			88.04
88. 05 08804 RURAL HEALTH CLINIC VI	47, 142	791, 460			0	88.05
90. 00 09000 CLINIC	43, 205	2, 142, 852				90.00
90. 01 09001 0NC0L0GY	60, 584	1, 138, 274			0	90.00
90. 02 09002 PALN MANAGEMENT	00, 564	1, 130, 274				90.01
90. 02 109002 PATN MANAGEMENT 91. 00 109100 EMERGENCY	201, 122	19, 247, 416			-	90.02
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	201, 122	3, 744, 756			0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	91, 664	896, 680				93.00
OTHER REIMBURSABLE COST CENTERS	71,004	070,000	0. 1022.	-0 0	0	33.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 653, 050	144, 643, 951		2, 537, 350	52 845	200.00
	2,000,000	177,073,731	I	2, 337, 330	1 52,045	200.00

Heal th	Financial Systems	DAVIESS COMMUN	TY HOSPITAL		In Lie	eu of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet D Part IV	
THROUG	GH COSTS		Component	CCN: 15-T061	To 12/31/2023		
			Title	e XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments 2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS	1.00	2/1	2.00	5/1	3.00	
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 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0 0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0 0	56.00
60.00	06000 LABORATORY	0	0		0 0	0 0	60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0	0		0 0	0 0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0 0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0		65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0		68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0 0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.00
76.00	03020 CARDI AC REHAB	0	0		0 0	0 0	76.00
76.01	03030 ADDI CTI ON SERVI CES	0	0		0 0	0 0	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0 0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0 0	78.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
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	88.03
88.04	08803 RURAL HEALTH CLINIC V	0	0		0 0	0	88.04
88.05	08804 RURAL HEALTH CLINIC VI	0	0		0 0	0	88.05
90.00	09000 CLINIC	0	0		0 0	0	90.00
90.01	09001 ONCOLOGY	0	0		0 0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0		0 0	0	90.02
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0	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	0 0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		II TY HOSPI TAL SS Provi der C	CN: 15 0061	Do	ri od:	u of Form CMS- Worksheet D	2002 1
THROUGH COSTS	KVICE UINEK PAS	S PIOVIDEI C	CN. 15-0001		om 01/01/2023	Part IV	
		Component	CCN: 15-T061	То		Date/Time Pre 5/31/2024 9:2	epared: 20 am
		Title	e XVIII	S	ubprovider - IRF	PPS	
Cost Center Description	All Other	Total Cost	Total	٦		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)	cols. 2, 3,		col. 8)	col. 7)	
			and 4)			(see	
						instructions)	
	4.00	5.00	6.00		7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			1		10.05(770	0.00000	1 50 00
50. 00 05000 OPERATING ROOM	0	-		0	13, 856, 778	0.00000	
51.00 05100 RECOVERY ROOM	0	-		0	1 177 754	0.00000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	1, 177, 754	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	23, 481, 565	0.00000	
56. 00 05600 RADI 0I SOTOPE	0	0		0	6, 098, 034	0. 000000	
60. 00 06000 LABORATORY	0	0		0	19, 936, 999	0.00000	
63. 00 06300 BLOOD STORING PROCESSING & TRANS.	0	0		0	582, 479	0.00000	
54.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0.00000	
65. 00 06500 RESPIRATORY THERAPY	0	0		0	4, 668, 430	0.00000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0	6, 515, 110	0.00000	
67. 00 06700 OCCUPATI ONAL THERAPY	0			0	3, 190, 992	0.00000	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0			0	868,070	0. 000000 0. 000000	
	0			0	1,041,396	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	8, 596, 341	0. 000000	
73.00 07200 DRUGS CHARGED TO PATIENTS	0			0	1, 792, 000 18, 067, 724	0. 000000	
75. 00 07300 DR0GS CHARGED TO PATTENTS 76. 00 03020 CARDI AC REHAB	0	0		0	490, 266	0. 000000	
76. 01 03020 ADDI CTI ON SERVI CES	0	0		0	81, 092	0. 000000	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0	01, 042	0. 000000	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	0. 000000	
OUTPATIENT SERVICE COST CENTERS	0	0		U	Ч	0.000000	/0.0
B8. 00 08800 RURAL HEALTH CLINIC	0	0		0	1, 186, 590	0. 000000	88.00
38. 01 08801 RURAL HEALTH CLINIC II	0	-		0	504, 987	0. 000000	
38. 02 08802 RURAL HEALTH CLINIC III	0			0	2, 457, 559	0. 000000	
38. 03 08805 RURAL HEALTH CLINIC IV	0	0		0	2, 10, 700,	0. 000000	
38. 04 08803 RURAL HEALTH CLINIC V	0	0		0	2, 088, 347	0. 000000	
38. 05 08804 RURAL HEALTH CLINIC VI	0	0		0	791, 460	0. 000000	
20. 00 09000 CLINIC	0	0		0	2, 142, 852	0. 000000	
20. 01 09001 0NC0L0GY	0	l o		0	1, 138, 274	0. 000000	
PO. 02 09002 PALN MANAGEMENT	0	0		0	0	0.000000	
91.00 09100 EMERGENCY	0	0		0	19, 247, 416	0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	3, 744, 756	0.000000	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0		0	896, 680	0.000000	
OTHER REIMBURSABLE COST CENTERS							1
95. 00 09500 AMBULANCE SERVICES							95.00
200.00 Total (lines 50 through 199)	0	0		0	144, 643, 951		200.00

	Financial Systems ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	DAVIESS COMMUNI	Provi der C	CN: 15 0061	Peri od:	u of Form CMS-2 Worksheet D	2002 1
FHROUGH		VICE UINER PASS	Provider C	CN. 15-0001	From 01/01/2023	Part IV	
INKUUGN	0313			CCN: 15-T061	To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
			Title	× XVIII	Subprovider -	PPS	_
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug	5	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	
	ANCI LLARY SERVICE COST CENTERS			1			
	D5000 OPERATING ROOM	0. 000000	412		0 0	0	50.00
	D5100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
	D5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	83, 861		0 0	0	54.0
	D5600 RADI OI SOTOPE	0. 000000	8, 478		0 0	0	56.0
	06000 LABORATORY	0. 000000	151, 831		0 0	0	60.0
	D6300 BLOOD STORING PROCESSING & TRANS.	0. 000000	14, 506		0 0	0	63.0
	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.0
	06500 RESPI RATORY THERAPY	0. 000000	577, 648		0 0	0	65.0
	06600 PHYSI CAL THERAPY	0. 000000	634, 224		0 0	0	66.0
57.00 C	06700 OCCUPATI ONAL THERAPY	0. 000000	539, 008		0 0	0	67.0
	06800 SPEECH PATHOLOGY	0. 000000	116, 842		0 0	0	68.0
59.00 C	06900 ELECTROCARDI OLOGY	0. 000000	7, 205		0 0	0	69.0
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	118, 319		0 0	0	71.0
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.0
73.00 0	07300 DRUGS CHARGED TO PATIENTS	0. 000000	227, 876		0 0	0	73.0
76.00 0	D3020 CARDI AC REHAB	0. 000000	0		0 0	0	76.0
76.01 0	D3030 ADDICTION SERVICES	0. 000000	0		0 0	0	76.0
77.00 0	D7700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.0
78.00 0	D7800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78.0
C	DUTPATIENT SERVICE COST CENTERS						
38.00 C	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.0
	08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.0
	08802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88.0
38. O3 🛛	08805 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	0	88.0
	08803 RURAL HEALTH CLINIC V	0. 000000	0		0 0	0	88.0
	08804 RURAL HEALTH CLINIC VI	0. 000000	0		0 0	0	88.0
	09000 CLINIC	0. 000000	0		0 0	0	90.0
	09001 ONCOLOGY	0. 000000	0		0 0	0	90.0
	09002 PAIN MANAGEMENT	0. 000000	0		0 0	0	90.0
	09100 EMERGENCY	0. 000000	57, 140		0 0	0	91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.0
	04040 OTHER OUTPATIENT SERVICE COST CENTE	0. 000000	0		0 0	0	93.0
	OTHER REIMBURSABLE COST CENTERS	-		1			
	09500 AMBULANCE SERVI CES						95.0
200.00	Total (lines 50 through 199)		2, 537, 350		0 0	0	200.0

APPORTIONMENT OF MEDICAL, OTHER HEALTH S	ERVICES AND VACCINE COST	Provider C	CN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre 5/31/2024 9:2	epared: 20 am
		. Ti tl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	0.000///		000.05		0	50.00
50.00 05000 OPERATING ROOM	0. 328668				0	1
51.00 05100 RECOVERY ROOM	0. 00000			0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 097283				0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 107282				0	
56. 00 05600 RADI 0I SOTOPE	0. 215730				0	
60. 00 06000 LABORATORY	0. 192654				0	
63.00 06300 BLOOD STORING PROCESSING &			-,		0	
64.00 06400 INTRAVENOUS THERAPY	0. 00000			0 0	0	64.00
65.00 06500 RESPI RATORY THERAPY	0. 255160				0	
66.00 06600 PHYSI CAL THERAPY	0. 32255				0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 22438				0	
68.00 06800 SPEECH PATHOLOGY	0. 393590				0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 129659				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO					0	
72.00 07200 IMPL. DEV. CHARGED TO PATIEN			00,00		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 328660				0	
76.00 03020 CARDI AC REHAB	0. 616814				0	1
76.01 03030 ADDI CTI ON SERVI CES	5. 311732				0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			0 0	0	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0.00000	0 0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS			1			
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 CLINIC	0. 374090				0	
90. 01 09001 ONCOLOGY	0. 548690		20,00		0	
90. 02 09002 PAIN MANAGEMENT	0. 000000			0 0	0	
91.00 09100 EMERGENCY	0. 338482				0	
92.00 09200 OBSERVATION BEDS (NON-DISTIN					0	
93.00 04040 OTHER OUTPATIENT SERVICE COS	T CENTE 1. 16814	5 (21, 16	01 0	0	93.00
OTHER REIMBURSABLE COST CENTERS		1	T	1		
95.00 09500 AMBULANCE SERVICES	0. 829314			0		95.00
200.00 Subtotal (see instructions)	_	0	2, 715, 76		0	200.00
201.00 Less PBP Clinic Lab. Service	s-Program			0 0		201.00
Only Charges	1	1	1	1		1
202.00 Net Charges (line 200 - line	224)		2, 715, 76	04 0	-	202.00

APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CC	CN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepar 5/31/2024 9:20 a	ared:
			Titl	e XIX	Hospi tal	Cost	
		Cost	ts				
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. I (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	D5000 OPERATING ROOM	92, 965	0			50	50.00
51.00	D5100 RECOVERY ROOM	0	0			51	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	8, 017	0			5.	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	53, 353	0			54	54.00
	D5600 RADI OI SOTOPE	28, 605	0			50	56.00
	D6000 LABORATORY	73, 185	0			60	60.00
	D6300 BLOOD STORING PROCESSING & TRANS.	180	0			63	63.00
	06400 I NTRAVENOUS THERAPY	0	0			64	64.00
	06500 RESPI RATORY THERAPY	13, 102	0				65.00
	D6600 PHYSI CAL THERAPY	41, 457	0				66.00
	06700 OCCUPATI ONAL THERAPY	12, 264	0				67.00
	D6800 SPEECH PATHOLOGY	5, 865	0				68.00
	D6900 ELECTROCARDI OLOGY	2, 555	0				69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	54, 764	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	15, 044	0				72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC REHAB	114, 304	0				73.00 76.00
	D3020 CARDI AC REHAB D3030 ADDI CTI ON SERVI CES	7, 138 10, 029	0				76.00 76.01
	D7700 ALLOGENEIC HSCT ACQUISITION	10, 029	0				77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0				77.00 78.00
	DUTPATIENT SERVICE COST CENTERS	0	0			/	0.00
	D8800 RURAL HEALTH CLINIC					8	88.00
	08801 RURAL HEALTH CLINIC II						88.01
	08802 RURAL HEALTH CLINIC III						88.02
	08805 RURAL HEALTH CLINIC IV						88. 03
88.04	D8803 RURAL HEALTH CLINIC V					8/	88. 04
88.05	08804 RURAL HEALTH CLINIC VI					8/	88. 05
	29000 CLINIC	18, 922	0			90	90.00
90.01	D9001 ONCOLOGY	14, 739	0			90	90.01
90.02	D9002 PAIN MANAGEMENT	0	О			90	90. 02
	D9100 EMERGENCY	140, 396	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	34, 106	0				92.00
	04040 OTHER OUTPATIENT SERVICE COST CENTE	24, 719	0			9:	93.00
	OTHER REIMBURSABLE COST CENTERS	,					
	09500 AMBULANCE SERVI CES	0					95.00
200.00	Subtotal (see instructions)	765, 709	0				00.00
201.00	Less PBP Clinic Lab. Services-Program	0				201	01.00
	Only Charges		I			I	

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	epare
		Title XVIII	Hospi tal	5/31/2024 9: 2 PPS	20 an
	Cost Center Description		- Hoopi tai	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			3, 355	
00	Inpatient days (including private room days, excluding swing-		riveta reem deve	3, 355	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation b			1, 869	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decemb	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5.			
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excludin	g swing-bed and	590	9
00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
~ ~	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
~~	through December 31 of the cost reporting period				1 4 9
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	res after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction)		3, 617, 894	21
	Swing-bed cost applicable to SNF type services through Decemb	<i>,</i>	ting period (line		
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24
~~	7 x line 19)	04			0
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 617, 894	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)		nur ges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	3, 617, 894	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see	•		1,078.36	
. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	2 38)		1, 078. 36 636, 232 0	39

MPUTATION OF INPATIENT OPERATING COST		TY HOSPITAL Provider C		Period:	u of Form CMS- Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
			× XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost	Inpati ent	Diem (col. 1 ÷ col. 2)		(col. 3 x	
	1.00	Days 2.00	3.00	4.00	<u>col.4)</u> 5.00	
. 00 NURSERY (title V & XIX only)	0	0				42.
Intensive Care Type Inpatient Hospital Uni		0	0.0	0 0	0	72.
. OO INTENSIVE CARE UNIT	1, 414, 289	574	2, 463. 9	2 238	586, 413	43.
. OO CORONARY CARE UNI T	.,,		_,			44.
. OO BURN INTENSIVE CARE UNIT						45.
. OO SURGICAL INTENSIVE CARE UNIT						46.
. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3,	line 200)			1, 526, 344	48.
.01 Program inpatient cellular therapy acquisi			III, line 10	column 1)	0	
.00 Total Program inpatient costs (sum of line					2, 748, 989	49.
PASS THROUGH COST ADJUSTMENTS						
.00 Pass through costs applicable to Program i	npatient routine s	services (fro	m Wkst. D, sur	m of Parts I and	84, 968	50.
111)						
.00 Pass through costs applicable to Program i	npatient ancillary	y services (f	rom Wkst. D, s	sum of Parts II	92, 657	51.
and IV)	c EO and E1				177 /05	EO
.00 Total Program excludable cost (sum of line .00 Total Program inpatient operating cost exc		atod non sh	veleian anost	notict and	177, 625 2, 571, 364	
medical education costs (line 49 minus lin	5 1	ated, non-pr	ysician anesti	netist, and	2, 571, 304	53.
TARGET AMOUNT AND LIMIT COMPUTATION	U JZJ					1
. 00 Program di scharges					0	54.
.00 Target amount per discharge					0.00	
.01 Permanent adjustment amount per discharge					0.00	55.
.02 Adjustment amount per discharge (contracto	r use only)				0.00	55.
.00 Target amount (line 54 x sum of lines 55,					0	56.
.00 Difference between adjusted inpatient oper	ating cost and tai	rget amount (line 56 minus	line 53)	0	57.
00 Bonus payment (see instructions)	0	0		,	0	58.
00 Trended costs (lesser of line 53 ÷ line 54	, or line 55 from	the cost rep	orting period	endi ng 1996,	0.00	59.
updated and compounded by the market baske						
.00 Expected costs (lesser of line 53 ÷ line 5	4, or line 55 from	m prior year	cost report, v	updated by the	0.00	60.
market basket)						1.1
.00 Continuous improvement bonus payment (if l 55.01, or line 59, or line 60, enter the l 53) are less than expected costs (lines 54	esser of 50% of th	ne amount by	which operati	ng costs (line	0	61.
enter zero. (see instructions)						
.00 Relief payment (see instructions)					0	
. 00 Allowable Inpatient cost plus incentive pa	yment (see instruc	ctions)			0	63.
PROGRAM INPATIENT ROUTINE SWING BED COST	anta thursuph Danas					1
.00 Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts through Decer	nder 31 of th	a cost report	ing period (see	0	64.
. 00 Medicare swing-bed SNF inpatient routine c	osts after Decembe	er 31 of the	cost reportin	a period (See	0	65.
instructions) (title XVIII only)			sost reporting	g period (See	0	0.00.
. 00 Total Medicare swing-bed SNF inpatient rou	tine costs (line d	64 plus line	65)(title XVI	ll only): for	0	66.
CAH, see instructions				<i></i>		
.00 Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31	of the cost r	eporting period	0	67.
(line 12 x line 19)						1
.00 Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	ine costs after De	ecember 31 of	the cost rep	orting period	0	68.
00 Total title V or XIX swing-bed NF inpatien	t routine costs (I	ine 67 + lin	e 68)		0	69.
PART III - SKILLED NURSING FACILITY, OTHER						1
00 Skilled nursing facility/other nursing fac)		70
00 Adjusted general inpatient routine service		ne 70 ÷ line	2)			71
00 Program routine service cost (line 9 x lin						72
00 Medically necessary private room cost appl						73
00 Total Program general inpatient routine se	•					74
00 Capital-related cost allocated to inpatien	τ routine service	costs (from	worksheet B, I	Part II, column		75
26, line 45) 00 Per diem capital related costs (line 75 ÷	line 2)					76
00 Per diem capital-related costs (line 75 ÷ 00 Program capital-related costs (line 9 x li						77
00 Inpatient routine service cost (line 74 mi						78
00 Aggregate charges to beneficiaries for exc		rovi den inecom	ds)			79
00 Total Program routine service costs for co				nus line 79)		80
00 Inpatient routine service costs for co	•					81
00 Inpatient routine service cost per dreim 11)				82
00 Reasonable inpatient routine service cost	·					83
00 Program inpatient ancillary services (see		-,				84
00 Utilization review - physician compensatio		ns)				85
00 Total Program inpatient operating costs (s						86
PART IV - COMPUTATION OF OBSERVATION BED PART					1	1
.00 Total observation bed days (see instructio					1, 486	87
		line 2)			1,078.36	

Health Financial Systems	DAVIESS COMMUN	I TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 602, 443	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	296, 756	3, 617, 894	0. 08202	1, 602, 443	131, 440	90.00
91.00 Nursing Program cost	0	3, 617, 894	0.00000	1, 602, 443	0	91.00
92.00 Allied health cost	0	3, 617, 894	0.0000	1, 602, 443	0	92.00
93.00 All other Medical Education	0	3, 617, 894	0.0000	1, 602, 443	0	93.00

Heal th	Financial Systems DAVIESS COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUT		Provider CCN: 15-0061 Component CCN: 15-SO61	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	
		Title XVIII	Subprovider - IPF	5/31/2024 9: 20 PPS	<u>0 am</u>
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	, excluding newborn)		3, 864	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing-b Private room days (excluding swing-bed and observation bed day do not complete this line.	ivate room days,	3, 864 0	2.00 3.00	
4.00 5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period	5 /	er 31 of the cost	3, 864 0	4.00 5.00
6.00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	5.		0	8.00
9.00	Total inpatient days including private room days applicable to newborn days) (see instructions)	0 1 0		3, 064	9.00
10. 00 11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on	i ons)	5 /	0	10.00 11.00
12.00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX	ter 0 on this line)		0	12.00
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	5 . 51	5 /	0	13.00
14.00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	s through December 31 c	of the cost	0.00	17.00
18.00	5				
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe $5 \times 1 \text{ ine } 17$)		ing period (line	3, 439, 710 0	21.00 22.00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportir	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20) $$	1 of the cost reporting	period (line 8	0	25.00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		0 3, 439, 710	26.00 27.00
28.00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1.1		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	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	up Line 22) (!!	ti ana)	0.00	
34.00	Average per diem private room charge differential (line 32 min		u ons)	0.00	
35.00	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	nd private room cost di	fferential (line	0 3, 439, 710	36.00 37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	CTMENTO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		Г	000 10	20.00
	Adjusted general inpatient routine service cost per diem (see	-		890.19	38.00
39.00 40.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra			2, 727, 542 0	39.00 40.00
	Total Program general inpatient routine service cost (line 39			2, 727, 542	
- I . OO	Total Trogram general inpatient fourthe service cost (THE 37		I	2, 121, 342	-1.00

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	DAVIESS COMMUN		CN: 15-0061	Period:	u of Form CMS- Worksheet D-1	
			Component	CCN: 15-S061	From 01/01/2023 To 12/31/2023		epared
			•	e XVIII	Subprovi der -	5/31/2024 9:2 PPS	
					I PF	PP3	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	lnpatient Days	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0	(0.	0 00	0	42.0
3.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			0.		0	43.0
4.00	CORONARY CARE UNIT	0	· · · · ·	0.1			44.0
5.00	BURN INTENSIVE CARE UNIT						45.0
5.00	SURGICAL INTENSIVE CARE UNIT						46.0
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
						1.00	
3.00	Program inpatient ancillary service cost (W	kst. D-3, col. 3	3, line 200)	LLL Line 10) oolumn 1)	776, 651	
3.01 9.00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines), column I)	0 3, 504, 193	
. 00	PASS THROUGH COST ADJUSTMENTS	TT through to: c				0,001,170	
0. 00	Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D, su	um of Parts I and	175, 966	50.
1.00	<pre>III) Pass through costs applicable to Program inp</pre>	nationt ancillar	y services (f	rom Wkst D	sum of Parts II	34, 411	51.
1.00	and IV)		y services (i	TOIL WKSt. D,	Sum of Farts II	34,411	51.
2.00	Total Program excludable cost (sum of lines					210, 377	
3.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anest	hetist, and	3, 293, 816	53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
1.00						0	54.
6.00	Target amount per discharge					0.00	
. 01 . 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor					0.00	
. 02	Target amount (line 54 x sum of lines 55, 55					0.00	
. 00	Difference between adjusted inpatient operation			line 56 minus	s line 53)	0	
. 00	Bonus payment (see instructions)					0	
0. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		n the cost rep	orting period	l endi ng 1996,	0.00	59.
. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)		om prior year	cost report,	updated by the	0.00	60.
1.00	Continuous improvement bonus payment (iflin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	sser of 50% of t	he amount by	which operati	ng costs (line	0	61.
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.
B. 00	Allowable Inpatient cost plus incentive payr	ment (see instru	ıcti ons)			0	
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ste through Doc	mbor 21 of th	a cost roport	ing poriod (Soo	0	64.
. 00	instructions) (title XVIII only)	sts through bece		e cost report	ing period (see		04.
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	per 31 of the	cost reportir	ng period (See	0	65.
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66.
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31	of the cost r	reporting period	0	67.
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin (line 12 x line 20)	ne costs after [ecember 31 of	the cost rep	oorting period	0	68.
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.
. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	itine service	cost (line 37	')		70.
00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.
00 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		line 14 v l	ine 35)			72.
00	Total Program general inpatient routine serv						74.
00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B,	Part II, column		75.
00	Per diem capital -related costs (line 75 ÷ li						76.
00 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.
00	Aggregate charges to beneficiaries for exces		orovider recor	ds)			79.
00	Total Program routine service costs for comp	parison to the c			nus line 79)		80.
00	Inpatient routine service cost per diem limi)				81.
00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs						82.
00	Program inpatient ancillary services (see in	•					84.
. 00	Utilization review - physician compensation	(see instruction					85.
. 00	Total Program inpatient operating costs (sur		nrough 85)				86.
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S INKUUGH CUSI					1

Health Financial Systems	DAVIESS COMMUN	I TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2023	Worksheet D-1	
		Component C	CN: 15-S061	To 12/31/2023		
		Title	XVIII	Subprovider - IPF	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	221, 901	3, 439, 710	0. 06451	2 0	0	90.00
91.00 Nursing Program cost	0	3, 439, 710	0.0000	0 0	0	91.00
92.00 Allied health cost	0	3, 439, 710	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	3, 439, 710	0.0000	0 0	0	93.00

		Component CCN: 15-TO61	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
		Title XVIII	Subprovider - IRF	PPS	<u> </u>
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		1, 344	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days do not complete this line.	rivate room days,	1, 344 0	2.00 3.00	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room reporting period	er 31 of the cost	1, 344 0	4.00 5.00	
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8.00
9. 00 10. 00	Total inpatient days including private room days applicable to newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII onl	0 1 0		1, 119 0	9.00 10.00
11.00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII on	ons)	<u> </u>	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX $$		te room days)	0	12.00
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13.00
14.00 15.00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)			0 0	14.00 15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to services reporting period	Ū.			17.00
18.00 19.00	Medicare rate for swing-bed SNF services applicable to services reporting period Medicaid rate for swing-bed NF services applicable to services			0.00	18.00 19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to services	5		0.00	
21.00	reporting period Total general inpatient routine service cost (see instructions)			1, 695, 408	
22.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 3 x line 18) Swing-bed cost applicable to NF type services through December			0	23.00 24.00
25.00	7×1 ine 19) Swing-bed cost applicable to NF type services after December 31		3 T X	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 (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			1, 695, 408	27.00
28.00 29.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cr	harges)	0	28.00 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 \div	line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	ic line 22) (cas instant	ations)	0.00	
34.00	Average per diem private room charge differential (line 32 minu		ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	5 31)		0.00	35.00 36.00
38.00 37.00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	nd private room cost di	fferential (line	1, 695, 408	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00 6-	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		1		0.0.0
	Adjusted general inpatient routine service cost per diem (see i	-		1, 261. 46	
	Program general inpatient routine service cost (line 9 x line 3	38 <i>)</i>		1, 411, 574	39.00
39.00 40.00	Medically necessary private room cost applicable to the Program	$(1100 14 \times 11 - 05)$		0	40.00

JMPUI	ATION OF INPATIENT OPERATING COST	DAVIESS COMMUN		CCN: 15-0061	Period:	worksheet D-1	
				CCN: 15-T061	From 01/01/2023 To 12/31/2023		
			•	e XVIII	Subprovi der -	5/31/2024 9:2	
					I RF	PPS	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0		0.	0 00	0	42.0
3. 00	Intensive Care Type Inpatient Hospital Unit: INTENSIVE CARE UNIT	s 0		0.0	0 00	0	43.0
4.00	CORONARY CARE UNIT						44.0
5.00	BURN INTENSIVE CARE UNIT						45.0
6.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY)						46.0
7.00	Cost Center Description						47.0
2 00	Description that and the second second (W		2 11 == 200			1.00	10 (
8.00 8.01	Program inpatient ancillary service cost (W Program inpatient cellular therapy acquisit	ion cost (Workst	3, TINE 200) Neet D-6 Part	III line 10) column 1)	697, 719 0	
9.00	Total Program inpatient costs (sum of lines				, oor ami'r 1)	2, 109, 293	
	PASS THROUGH COST ADJUSTMENTS		1		C. D I I	101 (/0	50
0. 00	Pass through costs applicable to Program in	patient routine	services (fro	om Wkst. D, si	im of Parts I and	131, 662	50.0
1. 00	Pass through costs applicable to Program in	patient ancillar	ry services (1	From Wkst. D,	sum of Parts II	52, 845	51.0
2 00	and IV)	EQ and E1				104 507	50
2.00 3.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		elated. non-pr	ivsi ci an anest	hetist. and	184, 507 1, 924, 786	
	medical education costs (line 49 minus line				,		
4.00	TARGET AMOUNT AND LIMIT COMPUTATION						
4.00 5.00	Program discharges Target amount per discharge					0.00	
5. 01	Permanent adjustment amount per discharge					0.00	
. 02	Adjustment amount per discharge (contractor					0.00	
. 00 . 00	Target amount (line 54 x sum of lines 55, 5 Difference between adjusted inpatient opera			lino E4 minus	Lino E2)	0	
. 00	Bonus payment (see instructions)	ting cost and ta	arget anount i		s TTHE 55)	0	
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period	l endi ng 1996,	0.00	
. 00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54		m prior voar	cost roport	undated by the	0.00	60.
. 00	market basket) Continuous improvement bonus payment (if li			•		0.00	
1.00	55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54	sser of 50% of t	the amount by	which operati	ng costs (line		
	enter zero. (see instructions)		the target t				
2.00	Relief payment (see instructions)					0	
3.00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	uctions)			0	63.
4.00	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of th	ne cost report	ing period (See	0	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decemb	per 31 of the	cost reportir	na period (See	0	65.
7. 00	instructions)(title XVIII only)						00.
5.00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66.
7.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routi	ne costs through	n December 31	of the cost r	eporting period	0	67.
2 00	(line 12 x line 19)	no opoto often [December 21 of	the east war	anting pariod	0	40
8.00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)				orting period		
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER I	NURSING FACILITY	, AND ICF/IID	ONLY		0	
0.00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service				")		70.
1.00 2.00	Program routine service cost (line 9 x line			- <i>L</i>)			72.
8.00	Medically necessary private room cost appli	cable to Program					73.
. 00 . 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient	•		,	Part II, column		74. 75.
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76.
. 00	Program capital -related costs (line 9 x lin						77.
. 00	Inpatient routine service cost (line 74 min	us line 77)					78.
. 00	Aggregate charges to beneficiaries for exce				pup Line 70)		79.
. 00 . 00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	cost fimitatio	on (IINe 78 mi	nus line /9)		80.
. 00	Inpatient routine service cost per drem from		1)				82
. 00	Reasonable inpatient routine service costs	(see instruction					83.
. 00	Program inpatient ancillary services (see i						84.
		ISPA INSTRUCTIO				1	85.
5.00	Utilization review - physician compensation Total Program inpatient operating costs (su	•					86.

Health Financial Systems	DAVIESS COMMUN	ILTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2023	Worksheet D-1	
		Component (CCN: 15-T061	To 12/31/2023		
		Title	XVIII	Subprovider - IRF	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	158, 129	1, 695, 408	0. 09326	59 0	0	90.00
91.00 Nursing Program cost	0	1, 695, 408	0.0000	0 0	0	91.00
92.00 Allied health cost	0	1, 695, 408	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	1, 695, 408		0 0	0	93.00
				•		

	Financial Systems DAVLESS COMMUNITY ATLON OF INPATIENT OPERATING COST	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet D-1 Date/Time Pre 5/31/2024 9:20	pare
		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		3, 355	1 1.
00	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			3, 355	2.
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(aveb bec		1, 869	4
00	Total swing-bed SNF type inpatient days (including private ro	5,	er 31 of the cost	1,007	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roc	om days) through Decembe	r 31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excludin	a swina-bed and	89	9
	newborn days) (see instructions)	0	0 0		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	/ear, enter O on this li	ne)		
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0 886	
	Nursery days (title V or XIX only)				16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
~~	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter becember 31 or	the cost	0.00	20
	Total general inpatient routine service cost (see instruction			3, 617, 894	21
. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
	x line 18)			-	
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
	x line 20)		5 1 1		
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 3, 617, 894	26
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 III Hus TTHE 20)		3,017,074	21
	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	30
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		ctions)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	3, 617, 894	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				ł
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 078. 36	
	Program general inpatient routine service cost (line 9 x line Medically persent private room cost applicable to the Progr			95, 974 0	39 40
111	Medically necessary private room cost applicable to the Progr	am (TITHE 14 X TITHE 35)		0	I 40

	ATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-	-2552-1 1
					From 01/01/2023 To 12/31/2023	Date/Time Pr	epared
						5/31/2024 9:	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	866, 218	886	977.6	7 78	76, 25	8 42.0
3.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 414, 289	574	2, 463. 92	2 24	59, 13	4 43.0
	CORONARY CARE UNIT	1, 414, 209	574	2,403.9.	2 24	59, 15	4 43.0
	BURN INTENSIVE CARE UNIT					1	45.0
	SURGI CAL I NTENSI VE CARE UNI T					1	46.0
7.00	OTHER SPECIAL CARE (SPECIFY)			L			47.0
	Cost Center Description					1.00	+
8.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			288, 73	7 48.0
8. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	eet D-6, Part		column 1)		0 48.0
9.00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instruc	ctions)		520, 10	3 49.0
0 00	PASS THROUGH COST ADJUSTMENTS	ationt routing	oorulooo (from	m Wkot D oum	of Dorto L and		
0.00	Pass through costs applicable to Program inp III)	attent routine	services (IIO	I WKSL. D, SUN	TOT Parts I and		0 50.0
1.00	Pass through costs applicable to Program inp	atient ancillar	y services (fi	rom Wkst. D, s	sum of Parts II		0 51.0
	and IV)		•			1	
2.00	Total Program excludable cost (sum of lines		lated act of		notict and		0 52.0
3.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line	5 1	rateu, non-phy	ysician anestr	ietist, and		0 53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
4.00	Program di scharges						0 54.0
5.00	Target amount per discharge					0.0	
	Permanent adjustment amount per discharge					0.0	
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.0	0 55. 0 56.
	Difference between adjusted inpatient operat		rget amount (l	ine 56 minus	line 53)		0 50.
3.00	Bonus payment (see instructions)	ing cost and ta	i got amount (i				0 58.
9.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	endi ng 1996,	0.0	0 59.
	updated and compounded by the market basket)						
0.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	m prior year o	cost report, u	ipdated by the	0.0	60.0
1.00	Continuous improvement bonus payment (if lin	e 53 ÷ line 54	is less than t	the lowest of	lines 55 plus		0 61.0
	55.01, or line 59, or line 60, enter the les					1	-
	53) are less than expected costs (lines 54 ${\rm x}$	60), or 1 % of	the target ar	nount (line 56	o), otherwise	1	
2.00	enter zero. (see instructions)					1	0 62.0
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				0 63.0
	PROGRAM INPATIENT ROUTINE SWING BED COST	•					
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See		0 64.0
F 00	instructions)(title XVIII only)	to ofter Decemb	on 21 of the	ant conceting	n nortiad (Coo	1	0 65.0
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb		Jost reporting	, period (see		0 65.0
6.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	l only); for	l .	0 66.0
	CAH, see instructions		•	, ,	5,		
7.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost re	porting period		0 67.0
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs after D	ocombor 21 of	the cost rong	orting poriod	1	0 68.0
0.00	(line 13 x line 20)		ecember 31 01	the cost repo	in thing period		0 00.0
9.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)			0 69.0
	PART III - SKILLED NURSING FACILITY, OTHER N						
0.00	Skilled nursing facility/other nursing facil	2		• •		1	70.
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line			<u>~)</u>		1	71.
	Medically necessary private room cost applic		(line 14 x li	ne 35)			73.
	Total Program general inpatient routine serv						74.
5.00	Capital-related cost allocated to inpatient	routine service	costs (from W	Norksheet B, F	art II, column'	1	75.
00	26, line 45) Per diam capital related costs (line 75 , li	no 2)				1	74
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.
. 00	Inpatient routine service cost (line 74 minu						78.
. 00	Aggregate charges to beneficiaries for exces	s costs (from p				1	79.
. 00	Total Program routine service costs for comp		ost limitation	ו (line 78 mir	nus line 79)	1	80.
. 00	Inpatient routine service cost per diem limi		`			1	81.
2.00 3.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 83.
1.00	Program inpatient ancillary services (see in		<i></i>			1	83.
	Utilization review - physician compensation		ns)			1	85.
5.00							86.
5.00 6.00	Total Program inpatient operating costs (sum	<u>or lines 83 th</u>	rougn 85)				
6.00	PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions	S THROUGH COST	rougn 85)			1, 48	

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	pared: 0 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 602, 443	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	296, 756	3, 617, 894	0. 08202	1, 602, 443	131, 440	90.00
91.00 Nursing Program cost	0	3, 617, 894	0.00000	1, 602, 443	0	91.00
92.00 Allied health cost	0	3, 617, 894	0.0000	1, 602, 443	0	92.00
93.00 All other Medical Education	0	3, 617, 894	0.00000	1, 602, 443	0	93.00

DMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-S061	In Lieu Period: From 01/01/2023 To 12/31/2023	5/31/2024 9:2	parec
	Cost Conton Decorintian	Title XIX	Subprovider -	Cost	
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS				-
	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		3, 864	1.
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		3, 864	2.
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only p	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		3, 864	4.
	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0,004	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7.
	reporting period			Ū	
00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	a swing-bed and	0	9.
	newborn days) (see instructions)			0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.
. 00	December 31 of the cost reporting period (if calendar year, e		room days) arter	0	' '
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
00	through December 31 of the cost reporting period		+	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	5 (51	<i>,</i>	0	13.
. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14
. 00	Total nursery days (title V or XIX only)			886	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			78	16.
	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17.
00	reporting period		++	0.00	10
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es al ter December 31 01	the cost	0.00	18.
. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0.00	19
00	reporting period	c ofter December 21 of	the cost	0.00	20
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 01	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	s)		3, 439, 710	21
. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na period (line A	0	23
	x line 18)	of the cost report		0	20
. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25
	x line 20)			-	
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)	l	3, 439, 710	27
	General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28
-	Private room charges (excluding swing-bed charges)		-	0	
	Semi-private room charges (excluding swing-bed charges)	Line 29)		0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- 1111e 20)		0.000000	
	Average semi-private room per diem charge (line 2) + line 3)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line		
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			-
	Adjusted general inpatient routine service cost per diem (see			890.19	38
. 00	Program general inpatient routine service cost (line 9 x line	38)		0	
	Medically necessary private room cost applicable to the Progr			0	
. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		0	4

OMPUT	ATION OF INPATIENT OPERATING COST	DAVIESS COMMUN		CCN: 15-0061	Period:	u of Form CMS- Worksheet D-1	
			Component	CCN: 15-S061	From 01/01/2023 To 12/31/2023	Date/Time Pre	epare
				le XIX	Subprovider -	5/31/2024 9:2 Cost	20 am
					I PF		
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0		0 0.	00 00	0	42.
~~	Intensive Care Type Inpatient Hospital Units					0	1 40
. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0		0.	00 0	0	43.
. 00	BURN INTENSIVE CARE UNIT						44
. 00	SURGI CAL I NTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			32, 873	48
. 01	Program inpatient cellular therapy acquisiti			t III, line 10), column 1)	0	
00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instru	uctions)		32, 873	49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	convious (fr	m Wkat D a	m of Dorto L one	0	1 50
. 00	The program representation of the pr	atient routine	Services (11)	JIII WKSL. D, SL	in of Parts Fand	0	50
. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (*	from Wkst. D,	sum of Parts II	0	51
<i>.</i> .	and IV)						
. 00	Total Program excludable cost (sum of lines					0	
. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		erateu, non-pi	iysi cran anesi	netist, and	0	53
	TARGET AMOUNT AND LIMIT COMPUTATION	~_/					1
. 00	Program discharges					0	
. 00	Target amount per discharge					0.00	
. 01 . 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor					0. 00 0. 00	
002	Target amount (line 54 x sum of lines 55, 55)			0.00	
00	Difference between adjusted inpatient operat			(line 56 minus	sline 53)	0	
00	Bonus payment (see instructions)	-	-			0	
. 00	Trended costs (lesser of line 53 ÷ line 54,		n the cost re	porting period	l ending 1996,	0.00	59
. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		om prior vear	cost report	undated by the	0.00	60
. 00	market basket)	01 11110 00 110	Sin prior year	0031 1 opoi 1,	apaarea by the	0.00	
. 00	Continuous improvement bonus payment (if lin					0	61
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)		the target a		o), otherwise		
. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of t	ne cost report	ing period (See	0	64
. 00	instructions)(title XVIII only)	tis through bece		le cost report	ing period (see	0	04
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportir	ng period (See	0	65
~~	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	reporting period	0	67
	(line 12 x line 19)	0					
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 o	f the cost rep	orting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lii	ne 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N						
. 00	Skilled nursing facility/other nursing facil				')		70
. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	e 2)			71
. 00 . 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	n (line 14 x)	ine 35)			72
. 00	Total Program general inpatient routine serv	0	•	,			74
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B,	Part II, column		75
00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital-related costs (line 75 ÷ 11 Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces	s costs (from p					79
00	Total Program routine service costs for comp		cost limitatio	on (line 78 mi	nus line 79)		80
. 00	Inpatient routine service cost per diem limi						81
. 00 . 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82
. 00	Program inpatient ancillary services (see in		1 <i>3 j</i>				84
. 00	Utilization review - physician compensation		ons)				85
~ ~	Total Program inpatient operating costs (sum	n of lines 83 th	nrough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS		<i>a</i> ,				

Health Financial Systems	DAVIESS COMMUN	I TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2023	Worksheet D-1	
		Component C		To 12/31/2023		
		Title	e XIX	Subprovider - IPF	Cost	
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	221, 901	3, 439, 710	0. 0645	12 0	0	90.00
91.00 Nursing Program cost	0	3, 439, 710	0.0000	0 00	0	91.00
92.00 Allied health cost	0	3, 439, 710	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	3, 439, 710	0.0000	0 00	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0061 Component CCN: 15-T061	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	pare
		Title XIX	Subprovi der - I RF	5/31/2024 9:2 Cost	<u>'0 am</u>
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	c oveluding nowhern)	1	1 244	1 1.
00	Inpatient days (including private room days, excluding swing- Inpatient days (including private room days, excluding swing-			1, 344 1, 344	
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only p	rivate room days,	0	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period		er 31 of the cost	1, 344 0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private roo reporting period			0	
00 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	5 /		0	
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	0		0	
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o	tions) nly (including private	5 .	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		te room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)		14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only) SWING BED ADJUSTMENT			886 78	15 16
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31	of the cost	0.00	17
00	Medicare rate for swing-bed SNF services applicable to service reporting period			0.00	
00	Medicaid rate for swing-bed NF services applicable to service reporting period Medicaid rate for swing-bed NF services applicable to service	C		0.00	
. 00	reporting period Total general inpatient routine service cost (see instruction		the cost	1, 695, 408	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)				
00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through Decembe			0	
. 00	7×1 ine 19) Swing-bed cost applicable to NF type services after December	·	5 T X	0	
. 00	x line 20) Total swing-bed cost (see instructions)			0	
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be		harges)	1, 695, 408	
00	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00 00	General inpatient routine service cost/charge ratio (line 27 -	÷ line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mil	nus line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	ifferential (line	0 1, 695, 408	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJI		1	1.0/4.//	1
	Adjusted general inpatient routine service cost per diem (see			1, 261. 46 0	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra			0	
. 00					

WPUT	ATION OF INPATIENT OPERATING COST		Provi der (Provider CCN: 15-0061 Period: Erom 01/01/2023			2552 1
			Component	CCN: 15-T061	From 01/01/2023 To 12/31/2023	Date/Time Pre	epare
				le XIX	Subprovider -	5/31/2024 9:2 Cost	20 an
			111		IRF	COST	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpati ent	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
		1.00	Days 2.00	3.00	4.00	5.00	+
. 00	NURSERY (title V & XIX only)	0		0 0.) 42.
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT	0		0.	0 00	0	
. 00 . 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
. 00	SURGI CAL I NTENSI VE CARE UNI T						40
	OTHER SPECIAL CARE (SPECIFY)					l	47
	Cost Center Description						
		-+ D 2 0		-		1.00	10
00 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			t III line 10	column 1)	0	
	Total Program inpatient costs (sum of lines					0	
	PASS THROUGH COST ADJUSTMENTS	······································	.,(
00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, su	m of Parts I and	0	50
00	III)			See		-	
00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (iiom WKST. D,	sum of Parts II	0) 51
00	Total Program excludable cost (sum of lines	50 and 51)				0	52
00	Total Program inpatient operating cost exclu	iding capital re	elated, non-pl	nysician anest	hetist, and	0	
	medical education costs (line 49 minus line	52)	· · ·			L	
00	TARGET AMOUNT AND LIMIT COMPUTATION						
00 00	Program discharges Target amount per discharge					0.00	
00	Permanent adjustment amount per discharge					0.00	
02	Adjustment amount per discharge (contractor	use only)				0.00	
00	Target amount (line 54 x sum of lines 55, 55					0	
00	Difference between adjusted inpatient operat	ing cost and ta	irget amount	(line 56 minus	iline 53)	0	
00	Bonus payment (see instructions)					0	
00	Trended costs (lesser of line $53 \div$ line 54 , updated and compounded by the market basket)		the cost re	borting period	i enui ng 1996,	0.00	59
00	Expected costs (lesser of line 53 ÷ line 54,		om prior year	cost report,	updated by the	0.00	60
	market basket)						
. 00	Continuous improvement bonus payment (if lin					0	61
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)		the target i				
00	Relief payment (see instructions)					0	
00	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			0	0 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of t	ne cost report	ing period (See	0	64
00	instructions)(title XVIII only)	tis through beec			ing period (see	l	/ 04
00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportir	ng period (See	0	65
	instructions)(title XVIII only)					-	
00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVI	II only); for	0) 66
00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67
	(line 12 x line 19)				,	l	
00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 o	f the cost rep	orting period	0	68
00	(line 13 x line 20) Total title V or XIX swing bod NE inpatient	routino costo (20.68)			69
00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	4 09
00	Skilled nursing facility/other nursing facil				')		70
00	Adjusted general inpatient routine service c	ost per diem (l					71
00	Program routine service cost (line 9 x line	,		i			72
00 00	Medically necessary private room cost applic Total Program general inpatient routine serv	0	•	,			73
00	Capital -related cost allocated to inpatient				Part II, column	1	75
-	26, line 45)		(1.1.5)	1	, , ,		
	Per diem capital-related costs (line 75 ÷ li						76
00 00	Program capital - related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provider reco	rds)		1	79
00	Total Program routine service costs for comp				nus line 79)	1	80
00	Inpatient routine service cost per diem limi					1	81
	Inpatient routine service cost limitation (I	ine 9 x line 81					82
00	Reasonable inpatient routine service costs (ıs)				83
	Program inpatient ancillary services (see in	istructi ons)				1	84
00	Ittilization roulow physician	(coo i potent'	nc)				
00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85

Health Financial Systems	DAVIESS COMMUN	ILTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC	CN: 15-0061	Period: From 01/01/2023	Worksheet D-1	
		Component (CCN: 15-T061	To 12/31/2023		
		Title	e XIX	Subprovider - IRF	Cost	
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	158, 129	1, 695, 408	0. 09320	59 0	0	90.00
91.00 Nursing Program cost	0	1, 695, 408	0.0000	0 0	0	91.00
92.00 Allied health cost	0	1, 695, 408	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	1, 695, 408	0.0000	0 0	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0061	Peri od:	Worksheet D-3	3
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epare
	Title	XVIII	Hospi tal	PPS	20 411
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 00 03000 ADULTS & PEDI ATRI CS			509, 592		30.
00 03100 I NTENSI VE CARE UNI T			629, 488		31.
00 04000 SUBPROVIDER - IPF			029,400		40.
00 04100 SUBPROVI DER – I RF			0		41.
00 04300 NURSERY			0		43.
ANCI LLARY SERVI CE COST CENTERS					101
00 05000 OPERATING ROOM		0. 32860	576, 982	189, 636	50.
00 05100 RECOVERY ROOM		0. 00000	0 00	0	51.
00 05200 DELIVERY ROOM & LABOR ROOM		1. 09728	33 0	0	52.
00 05400 RADI OLOGY-DI AGNOSTI C		0. 10728	32 995, 103	106, 757	54.
00 05600 RADI OI SOTOPE		0. 21573	30 192, 896	41, 613	56.
00 06000 LABORATORY		0. 1926		237, 734	60.
00 06300 BLOOD STORING PROCESSING & TRANS.		0. 03120		3, 060	
00 06400 INTRAVENOUS THERAPY		0.0000		0	
00 06500 RESPI RATORY THERAPY		0. 25516			
00 06600 PHYSI CAL THERAPY		0. 3225			
00 06700 OCCUPATI ONAL THERAPY		0. 22438			
00 06800 SPEECH PATHOLOGY		0. 39359			
00 06900 ELECTROCARDI OLOGY		0. 1296			
00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 3633			
00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4198			
00 07300 DRUGS CHARGED TO PATIENTS 00 03020 CARDIAC REHAB		0. 32860			
01 03030 ADDI CTI ON SERVI CES		0. 6168 ⁻ 5. 3117:		-	
00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000			
00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000			
OUTPATIENT SERVICE COST CENTERS		0.00000		0	/ /0
00 08800 RURAL HEALTH CLINIC		0.0000	20	0	88
01 08801 RURAL HEALTH CLINIC II		0.0000		0	88
02 08802 RURAL HEALTH CLINIC III		0.0000		0	88
03 08805 RURAL HEALTH CLINIC IV		0.0000	00	0	88
04 08803 RURAL HEALTH CLINIC V		0.0000	00	0	88
05 08804 RURAL HEALTH CLINIC VI		0.0000	00	0	88
00 09000 CLINIC		0. 3740	90 0	0	90
01 09001 0NCOLOGY		0. 54869		115	90
02 09002 PAIN MANAGEMENT		0.0000		-	
00 09100 EMERGENCY		0. 33848			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4279			
00 04040 OTHER OUTPATIENT SERVICE COST CENTE		1. 16814	45 105	123	93
OTHER REIMBURSABLE COST CENTERS				1	1
00 09500 AMBULANCE SERVICES			F 070 (0)	1 50/ 0/	95
D.00 Total (sum of lines 50 through 94 and 96 through 98)			5, 979, 696	1, 526, 344	200
1.00 Less PBP Clinic Laboratory Services-Program only char					

NPATIENT ANCILLARY SERVIC	E COST APPORTIONMENT	Provider C	CN: 15-0061	Peri od:	Worksheet D-3	3
		li ovrači o		From 01/01/2023		,
		Component	CCN: 15-S061	To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epared
		Title	e XVIII	Subprovider -	PPS	
Cost Contor D	conintion		Datio of Cor	I PF		-
Cost Center De	scription		Ratio of Cos		Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x	
				charges	col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE S	ERVICE COST CENTERS		1 1100	2100	0100	
30. 00 03000 ADULTS & PEDI A						30.0
31.00 03100 INTENSIVE CARE	UNIT					31.0
0.00 04000 SUBPROVI DER -	I PF			5, 124, 957	,	40.0
1.00 04100 SUBPROVI DER -	I RF					41.0
3. 00 04300 NURSERY						43.0
ANCILLARY SERVICE C			1		1	
0.00 05000 OPERATING ROOM			0. 3286		-	
1.00 05100 RECOVERY ROOM			0.0000		-	
2.00 05200 DELIVERY ROOM			1.0972		0	
4. 00 05400 RADI OLOGY-DI A0	NOSTIC		0. 1072			
6. 00 05600 RADI OI SOTOPE			0. 2157			
0.00 06000 LABORATORY			0. 1926			
	PROCESSING & TRANS.		0.0312		-	
4. 00 06400 I NTRAVENOUS TH			0.0000		-	
5. 00 06500 RESPI RATORY TH			0. 2551			
6. 00 06600 PHYSI CAL THER 7. 00 06700 OCCUPATI ONAL 1			0. 3225 0. 2243			
8.00 06800 SPEECH PATHOLO			0. 2243			
9. 00 06900 ELECTROCARDI OL			0. 3935			
	ES CHARGED TO PATIENT		0. 1290			
2.00 07200 IMPL. DEV. CHA			0. 3033			
3. 00 07300 DRUGS CHARGED			0. 3286			
6. 00 03020 CARDI AC REHAB	TO TATIENTS		0. 6168			
6. 01 03030 ADDI CTI ON SERV	I CES		5. 3117			
7.00 07700 ALLOGENEIC HSC			0.0000			
8.00 07800 CAR T-CELL IMM			0.0000			
OUTPATIENT SERVICE			I			
8.00 08800 RURAL HEALTH (0.0000	00	0	88.0
8.01 08801 RURAL HEALTH (LINIC II		0.0000	00	0	88.0
8.02 08802 RURAL HEALTH (LINIC III		0.0000	00	0	88.0
8.03 08805 RURAL HEALTH (LINIC IV		0.0000	00	0	88.0
8.04 08803 RURAL HEALTH (LINIC V		0.0000	00	0	88.
8.05 08804 RURAL HEALTH (LINIC VI		0.0000	00	0	88.
0. 00 09000 CLINIC			0. 3740	90 0	0	90.0
0. 01 09001 ONCOLOGY			0. 5486		-	
0. 02 09002 PAIN MANAGEMEN	IT		0.0000		0	
1.00 09100 EMERGENCY			0. 3384			
	DS (NON-DISTINCT PART		0. 4279			
	NT SERVICE COST CENTE		1. 1681	45 0	0	93. (
OTHER REIMBURSABLE			1		1	
5.00 09500 AMBULANCE SERV						95.0
	lines 50 through 94 and 96 through 98)			2, 869, 777		
	c Laboratory Services-Program only charge	es (line 61)		0		201.0
202.00 Net charges (I	ine 200 minus line 201)		1	2, 869, 777	1	202.0

INPATIENT AN	ICI LLARY SERVICE COST APPORTIONMENT	DAVIESS COMMUNITY HOS		CN: 15-0061	Por	i od:	Worksheet D-3	2552-10 3
	ICTELART SERVICE COST AFFORTIONWENT	FIO	viuei c	CN. 15-0001		om 01/01/2023	WULKSHEEL D-3)
		Com	ponent	CCN: 15-T061	То	12/31/2023	Date/Time Pre 5/31/2024 9:2	
			Title	× XVIII	Su	ıbprovi der -	PPS	
					<u> </u>	I RF	<u> </u>	
	Cost Center Description			Ratio of Cos		Inpati ent	Inpatient	
				To Charges		Program Charges	Program Costs (col. 1 x	
						charges	col. 2)	
				1.00		2.00	3.00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS							
	ADULTS & PEDIATRICS							30.00
	INTENSIVE CARE UNIT							31.00
	SUBPROVIDER - IPF							40.00
	SUBPROVIDER - IRF					1, 672, 346		41.00
	NURSERY							43.00
	LARY SERVICE COST CENTERS			0.2207	(0)	410	135	50.00
	RECOVERY ROOM			0. 3286 0. 0000		412 0	135	
	DELIVERY ROOM & LABOR ROOM			1. 0972		0	0	
	RADI OLOGY-DI AGNOSTI C			0. 1072		83, 861	8, 997	
	RADI OI SOTOPE			0. 2157		8, 478	1, 829	
	LABORATORY			0. 1926		151, 831	29, 251	
	BLOOD STORING PROCESSING & TRANS.			0.0312		14, 506	453	
	I NTRAVENOUS THERAPY			0.0000		0	0	
	RESPI RATORY THERAPY			0. 2551		577, 648	147, 393	65.00
	PHYSI CAL THERAPY			0. 3225	57	634, 224	204, 573	66.00
67.00 06700	OCCUPATI ONAL THERAPY			0. 2243	81	539, 008	120, 943	67.00
	SPEECH PATHOLOGY			0. 3935	96	116, 842	45, 989	68.00
	ELECTROCARDI OLOGY			0. 1296		7, 205	934	
	MEDICAL SUPPLIES CHARGED TO PATIENT			0. 3633		118, 319	42, 987	
	IMPL. DEV. CHARGED TO PATIENTS			0. 4198		0	0	
	DRUGS CHARGED TO PATIENTS			0. 3286		227, 876	74, 894	
	CARDI AC REHAB			0. 6168		0	0	
	ADDICTION SERVICES ALLOGENEIC HSCT ACQUISITION			5. 3117		0	0	
	CAR T-CELL IMMUNOTHERAPY			0. 0000 0. 0000		0	0	
	TIENT SERVICE COST CENTERS			0.0000		0	0	78.00
	RURAL HEALTH CLINIC			0.0000	00		0	88.00
	RURAL HEALTH CLINIC II			0.0000			0	
	RURAL HEALTH CLINIC III			0.0000			0	
	RURAL HEALTH CLINIC IV			0.0000			0	
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	CLINIC			0. 3740	90	0	0	90.00
	ONCOLOGY			0. 5486	90	0	0	90.01
	PAIN MANAGEMENT			0.0000		0	0	
	EMERGENCY			0. 3384		57, 140	19, 341	
	OBSERVATION BEDS (NON-DISTINCT PART			0. 4279		0	0	
	OTHER OUTPATIENT SERVICE COST CENTE			1. 1681	45	0	0	93.00
	REI MBURSABLE COST CENTERS AMBULANCE SERVI CES				_			95.00
20.00 02000	Total (sum of lines 50 through 94 and	96 through 99				2, 537, 350	697, 719	
200 00						2,037,330	071,119	1200.00
200.00	Less PBP Clinic Laboratory Services-P		ne 61)			0		201.00

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0061	Peri od:	Worksheet D-3	6
			From 01/01/2023		
			To 12/31/2023		pare
	Ti tl	e XIX	Hospi tal	5/31/2024 9:2 Cost	U alli
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			-	col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			107 100		1 20
0. 00 03000 ADULTS & PEDIATRICS			107, 109		30.
I. 00 03100 I NTENSI VE CARE UNI T			54, 842		31.
0. 00 04000 SUBPROVIDER - IPF			275, 911		40.
I. 00 04100 SUBPROVIDER - IRF			85, 916		41.
3. 00 04300 NURSERY			50, 012		43.
ANCI LLARY SERVICE COST CENTERS		0.000/	(0) 00 (50		1 - 0
0. 00 05000 OPERATING ROOM		0. 3286		26, 442	
I. 00 05100 RECOVERY ROOM		0.0000		-	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		1.0972		40, 908	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1072		11, 115	
0. 00 05600 RADI OI SOTOPE		0. 2157			
0. 00 06000 LABORATORY		0. 1926			
8. 00 06300 BLOOD STORING PROCESSING & TRANS.		0. 0312			
. 00 06400 I NTRAVENOUS THERAPY		0.0000			
0. 00 06500 RESPI RATORY THERAPY		0. 2551	60 107, 048	27, 314	65
0. 00 06600 PHYSI CAL THERAPY		0. 3225	57 45, 947	14, 821	66
06700 OCCUPATI ONAL THERAPY		0. 2243	81 37, 594	8, 435	67
B. 00 06800 SPEECH PATHOLOGY		0. 3935	96 10, 168	4, 002	68
2. 00 06900 ELECTROCARDI OLOGY		0. 1296	59 8, 866	1, 150	69
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3633	16 94, 917	34, 485	71
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4198	12 11, 759	4, 937	72
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3286	60 143, 141	47,045	73
5. 00 03020 CARDI AC REHAB		0. 6168	14 0	0	76
5. 01 03030 ADDICTION SERVICES		5. 3117		255	76
2.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00 0	0	77
3. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.0000		0	
OUTPATIENT SERVICE COST CENTERS					
. OO 08800 RURAL HEALTH CLINIC		1. 1600			
01 08801 RURAL HEALTH CLINIC II		2.0367			
8. 02 08802 RURAL HEALTH CLINIC III		0. 7936			
. 03 08805 RURAL HEALTH CLINIC IV		0.0000			
. 04 08803 RURAL HEALTH CLINIC V		1. 2538			
. 05 08804 RURAL HEALTH CLINIC VI		1. 2086			
. 00 09000 CLINIC		0. 3740			
. 01 09001 ONCOLOGY		0. 5486		-	
. 02 09002 PAIN MANAGEMENT		0.0000		-	
. 00 09100 EMERGENCY		0. 3384			
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4279		6, 765	
B. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE		1. 1681	45 9	11	93
OTHER REIMBURSABLE COST CENTERS		1			4
0.00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50 through 94 and 96 through 98)			968, 762		
11.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201
02.00 Net charges (line 200 minus line 201)			968, 762		202

	ICI al Systems DAVIESS COMMU VCILLARY SERVICE COST APPORTIONMENT	NITY HOSPITAL	CN. 1E 0041		u of Form CMS-	
INPAILENT A	NCILLARY SERVICE CUST APPORTIONMENT	Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet D-3)
		Component	CCN: 15-SO61	To 12/31/2023		
		Ti tl	e XIX	Subprovider -	Cost	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
			5	Charges	(col. 1 x	
					col. 2)	
			1.00	2.00	3.00	
	I ENT ROUTI NE SERVI CE COST CENTERS		1			1 00 00
	ADULTS & PEDIATRICS INTENSIVE CARE UNIT					30.00
	SUBPROVIDER - IPF			244 401		40.00
	SUBPROVIDER - IRF			246, 401		40.00
	NURSERY					41.00
	LARY SERVICE COST CENTERS					43.00
	OPERATING ROOM		0. 3286	68 0	0	50.00
	RECOVERY ROOM		0.0000			
	DELIVERY ROOM & LABOR ROOM		1.0972		0	52.00
	RADI OLOGY-DI AGNOSTI C		0. 1072		869	
	RADI OI SOTOPE		0. 2157	30 848	183	56.00
60.00 06000	LABORATORY		0. 1926	54 23, 620	4, 550	60.00
63.00 06300	BLOOD STORING PROCESSING & TRANS.		0. 0312	26 2	0	63.00
64.00 06400	INTRAVENOUS THERAPY		0.0000	0 00	0	64.00
	RESPI RATORY THERAPY		0. 2551	60 18, 135	4, 627	65.00
	PHYSI CAL THERAPY		0. 3225			66.00
	OCCUPATI ONAL THERAPY		0. 2243			
	SPEECH PATHOLOGY		0. 3935			
	ELECTROCARDI OLOGY		0. 1296			
	MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0.3633			
	I MPL. DEV. CHARGED TO PATIENTS		0. 4198		e e e e e e e e e e e e e e e e e e e	
	DRUGS CHARGED TO PATIENTS		0. 3286			
	CARDI AC REHAB		0.6168			
	ADDICTION SERVICES ALLOGENEIC HSCT ACQUISITION		5. 3117 0. 0000			
	CAR T-CELL IMMUNOTHERAPY		0.0000		-	
	TIENT SERVICE COST CENTERS		0.0000	0	0	/0.00
	RURAL HEALTH CLINIC		1. 1600	22 0	0	88.00
	RURAL HEALTH CLINIC II		2.0367		0	
88. 02 08802	RURAL HEALTH CLINIC III		0. 7936	44 0	0	88.02
	RURAL HEALTH CLINIC IV		0.0000	0 00	0	88.03
88. 04 08803	RURAL HEALTH CLINIC V		1. 2538	28 0	0	88.04
	RURAL HEALTH CLINIC VI		1. 2086		0	88.05
90.00 09000	CLINIC		0. 3740	90 0	0	90.00
	ONCOLOGY		0. 5486		-	
	PAIN MANAGEMENT		0.0000			
	EMERGENCY		0. 3384			
	OBSERVATION BEDS (NON-DISTINCT PART		0. 4279			
	OTHER OUTPATIENT SERVICE COST CENTE		1. 1681	45 46	54	93.00
	REIMBURSABLE COST CENTERS AMBULANCE SERVICES					95.00
95.00 09500 200.00	Total (sum of lines 50 through 94 and 96 through 98)			119, 851	27 070	200.00
200.00	Less PBP Clinic Laboratory Services-Program only cha			119,851		200.00
201.00						

INPATIENT ANCILL	Systems DAVIESS COMMUNIT ARY SERVICE COST APPORTIONMENT		CN: 15-0061	In Lie Period:	Worksheet D-3	3
				From 01/01/2023		
		Component	CCN: 15-T061	To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
		Ti tl	e XIX	Subprovider - IRF	Cost	
Cost	Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1.00	2.00	<u>col.2)</u> 3.00	
ΙΝΡΔΤΙΕΝΤ	ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
	TS & PEDIATRICS					30.00
	NSI VE CARE UNI T					31.00
40. 00 04000 SUBF	ROVIDER - IPF					40.00
	ROVIDER – IRF			1		41.00
43.00 04300 NURS						43.00
	SERVICE COST CENTERS		0.000/	(0)		50.00
50.00 05000 0PER 51.00 05100 RECO	ATING ROOM		0.3286			
	VERY ROOM VERY ROOM & LABOR ROOM		0.0000			
	OLOGY-DI AGNOSTI C		0. 1072		-	
56.00 05600 RADI			0. 2157		-	
60.00 06000 LABC			0. 1926			
53.00 06300 BLOC	D STORING PROCESSING & TRANS.		0. 0312	06 C	0	63.00
54.00 06400 INTR	AVENOUS THERAPY		0.0000		-	
	IRATORY THERAPY		0. 2551		-	
	I CAL THERAPY		0. 3225			
	PATIONAL THERAPY		0. 2243		-	
	CH PATHOLOGY TROCARDI OLOGY		0. 3935 0. 1296			
	CAL SUPPLIES CHARGED TO PATIENT		0. 3633			
	. DEV. CHARGED TO PATIENTS		0. 4198		-	1
	S CHARGED TO PATIENTS		0. 3286		0	
76.00 03020 CARE	I AC REHAB		0. 6168	14 C	0	76.00
	CTI ON SERVICES		5. 3117		-	
	GENEIC HSCT ACQUISITION		0.0000			
	T-CELL IMMUNOTHERAPY SERVICE COST CENTERS		0.0000	00 C	0	78.00
	L HEALTH CLINIC		1. 1600	22 C	0	88.00
	L HEALTH CLINIC II		2.0367			
	L HEALTH CLINIC III		0. 7936			
38. 03 08805 RURA	L HEALTH CLINIC IV		0.0000	00 C	0	88.03
38. 04 08803 RURA	L HEALTH CLINIC V		1. 2538	28 C	0	88.04
	L HEALTH CLINIC VI		1. 2086			
0.00 09000 CLIN			0. 3740		-	
90.01 09001 ONCC			0. 5486		-	
90.02 09002 PAIN 91.00 09100 EMER	MANAGEMENT		0.0000		-	
	RVATION BEDS (NON-DISTINCT PART		0. 3384		-	
	R OUTPATIENT SERVICE COST CENTE		1. 1681			
	IBURSABLE COST CENTERS					1
95.00 09500 AMBL						95.00
	l (sum of lines 50 through 94 and 96 through 98)			C	0	200.00
	PBP Clinic Laboratory Services-Program only charge	es (line 61)		C		201.00
202.00 Net	charges (line 200 minus line 201)			C		202.00

Health Financial Systems	DAVIESS COMMUNIT			u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMEN	Γ	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023		pared:
		Title XVIII	Hospi tal	5/31/2024 9: 2 PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERV 1.00 DRG Amounts Other than Outlier F				0	1.00
1.01 DRG amounts other than outlier p		ring prior to October 1	(see	1, 582, 947	
<pre>instructions) 1.02 DRG amounts other than outlier p instructions)</pre>	ayments for discharges occur	ring on or after October	1 (see	545, 309	1.02
1.03 DRG for federal specific operati	ng payment for Model 4 BPCI	for discharges occurring	prior to October	0	1.03
 (see instructions) DRG for federal specific operati October 1 (see instructions) 	ng payment for Model 4 BPCI	for discharges occurring	on or after	0	1.04
 2.00 Outlier payments for discharges. 2.01 Outlier reconciliation amount 	(see instructions)			0	2.00 2.01
2.02 Outlier payment for discharges f	,			0	2.02
2.03 Outlier payments for discharges2.04 Outlier payments for discharges				0	
3.00 Managed Care Simulated Payments	C C			886, 868	3.00
4.00 <u>Bed days available divided by nu</u> Indirect Medical Education Adjus		orting period (see instr	ructions)	37.86	4.00
5.00 FTE count for allopathic and ost or before 12/31/1996. (see instru	eopathic programs for the mo uctions)				
5.01 FTE cap adjustment for qualifing 6.00 FTE count for allopathic and ost	eopathic programs that meet			0.00 0.00	•
 new programs in accordance with Rural track program FTE cap limithe CAA 2021 (see instructions) 		cap-building window clos	ed under §127 of	0.00	6.26
7.00 MMA Section 422 reduction amount 7.01 ACA § 5503 reduction amount to t				0. 00 0. 00	
 cost report straddles July 1, 20 Adjustment (increase or decrease track programs with a rural track 	M1 then see instructions. •) to the hospital's rural tr •k for Medicare GME affiliate	ack program FTE limitati	on(s) for rural	0.00	7. 02
and 87 FR 49075 (August 10, 2022 8.00 Adjustment (increase or decrease affiliated programs in accordance 1000) and (7.76 50000 (August 1	e) to the FTE count for allop e with 42 CFR 413.75(b), 413			0.00	8.00
8.01 1998), and 67 FR 50069 (August 1 The amount of increase if the ho	spital was awarded FTE cap s	lots under § 5503 of the	e ACA. If the cost	0.00	8. 01
8.02 report straddles July 1, 2011, s The amount of increase if the ho under § 5506 of ACA. (see instru	spital was awarded FTE cap s	lots from a closed teach	ning hospital	0.00	8. 02
8.21 The amount of increase if the ho instructions)		lots under §126 of the C	CAA 2021 (see	0.00	8. 21
9.00 Sum of lines 5 and 5.01, plus li minus line 7.02, plus/minus line			nd 7.01, plus or	0.00	9.00
10.00 FTE count for allopathic and ost 11.00 FTE count for residents in denta		rent year from your reco	ords		10.00 11.00
12.00 Current year allowable FTE (see					12.00
 13.00 Total allowable FTE count for th 14.00 Total allowable FTE count for th otherwise enter zero. 		wear ended on or after Se	ptember 30, 1997,		13.00 14.00
15.00 Sum of lines 12 through 14 divid	3				15.00
16.00 Adjustment for residents in init 17.00 Adjustment for residents displac					16.00 17.00
18.00 Adjusted rolling average FTE cou	int			0.00	18.00
19.00 Current year resident to bed rat 20.00 Prior year resident to bed ratio		4).		0.000000	
20.00 Prior year resident to bed ratio 21.00 Enter the lesser of lines 19 or				0. 000000 0. 000000	
22.00 IME payment adjustment (see inst	ructions)			0	22.00
22.01 IME payment adjustment - Managed Indirect Medical Education Adjus		22 of the MMA		0	22.01
23.00 Number of additional allopathic $(f)(1)(iv)(C)$.	and osteopathic IME FTE resi	dent cap slots under 42	CFR 412.105	0.00	23.00
24.00 IME FTE Resident Count Over Cap					24.00
25.00 f the amount on line 24 is greatinstructions)	iter than -U-, then enter the	e lower of line 23 of lir	ie 24 (see		25.00
26.00 Resident to bed ratio (divide li 27.00 IME payments adjustment factor.				0. 000000 0. 000000	
28.00 IME add-on adjustment amount (se				0.000000	1
28.01 IME add-on adjustment amount - M		is)		0	1
29.00 Total IME payment (sum of lines		01)		0	
29.01 Total IME payment - Managed Care Disproportionate Share Adjustmen				0	29.01
30.00 Percentage of SSI recipient pati	ent days to Medicare Part A	patient days (see instru	ictions)	4.65	•
31.00 Percentage of Medicaid patient c 32.00 Sum of Lines 30 and 31	lays (see instructions)			34. 12 38. 77	•
				50.77	1 02.00

ALCULAT	ION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023	Worksheet E Part A	
			To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
		Title XVIII	Hospi tal	PPS	
				1.00	
4.00 D	isproportionate share adjustment (see instructions)			63, 848	34.
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	ncompensated Care Payment Adjustment		4 074 400 450	5 000 00/ 757	1 05
1	otal uncompensated care amount (see instructions) actor 3 (see instructions)		0. 000066664	5, 938, 006, 757 0. 000063990	
	ospital UCP, including supplemental UCP (see instruction	ns)	458, 274	379, 974	
	ro rata share of the hospital UCP, including supplementa		342, 764	95, 513	
1	otal UCP adjustment (sum of columns 1 and 2 on line 35.0	,	438, 277	,0,010	36.
Ac	dditional payment for high percentage of ESRD beneficiar	ry discharges (lines 40 thr			
0. 00 T	otal Medicare discharges (see instructions)	<i>2</i> <u>2</u> <u>2</u>	0		40.
	otal ESRD Medicare discharges (see instructions)		0		41.
	otal ESRD Medicare covered and paid discharges (see ins ⁻	-	0		41.
	ivide line 41 by line 40 (if less than 10%, you do not o	qualify for adjustment)	0.00		42.
	otal Medicare ESRD inpatient days (see instructions)		0		43
	atio of average length of stay to one week (line 43 divi	Idea by IIne 41 alvidea by	7 0.00000		44.
	ays) verage weekly cost for dialysis treatments (see instruc	tions)	0.00		45.
	otal additional payment (line 45 times line 44 times lin		0.00		46
	ubtotal (see instructions)		2, 630, 381		47
	ospital specific payments (to be completed by SCH and MI	DH, small rural hospitals	0		48
0	nly. (see instructions)	· ·			
				Amount	
				1.00	
	otal payment for inpatient operating costs (see instruction		-)	2, 630, 381	
	ayment for inpatient program capital (from Wkst. L, Pt. xception payment for inpatient program capital (Wkst. L,			159, 145 0	
	irect graduate medical education payment (from Wkst. E.			0	
	ursing and Allied Health Managed Care payment).	0	53
	pecial add-on payments for new technologies			0	
	slet isolation add-on payment			0	54
5.00 N	et organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ine 69)		0	55
5.01 C	ellular therapy acquisition cost (see instructions)			0	55
5.00 C	ost of physicians' services in a teaching hospital (see	intructions)		0	56
	outine service other pass through costs (from Wkst. D, I		through 35).	0	57
1	ncillary service other pass through costs from Wkst. D,	Pt. IV, col. 11 line 200)		0	
	otal (sum of amounts on lines 49 through 58)			2, 789, 526	
	rimary payer payments	minus line (0)		4, 383	
	otal amount payable for program beneficiaries (line 59 r eductibles billed to program beneficiaries	minus inne 60)		2, 785, 143 327, 780	
	oinsurance billed to program beneficiaries			0	
	llowable bad debts (see instructions)			28, 683	
	djusted reimbursable bad debts (see instructions)			18, 644	
	llowable bad debts for dual eligible beneficiaries (see	instructions)		5, 125	
1	ubtotal (line 61 plus line 65 minus lines 62 and 63)	,		2, 476, 007	67
3. 00 C	redits received from manufacturers for replaced devices	for applicable to MS-DRGs	(see instructions)	0	68
	utlier payments reconciliation (sum of lines 93, 95 and	96). (For SCH see instructi	ons)	0	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	ural Community Hospital Demonstration Project (§410A Der		e instructions)	0	70
	95 respirator payment adjustment amount (see instruction	-		0	
	emonstration payment adjustment amount before sequestra CH or MDH volume decrease adjustment (contractor use on			0	
	CH or MDH volume decrease adjustment (contractor use onl ioneer ACO demonstration payment adjustment amount (see	•		0	70
	SP bonus payment HVBP adjustment amount (see instruction			0	
	SP bonus payment HRR adjustment amount (see instructions	-		0	
	undled Model 1 discount amount (see instructions)	.,		0	70
	VBP payment adjustment amount (see instructions)			-9, 699	
				-633	
D. 94 H	RR adjustment amount (see instructions)			-033	1 /0

	Financial Systems DAVLESS COMMUNIT ATLON OF RELIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0061	Peri od:	u of Form CMS-2 Worksheet E	
				From 01/01/2023 To 12/31/2023	Part A Date/Time Pre 5/31/2024 9:2	pared: 0 am
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
10.0/	Lew values adjustment for foreigned figure (very) (fotos)			0	1.00	70.0
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	in column u		2023	400, 489	70.90
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		2024	142, 116	70.9
	the corresponding federal year for the period ending on or at				,	
0. 98	Low Volume Payment-3			0	0	70.98
0. 99	HAC adjustment amount (see instructions)				0	70.9
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			3,008,280	71.00
71.01	Sequestration adjustment (see instructions)				60, 166	71.0
71.02 71.03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs				0	71.0
72.00	Interim payments				2, 694, 907	72.0
2.01	Interim payments-PARHM				2/0/1//0/	72.0
73.00	Tentative settlement (for contractor use only)				0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)					73.0
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.0	02, 72, and			253, 207	74.00
						74.0
74.01 75.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	anco with			0	74.0 [°] 75.00
5.00	CMS Pub. 15-2, chapter 1, §115.2	ance with			0	75.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)			I		
0.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
	plus 2.04 (see instructions)					
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00	Operating outlier reconciliation adjustment amount (see instr				0	92.00
93.00 94.00	Capital outlier reconciliation adjustment amount (see instruct The rate used to calculate the time value of money (see instr	,			0 0.00	93.00 94.00
95.00	Time value of money for operating expenses (see instructions)				0.00	94.00
	Time value of money for capital related expenses (see instructions)				0	96.00
			1	Prior to 10/1	On/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
01 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 0000000000	0.000000000	101 0
	HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0.0000000000000000000000000000000000000		102.00
	HRR Adjustment for HSP Bonus Payment					
03.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103.00
	HRR adjustment amount for HSP bonus payment (see instructions	-)				404 01
04.00				0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonst	tration) Adju	ustment	0		
	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	tration) Adju	ustment the 21st			200. 00
	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	tration) Adju	ustment the 21st			
200.00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	tration) Adju eriod under	ustment the 21st			200. 00
200. 00 201. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	tration) Adju eriod under	ustment the 21st			
200. 00 201. 00 202. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	tration) Adju eriod under	ustment the 21st			200. 00 201. 00
200. 00 201. 00 202. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)	tration) Adju eriod under ne 49)	the 21st			200. 00 201. 00 202. 00
200. 00 201. 00 202. 00 203. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	tration) Adju eriod under ne 49)	the 21st		tration	200. 00 201. 00 202. 00 203. 00
200. 00 201. 00 202. 00 203. 00 203. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	tration) Adju eriod under ne 49)	the 21st		tration	200. 00 201. 00 202. 00 203. 00 204. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	tration) Adju eriod under ne 49) n first year	the 21st		tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
00. 00 01. 00 02. 00 03. 00 04. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	tration) Adju eriod under ne 49) n first year	the 21st		tration	200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0
00. 00 01. 00 02. 00 03. 00 04. 00 05. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	tration) Adju eriod under ne 49) n first year)	the 21st		trati on	200. 00 201. 00 202. 00 203. 00 204. 00
00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	tration) Adju eriod under ne 49) n first year) tructions)	the 21st		tration	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 206. 0
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 207. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	tration) Adju eriod under ne 49) n first year) tructions)	the 21st		tration	200. 0 201. 0 202. 0 203. 0 205. 0 205. 0 206. 0 207. 0 208. 0 209. 0
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 206. 00 206. 00 209. 00 209. 00 210. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	tration) Adju eriod under ne 49) n first year) tructions) , line 59)	the 21st		tration	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 206. 00 206. 00 209. 00 209. 00 210. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	tration) Adju eriod under ne 49) n first year) tructions) , line 59)	the 21st		tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
200. 00 201. 00 202. 00 203. 00 203. 00 205. 00 205. 00 206. 00 207. 00 208. 00 208. 00 208. 00 208. 00 208. 00 209. 00 211. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	tration) Adju eriod under ne 49) n first year) tructions) , line 59)	the 21st		trati on	200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 211.00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 205. 00 206. 00 207. 00 209. 00 210. 00 211. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (see instructions) Total adjustment to Medicare Part A IPPS payments (from line	tration) Adju eriod under ne 49) n first year) tructions) , line 59)	the 21st		tration	200. 0 201. 0 202. 0 203. 0 205. 0 205. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0 211. 0 212. 0
200. 00 201. 00 202. 00 203. 00 205. 00 205. 00 206. 00 206. 00 209. 00 210. 00 211. 00 211. 00 211. 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	tration) Adju eriod under ne 49) n first year) tructions) , line 59)) 211)	of the curre		tration	200.00 201.00 202.00 203.00 205.00 206.00 207.00 208.00 209.00 210.00

v vo	LUME CALCULATION EXHIBIT 4			Provider CO		eriod: rom 01/01/2023	Worksheet E Part A Exhibi	t 4
					To		Date/Time Pre 5/31/2024 9:2	pare
				Title	XVIII	Hospi tal	PPS	U ai
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		l i ne	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1
)1	DRG amounts other than outlier payments for discharges	1.01	1, 582, 947	0	1, 582, 947		1, 582, 947	1
2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1.02	545, 309	0		545, 309	545, 309	1
3	DRG for Federal specific operating payment for Model 4	1.03	0	0	о		0	1
4	BPCI occurring prior to October 1 DRG for Federal specific	1. 04	0	0		0	0	1
	operating payment for Model 4 BPCI occurring on or after October 1		Ŭ	0		0	0	
0	Outlier payments for discharges (see instructions)	2.00						2
1	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2
3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2
0	Operating outlier reconciliation	2.01	0	0	0	0	0	3
0	Managed care simulated payments	3.00	886, 868	0	676, 530	210, 338	886, 868	4
0	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0.000000	0.000000	0. 000000		5
0	A, line 21 (see instructions)	21100	0.000000	0.000000	01000000	0.000000		
0	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	
1	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6
	Indirect Medical Education Adju	stment for the	e Add-on for Se	ction 422 of 1	the MMA	I		1
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 000000	0. 000000		7
0	IME adjustment (see instructions)	28.00	0	0	0	0	0	
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	
0	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29. 00 29. 01	0	0	0	0	0	
	care (sum of lines 6.01 and 8.01)		0	0	0	0	0	7
	Disproportionate Share Adjustme		0 1000	0 1000	0 1000	0 1000		110
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 1200	0. 1200	0. 1200		10
	Disproportionate share adjustment (see instructions)	34.00	63, 848	0	47, 489	16, 359	63, 848	
01	Uncompensated care payments	36.00	438, 277	di cohorgoo	342, 764	95, 513	438, 277	11
00	Additional payment for high per Total ESRD additional payment	Centage of ESI 46.00		di scharges 0	0	0	0	12
20	(see instructions)		0	0	Ŭ	0	0	'2
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	2, 630, 381 0	0 0	1, 973, 200 0	657, 181 0	2, 630, 381 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	2, 630, 381	0	1, 973, 200	657, 181	2, 630, 381	15

	Financial Systems DLUME CALCULATION EXHIBIT 4		DAVIESS COMMUN	Provider C	CN: 15-0061	Peri od:	u of Form CMS-: Worksheet E	2002-
	JEUNE CALCULATION EATIBLE 4					From 01/01/2023 To 12/31/2023	Part A Exhibi Date/Time Pre 5/31/2024 9:2	pared
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
6. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	159, 145	0	117, 13	42, 011	159, 145	16. (
7.00	Special add-on payments for new technologies	54.00	0	0		0 0	C	
7.01	Net organ aquisition cost							17.0
7.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	O) 17.C
8.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	O	18.0
9.00	SUBTOTAL			0	2, 090, 33	699, 192	2, 789, 526	19.0
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
0.00	Capital DRG other than outlier	1.00	159, 145	0	117, 13	42, 011	159, 145	20.0
0. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0		0 0	C	20.0
1.00	Capital DRG outlier payments	2.00	0	0		0 0	0	21.
1. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	O	
2.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000				22.
3.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.
4.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.(
5.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	C	25.0
6.00	Total prospective capital payments (see instructions)	12.00	159, 145	0	117, 13	42, 011	159, 145	26.0
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
7.00 8.00	Low volume adjustment factor Low volume adjustment	70. 96			0. 19159 400, 48		400, 489	27. 28.
9.00	(transfer amount to Wkst. E, Pt. A, line) Low volume adjustment	70. 97				142, 116	142, 116	20
9.00	(transfer amount to Wkst. E, Pt. A, line)	10.91				142, 110	142, 110	29.
00.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.

SPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/31/2024 9:20	pared:
		Wkst. E, Pt. A, line	Title Amt. from Wkst. E, Pt.	Period to 10/01	Hospital Periodon after 10/01	PPS Total (cols. 2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00	1.00	2.00	5.00	4.00	1.00
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1, 582, 947	1, 582, 94	7	1, 582, 947	1.01
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	545, 309		545, 309	545, 309	1.0
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0		0	0	1.0
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0		0	0	1.0
00	October 1 Outlier payments for discharges (see instructions)	2.00					2.0
01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2.0
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0		0	0	2.0
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.0
00	Operating outlier reconciliation	2. 01	0		0 0	0	3. C
00	Managed care simulated payments	3.00	886, 868		0 0	0	4.0
00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0 0. 000000		5.(
00	(see instructions) IME payment adjustment (see instructions)	22.00	0		0 0	0	6.0
01	IME payment adjustment for managed care (see instructions)		0		0 0	0	6.0
~~	Indirect Medical Education Adjustment for the						
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000			7.0
00 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0 0		0 0 0 0	0 0	8. (8. (
00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29.00	о		0 0	о	9. (
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0 0	0	9.
	Disproportionate Share Adjustment						
. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 120	0 0. 1200		10.
. 00	Disproportionate share adjustment (see instructions)	34.00	63, 848	47, 48	9 16, 359	63, 848	11. (
. 01	Uncompensated care payments Additional payment for high percentage of ESI	36.00 RD beneficiary	438, 277 di scharges	342, 76	4 95, 513	438, 277	11.
. 00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12. (
. 00	Subtotal (see instructions)	47.00	2, 630, 381	1, 973, 20		2, 630, 381	
. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14.0
. 00	Total payment for inpatient operating costs (see instructions)	49.00	2, 630, 381	1, 973, 20	0 657, 181	2, 630, 381	15. (
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	159, 145	117, 13	4 42, 011	159, 145	16. (
. 00 . 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17. (17. (
. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.(
. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.
. 00	SUBTOTAL			2, 090, 33	4 699, 192	2, 789, 526	19.

	DAVIESS COMMUN			In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	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	159, 145	117, 13	42, 011	159, 145	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	0		0 0	0	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	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	159, 145	117, 13	42, 011	159, 145	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt.				
	0	A) 1.00	2.00	3.00	4.00	
27.00	0	1.00	2.00	3.00	4.00	27.00
28.00 Low volume adjustment prior to October 1	70, 96	400, 489	400, 48	20	400, 489	
29.00 Low volume adjustment on or after October 1	70.97	142, 116		142, 116		
30.00 HVBP payment adjustment (see instructions)	70.93	-9, 699		0 -9,699		
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0,079		0 0		
31.00 HRR adjustment (see instructions)	70, 94	-633	-63	13 0	-633	31.00
31.01 HRR adjustment (see histituctions) instructions)	70. 91	033	-00	0 0	0	
1.1.01.001.010/					(Amt. to	
					Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Ν				100.00

CALCULATION OF SELENDERSTELET Provide CX: 15 061		Financial Systems DAVIESS COMMUNITY HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT Provider CCN:	15 0061	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
Title XULL Hissipital PS 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 0.01 1.00	CALCUL	ATTON OF REIMBORSEMENT SETTLEMENT Provider CON:		From 01/01/2023	Part B Date/Time Pre	
MART B MART CA MART CA No. 100 Medical and other services (see instructions) 7,256,05 7,257,05 100 Delicity and other services (see instructions) 7,257,05 7,257,05 100 Delicity and other services (see instructions) 0,471 1,000 100 Delicity permet (see instructions) 0,471 1,000 100 Delicity permet (see instructions) 0,000 0,000 0,000 100 Delicity new (see other pees, through casts) including RPI direct graduate medical education costs from 0,000 100 Delicity new (see other pees, through casts) including RPI direct graduate medical education costs from 0,000 100 Delicity new (see other pees, through casts) including RPI direct graduate medical education costs from 0,000 100 Delicity new (see other pees, through casts) including RPI direct graduate medical education costs from 0,000 1010 Delicity new (see other pees, through casts) including RPI direct graduate medical education costs from 0,000 100 Delicity new (see other pees, through casts) including RPI direct graduate medical education costs from 0,000 100 Delicity new (seatr dir		Title XV	/111	Hospi tal		
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	93.00	Time Value of Money (see instructions)			0	93.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period:	Worksheet E	
		From 01/01/2023 To 12/31/2023		epared: 20 am
	Title XVIII	Hospi tal	PPS	
			1.00	
94.00 Total (sum of lines 91 and 93)			0	94.00
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0061	Period: From 01/01/2023 To 12/31/2023		pare
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		2, 694, 9	07 0	4, 766, 884 0	1. 2. 3.
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
~ 1	Program to Provider					
01 02	ADJUSTMENTS TO PROVIDER			0	0	3.
03				0	0	3
04				0	0	
05				0	0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
50 51	ADJUSTNENTS TO FROOMAM			0	0	
52				0	0	
53				0	0	-
54	Culture of Lines 2 01 2 40 minus sum of Lines			0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 694, 9	07	4, 766, 884	4
	TO BE COMPLETED BY CONTRACTOR					1
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	
03	Drouidor to Drogram			0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
51				0	0	
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		253, 2	07 0	1, 132 0	6
02	Total Medicare program liability (see instructions)		2, 948, 1		4, 768, 016	
			_, , , , , , , ,	Contractor	NPR Date	Ĺ
		C)	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor	ų.		1.00	2.00	6

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0061 CCN: 15-S061	Period: From 01/01/20 To 12/31/20	D23 Date/Time Pr 5/31/2024 9:	epared
		Titl€	e XVIII	Subprovi der I PF	- PPS	
		I npati er	nt Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyy		
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 014, 8	36 0		0 1. 0 2. 3.
	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					
01	ADJUSTMENTS TO PROVIDER			0		3.
02 03				0) 3.) 3.
03				0) 3.) 3.
05				0		3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0		3.
51				0) 3
52				0		3
53 54				0) 3.) 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0 3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 014, 8	36	(4
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
01	Program to Provider TENTATIVE TO PROVIDER		1	0		5 5
)2				0		5 5
03				0		5
	Provider to Program		1			
50	TENTATIVE TO PROGRAM			0	(
51 52				0) 5) 5
92 99	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
01	SETTLEMENT TO PROVIDER		6,0	04) 6
02	SETTLEMENT TO PROGRAM		2 000 0	0		
00	Total Medicare program liability (see instructions)		3, 020, 8	40 Contractor		7 (
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0061 CCN: 15-T061	Period: From 01/01/20 To 12/31/20		epare
		Title	e XVIII	Subprovi der I RF		
		Inpatien	it Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyy		
. 00	Total interim payments paid to provider	1.00	2.00 2,158,7	3.00	4.00	0 1.
. 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		2, 130, 7	0		0 2.
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	(о з.
. 02				0		0 3.
. 03				0		0 3.
04 05				0		0 3. 0 3.
05	Provider to Program			0	``	
50	ADJUSTMENTS TO PROGRAM			0	(0 3
51				0	(0 3
52				0		0 3
53				0		0 3 0 3
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0		0 3 0 3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 158, 7	06	(0 4.
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider		1	- 1		
01 02	TENTATI VE TO PROVI DER			0		0 5 0 5
02				0		0 5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0		0 5
51				0		0 5
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		0 5 0 5
77 00	5. 50-5. 98) Determined net settlement amount (balance due) based on			0		
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		34, 7	28		0 6
02	SETTLEMENT TO PROGRAM			0		0 6
00	Total Medicare program liability (see instructions)		2, 193, 4	34 Contractor		0 7
				Number	(Mo/Day/Yr)	
		(о С	1.00	2.00	

Heal th	Financial Systems DAVIESS COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0061	Period:	Worksheet E-	-1
			From 01/01/2023 To 12/31/2023		concered.
			10 12/31/2023	5/31/2024 9:	
		Title XVIII	Hospi tal	PPS	20 411
		÷			
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	NC			
1.00	Total hospital discharges as defined in AARA §4102 from Wks	t. S-3, Pt. I col. 15 lin	ne 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	/Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ons)		32.00

.2002	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023	Worksheet E-3 Part II	
		Component CCN: 15-SO61	To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
		Title XVIII	Subprovider -	PPS	
			-	1.00	
	PART II – MEDICARE PART A SERVICES – IPF PPS				
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	medical education payments)	3, 372, 616	
00	Net IPF PPS Outlier Payments			5, 231	2
00	Net IPF PPS ECT Payments			0	3
00	Unweighted intern and resident FTE count in the most recen	it cost report filed on or	before November	0.00	4
01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE c	ount for residents that we	ro displaced by	0.00	4
01	program or hospital closure, that would not be counted wit			0.00	4
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth	period of a "new	0.00	6
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents with	in the new program growth	period of a "new	0.00	7
	teaching program" (see instuctions)				
00	Intern and resident count for IPF PPS medical education ad	ljustment (see instructions)	0.00	
00	Average Daily Census (see instructions) Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	to the newer of FIFO 1)		10. 586301	
. 00	Teaching Adjustment (line 1 multiplied by line 10).	to the power of . 5150 -1}.		0. 000000 0	10
00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 1	1)		3, 377, 847	
00	Nursing and Allied Health Managed Care payment (see instru	·		0, 37, 77, 847	1:
00	Organ acquisition (DO NOT USE THIS LINE)				14
00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	
00	Subtotal (see instructions)			3, 377, 847	10
. 00	Primary payer payments			0	1
00	Subtotal (line 16 less line 17).			3, 377, 847	
00	Deductibles			143, 692	
00	Subtotal (line 18 minus line 19)			3, 234, 155	
00	Coinsurance Subtotal (line 20 minus line 21)			157, 791 3, 076, 364	
00	Allowable bad debts (exclude bad debts for professional se	arvices) (see instructions)		9, 424	
00	Adjusted reimbursable bad debts (see instructions)			6, 126	
00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		4, 756	
00	Subtotal (sum of lines 22 and 24)	,		3, 082, 490	
00	Direct graduate medical education payments (see instructio	ons)		0	2
00	Other pass through costs (see instructions)			0	2
00	Outlier payments reconciliation			0	2
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
50	Pioneer ACO demonstration payment adjustment (see instruct	ions)		0	30
98	Recovery of accelerated depreciation.	o.n.		0	30
99 00	Demonstration payment adjustment amount before sequestrati Total amount payable to the provider (see instructions)	Off		0 3, 082, 490	30
00	Sequestration adjustment (see instructions)			61, 650	
	Demonstration payment adjustment amount after sequestratio	n		01,000	
00	Interim payments			3, 014, 836	
00	Tentative settlement (for contractor use only)			0	
00	Balance due provider/program (line 31 minus lines 31.01, 3	31.02, 32 and 33)		6, 004	
00	Protested amounts (nonallowable cost report items) in acco	ordance with CMS Pub. 15-2,	chapter 1,	0	35
	<u>§115. 2</u>				
~~	TO BE COMPLETED BY CONTRACTOR	2		E 05.	
	Original outlier amount from Worksheet E-3, Part II, line			5, 231	
. 00	Outlier reconciliation adjustment amount (see instructions	, j		0	51
. 00 . 00	The rate used to calculate the Time Value of Money			0.00 0	
. 00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 COVID-19 PHE)	AND BEGINNING ON OR BEFORE	MAY 11, 2023 (TH		
					99

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023	Worksheet E-3 Part III	i
		Component CCN: 15-T061	To 12/31/2023		
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
00	Net Federal PPS Payment (see instructions)			2, 134, 283	
00	Medicare SSI ratio (IRF PPS only) (see instructions)	`		0.0417	
00 00	Inpatient Rehabilitation LIP Payments (see instructions	5)		74, 486 62, 657	
00	Outlier Payments Unweighted intern and resident FTE count in the most re	ecent cost reporting period e	nding on or prior	02, 057	
01	to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FT	E count for recidents that we	ro dical acad by	0.00	Ę
01	program or hospital closure, that would not be counted			0.00	
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions	1 3 1 3			
00	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FT	Es in the new program growth	period of a "new	0.00	
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents w	ithin the new program growth	period of a "new	0.00	8
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education	adjustment (see instructions)	0.00	
). 00	Average Daily Census (see instructions)			3.682192	
. 00	Teaching Adjustment Factor (see instructions)			0.000000	
2.00	Teaching Adjustment (see instructions) Total PPS Payment (see instructions)			2, 271, 426	1:
. 00	Nursing and Allied Health Managed Care payments (see in	ustruction)		2, 271, 420	
5.00				0	1
. 00	Cost of physicians' services in a teaching hospital (se	e instructions)		0	
7.00	Subtotal (see instructions)			2, 271, 426	1
3. 00	Primary payer payments			0	1
0. 00				2, 271, 426	
). 00	Deductibles			35, 112	
. 00	Subtotal (line 19 minus line 20)			2, 236, 314	
. 00	Coinsurance Subtotal (line 21 minus line 22)			2, 800 2, 233, 514	
	Allowable bad debts (exclude bad debts for professional	sarvicas) (saa instructions)		2, 233, 514	
5.00	Adjusted reimbursable bad debts (see instructions)			4, 684	
	Allowable bad debts for dual eligible beneficiaries (se	e instructions)		4, 612	
. 00	Subtotal (sum of lines 23 and 25)	· · · · · · · · · · · · · · · · · · ·		2, 238, 198	
8.00	Direct graduate medical education payments (from Wkst.	E-4, line 49)		0	2
. 00	Other pass through costs (see instructions)			0	2
). 00	Outlier payments reconciliation			0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50 . 98	Pioneer ACO demonstration payment adjustment (see instr Recovery of accelerated depreciation.	uctions)		0	
. 90 . 99	Demonstration payment adjustment amount before sequestr	ation		0	-
2.00	Total amount payable to the provider (see instructions)			2, 238, 198	
	Sequestration adjustment (see instructions)			44, 764	
	Demonstration payment adjustment amount after sequestra	iti on		0	
3.00	Interim payments			2, 158, 706	33
. 00	Tentative settlement (for contractor use only)			0	34
5.00	Balance due provider/program (line 32 minus lines 32.01			34, 728	
. 00	Protested amounts (nonallowable cost report items) in a	ccordance with CMS Pub. 15-2,	chapter 1,	0	36
	§115. 2				-
. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4			62, 657	50
. 00	Outlier reconciliation adjustment amount (see instructi			02,057	
2.00	The rate used to calculate the Time Value of Money	013/		0.00	
3.00	Time Value of Money (see instructions)			0.00	
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 20	20 AND BEGINNING ON OR BEFORE	MAY 11, 2023 (TH		1 ``
	COVID-19 PHE)				
. 00	Teaching Adjustment Factor for the cost reporting perio			0.00000	1 00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023		pared:
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR 2	KIX SERVICES		-
~~	COMPUTATION OF NET COST OF COVERED SERVICES		500.400		1
00	Inpatient hospital/SNF/NF services		520, 103	7/5 700	1.0
00	Medical and other services			765, 709	2.0
00 00	Organ acquisition (certified transplant programs only) Subtotal (sum of lines 1, 2 and 3)		0 520, 103	765, 709	3.0
00	Inpatient primary payer payments		520, 105	705,704	5.0
00	Outpatient primary payer payments		0	0	1
00	Subtotal (line 4 less sum of lines 5 and 6)		520, 103	765, 709	1
	COMPUTATION OF LESSER OF COST OR CHARGES		0207100	100,101	
	Reasonable Charges				1
00	Routine service charges		0		8.0
00	Ancillary service charges		968, 762	2, 715, 764	9.0
). 00	Organ acquisition charges, net of revenue		0		10.0
. 00	Incentive from target amount computation		0		11.0
2.00	Total reasonable charges (sum of lines 8 through 11)		968, 762	2, 715, 764	12.0
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.0
	basi s			0	110
1.00	Amounts that would have been realized from patients liable for		on 0	0	14.0
5.00	a charge basis had such payment been made in accordance with A Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR 9413.13(e)	0. 000000	0.000000	15.0
5.00 5.00	Total customary charges (see instructions)		968, 762	2, 715, 764	
7.00	Excess of customary charges over reasonable cost (complete onl	vifline 16 exceeds	448, 659	1, 950, 055	
. 00	line 4) (see instructions)		110,007	1, 700, 000	17.0
3. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds li	ne 0	0	18.0
	16) (see instructions)	-			
9.00	Interns and Residents (see instructions)		0	0	19.0
0. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		520, 103	765, 709	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS prov			
2.00	Other than outlier payments		0	0	
3.00 4.00	Outlier payments		0	0	23.0
5.00	Program capital payments Capital exception payments (see instructions)		0		24.0
5.00 5.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		520, 103	765, 709	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
0. 00	Excess of reasonable cost (from line 18)		0	0	30.0
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	520, 103	765, 709	31.0
2.00	Deductibles		0	0	32.0
3.00	Coinsurance		0	0	33.0
	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0		35.0
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	520, 103		
7.00	ZERO OUT MEDICAID		-520, 103	-765, 709	
3.00	Subtotal (line $36 \pm line 37$)		0	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.0
0.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
. 00 2. 00	Interim payments Balance due provider/program (line 40 minus line 41)		0	0	
2.00 3.00	Protested amounts (nonallowable cost report items) in accorda	ace with CMS Dub 15.2	0	0	•
. 00	chapter 1, §115.2	ICC WITTI OWD FUD TO-Z,	0	0	+3.0

LCOL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023	Worksheet E-3 Part VII	,
		Component CCN: 15-SO61	To 12/31/2023	Date/Time Pre 5/31/2024 9:20	
		Title XIX	Subprovider - IPF	Cost	_
			Inpatient	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	FRVICES FOR TITLES V OR	1.00 XIX_SERVICES	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		32, 873		1 ·
00	Medical and other services			0	
00	Organ acquisition (certified transplant programs only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		32, 873	0	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments		22.072	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		32, 873	0	
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				1
00	Routi ne servi ce charges		0		1
00	Ancillary service charges		119, 851	0	
. 00	Organ acquisition charges, net of revenue		0	-	10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		119, 851	0	12
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment f	for services on a charge	0	0	1:
	basi s				
. 00	Amounts that would have been realized from patients liable f		on 0	0	14
00	a charge basis had such payment been made in accordance with Ratio of line 13 to line 14 (not to exceed 1.000000)	1 42 CFR §413.13(e)	0. 000000	0. 000000	1
. 00 . 00	Total customary charges (see instructions)		119, 851	0.000000	
. 00	Excess of customary charges over reasonable cost (complete c				
. 00	line 4) (see instructions)	in y 11 11he 10 exceeds	86, 978	0	1'
. 00	Excess of reasonable cost over customary charges (complete c	onlvifline 4 exceeds li	ne 0	0	18
	16) (see instructions)	3			
. 00	Interns and Residents (see instructions)		0	0	10
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		32, 873	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b	e completed for PPS prov			4
. 00	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	
. 00 . 00	Program capital payments Capital exception payments (see instructions)		0		24
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)	1	0	Ő	
. 00	Titles V or XIX (sum of lines 21 and 27)		32, 873	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	32, 873	0	
	Deducti bl es		0	0	
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review	and 22)	0		3
. 00 . 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a ZERO OUT MEDICAID	anu 33 <i>)</i>	32, 873 -32, 873	0	
. 00	Subtotal (line 36 ± line 37)		-32, 873	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	0	3
. 00	Total amount payable to the provider (sum of lines 38 and 39	9)	0	0	
. 00	Interim payments		0	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
. 00					

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Period: From 01/01/2023	Worksheet E-3 Part VII
		Component CCN: 15-T061	To 12/31/2023	Date/Time Prep 5/31/2024 9:20
		Title XIX	Subprovider - IRF	Cost
			I npati ent	Outpati ent
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH	SERVICES FOR TITLES V OR	1.00	2.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
00	Inpatient hospital/SNF/NF services		0	
00	Medical and other services			0
00	Organ acquisition (certified transplant programs only)		0	
00	Subtotal (sum of lines 1, 2 and 3)		0	0
00	Inpatient primary payer payments		0	
00	Outpatient primary payer payments			0
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0
	COMPUTATION OF LESSER OF COST OR CHARGES			
~~	Reasonable Charges		0	
00 00	Routi ne servi ce charges		0	0
. 00	Ancillary service charges Organ acquisition charges, net of revenue		0	0
. 00	Incentive from target amount computation		0	
. 00	Total reasonable charges (sum of lines 8 through 11)		0	0
. 00	CUSTOMARY CHARGES			
. 00	Amount actually collected from patients liable for payment	t for services on a charge	0	0
	basi s			-
. 00	Amounts that would have been realized from patients liable	e for payment for services	on 0	0
	a charge basis had such payment been made in accordance wi	th 42 CFR §413.13(e)		
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000
. 00	Total customary charges (see instructions)		0	0
. 00	Excess of customary charges over reasonable cost (complete	e only if line 16 exceeds	0	0
~ ~	line 4) (see instructions)			
. 00	Excess of reasonable cost over customary charges (complete	e only if line 4 exceeds li	ne 0	0
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0
. 00	Cost of physicians' services in a teaching hospital (see i	nstructions)	0	0
. 00	Cost of covered services (enter the lesser of line 4 or li	•	0	o
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only			0
. 00	Other than outlier payments		0	0
. 00	Outlier payments		0	0
. 00	Program capital payments		0	
. 00	Capital exception payments (see instructions)		0	
. 00	Routine and Ancillary service other pass through costs		0	0
. 00	Subtotal (sum of lines 22 through 26)		0	0
. 00	Customary charges (title V or XIX PPS covered services onl	у)	0	0
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		-	-
	Excess of reasonable cost (from line 18)		0	0
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 ar	ia 6)	0	0
. 00 . 00	Deducti bl es Coi nsurance		0	0
. 00	Allowable bad debts (see instructions)		0	0
. 00	Utilization review		0	0
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32	2 and 33)	0	0
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
. 00	Subtotal (line 36 ± 1 ine 37)		0	Ő
	Direct graduate medical education payments (from Wkst. E-4	4)	0	Ű
. 00	Total amount payable to the provider (sum of lines 38 and		0	0
	Interim payments	-	0	0
. 00	Balance due provider/program (line 40 minus line 41)		0	0
		ordance with CMS Pub 15-2,	0	0

Health Financial Systems	DAVIESS COMMUNITY	Y HOSPI TAL	In Lieu	u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0061	Period:	Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/31/2024 9:20	oared:) 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 adjustme	ent amount (see instr	ructions)		0	3.00
4.00 Capital outlier reconciliation adjustment	amount (see instruc	ctions)		0	4.00
5.00 The rate used to calculate the time value	e of money (see instr	ructions)		0.00	5.00
6.00 Time value of money for operating expense	es (see instructions)			0	6.00
7.00 Time value of money for capital related e	expenses (see instruc	ctions)		0	7.00
	•				

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0061 Pe	eriod: com 01/01/2023	Worksheet G	
nly)			Тс		Date/Time Pre 5/31/2024 9:2	
	_	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	12, 713, 735	0	0	0	1.0
. 00	Temporary investments Notes receivable	0	0	0	0	2.0
. 00 . 00	Accounts receivable	25, 062, 651	0	0	0	3.C
. 00	Other receivable	859, 873	0	0	0	5.0
. 00	Allowances for uncollectible notes and accounts receivable	-15, 329, 549	0	0	0	6.0
. 00	Inventory	2, 396, 947	0	0	0	7.0
. 00 . 00	Prepaid expenses Other current assets	551, 107 0	0	0	0	8.0 9.0
	Due from other funds	0	0	0	0	10.
	Total current assets (sum of lines 1-10)	26, 254, 764	0	0	0	11.0
	FIXED ASSETS	1 000 055				
	Land Land improvements	1, 280, 955 687, 865	0	0	0	12. (13. (
	Accumulated depreciation	-686, 823	0	0	0	14.0
	Buildings	69, 258, 443	0	0	0	15.
	Accumulated depreciation	-48, 564, 532	0	0	0	16.
	Leasehold improvements	39, 119	0	0	0	17.
	Accumulated depreciation Fixed equipment	-37, 518 11, 443, 481	0	0	0	18. 19.
	Accumulated depreciation	-8, 087, 211	0	0	0	20.
	Automobiles and trucks	0	0	0	0	21.
	Accumulated depreciation	0	0	0	0	22.
	Major movable equipment	32, 522, 742	0	0	0	23.
	Accumulated depreciation Minor equipment depreciable	-27, 953, 484	0	0	0	24. 25.
	Accumulated depreciation	0	0	0	0	26.
7.00	HIT designated Assets	0	0	0	0	27.
	Accumulated depreciation	0	0	0	0	28.
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	0 29, 903, 037	0	0	0	29. 30.
	OTHER ASSETS	27, 703, 037		0	0	30.
	Investments	3, 392, 801	0	0	0	31.
	Deposits on Leases	0	0	0	0	32.
	Due from owners/officers Other assets	0 1, 640, 621	0	0	0	33. 34.
	Total other assets (sum of lines 31-34)	5, 033, 422	0	0	0	34.
	Total assets (sum of lines 11, 30, and 35)	61, 191, 223	0	0	0	36.
	CURRENT LI ABI LI TI ES		- 1			
	Accounts payable Salaries, wages, and fees payable	2, 094, 798 1, 006, 664	0	0	0	37. 38.
	Payrol I taxes payable	689, 197	0	0	0	30.
	Notes and Loans payable (short term)	1, 490, 695	0	0	0	40.
1.00	Deferred income	0	0	0	0	41.
	Accel erated payments	0	0	0	0	42.
	Due to other funds Other current liabilities	0 3, 325, 622	0 0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	8, 606, 976	0	0	0	
	LONG TERM LIABILITIES	· · ·				
	Mortgage payable	0	0	0	0	
	Notes payable	0	0	0	0	47.
	Unsecured Loans Other Long term Liabilities	0 6, 845, 808	0	0	0	48. 49.
	Total long term liabilities (sum of lines 46 thru 49)	6, 845, 808	-	0	0	50.
1.00	Total liabilities (sum of lines 45 and 50)	15, 452, 784	0	0	0	51.
	CAPITAL ACCOUNTS					
	General fund balance	45, 738, 443	0			52. 53.
	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53. 54.
	Donor created - endowment fund balance - unrestricted			0		55.
6.00	Governing body created - endowment fund balance			0		56.
	Plant fund balance - invested in plant				0	57.
8.00	Plant fund balance - reserve for plant improvement,				0	58.
9.00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	45, 738, 443	0	0	0	59.
		10, 100, 740	0	0	0	1 0 / .

Health Financial Systems	DAVIESS COMMUNIT	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet G- Date/Time Pro	epared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
<pre>1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 IDENTIFIED ON TRIAL BALANCE 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance</pre>	0 0 0 0 0 0 0 700, 133 0 0 0 0 0 0 0	49, 797, 814 -3, 359, 238 46, 438, 576 0 46, 438, 576 0 46, 438, 576 700, 133 45, 738, 443				5.00 6.00 7.00 8.00 9.00 10.00 11.00 0 13.00 14.00 15.00 16.00
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
 Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) O O O O O O O 	0	000000000000000000000000000000000000000		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 I DENTIFIED ON TRIAL BALANCE 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17)	0	0 0 0 0 0 0		0 0 0		9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

ATEMI	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	- CCN: 15-0061	Period: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I & II Date/Time Pre 5/31/2024 9:2	pared
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services					
	Hospi tal		6, 837, 8		6, 837, 860	
	SUBPROVIDER - IPF		7, 464, 1		7, 464, 147	
00 00	SUBPROVI DER – I RF SUBPROVI DER		2, 169, 1	59	2, 169, 159	
00	Subprovider Swing bed - SNF			0	0	4.C
00	Swing bed - NF			0	0	
00	SKILLED NURSING FACILITY			0	0	7.0
	NURSING FACILITY					8.0
	OTHER LONG TERM CARE					9.0
	Total general inpatient care services (sum of lines 1-9)		16, 471, 1	66	16, 471, 166	1
	Intensive Care Type Inpatient Hospital Services			· · ·		
. 00	INTENSIVE CARE UNIT		2, 112, 4	88	2, 112, 488	111. C
. 00	CORONARY CARE UNIT					12.0
. 00	BURN I NTENSI VE CARE UNI T					13.0
	SURGI CAL I NTENSI VE CARE UNI T					14.0
	OTHER SPECIAL CARE (SPECIFY)					15.0
. 00	Total intensive care type inpatient hospital services (sum of	i nes	2, 112, 4	88	2, 112, 488	16.0
	11-15)					
	Total inpatient routine care services (sum of lines 10 and 16)		18, 583, 6		18, 583, 654	
	Ancillary services		23, 387, 1		146, 712, 516	
	Outpatient services			0 2, 349, 671	2, 349, 671	
	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II			0 1, 186, 590 0 504, 987	1, 186, 590 504, 987	
	RURAL HEALTH CLINIC III			0 2, 457, 559	2, 457, 559	
	RURAL HEALTH CLINIC IV			0 2,437,337	2,437,337	
	RURAL HEALTH CLINIC V			0 2, 518, 744	2, 518, 744	
	RURAL HEALTH CLINIC VI			0 791, 460	791, 460	
	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
	HOME HEALTH AGENCY			0	0	
	AMBULANCE SERVICES			0 0	0	
. 00	CMHC					24.0
. 10	CORF			0 0	0	24.1
	AMBULATORY SURGICAL CENTER (D. P.)					25.0
	HOSPI CE			0 817, 520		
	AMBULANCE			25 4, 970, 621	4, 971, 146	
. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	41, 971, 3	51 138, 922, 496	180, 893, 847	28.0
	G-3, line 1) PART II - OPERATING EXPENSES					-
	Operating expenses (per Wkst. A, column 3, line 200)			78, 718, 475		29.0
	ADD (SPECIFY)			0		30.0
. 00				0		31.
. 00				0		32.
. 00				0		33.
. 00				0		34.
. 00				0		35.
. 00	Total additions (sum of lines 30-35)			0		36.
. 00	IGT EXPENSES NOT ON W/S A		7, 143, 8	86		37.
. 00				0		38.
. 00				0		39.
. 00				0		40.
. 00				0		41.
	Total deductions (sum of lines 37-41)		~	7, 143, 886		42.0
. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	71, 574, 589		43.

Heal th	Financial Systems DAVIESS COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0061	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023		narod
			10 12/31/2023	5/31/2024 9: 20	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I			180, 893, 847	1.00
2.00	Less contractual allowances and discounts on patients' acco	unts		121, 338, 229	2.00
	Net patient revenues (line 1 minus line 2)			59, 555, 618	3.00
	Less total operating expenses (from Wkst. G-2, Part II, lin	e 43)		71, 574, 589	4.00
	Net income from service to patients (line 3 minus line 4)			-12, 018, 971	5.00
	OTHER INCOME				
	Contributions, donations, bequests, etc			0	6.00
	Income from investments			728, 775	7.00
	Revenues from telephone and other miscellaneous communicati	on services		0	8.00
	Revenue from television and radio service			0	9.00
	Purchase di scounts			4, 736	
	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 guests			162, 974	
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
	Revenue from sale of drugs to other than patients			142, 381	
	Revenue from sale of medical records and abstracts				18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			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			193, 406	
	Governmental appropriations			0	23.00
	OTHER - INCLUDES EHR REVENUE			7, 421, 581	24.00
	COVI D-19 PHE Fundi ng			0	24.50
	Total other income (sum of lines 6-24)			8, 659, 733	
	Total (line 5 plus line 25)			-3, 359, 238	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-3, 359, 238	29.00

NALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider C		eri od:	Worksheet O	
			Hospi ce CCI			Date/Time Pre 5/31/2024 9:2	
		SALARI ES	OTHER	SUBTOTAL (col. 1 pl us	Hospi ce 1 RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1					
. 00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	
. 00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	
. 00	EMPLOYEE BENEFITS DEPARTMENT* ADMINISTRATIVE & GENERAL*	85, 071	0 13, 879	0 98, 950	0	0 98, 950	
. 00	PLANT OPERATION & MAINTENANCE*	03,071	13, 079	70, 700 0	0	48, 450 0	
. 00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	
. 00	HOUSEKEEPI NG*	0	0	0	0	0	7.0
. 00	DI ETARY*	0	0	0	0	0	8.0
. 00	NURSING ADMINISTRATION*	0	0	0	0	0	9.0
0.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	
1.00	MEDI CAL RECORDS*	0	0	0	0	0	
2.00	STAFF TRANSPORTATION*	0	4, 479	4, 479	0	4, 479	
3.00 4.00	VOLUNTEER SERVICE COORDINATION* PHARMACY*	0	0	0	0	0	
4.00	PHARMACT PHYSI CLAN ADMI NI STRATI VE SERVI CES*	0	64	64 0	0	64	14.0
6.00	OTHER GENERAL SERVICE*	0	0	0	0	0	
7.00	PATI ENT/RESI DENTI AL CARE SERVI CES		-	-	-	-	17.0
	DIRECT PATIENT CARE SERVICE COST CENTERS						
5.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	
6.00	PHYSICIAN SERVICES**	0	22, 242	22, 242	0	22, 242	
7.00	NURSE PRACTITIONER**	101 5 10	0	0	0	0	
8.00 9.00	REGI STERED NURSE** LPN/LVN**	101, 548	128, 426	229, 974	0	229, 974 0	
0.00	PHYSICAL THERAPY**	0	0	0	0	0	
1.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	
3.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.0
4.00	SPIRITUAL COUNSELING**	0	0	0	0	0	
5.00	DI ETARY COUNSELI NG**	0	0	0	0	0	
6.00	COUNSELING - OTHER**	0	0	0	0	0	
7.00	HOSPI CE AI DE & HOMEMAKER SERVI CES** DURABLE MEDI CAL EQUI PMENT/OXYGEN**	52, 442	0	52, 442 0	0	52, 442 0	
9.00	PATIENT TRANSPORTATION**	0	0	0	0	0	
0.00	I MAGI NG SERVI CES**	0	0	0	0	0	
1.00	LABS & DI AGNOSTI CS**	0	0	0	0	0	
2.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	0	0	0	42.0
2.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.
3.00	OUTPATIENT SERVICES**	0	0	0	0	0	
4.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	
5.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	
0.00	OTHER PATIENT CARE SERVICES (SPECIFY)** NONREIMBURSABLE COST CENTERS	0	0	0	0	0	46.0
0.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.0
1.00	VOLUNTEER PROGRAM *	0	0	0	0	0	
2.00	FUNDRAI SI NG*	0	0	0	0	0	
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.0
4.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	
5.00	OTHER PHYSI CI AN SERVI CES*	0	0	0	0	0	
6.00	RESIDENTIAL CARE*	0	0	0	0	0	
	ADVERTI SI NG*	0	0	0	0	0	
8.00	TELEHEALTH/TELEMONI TORI NG*	0	0	0	0	0	
9.00 0.00	THRIFT STORE* NURSING FACILITY ROOM & BOARD*		0	0	0	0	
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	
			0	0	0	0	1 1 1 1

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

LYS	IS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	I: 15-0061	Peri od:	Worksheet O
			Hospi ce CCN:	15-1553	From 01/01/2023 To 12/31/2023	Date/Time Prepa 5/31/2024 9:20
		1			Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)			
	r	6.00	7.00			
	GENERAL SERVICE COST CENTERS					
0	CAP REL COSTS-BLDG & FIXT*	0	0			
0	CAP REL COSTS-MVBLE EQUIP*	0	0			
0	EMPLOYEE BENEFITS DEPARTMENT*	0	0			
0 0	ADMINISTRATIVE & GENERAL* PLANT OPERATION & MAINTENANCE*	0	98, 950 0			
0	LAUNDRY & LINEN SERVICE*	0	0			
0	HOUSEKEEPING*	0	0			
0	DI ETARY*	0	0			
0	NURSI NG ADMI NI STRATI ON*	0	0			
00	ROUTI NE MEDI CAL SUPPLI ES*	0	0			1
00	MEDI CAL RECORDS*	0	0			1
00	STAFF TRANSPORTATION*	0	4, 479			1
00	VOLUNTEER SERVICE COORDINATION*	0	-, -, / /			1
00	PHARMACY*	0	64			1
00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0			1
00	OTHER GENERAL SERVICE*	0	0			1
00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0			1
00	DI RECT PATIENT CARE SERVICE COST CENTERS	11				'
00	INPATIENT CARE-CONTRACTED**	0	0			2
00	PHYSICIAN SERVICES**	0	22, 242			2
00	NURSE PRACTITIONER**	0	22, 242			2
00	REGI STERED NURSE**	0	229, 974			2
00	LPN/LVN**	0	0			2
00	PHYSICAL THERAPY**	0	0			3
00	OCCUPATIONAL THERAPY**	0	0			3
00	SPEECH/LANGUAGE PATHOLOGY**	0	0			3
00	MEDI CAL SOCI AL SERVI CES**	0	o			3
00	SPIRITUAL COUNSELING**	0	o			3
00	DI ETARY COUNSELI NG**	0	Ő			3
00	COUNSELING - OTHER**	0	o			3
00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	52, 442			3
00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0			3
00	PATIENT TRANSPORTATION**	0	0			3
00	I MAGI NG SERVI CES**	0	o			4
00	LABS & DI AGNOSTI CS**	0	o			4
00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	o			4
50	DRUGS CHARGED TO PATI ENTS**	0	o			4
00	OUTPATI ENT SERVI CES**	0	o			4
00	PALLIATIVE RADIATION THERAPY**	0	o			4
00	PALLIATIVE CHEMOTHERAPY**	0	0			4
00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0			4
	NONREIMBURSABLE COST CENTERS					
00	BEREAVEMENT PROGRAM *	0	0			6
00	VOLUNTEER PROGRAM *	0	0			6
00	FUNDRAI SI NG*	0	0			6
00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0			6
00	PALLIATIVE CARE PROGRAM*	0	0			6
00	OTHER PHYSICIAN SERVICES*	0	0			6
00	RESI DENTI AL CARE*	0	0			6
00	ADVERTI SI NG*	0	0			6
00	TELEHEALTH/TELEMONI TORI NG*	0	0			6
00	THRI FT STORE*	0	0			6
00	NURSING FACILITY ROOM & BOARD*	0	o			7
00	OTHER NONREIMBURSABLE (SPECIFY)*	0	o			7
	TOTAL	1	408, 151			10

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Heal th	Financial Systems	DAVIESS COMMUNI	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE ROUTINE HOME	Provider C	CN: 15-0061	Period:	Worksheet 0-2	
CARE			Hospi ce CC	N: 15-1553	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATIONS		
				col. 2)			
	Γ	1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	1					
25.00	INPATIENT CARE-CONTRACTED						25.00
	PHYSI CI AN SERVI CES	0	22, 100	22, 10	0 0	22, 100	
	NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00	REGI STERED NURSE	100, 898	127, 604	228, 50	02 0	228, 502	28.00
29.00	LPN/LVN	0	0		0 0	0	29.00
30.00	PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00	COUNSELING - OTHER	0	0		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	52, 106	0	52, 10	06 0	52, 106	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		0 0	0	39.00

37.00		0	0	0	0	0	37.00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	153, 004	149, 704	302, 708	0	302, 708	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51					

		ADJUSTMENTS	TOTAL (col. 5		
		6, 00	<u>± col. 6)</u> 7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00		
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSI CI AN SERVI CES	0	22, 100		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	228, 502		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	SPI RI TUAL COUNSELI NG	0	0		34.00
35.00	DI ETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	52, 106		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		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	OUTPATI ENT SERVI CES	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	302, 708	1	00.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51			

Health Financial Systems	DAVIESS COMMUNIT				u of Form CMS-	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HO	SPICE GENERAL	Provider CC	N: 15-0061	Period:	Worksheet 0-4	ļ
INPATIENT CARE		Hospi ce CCN	l: 15-1553	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	epared: 20 am
				Hospi ce I		_
	SALARI ES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
26.00 PHYSI CLAN SERVI CES	0	142	1.	42 0	142	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	650	822	1, 4	72 0	1, 472	
29.00 LPN/LVN	0	0		0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	02.00
33.00 MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
34.00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35.00 DI ETARY COUNSELI NG	0	0		0 0	0	00.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	336	0	33	36 0	336	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 OUTPATIENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *	986	964	1, 9	50 0	1, 950	100.00

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 45.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 986

 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
		6,00	± col. 6) 7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	142		26.00
27.00	NURSE PRACTI TI ONER	0	0		27.00
28.00	REGI STERED NURSE	0	1, 472		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	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	0	336		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	0		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	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1, 950	10	00.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53	l.		

Heal th	Financial Systems DAVIESS COMMUNI	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C		Period:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION	Hospi ce CC		From 01/01/2023 To 12/31/2023		narod
		nospi ce cc	N. 15-1555	10 12/31/2023	5/31/2024 9:2	
				Hospi ce I	0/01/2021 //2	
	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			
1.00	CAP REL COSTS-BLDG & FIXT			0 6, 454		1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 49, 713		3.00
4.00	ADMI NI STRATI VE & GENERAL		98, 95			4.00
5.00	PLANT OPERATION & MAINTENANCE			0 15, 441	15, 441	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	-	6.00
7.00	HOUSEKEEPING			0 4, 194		7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0 20, 865		9.00
10.00	ROUTINE MEDICAL SUPPLIES			0 921	921	10.00
11.00	MEDI CAL RECORDS			0 6, 813		11.00
12.00	STAFF TRANSPORTATION		4, 47		4, 479	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00			6	4 O		14.00
15.00 16.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE			0 0	0	15.00 16.00
16.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
17.00	LEVEL OF CARE		1	0	0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		302, 70		302, 708	51.00
52.00	HOSPI CE I NPATI ENT RESPI TE CARE			0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		1, 95		1, 950	53.00
00.00	NONREI MBURSABLE COST CENTERS		1,70	<u> </u>	1, 700	00.00
60.00	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	THRI FT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	71.00
99.00	NEGATI VE COST CENTER			0	0	99.00
100.00	TOTAL		408, 15	1 175, 994	584, 145	100.00

	Financial Systems	DAVIESS COMMUN	I TY HOSPI TAL			In Lieu	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVI CE COSTS	Provider C Hospice CC			eriod: com 01/01/2023 o 12/31/2023	Worksheet 0-6 Part I Date/Time Pre 5/31/2024 9:2	pared:
						Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBI EQUI P	LE	EMPLOYEE BENEFI TS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS						-	
1.00	CAP REL COSTS-BLDG & FIXT	6, 454	6, 454					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	49, 713	0		0	49, 713		3.00
4.00	ADMI NI STRATI VE & GENERAL	170, 543	0		0	18, 397	188, 940	4.00
5.00	PLANT OPERATION & MAINTENANCE	15, 441	0		0	0	15, 441	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0	0	0	6.00
7.00	HOUSEKEEPING	4, 194	0		0	0	4, 194	7.00
8.00	DI ETARY	0	0		0	0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	20, 865	0		0	0	20, 865	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	921	0		0	0	921	10.00
11.00	MEDI CAL RECORDS	6, 813	0		0	0	6, 813	
12.00	STAFF TRANSPORTATION	4, 479	0		0	0	4, 479	12.00
12.00	VOLUNTEER SERVICE COORDINATION	4,479	0		0	0	4,477	13.00
14.00	PHARMACY	64	0		0	0	64	14.00
14.00	PHARMACT PHYSICIAN ADMINISTRATIVE SERVICES	04	0		0	0	04	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	0	17.00
17.00	LEVEL OF CARE		0		U		0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0		1	- 1	0	0	50.00
51.00	HOSPICE CONTINUOUS HOME CARE	302, 708				31, 198	333, 906	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	302,708	0		0	31, 190	333, 900	52.00
52.00	HOSPICE INPATIENT RESPICE CARE	1, 950	0		0	118	2,068	
55.00	NONREI MBURSABLE COST CENTERS	1, 700	0		U	110	2,000	55.00
60,00	BEREAVEMENT PROGRAM	0	0	1	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	0	0	61.00
62.00	FUNDRAI SI NG	0	0		0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	0	0	64.00
64.00 65.00		0	0		0	0	0	
	OTHER PHYSI CI AN SERVI CES	0	0		0	0	-	65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTI SI NG	0	0		U	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		U	0	0	68.00
69.00	THRIFT STORE	0	0		U	0	0	69.00
	NURSING FACILITY ROOM & BOARD	0	<i>, .</i>				0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	6, 454		0	0	6, 454	
	NEGATIVE COST CENTER	0	0		0	0	504 445	99.00
100.00	TOTAL	584, 145	6, 454		0	49, 713	584, 145	100.00

	n Financial Systems ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	DAVIESS COMMUN		CN: 15-0061	Po	In Lieu eriod:	u of Form CMS Worksheet O		552-10
00317	ALLOCATION - HOSFITAL-DAGLD HOSFICE GENERAL	SERVICE COSTS	Hospi ce CC			om 01/01/2023	Part I Date/Time P 5/31/2024 9	rep	ared:
						Hospi ce I	373172024 7	. 20	an
	Descriptions	ADMI NI STRATI V E & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY &		HOUSEKEEPI NG	DI ETARY		
		4.00	5.00	6.00		7.00	8.00	-	
	GENERAL SERVICE COST CENTERS		0.00	0.00		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0100		
1.00 2.00 3.00 4.00 5.00 6.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE	188, 940 7, 382 0	22, 823 0		0				1.00 2.00 3.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00 12.00 13.00	MEDI CAL RECORDS STAFF TRANSPORTATI ON	2, 005 0 9, 975 440 3, 257 2, 141 0				6, 199 0 0 0 0 0 0		0	7.00 8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE PATI ENT/RESI DENTI AL CARE SERVI CES LEVEL OF CARE	31 0 0 0				0 0 0			14.00 15.00 16.00 17.00
50.00 51.00 52.00 53.00	HOSPI CE ROUTI NE HOME CARE HOSPI CE I NPATI ENT RESPI TE CARE	0 159, 634 0 989	0		0 0	0		0	50.00 51.00 52.00 53.00
71. 00 99. 00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22, 823 22, 823		0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 6, 199 0 6, 199		0	60.00 61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00

Heal th	n Financial Systems	DAVIESS COMMUNI	TY HOSPI TAL			In Lie	u of Form CMS-:	2552-10
COST /	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provider CO Hospice CCI			eriod: com 01/01/2023 o 12/31/2023	Worksheet 0-6 Part I Date/Time Pre 5/31/2024 9:2	
					+	Hospi ce I	5/31/2024 9:2	
	Descriptions	NURSI NG ADMI NI STRATI O	ROUTI NE MEDI CAL	MEDI CAL RECORDS		STAFF TRANSPORTATI 0	VOLUNTEER SERVI CE	
		N	SUPPLI ES			N	COORDI NATI ON	
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS	1						1
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINI STRATI VE & GENERAL PLANT OPERATI ON & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY NURSING ADMINI STRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION	30, 840 0 0 0	1, 361	10, 0)70	6, 620		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00	LEVEL OF CARE					0 0 0	0000000	13.00 14.00 15.00 16.00 17.00
50.00 51.00 52.00 53.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	0 30, 840 0 0	0 1, 351 0 10	9,9	0 996 0 74	0 6, 620 0 0	0 0 0	50.00 51.00 52.00 53.00
71.00 99.00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 1, 361	10, 0	0)70	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	99.00

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-:	2552-10
	LLOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL S	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2023 To 12/31/2023	Worksheet 0-6 Part I Date/Time Pre 5/31/2024 9:2	pared:
-					Hospice I		
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI V E SERVI CES	OTHER GENERA SERVI CE		TOTAL	
		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						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						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	95					14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0			0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17.00
	LEVEL OF CARE						
	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	
	HOSPICE ROUTINE HOME CARE	95	0		0	542, 442	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	0	52.00
	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	3, 141	53.00
	NONREIMBURSABLE COST CENTERS			1			
	BEREAVEMENT PROGRAM	0			0	0	
61.00	VOLUNTEER PROGRAM	0			0	0	
62.00	FUNDRAI SI NG	0			0	0	
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	
	PALLIATIVE CARE PROGRAM	0			0	0	
	OTHER PHYSICIAN SERVICES	0			0	0	
	RESI DENTI AL CARE	0	0		0 0	0	66.00
	ADVERTI SI NG	0			0	0	
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	
	THRIFT STORE	0			0	0	
	NURSING FACILITY ROOM & BOARD		_			0	
	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	38, 562	
	NEGATI VE COST CENTER	0	0		0 0	0	
100.00	IUTAL	95	0	1	0 0	584, 145	100.00

Heal th	Financial Systems	DAVIESS COMMUN	NETY HOSPETAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GEN	ERAL SERVICE COSTS	Provider C	CN: 15-0061	Period:	Worksheet 0-6	
STATI S	TI CAL BASI S		lloopi oo CCI	N. 1E 1EEO	From 01/01/2023		norod.
			Hospi ce CCI	N: 15-1553	To 12/31/2023	Date/Time Pre 5/31/2024 9:2	pareu: O am
					Hospi ce I	5/51/2024 7.2	
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCILIATIO	ADMI NI STRATI V	
		& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
			· ·	SALARI ES)		,	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	585					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	C	0	236, 94	19		3.00
4.00	ADMI NI STRATI VE & GENERAL	C	0	87, 68	-188, 940	395, 205	4.00
5.00	PLANT OPERATION & MAINTENANCE	C	0		0 0	15, 441	5.00
6.00	LAUNDRY & LINEN SERVICE	C	0		0 0	0	6.00
7.00	HOUSEKEEPING	C	0		0 0	4, 194	7.00
8.00	DI ETARY	C	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION	C	0		0 0	20, 865	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	C	0		0 0	921	10.00
11.00	MEDI CAL RECORDS	C	0		0 0	6, 813	11.00
12.00	STAFF TRANSPORTATION	C	0		0 0	4, 479	12.00
13.00	VOLUNTEER SERVICE COORDINATION	C	0		0 0	0	13.00
14.00	PHARMACY	C	0		0 0	64	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	C	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE	C	0		0 0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	C	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			148, 70	0 00	333, 906	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	C	0		0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	C	0	56	52 0	2, 068	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	C	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	C	0		0 0	0	61.00
62.00	FUNDRAI SI NG	C	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	C	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	C	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	C	0		0 0	0	65.00
66.00	RESI DENTI AL CARE	C	0		0 0	0	66.00
67.00	ADVERTI SI NG	C	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	C	0		0 0	0	68.00
69.00	THRI FT STORE	C	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	585	0		0 0	6, 454	
	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, F			49, 71		188, 940	
101.00	UNIT COST MULTIPLIER	11. 032479	0. 000000	0. 20980	05	0. 478081	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS Provider CCN: 15-0061 Hospice CCN: 15-1553 Period: From 01/01/2023 To 12/31/2023 Worksheet 0-6 Part II Date/Time Prepared: 5/31/2024 9: 20 am Cost Center Descriptions PLANT OPERATION & MAINTENANCE (SQUARE FEET) LAUNDRY & LINEN SERVICE (SQUARE FEET) HOUSEKEEPING (SQUARE FEET) DI ETARY (IN-FACILITY DAYS) NURSING ADMINISTRATIO N (DI RECT NURS. HRS.)
Cost Center Descriptions PLANT LAUNDRY & LI NEN SERVICE HOUSEKEEPING (SQUARE FEET) DI ETARY NURSING MAI NTENANCE (I N-FACI LI TY (SQUARE FEET) (I N-FACI LI TY DAYS) DAYS) DI ETARY NURSING
Cost Center DescriptionsPLANTLAUNDRY & LINEN SERVICEHOUSEKEEPING (SQUARE FEET)DIETARY (IN-FACILITY DAYS)NURSING ADMINISTRATIO N (DIETARYCost Center DescriptionsPLANTLAUNDRY & OPERATION & MAINTENANCE (SQUARE FEET)HOUSEKEEPING (SQUARE FEET)DIETARY (IN-FACILITY DAYS)NURSING ADMINISTRATIO N (DI RECT NURS.
OPERATION & LI NEN SERVICE (SQUARE FEET) (I N-FACILITY ADMINISTRATIO MAINTENANCE (I N-FACILITY DAYS) N (SQUARE FEET) DAYS) (DI RECT NURS.
MAI NTENANCE (I N-FACI LI TY DAYS) N (SQUARE FEET) DAYS) (DI RECT NURS.
(SQUARE FEET) DAYS) (DI RECT NURS.
5.00 6.00 7.00 8.00 9.00
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 ADMI NI STRATI VE & GENERAL 4. 00
5.00 PLANT OPERATION & MAINTENANCE 585 5.00
6.00 LAUNDRY & LI NEN SERVI CE 0 0 0 6.00
7. 00 HOUSEKEEPING 0 585 7. 00
8.00 DI ETARY 0 0 0 8.00
9.00 NURSING ADMINISTRATION 0 0 7,728 9.00
10. 00 ROUTINE MEDICAL SUPPLIES 0 0 0 10. 00
11.00 MEDICAL RECORDS 0 0 11.00
12.00 STAFF TRANSPORTATION 0 0 12.00
13.00 VOLUNTEER SERVICE COORDINATION 0 0 13.00
14.00 PHARMACY 0 0 14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 15.00
16.00 OTHER GENERAL SERVICE 0 0 16.00
17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES 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 52. 00
53. 00 HOSPICE GENERAL I NPATI ENT CARE 0 0 0 0 0 53. 00
NONREI MBURSABLE COST CENTERS
60. 00 BEREAVEMENT_PROGRAM 0 0 60. 00
61. 00 VOLUNTEER PROGRAM 0 0 61. 00
62. 00 FUNDRALSING 0 0 62. 00
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63. 00
64. 00 PALLIATIVE CARE PROGRAM 0 0 64. 00
65. 00 OTHER PHYSI CLAN SERVICES 0 0 65. 00
66.00 RESIDENTIAL CARE 0 0 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 70. 00 71. 00
71. 00 OTHER NONREI MBURSABLE (SPECI FY) 585 0 0 71. 00
99.00 NEGATI VE COST CENTER 99.00
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 22,823 0 6,199 0 30,840 100.00
101. 00 UNIT COST MULTIPLIER 39. 013675 0. 000000 10. 596581 0. 000000 3. 990683 101. 00

Heal th	Financial Systems	DAVIESS COMMUNIT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C	CN: 15-0061	Period:	Worksheet 0-6)
STATI S	TI CAL BASI S		Hospi ce CC	N: 15-1553	From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 5/31/2024 9:2	
		-			Hospi ce I		
	Cost Center Descriptions	ROUTINE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL SUPPLI ES	RECORDS	TRANSPORTATI	0 SERVICE COORDINATION	(CHARGES)	
		(PATIENT	(PATI ENT DAYS)	N (MI LEAGE)	(HOURS OF		
		DAYS)	DATS)		SERVICE)		
		10.00	11.00	12.00	13.00	14.00	
-	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	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00							8.00
9.00	NURSI NG ADMI NI STRATI ON	2,002					9.00
10. 00 11. 00	ROUTI NE MEDI CAL SUPPLI ES	2, 993	2 002				10.00
12.00	MEDI CAL RECORDS STAFF TRANSPORTATI ON		2, 993	4, 20	7		12.00
12.00	VOLUNTEER SERVICE COORDINATION			4,20	0 0		12.00
14.00	PHARMACY				0 0	270	14.00
15.00	PHYSI CLAN ADMI NI STRATI VE SERVI CES				0 0	2/0	15.00
16.00	OTHER GENERAL SERVICE				0 0	0	
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				ů ů	0	17.00
	LEVEL OF CARE	I		1			1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2, 971	2, 971	4, 20	57 0	270	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	22	22		0 0	0	53.00
	NONREI MBURSABLE COST CENTERS			1	-	-	
60.00	BEREAVEMENT PROGRAM				0 0	0	
61.00	VOLUNTEER PROGRAM				0 0	0	61.00
62.00					0 0	0	62.00
63.00 64.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM				0 0	0	63.00 64.00
65.00	OTHER PHYSICIAN SERVICES				0 0	0	65.00
66.00	RESIDENTIAL CARE				0 0	0	66.00
67.00	ADVERTI SI NG				0 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 NONREI MBURSABLE (SPECI FY)				0 0	0	•
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		10, 070	6, 62			100.00
101.00	UNIT COST MULTIPLIER	0. 454728	3. 364517	1. 55144	0. 000000	0. 351852	101.00

Heal th	Financial Systems	DAVIESS COMMUN	ILTY HOSPITAL		In Lie	u of Form CMS	-2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI TICAL BASIS	ERVICE COSTS	Provider C Hospice CC	CN: 15-0061 N: 15-1553	Period: From 01/01/2023 To 12/31/2023	Worksheet O- Part II Date/Time Pr	repared:
					Hospi ce I	5/31/2024 9:	20 am
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL	_		
		E SERVICES	(SPECI FY	CARE SERVICE			
		(PATI ENT	BASIS)	(IN-FACILIT			
		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	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						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							14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0					15.00
16.00	OTHER GENERAL SERVICE		0		10		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				13		17.00
50.00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	0	C				50.00
51.00	HOSPICE CONTINUOUS HOME CARE	0					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	-		0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0			13		53.00
00.00	NONREI MBURSABLE COST CENTERS		. · · · · ·		10		
60.00	BEREAVEMENT PROGRAM		C				60.00
61.00	VOLUNTEER PROGRAM						61.00
62.00	FUNDRAI SI NG						62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00	PALLIATIVE CARE PROGRAM		0)			64.00
65.00	OTHER PHYSICIAN SERVICES		0)			65.00
66.00	RESIDENTIAL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRI FT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.00
99.00	NEGATIVE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0		0		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	00		101.00

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
	I ONMENT OF HOSPI TAL-BASED HOSPI CE SHARED SER	VICE COSTS BY	Provider C	CN: 15-0061	Period:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCI	N: 15-1553	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 9:2	pared: 0 am
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to	НСНС	HRHC	HI RC	
		Part I, Col. 9 line	Charge Ratio	nene	TIKIC	TH KC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66.00	0. 322557		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0. 224381		0 0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0. 393596		0 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 328660		0 0	0	4.00
5.00 6.00	DURABLE MEDICAL EQUIP-RENTED LABORATORY	96.00 60.00	0. 192654		0 0	0	5.00 6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0. 363316			0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTE	93.00	1. 168145		0 0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00			0	Ũ	9.00
10.00	CARDI AC REHAB	76.00	0. 616814		0 0	0	10.00
10.01	ADDICTION SERVICES	76.01	5. 311732		0 0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00
		Charges by		Shared Serv	ce Costs by LOC		
		LOC (from Provider					
		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)	
		5.00	6.00	7.00	8.00	9.00	
	ANCI LLARY SERVICE COST CENTERS		-	L			
1.00	PHYSI CAL THERAPY	0	0		0 0	0	1.00
2.00 3.00	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0		0 0	0	2.00 3.00
3.00 4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	4.00
4.00 5.00	DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	5.00
6.00	LABORATORY	0	0		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0		0 0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C						9.00
10.00	CARDI AC REHAB	0	0		0 0	0	
10.01	ADDI CTI ON SERVI CES	0	0		0 0	0	
11.00	Totals (sum of lines 1–11)	1	0		0 0	0	11.00

CALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider C	CN: 15-0061	Peri od:	Worksheet 0-8	;
		Hospi ce CC	N: 15-1553	From 01/01/2023 To 12/31/2023		
				Hospi ce I		_
			TITLE XVIII		TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE					
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			0	1.0
	line 11)					
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	
. 00	Total average cost per diem (line 1 divided by line 2)	10)			0.00	
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	ie 10)				4.0
. 00	Program cost (line 3 times line 4) HOSPICE ROUTINE HOME CARE			0 (5.0
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7 col 7	1		542, 442	6.0
. 00	line 11)	7, COL. 7,			542, 442	0.1
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				2,971	7.
. 00	Total average cost per diem (line 6 divided by line 7)				182.58	
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	2,9	71 (9.0
0.00	Program cost (line 8 times line 9)		542, 4			10.0
	HOSPICE INPATIENT RESPITE CARE				-	
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7, col. 8,			0	11. (
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				0	12.0
3.00	Total average cost per diem (line 11 divided by line 12)				0.00	13.
4.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		0 (14.0
5.00	Program cost (line 13 times line 14)			0 (15.
	HOSPICE GENERAL INPATIENT CARE		1		1	
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7, col. 9,			3, 141	16. (
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				22	
8.00	Total average cost per diem (line 16 divided by line 17)	10)		22	142.77	
9.00 0.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne is)	3, 1	22 (19. (20. (
0.00	Program cost (line 18 times line 19) TOTAL HOSPICE CARE		3, 1	41 (<u>и</u>	20.1
1.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				545, 583	21.
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				2, 993	
	Average cost per diem (line 21 divided by line 22)				182. 29	
5.00	Average cost per drem (The 21 drvided by The 22)		I	1	1 102.29	ZJ.

Capital DRG outlier pModel 4 BPCI CapitalTotal inpatient daysNumber of interns & rIndirect medical educIndirect medical educ	n outlier DRG other than outlier ayments DRG outlier payments divided by number of days in the o esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	3)	Hospi tal	5/31/2024 9: 2 PPS 1. 00 159, 145 0 0 0 7. 23	1. (1. (2. (
CAPITAL FEDERAL AMOUNTCapital DRG other thaModel 4 BPCI CapitalCapital DRG outlier pModel 4 BPCI CapitalTotal inpatient daysNumber of interns & rIndirect medical educIndirect medical educ	n outlier DRG other than outlier ayments DRG outlier payments divided by number of days in the o esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	cost reporting period (see ins		1.00 159,145 0 0 0	1. 0 2. 0
CAPITAL FEDERAL AMOUNTCapital DRG other thaModel 4 BPCI CapitalCapital DRG outlier pModel 4 BPCI CapitalTotal inpatient daysNumber of interns & rIndirect medical educIndirect medical educ	n outlier DRG other than outlier ayments DRG outlier payments divided by number of days in the o esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	3)	tructions)	159, 145 0 0 0	1. 0 2. 0
CAPITAL FEDERAL AMOUNTCapital DRG other thaModel 4 BPCI CapitalCapital DRG outlier pModel 4 BPCI CapitalTotal inpatient daysNumber of interns & rIndirect medical educIndirect medical educ	n outlier DRG other than outlier ayments DRG outlier payments divided by number of days in the o esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	3)	tructions)	0 0 0	1. 0 2. 0
Capital DRG other tha Model 4 BPCI Capital Capital DRG outlier p Model 4 BPCI Capital Model 4 BPCI Capital Total inpatient days Number of interns & r Indirect medical educ Indirect medical educ	n outlier DRG other than outlier ayments DRG outlier payments divided by number of days in the o esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	3)	tructions)	0 0 0	1. 0 2. 0
D1Model 4 BPCI CapitalD0Capital DRG outlier pD1Model 4 BPCI CapitalD0Total inpatient daysD0Number of interns & rD0Indirect medical educD0Indirect medical educ	DRG other than outlier ayments DRG outlier payments divided by number of days in the o esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	3)	tructions)	0 0 0	1. (2. (
Capital DRG outlier pModel 4 BPCI CapitalTotal inpatient daysNumber of interns & rIndirect medical educIndirect medical educ	ayments DRG outlier payments divided by number of days in the c esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	3)	tructions)	0	2.0
D1Model4 BPCI CapitalD0Total inpatient daysD0Number of interns & rD0Indirect medical educD0Indirect medical educ	DRG outlier payments divided by number of days in the c esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	3)	tructions)	0	
Total inpatient daysNumber of interns & rIndirect medical educIndirect medical educ	divided by number of days in the c esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	3)	tructions)	-	
00 Number of interns & r 00 Indirect medical educ 00 Indirect medical educ	esidents (see instructions) ation percentage (see instructions ation adjustment (multiply line 5	3)	tructions)	7.23	1
00 Indirect medical educ 00 Indirect medical educ	ation percentage (see instructions ation adjustment (multiply line 5	·			
00 Indirect medical educ	ation adjustment (multiply line 5	·		0.00	
				0.00	
1.01)(see instruction	3)	by the sum of lines 1 and 1.0	1, columns 1 and	0	6.
00 Percentage of SSI rec 30) (see instructions	ipient patient days to Medicare Pa)	art A patient days (Worksheet	E, part A line	0.00	7.
9	d patient days to total days (see	instructions)		0.00	
00 Sum of lines 7 and 8				0.00	
	onate share percentage (see instru	uctions)		0.00	
	e adjustment (see instructions)			0	1
00 Total prospective cap	tal payments (see instructions)			159, 145	12.
			-	1.00	-
PART II - PAYMENT UND				1.00	-
	tine capital cost (see instruction			0	1 1.
	illary capital cost (see instruction			0	1
	am capital cost (line 1 plus line			0	
1 1 3	factor (see instructions)	2)		0	
	am capital cost (line 3 x line 4)			0	1
			-	1.00	
PART III - COMPUTATIO	I OF EXCEPTION PAYMENTS			1.00	
00 Program inpatient cap	tal costs (see instructions)			0	1.
	tal costs for extraordinary circu			0	
	capital costs (line 1 minus line	2)		0	
1	percentage (see instructions)			0.00	
	arison to payments (line 3 x line			0	
5 5	for extraordinary circumstances (,		0.00	
1 5	minimum payment level for extraor	dinary circumstances (line 2	x line 6)	0	1
	nt level (line 5 plus line 7)			0	
	payments (from Part I, line 12, as			0	1
.00 Carryover of accumula	on of capital minimum payment leve ted capital minimum payment level			0	1
Worksheet L, Part III				-	
	tal minimum payment level to capi		,	0	1
	n payment (if line 12 is positive,			0	
(if line 12 is negati	ted capital minimum payment level ve, enter the amount on this line)		tollowing period	0	
	e operating and capital payment (s			0	1
	g and capital costs (see instructi n offset amount (see instructions)			0	16. 17.

	Financial Systems	DAVIESS COMMUN	Provider C	NI 15 0041	Do	eri od:	u of Form CMS-2 Worksheet M-1	
ANALIS	SIS OF HUSPITAL-BASED RHC/FUHC CUSIS		Provider C	JN: 15-0001		om 01/01/2023	worksneet m-1	
			Component	CCN: 15-8500	То			
						RHC I	5/31/2024 9:2 Cost	0 am
		Compensation	Other Costs	Total (col	1	Reclassi fi cat	Recl assi fi ed	
		compensation	01101 00313	+ col. 2)		ions	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	303, 333	0	303, 33		0	303, 333	1.00
2.00 3.00	Physician Assistant Nurse Practitioner	0 188, 444	0	188, 4	0	0	0 188, 444	2.00 3.00
3.00 4.00	Visiting Nurse	100, 444	0	100, 44	44	0	100, 444	4.00
4.00 5.00	Other Nurse	0	0		0	0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
7.10	Marriage and Family Therapist	-				-		7.10
7.11	Mental Health Counselor							7.1
3. 00	Laboratory Techni ci an	0	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	180, 557	0	180, 5		0	180, 557	9.0
0.00	Subtotal (sum of lines 1 through 9)	672, 334	0	672, 3	34	0	672, 334	
1.00	Physician Services Under Agreement	0	0		0	0	0	
2.00	Physician Supervision Under Agreement	0	0		0	0	0	12.0
13.00	Other Costs Under Agreement	0	0		0	0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0 17, 088	17, 0	0	0	0	
15.00 16.00	Medical Supplies Transportation (Health Care Staff)	0	17,088	17,00	88 0	0	17, 088 0	
17.00	Depreciation-Medical Equipment	0	0		0	0	0	
18.00	Professional Liability Insurance	0	0		0	0	0	18.0
9.00	Other Heal th Care Costs	0	0		0	0	0	
20.00	Allowable GME Costs	-	-		-	-		20.0
21.00	Subtotal (sum of lines 15 through 20)	0	17, 088	17, 08	88	0	17, 088	21.0
22.00	Total Cost of Health Care Services (sum of	672, 334	17, 088	689, 42	22	0	689, 422	22.0
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES	-		L	-	-	-	
23.00	Pharmacy	0	0		0	0	0	
24.00	Dental	0	0		0 0	0	0	
25.00 25.01	Optometry Telehealth	0	0		0	0	0	25.0 25.0
25.01	Chronic Care Management	0	0		0	0	0	25.0
26.00	All other nonreimbursable costs	0	0		0	0	0	
27.00	Nonal I owable GME costs	0	0		Ŭ	0	0	27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	
	through 27)							
	FACILITY OVERHEAD							
29.00	Facility Costs	0	62, 662			0	62, 662	
30.00	Administrative Costs	72, 773	0	72, 7		0	72, 773	
31.00	Total Facility Overhead (sum of lines 29 and	72, 773	62, 662	135, 43	35	0	135, 435	31.0
22 00	30) Total facility costs (sum of lines 22, 29	745 107		004 0	E 7	0	004 057	22 0
32.00	Total facility costs (sum of lines 22, 28 and 31)	745, 107	79, 750	824, 8	ວ/	0	824, 857	32.00

		DAVIESS COMMUN		01 15 00/1		J OF FORM CMS	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet M-	1
			Component	CCN: 15-8500	To 12/31/2023	Date/Time Pr 5/31/2024 9:	
					RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6.00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	6.00	7.00				-
1.00	Physician	0	303, 333				1.00
2.00	Physician Assistant	0		1			2.00
2.00	Nurse Practitioner	0	188, 444				3.00
4.00	Visiting Nurse	0	100, 444	1			4.00
4.00 5.00	Other Nurse	0					5.00
5.00 6.00	Clinical Psychologist	0					6.00
7.00	Clinical Social Worker	0					7.00
7.10	Marriage and Family Therapist	0	L L				7.10
7.11 8.00	Mental Health Counselor	0	c				7.11
	Laboratory Technician	0	-				
9.00	Other Facility Health Care Staff Costs	0	180, 557				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	672, 334	1			10.00
11.00	Physician Services Under Agreement	0	C				11.00
12.00	Physician Supervision Under Agreement	0	C	1			12.00
13.00	Other Costs Under Agreement	0	C				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	17,088	1			15.00
	Transportation (Health Care Staff)	0	C				16.00
	Depreciation-Medical Equipment	0	C				17.00
	Professional Liability Insurance	0	C				18.00
	Other Health Care Costs	0	C				19.00
	Allowable GME Costs		17.000				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17, 088	•			21.00
22.00	Total Cost of Health Care Services (sum of	0	689, 422				22.00
	lines 10, 14, and 21)						-
22 00	COSTS OTHER THAN RHC/FQHC SERVICES	0	C				23.00
		0					
24.00	Dental	0					24.00
25.00	Optometry Talahaalith	0	-				25.00
25.01	Tel eheal th	0					25.01
25.02	Chronic Care Management	0	-				25.02
26.00	All other nonreimbursable costs	0	C				26.00
27.00	Nonallowable GME costs	0	-				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	C				28.00
	through 27)						-
20 00	FACILITY OVERHEAD	0	40 440				1 20 00
29.00 30.00	Facility Costs	0					29.00
	Administrative Costs	-					
31.00	Total Facility Overhead (sum of lines 29 and	0	135, 435	1			31.00
32.00	30) Total facility costs (sum of lines 22, 28	0	00/ 057				22 00
32 111	Total facility costs (sum of lines 22, 28	0	824, 857	1			32.00

	Financial Systems	DAVIESS COMMUN	Provider C	CNI 15 0041	Do	ri od:	u of Form CMS-2 Worksheet M-1	2002-1
ANALIS	SIS OF HUSPITAL-BASED RHC/FUHC CUSIS		Provider C	CN: 15-0001		om 01/01/2023	worksneet M-1	
			Component	CCN: 15-3999	To		Date/Time Pre	
						RHC II	5/31/2024 9:20	0 am
		Compensation	Other Costs	Total (col	1 0	Reclassi fi cat	Cost Reclassified	
		compensation	Uther Costs	+ col. 2)	· · ·	ions	Trial Balance	
						1 0110	(col. 3 +	
							col. 4)	
		1.00	2.00	3.00		4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	284, 810	0	284, 8		0	284, 810	1.00
2.00	Physician Assistant	0	0		0	0	0	2.00
3.00	Nurse Practitioner	84, 253	0	84, 2	53	0	84, 253	3.00
4.00 5.00	Visiting Nurse Other Nurse	0	0		0	0	0	4.00 5.00
5.00 6.00	Clinical Psychologist	0	0		0	0	0	5.00 6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
7.10	Marriage and Family Therapist	0	0		0	0	0	7.10
7.11	Mental Health Counsel or							7.1
8.00	Laboratory Techni ci an	0	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	113, 524	0	113, 5	24	0	113, 524	9.00
10.00	Subtotal (sum of lines 1 through 9)	482, 587	0	482, 5	87	0	482, 587	10.00
11.00	Physician Services Under Agreement	0	0		0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	0	12.0
13.00	Other Costs Under Agreement	0	0		0	0	0	13.0
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14.0
15.00	Medical Supplies	0	29, 456	29, 4		0	29, 456	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	0	17.00
18.00 19.00	Professional Liability Insurance Other Health Care Costs	0	0		0	0	0	18.00 19.00
20.00	Allowable GME Costs	0	0		0	0	0	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	29, 456	29, 4	56	0	29, 456	
22.00	Total Cost of Health Care Services (sum of	482, 587	29,456			0	512,043	
22.00	lines 10, 14, and 21)	102,007	2,, 100	0.2,0		Ũ	012,010	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	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	25.0
25.02	Chronic Care Management	0	0		0	0	0	25.02
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00 28.00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	27.00 28.00
28.00	through 27)	0	0		0	0	0	28.00
	FACILITY OVERHEAD							
29.00	Facility Costs	0	41, 485	41.4	85	0	41, 485	29.00
30.00	Administrative Costs	76, 136	0	76, 1		0	76, 136	30.0
31.00	Total Facility Overhead (sum of lines 29 and	76, 136	41, 485			0	117, 621	31.0
	30)	.,		,-		-		
32.00	Total facility costs (sum of lines 22, 28	558, 723	70, 941	629, 6	64	0	629, 664	32.00
	and 31)							

		DAVIESS COMMUN		011 45 00/4		J OF FORM CMS	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet M-	1
			Component	CCN: 15-3999	To 12/31/2023	Date/Time Pr 5/31/2024 9:	
					RHC II	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6.00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	6.00	7.00				-
1.00	Physician	0	284, 810	1			1.00
2.00	Physician Assistant	0					2.00
2.00 3.00	Nurse Practitioner	0	84, 253	•			3.00
4.00	Visiting Nurse	0	04,200	1			4.00
+.00 5.00	Other Nurse	0		•			5.00
5.00	Clinical Psychologist	0					6.00
7.00	Clinical Social Worker	0					7.00
7.10	Marriage and Family Therapist	0	L L				7.10
7.11 3.00	Mental Health Counselor	0	c				7.11
	Laboratory Technician	0	-				
9.00	Other Facility Health Care Staff Costs	0	113, 524				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	482, 587				10.00
11.00	Physician Services Under Agreement	0	C				11.00
12.00	Physician Supervision Under Agreement	0	C	•			12.00
13.00	Other Costs Under Agreement	0	C				13.00
	Subtotal (sum of lines 11 through 13)	0	00.454				14.00
15.00	Medical Supplies	0	29, 456				15.00
	Transportation (Health Care Staff)	0	C	1			16.00
	Depreciation-Medical Equipment	0	C				17.00
	Professional Liability Insurance	0	C				18.00
	Other Health Care Costs	0	C)			19.00
	Allowable GME Costs		00 151				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29, 456	•			21.00
22.00	Total Cost of Health Care Services (sum of	0	512, 043				22.00
	lines 10, 14, and 21)						-
12 00	COSTS OTHER THAN RHC/FQHC SERVICES	0	<u> </u>	1			23.00
	Pharmacy			•			
24.00	Dental	0	C	•			24.00
25.00	Optometry	0	-				25.00
25.01	Tel eheal th	0	C	•			25.01
25.02	Chronic Care Management	0	C				25.02
26.00	All other nonreimbursable costs	0	C				26.00
27.00	Nonallowable GME costs	0					27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	C)			28.00
	through 27)			I			-
0 00	FACILITY OVERHEAD	^	44 405	•			1 20 00
29.00	Facility Costs	0					29.00
30.00	Administrative Costs	0		•			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	117, 621				31.00
	30) Tatal facility costs (our of lines 22, 20	~	100 111				
32.00	Total facility costs (sum of lines 22, 28	0	629, 664	•			32.00

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL			In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0061	Pe	eri od:	Worksheet M-1	
			Component	CCN: 15-8501	Fr Tc	rom 01/01/2023 0 12/31/2023	Date/Time Pre 5/31/2024 9:20	
						RHC III	Cost	
		Compensation	Other Costs	Total (col.	1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)		ions	Trial Balance	
				, í			(col. 3 +	
							col. 4)	
		1.00	2.00	3.00		4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	0		0	0	0	1.00
2.00	Physician Assistant	0	0		0	0	0	2.00
3.00	Nurse Practitioner	635, 457	0	635, 4		0	635, 457	3.00
4.00	Visiting Nurse	0	0		0	0	0	4.00
5.00	Other Nurse	0	0		0	0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
7. 10 7. 11	Marriage and Family Therapist Mental Health Counselor							7.10 7.11
8.00	Laboratory Techni ci an	0	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	286, 495	0	286. 4	~	0	286, 495	9.00
10.00	Subtotal (sum of lines 1 through 9)	921, 952	0	921, 9		0	921, 952	10.00
11.00	Physician Services Under Agreement	,21, ,32	96, 150			0	96, 150	
12.00	Physician Supervision Under Agreement	0	, 130 0	, , , ,	0	0	0, 130	12.00
13.00	Other Costs Under Agreement	0	0		0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	96, 150	96, 1	50	0	96, 150	
15.00	Medical Supplies	0	22, 396			0	22, 396	
16.00	Transportation (Health Care Staff)	0	0		0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	0	19.00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22, 396	22, 39	96	0	22, 396	
22.00	Total Cost of Health Care Services (sum of	921, 952	118, 546	1, 040, 49	98	0	1, 040, 498	22.00
	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		0	0	0	24.00
25.00	Optometry	0	0		0	0	0	25.00
25. 01 25. 02	Telehealth Chronic Care Management	0	0		0	0	0	25.01 25.02
25.02	Chronic Care Management All other nonreimbursable costs	0	0		0	0	0	25.02 26.00
28.00	Nonallowable GME costs	0	0		U	0	0	28.00
27.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	27.00
20.00	through 27)	0	0		U	0	0	20.00
	FACILITY OVERHEAD							
29.00	Facility Costs	0	62, 475	62, 4	75	0	62, 475	29.00
30.00	Administrative Costs	125, 627	0	125, 62		0	125, 627	30.00
31.00	Total Facility Overhead (sum of lines 29 and		62, 475			0	188, 102	
	30)		·					
32.00	Total facility costs (sum of lines 22, 28	1, 047, 579	181, 021	1, 228, 60	00	0	1, 228, 600	32.00
	and 31)							

		DAVIESS COMMUN				u of Form CMS	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet M-	1
			Component	CCN: 15-8501	To 12/31/2023	Date/Time Pr 5/31/2024 9:	
					RHC III	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6. 00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1.00	Physi ci an	0	C				1.00
2.00	Physician Assistant	0		•			2.00
3.00	Nurse Practitioner	0	635, 457	1			3.00
4.00	Visiting Nurse	0	C 000, 407	•			4.00
5.00	Other Nurse	0	0	•			5.00
5.00	Clinical Psychologist	0					6.00
7.00	Clinical Social Worker	0					7.00
7.10	Marriage and Family Therapist	0	C				7.10
7.11	Mental Health Counselor						7.11
3.00	Laboratory Techni ci an	0	c				8.00
9.00 9.00	Other Facility Health Care Staff Costs	0	286, 495				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	921, 952				10.00
11.00	Physician Services Under Agreement	0	96, 150				11.00
12.00	Physician Supervision Under Agreement	0	70, 150 C	•			12.00
13.00	Other Costs Under Agreement	0	C	•			12.00
14.00	Subtotal (sum of lines 11 through 13)	0		1			14.00
15.00	Medical Supplies	0	96, 150 22, 396				14.00
16.00	Transportation (Health Care Staff)	0	22, 390	•			16.00
		0		1			17.00
17.00 18.00	Depreciation-Medical Equipment Professional Liability Insurance	0	C				18.00
	Other Health Care Costs	0	C	1			19.00
	Allowable GME Costs	0	L L	,			20.00
20.00	Subtotal (sum of lines 15 through 20)	0	22, 396				20.00
22.00	Total Cost of Health Care Services (sum of	0					21.00
22.00	lines 10, 14, and 21)	0	1, 040, 498				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						-
23.00	Pharmacy	0	C				23.00
24.00	Dental	0	C	•			24.00
25.00	Optometry	0	C	•			25.00
25.01	Tel eheal th	0	C				25.00
25.02	Chronic Care Management	0	C				25.02
26.00	All other nonreimbursable costs	0	C				26.02
27.00	Nonal I owable GME costs	0	, c	·			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	C				28.00
20.00	through 27)	0		`			20.00
	FACILITY OVERHEAD			1			
29.00	Facility Costs	0	62, 475	j			29.00
30.00	Administrative Costs	0					30.00
31.00	Total Facility Overhead (sum of lines 29 and	-	188, 102				31.00
	30)	0					
32.00	Total facility costs (sum of lines 22, 28	0	1, 228, 600				32.00
	and 31)	0	,, 500				

	Financial Systems	DAVIESS COMMUN	Provi der C	CNI 15 0041	Peri		u of Form CMS-2 Worksheet M-1	
ANAL 13	IS OF NOSPITAL-DASED RNC/FUNC COSTS					n 01/01/2023		
			Component	CCN: 15-8503	То	12/31/2023	Date/Time Pre 5/31/2024 9:2	
						RHC V	Cost	U alli
		Compensation	Other Costs	Total (col.	1 Re		Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
		1.00	2.00	3.00		4.00	<u>col. 4)</u> 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00		4.00	5.00	
. 00	Physi ci an	865, 805	0	865, 8	05	0	865, 805	1.00
2.00	Physician Assistant	0	0		0	0	0	2.00
3.00	Nurse Practitioner	403, 958	0	403, 9	58	0	403, 958	3.00
I. 00	Visiting Nurse	0	0		0	0	0	4.00
5.00	Other Nurse	0	0		0	0	0	5.00
b. 00	Clinical Psychologist	0	0		0	0	0	6.00
. 00	Clinical Social Worker	0	0		0	0	0	7.00
7.10	Marriage and Family Therapist							7.1
7.11	Mental Health Counselor							7.1
3.00	Laboratory Techni ci an	0	0		0	0	0	8.0
9.00	Other Facility Health Care Staff Costs	248, 692	0	248, 6		0	248, 692	9.0
0.00	Subtotal (sum of lines 1 through 9)	1, 518, 455	0 9, 000	1, 518, 4		0	1, 518, 455	
1.00	Physician Services Under Agreement Physician Supervision Under Agreement	0	9,000	9,0	00	0	9, 000 0	11.0 12.0
2.00 3.00	Other Costs Under Agreement	0	0		0	0	0	13.0
4.00	Subtotal (sum of lines 11 through 13)	0	9,000	9,0	0	0	9,000	
5.00	Medical Supplies	0	151, 307	151, 3		0	151, 307	15.0
6.00	Transportation (Health Care Staff)	0	131, 307	131, 3	0	0	0	16.0
7.00	Depreciation-Medical Equipment	0	0		0	0	0	17.0
8.00	Professional Liability Insurance	o	0		0	0	0	18.0
9.00	Other Health Care Costs	0	0		0	0	0	19.0
0.00	Allowable GME Costs							20.0
1.00	Subtotal (sum of lines 15 through 20)	0	151, 307	151, 3	07	0	151, 307	21.0
22.00	Total Cost of Health Care Services (sum of	1, 518, 455	160, 307	1, 678, 7	62	0	1, 678, 762	22.0
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
3.00	Pharmacy	0	0		0	0	0	23.0
4.00	Dental	0	0		0	0	0	24.0
25.00	Optometry	0	0		0	0	0	25.0
5.01 5.02	Telehealth Chronic Care Management	0	0		0	0	0	25.0 25.0
26.002	All other nonreimbursable costs	0	0		0	0	0	26.0
7.00	Nonallowable GME costs	0	0		0	0	0	20.0
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.0
.0.00	through 27)	0	0		Ŭ	Ű	0	20.0
	FACILITY OVERHEAD							
9.00	Facility Costs	0	30, 598	30, 5	98	0	30, 598	29.0
30.00	Administrative Costs	123, 114	0	123, 1	14	0	123, 114	30.0
1. 00	Total Facility Overhead (sum of lines 29 and	123, 114	30, 598	153, 7	12	0	153, 712	31.0
	30)							
32.00	Total facility costs (sum of lines 22, 28	1, 641, 569	190, 905	1, 832, 4	74	0	1, 832, 474	32.0
	and 31)							

		DAVIESS COMMUN		01 45 00/4		J OF FORM CMS	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet M-	1
			Component	CCN: 15-8503	To 12/31/2023	Date/Time Pr 5/31/2024 9:	
					RHC V	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6.00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1.00	Physi ci an	0	865, 805				1.00
2.00	Physician Assistant	0					2.00
3.00	Nurse Practitioner	0	403, 958				3.00
4.00	Visiting Nurse	0	100, 700 C	•			4.00
5.00	Other Nurse	0	C	•			5.00
5.00 5.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
7.10	Marriage and Family Therapist	0	C C	,			7.10
7.11	Mental Health Counselor						7.11
7.11 B.00	Laboratory Techni ci an	0	c				8.00
9.00 9.00	Other Facility Health Care Staff Costs	0	-				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 518, 455				10.00
11.00	Physician Services Under Agreement	0	9,000				11.00
	3	0					12.00
12.00 13.00	Physician Supervision Under Agreement Other Costs Under Agreement	0	C	•			12.00
	5	0	9,000				14.00
14.00	Subtotal (sum of lines 11 through 13)	0		•			14.00
15.00 16.00	Medical Supplies	0	151, 307				16.00
	Transportation (Health Care Staff) Depreciation-Medical Equipment	0	C	1			
		0					17.00
	Professional Liability Insurance	0		•			
	Other Health Care Costs	0	U				19.00
	Allowable GME Costs	0	151 007	,			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	151, 307	•			21.00
22.00	Total Cost of Health Care Services (sum of	0	1, 678, 762				22.00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	C				23.00
24.00	Dental	0	C	•			24.00
25.00	Optometry	0	0	•			25.00
25.00	Tel eheal th	0	0				25.00
25.01	Chronic Care Management	0					25.01
26.02	All other nonreimbursable costs	0	C				26.00
27.00	Nonallowable GME costs	0	C				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	c				27.00
20.00	through 27)	0	C	, I			20.00
	FACILITY OVERHEAD			I			-
29.00	Facility Costs	0	30, 598				29.00
30.00	Administrative Costs	0					30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	153, 712	•			31.00
	30)	0	155,712				
32.00	Total facility costs (sum of lines 22, 28	0	1, 832, 474				32.00
	and 31)	0	.,				02.00

	Financial Systems	DAVIESS COMMUN	Provider C	CN: 15 0041	Peri		u of Form CMS-2 Worksheet M-1	2002-1
NALIS	IS OF HUSPITAL-BASED RHC/FURC CUSTS		Provider C	CN. 15-0001		n 01/01/2023		
			Component	CCN: 15-8506	То	12/31/2023	Date/Time Pre 5/31/2024 9:20	
						RHC VI	Cost	0 ani
		Compensation	Other Costs	Total (col.	1 Re		Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
		1.00	2.00	3.00		4.00	<u>col. 4)</u> 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	0.00		1.00	0.00	
. 00	Physi ci an	204, 965	0	204, 9	65	0	204, 965	1.0
. 00	Physician Assistant	0	0		0	0	0	2.0
. 00	Nurse Practitioner	114, 726	0	114, 7	26	0	114, 726	3.0
. 00	Visiting Nurse	0	0		0	0	0	4.0
. 00	Other Nurse	0	0		0	0	0	5.0
. 00	Clinical Psychologist	0	0		0	0	0	6.0
. 00	Clinical Social Worker	0	0		0	0	0	7.0
. 10	Marriage and Family Therapist							7.1
. 11	Mental Health Counselor		-		-			7.1
. 00	Laboratory Technician	0	0		0	0	0	8.0
. 00	Other Facility Health Care Staff Costs	164, 156	0	164, 1		0	164, 156	9.0
0.00	Subtotal (sum of lines 1 through 9)	483, 847	0	483, 8		0	483, 847	10.0
1.00	Physician Services Under Agreement Physician Supervision Under Agreement	0	0		0 0	0	0	11. (12. (
2.00 3.00	Other Costs Under Agreement	0	0		0	0	0	12.0
4.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14. (
5.00	Medical Supplies	0	21, 234	21, 2	-	0	21, 234	
6.00	Transportation (Health Care Staff)	0	21, 234	21,2	0	0	21, 234	16.0
7.00	Depreciation-Medical Equipment	0	0		0	0	0	17.0
8.00	Professional Liability Insurance	0	0		0	0	0	18.0
9.00	Other Health Care Costs	ō	0		0	Ō	0	19.0
0.00	Allowable GME Costs	-						20.0
1.00	Subtotal (sum of lines 15 through 20)	0	21, 234	21, 2	34	0	21, 234	21.0
2.00	Total Cost of Health Care Services (sum of	483, 847	21, 234	505, 0	81	0	505, 081	22.0
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES				-	-		
3.00	Pharmacy	0	0		0	0	0	23.0
4.00	Dental	0	0		0	0	0	24.0
5.00	Optometry	0	0		0	0	0	25.0
5.01	Tel eheal th	0	0		0	0	0	25.0
5.02 6.00	Chronic Care Management All other nonreimbursable costs	0	0		0	0	0	25. (26. (
7.00	Nonallowable GME costs	0	0		0	0	0	20.0
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	27.0
0.00	through 27)	0	0		0	0	0	20.0
	FACILITY OVERHEAD				_			
9.00	Facility Costs	0	32, 684	32, 6	84	0	32, 684	29.0
0.00	Administrative Costs	66, 314	0	66, 3		0	66, 314	30.0
1.00	Total Facility Overhead (sum of lines 29 and	66, 314	32, 684	98, 9		0	98, 998	
	30)							
2.00	Total facility costs (sum of lines 22, 28	550, 161	53, 918	604, 0	79	0	604, 079	32.0
	and 31)							

		DAVIESS COMMUN		011 45 00/4		J OF FORM CMS	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet M-	1
			Component	CCN: 15-8506	To 12/31/2023	Date/Time Pr 5/31/2024 9:	
				_	RHC VI	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6.00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	6.00	7.00				-
1.00	Physician	0	204, 965				1.00
2.00	Physician Assistant	0					2.00
2.00	Nurse Practitioner	0	114, 726				3.00
4.00	Visiting Nurse	0	114,720	1			4.00
4.00 5.00	Other Nurse	0					5.00
5.00 6.00	Clinical Psychologist	0					6.00
7.00	Clinical Social Worker	0					7.00
7.10	Marriage and Family Therapist	0	l l				7.10
7.11 8.00	Mental Health Counselor Laboratory Technician	0	C				7.11
9.00 9.00		0	-				9.00
9.00 10.00	Other Facility Health Care Staff Costs	0	164, 156 483, 847				10.00
	Subtotal (sum of lines 1 through 9)	0	483, 847				11.00
11.00	Physician Services Under Agreement	0					
12.00	Physician Supervision Under Agreement	0					12.00
13.00	Other Costs Under Agreement	0	-				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	01 00				14.00
15.00	Medical Supplies	0	21, 234				15.00
	Transportation (Health Care Staff)	0	0				16.00
	Depreciation-Medical Equipment	0	0				17.00
	Professional Liability Insurance	0	0				18.00
	Other Health Care Costs	0	C				19.00
	Allowable GME Costs	0	01.00				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21, 234	•			21.00
22.00	Total Cost of Health Care Services (sum of	0	505, 081				22.00
	l i nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23.00	Pharmacy	0	(23.00
23.00	Dental	0					23.00
24.00	Optometry	0					24.00
	1 5	0	-				25.00
25.01	Tel eheal th	0					25.01
25.02	Chronic Care Management	0	-				
26.00	All other nonreimbursable costs	0	C				26.00
27.00	Nonallowable GME costs	0	C				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	L C				28.00
	through 27) FACILITY OVERHEAD						-
20 00		0	22 404				1 20 00
29.00 30.00	Facility Costs	0					29.00
	Administrative Costs	-	66, 314	1			
31.00	Total Facility Overhead (sum of lines 29 and	0	98, 998	2			31.00
32.00	30) Total facility costs (sum of lines 22, 28	0	604 070				32.00
	Total facility costs (sum of lines 22, 28	0	604, 079	1			1 32.00

	Financial Systems	DAVIESS COMMUN				eu of Form CMS-2	
ALLOC/	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHO	C SERVICES	Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet M-2	
			Component	CCN: 15-8500	To 12/31/2023		
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi t	y Minimum	Greater of	
		Personnel		Standard (1) Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions		1	1		1	
. 00	Physi ci an	1.50			1 2	2	1.0
. 00	Physician Assistant	0.00			1 C		2.0
. 00	Nurse Practitioner	1.43			1 1		3.0
. 00	Subtotal (sum of lines 1 through 3)	2.93			3	6, 102	
. 00	Visiting Nurse	0.00				0	5.0
. 00	Clinical Psychologist	0.00				0	6.0
00	Clinical Social Worker	0.00				0	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.0
. 03	Marriage and Family Therapist						7.0
. 04	Mental Health Counselor						7.0
. 00	Total FTEs and Visits (sum of lines 4 through 7)	2.93	6, 102			6, 102	8.0
. 00	Physician Services Under Agreements		0			0	9.0
	DETERMINATION OF ALLOWARD F. COOT ARRIVARD					1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE			RVICES		1 (00, 100	1
0.00	Total costs of health care services (from					689, 422	
1.00	Total nonreimbursable costs (from Wkst. M-					0	
2.00						689, 422	
3.00	Ratio of hospital -based RHC/FQHC services			(no. 21)		1.000000	
4.00 5.00				ine si)		135, 435	
		inty (see instru	ctions)			551, 613	
	Total overhead (sum of lines 14 and 15) Allowable GME overhead (see instructions)					687, 048	
	Enter the amount from line 16					697 049	
	Overhead applicable to hospital-based RHC/	ENHC somulaos (1)	ino 12 y lino	10)		687, 048 687, 048	
9.00	overnead applicable to nospital-based RHC/		ine is x line	18)		687,048	19.

20.00 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19) 1, 376, 470 20.00

00 Physician Assistant 0.00 0 1 0 2 00 Nurse Practitioner 0.61 1,271 1	leal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL			u of Form CMS-2	2552-1	
Component CCN: 15-3999 To 12/31/2023 Date/Time Preparts 5/31/2024 9:20 at 9: visits (col. 1 x col. 3) VISITS AND PRODUCTIVITY Number of FTE Personnel Total Visits Productivity Standard (1) Minimum Visits (col. 1 x col. 3) Date/Time Preparts (col. 4) 00 Physician 0.00 2.00 3.00 4.00 5.00 01 Positions 0.74 1,532 1 1 1 00 Physician Assistant 0.00 0 1 0 2 00 Nurse Practitioner 0.61 1,271 1 1 1 01 Usiting Nurse 0.00 0 0 0 0 02 Clinical Social Worker 0.00 0 0 0 7 03 Marriage and Family Therapist 0.00 0 0 7 04 Merial Health Counselor 0 0 7 7 04 Total Social Worker 0 0 7 7 05 Total Family Therapist	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHO	C SERVICES	Provider C	CN: 15-0061				
VI SITS AND PRODUCTIVITY Number of FTE Personnel Total Visits Productivity Standard (1) Minimum Visits (col. 3) Greater of col. 4 VI SITS AND PRODUCTIVITY 1.00 2.00 3.00 4.00 5.00 Physician 0.01 1.00 2.00 3.00 4.00 5.00 0 Physician Assistant 0.01 0 1 0 2.803 00 Nurse Practitioner 0.61 1.271 1 1 2.803 00 Visits (um of lines 1 through 3) 1.35 2.803 2.803 0 0 5.00 01 1 0.00 0 0 0 5.00 5.00 02 Diabetes Self Management Training (FOHC only) 0.00 0 0 7 03 Marriage and Family Therapist 0 0 0 7 04 Total Cests of health care services (from Wkst. M-1, col. 7, line 22) 512,043 1 00 Total cests of health care services (from Wkst. M-1, col. 7, line 23) 1 1 1				Component	CCN: 15-3999			pared	
Number of FTE Personnel Total Visits Productivity Standard (1) Winimum Visits (col. 1 x col. 3) Greater of col. 2 or col. 4 VISITS AND PRODUCTIVITY 1.00 2.00 3.00 4.00 5.00 Visits (cian 00 Physician Physician Assistant 0.74 1,532 1 1 1 00 Physician Assistant 0.61 1,271 1 1 2 01 Nurse Practitioner 0.61 1,271 1 1 0 2 02 Visiting Nurse 0.00 0							5/31/2024 9:2		
Personnel Standard (1) Visits (col. 1 x col. 2) col. 2 or col. 4 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY									
VISITS AND PRODUCTIVITY 1.00 2.00 3.00 4.00 5.00 Physician 0.74 1.532 1 1 1 1 00 Physician Assistant 0.74 1.532 1 1 1 1 00 Physician Assistant 0.00 0 1 0 2 2,803 2 2,803 4 0 6 6 6 0 6 0 <t< td=""><td></td><td></td><td></td><td>Total Visits</td><td></td><td>J</td><td></td><td></td></t<>				Total Visits		J			
I .00 2.00 3.00 4.00 5.00 Positions 0.74 1.532 1 1 1 00 Physician 0.74 1.532 1 1 1 01 Physician Assistant 0.00 0 1 0 2 02 Nurse Practitioner 0.61 1.271 1 1 3 03 Subtotal (sum of lines 1 through 3) 1.35 2.803 2 2.803 0 0 5 0 0 5 0 0 5 0 0 5 0 0 5 0 0 5 0 0 5 0 0 5 0 0 5 0 0 0 5 0<			Personnel		Standard (1				
VISITS AND PRODUCTIVITY Positions 00 Physician 0.74 1,532 1 3 3 1 3 1 3 1 3 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			1.00	2.00	2.00				
Positions 00 Physician 0.74 1,532 1 <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>			1.00	2.00	3.00	4.00	5.00		
00 Physician 0.74 1,532 1 1 1 00 Physician Assistant 0.00 0 1 0 2 00 Nurse Practitioner 0.61 1.271 1 1 3 00 Subtotal (sum of Lines 1 through 3) 1.35 2,803 2 2,803 4 00 Visiting Nurse 0.00 0 0 0 5 01 Itical Psychologist 0.00 0 0 0 6 02 Clinical Social Worker 0.00 0 0 0 7 02 Diabetes Self Management Training (FQHC 0.00 0 0 7 03 Marriage and Family Therapist 0 0 7 7 04 Mental Health Counsel or 7 7 7 7 04 Total FTEs and Visits (sum of Lines 4 1.35 2,803 2,803 1 0 05 Physician Services Under Agreements 0									
00 Phýsician Assistant 0.00 0 1 0 2 00 Nurse Practitioner 0.61 1,271 1	. 00		0.74	1, 532		1 1		1 1.0	
00 Subtotal (sum of lines 1 through 3) 1.35 2,803 2 2,803 4 00 Visiting Nurse 0.00 0	00	Physician Assistant	0.00	0		1 0		2.0	
00 Visiting Nurse 0.00 0 0 5 00 Clinical Psychologist 0.00 0 0 6 01 Medical Worker 0.00 0 0 7 01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 7 02 Diabetes Self Management Training (FQHC 0.00 0 0 7 03 Marriage and Family Therapist 7 7 7 7 04 Mental Health Counselor 7 7 7 05 Total FTEs and Visits (sum of lines 4 1.35 2,803 2,803 8 01 Physician Services Under Agreements 0 0 9 9 02 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 512,043 10 02 Total costs of health care services (from Wkst. M-1, col. 7, line 28) 0 1 0 03 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13 117,621 1 04 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 138,8875 <	00		0. 61	1, 271		1 1		3.0	
00 Clinical Psychologist 0.00 0 <td>00</td> <td>Subtotal (sum of lines 1 through 3)</td> <td>1.35</td> <td>2, 803</td> <td>1</td> <td>2</td> <td>2, 803</td> <td>4.</td>	00	Subtotal (sum of lines 1 through 3)	1.35	2, 803	1	2	2, 803	4.	
00Clinical Social Worker0.0000701Medical Nutrition Therapist (FQHC only)0.00000702Diabetes Self Management Training (FQHC0.00000703Marriage and Family Therapist000704Mental Health Counselor7705Total FTEs and Visits (sum of lines 41.352,8032,80300Total FTEs and Visits (sum of lines 41.352,803001Physician Services Under Agreements00901DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES011.0001Total costs of health care services (from Wkst. M-1, col. 7, line 28)0000Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.0000001300Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.0000001300Total coverhead (sum of lines 14 and 15)516,4961400Allowable GME overhead (see instructions)07117,62100Detre the amount from line 16516,496161700Prent provider to hospital -based RHC/FQHC services (line 13 x line 18)516,496	00	Visiting Nurse	0.00	0			0	5.	
01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 0 7 02 Diabetes Self Management Training (FQHC only) 0.00 0 0 0 7 03 Marriage and Family Therapist 0 0 0 7 04 Mental Health Counselor 7 7 7 00 Total FTEs and Visits (sum of lines 4 1.35 2,803 2,803 2,803 8 00 Physician Services Under Agreements 0 0 9 9 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 512,043 10 00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11 00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 512,043 12 00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 1.000000 13 00 Total hospital -based RHC/FQHC services (line 10 divided by line 12) 1.000000 13 00 Total h							0	6.	
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00 Total FTEs and Visits (sum of lines 4 through 7) 1.35 2,803 2,803 8 00 Physician Services Under Agreements 0 0 0 9 Incorrect Colspan="2">Incorrect Colspan="2">Incorect Colspan="2">Incorrect Colspan="2">Incorrect Colspan=	03	Marriage and Family Therapist						7.	
through 7) 00 Physician Services Under Agreements 0 0 9 Intervices Under Agreements 0 0 9 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES Dettermination of ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1.00 Cost of all services (excluding overhead - (from Worksheet. M-1, col. 7, line 31) 1.00 Cost of all services (see instructions) 00 Cost of all services (see instructions) 00 Cost	04	Mental Health Counselor						7.	
00 Physician Services Under Agreements 0 0 9 Image: Colspan="2">Image: Colspan="2">Image: Colspan="2">O 0 9 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES Image: Colspan="2">Image: Colspan="2" <td co<="" td=""><td>00</td><td></td><td>1.35</td><td>2, 803</td><td></td><td></td><td>2, 803</td><td>8.</td></td>	<td>00</td> <td></td> <td>1.35</td> <td>2, 803</td> <td></td> <td></td> <td>2, 803</td> <td>8.</td>	00		1.35	2, 803			2, 803	8.
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)512,04310.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)01.00Cost of all services (excluding overhead) (sum of lines 10 and 11)512,04312.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.00000013.00Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)117,62114.00Parent provider overhead allocated to facility (see instructions)398,87515.00Total overhead (sum of lines 14 and 15)516,49616.00Allowable GME overhead (see instructions)1717.00Enter the amount from line 16516,49618.00Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)516,496									
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)512,04310.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)011.00Cost of all services (excluding overhead) (sum of lines 10 and 11)512,04312.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.00000013.00Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)117,62114.00Parent provider overhead allocated to facility (see instructions)398,87515.00Allowable GME overhead (see instructions)516,49616.00Enter the amount from line 16516,49618.00Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)516,49619	00	Physician Services Under Agreements		0			0	9.	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)512,04310.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)011.00Cost of all services (excluding overhead) (sum of lines 10 and 11)512,04312.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.00000013.00Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)117,62114.00Parent provider overhead allocated to facility (see instructions)398,87515.00Allowable GME overhead (see instructions)516,49616.00Enter the amount from line 16516,49618.00Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)516,49619							1 00		
.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)512,04310.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)011.00Cost of all services (excluding overhead) (sum of lines 10 and 11)512,04312.00Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)1.00000013.00Total nonreimbursable costs (from Worksheet. M-1, col. 7, line 31)117,62114.00Parent provider overhead allocated to facility (see instructions)398,87515.00Allowable GME overhead (see instructions)516,49616.00Enter the amount from line 16516,49618.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)516,49619		DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL-BASE	ED RHC/FQHC SE	RVICES		1.00		
.00Cost of all services (excluding overhead) (sum of lines 10 and 11)512,04312.00Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)1.00000013.00Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)117,62114.00Parent provider overhead allocated to facility (see instructions)398,87515.00Total overhead (sum of lines 14 and 15)516,49616.00Allowable GME overhead (see instructions)017.00Enter the amount from line 16516,49618.00Overhead applicable to hospital -based RHC/FQHC services (line 13 x line 18)516,496							512, 043	10.	
.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.00000013.00Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)117, 62114.00Parent provider overhead allocated to facility (see instructions)398, 87515.00Total overhead (sum of lines 14 and 15)516, 49616.00Allowable GME overhead (see instructions)07.00Enter the amount from line 16516, 49619.00Overhead applicable to hospital -based RHC/FOHC services (line 13 x line 18)516, 49619	. 00	Total nonreimbursable costs (from Wkst. M-	1, col. 7, line 1	28)			0	11.	
.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)117, 62114.00Parent provider overhead allocated to facility (see instructions)398, 87515.00Total overhead (sum of lines 14 and 15)516, 49616.00Allowable GME overhead (see instructions)017.00Enter the amount from line 16516, 49618.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)516, 496							512, 043	12.	
.00Parent provider overhead allocated to facility (see instructions)398,87515.00Total overhead (sum of lines 14 and 15)516,49616.00Allowable GME overhead (see instructions)017.00Enter the amount from line 16516,49618.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)516,49619	. 00	Ratio of hospital-based RHC/FQHC services	(line 10 divided	by line 12)			1.000000	13.	
.00Total overhead (sum of lines 14 and 15)516,49616.00Allowable GME overhead (see instructions)017.00Enter the amount from line 16516,49618.00Overhead applicable to hospital -based RHC/FQHC services (line 13 x line 18)516,49619					ine 31)				
.00Allowable GME overhead (see instructions)017.00Enter the amount from line 16516,49618.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)516,49619			lity (see instru	ctions)					
.00Enter the amount from line 16516,49618.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)516,49619									
.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 516,496 19							-		
	9.00			ine 13 x line				19.	

20. 00 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19) 1, 028, 539 20. 00

	n Financial Systems	DAVIESS COMMUN				u of Form CMS-2	
ALLOC/	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	C SERVI CES	Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet M-2	
			Component	CCN: 15-8501	To 12/31/2023		
					RHC III	Cost	
		Number of FTE	Total Visits	Producti vi t	y Minimum	Greater of	
		Personnel		Standard (1) Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions		1	1			
I. 00	Physi ci an	0. 27			1 0		1.0
2.00	Physician Assistant	0.00			1 0		2.0
. 00	Nurse Practitioner	6. 91			1 7		3.0
. 00	Subtotal (sum of lines 1 through 3)	7.18			7	14, 937	4.0
. 00	Visiting Nurse	0.00				0	5.0
. 00	Clinical Psychologist	0.00				0	6.0
. 00	Clinical Social Worker	0.00				0	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.0
. 03	Marriage and Family Therapist						7.0
. 04	Mental Health Counselor						7.0
. 00	Total FTEs and Visits (sum of lines 4	7.18	14, 937			14, 937	8.0
	through 7)						
. 00	Physician Services Under Agreements		0			0	9.0
						1.00	
	DETERMINATION OF ALLOWARDER COST ADDITIONE					1.00	
0 00	DETERMINATION OF ALLOWABLE COST APPLICABLE			RVICES		1 0 4 0 4 0 0	10.0
0.00						1, 040, 498	
	Total nonreimbursable costs (from Wkst. M-					0	
2.00						1, 040, 498	
3.00	Ratio of hospital -based RHC/FQHC services			ing 21)		1.000000	
4.00 5.00				ine si)		188, 102	
		inty (see instru	ctions)			721, 826	
6.00						909, 928	
	Allowable GME overhead (see instructions) Enter the amount from line 16						
	Overhead applicable to hospital-based RHC/	EOUC convisions (1	ino 12 v lino	10)		909, 928	
9.00	Overhead applicable to nospital-based RHC/		ine is x iine	18)		909, 928	19.0

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 1, 950, 426
 20.00

	n Financial Systems	DAVIESS COMMUN				u of Form CMS-2	
\LLOC/	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHO	C SERVICES	Provider C	CN: 15-0061	Period: From 01/01/2023	Worksheet M-2	
			Component	CCN: 15-8503	To 12/31/2023		
					RHC V	Cost	
		Number of FTE	Total Visits	Producti vi t	y Minimum	Greater of	
		Personnel		Standard (1) Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions		1			1	
. 00	Physi ci an	0.95			1 1		1.0
. 00	Physician Assistant	0.00			1 0		2.0
00	Nurse Practitioner	2.02			1 2		3.0
00	Subtotal (sum of lines 1 through 3)	2.97			3	6, 188	
00	Visiting Nurse	0.00				0	5.0
00	Clinical Psychologist	0.00				0	6.0
00	Clinical Social Worker	0.00				0	7.0
01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.0
03	Marriage and Family Therapist						7.0
04	Mental Health Counselor						7.(
00	Total FTEs and Visits (sum of lines 4 through 7)	2.97	6, 188			6, 188	8.0
00	Physician Services Under Agreements		0			0	9.
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE					1.00	
. 00				VICES		1 (70 7()	1 10
						1, 678, 762 0	
1.00 2.00						1, 678, 762	
. 00	Ratio of hospital-based RHC/FQHC services					1, 078, 782	
. 00				ing 31)		153, 712	
. 00				116 31)		785, 954	
. 00		inty (See Institu				939, 666	
. 00 . 00	. , , , , , , , , , , , , , , , , , , ,					939,000	
	Enter the amount from line 16					939, 666	
	Overhead applicable to hospital-based RHC/	(FOHC services ()	ing 13 v ling	18)		939, 666	
9.00	overhead appricable to hospital-based RHC/			10)		939,000	19.

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 2,618,428
 20.00

00 Physician Assistant 0.00 0 1 0 2 00 Nurse Practitioner 1.14 2,370 1 1 3 00 Subtotal (sum of lines 1 through 3) 2.26 4,704 2 4,704 2 00 Visiting Nurse 0.00 0 0 0 5 00 Clinical Psychologist 0.00 0 0 6 01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7 01 Medical FEs and Visits (sum of lines 4 2.26 4,704 4 7 02 Diabetes Self Management Training (FOHC 0.00 0 0 7 03 Marriage and Family Therapist 0 0 7 7 04 Mental Health Counselor 0 7 7 7 04 Mental Health Counselor 0 9 9 00 Dital costs of health care services (from Wkst. M-1, col. 7, line 22) 505,081 10 1.00 Total costs of health care services (from Wkst. M-1, col. 7, line 28) 0 1		Financial Systems	DAVIESS COMMUN	NETY HOSPITAL		In Lie	u of Form CMS-2	2552-10
Component CCN: 15-8506 To 12/31/2023 Date/Time Preparation 2024 9:20 at 2014 Number of FTE Personnel Total Visits Productivity Minimum Greater of col. 2 or col. 4 Visits AND PRODUCTIVITY Productivity Number of FTE Personnel Total Visits Productivity Number of FTE 1 x col. 3) Output Visits AND PRODUCTIVITY 1.00 2.00 3.00 4.00 5.00 Physician 1.12 2.334 1 1 1 00 Physician Assistant 0.00 0 1 0 2 00 Subtotal (sum of lines 1 through 3) 2.26 4.704 2 4.704 1 00 Clinical Social Worker 0.00 0	ALLOC	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHO	C SERVICES	Provider C	CN: 15-0061		Worksheet M-2	
Image: constraint of the second sec				Component	CCN: 15-8506			
Personnel Standard (1) Visits (col. col. 2 or col. 4 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY						RHC VI		
VISITS AND PRODUCTIVITY 1.00 2.00 3.00 4.00 5.00 Physician 1.12 2.334 1 1 1 1 00 Physician 0.00 0 1 0 2 00 Nurse Practitioner 1.14 2.370 1 1 3 00 Nurse Practitioner 1.14 2.370 1 1 3 00 Subtotal (sum of lines 1 through 3) 2.26 4.704 2 4.704 00 Visiting Nurse 0.00 0 0 6 5 00 Clinical Social Worker 0.00 0 0 6 6 01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7 01 Medical Nutrition Therapist 0.00 0 0 7 03 Marriage and Family Therapist 0 0 7 7 04 Mental Health Counselor 7 7 7 7 7			Number of FTE	Total Visits	Producti vi t	y Minimum	Greater of	
I.00 2.00 3.00 4.00 5.00 Positions 1.12 2.334 1 1 1 1 00 Physician 1.12 2.334 1 1 1 1 1 00 Nurse Practitioner 1.14 2.370 1 1 2 4,704 2 4,704 2 4,704 4 0 0 5 0 0 5 0 0 5 0 0 2 4,704 2 4,704 4 2 4,704 4 0			Personnel		Standard (1) Visits (col.	col. 2 or	
VISITS AND PRODUCTIVITY Positions 00 Physician Assistant 0.00 0 1 1 1 00 Physician Assistant 0.00 0 1 0 2 4,704 3 00 Nurse Practitioner 1.14 2,370 1 1 3 00 Subtotal (sum of lines 1 through 3) 2.26 4,704 2 4,704 4 00 Clinical Psychologist 0.00 0 0 6 6 00 Clinical Social Worker 0.00 0 0 7 7 01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7 02 Diabetes Self Management Training (FOHC 0.00 0 0 7 03 Marriage and Family Therapist 0 0 7 7 04 Mental Health Counsel or 7 7 7 7 04 Mental Health Counsel or 7 7 7 7						1 x col. 3)	col. 4	
Positions 00 Physician 1.12 2,334 1 1 1 1 00 Physician 0.00 0 1 0 2 3 00 Nurse Practitioner 1.14 2,370 1 1 3 00 Subtotal (sum of lines 1 through 3) 2.26 4,704 2 4,704 00 Visiting Nurse 0.00 0 0 0 5 00 Clinical Social Worker 0.00 0 0 6 6 01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7 01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7 02 Diabetes Self Management Training (FOHC 0.00 0 0 7 03 Marriage and Family Therapist 0 0 9 7 04 Mental Heal th Counselor 0 0 9 0 9 04 DetrerMINATION OF ALLO			1.00	2.00	3.00	4.00	5.00	
00 Physician 1.12 2.334 1 1 1 00 Physician Assistant 0.00 0 1 0 2 00 Nurse Practitioner 1.14 2.370 1 1 3 00 Subtotal (sum of lines 1 through 3) 2.26 4.704 2 4.704 4 00 Visiting Nurse 0.00 0 0 0 6 6 00 Clinical Social Worker 0.00 0 0 0 7 01 Medical Nutrition Therapist (F0HC only) 0.00 0 0 7 01 Medical Nutrition Therapist 0 0 0 7 02 Diabetes Self Management Training (F0HC 0.00 0 0 7 03 Marriage and Family Therapist 7 7 7 7 04 Mental Heal th Counsel or 7 7 7 7 00 Total FEs and Visits (sum of lines 4 2.26 4.704 4.704 8 01 Total costs of heal th care services (from Wkst. M-1, col. 7, l		VISITS AND PRODUCTIVITY						
00 Physician Assistant 0.00 0 1 0 2 00 Nurse Practitioner 1.14 2,370 1 1 3 00 Subtral (sum of lines 1 through 3) 2.26 4,704 2 4,704 2 00 Visiting Nurse 0.00 0 0 2 4,704 2 00 Clinical Social Worker 0.00 0 0 0 6 01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7 01 Medical Ramily Therapist 0 0 0 7 02 Diabets Self Management Training (FOHC 0.00 0 0 7 03 Marriage and Family Therapist 0 0 7 7 04 Mental Health Counselor 0 0 9 9 9 0.0 Physician Services Under Agreements 0 0 9 9 9 0.0 Dital costs of health care services (from Wkst. M-1, col. 7, line 22) 505,081 10 11 10 11 10 <t< td=""><td></td><td></td><td>E</td><td>1</td><td>1</td><td></td><td></td><td></td></t<>			E	1	1			
00 Nurse Practitioner 1.14 2,370 1 1 3 00 Subtotal (sum of lines 1 through 3) 2.26 4,704 2 4,704 4 00 Visiting Nurse 0.00 0 0 5 5 6 6 5 00 Clinical Social Worker 0.00 0 0 6 6 6 00 Clinical Social Worker 0.00 0 0 7 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 <td< td=""><td>1.00</td><td>5</td><td></td><td></td><td></td><td>1 1</td><td></td><td>1.00</td></td<>	1.00	5				1 1		1.00
00 Subtotal (sum of lines 1 through 3) 2.26 4,704 2 4,704 4 00 Visiting Nurse 0.00 0	2.00					1 0		2.00
00 Visiting Nurse 0.00 0	3.00					1 1		3.00
00 Clinical Psychologist 0.00 0<	1.00	5,				2		4.0
00 Clinical Social Worker 0.00 0 0 0 7 01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 7 02 Diabetes Self Management Training (FQHC only) 0.00 0 0 7 03 Marriage and Family Therapist 0.00 0 0 7 04 Mental Health Counsel or 7 7 7 00 Total FTEs and Visits (sum of lines 4 2.26 4,704 4,704 8 00 Physician Services Under Agreements 0 0 9 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 505,081 10 1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11 505,081 12 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 505,081 12 1.000000 13 3.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000	5.00						0	5.00
01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 0 7 02 Diabetes Self Management Training (FQHC only) 0.00 0 0 0 7 03 Marriage and Family Therapist 0.00 0 0 0 7 04 Mental Health Counsel or 7 7 7 7 04 Mental Health Counsel or 2.26 4,704 4,704 8 00 Total FTEs and Visits (sum of lines 4 2.26 4,704 4,704 8 00 Physician Services Under Agreements 0 0 0 9 00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 505,081 10 0.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 505,081 12 3.00 Ratio of hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 98,998 14 4.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 352,558 15 5.00 Paren	. 00						0	6.0
02 Diabetes Self Management Training (FOHC 0.00 0 0 0 7 03 Marriage and Family Therapist 7 7 7 04 Mental Heal th Counselor 7 7 00 Total FTEs and Visits (sum of lines 4 2.26 4,704 4,704 8 00 Physician Services Under Agreements 0 0 0 9 Locotation of the services (from Wkst. M-1, col. 7, line 22) 0 9 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 1 0 0 100 11.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 1 0 0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 505,081 10 1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 0 11 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 505,081 12 3.00 Ratio of hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 98,998 14 5.00 Parent provider overhead al	. 00						0	7.0
onl y)onl y)onl y).03Marriage and Family Therapist7.04Mental Health Counsel or7.00Total FTEs and Visits (sum of lines 4 through 7)2.264,704.00Physician Services Under Agreements00.00Physician Services Under Agreements00.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)505,081.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)02.00Cost of all services (excluding overhead) (sum of lines 10 and 11)505,0813.00Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)1.0000004.00Total nonreimbursable cost of facility (see instructions)352,5585.00Parent provider overhead allocated to facility (see instructions)352,5586.00Total overhead (sum of lines 14 and 15)451,5568.00Enter the amount from line 16451,556	7.01						Ű	7.0
04Mental Heal th Counsel or Total FTEs and Visits (sum of lines 4 through 7)2.264,7047.00Physician Services Under Agreements000.00Physician Services Under Agreements00.00DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES0.00Total costs of heal th care services (from Wkst. M-1, col. 7, line 22)505,081.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)0.00Cost of all services (excluding overhead) (sum of lines 10 and 11)505,081.00Total hospital-based RHC/FOHC services (line 10 divided by line 12)1.000000.00Total overhead allocated to facility (see instructions)352,558.00Total overhead (sum of lines 14 and 15)451,556.00Enter the amount from line 16451,556	7.02		0.00	0			0	7.0
00Total FTEs and Visits (sum of lines 4 through 7)2.264,7044,70480Physician Services Under Agreements0091.00DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES01.00O Total costs of health care services (from Wkst. M-1, col. 7, line 22)505,0811.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)02.00Cost of all services (excluding overhead) (sum of lines 10 and 11)505,0813.00Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)1.0000004.00Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)98,9984.00Total overhead (sum of lines 14 and 15)352,5587.00Allowable GME overhead (see instructions)08.00Enter the amount from line 16451,556	1.03	Marriage and Family Therapist						7.0
through 7) Physician Services Under Agreements 0 0 9 In OD DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 0 O Total costs of health care services (from Wkst. M-1, col. 7, line 22) 0 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 0 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 Into a services (excluding overhead) (sum of lines 10 and 11) 505,081 12 1.00 0 Cost of all services (excluding overhead) (sum of lines 10 and 11) 300 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.00 3.00 Ratio of hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 98,998 4.00 Total noverhead (sum of lines 14 and 15) 2.00 Cost of all services (sum of lines 14 and 15) 2.01 Total overhead (see instructions) 5.00 Total overhead (see instructions) 5.00 Finter the amount from line 16	. 04	Mental Health Counselor						7.0
00 Physician Services Under Agreements 0 0 9 Image: Colspan="2">Image: Colspan="2">Image: Colspan="2">Omega: Colspan="2">Colspan="2"C/FOHC colspan="2"C/FOHC colspan="2"C/FOHC colspan="2"C/FOH	3.00	Total FTEs and Visits (sum of lines 4	2.26	4, 704			4, 704	8.0
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0.00 Total services (excluding overhead) (sum of lines 10 and 11) 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 3.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 4.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 98,998 14 5.00 Parent provider overhead allocated to facility (see instructions) 6.00 Total overhead (sum of lines 14 and 15) 7.00 Allowable GME overhead (see instructions) 8.00 Enter the amount from line 16								
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES0.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)505,081101.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)0112.00Cost of all services (excluding overhead) (sum of lines 10 and 11)505,081123.00Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)1.000000134.00Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)98,998145.00Parent provider overhead allocated to facility (see instructions)352,558156.00Total overhead (sum of lines 14 and 15)451,556167.00Allowable GME overhead (see instructions)0178.00Enter the amount from line 16451,55618	0. 00	Physician Services Under Agreements		0			0	9.0
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES0.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)505,081101.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)0112.00Cost of all services (excluding overhead) (sum of lines 10 and 11)505,081123.00Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)1.000000134.00Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)98,998145.00Parent provider overhead allocated to facility (see instructions)352,558156.00Total overhead (sum of lines 14 and 15)451,556167.00Allowable GME overhead (see instructions)0178.00Enter the amount from line 16451,55618							1.00	
D. 00Total costs of health care services (from Wkst. M-1, col. 7, line 22)505,081101. 00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)0112. 00Cost of all services (excluding overhead) (sum of lines 10 and 11)505,081123. 00Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)1.000000134. 00Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)98,998145. 00Parent provider overhead allocated to facility (see instructions)352,558156. 00Total overhead (sum of lines 14 and 15)451,556188. 00Enter the amount from line 16451,55618		DETERMINATION OF ALLOWARLE COST ADDITCARLE					1.00	
1.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)0112.00Cost of all services (excluding overhead) (sum of lines 10 and 11)505,081123.00Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)1.000000134.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)98,998145.00Parent provider overhead allocated to facility (see instructions)352,558156.00Total overhead (sum of lines 14 and 15)451,556167.00Allowable GME overhead (see instructions)0178.00Enter the amount from line 16451,55618	0 00				KVICES		EOE 091	10.00
22.00Cost of all services (excluding overhead) (sum of lines 10 and 11)505,081123.00Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)1.000000134.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)98,998145.00Parent provider overhead allocated to facility (see instructions)352,558156.00Total overhead (sum of lines 14 and 15)451,556167.00Allowable GME overhead (see instructions)078.00Enter the amount from line 16451,55618								
3.00Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)1.000000134.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)98,998145.00Parent provider overhead allocated to facility (see instructions)352,558156.00Total overhead (sum of lines 14 and 15)451,556167.00Allowable GME overhead (see instructions)0178.00Enter the amount from line 16451,55618								
4.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)98,998145.00Parent provider overhead allocated to facility (see instructions)352,558156.00Total overhead (sum of lines 14 and 15)451,556167.00Allowable GME overhead (see instructions)0178.00Enter the amount from line 16451,55618								
5.00Parent provider overhead allocated to facility (see instructions)352,558156.00Total overhead (sum of lines 14 and 15)451,556167.00Allowable GME overhead (see instructions)0178.00Enter the amount from line 16451,55618					ino 21)			
6.00 Total overhead (sum of lines 14 and 15) 451,556 16 7.00 Allowable GME overhead (see instructions) 0 17 8.00 Enter the amount from line 16 451,556 18					116 31)			
7.00Allowable GME overhead (see instructions)0178.00Enter the amount from line 16451,55618			inty (See Institu					
8.00 Enter the amount from line 16 451,556 18								
	19.00		FOHC services (1	ine 13 v line	18)			•

20.00Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)451, 33017.0020.00Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)956, 63720.00

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	(HOSPITAL Provider CCN: 15-0061	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVICES	Component CCN: 15-8500	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		DUCI	5/31/2024 9:20	0 am
	Title XVIII	RHC I	Cost	
DETERMINATION OF DATE FOR MOCRETAL DACED DUC/FOMO CEDVICES			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES Total Allowable Cost of hospital-based RHC/FOHC Services (from	m Wkst M_2 line 20)		1, 376, 470	1.0
00 Cost of injections/infusions and their administration (from W	· · · · ·		2, 110	2.0
.00 Total allowable cost excluding injections/infusions (line 1 m			1, 374, 360	3.0
.00 Total Visits (from Wkst. M-2, column 5, line 8)	,		6, 102	4.0
.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)			6, 102	6.0
.00 Adjusted cost per visit (line 3 divided by line 6)			225.23	7.0
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
		1.00	12/31/2023)	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	0.00	2.00 219.35	8.0
.00 Rate for Program covered visits (see instructions)		0.00	219.35	9.0
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from	contractor records)	0	938	10.0
1.00 Program cost excluding costs for mental health services (line	9 x line 10)	0	205, 750	11.0
2.00 Program covered visits for mental health services (from contra	•	0	0	12.0
3.00 Program covered cost from mental health services (line 9 x li		0	0	13.0
4.00 Limit adjustment for mental health services (see instructions		0	0	14.0
5.00 Graduate Medical Education Pass Through Cost (see instruction)		0	205 750	15.0
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 6.01 Total program charges (see instructions)(from contractor's re		0	205, 750 205, 097	16.0 16.0
6.02 Total program preventive charges (see instructions)(from contractor site	-		10, 043	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	-		10,075	
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0			139, 618	
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	149, 693	
7.00 Primary payer amounts			0	17.0
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		21, 153	18.0
records) 9.00 Beneficiary coinsurance for RHC/FQHC services (see instructio	uns) (from contractor		34, 781	19.0
records)			54,701	
0.00 Net program cost excluding injections/infusions (see instruct	ions)		149, 693	20.0
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		1, 138	21.0
1.50 Total program IOP OPPS payments (see instructions)				21.5
1.55 Total program IOP Costs (see instructions)				21.5
1.60 Program IOP deductible and coinsurance (see instructions)			450.004	21.6
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1	minus line 21.60)		150, 831 0	
3.00 Allowable bad debts (see instructions) 3.01 Adjusted reimbursable bad debts (see instructions)			0	
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.0
5.50 Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25.5
5.99 Demonstration payment adjustment amount before sequestration	,		0	25.9
6.00 Net reimbursable amount (see instructions)			150, 831	
6.01 Sequestration adjustment (see instructions)			3, 017	
6.02 Demonstration payment adjustment amount after sequestration			0	26.0
7.00 Interim payments			146, 002	
8.00 Tentative settlement (for contractor use only)	$02 \ 27 \ and \ 28)$		0 1 012	28.0
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0 0.00 Protested amounts (nonallowable cost report items) in accorda			1, 812 0	29.0 30.0
			01	, JU, U

LCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Component CCN: 15-3999	Period: From 01/01/2023	Worksheet M-3	
	001, 10 0777	To 12/31/2023	Date/Time Prep 5/31/2024 9:20	
	Title XVIII	RHC II	Cost	<u>o an</u>
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		I	1.00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2. line 20)		1, 028, 539	1.
00 Cost of injections/infusions and their administration (from W			1, 095	
00 Total allowable cost excluding injections/infusions (line 1 m			1, 027, 444	
00 Total Visits (from Wkst. M-2, column 5, line 8)			2, 803	
00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
00 Total adjusted visits (line 4 plus line 5)			2, 803	6.
00 Adjusted cost per visit (line 3 divided by line 6)			366.55	7.
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
			12/31/2023)	
		1.00	2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	204.01	8.
00 Rate for Program covered visits (see instructions)		0.00	204.01	9.
CALCULATION OF SETTLEMENT				
00 Program covered visits excluding mental health services (from	-	0	483	
00 Program cost excluding costs for mental health services (line	-	0	98, 537	
00 Program covered visits for mental health services (from contra		0	0	
00 Program covered cost from mental health services (line 9 x li		0	0	
00 Limit adjustment for mental health services (see instructions		0	0	
00 Graduate Medical Education Pass Through Cost (see instruction:		0	00 527	15
00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	98, 537	
01 Total program charges (see instructions)(from contractor's re- 02 Total program preventive charges (see instructions)(from prov	-		92, 931	
02 Total program preventive charges (see instructions)(from prov 03 Total program preventive costs ((line 16.02/line 16.01) times	-		1, 231 1, 305	
04 Total Program non-preventive costs ((The 16.02711) 16.07) times			66, 937	
(Titles V and XIX see instructions.)	is and to) trilles . ob)		00, 737	10
05 Total program cost (see instructions)		0	68, 242	16
00 Primary payer amounts		0	00, 212	17
00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		13, 561	
records)	(
00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		15, 591	19.
records)				
00 Net program cost excluding injections/infusions (see instruct			68, 242	20
00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		623	
50 Total program IOP OPPS payments (see instructions)				21
55 Total program IOP Costs (see instructions)				21
60 Program IOP deductible and coinsurance (see instructions)			(0.0/5	21
00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1	minus line 21.60)		68, 865	
00 Allowable bad debts (see instructions)			0	
01 Adjusted reimbursable bad debts (see instructions)	ructions)		0	
00 Allowable bad debts for dual eligible beneficiaries (see inst 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50 Pioneer ACO demonstration payment adjustment (see instruction:	s)		0	
99 Demonstration payment adjustment amount before sequestration			0	25
00 Net reimbursable amount (see instructions)			68, 865	
01 Sequestration adjustment (see instructions)			1, 377	
02 Demonstration payment adjustment amount after sequestration			0	
00 Interim payments			66, 795	
00 Tentative settlement (for contractor use only)			0	
00 Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		693	
as paranes due compenents program (rine zo minus rines zo. 01, zo.	nce with CMS Pub. 15-II		o	30

alth Financial Systems DAVIESS COMMUNITY ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC		Peri od:	u of Form CMS-2 Worksheet M-3	
RVICES	Component CCN: 15-8501	From 01/01/2023 To 12/31/2023		pare
	Title XVIII	RHC III	Cost	U alli
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	NWkst. M-2. line 20)		1, 950, 426	1.
00 Cost of injections/infusions and their administration (from Wk			703	2.
00 Total allowable cost excluding injections/infusions (line 1 mi	· · ·		1, 949, 723	3.
00 Total Visits (from Wkst. M-2, column 5, line 8)			14, 937	4.
00 Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5.
00 Total adjusted visits (line 4 plus line 5)			14, 937	6.
00 Adjusted cost per visit (line 3 divided by line 6)			130.53	7.
		Calculation	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
			12/31/2023)	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	4 or your contractor	1.00	2.00	8.
00 Rate for Program covered visits (see instructions)	6 or your contractor)	0.00	156. 85 130. 53	
CALCULATION OF SETTLEMENT		0.00	130. 33	7.
0.00 Program covered visits excluding mental health services (from	contractor records)	0	1, 312	10.
1.00 Program cost excluding costs for mental health services (line		0	171, 255	
2.00 Program covered visits for mental health services (from contra	-	0	0	
3.00 Program covered cost from mental health services (line 9 x lir		0	0	13.
4.00 Limit adjustment for mental health services (see instructions)		0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instructions	5)			15.
5.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	171, 255	16.
5.01 Total program charges (see instructions)(from contractor's rec			237, 838	
5.02 Total program preventive charges (see instructions)(from provi			4, 897	
5.03 Total program preventive costs ((line 16.02/line 16.01) times	-		3, 526	
5.04 Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		102, 654	16.
(Titles V and XIX see instructions.)		0	10(100	14
5.05 Total program cost (see instructions) 7.00 Primary payer amounts		0	106, 180	16. 17.
7.00 Primary payer amounts 3.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		39, 411	
records)			57,411	10.
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		38, 681	19.
records) D. OO Net program cost excluding injections/infusions (see instructi	opc)		106, 180	20
1.00 Program cost of vaccines and their administration (from Wkst.			449	
1.50 Total program IOP OPPS payments (see instructions)	M-4, 1111e 10)		447	21.
1.55 Total program IOP Costs (see instructions)				21.
1.60 Program IOP deductible and coinsurance (see instructions)				21.
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, m	ninus line 21.60)		106, 629	
3.00 Allowable bad debts (see instructions)			0	
3.01 Adjusted reimbursable bad debts (see instructions)			0	23.
4.00 Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24.
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.
5.50 Pioneer ACO demonstration payment adjustment (see instructions	5)		0	25.
5.99 Demonstration payment adjustment amount before sequestration			0	25.
5.00 Net reimbursable amount (see instructions)			106, 629	
5. 01 Sequestration adjustment (see instructions)			2, 133	
5.02 Demonstration payment adjustment amount after sequestration			120 579	26.
7.00 Interim payments 2.00 Toptative settlement (for contractor use only)			120, 578	
3.00 Tentative settlement (for contractor use only)	$12 \ 27 \ and \ 29$		16 092	28.
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0			-16, 082	
).00 Protested amounts (nonallowable cost report items) in accordar	NCO WITH CMS DUN 15 !!		0	30.

LCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	HOSPITAL Provider CCN: 15-0061	Peri od:	u of Form CMS-2 Worksheet M-3	
RVICES	Component CCN: 15-8503	From 01/01/2023 To 12/31/2023		pare
	Title XVIII	RHC V	Cost	u ui
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst. M-2, line 20)		2, 618, 428	1 1.
00 Cost of injections/infusions and their administration (from Wks			0	2.
00 Total allowable cost excluding injections/infusions (line 1 min	nus line 2)		2, 618, 428	3.
00 Total Visits (from Wkst. M-2, column 5, line 8)			6, 188	4.
00 Physicians visits under agreement (from Wkst. M-2, column 5, li	ine 9)		0	5
00 Total adjusted visits (line 4 plus line 5)			6, 188	6
00 Adjusted cost per visit (line 3 divided by line 6)			423.15	7
		Calculation	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
			12/31/2023)	
		1.00	2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.0	6 or your contractor)	0.00	335.83	
00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	335.83	9
.00 Program covered visits excluding mental health services (from a	contractor records)	0	6	10
.00 Program cost excluding costs for mental health services (line (0	2,015	
.00 Program covered visits for mental health services (from contrac		0	2,013	
.00 Program covered cost from mental health services (line 9 x line	,	0	0	
.00 Limit adjustment for mental health services (see instructions)		0	0	14
. 00 Graduate Medical Education Pass Through Cost (see instructions))			15
.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a	e	0	2, 015	
.01 Total program charges (see instructions)(from contractor's reco			1, 129	16
.02 Total program preventive charges (see instructions) (from provid	der's records)		0	16
.03 Total program preventive costs ((line 16.02/line 16.01) times	line 16)		0	16
.04 Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		1, 431	16
(Titles V and XIX see instructions.)				
.05 Total program cost (see instructions)		0	1, 431	
.00 Primary payer amounts			0	17
.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		226	18
.00 Beneficiary coinsurance for RHC/FQHC services (see instructions	c) (from contractor		101	19
.00 Beneficiary coinsurance for RHC/FQHC services (see instructions records)			181	19
. 00 Net program cost excluding injections/infusions (see instructions)	ons)		1, 431	20
.00 Program cost of vaccines and their administration (from Wkst. 1			0	
.50 Total program IOP OPPS payments (see instructions)				21
.55 Total program IOP Costs (see instructions)				21
.60 Program IOP deductible and coinsurance (see instructions)				21
.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, mi	inus line 21.60)		1, 431	22
.00 Allowable bad debts (see instructions)			0	
.01 Adjusted reimbursable bad debts (see instructions)			0	23
.00 Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		0	
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50 Pioneer ACO demonstration payment adjustment (see instructions))		0	25
. 99 Demonstration payment adjustment amount before sequestration			0	25
.00 Net reimbursable amount (see instructions)			1, 431	
.01 Sequestration adjustment (see instructions) .02 Demonstration payment adjustment amount after sequestration			29 0	26 26
. 00 Interim payments			1, 302	
. 00 Tentative settlement (for contractor use only)			1, 302	28
. 00 Balance due component/program (line 26 minus lines 26.01, 26.02	2 27 and 28)		100	
	,		0	30
.00 Protested amounts (nonallowable cost report items) in accordance				

alth Financial Systems DAVIESS COMMUNITY ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	HOSPITAL Provider CCN: 15-0061	Peri od:	u of Form CMS-2 Worksheet M-3	
RVI CES	Component CCN: 15-8506	From 01/01/2023 To 12/31/2023		pare
	Title XVIII	RHC VI	Cost	U alli
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	n Wkst M-2 line 20)		956, 637	1.
00 Cost of injections/infusions and their administration (from Wk			1, 553	2.
00 Total allowable cost excluding injections/infusions (line 1 mi	· · · · ·		955, 084	3.
00 Total Visits (from Wkst. M-2, column 5, line 8)			4, 704	4.
00 Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5.
00 Total adjusted visits (line 4 plus line 5)			4, 704	6.
00 Adjusted cost per visit (line 3 divided by line 6)			203.04	7.
		Cal cul ati on		
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
			12/31/2023)	
		1.00	2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	198.37	8.
00 Rate for Program covered visits (see instructions)	-	0.00	198.37	9.
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from	contractor records)	0	971	10.
1.00 Program cost excluding costs for mental health services (line	-	0	192, 617	
2.00 Program covered visits for mental health services (from contra		0	0	
3.00 Program covered cost from mental health services (line 9 x lin		0	0	13.
4.00 Limit adjustment for mental health services (see instructions)		0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instructions			100 (17	15.
5.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	192, 617	
5.01 Total program charges (see instructions)(from contractor's rec	-		176, 522	
5.02 Total program preventive charges (see instructions) (from provi	-		506	
5.03 Total program preventive costs ((line 16.02/line 16.01) times 5.04 Total Program non-preventive costs ((line 16 minus lines 16.03	-		552 131, 589	16. 16.
5.04 Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	s and to) trilles . ou)		131, 309	10.
5. 05 Total program cost (see instructions)		0	132, 141	16.
7.00 Primary payer amounts		0	132, 141	17.
3.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		27, 579	
records)			2,,0,,	
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		29, 688	19.
records)				
0.00 Net program cost excluding injections/infusions (see instructi			132, 141	20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		1, 079	
I.50 Total program IOP OPPS payments (see instructions)				21.
I.55 Total program IOP Costs (see instructions)				21.
I. 60 Program IOP deductible and coinsurance (see instructions)			400.000	21.
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, m	ninus line 21.60)		133, 220	
3.00 Allowable bad debts (see instructions)			0	
3. 01 Adjusted reimbursable bad debts (see instructions)			0	
1.00 Allowable bad debts for dual eligible beneficiaries (see instr 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	-)		0	25. 25.
5.50 Pioneer ACO demonstration payment adjustment (see instructions 5.99 Demonstration payment adjustment amount before sequestration	<i>>)</i>		0	25.
5. 00 Net reimbursable amount (see instructions)			133, 220	
5. 01 Sequestration adjustment (see instructions)			2, 664	20.
5.02 Demonstration payment adjustment amount after sequestration			2,004	26.
7.00 Interim payments			127, 619	
3.00 Tentative settlement (for contractor use only)			0	28.
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0)2, 27, and 28)		2, 937	29.
			2, 737	30.
).00 Protested amounts (nonallowable cost report items) in accordan				

	Financial Systems DAVLESS COMMUN ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider C	°N· 15_0061	Peri od:	u of Form CMS-2 Worksheet M-4	
JUNFUT	ATTON OF HOSFITAE-DASED RHC/TQHC VACCTINE COST	FIOVICEI C	GN. 15-0001	From 01/01/2023		
			CCN: 15-8500	To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY	
		VACCINES	VACCINES	VACCINES	PRODUCTS	
		1.00	2.00	2.01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	672, 334				1.0
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 000123				
. 00	Injection/infusion health care staff cost (line 1 x line 2)	83	9	74 C	0	3. C
. 00	Injections/infusions and related medical supplies costs (from your records)	0		0 0	0	4.C
5.00	Direct cost of injections/infusions (line 3 plus line 4)	83	9	74 C	0	5.0
b. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	689, 422				6.0
. 00	Total overhead (from Wkst. M-2, line 19)	687, 048				7.0
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000120				
9. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	82 165		71 C 45 C	-	
1.00	Total number of injections/infusions (from your records)	8		94 C	0	11.0
2.00	Cost per injection/infusion (line 10/line 11)	20.63	20.	69 0.00	0.00	12.0
3.00	Number of injection/infusion administered to Program beneficiaries	2		53 C	0	13.0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			C	0	13.0
4.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	41	1, 0	97 C		14.0
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
5.00	Total cost of injections/infusions and their administratic 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		2, 110	15.0
			s (sum of	1	1, 138	

	Financial Systems DAVIESS COMMU TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	VITY HOSPITAL Provider CO	N. 15 0061	Peri od:	u of Form CMS-2 Worksheet M-4	
JUNPUT	ATTON OF HUSPITAL-DASED RHC/FUNC VACCINE CUST	Provider C	JN. 15-0001	From 01/01/2023		
			CCN: 15-3999	To 12/31/2023		
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY	
					PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	482, 587	482, 5			1.0
. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000136				
. 00	Injection/infusion health care staff cost (line 1 x line 2)	66	4	79 C	0	3.0
. 00	Injections/infusions and related medical supplies costs (from your records)	0		0 0	0	4.0
5.00	Direct cost of injections/infusions (line 3 plus line 4)	66	4	79 C	0	5.0
o. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	512, 043	512, 0	43 512, 043	512, 043	6.0
. 00	Total overhead (from Wkst. M-2, line 19)	516, 496			516, 496	7.0
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000129	0. 0009	35 0. 000000	0. 000000	8. (
0. 00	Overhead cost - injection/infusion (line 7 x line 8)	67		83 C	0	9.0
0.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	133	9	62 C	0	10. (
1.00	Total number of injections/infusions (from your records)	7		51 C		11. (
2.00	Cost per injection/infusion (line 10/line 11)	19.00	18.	86 0.00		
3.00	Number of injection/infusion administered to Program beneficiaries	4		29 C	0	13.0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			C	0	13. (
4.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	76	5	47 C		14.(
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
5.00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		1, 095	15.0
6.00	Total Program cost of injections/infusions and their admir		s (sum of		623	16. (

	Financial Systems DAVLESS COMMUN ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der C	N: 15 0061	Peri od:	u of Form CMS-2 Worksheet M-4	
JUNFUT	ATTON OF HOSFITAE-DASED RHC/TQHC VACCTINE COST	FIOVICEI C	GN. 15-0001	From 01/01/2023		
			CCN: 15-8501	To 12/31/2023	Date/Time Pre 5/31/2024 9:2	
			XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	921, 952				1.0
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 000017				
8. 00	Injection/infusion health care staff cost (line 1 x line 2)	16	3	59 C	0	3.0
. 00	Injections/infusions and related medical supplies costs (from your records)	0		0 0	0	4.C
5.00	Direct cost of injections/infusions (line 3 plus line 4)	16		59 C	0	5.0
5.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 040, 498	, , .			
. 00	Total overhead (from Wkst. M-2, line 19)	909, 928		-		7.0
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000015				
9.00 10.00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	14 30		14 C 73 C	-	
1.00	Total number of injections/infusions (from your records)	2		45 C		11.0
2.00 3.00	Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	15.00 0		96 0.00 30 0		12.0 13.0
	benefi ci ari es					
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			C	0	13.(
4.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	4	49 C		14.0
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
5.00	Total cost of injections/infusions and their administratic 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		703	15.0
	12, 2.2., 2.2. $1.02, 1.00$ $10, (1.00)$ $10, 0.00$		s (sum of	1	1	16.0

	Financial Systems DAVLESS COMMUN TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider C	2N. 1E 00(1	Period:	u of Form CMS-2 Worksheet M-4	
COMPUT	ATTON OF HUSPITAL-BASED RHC/FUHC VACCINE CUST	Provi der C	JN: 15-0061	From 01/01/2023		
		Component	CCN: 15-8506	To 12/31/2023		
			XVIII	RHC VI	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	483, 847	483, 8	47 483, 847	483, 847	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 000054	0. 0016	42 0. 000000	0. 000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	26	7	94 0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0		0 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	26	7	94 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	505, 081	505, 0	81 505, 081	505, 081	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	451, 556	451, 5	56 451, 556	451, 556	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000051	0. 0015	0. 000000	0. 000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	23		10 0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	49	1, 5	04 0	0	10.00
11.00	Total number of injections/infusions (from your records)	3		92 0	-	
12.00	Cost per injection/infusion (line 10/line 11)	16.33	16.	35 0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0		66 0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1, 0	79 0		14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
15.00	Total cost of injections/infusions and their administratic 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		1, 553	15.00
16.00	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou	istration cost			1, 079	16.00

Health Financial Systems DAVIESS COMMU	NI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-0061	Period:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2023		
	Component CCN: 15-8500	To 12/31/2023		
		RHC I	5/31/2024 9: 20 Cost	u am
			T B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC		1.00	146,002	1.00
2.00 Interim payments payable on individual bills, either submi	ttod or to be submitted to		140, 002	2.00
the contractor for services rendered in the cost reporting			0	2.00
"NONE" or enter a zero	g period. Trillone, write			
3.00 List separately each retroactive lump sum adjustment amour	at based on subsequent			3.00
revision of the interim rate for the cost reporting period				5.00
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program				5.05
3. 50			0	3.50
3.51			0	3.51
3. 52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3	3 98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trar		_	146, 002	4.00
27)			110,002	1.00
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after de	esk review. Also show date (of		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
5.01			0	5.01
5. 02			0	5.02
5. 03			o	5.03
Provider to Program				
5. 50			0	5.50
5. 51			ol	5.51
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5	5. 98)		0	5.99
6.00 Determined net settlement amount (balance due) based on th				6.00
6. 01 SETTLEMENT TO PROVIDER			1, 812	6.01
6.02 SETTLEMENT TO PROGRAM			0	6.02
7.00 Total Medicare program liability (see instructions)			147, 814	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	
8.00 Name of Contractor				8.00

Health Financial Systems DAVIESS COMMU	NI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-0061	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-3999	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/31/2024 9:20	
		RHC II	Cost	
		Par	t B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
 Total interim payments paid to hospital-based RHC/FQHC Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero 			66, 795 0	1.00 2.00
3.00 List separately each retroactive lump sum adjustment amoun revision of the interim rate for the cost reporting period payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider			-	
3. 01			0	3.01
3. 02 3. 03			0	3.02 3.03
3. 04			0	3.03
3. 05			0	3.04
Provider to Program				0.00
3.50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3. 53			0	3.53
3. 54			0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3			0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (tran 27)	nster to Worksheet M-3, line	e	66, 795	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after de	esk review Also show date (of		5.00
each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				0.00
5. 01			0	5.01
5. 02			0	5.02
5. 03			Ő	5.03
Provider to Program		U		
5. 50			0	5.50
5. 51			0	5.51
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5			0	5.99
6.00 Determined net settlement amount (balance due) based on th	ne cost report. (1)			6.00
6. 01 SETTLEMENT TO PROVIDER			693	6.01
6.02 SETTLEMENT TO PROGRAM			0 67, 488	6.02
7.00 Total Medicare program liability (see instructions)		Contractor	NPR Date	7.00
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	
8.00 Name of Contractor				8.00

Heal th	Financial Systems DAVIESS COMMUN	I TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-0061	Peri od:	Worksheet M-5	
SERVI C	CES RENDERED TO PROGRAM BENEFICIARIES	Companyont CCN: 15 9501	From 01/01/2023 To 12/31/2023		narad
		Component CCN: 15-8501	10 12/31/2023	5/31/2024 9: 20	
			RHC III	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			120, 578	1.00
2.00	Interim payments payable on individual bills, either submit			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
2 00	"NONE" or enter a zero	•			2 00
3.00	List separately each retroactive lump sum adjustment amount				3.00
	revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)	Also show date of each			
	Program to Provider				
3. 01				0	3.01
3.02				0	3.02
3.03				Ő	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50	, , , , , , , , , , , , , , , , , , ,			0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	Э	120, 578	4.00
	27) TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk roviow Also show data	of		5.00
5.00	each payment. If none, write "NONE" or enter a zero. (1)	SK TEVTEW. ATSO SHOW DATE (5.00
	Program to Provider				
5.01				0	5.01
5.02				Ő	5.02
5.03				0	5.03
	Provider to Program				
5.50	Ŭ			0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			16, 082	6.02
7.00	Total Medicare program liability (see instructions)			104, 496	7.00
			Contractor	NPR Date	
		0	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
		U			

Health Financial Systems DAVIESS COMMUN	II TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-0061	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2023		
	Component CCN: 15-8503	To 12/31/2023		
			5/31/2024 9:20	0 am
		RHC V	Cost	
			rt B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC			1, 302	1.00
2.00 Interim payments payable on individual bills, either submit			0	2.00
the contractor for services rendered in the cost reporting	period. If none, write			
"NONE" or enter a zero				
3.00 List separately each retroactive lump sum adjustment amount	t based on subsequent			3.00
revision of the interim rate for the cost reporting period.	. Also show date of each			
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3. 01			0	3.01
3. 02			0	3.02
3. 03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program				
3. 50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3. 53			0	3.53
3. 54			ol	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)		ol	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trans		e	1, 302	4.00
27)	· · · · · · · · · · · · · · · · · · ·	-	,	
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after des	sk review. Also show date o	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider			·	
5.01			0	5.01
5. 02			0	5.02
5. 03			0	5.03
Provider to Program				
5. 50			0	5.50
5. 51			ol	5.51
5. 52			o	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	. 98)		o	5.99
6.00 Determined net settlement amount (balance due) based on the				6.00
6. 01 SETTLEMENT TO PROVIDER			100	6.01
6.02 SETTLEMENT TO PROGRAM			0	6.02
7.00 Total Medicare program liability (see instructions)			1, 402	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	

Heal th	Financial Systems DAVLESS COMMUN	II TY HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	IS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR	Provider CCN: 15-0061	Peri od:	Worksheet M-5	
	ES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8506	From 01/01/2023 To 12/31/2023		
		component cen. 13-0300	10 12/31/2023	5/31/2024 9: 20	
			RHC VI	Cost	<u> </u>
				rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			127, 619	1.00
2.00	Interim payments payable on individual bills, either submi-	tted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amoun	t based on subsequent			3.00
	revision of the interim rate for the cost reporting period.	. Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	e	127, 619	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program			-	
5.50				0	5.50
5.51				0	5.51
5.52		22)		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)		0.007	6.00
6.01	SETTLEMENT TO PROVIDER			2, 937	6.01
6.02	SETTLEMENT TO PROGRAM				6.02
7.00	Total Medicare program liability (see instructions)		Contracto	130, 556	7.00
			Contractor	NPR Date	
		0	Number 1.00	(Mo/Day/Yr)	
8.00	Name of Contractor	0	1.00	2.00	8.00
0.00		I	I	I	0.00