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 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0061 Worksheet S Peri od: From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 5/29/2019 4:30 pm use only ] Manually submitted cost report ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DAVIESS COMMUNITY HOSPITAL (15-0061) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)	
	Officer or Administrator of Provider(s)
Title	

			Title	XVIII			
	Cost Center Description	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	69, 412	36, 204	0	0	1. 00
2.00	Subprovider - IPF	0	22, 947	0		0	2. 00
3.00	Subprovider - IRF	0	-1, 053	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		-15, 296		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		41, 416		0	10. 01
10. 02	RURAL HEALTH CLINIC III	0		-22, 381		0	10. 02
10.04	RURAL HEALTH CLINIC V	0		266		0	10. 04
10.05	RURAL HEALTH CLINIC VI	0		33, 009		0	10. 05
200.00	Total	0	91, 306	73, 218	0	0	200. 00

Date

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. 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.

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX I	DAVIESS COMMUNI	_	TAL der CCN: 1		lr Period: From 01/01/ To 12/31/	2018 2018	of For Workshe Part I Date/Ti 5/29/20	et S-2 me Pre	pared:
	1.00	2. 00		3. 00		4	4. 00	3/2//20	717 4.5	O piii
4 00	Hospital and Hospital Health Care Co		1							4 00
1. 00 2. 00	Street: 1314 E. WALNUT STREET City: WASHINGTON	PO Box: 760 State: IN	Zin Cod	e: 47501	Count	y: DAVI ESS				1. 00 2. 00
2.00	orty. Washington	Component Name	CCN	CBSA	Provi der	7	Payme	nt Syst	em (P,	2.00
		·	Number	Number	Туре	Certi fi ed	T,	0, or	N)	
		1 00	2.00	2.00	4.00	F 00	V 00	XVIII		
	Hospital and Hospital-Based Componen	1.00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	
3.00	Hospi tal	DAVI ESS COMMUNI TY	150061	99915	1	07/01/1966	N	Р	0	3.00
4 00	6.1 185	HOSPI TAL	4500/4	00045		04 (04 (0000				4 00
4. 00 5. 00	Subprovi der - IPF Subprovi der - IRF	DCH - PSYCH DCH - REHAB	15S061 15T061	99915 99915	4 5	01/01/2003	N N	P P	0	4. 00 5. 00
6. 00	Subprovi der - (Other)	NEW IS	101001	/////		017 017 2000		1		6. 00
7.00	Swing Beds - SNF	DAVIESS COMMUNITY	15U061	99915		11/10/1999	N	P	N	7. 00
8. 00	Swing Beds - NF	HOSPI TAL								8. 00
9. 00	Hospi tal -Based SNF									9. 00
10.00	Hospi tal -Based NF									10. 00
11.00	Hospi tal Based OLTC									11.00
12. 00 13. 00	Hospital-Based HHA Separately Certified ASC									12. 00 13. 00
14. 00	Hospi tal -Based Hospi ce	HELPING HEART HOSPICE	151553	99915		07/11/1996				14. 00
15. 00	Hospital-Based Health Clinic - RHC	DAVIESS COMMUNITY	158500	99915		12/17/2003	N	0	N	15. 00
15. 01	Hospital-Based Health Clinic - RHC	HOSPITAL MC NORTH DAVIESS MEDICAL	153999	99915		12/17/2003	N	0	N	15. 01
13.01	II	CENTER	133777	/////		12/1//2003	"		"	13.01
15. 02	Hospital-Based Health Clinic - RHC	DCH HEALTH PAVILION	158501	99915		03/30/2004	N	0	N	15. 02
15 04		GRAND AVENUE PEDLATRICS	158503	99915		01/27/2005	N	0	N	15. 04
15. 05	Hospital -Based Health Clinic - RHC	MARTIN MEDICAL CLINIC	158506	99915		10/31/2006	N	o o	N	15. 05
4 / 00	VI									
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16. 00 17. 00
	Hospital -Based (CORF) I									17. 10
18. 00	Renal Dialysis									18. 00
19. 00	Other					From:		To	<u> </u>	19. 00
	1.00 2.00									
	Cost Reporting Period (mm/dd/yyyy)					01/01/20	018	12/31/	′2018	20. 00
21. 00	Type of Control (see instructions)					8				21. 00
					1. 00	2. 00		3. 0	00	
	Inpatient PPS Information									
22. 00	Does this facility qualify and is it disproportionate share hospital adju				Υ	N				22. 00
	§412.106? In column 1, enter "Y" fo			`						
	facility subject to 42 CFR Section §	412.106(c)(2)(Pickle ame								
22 01	hospital?) In column 2, enter "Y" fo		c for thi	_	Υ	Y				22. 01
22. 01	Did this hospital receive interim un cost reporting period? Enter in colu				Ţ	T T				22.01
	the portion of the cost reporting pe	riod occurring prior to	October 1	1.						
	Enter in column 2, "Y" for yes or "N	·		cost						
22. 02	reporting period occurring on or aft Is this a newly merged hospital that			-e	N	N				22. 02
	payments to be determined at cost re	port settlement? (see in	struction							
	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob			,,,,,,						
	or "N" for no, for the portion of th									
	October 1.									
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar				N	N		N		22. 03
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin	g period prior to Octobe	r 1. Ente							
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least			as						
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" fo	or						
23 00	yes or "N" for no. Which method is used to determine Me	dicaid days on lines 24	and/or 25	,		2 N				23. 00
23.00	below? In column 1, enter 1 if date									23.00
	if date of discharge. Is the method	of identifying the days	in this o							
	reporting period different from the reporting period? In column 2, ente									
	p. sps. tring porrou. The condition 2, effice	101 yes of 14 101	.10.	1		T	I			1

for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is

Ν

58.00

59.00

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

Health Financial Systems DAVIESS	COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		eri od:	Worksheet S-2	
			T	rom 01/01/2018 o 12/31/2018	Part I Date/Time Prep	
			NAHE 413.85	Worksheet A	5/29/2019 4: 30 Pass-Through	) pm
			Y/N	Line #	Qualification	
					Criterion Code	
	· · · · · · · · ·		1. 00	2.00	3. 00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?		costs for tructions)	N			60. 00
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4.00	5. 00	
61.00 Did your hospital receive FTE slots under ACA	N			0.00		61. 00
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)						
61.01 Enter the average number of unweighted primary care						61. 01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						
instructions) 61.02 Enter the current year total unweighted primary care						61. 02
FTE count (excluding OB/GYN, general surgery FTEs,						01.02
and primary care FTEs added under section 5503 of ACA). (see instructions)						
61.03 Enter the base line FTE count for primary care						61. 03
and/or general surgery residents, which is used for determining compliance with the 75% test. (see						
i nstructi ons)						
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04
current cost reporting period. (see instructions).						
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61. 05
primary care and/or general surgery FTE counts (line						
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being						61. 06
used for cap relief and/or FTEs that are nonprimary						
care or general surgery. (see instructions)	Prog	gram Name	Program Code	Unweighted IME	Unwei ghted	
				FTE Count	Direct GME FTE Count	
		1.00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0. 00	0.00	61. 10
for each new program. (see instructions) Enter in						
column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE						
unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
61.20 Of the FTEs in line 61.05, specify each expanded				0.00	0. 00	61. 20
program specialty, if any, and the number of FTE residents for each expanded program. (see						
instructions) Enter in column 1, the program name.						
Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,						
the direct GME FTE unweighted count.						
					1.00	
ACA Provisions Affecting the Health Resources and Set 62.00 Enter the number of FTE residents that your hospital				ad for which		62. 00
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc		TH this cost	reporting peri	od for will cit	0.00	62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC productions.				your hospital	0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide	er Settir	ngs				
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N	63. 00
, ,		2. 2 0009.1 0	Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	·		
Section 5504 of the ACA Base Year FTE Residents in No	onprovi de	er Settinas1	1.00 This base year	is your cost r	3.00 eporting	
period that begins on or after July 1, 2009 and before	re June 3	30, 2010.				(4.00
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor			0.00	0.00	0. 000000	04. UU
resident FTE's attributable to rotations occurring in settings. Enter in column 2 the number of unweighted						
resident FTEs that trained in your hospital. Enter in	n column	3 the ratio				
of (column 1 divided by (column 1 + column 2)). (see	ınstruct	ti ons)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0061 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 4:30 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-0061	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pro 5/29/2019 4:3	epared:	
				1.00		
Long Term Care Hospital PPS					I	
.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a .00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.  TEFRA Providers			ng period? Enter	N N	80. C 81. C	
.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) .00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 0 86. 0	
.00 Is this hospital an extended neoplastic disease care hospital	cl assi fi ed	under section	า	N	87. 0	
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XLX	_	
			1. 00	2. 00		
Title V and XIX Services  .00 Does this facility have title V and/or XIX inpatient hospital	servi ces? E	nter "Y" for	N	Υ	90. (	
yes or "N" for no in the applicable column.  .00 Is this hospital reimbursed for title V and/or XIX through the	e cost repor	t either in	N	Υ	91. 0	
full or in part? Enter "Y" for yes or "N" for no in the application of the application of the Aretitle XIX NF patients occupying title XVIII SNF beds (dual		N	92. 0			
instructions) Enter "Y" for yes or "N" for no in the applicable	N.					
.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.				N	93.0	
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, an applicable column.	nd "N" for n	o in the	N	N	94.0	
<ul> <li>.00 If line 94 is "Y", enter the reduction percentage in the appli</li> <li>.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.</li> </ul>	0. 00 N	0. 00 N	95. 0 96. 0			
.00 If line 96 is "Y", enter the reduction percentage in the appli .00 Does title V or XIX follow Medicare (title XVIII) for the into stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	0. 00 Y	97. C 98. C				
column 1 for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for the repr C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl title XIX.	Y	98. 0				
.02 Does title V or XIX follow Medicare (title XVIII) for the cald	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Y bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1					
.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98. 0	
.04 Does title V or XIX follow Medicare (title XVIII) for a CAH ro outpatient services cost? Enter "Y" for yes or "N" for no in o			N b	N	98. (	
in column 2 for title XIX.  .05 Does title V or XIX follow Medicare (title XVIII) and add bacl Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col				Y	98. (	
column 2 for title XIX.  .06 Does title V or XIX follow Medicare (title XVIII) when cost rough IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.0	
Rural Providers			NI NI		105 6	
5.00 Does this hospital qualify as a CAH? 6.00 If this facility qualifies as a CAH, has it elected the all-in	nclusive met	nod of payme	nt N		105. 0 106. 0	
for outpatient services? (see instructions) 7.00  f this facility qualifies as a CAH, is it eligible for cost of training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2	1. (see inst	ructions) If			107. 0	
reimbursed. If yes complete Wkst. D-2, Pt. II. 8.00 sthis a rural hospital qualifying for an exception to the Cl CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee sche	dul e? See 4:	2 N		108.0	
	Physi cal	Occupation		Respiratory		
9.00   f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2.00 N	3. 00 N	4. 00 N	109. 0	
				4.00		
0.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y' complete Worksheet E, Part A, lines 200 through 218, and Works	" for yes or	"N" for no.	If yes,	1.00 N	110. 0	

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-0061	Peri od: From 01/01/ To 12/31/			t S-2 e Prepared: 9 4:30 pm
		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 co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	st reporting period? Ente lumn 1 is Y, enter the ticipating in column 2.	N N		2.00	111. 0
			1. 00	2.00	3. 00
Miscellaneous Cost Reporting Information  15.00 sthis an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.  16.00 sthis facility classified as a referral center? Enter "Y"	If column 2 is "E", ente t for long term care (inc s) based on the definition	er in column Hudes	N N		0 115. 0
17.00 is this facility legally-required to carry malpractice insurno.	ance? Enter "Y" for yes o		Y		117. 0
18.00 Is the mal practice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 if the polic	y is	2		118. 0
	Premi ums	Losse	S	Insurar	nce
	1.00	2.00		3. 00	1
18.01 List amounts of malpractice premiums and paid losses:	103,	807	0		0 118. 0
		1. 00		2. 00	)
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 DO NOT USE THIS LINE		N			118. 0
20.00 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 amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes or alifies for the Outpatien	,		N	120. 0
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntable devices charged to	Y			121. 0
22.00 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.					122. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N" for no. If	N			125. 0
yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 of this is a Medicare certified kidney transplant center, en		е			126. 0
in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certification date	:			127. 0
28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certification date	•			128. 0
29.00 of this is a Medicare certified lung transplant center, ente		in			129. 0
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col					130. 0
31.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col	, enter the certification	1			131. 0
32.00 If this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2					132. 0
33.00 If this is a Medicare certified other transplant center, ent in column 1 and termination date, if applicable, in column 2		•			133. 0
34.00  If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.  All Providers	e OPO number in column 1				134. 0
40.00 Are there any related organization or home office costs as d chapter 10? Enter "Y" for yes or "N" for no in column 1. If		Y			140. 0

Health Financial Systems DAVIESS COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0061 Peri od: Worksheet S-2 From 01/01/2018 Part I То 12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 Ν Ν 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158. 00 159. 00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 161. 10 CORF Ν Ν Ν 161. 10 1.00 Mul ti campus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Zi p Code Name CBSA County State 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment	Act		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),	enter the		0168.00
reasonable cost incurred for the HIT assets (see instructions)			1/0 01
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	a nardsnip		168. 01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "transition factor. (see instructions)	N"), enter the	9. 9	99169. 00
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	12/31/2018	170. 00
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section	N	(	0 171. 00

Heal th	Financial Systems DAVIESS COMMUN	II TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 01/01/2018	Worksheet S-2	
				To 12/31/2018	Date/Time Pre	
				Y/N	5/29/2019 4:3 Date	BO pm
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	sponses. Ente	r all dates in t		
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					+
1.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in c	column 2. (see				
			1.00	2. 00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare F	Program? If	N N	2.00	3.00	2. 00
	yes, enter in column 2 the date of termination and in colum					
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	na management	N			3.00
3.00	contracts, with individuals or entities (e.g., chain home of		1			3.00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other					
	relationships? (see instructions)	ei Silliiai				
			Y/N	Туре	Date	
	Figure 1 Data and Danage		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Public	Y	A		4.00
00	Accountant? Column 2: If yes, enter "A" for Audited, "C" f			,		
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
5. 00	column 3. (see instructions) If no, see instructions.  Are the cost report total expenses and total revenues differences.	erent from	l N			5. 00
3.00	those on the filed financial statements? If yes, submit rec		1			3.00
			•	Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2:	If ves. is th	ne provider is	N		6. 00
	the legal operator of the program?					
7.00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7. 00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	auring the	N		8. 00
9.00	Are costs claimed for Interns and Residents in an approved	graduate medic	cal education	N		9. 00
40.00	program in the current cost report? If yes, see instruction					40.00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N 1. 00	
	Bad Debts				1.00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes				Y	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection bad debt collection provider's bad debt collection bad debt collect	oolicy change o	during this co	st reporting	N	13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	ves, see ins	tructions.	N	14. 00
00	Bed Complement	nar rour in	J007 000 1110	tr do tr onor		1 00
15. 00	Did total beds available change from the prior cost reporti				N N	15. 00
		Y/N	Tt A Date	Y/N	t B Date	
		1.00	2.00	3. 00	4.00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only?  If either column 1 or 3 is yes, enter the paid-through	N		N		16. 00
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Y	04/23/2019	Y	04/23/2019	17. 00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	Y		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	I	1	1	I	1

	Financial Systems DAVIESS COMMUNI FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CO	CN: 15-0061	Peri od:	u of Form CM: Worksheet S			
				From 01/01/2018 To 12/31/2018	Part II Date/Time P			
		Descri	nti on	Y/N	5/29/2019 4 Y/N	: 30 pm		
		(		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. 0		
	report data for other: beserve the other day astments.	Y/N	Date	Y/N	Date			
14 00		1.00	2. 00	3. 00	4. 00	04.0		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS H	OSPI TALS)					
2. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 0		
3. 00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.		als made du	ring the cost		23. 0		
24. 00	Were new leases and/or amendments to existing leases entered lf yes, see instructions	d into during	this cost re	eporting period?		24. 0		
5. 00	Have there been new capitalized leases entered into during tinstructions.	the cost repor	ting period <sup>°</sup>	? If yes, see		25. 0		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period?	If yes, see		26. 0		
7. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? I	f yes, submit		27. 0		
8. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit ent	tered into dur	ing the cos	t reporting		28. 0		
9. 00	period? If yes, see instructions.  00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
0. 00								
1. 00	instructions.  Has debt been recalled before scheduled maturity without issinstructions.	suance of new	debt? If yes	s, see		31.0		
2. 00	Purchased Services Have changes or new agreements occurred in patient care serv		d through co	ontractual		32. 0		
33. 00	arrangements with suppliers of services? If yes, see instruction 1f line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.		g to competi	itive bidding? If		33. 0		
	Provi der-Based Physi ci ans							
4. 00	Are services furnished at the provider facility under an arr If yes, see instructions.	rangement with	provi der-ba	ased physicians?		34. 0		
5. 00	If line 34 is yes, were there new agreements or amended exisphysicians during the cost reporting period? If yes, see ins		ts with the	provi der-based		35. C		
	The second darring the cook reporting portion in your cook in	311 4311 31131		Y/N	Date			
	Hama Offi on Conta			1. 00	2. 00			
36. 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00		
	If line 36 is yes, has a home office cost statement been pro- lif yes, see instructions.	epared by the	home office			37. 0		
8. 00				f		38. C		
9. 00				S,		39. 0		
0. 00	If line 36 is yes, did the provider render services to the hinstructions.	home office?	If yes, see			40. 0		
		1.	00	2.	00			
	Cost Report Preparer Contact Information	1.		Ζ.				
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	VI CHOLAS		EI CHELMAN		41.0		
11. 00				1		II .		
11. 00	respectively.  Enter the employer/company name of the cost report preparer.	BKD, LLP				42.0		

Heal th	Financial Systems	DAVIESS COMMUNI	TY HOSPI TAI	_			In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE	Provi der	CCN:	15-0061	Peri		Worksheet S-	2
						To			enared:
						10	127 517 2010	5/29/2019 4:	30 pm
				3.00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the tit		I RECTOR						41.00
	held by the cost report preparer in columns	1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the cost	report							42. 00
	preparer.								
	Enter the telephone number and email addres								43. 00
	report preparer in columns 1 and 2, respect	i vel y.							

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: | Part | P 
 Heal th Financial
 Systems
 DAVIESS

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-0061

						10	12/31/2018	5/29/2019 4		
								I/P Days / 0		, bill
								Visits / Tri		
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	70	
		Line Number			Avai I abl e					
		1. 00		2.00	3.00	T	4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		37	13, 50	)5	0.00		0	1. 00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
	for the portion of LDP room available beds)									
2.00	HMO and other (see instructions)									2.00
3.00	HMO IPF Subprovider									3.00
4.00	HMO IRF Subprovider									4.00
5.00	Hospital Adults & Peds. Swing Bed SNF								0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF								0	6.00
7.00	Total Adults and Peds. (exclude observation			37	13, 50	)5	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)									12.00
13.00	NURSERY	43. 00							0	13.00
14. 00	Total (see instructions)			42	15, 33	30	0.00		0	14.00
15. 00	CAH visits								0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		20					0	16.00
17. 00	SUBPROVI DER - I RF	41. 00		12	4, 38	30			0	17. 00
18. 00	SUBPROVI DER									18. 00
19. 00	SKILLED NURSING FACILITY									19. 00
20. 00	NURSING FACILITY									20.00
21. 00	OTHER LONG TERM CARE									21. 00
22. 00	HOME HEALTH AGENCY	101. 00							0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )									23. 00
24. 00	HOSPI CE	116. 00		0	1	0				24. 00
24. 10	HOSPICE (non-distinct part)	30. 00								24. 10
25. 00	CMHC - CMHC	00.40								25. 00
25. 10	CMHC - CORF	99. 10							0	25. 10
26. 00	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							0	26. 04
26. 05	RURAL HEALTH CLINIC VI	88. 05							0	26. 05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00							0	26. 25
27. 00	Total (sum of lines 14-26)			74						27. 00
28. 00	Observation Bed Days								0	28. 00
29. 00	Ambul ance Tri ps									29. 00
30.00	Employee discount days (see instruction)									30.00
31. 00	Employee discount days - IRF			^						31. 00
32. 00	Labor & delivery days (see instructions)			0	1	0				32. 00
32. 01	Total ancillary labor & delivery room				1					32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days				1					33. 00
	LTCH non-covered days LTCH site neutral days and discharges				1					33. 00
33.01	LETON SITE NEUTRAL MAYS AND UISCHALGES		l		I	- 1		l	I	55.01

Provider CCN: 15-0061

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part | | Date/Time Prepared: | 5/29/2019 4:30 pm | Full Time Foul valents

Component			I/P Days	o / O/P Visits	/ Trips Full Time Equivalents			
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   1.00		Component	Title XVIII	Title XIX	Total All			
Hospital Adults & Peds. (Columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 For the portion or IDP room available beds)   144   1, 214								
B exclude Swing Bed, Observation Bed and Hospite deays) (see instructions for cot. 2 for the portion of LIDP room available beds)							10.00	
Hospice days) (see instructions for col. 2   For the portion of LDP room available beds)   144   1,214   2.00   1.00	1. 00		1, 822	113	3, 419			1. 00
For the portion of LDP room avail able beds)   144   1,214   2,00   3.00   4M0 and other (see instructions)   144   1,214   3.00   3.00   4M0 (IPF Subprovi der   16   4.55   3.00   4.00   4M0 (IPF Subprovi der   16   4.55   3.00   4.00   4.00   4.00   4M0 (IPF Subprovi der   1.66   4.55   3.00   4.00								
2.00								
3.00   HMO   PF Subprovi der   130   1,825   3.00   5.00   6.00	2 00		144	1 214				2 00
4.00			· •					
5.00		1	l .					
Bospital Adults & Peds. Swing Bed NF   1,822   113   3,419			l :		0			
Bods   (see instructions)	6.00			o	0			6. 00
8.00   INTENSIVE CARE UNIT	7.00	Total Adults and Peds. (exclude observation	1, 822	113	3, 419			7. 00
9.00   CORONARY CARE UNIT		beds) (see instructions)						
10.00   BURN INTENSIVE CARE UNIT		l e	436	25	726			
11. 00   OTHER SPECIAL CARE (SPECIFY)		I I						
12. 00   OTHER SPECIAL CARE (SPECIFY)     28   815     13. 00								
13. 00   NURSERY   13. 00   Total (see instructions)   2,258   166   4,960   0.00   269.70   14. 00   15. 00   15. 00   14. 00   15. 00   14. 00   15. 00   14. 00   15. 00   15. 00   15. 00   14. 00   15. 00   15. 00   15. 00   15. 00   16. 00   16. 00   18. 00								
14. 00   Total (see instructions)   2, 258   166   4, 960   0.00   269.70   14. 00   15. 00   CAH visits   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0.4.5			
15.00   CAH visits   CAH visi			0.050				0.00 70	
16. 00 SUBPROVIDER - IPF			2, 258		4, 960	0.00	269. 70	
17.00   SUBPROVI DER - IRF   1,265   0   1,519   0.00   12.30   17.00     18.00   SUBPROVI DER   1,000   SKILLED NURSI NG FACILITY   19.00     20.00   NURSI NG FACILITY   20.00     21.00   OTHER LONG TERM CARE   20.00   HOME HEALTH AGENCY   0   0   0   0   0     23.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00     24.00   HOSPI CE   (non-distinct part)   28   24.10     25.00   CMHC - CMHC   25.00     26.00   RURAL HEALTH CLINIC   1   1,927   1,406   5,810   0.00     26.01   RURAL HEALTH CLINIC   1   1,927   1,406   5,810   0.00     26.02   RURAL HEALTH CLINIC   1   1,927   1,406   5,810   0.00     26.01   RURAL HEALTH CLINIC   1   1,944   4,695   14,024   0.00     26.02   RURAL HEALTH CLINIC   1   1,944   4,695   14,024   0.00     26.03   RURAL HEALTH CLINIC   1   1,842   438   4,379   0.00   374.57     27.00   28.00   0   0   0   0   0     28.00   0   0   0   0   0     30.00   Employee discount days   IFF   0     30.00   Employee discount days   See instructions   0     30.00   ITCH non-covered days   0   0   0     30.00   ITCH non-covered days   0   0   0      30.00   ITCH non-covered days   0   0   0      31.00   17.00   17.50   0     31.00   17.00   1		i i	E 000		4 020	0.00	24 02	
18. 00   SUBPROVI DER		· ·						
19.00   SKILLED NURSING FACILITY   20.00   NURSING FACILITY   21.00   OTHER LONG TERM CARE   OTHER LEATH CALL CENTER (D.P.)   OTHER LONG TERM CARE   OTHER LEATH CALL CENTER (D.P.)   OTHER LONG TERM CARE   OTHER LEATH CALL CENTER (D.P.)   OTHER LONG TERM CARE   OTHER LEATH CALL CORF   OTHER LEATH CALL CORF   OTHER LONG TERM CALL CENTER   OTHER LATH CALL CALL CALL CALL CALL CALL CALL CAL		· ·	1, 203	O	1, 517	0.00	12.30	
20. 00   NURSING FACILITY   21. 00   O   O   O   O   O   O   O   O   O		i i						
21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPI CE 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC III 26. 00 RURAL HEALTH CLINIC III 27. 00 CMC 28. 00 TOTAL CLINIC V 29. 00 TOTAL (Sum of lines 14-26) 29. 00 TOTAL (Sum of lines 14-26) 29. 00 AMBULATORY SURGICAL CENTER (D.P.) 21. 00 O O O O O O O O O O O O O O O O O O								
22. 00 HOME HEALTH AGENCY		i i						
24.00 HOSPICE		i i	o	o	0	0.00	0.00	
24. 10	23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 01 RURAL HEALTH CLINIC III 26. 01 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 27. 295 1, 291 7, 116 0.00 10.83 26.00 28. 04 RURAL HEALTH CLINIC V 29. 05 RURAL HEALTH CLINIC V 29. 00 RURAL HEALTH CLINIC V 20. 00 RURAL HEALTH CL	24.00	HOSPI CE	4, 620	247	5, 043	0.00	5. 55	24.00
25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 01 RURAL HEALTH CLINIC II 26. 02 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 26. 02 RURAL HEALTH CLINIC III 27. 04 RURAL HEALTH CLINIC III 28. 02 RURAL HEALTH CLINIC III 29. 04 RURAL HEALTH CLINIC V 30. 05 RURAL HEALTH CLINIC V 30. 06 RURAL HEALTH CLINIC V 30. 07 RURAL HEALTH CLINIC V 30. 08 RURAL HEALTH CLINIC V 30. 09 RURAL HEALTH CLINIC VI 30. 00 Bervation Bed Days 30. 00 Bervation Bed Days 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 34. 00 0. 00		HOSPICE (non-distinct part)			28			24. 10
26. 00 RURAL HEALTH CLINIC 1, 927 1, 406 5, 810 0. 00 7. 85 26. 00 26. 01 RURAL HEALTH CLINIC II 2, 295 1, 291 7, 116 0. 00 10. 83 26. 01 26. 02 RURAL HEALTH CLINIC III 1, 994 4, 695 14, 024 0. 00 15. 24 26. 02 26. 04 RURAL HEALTH CLINIC V 6 4, 002 7, 530 0. 00 8. 66 26. 04 26. 05 RURAL HEALTH CLINIC VI 1, 842 438 4, 379 0. 00 7. 52 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 00 0. 00 0. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 374. 57 27. 00 28. 00 Observation Bed Days 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days		· ·						
26. 01 RURAL HEALTH CLINIC III 2, 295 1, 291 7, 116 0. 00 10. 83 26. 01 26. 02 RURAL HEALTH CLINIC III 1, 994 4, 695 14, 024 0. 00 15. 24 26. 02 26. 04 RURAL HEALTH CLINIC V 6 4, 002 7, 530 0. 00 8. 66 26. 04 26. 05 RURAL HEALTH CLINIC VI 1, 842 438 4, 379 0. 00 7. 52 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 00 0. 00 0. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 374. 57 27. 00 28. 00 Observation Bed Days 380 1, 731 28. 00 29. 00 Ambul ance Tri ps 0 Employee di scount days (see instruction) 31. 00 Employee di scount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0 0 10. 00 10. 83 26. 01 10. 84 26. 02 10. 84 26		I I	0	0				
26. 02 RURAL HEALTH CLINIC IIII		I I						
26. 04 RURAL HEALTH CLINIC V 26. 05 RURAL HEALTH CLINIC VI 26. 05 RURAL HEALTH CLINIC VI 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 29. 01 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  26. 04 4, 002 7, 530 0. 00 8, 66 26. 04 4, 002 7, 530 0. 00 8, 66 26. 04 4, 002 7, 530 0. 00 9, 00 9		l e						
26. 05 RURAL HEALTH CLINIC VI 1,842 438 4,379 0.00 7.52 26.05 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 0.00 374.57 27.00 28.00 Observation Bed Days 380 1,731 28.00 29.00 Ambul ance Trips 0 Employee discount days (see instruction) Employee discount days - IRF 0 32.00 Labor & delivery days (see instructions) 0 71 125 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 LTCH non-covered days 0 9.00 33.00 33.00		l e	1, 994					
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 374. 57 27. 00 28. 00 Observation Bed Days 380 1, 731 28. 00 29. 00 Ambul ance Trips 0 Employee discount days (see instruction) 141 30. 00 Employee discount days - IRF 0 31. 00 Employee discount days (see instructions) 2. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0 0 33. 00 33. 00 33. 00		l e	1 042					
27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total (sum of lines 14-26) 380 1, 731 28. 00 29. 00 30. 00 31. 00 31. 00 31. 00 31. 00 31. 00 32. 01 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 LTCH non-covered days 33. 00		l e	1, 842		The state of the s			
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  380 1,731 28.00 29.00 30.00 71 125 32.00 31.00 32.01 32.01			٥	U	U			
29.00 Ambulance Trips 0 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 71 125 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01  33.00 LTCH non-covered days 0 33.00				380	1 731	0.00	374.37	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)  32.01 LTCH non-covered days  30.00 31.00		, and the second	٥	300	1, 731			
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  31.00 31.00 71 125 32.00 32.00 32.01			١		141			
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  32.00 32.01								
32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  0 32.01			o	71	125			
outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00								
33.01   LTCH site neutral days and discharges 0   33.01		,						
	33. 01	LTCH site neutral days and discharges	이				l	33. 01

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0061

				To	12/31/2018	Date/Time Prep 5/29/2019 4:30	
		Full Time		Di sch	arges	372772017 4. 3	O PIII
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and			0 658	327	1, 455	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)				_		
2.00	HMO and other (see instructions)			46	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO I RF Subprovi der				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions)   INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00		0 658	327	1, 455	
15. 00	CAH visits	0.00			027	.,	15. 00
16. 00	SUBPROVIDER - IPF	0. 00		0 255	33	319	16. 00
17. 00	SUBPROVIDER - IRF	0. 00		0 100	3	121	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26. 04	RURAL HEALTH CLINIC V	0.00					26. 04
26. 05	RURAL HEALTH CLINIC VI	0.00					26. 05 26. 25
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					26. 25
28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00					28.00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see Histruction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 00
52.01	outpatient days (see instructions)						02.01
33.00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
	,			•		'	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0061

					To	12/31/2018	Date/Time Prep 5/29/2019 4:30	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2. 00	A-6) 3. 00	3) 4. 00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	25, 710, 605	О	25, 710, 605	962, 876. 00	26. 70	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	C	0	0. 00	0.00	2. 00
3. 00	Non-physician anesthetist Part		0	С	0	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	О	0	0.00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0		0. 00 0. 00		4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC services		0	C	0	0.00	0.00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	С	0	0.00	0.00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	C	О	0.00	0.00	7. 01
8.00	Home office and/or related organization personnel		0	C	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	0 5, 967, 479	0 14, 161	0 5, 981, 640	0. 00 196, 384. 00		9. 00 10. 00
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		0	0	O	0.00	0.00	11. 00
12. 00	Care Contract Labor: Top Level		493, 553	_		4, 160. 00		
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		0	C	0	0.00	0.00	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	С	0	0.00	0.00	14. 00
14. 01 14. 02	Home office salaries Related organization salaries		0	0	0	0. 00 0. 00		14. 01 14. 02
15. 00	Home office: Physician Part A		0	o	O	0.00		
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	О	0	0.00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		4, 308, 044		4, 308, 044			17. 00
	instructions)							
18. 00	Wage-related costs (other) (see instructions)		0	_				18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 189, 757 0	0	, , , , ,			19. 00 20. 00
21. 00	Non-physician anesthetist Part		0	С	0			21. 00
22. 00	Physician Part A - Administrative		0	C	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24.00	Wage-related costs (RHC/FQHC)		0	Ö	0			24. 00
25. 00 25. 50	Interns & residents (in an approved program) Home office wage-related		0	0	0			25. 00 25. 50
25. 51	(core) Related organization		0					25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0	0			25. 52
25.52	- Administrative - wage-related (core)		_	_	_			25 52
25. 53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	C	0			25. 53
	OVERHEAD COSTS - DIRECT SALARIE							
	Employee Benefits Department Administrative & General	4. 00 5. 00	140, 120 2, 297, 999			5, 726. 00 100, 908. 00	24. 47 22. 27	26. 00 27. 00

Provi der CCN: 15-0061

						rom 01/01/2018		
					T	o 12/31/2018		
							5/29/2019 4: 3	
		Wkst. A Line		Recl assi fi cati			Average Hourly	
		Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28.00	Administrative & General under		193, 465	0	193, 465	1, 086. 00	178. 14	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	243, 192	0	243, 192	10, 800. 00	22. 52	29. 00
30.00	Operation of Plant	7. 00	0	0	C	0.00	0.00	30.00
31.00	Laundry & Linen Service	8. 00	0	0	C	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	468, 817	0	468, 817	37, 632. 00	12. 46	32. 00
33.00	Housekeeping under contract		0	0	C	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	522, 490	-437, 156	85, 334	5, 631. 00	15. 15	34.00
35.00	Di etary under contract (see		0	0	l c	0.00	0.00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	349, 211	349, 211	23, 041. 00	15. 16	36.00
37.00	Maintenance of Personnel	12. 00	0	0	C	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	808, 421	0	808, 421	23, 525. 00	34. 36	38. 00
39.00	Central Services and Supply	14. 00	275, 789	0	275, 789	13, 427. 00	20. 54	39. 00
40.00	Pharmacy	15. 00	458, 304	0	458, 304	13, 939. 00	32. 88	40. 00
41.00	Medical Records & Medical	16. 00	450, 385	l .	450, 385		l .	41.00
	Records Library		,			, , , , , , , , , , , , , , , , , , , ,		
42.00	Soci al Servi ce	17. 00	0	91, 009	91, 009	5, 581. 00	16. 31	42.00
43.00	Other General Service	18. 00	0	0		0.00	l .	43.00
	1			1	'	1	1	

					Т	o 12/31/2018	Date/Time Prep 5/29/2019 4:30	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		25, 904, 070	0	25, 904, 070	963, 962. 00	26. 87	1.00
	instructions)							
2.00	Excluded area salaries (see		5, 967, 479	14, 161	5, 981, 640	196, 384. 00	30. 46	2.00
	instructions)							
3.00	Subtotal salaries (line 1		19, 936, 591	-14, 161	19, 922, 430	767, 578. 00	25. 95	3.00
	minus line 2)							
4.00	Subtotal other wages & related		493, 553	0	493, 553	4, 160. 00	118. 64	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		4, 308, 044	0	4, 308, 044	0.00	21. 62	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		24, 738, 188	-14, 161	24, 724, 027	771, 738. 00	32. 04	6.00
7.00	Total overhead cost (see		5, 858, 982	-47, 310	5, 811, 672	263, 770. 00	22. 03	7.00
	instructions)							

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0061	Peri od: Worksheet S-3 From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared:

	To 12/31/2018	Date/lime Prep 5/29/2019 4:30	bared: D pm
		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 Contribution	ol	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	366, 593	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	37, 067	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3, 066, 642	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	26, 522	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00		36, 421	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	162, 633	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		l
	TAXES		
17. 00		0	17. 00
18. 00		1, 753, 319	18. 00
19. 00		0	19. 00
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00		0	21. 00
	instructions))	_	
22. 00	1 19 11 11 11 11 11 11 11 11 11 11 11 11	0	22. 00
23. 00		48, 604	23. 00
24. 00		5, 497, 801	24. 00
05.00	Part B - Other than Core Related Cost		05.00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0061	Peri od: Worksheet S-3
		From 01/01/2018   Part V

		From 01/01/2018		
		To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
	Cost Center Description	Contract Labor		Э ріп
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1. 00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF	0	0	3.00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC			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. 04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14. 05	Hospital-Based Health Clinic RHC 5	0	0	14.05
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10
17.00	Renal Dialysis			17.00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems	DAVIESS COMMUN	NITY HOSPITAL		In Lie	eu of Form CMS-	-2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-0061	Peri od:	Worksheet S-8	
			Component	CCN: 15-8500	From 01/01/2018 To 12/31/2018		enared:
			Component	CCN. 13-0300	10 12/31/2010	5/29/2019 4:3	
					RHC I	Cost	
					1	. 00	-
	Clinic Address and Identification					00	
1.00	Street		_		1402 GRAND AVE	NUE	1.00
				ty	State	ZIP Code	
0.00	0.1 0.1 7.0 0.1 0.1			00	2. 00	3.00	0.00
2.00	City, State, ZIP Code, County		WASHI NGTON		110	V 47501	2. 00
						1.00	
3. 00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for ι	urban		(	3.00
					nt Award	Date	
	Source of Endoral Funds				1. 00	2. 00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)					4.00
5. 00	Mi grant 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 (SPECIFY)						9. 00
					1. 00	2.00	
10. 00	Does this facility operate as other than a h	ospi tal -based I	RHC or FQHC? Er	nter "Y" for	N N		10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o	f other operati	ion(s) and the	operati ng			
	hours.)	Cur	 nday		londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4. 00	5. 00	
	Facility hours of operations (1)						
11. 00	CLINIC			08: 00	17: 00	08: 00	11. 00
					1.00	2.00	
12. 00	Have you received an approval for an exception	on to the produ	ictivity standa	ard?	1. 00 N	2.00	12. 00
	Is this a consolidated cost report as define				N N		13.00
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report.	List the name	s of all provid	ders and			
	numbers below.			Dray	i dan nama	CCN number	
					ider name 1.00	2.00	
14. 00	RHC/FQHC name, CCN number				50	2.00	14. 00
		Y/N	V	XVIII	XIX	Total Visits	
	I	1.00	2. 00	3.00	4. 00	5.00	
15. 00	Have you provided all or substantially all						15. 00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		0	lntv.			
				unty 00			
2.00	City, State, ZIP Code, County		DAVI ESS	00			2.00
		Tuesday		esday	Thui	rsday	2.00
		to	from	to	from	to	
		6. 00	7. 00	8. 00	9. 00	10.00	
11 00	Facility hours of operations (1)	17. 00	00.00	17.00	00.00	17.00	11 00
11.00	CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
				From 01/01/2018		
		Component	CCN: 15-8500	To 12/31/2018		
					5/29/2019 4: 3	0 pm
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

Heal th	Financial Systems	DAVIESS COMMUN	NITY HOSPITAL		In Li	eu of Form CMS	-25	52-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0061	Peri od:	Worksheet S-	-8	
			Component	CCN: 15-3999	From 01/01/2018 To 12/31/2018		epa	red:
			'			5/29/2019 4:	30	
					RHC II	Cost	_	
					1	. 00	$\dashv$	
	Clinic Address and Identification							
1. 00	Street		1		202 NORTH WEST	_	4	1. 00
				ty	State	ZIP Code 3. 00		
2.00	City, State, ZIP Code, County		ODON 1.	. 00	2.00	N 47562		2. 00
2.00	jorty, state, zir sode, sodity		00014			177002		2.00
	Lugger Tay Bases Follo Sun V B					1. 00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for i		nt Award	Date	0	3. 00
					1. 00	2. 00	+	
	Source of Federal Funds			1	1.00	2.00		
4.00	Community Health Center (Section 330(d), PHS	Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS A							5.00
6.00	Health Services for the Homeless (Section 34)	O(d), PHS Act)						6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes							7. 00 8. 00
9. 00	OTHER (SPECIFY)							9. 00
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
					1. 00	2. 00		
10. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operation	ns in column	N		0	10. 00
	inour s. )	Sur	nday	l N	Monday	Tuesday		
		from	to	from	to	from		
		1.00	2.00	3.00	4. 00	5. 00		
11 00	Facility hours of operations (1)			00.00	17.00	100,00	-	11 00
11.00	CLINIC			08: 00	17: 00	08: 00		11. 00
					1. 00	2.00		
	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In numbers below.	d in CMS Pub. ' umn 1. If yes,	100-04, chapteı enter in colur	9, section nn 2 the	N N			12. 00 13. 00
				Prov	ider name	CCN number		
	Inua (Faus				1. 00	2. 00		
14. 00	RHC/FQHC name, CCN number	V/N	V	VVIII	VIV	Total Visits	_	14. 00
		1. 00	2.00	3. 00	XI X 4. 00	Total Visits 5.00		
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		2.00	3.00	7.00	3. 30		15. 00
				unty				
2.00	City, Ctata 71D Cada C			00				2 22
2.00	City, State, ZIP Code, County	Tuesday	DAVI ESS Wedn	esday	Thu	rsday	-	2. 00
		to	from	to	from	to		
		6.00	7. 00	8.00	9. 00	10.00		
	Facility hours of operations (1)							
11. 00	CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00		11. 00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 15-0061	Peri od:	Worksheet S-8	
		Component	CCN: 15-3999	From 01/01/2018 To 12/31/2018		
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0061	Peri od:	Worksheet S-8	
		Component	CCN: 15-8501	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
				RHC III	Cost	о ріп
Clinic Address and Identification				1.	00	
1.00 Street				1805 S. STATE	RD. 57	1.00
			ty	State	ZIP Code	
0.00 011 011 710 0 1			00	2. 00	3.00	0.00
2.00 City, State, ZIP Code, County		WASHI NGTON		IN	47501	2. 00
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	ıl or "U" for ι			0	3.00
				nt Award	Date	
Source of Federal Funds				1. 00	2. 00	
4.00 Community Health Center (Section 330(d), PHS	Act)					4. 00
5.00 Migrant Health Center (Section 329(d), PHS A						5. 00
6.00 Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7.00 Appal achi an Regi onal Commissi on 8.00 Look-Alikes						7. 00 8. 00
9. 00 OTHER (SPECIFY)						9.00
			'			
		501100 5	. ""	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 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	ther operation	s in column	N	0	10.00
noui ș. )	Sun	day	l N	londay	Tuesday	
	from	to	from	to	from	
	1.00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	08: 00	11. 00
TI. 00   CEINI C			00.00	17.00	00.00	11.00
	-			1. 00	2. 00	
12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colum	9, section nn 2 the	N N	o	12.00
			Prov	der name	CCN number	
14 00 DUC/FOUC name CCN number				1. 00	2. 00	14.00
14.00 RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14. 00
	1.00	2.00	3. 00	4. 00	5. 00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15. 00
			inty			
2.00 City State 7LD Code County		DAVI ESS	00			2.00
2.00   City, State, ZIP Code, County	Tuesday		esday	Thur	sday	2.00
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10. 00	
Facility hours of operations (1)	17. 00	00.00	17. 00	00.00	17.00	11 00
11. 00   CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0061	Peri od:	Worksheet S-8	
				From 01/01/2018		
		Component	CCN: 15-8501	To 12/31/2018		
		·			5/29/2019 4:3	0 pm
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0061	Peri od: From 01/01/2018	Worksheet S-8	3
			Component	CCN: 15-8503	To 12/31/2018		
					RHC V	Cost	, с р
	Clinic Address and Identification					. 00	
1. 00	Street				1402 GRAND AVE	-	1.00
11.00	1000		Ci	ty	State	ZIP Code	1.00
				00	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 - Ente	er "R" for rura	l or "U" for ι	urban		0	3.00
					nt Award	Date	
	In				1. 00	2. 00	
4. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		T		Τ	4.00
5.00	Mi grant Heal th Center (Section 329(d), PHS Ad						5.00
6.00	Health Services for the Homeless (Section 340						6. 00
7.00	Appalachian Regional Commission						7. 00
8.00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9. 00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica	ite number of a	ther operation	ns in column	N	0	10.00
	2. (Enter in subscripts of line 11 the type of hours.)	other operati	on(s) and the	operating			
	1100101	Sun	day	Me	onday	Tuesday	
		from	to	from	to	from	
	F: 1: to boom of sociations (1)	1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11. 00
11.00	JOETHI O			100.00	17.00	00.00	11.00
					1. 00	2. 00	
12.00	Have you received an approval for an exception				N		12.00
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu				N	0	13. 00
	number of providers included in this report.						
	numbers below.		<u> </u>				
					der name	CCN number	-
14 00	RHC/FQHC name, CCN number				1. 00	2. 00	14. 00
00	Timo, Fario Hamo, Ook Hambol	V/ /NI	V	V/// 1 1	XIX	Total Visits	1 7. 00
		Y/N	V	XVIII	AT A		
		1. 00	2.00	3. 00	4.00	5. 00	
15. 00	Have you provided all or substantially all			-			15. 00
15. 00	GME cost? Enter "Y" for yes or "N" for no in			-			15. 00
15. 00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and			-			15. 00
15. 00	GME cost? Enter "Y" for yes or "N" for no in			-			15. 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			-			15. 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.			-			15. 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		2.00	3.00			15. 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.		2. 00 Cou	-			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.	1.00	2. 00  Cot 4. DAVI ESS	3.00 unty 00	4.00	5.00	
	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)	1.00 Tuesday	2.00  Cou  4.  DAVI ESS  Wedn	3.00  unty 00  esday	4. 00	5. 00	15. 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)	1.00 Tuesday	2.00  Cou 4.  DAVIESS  Wedn  from	3.00  unty 00  esday to	4.00  Thui	5. 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)	1.00 Tuesday	2.00  Cou  4.  DAVI ESS  Wedn	3.00  unty 00  esday	4. 00	5. 00	

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (	CCN: 15-0061	Peri od:	Worksheet S-8	
				From 01/01/2018		
		Component	CCN: 15-8503	To 12/31/2018	Date/Time Pre	pared:
					5/29/2019 4:3	O pm
				RHC V	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

Health Financial Systems DAVIESS HOSPITAL-BASED RHC/FOHC STATISTICAL DATA		SPI TAL		In Lit	eu of Form CMS	-2552-10
	Pr		N: 15-0061	Peri od:	Worksheet S-	
	Со	mponent C	CN: 15-8506	From 01/01/2018 To 12/31/2018		
				RHC VI	Cost	
	<u> </u>					
Clinic Address and Identification				1.	. 00	
Clinic Address and Identification  1.00 Street				12546 E US HWY	( 50	1.00
n oo ou oo		Ci 1	ty	State	ZIP Code	11.00
		1. (	00	2. 00	3. 00	
2.00 City, State, ZIP Code, County	L00G00	TEE			47553	2. 00
					1. 00	
3.00   HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" fo	or rural or "	U" for u	-ban			0 3.00
				nt Award	Date	
Source of Federal Funds				1. 00	2.00	
4.00 Community Health Center (Section 330(d), PHS Act)						4.00
5.00 Migrant Health Center (Section 329(d), PHS Act)						5. 00
6.00 Health Services for the Homeless (Section 340(d), PHS	S Act)					6. 00
7.00   Appal achi an Regional Commission 8.00   Look-Alikes						7. 00 8. 00
9.00 OTHER (SPECIFY)						9. 00
The second secon	,					
				1. 00	2. 00	
10.00 Does this facility operate as other than a hospital-byes or "N" for no in column 1. If yes, indicate number 2. (Enter in subscripts of line 11 the type of other (hours.)	er of other o	perati ons	s in column	N	'	0 10.00
	Sunday		M	onday	Tuesday	
fro		to	from	to	from	
1.0	0   2	. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC		l	08: 00	17: 00	08: 00	11.00
				1. 00	2. 00	
12.00 Have you received an approval for an exception to the 13.00 Is this a consolidated cost report as defined in CMS 30.8? Enter "Y" for yes or "N" for no in column 1. It number of providers included in this report. List the	Pub. 100-04, fyes, enter	chapter in column	9, section n 2 the	N N		12. 00 0 13. 00
· · · · · · · · · · · · · · · · · · ·						
numbers below.			Provi	der name	CCN number	
numbers below.		-		der name 1.00	CCN number 2.00	11.00
numbers below.  14.00 RHC/FQHC name, CCN number	M. I	V		1. 00	2. 00	14.00
numbers below.  14.00 RHC/FQHC name, CCN number  Y/1		V . 00	XVIII	1. 00 XI X	2.00 Total Visits	
numbers below.  14.00 RHC/FQHC name, CCN number		.00	XVIII 3. 00	1. 00	2. 00	
numbers below.  14.00 RHC/FQHC name, CCN number  Y/I  15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		Cour	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
numbers below.  14.00 RHC/FOHC name, CCN number  Y/I  15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	2	. 00 Cour 4. (	XVIII 3.00	1. 00 XI X	2.00 Total Visits	15.00
numbers below.  14.00 RHC/FOHC name, CCN number  Y/I  15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  2.00 City, State, ZIP Code, County	DAVI ES	Cour 4. (S	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits 5.00	
numbers below.  14.00 RHC/FOHC name, CCN number  Y/I  15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	DAVI ES	. 00 Cour 4. (	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits	15.00
numbers below.  14.00 RHC/FQHC name, CCN number  Y/I  15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)  2.00 City, State, ZIP Code, County	DAVIES		XVIII 3.00	1. 00  XI X  4. 00	2.00 Total Visits 5.00	15.00

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
				From 01/01/2018		
		Component	CCN: 15-8506	To 12/31/2018		
					5/29/2019 4: 30	O pm
				RHC VI	Cost	
	Fri	day	Sa <sup>-</sup>	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

	<u>Financial Systems</u> TAL-BASED HOSPICE IDENTIFICATION	LDATA	DAVIESS COMMUN	Provider C	CN. 1F 00/1	Peri od:	u of Form CMS-2 Worksheet S-9	2552-10
HUSPI I	AL-BASED HOSPICE IDENTIFICATION	IDATA		Provider C	CN: 15-0061	From 01/01/2018		GH IV
				Hospi ce CC	N: 15-1553	To 12/31/2018		pared:
						Hospi ce I		
		Unduplicated						
		Days		1				
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
		1.00	2.00	Facility 3.00	4.00	5. 00	/ 00	
	PART I - ENROLLMENT DAYS FOR CO					5.00	6. 00	
1. 00	Hospice Continuous Home Care	I REPORTING P	PERIODS DEGININI	NG BEFORE OCIC	DER 1, 2013			1. 00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3.00
4. 00	Hospice General Inpatient Care							4. 00
5. 00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6.00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8. 00
0.00	/ line 6)							9. 00
9.00	Unduplicated census count							9.00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
							through 3)	
				1. 00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1,			
10.00	Hospice Continuous Home Care			0	1	0 0	0	
11.00	Hospice Routine Home Care			4, 620	1	0 717		11.00
12.00	Hospice Inpatient Respite Care			0		0 0	0	
13.00	Hospice General Inpatient Care			4 4 20		0 0 717	0	10.00
14. 00	Total Hospice Days PART IV - CONTRACTED STATISTICA	NI DATA END COS	ST DEDODTING DE	4, 620		7.17		14. 00
15. 00	Hospice Inpatient Respite Care		DI KEPUKIING PE	CRIODS REGINNIN		O O		15. 00
	Hospice General Inpatient Care					0 0		
10.00	Thospice delief at Tripatifelit care			1	1	9	١	10.00

	AL UNCOMPENSATED AND INDIGENT CARE DATA Provide	r CCN: 15-0061	Peri od:	Worksheet S-1	0		
			From 01/01/2018 To 12/31/2018	Date/Time Pre	naro		
			10 12/31/2010	5/29/2019 4:3			
				1. 00			
	Uncompensated and indigent care cost computation						
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided b	y line 202 colu	mn 8)	0. 332532	1.		
00	Medicaid (see instructions for each line) Net revenue from Medicaid			4, 950, 081	2.		
00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3.		
00	If line 3 is yes, does line 2 include all DSH and/or supplemental pay	ments from Medi	cai d?	Υ	4.		
00	If line 4 is no, then enter DSH and/or supplemental payments from Med	cai d		0			
00 00	Medicaid charges Medicaid cost (line 1 times line 6)			25, 038, 549 8, 326, 119	1		
00	Difference between net revenue and costs for Medicaid program (line 7	minus sum of L	ines 2 and 5: if	3, 376, 038	1		
	< zero then enter zero)			2, 2, 2, 2, 2	]		
	Children's Health Insurance Program (CHIP) (see instructions for each	line)		0	9.		
00							
. 00	00   Stand-alone CHIP charges 00   Stand-alone CHIP cost (line 1 times line 10)						
. 00	if < zero then	0	11. 12.				
	enter zero)						
00	Other state or local government indigent care program (see instruction) Net revenue from state or local indigent care program (Not included o			0	   13		
. 00 . 00	Charges for patients covered under state or local indigent care program (Not included o			0			
. 00	10)	am (Not Therade	u 111 111103 0 01		'-		
. 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	care program (I	ine 15 minus line	0	16		
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and:	state/Local ind	gent care program	l			
	instructions for each line)	, , , , , , , , , , , , , , , , , , ,	gorre our o program				
. 00	Private grants, donations, or endowment income restricted to funding	,		0	1 47		
	3.00 Government grants, appropriations or transfers for support of hospital operations						
$\cap \cap$		•	me (sum of lines	3 376 038	18.		
0. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig	•	ms (sum of lines	0 3, 376, 038			
. 00		Uni nsured	I Insured	3, 376, 038 Total (col. 1	18.		
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig	Uni nsured pati ents	I Insured patients	3, 376, 038  Total (col. 1 + col. 2)	18.		
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)	Uni nsured	I Insured	3, 376, 038 Total (col. 1	18		
	Total unreimbursed cost for Medicaid , CHIP and state and local indig	Uni nsured pati ents	I Insured patients 2.00	3, 376, 038  Total (col . 1 + col . 2)  3.00	18.		
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions)	Uni nsurec pati ents 1.00	I Insured pati ents 2.00	3, 376, 038  Total (col. 1 + col. 2) 3.00	18.		
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (s	Uni nsurec pati ents 1.00	I Insured pati ents 2.00	3, 376, 038  Total (col. 1 + col. 2) 3.00	18.		
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)	Uni nsured patients 1.00 382, pee 127,	I Insured patients 2.00 147,824 257 147,824	3, 376, 038  Total (col. 1 + col. 2)  3.00  530, 514  275, 081	20:		
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (s	Uni nsured patients 1.00 382, pee 127,	I Insured pati ents 2.00	3, 376, 038  Total (col. 1 + col. 2) 3.00  530, 514 275, 081	20:		
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care	Uni nsured patients 1.00 382, pee 127,	1 I nsured pati ents 2.00  690 147,824  758 21,698	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514 275, 081 29, 456	20. 21. 22.		
. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care	Uni nsured patients 1.00 382, pee 127, 7,	1 I nsured pati ents 2.00  690 147,824  758 21,698	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514 275, 081 29, 456 245, 625	20. 21. 22.		
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)	Uni nsurec pati ents 1.00 382, ee 127, 7, 119,	1 Insured pati ents 2.00 690 147, 824 257 147, 824 758 21, 698 499 126, 126	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514  275, 081  29, 456  245, 625	20. 21. 22.		
. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra	Uni nsured patients 1.00 382, 20 127, 7, 119, beyond a Lengt	I Insured pati ents 2.00  690 147,824  257 147,824  758 21,698  499 126,126	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514 275, 081 29, 456 245, 625	18. 19. 20. 21.		
. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indi	Uni nsured patients 1.00 382, 20 127, 7, 119, beyond a Lengt	I Insured pati ents 2.00  690 147,824  257 147,824  758 21,698  499 126,126	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514  275, 081  29, 456  245, 625	20. 21. 22. 23.		
. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit	Uni nsured patients 1.00  382, 20e 127, 7, 119,  beyond a lengt n? gent care progra	I Insured pati ents 2.00  690 147,824  257 147,824  758 21,698  499 126,126	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514 275, 081 29, 456 245, 625  1. 00 N	20 21 22 23 24 25		
. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit  Total bad debt expense for the entire hospital complex (see instruction)	Uni nsured patients  1.00  382,  ee 127,  7,  119,  beyond a length on? gent care progra	I Insured pati ents 2.00  690 147,824  257 147,824  758 21,698  499 126,126	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514 275, 081 29, 456 245, 625  1. 00 N 0 4, 000, 100	20 21 22 23 24 25 26		
	Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit	Uni nsurece patients  Uni nsurece patients  1.00  382,  200  127,  7,  119,  beyond a Length of the program ons)  Instructions)	I Insured pati ents 2.00  690 147,824  257 147,824  758 21,698  499 126,126	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514 275, 081 29, 456 245, 625  1. 00 N	20. 21. 22. 23. 24. 25. 26. 27.		
2. 00 3. 00 5. 00 6. 00 7. 00 7. 01 3. 00	Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit  Total bad debt expense for the entire hospital complex (see instructimedicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see ins Non-Medicare bad debt expense (see instructions)	Uninsured patients  Uninsured patients  1.00  382, 20  127, 7, 119,  beyond a length m? gent care programs ons) nstructions)	I Insured patients 2.00  690 147,824 257 147,824 758 21,698 499 126,126  h of stay limit am's length of	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514 275, 081 29, 456 245, 625  1. 00 N 0 4, 000, 100 250, 186 384, 901 3, 615, 199	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.		
	Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (sinstructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care progra If line 24 is yes, enter the charges for patient days beyond the indistay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see instructions)	Uninsured patients  Uninsured patients  1.00  382, 20  127, 7, 119,  beyond a length m? gent care programs ons) nstructions)	I Insured patients 2.00  690 147,824 257 147,824 758 21,698 499 126,126  h of stay limit am's length of	3, 376, 038  Total (col. 1 + col. 2) 3. 00  530, 514 275, 081 29, 456 245, 625  1. 00 N 0 4, 000, 100 250, 186 384, 901	20 21 22 23 24 25 26 27 27 28 29		

Heal th	Financial Systems	DAVIESS COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der C	CN: 15-0061	Peri od:	Worksheet A	
					From 01/01/2018	D 1 /T' D	
					To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
	Cost Center Description	Sal ari es	Other	Total (col 1	Reclassi fi cati	Reclassi fi ed	U pili
	cost denter bescription	Jai ai i es	other	+ col . 2)	ons (See A-6)	Trial Balance	
				+ COI. 2)	0113 (See A-0)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 206, 361	2, 206, 36	1 697, 134	2, 903, 495	1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 351, 839	1			2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		1, 331, 637		0 30, 747	1, 340, 788	3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	140, 120	5, 576, 408	1	٦ <sub> </sub> ۲	5, 637, 921	4.00
		1		1			5.00
5.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	2, 297, 999	9, 688, 885	1		11, 373, 451	
6.00		243, 192	1, 731, 871	1		1, 975, 063	6.00
7.00	00700 OPERATION OF PLANT	0	799, 208	1		799, 208	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	364, 388	1		364, 388	
9.00	00900 HOUSEKEEPI NG	468, 817	87, 905	1		556, 722	9.00
10.00	01000 DI ETARY	522, 490	457, 220			160, 009	1
11.00	01100 CAFETERI A	0	07.470	•	0 654, 798		
13.00	01300 NURSING ADMINISTRATION	808, 421	37, 170			845, 591	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	275, 789	269, 092	1		544, 881	
15.00	01500 PHARMACY	458, 304	349, 009	1		807, 313	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	450, 385	116, 741	1		567, 126	
17. 00	01700 SOCIAL SERVICE	0	389	9 38	9 91, 009	91, 398	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.040.070	004 070			2 122 //1	
30.00	03000 ADULTS & PEDIATRICS	2, 343, 973	281, 972	1			1
31. 00	03100 INTENSIVE CARE UNIT	691, 452	24, 860				
40. 00	04000 SUBPROVI DER - I PF	1, 880, 208	320, 448				
41. 00	04100 SUBPROVI DER - I RF	729, 912	53, 595	1		789, 511	
43.00	04300 NURSERY	0	9, 795	9, 79	5 291, 195	300, 990	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	1, 133, 180	1, 733, 155	2, 866, 33	5 0	2, 866, 335	
51. 00	05100 RECOVERY ROOM	0	0	)	0 0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0 287, 275	287, 275	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	696, 271	448, 396	1, 144, 66	7 35, 192	1, 179, 859	54.00
56. 00	05600 RADI OI SOTOPE	226, 343	71, 237	297, 58	0 0	297, 580	56. 00
60.00	06000 LABORATORY	974, 288	1, 374, 633	2, 348, 92	1 37, 217	2, 386, 138	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	199, 120	199, 12	0 0	199, 120	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	524, 936	97, 278	622, 21	4 0	622, 214	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 066, 665	106, 772	1, 173, 43	7 0	1, 173, 437	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	289, 006	235	289, 24	1 0	289, 241	67. 00
68.00	06800 SPEECH PATHOLOGY	124, 798	13, 036	137, 83	4 0	137, 834	68. 00
69.00	06900 ELECTROCARDI OLOGY	71, 908	20, 236	92, 14	4 0	92, 144	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 578, 748	1, 578, 74	8 -120, 318	1, 458, 430	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 120, 318	120, 318	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 683, 636	2, 683, 63	6 0	2, 683, 636	73. 00
76.00	03020 CARDI AC REHAB	100, 727	4, 422	105, 14	9 0	105, 149	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	588, 849	127, 296	716, 14	5 0	716, 145	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	722, 690	83, 291				
88. 02	08802 RURAL HEALTH CLINIC III	866, 331	429, 502		3 0	1, 295, 833	
88. 04	08803 RURAL HEALTH CLINIC V	882, 873	144, 688	1		1, 027, 561	
88. 05	08804 RURAL HEALTH CLINIC VI	455, 005	49, 102	1		504, 107	
90.00	09000 CLI NI C	410, 127	26, 139			436, 266	1
90. 01	09001 ONCOLOGY	162, 946	241, 462	1		404, 408	
90. 02	09002 PAIN MANAGEMENT	0	,	)	o o	0	90. 02
91. 00	09100 EMERGENCY	1, 168, 981	1, 114, 220	2, 283, 20	1 -15, 478		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 100, 101	., , ===	_,,		1	92.00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	576, 260	167, 526	743, 78	6 -2, 706	741, 080	93. 00
70.00	OTHER REIMBURSABLE COST CENTERS	0,0,200	107,7020	, , , , , , ,	2,700	7 1 1 7 0 0 0	70.00
99 10	09910 CORF	0	C	)	0 0	0	99. 10
	10100 HOME HEALTH AGENCY		0	1	o o		101.00
101.00	SPECIAL PURPOSE COST CENTERS	, o <sub>l</sub>		1	٥, ٥	0	1.01.00
113 00	11300   INTEREST EXPENSE		1, 299, 099	1, 299, 09	9 -631, 376	667, 723	113 00
	11600 HOSPI CE	267, 933	306, 043				
118.00		22, 621, 179	36, 046, 428	1			
110.00	NONREI MBURSABLE COST CENTERS	22,021,119	30, 040, 428	JU, UU1, 0U	-240,030	JU, 421, 111	110.00
102.00	19200 PHYSICIANS' PRIVATE OFFICES	O			ol ol	0	192. 00
	07951 OTHER NONREIMBURSABLE AND PHYSICIAN	3, 089, 426	1, 098, 032				
200.00		25, 710, 605	37, 144, 460				
∠00. U(	PI TOTAL (SUM OF LINES TTO LITTOUGH 199)	23, 110, 003	J1, 144, 40U	/ <sub>1</sub> 02,000,00	ار ا	02, 000, 000	1200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0061

Peri od: Worksheet A From 01/01/2018 To 12/31/2018 Date/Time Prepared:

5/29/2019 4:30 pm Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 0 2, 903, 495 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 0 1, 390, 788 2.00 2.00 3.00 00300 OTHER CAPITAL RELATED COSTS 0 3.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 -224, 317 5, 413, 604 4 00 5.00 00500 ADMINISTRATIVE & GENERAL -4, 252, 303 7, 121, 148 5.00 1, 975, 063 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 0 799, 208 7.00 00800 LAUNDRY & LINEN SERVICE 0 364, 388 8.00 8 00 9.00 00900 HOUSEKEEPI NG 0 556, 722 9.00 10.00 01000 DI ETARY 160,009 10 00 01100 CAFETERIA 11 00 378, 074 11 00 -276, 724 01300 NURSING ADMINISTRATION 13.00 845, 591 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY -6, 055 538, 826 14.00 01500 PHARMACY 807, 313 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 -13.208553, 918 16.00 17.00 01700 SOCIAL SERVICE 91, 398 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 979, 244 -520, 417 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 -1.500 644. 239 31 00 04000 SUBPROVIDER - IPF -551, 799 1, 618, 942 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 -162, 761 626, 750 41.00 04300 NURSERY 300, 990 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM -1, 448, 319 1, 418, 016 50.00 51.00 05100 RECOVERY ROOM 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 287, 275 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C -225,000 954, 859 54.00 05600 RADI OI SOTOPE 56.00 -1,800 295, 780 56.00 60.00 06000 LABORATORY 2.383.638 60.00 -2.500 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 199, 120 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 65.00 -44, 272 577, 942 65.00 66 00 06600 PHYSI CAL THERAPY 1, 173, 437 66 00 0 06700 OCCUPATI ONAL THERAPY 67.00 0 289, 241 67.00 06800 SPEECH PATHOLOGY 0 137, 834 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY -13, 950 78, 194 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 458, 430 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 120, 318 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 2, 683, 636 73.00 76 00 03020 CARDI AC REHAB 105, 149 76 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 716, 145 88.00 88. 01 08801 RURAL HEALTH CLINIC II 0 805, 981 88.01 08802 RURAL HEALTH CLINIC III 0 88 02 1, 295, 833 88 02 88.04 08803 RURAL HEALTH CLINIC V 0 1,027,561 88.04 504, 107 88.05 08804 RURAL HEALTH CLINIC VI 0 88.05 90.00 09000 CLI NI C -221, 995 214, 271 90.00 09001 ONCOLOGY 176, 306 90.01 -228, 102 90 01 90.02 09002 PAIN MANAGEMENT 238, 442 238, 442 90.02 09100 EMERGENCY 91.00 -5, 646 2, 262, 077 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER -479,<u>046</u> 93 00 262, 034 93.00 OTHER REIMBURSABLE COST CENTERS 99 10 09910 CORF 0 99. 10 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE -667, 723 113.00 116. 00 11600 HOSPI CE 577, 446 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 -9.108.995 49, 312, 782 118.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 194.00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 4, 433, 288 194.00 0 -9, 108, 995 200.00 TOTAL (SUM OF LINES 118 through 199) 53, 746, 070 200.00

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					5/29/2019 4:30 p
	Increases				
Cost Center	Li ne #	Salary	0ther		
2.00	3. 00	4. 00	5. 00		
A - DI ETARY O CAFETERI A	11. 00	349, 211	305, 587		
O OTHER NONREIMBURSABLE AND	194.00	87, 945	76, 958		2
PHYSI CI AN	174.00	07, 743	70, 730		2
0	+	437, 156	382, 545		
B - INTEREST EXPENSE		,	22=7 2.0		
O NEW CAP REL COSTS-BLDG &	1.00	0	596, 174		1
FIXT					
O NEW CAP REL COSTS-MVBLE	2. 00	0	35, 202		2
EQUI P	+				
0		0	631, 376		
C - BILLING COSTS	101.00	22 222	00.007		
O OTHER NONREI MBURSABLE AND	194. 00	20, 222	29, 307		1
PHYSICIAN	+		<sub>29, 307</sub>		
D - LAB/XRAY		20, 222	27, 307		
0 LABORATORY	60.00	36, 028	1, 189		1
O RADI OLOGY-DI AGNOSTI C	54.00	34, 067	1, 125		
0	— — <del></del> +	70, 095	$\frac{1}{2}$ , $\frac{1}{3}$ 14		
F - OBSTETRICS			, ,		
O NURSERY	43.00	268, 592	22, 603		1
O DELIVERY ROOM & LABOR ROOM _	52.00	264, 976	22, 299		2
0		533, 568	44, 902		
G - I NSURANCE					
NEW CAP REL COSTS-BLDG &	1. 00	0	100, 960		
FLXT	0.00		0.747		
NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	3, 747		2
O OTHER NONREI MBURSABLE AND	194. 00	0	103, 807		
PHYSI CI AN	194.00	o o	103, 607		,
0	+		208, 514		
H - IMPLANTABLE DEVICES	1	-1	=======================================		
O IMPL. DEV. CHARGED TO	72.00	0	120, 318		
PATI ENT					
0		0	120, 318		
I - SOCIAL SERVICES					
O SOCIAL SERVICE	17. 00	91, 009	0		
0	0.00	0	0		3
0   0	0.00	O O	0		
0	0. 00 0. 00	0	0		
0	0.00	0	0		
0	0.00	0			
°		91, 009	0		j '
J - OTHER		,,	<u> </u>		
0 HOSPI CE	116. 00	0	3, 470		1
O ADULTS & PEDIATRICS	30.00	55, 044	0		
SUBPROVIDER - IPF	40.00	6, 116	0		
SUBPROVI DER - I RF	41.00	<u>6, 1</u> 16	0		4
0		67, 276	3, 470		
K - HOSPITALIST RECLASS					
O ADULTS & PEDIATRICS	30.00	•	400, 375		
U ADMINI DECENIL TING AND ASSES	DTI CLNC	0	400, 375		
L - ADMIN RECRUITING AND ADVE			70 (07		
O ADMI NI STRATI VE & GENERAL			7 <u>8, 6</u> 07		
. 00 Grand Total: Increases		1 210 224	78, 607		500
. oo paranu Totar. Thereases	l	1, 219, 326	1, 901, 728		1 500

LCLASSITICATIONS	i i ovi dei	CCIV.	13-0001		Ju.	WOLKSHEEL	A-0	
l l				From	01/01/2018			
I				To	12/31/2018	Date/Time	Prepared:	
l l						5/29/2019	4 · 3 ∩ nm	

						5/29/2019 4:30 pm
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - DIETARY					
1.00	DI ETARY	10.00	437, 156	382, 545		1.00
2.00		0.00	•		<u> </u>	2.00
	0		437, 156	382, 545	5	
	B - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113. 00	0	631, 376		1.00
2.00		0.00	•			2.00
	0		0	631, 376		
	C - BILLING COSTS		00.000			
1.00	ADMI NI STRATI VE & GENERAL		20, 222	2 <u>9, 3</u> 07		1.00
	0		20, 222	29, 307	/	
	D - LAB/XRAY	404.00	70.005			
1.00	OTHER NONREI MBURSABLE AND	194. 00	70, 095	2, 314	0	1.00
0.00	PHYSICIAN	0.00		_		
2.00					<u> </u>	2.00
	U		70, 095	2, 314	!	
1 00	F - OBSTETRICS ADULTS & PEDIATRICS	20.00	E22 E40	44, 902		1.00
1.00	ADULTS & PEDIATRICS	30. 00 0. 00	533, 568	•	1	1.00
2.00						2.00
	U LINCUDANCE		533, 568	44, 902	<u> </u>	
1 00	G - I NSURANCE ADMI NI STRATI VE & GENERAL	E 00	ما	200 514	10	1, 00
1.00	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	208, 514	1	
2.00		0.00	0	C	12	2.00
3. 00			_ — — 🟪	00 208, 514		3.00
	H - IMPLANTABLE DEVICES		U_	200, 314		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	120, 318	B 0	1.00
1.00	PATI ENTS	71.00	٩	120, 310	,	1.00
		+		120, 318	<del> </del> +	
	I - SOCIAL SERVICES		<u> </u>	120, 510	<b>'</b>	
1.00	ADMI NI STRATI VE & GENERAL	5. 00	30, 152	C	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	3, 233	C		2.00
3.00	INTENSIVE CARE UNIT	31.00	3, 297	C		3.00
4.00	SUBPROVI DER - I PF	40.00	36, 031	C		4.00
5. 00	SUBPROVI DER - I RF	41.00	112	Č		5. 00
6. 00	EMERGENCY	91.00	15, 478	C	ol ol	6. 00
7. 00	OTHER OUTPATIENT SERVICE	93. 00	2, 706	Ċ		7. 00
	COST CENTER		_,	_		
			91, 009			
	J - OTHER	<u> </u>	,		· · · · · · · · · · · · · · · · · · ·	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 470	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	67, 276	C		2.00
3.00		0.00	o	C		3.00
4. 00		0.00	ol	C	ol ol	4.00
			67, 276	3, 470		
	K - HOSPITALIST RECLASS		,	-,		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	400, 375	5 0	1.00
	0			400, 375		
	L - ADMIN RECRUITING AND ADVE	RTISING	-1			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	78, 607	7 0	1.00
	0	— — — <del>- *</del> +	<del>-</del> <del>-</del>	78, 607	<del>,</del>	55
500.00	Grand Total: Decreases		1, 219, 326	1, 901, 728		500.00
		ı		=-		1

Provider CCN: 15-0061

					To 12/31/2018	Date/Time Pre	
			Acqui si ti ons			5/29/2019 4: 3	O pm
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	i ui chases	Donation	Total	Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 280, 955	0		0 0	0	1. 00
2.00	Land Improvements	687, 865	0		0 0	0	2. 00
3.00	Buildings and Fixtures	42, 857, 849	0		0 0	0	3. 00
4.00	Building Improvements	39, 119	0		0 0	0	4. 00
5.00	Fi xed Equipment	6, 303, 153	579, 987		0 579, 987	4, 990	5. 00
6.00	Movable Equipment	29, 438, 774	583, 410		0 583, 410	135, 670	6. 00
7.00	HIT designated Assets	0	0		0 0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	80, 607, 715	1, 163, 397		0 1, 163, 397	140, 660	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	80, 607, 715	1, 163, 397		0 1, 163, 397	140, 660	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 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	42, 857, 849	0				3. 00
4.00	Building Improvements	39, 119	0				4. 00
5.00	Fi xed Equi pment	6, 878, 150	0				5. 00
6.00	Movable Equipment	29, 886, 514	0				6. 00
7.00	HIT designated Assets	04 (00 450	0				7. 00
8.00	Subtotal (sum of lines 1-7)	81, 630, 452	0				8. 00
9.00	Reconciling Items	01 420 450	0				9.00
10. 00	Total (line 8 minus line 9)	81, 630, 452	0	l			10. 00

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	F	Period: From 01/01/2018 To 12/31/2018		
			SL	JMMARY OF CAPIT	ΓAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 991, 496	0	214, 865	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 021, 403	279, 877	C	0	50, 559	2.00
3.00	Total (sum of lines 1-2)	3, 012, 899	279, 877	214, 865	0	50, 559	3.00
		SUMMARY OF	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15.00				

0 0

2, 206, 361 1, 351, 839 3, 558, 200

1. 00 2. 00 3. 00

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2

1.00 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E 3.00 Total (sum of lines 1-2)

NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP

Heal th	n Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Period: From 01/01/2018 To 12/31/2018		pared:	
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	5 p	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		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 CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT	51, 743, 938	4, 373, 934	47, 370, 00	4 0. 634587	0	1. 00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	29, 886, 514					2. 00	
3. 00	Total (sum of lines 1-2)	81, 630, 452					3. 00	
		ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
			Capi tal -Relate					
			d Costs	through 7)				
	DART III DECONOLILATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00		
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CONTROL NEW CAP REL COSTS-BLDG & FIXT	ENTERS			0 1, 991, 496	0	1. 00	
2. 00	NEW CAP REL COSTS-BLDG & FIXT	0			0 1, 991, 498		2.00	
3.00	Total (sum of lines 1-2)				0 3, 012, 899		3. 00	
3.00	Total (Sull of Tries 1.2)		SI	JMMARY OF CAPI		217,017	3. 00	
			0.0		.,,,_			
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum		
			instructions)	instructions)	Capi tal -Relate			
					d Costs (see	through 14)		
		11 00	10.00	10.00	instructions)	45.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12.00	13.00	14. 00	15. 00		
1. 00	NEW CAP REL COSTS-BLDG & FIXT	811, 039	100, 960		0 0	2, 903, 495	1. 00	
2. 00	NEW CAP REL COSTS-BLDG & FIXT	35, 202			-	1, 390, 788	2.00	
3.00	Total (sum of lines 1-2)	846, 241						
0.00	1.2.2. (22 31 1.1.33 1.2)	3.3,211	, , , , , ,	1 23,00	.,	1 ., 2 , ., 200	0.00	

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0061	Worksheet A-8 Date/Time Prepared: 5/29/2019 4:30 pm		
			То	Expense Classification of From Which the Amount i			
	Cost Center Description	Basis/Code (2)	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			W CAP REL COSTS-BLDG &	1.00	0	1. 00
2. 00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			W CAP REL COSTS-MVBLE UIP	2.00	0	2. 00
3. 00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time	В	-6, 055 CE	NTRAL SERVICES & SUPPLY	14. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		О		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		О		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	А	-5, 027 AD	MINISTRATIVE & GENERAL	5. 00	0	7. 00
8.00	21)   Tellevision and radio service   (chapter 21)	A	-11, 701 AD	MINISTRATIVE & GENERAL	5. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -3, 901, 461		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00		
12. 00	(chapter 23) Related organization	A-8-1	238, 442			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		O		0.00	О	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others		-276, 724 CA 0	FETERI A	11. 00 0. 00		
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17. 00	Sale of drugs to other than patients		О		0.00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-13, 208 ME	DICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of	A	0 -222AD	MINISTRATIVE & GENERAL	0. 00 5. 00	0	
21.00	interest, finance or penalty charges (chapter 21)		222/10	WINI STRATIVE & GENERAL	3.00		21.00
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22. 00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	O RE	SPIRATORY THERAPY	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OPH	YSICAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0 **	* Cost Center Deleted ***	* 114.00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL		ONE	W CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	•			W CAP REL COSTS-MVBLE	2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		<b>I</b>	UIP * Cost Center Deleted ** <sup>*</sup>			28. 00
29. 00 30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0 0 0 0	CUPATI ONAL THERAPY	0. 00 67. 00		29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		OAD	ULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	OSP	EECH PATHOLOGY	68. 00		31. 00
	Trimitation (Chapter 14)	ı I	I		1	ı	I

Heal th	Financial Systems		DAVIESS COMMUN	II TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2018		
					Γο 12/31/2018	Date/Time Pre 5/29/2019 4:3	
				Expense Classification or	Workshoot A	3/29/2019 4.3	O pili
				To/From Which the Amount is			
				TO/TTOIL WITCH THE AMOUNT IS	to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	5551 551151 55551 Pt. 511	1.00	2. 00	3.00	4. 00	5. 00	
32. 00	CAH HIT Adjustment for		0		0.00	0	32, 00
	Depreciation and Interest						
33.00	ADVERTISING EXPENSES	A	-293, 002	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
34.00	PHYSICIAN RECRUITMENT EXPENSES	A	-455, 864	ADMINISTRATIVE & GENERAL	5. 00	0	34.00
35. 01	NON-ALLOWABLE COSTS	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	35. 01
35. 04	PHYSICIAN BENEFITS	A	-224, 317	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35. 04
36. 00	CPR CLASS INCOME	В	-	EMERGENCY	91.00		36. 00
36. 01	MISC. INCOME	В	•	ADMINISTRATIVE & GENERAL	5. 00	0	36. 01
36. 02	INTEREST EXPENSE OFFSET	A	-	INTEREST EXPENSE	113.00	0	36. 02
38. 00	LOBBYING EXPENSE	A	-6, 315	ADMINISTRATIVE & GENERAL	5. 00	0	38. 00

-9, 108, 995

21, 425 ADMINI STRATI VE & GENERAL

-3, 450, 469 ADMI NI STRATI VE & GENERAL

5.00

5.00

39.00

40.00

50.00

TOTAL (sum of lines 1 thru 49)

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

39.00 DEBT I SSUANCE COST

HAF

40.00

50.00

AMORTI ZATI ON

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

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

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

B. Amount Received - if cost cannot be determined.

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

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

Heal th	Financial Systems	DAVIESS COMMU	NITY HOSPITAL	In Lieu of Form CMS-2552-10			
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0061	Peri od:	Worksheet A-8	B-1	
OFFI CE	COSTS			From 01/01/2018 To 12/31/2018			
	Li ne No.	Cost Center	Expense Items	Amount of	Amount		
				Allowable Cost			
					Wks. A, column		
					5		
	1. 00	2. 00	3. 00	4. 00	5. 00		
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANI ZATI ONS OR	CLAI MED		
	HOME OFFICE COSTS:						
1.00	90. 02	PAIN MANAGEMENT	SALARIES AND OTHER	238, 442	0	1.00	
2.00	0.00			0	0	2. 00	
3.00	0.00			0	0	3.00	
4.00	0.00			0	0	4.00	
5.00	TOTALS (sum of lines 1-4).			238, 442	0	5.00	
	Transfer column 6, line 5 to						
	L			ı			

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

 p		ino i ana, or 2, the amount arremable cheara be interested in corami i or the parti							
			Related Organization(s) and/	or Home Office					
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2. 00	3. 00	4. 00	5. 00					
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:							

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

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

6.00	С	O. OO JV PAIN CLINIC 0. OO	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Worksheet A-8, column 2,

line 12.

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems		DAVI	ESS COMMUNITY	/ HOSPITAL				In Lie	u of Form CMS	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI O	NS AND HOME	Provi der	CCN:	15-0061	Peri od		Worksheet A-	8-1
OFFICE	COSTS									01/01/2018	D 1 /T' D	
									To '	12/31/2018	Date/Time Pr 5/29/2019 4:	
	Net	Wkst. A-7 Ref									3/29/2019 4.	JU pili
	Adjustments	WKSt. A / KCI										
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUST	MENTS REC	QUI RED AS A	RESULT OF TRA	NSACTI ONS	WI TH	RELATED C	RGANI Z	ATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:										
1.00	238, 442											1. 00
2.00	0											2.00
3.00	0											3.00
4.00	0											4. 00
5.00	238, 442											5.00

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

nas not	been posted to worksheet A,	cordinate and the amount arrowable should be murcated in cordinate and this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00		6. 00
7.00		7. 00
8.00		8. 00 9. 00
9.00		9. 00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0061 

						o 12/31/2018	3 Date/lime Pre   5/29/2019 4:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	JO PIII
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	520, 417	520, 417	0	0	0	1. 00
2.00	31. 00	INTENSIVE CARE UNIT	1, 500	1, 500	0	0	0	2. 00
3.00	40.00	SUBPROVIDER - IPF	551, 799	551, 799	0	0	0	3. 00
4.00	41. 00	SUBPROVIDER - IRF	183, 225	162, 761	20, 464	211, 500	277	4. 00
5.00	50.00	OPERATING ROOM	1, 448, 319	1, 448, 319	0	0	0	5. 00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	225, 000	225, 000	0	0	0	6. 00
7.00		RADI OI SOTOPE	1, 800	1, 800	0	0	0	7. 00
8.00	60.00	LABORATORY	32, 500	2, 500	30, 000	260, 300	960	8. 00
9.00	65. 00	RESPI RATORY THERAPY	44, 272	44, 272	. 0	0	0	9. 00
10.00	69. 00	ELECTROCARDI OLOGY	13, 950	13, 950	0	0	0	10.00
11.00	90. 00	CLI NI C	232, 265	214, 265	18, 000	211, 500	101	11. 00
12.00	90. 01	ONCOLOGY	228, 102	228, 102	0	0	0	12. 00
13.00	93. 00	OTHER OUTPATIENT SERVICE	494, 298	470, 298	24,000	211, 500	150	13. 00
		COST CENTER						
200.00			3, 977, 447					200. 00
	Wkst. A Line #	3	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0.00	9.00		13.00	14.00	1. 00
2. 00		INTENSIVE CARE UNIT			_	0		
3. 00		SUBPROVI DER - I PF	0	· ·	_	0	0	
4. 00		SUBPROVI DER - I RF	28, 166	~		0	0	
5. 00		OPERATING ROOM	0	1	o o	0	0	5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	0	1	0	0	Ö	
7. 00		RADI OI SOTOPE	0	1	_	0	0	
8. 00		LABORATORY	120, 138	6, 007	0	0	0	
9.00	65. 00	RESPI RATORY THERAPY	0		0	0	0	9. 00
10.00	69. 00	ELECTROCARDI OLOGY	0	C	0	0	0	10. 00
11. 00	90.00	CLINIC	10, 270	514	. 0	0	0	11. 00
12.00		ONCOLOGY	0	C	0	0	0	12. 00
13.00		OTHER OUTPATIENT SERVICE	15, 252	763	0	0	0	13. 00
		COST CENTER						
200.00		0 1 0 1 (5)	173, 826			0	0	200. 00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0			520, 417		1. 00
2. 00		INTENSIVE CARE UNIT	Ö		_	1, 500		2. 00
3.00		SUBPROVIDER - IPF	0	l c	0	551, 799		3. 00
4.00	41.00	SUBPROVIDER - IRF	0	28, 166	0	162, 761		4. 00
5.00	50.00	OPERATING ROOM	0	C	0	1, 448, 319		5. 00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	0	C	0	225, 000		6. 00
7.00	56.00	RADI OI SOTOPE	0	C	0	1, 800		7. 00
8.00		LABORATORY	0		0	2, 500		8. 00
9. 00		RESPI RATORY THERAPY	0		0	44, 272		9. 00
10.00		ELECTROCARDI OLOGY	0		0	13, 950		10. 00
11. 00		CLINIC	0		7, 730	221, 995	1	11. 00
12.00		ONCOLOGY	0		0	228, 102		12.00
13. 00	93. 00	OTHER OUTPATIENT SERVICE	0	15, 252	8, 748	479, 046		13. 00
200. 00		COST CENTER		172 024	16, 478	3, 901, 461		200. 00
∠∪∪. ∪∪	I	I	0	173, 826	10,4/8	3, 701, 401	I	<sub>1</sub> 200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems DAVIESS COMMUNITY HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0061 Peri od: Worksheet B From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** Cost Center Description Net Expenses Subtotal for Cost FLXT EQUI P **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 2, 903, 495 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 2, 903, 495 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 1, 390, 788 1, 390, 788 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5, 413, 604 7,056 4, 965 5, 425, 625 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 7, 121, 148 158, 211 96, 875 476, 908 7, 853, 142 5.00 00600 MAINTENANCE & REPAIRS 1, 975, 063 2, 142, 441 6.00 86, 721 29,056 51,601 6.00 7.00 00700 OPERATION OF PLANT 799, 208 557, 651 0 0 1, 356, 859 7.00 00800 LAUNDRY & LINEN SERVICE 364, 388 6, 002 370, 390 8.00 0 o 8.00 00900 HOUSEKEEPI NG 556, 722 19, 871 4, 193 99, 475 680, 261 9.00 9 00 245, 196 10.00 01000 DI ETARY 160,009 52, 107 14, 974 18, 106 10.00 11.00 01100 CAFETERI A 378, 074 19, 087 74, 097 471, 258 11.00 13.00 01300 NURSING ADMINISTRATION 845, 591 38, 341 5, 581 171, 533 1, 061, 046 13.00 663, 539 14.00 01400 CENTRAL SERVICES & SUPPLY 8, 548 538, 826 58, 518 57, 647 14.00 15. 00 01500 PHARMACY 807, 313 23, 329 61, 816 97, 244 989, 702 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 553, 918 127, 221 2, 571 95, 564 779, 274 16. 00

	U 1600 MEDI CAL RECORDS & LI BRARY	553, 918	127, 221	2, 5/1	95, 564	119, 214	16.00
17.00	01700 SOCI AL SERVI CE	91, 398	0	66	19, 311	110, 775	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·			<u> </u>		i
30. 00	03000 ADULTS & PEDI ATRI CS	1, 979, 244	121, 759	136, 001	395, 131	2, 632, 135	30.00
31. 00	03100 INTENSIVE CARE UNIT	644, 239	30, 732	14, 751	131, 740	821, 462	
40.00	04000 SUBPROVI DER - I PF	1, 618, 942	126, 502	17, 055	392, 601	2, 155, 100	40. 00
41.00	04100 SUBPROVI DER - I RF	626, 750	111, 489	11, 756	156, 149	906, 144	41.00
43.00	04300 NURSERY	300, 990	12, 236	0	56, 991	370, 217	43.00
.0.00	ANCILLARY SERVICE COST CENTERS	333,773	.2,200	<u> </u>	00,771	0.0,21.	10.00
50. 00	05000 OPERATING ROOM	1, 418, 016	174, 264	229, 952	240, 442	2, 062, 674	50.00
		1, 416, 016		·			
51. 00	05100 RECOVERY ROOM	U	0	0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	287, 275	126, 682	5, 013	56, 223	475, 193	52. 00
54.00	05400   RADI OLOGY-DI AGNOSTI C	954, 859	156, 372	540, 125	154, 965	1, 806, 321	54.00
56.00	05600 RADI OI SOTOPE	295, 780	14, 627	14, 940	48, 026	373, 373	56.00
60.00	06000 LABORATORY	2, 383, 638	43, 778	15, 434	214, 372	2, 657, 222	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	199, 120	2, 558	0	0	201, 678	•
		199, 120		-	ol Ol		1
64.00	06400 I NTRAVENOUS THERAPY	533 010	0	0	- 1	0	64.00
65. 00	06500 RESPI RATORY THERAPY	577, 942	33, 637	40, 505	111, 382	763, 466	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 173, 437	86, 695	3, 160	226, 328	1, 489, 620	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	289, 241	18, 470	0	61, 322	369, 033	67.00
68.00	06800 SPEECH PATHOLOGY	137, 834	13, 085	799	26, 480	178, 198	68. 00
69. 00	06900 ELECTROCARDI OLOGY	78, 194	7, 969	7, 713	15, 258	109, 134	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		7, 707		13, 230		1
		1, 458, 430	-1	15, 482	- 1	1, 473, 912	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	120, 318	0	0	0	120, 318	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 683, 636	4, 126	8, 479	0	2, 696, 241	73. 00
76.00	03020 CARDI AC REHAB	105, 149	72, 325	0	21, 373	198, 847	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	716, 145	62, 531	3, 829	124, 944	907, 449	88.00
88. 01	08801 RURAL HEALTH CLINIC II	805, 981	44, 781	1, 666	153, 343	1, 005, 771	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	1, 295, 833	88, 160	3, 142	183, 821	1, 570, 956	
88. 04	08803 RURAL HEALTH CLINIC V	1, 027, 561	24, 961	3, 509	187, 331	1, 243, 362	1
88. 05	08804 RURAL HEALTH CLINIC VI	504, 107	32, 789	1, 652	96, 544	635, 092	88. 05
90.00	09000 CLI NI C	214, 271	48, 315	2, 986	87, 022	352, 594	90.00
90. 01	09001 0NC0L0GY	176, 306	0	0	34, 574	210, 880	90. 01
90. 02	09002 PAIN MANAGEMENT	238, 442	22, 030	0	. 0	260, 472	90. 02
91. 00	09100 EMERGENCY	2, 262, 077	82, 903	18, 361	244, 754	2, 608, 095	
		2, 202, 077	02, 703	10, 301	244, 734	2,000,073	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000	7. 00.		404 (00	-	92.00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	262, 034	74, 986	621	121, 698	459, 339	93. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0	0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	ol	o	0	o	0	101.00
	SPECIAL PURPOSE COST CENTERS			-			
112 00	11300   I NTEREST EXPENSE						113. 00
		533 444	7 540		E ( 0E4	(44.04/	1
	11600 HOSPI CE	577, 446	7, 519	0	56, 851	641, 816	
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	49, 312, 782	2, 799, 525	1, 325, 576	4, 762, 022	48, 479, 997	]118. 00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	474	0	474	192. 00
	07951 OTHER NONREIMBURSABLE AND PHYSICIAN	4, 433, 288	103, 970	64, 738	663, 603	5, 265, 599	194 00
200.00		., .55, 250	.55, .76	5.,.00	555, 550		200.00
					0		
201.00		E0 7.1 075	0 000 10=	0	٠,		201. 00
202.00	TOTAL (sum lines 118 through 201)	53, 746, 070	2, 903, 495	1, 390, 788	5, 425, 625	53, 746, 070	J202. 00

Provider CCN: 15-0061

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm

						5/29/2019 4: 3	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& 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 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	7, 853, 142					5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	366, 612	2, 509, 053				6.00
7. 00	00700 OPERATION OF PLANT	232, 184	527, 691				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	63, 381	5, 680				8. 00
9.00	00900 HOUSEKEEPI NG	116, 406	18, 804			870, 930	9. 00
10.00	01000 DI ETARY	41, 958	49, 308	52, 676	3, 100	21, 945	10.00
11. 00	01100 CAFETERI A	80, 641	18, 062	19, 296	0	8, 039	11. 00
13.00	01300 NURSING ADMINISTRATION	181, 565	36, 281	38, 760	0	16, 147	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	113, 544	54, 550	58, 277	0	24, 278	14. 00
15. 00	01500 PHARMACY	169, 357	22, 075	23, 584	0	9, 825	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	133, 349	120, 386	128, 611	0	53, 579	16. 00
17. 00	01700 SOCI AL SERVI CE	18, 956	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00	03000 ADULTS & PEDI ATRI CS	450, 408	115, 217				30.00
31. 00	03100 I NTENSI VE CARE UNI T	140, 568	29, 081	1		12, 943	31.00
40. 00	04000 SUBPROVIDER - I PF	368, 779	119, 705				1
41.00	04100 SUBPROVI DER - I RF	155, 058	105, 499			46, 954	41.00
43. 00	04300 NURSERY	63, 351	11, 579	12, 370	0	5, 153	43. 00
EO 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	252.043	1/4 002	17/ 1/0	F2 702	73, 389	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	352, 963 0	164, 902 0		52, 702 0	73, 389	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	81, 315	119, 875	1	_	53, 352	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	309, 096	147, 971		103, 525		54.00
56. 00	05600 RADI OI SOTOPE	63, 891	13, 841		103, 323	6, 160	56.00
60. 00	06000 LABORATORY	454, 701	41, 426		0	l	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	34, 511	2, 420			1, 077	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	2, 120		o O	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	130, 644	31, 830	34, 004	6, 200	1	65. 00
66. 00	06600 PHYSI CAL THERAPY	254, 902	82, 037			36, 512	66.00
67.00	06700 OCCUPATI ONAL THERAPY	63, 149	17, 478	18, 672	0	7, 779	67. 00
68. 00	06800 SPEECH PATHOLOGY	30, 493	12, 382	13, 228	0	5, 511	68. 00
69.00	06900 ELECTROCARDI OLOGY	18, 675	7, 541	8, 056	0	3, 356	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	252, 214	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	20, 589	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	461, 378	3, 904	4, 171	0	1, 738	73. 00
76. 00	03020 CARDI AC REHAB	34, 026	68, 439	73, 115	0	30, 460	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	155, 282	59, 171			,	•
88. 01	08801 RURAL HEALTH CLINIC II	172, 107	42, 375			l	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	268, 820	83, 424			37, 129	88. 02
88. 04	08803 RURAL HEALTH CLINIC V	212, 763	23, 620	1	1, 252		88. 04
88. 05	08804 RURAL HEALTH CLINIC VI	108, 676	31, 027		2 254	13, 809	88. 05
90.00	09000 CLINIC	60, 336	45, 720				
90. 01	09001 ONCOLOGY 09002 PAI N MANAGEMENT	36, 086 44, 572	20, 847		_	0 9, 278	90. 01
91.00	09100 EMERGENCY	446, 295	78, 449	•		34, 915	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	440, 293	70, 449	03, 009	40, 301	34, 913	92.00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	78, 602	70, 957	75, 805	0	31, 580	93.00
73.00	OTHER REIMBURSABLE COST CENTERS	70,002	70, 737	75,005	0	31, 300	73.00
99 10	09910 CORF	0	C	0	0	0	99. 10
	10100 HOME HEALTH AGENCY	o	0	l e		•	101. 00
	SPECIAL PURPOSE COST CENTERS	-1	-				
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	109, 827	7, 115	7, 601	0	3, 167	116. 00
118.00		6, 952, 030	2, 410, 669				
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	81	0	0	0		192. 00
	07951 OTHER NONREIMBURSABLE AND PHYSICIAN	901, 031	98, 384	105, 106	0	43, 787	194. 00
200.00				1			200. 00
201.00		0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	7, 853, 142	2, 509, 053	2, 116, 734	445, 519	870, 930	202. 00

Provider CCN: 15-0061

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm

				12/31/2010	5/29/2019 4: 30	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10.00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS	<u>'</u>			'		
1. 00   00100   NEW CAP REL COSTS-BLDG & FIXT   2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP   4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT   5. 00   00500   AMINTENANCE & REPAIRS   7. 00   00700   OPERATION OF PLANT   00100   00						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900 HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY	414, 183					10.00
11. 00 01100 CAFETERI A	0	597, 296				11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	18, 035				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	10, 293		924, 481		14. 00
15. 00 01500 PHARMACY	o	10, 686		1, 922	1, 227, 151	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	17, 229		13	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	4, 278		103	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>	•				
30. 00 03000 ADULTS & PEDI ATRI CS	138, 166	61, 743	264, 271	23, 802	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	37, 689	17, 446	74, 671	4, 779	0	31. 00
40. 00   04000   SUBPROVI DER - 1 PF	192, 086	58, 878	252, 009	8, 883	0	40.00
41. 00   04100   SUBPROVI DER - I RF	46, 242	19, 619	83, 973	3, 148	0	41.00
43. 00 04300 NURSERY	0	7, 326	31, 356	2, 762	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	33, 777	144, 571	32, 209	0	50. 00
51. 00   05100   RECOVERY ROOM	0	0	-	0	0	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	7, 227		0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	22, 274	95, 336	18, 597	0	54.00
56. 00   05600   RADI 0I SOTOPE	0	4, 595		7, 048	0	56. 00
60. 00   06000   LABORATORY	0	37, 624		268, 926	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	51, 651	0	63.00
64. 00   06400   I NTRAVENOUS THERAPY	0	14 441	0	10.0((	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	14, 441	0	10, 066	0	65. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0	26, 889		1, 376	0	66.00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	7, 750 2, 853		0	0	67. 00 68. 00
69. 00   06900   ELECTROCARDI OLOGY		2, 354	0	1, 489	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 354	0	439, 470	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	Ö	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	O	o	1, 227, 151	73. 00
76. 00 03020 CARDI AC REHAB	O	2, 947	12, 613	432	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	12, 520	0	676	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	17, 270		2, 204	0	88. 01
88. 02   08802   RURAL HEALTH CLINIC III	0	24, 300		1, 908	0	88. 02
88. 04   08803 RURAL HEALTH CLINIC V	0	13, 810		2, 659	0	88. 04
88. 05 08804 RURAL HEALTH CLINIC VI	0	11, 988		521	0	88. 05
90. 00   09000  CLI NI C 90. 01   09001  0NC0L0GY	0	6, 717 3, 818		11, 936	0	90. 00 90. 01
90. 02   09002   PALN   MANAGEMENT	0	4, 884		826	0	90.01
91. 00 09100 EMERGENCY		33, 527		10, 732	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		33, 327	143, 302	10, 732	١	92. 00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	8, 147	0	45	0	93. 00
OTHER REIMBURSABLE COST CENTERS			- 1			
99. 10 09910 CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE					ļ	113. 00
116. 00 11600 H0SPI CE	0	8, 854		13, 648		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	414, 183	534, 099	1, 351, 834	921, 831	1, 227, 151	118. 00
NONREI MBURSABLE COST CENTERS				٦		192. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0	(2.107	0	2 450		192. 00 194. 00
200.00 Cross Foot Adjustments	"	63, 197	ا ۱	2, 650		200. 00
201.00 Negative Cost Centers		Λ	n	٥		200.00
202.00 TOTAL (sum lines 118 through 201)	414, 183	597, 296	1, 351, 834	924, 481	1, 227, 151	
(	,	, = 70	, , , , , , , , , , , , , , , , , , , ,	, .0 .]	, == , , , , , , ,	

Heal th	Financial Syst	tems	DAVIESS COMMUN	ITY HOS	PI TAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GE	NERAL SERVICE COSTS		Prov	vider CCN	F	Period: From 01/01/2018	Worksheet B Part I	
						7	To 12/31/2018	Date/Time Pre 5/29/2019 4:3	pared:
	Cost Cen	iter Description	MEDI CAL RECORDS & LI BRARY	SOCI AL	SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	O pili
			16. 00	17.	00	24. 00	25. 00	26. 00	
	GENERAL SERVIC	CE COST CENTERS							
1.00		REL COSTS-BLDG & FIXT							1.00
2.00		REL COSTS-MVBLE EQUIP							2.00
4. 00 5. 00		BENEFITS DEPARTMENT RATIVE & GENERAL							4. 00 5. 00
6. 00	00600 MAI NTENA								6. 00
7. 00	00700 OPERATI 0								7. 00
8.00		& LINEN SERVICE							8. 00
9.00	00900 HOUSEKEE	PING							9. 00
10.00	01000 DI ETARY	•							10.00
11. 00 13. 00	01100 CAFETERI	ADMI NI STRATI ON							11. 00
14. 00	1	SERVICES & SUPPLY							14.00
15. 00	01500 PHARMACY								15. 00
16.00	01600 MEDI CAL	RECORDS & LI BRARY	1, 232, 441						16. 00
17. 00	01700 SOCIAL S		0		134, 112				17. 00
20.00		TINE SERVICE COST CENTERS	22.245		2 572	2 000 10		2 000 102	20.00
30. 00 31. 00	03000 ADULTS & 03100 I NTENSI V		22, 265 25, 680		2, 572 2, 980	3, 989, 193 1, 213, 868		3, 989, 193 1, 213, 868	1
40. 00	04000 SUBPROVI		80, 590		52, 275	3, 528, 367	1	3, 528, 367	1
41. 00	04100 SUBPROVI		18, 310		120	1, 516, 375		1, 516, 375	
43.00	04300 NURSERY		6, 671		0	510, 785	5 0	510, 785	43.00
F0 00		/I CE COST CENTERS	00.070		ما	0 400 001	-1 -1	0 400 005	F0 00
50. 00 51. 00	05000 OPERATI N 05100 RECOVERY		89, 970 0		0	3, 183, 325 (	1	3, 183, 325 0	1
52. 00	1 1	ROOM & LABOR ROOM	6, 581		0	902, 54	1	902, 541	1
54. 00	05400 RADI OLOG		203, 680		o	2, 930, 737	1	2, 930, 737	1
56.00	05600 RADI 0I S0		49, 767		О	553, 130		553, 130	1
60.00	06000 LABORATO		217, 677		0	3, 901, 306		3, 901, 306	1
63. 00		ORING, PROCESSING & TRANS.	7, 691		0	301, 614		301, 614	1
64. 00 65. 00	06400 I NTRAVEN 06500 RESPI RAT		20, 536		0	1, 025, 353		0 1, 025, 353	
66. 00	06600 PHYSI CAL		33, 265		0	2, 012, 243	1	2, 012, 243	
67. 00	06700 OCCUPATI		13, 244		o	497, 105		497, 105	
68. 00	06800 SPEECH P	PATHOLOGY	3, 229		0	245, 894	4 O	245, 894	68. 00
69. 00	06900 ELECTROC		10, 106		0	160, 71		160, 711	1
71. 00 72. 00		SUPPLIES CHARGED TO PATIENTS	51, 860		0	2, 217, 456		2, 217, 456	
72.00	1	V. CHARGED TO PATIENT NARGED TO PATIENTS	4, 726 114, 576		0	145, 633 4, 509, 159		145, 633 4, 509, 159	
76. 00	03020 CARDI AC		1, 931		0	422, 810		422, 810	
	OUTPATIENT SER	RVICE COST CENTERS							1
	08800 RURAL HE		9, 527		0	1, 234, 174		1, 234, 174	
	08801 RURAL HE		11, 029		0	1, 317, 349		1, 317, 349	
88. 02 88. 04	08802 RURAL HE	ALTH CLINIC III	20, 919 12, 663		0	2, 096, 580 1, 545, 875		2, 096, 580 1, 545, 875	
88. 05		ALTH CLINIC VI	6, 319		o	840, 579		840, 579	
90.00	09000 CLI NI C		11, 901		О	561, 749		561, 749	1
90. 01	09001 ONCOLOGY		18, 042		0	269, 652		269, 652	1
90. 02	09002 PAIN MAN		4, 634		0	366, 958	0	366, 958	
91. 00 92. 00	09100 EMERGENC	.Y ION BEDS (NON-DISTINCT PART)	85, 114		12, 931	3, 577, 670	0 0	3, 577, 670	91.00
93. 00		TON BEDS (NON-BISTING) FART)	5, 289		2, 932	732, 696	1	732, 696	1
		SABLE COST CENTERS	,		, ,		-,	, , , , , , , , , , , , , , , , , , , ,	
	09910 CORF		0		0	(			99. 10
101.00	10100 HOME HEA		0		0	(	0	0	101. 00
113 00	11300 I NTEREST	SE COST CENTERS			T		T		113. 00
	11600 HOSPI CE	EXI ENSE	10, 941		60, 302	901, 166	s o	901, 166	
118.00	1 1	S (SUM OF LINES 1 through 117)	1, 178, 733		134, 112	47, 212, 053		47, 212, 053	
		LE COST CENTERS							
		NS' PRIVATE OFFICES	0		0	555			192.00
194. 00 200. 00		NREIMBURSABLE AND PHYSICIAN oot Adjustments	53, 708		U	6, 533, 462		6, 533, 462 0	200.00
200.00	1	: Cost Centers	0		o	(			201. 00
202.00		sum lines 118 through 201)	1, 232, 441		134, 112	53, 746, 070		53, 746, 070	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Pare 2014 | Pare Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0061

				То	12/31/2018	Date/Time Pre 5/29/2019 4:3	
			CAPI TAL REI	ATED COSTS		372772017 4.3	O pili
	Cost Center Description	Di rectl y	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FLXT	EQUI P		BENEFI TS	
		Capi tal Rel ated Costs				DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
GENEF	RAL SERVICE COST CENTERS		11.00	2.00		1.00	
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
	NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	D EMPLOYEE BENEFITS DEPARTMENT	0	7, 056		12, 021		4. 00
	O ADMINISTRATIVE & GENERAL	0	158, 211		255, 086	'	1
	D MAINTENANCE & REPAIRS D OPERATION OF PLANT	0	86, 721 557, 651		115, 777 557, 651	114 0	6. 00 7. 00
	D LAUNDRY & LINEN SERVICE	0	6, 002		6, 002		8.00
	HOUSEKEEPI NG	0	19, 871		24, 064	220	9. 00
	D DI ETARY	O	52, 107	· ·	67, 081	40	1
11.00 01100	CAFETERIA	0	19, 087	0	19, 087	164	11. 00
	NURSING ADMINISTRATION	0	38, 341		43, 922	380	13. 00
	CENTRAL SERVICES & SUPPLY	0	57, 647		66, 195		1
	D PHARMACY	0	23, 329		85, 145		1
•	MEDICAL RECORDS & LIBRARY  SOCIAL SERVICE	0	127, 221 0		129, 792 66		16. 00 17. 00
	TIENT ROUTINE SERVICE COST CENTERS	J O	0	00	00	43	17.00
	ADULTS & PEDIATRICS	0	121, 759	136, 001	257, 760	875	30. 00
	INTENSIVE CARE UNIT	0	30, 732		45, 483		1
40. 00 04000	SUBPROVIDER - IPF	0	126, 502	17, 055	143, 557	870	40. 00
•	SUBPROVIDER - IRF	0	111, 489		123, 245		1
	NURSERY	0	12, 236	0	12, 236	126	43. 00
	LARY SERVICE COST CENTERS		174 0/4	220 052	40.4 21.6	F22	F0 00
	O OPERATING ROOM RECOVERY ROOM	0	174, 264 0		404, 216 0	533 0	50. 00 51. 00
	D DELIVERY ROOM & LABOR ROOM	0	126, 682	-	131, 695		1
	RADI OLOGY-DI AGNOSTI C	0	156, 372		696, 497		1
	RADI OI SOTOPE	0	14, 627		29, 567		1
60.00 06000	LABORATORY	0	43, 778	15, 434	59, 212	475	60.00
	BLOOD STORING, PROCESSING & TRANS.	0	2, 558		2, 558		63. 00
	I NTRAVENOUS THERAPY	0	0	1	0	_	64. 00
	O RESPI RATORY THERAPY	0	33, 637		74, 142		65.00
	D PHYSI CAL THERAPY D OCCUPATI ONAL THERAPY	0	86, 695 18, 470		89, 855 19, 470		66. 00 67. 00
	SPEECH PATHOLOGY	0	13, 085		18, 470 13, 884		1
	ELECTROCARDI OLOGY	0	7, 969		15, 682		69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		15, 482		71. 00
	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
	DRUGS CHARGED TO PATIENTS	0	4, 126		12, 605		73. 00
76. 00 03020	CARDI AC REHAB	0	72, 325	0	72, 325	47	76. 00
	ATIENT SERVICE COST CENTERS DRURAL HEALTH CLINIC	O	40 E01	3, 829	66, 360	277	88. 00
	RURAL HEALTH CLINIC	0	62, 531 44, 781		46, 447		88. 00
	2 RURAL HEALTH CLINIC III	0	88, 160		91, 302		88. 02
	3 RURAL HEALTH CLINIC V	i o	24, 961		28, 470		88. 04
88. 05 08804	4 RURAL HEALTH CLINIC VI	0	32, 789		34, 441	214	1
	D CLI NI C	0	48, 315	2, 986	51, 301	193	90. 00
	1 ONCOLOGY	0	0	-	0	77	90. 01
•	2 PAIN MANAGEMENT	0	22, 030		22, 030		90. 02
	DEMERGENCY DOBSERVATION BEDS (NON-DISTINCT PART)	0	82, 903	18, 361	101, 264	542	91. 00 92. 00
	O OTHER OUTPATIENT SERVICE COST CENTER	0	74, 986	621	75, 607	270	1
	R REIMBURSABLE COST CENTERS	<u> </u>	74,700	021	73,007	210	75.00
99. 10 09910		0	0	0	0	0	99. 10
101.00 10100	HOME HEALTH AGENCY	0			0	0	101. 00
	AL PURPOSE COST CENTERS						
	O INTEREST EXPENSE						113. 00
116.00 11600		0			7, 519		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 799, 525	1, 325, 576	4, 125, 101	10, 550	118. 00
	EIMBURSABLE COST CENTERS DIPHYSICIANS' PRIVATE OFFICES	0	0	474	474	0	192. 00
	1 OTHER NONREIMBURSABLE AND PHYSICIAN		103, 970		168, 708		194. 00
200. 00	Cross Foot Adjustments		100, 770	01,750	0	1, 771	200. 00
201. 00	Negative Cost Centers	[	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	o	2, 903, 495	1, 390, 788	4, 294, 283		202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0061

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/29/2019 4:30 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 256, 142 5 00 6.00 00600 MAINTENANCE & REPAIRS 11, 957 127, 848 6.00 00700 OPERATION OF PLANT 7,573 592, 111 7.00 26, 887 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 2,067 289 1.697 10, 055 8.00 00900 HOUSEKEEPI NG 9.00 3.797 958 5.619 798 35, 456 9 00 10.00 01000 DI ETARY 1,368 2, 512 14, 735 70 893 10.00 11.00 01100 CAFETERI A 2,630 920 5, 398 0 327 11.00 01300 NURSING ADMINISTRATION 5.922 1 849 10.842 0 13 00 13 00 657 14.00 01400 CENTRAL SERVICES & SUPPLY 3,703 2, 780 16, 302 0 988 14.00 15.00 01500 PHARMACY 5,524 1, 125 6, 597 0 400 15.00 01600 MEDICAL RECORDS & LIBRARY 4, 349 35, 976 0 16, 00 2, 181 16, 00 6, 134 01700 SOCIAL SERVICE 17.00 618 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 14,690 5, 871 34, 432 2, 352 2,088 30.00 03100 INTENSIVE CARE UNIT 1, 482 8, 691 31.00 4.585 527 31.00 350 04000 SUBPROVIDER - IPF 2, 169 40 00 12.028 6, 100 35, 773 1, 329 40 00 04100 SUBPROVIDER - IRF 5,057 5, 376 31, 527 1, 911 41.00 420 41.00 04300 NURSERY 43.00 2,066 590 3, 460 210 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11, 512 8, 403 49, 279 1, 189 2, 987 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 2,652 6, 108 35, 824 2, 172 52.00 05400 RADI OLOGY-DI AGNOSTI C 10, 081 7, 540 54.00 44, 220 2, 337 2, 681 54.00 56.00 05600 RADI OI SOTOPE 2,084 705 4, 136 251 56.00 0 06000 LABORATORY 60.00 14,830 2, 111 12, 380 0 751 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 1, 126 723 0 123 44 63.00 06400 INTRAVENOUS THERAPY 64.00  $\cap$ 0 Ω 64.00 65.00 06500 RESPIRATORY THERAPY 4, 261 1,622 9, 512 140 577 65.00 06600 PHYSI CAL THERAPY 66.00 8, 314 4, 180 24, 516 0 1, 486 66.00 06700 OCCUPATIONAL THERAPY 0 67 00 2 060 891 5 223 317 67 00 06800 SPEECH PATHOLOGY 3,700 0 68.00 995 631 224 68.00 06900 ELECTROCARDI OLOGY 609 384 2, 254 0 137 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 8.226 0 71.00 C 0 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 671 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 15,048 199 1, 167 0 71 73.00 03020 CARDI AC REHAB 20, 452 76.00 1, 110 3, 487 0 1, 240 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 5,064 3,015 17, 683 1,072 88.00 08801 RURAL HEALTH CLINIC II 5, 613 2, 159 12, 663 56 768 88.01 88.01 88.02 08802 RURAL HEALTH CLINIC III 8,768 4, 251 24, 930 0 1,512 88.02 6, 939 08803 RURAL HEALTH CLINIC V 7 059 28 1, 204 88 04 88 04 428 88.05 08804 RURAL HEALTH CLINIC VI 3,544 1, 581 9, 272 0 562 88.05 1, 968 90.00 09000 CLI NI C 2, 330 13,663 76 828 90.00 09001 ONCOLOGY 90. 01 90.01 1.177 0 0 09002 PAIN MANAGEMENT 1, 062 90.02 6.230 O 378 90 02 1.454 91.00 09100 EMERGENCY 14,556 3, 997 23, 444 910 1, 421 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER
OTHER REIMBURSABLE COST CENTERS 93.00 2,564 3,616 21, 205 1, 286 93.00 0 99. 10 09910 CORF 0 99. 10 0 0 101.00 10100 HOME HEALTH AGENCY 0 Ω 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 3,582 129 116.00 363 2, 126 33, 673 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 226, 742 122, 835 562, 710 10, 055 NONREI MBURSABLE COST CENTERS

192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 192. 00 C 0 194.00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 29, 397 5, 013 29, 401 0 1, 783 194. 00 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 592, 111 10, 055 35, 456 202. 00 202.00 256, 142 127, 848

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0061

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II

					To	12/31/2018	Date/Time Pre	
		Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	5/29/2019 4: 30 PHARMACY	J pm
			10.00	11 00	12.00	SUPPLY	15.00	
	CENED	AL SERVICE COST CENTERS	10. 00	11. 00	13. 00	14. 00	15. 00	
1.00		NEW CAP REL COSTS-BLDG & FIXT						1. 00
2. 00		NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500	ADMINISTRATIVE & GENERAL						5. 00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00		OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8. 00
9.00	1	HOUSEKEEPI NG	04 400					9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	86, 699	28, 526				10. 00 11. 00
13. 00	1	NURSI NG ADMI NI STRATI ON	0	861				13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	o	492		90, 590		14. 00
15. 00	01500	PHARMACY	o	510	0	188	99, 704	15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	823		1	0	16. 00
17. 00		SOCIAL SERVICE	0	204	0	10	0	17. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	28, 922	2, 949	12, 596	2, 332	0	30. 00
31. 00	1	INTENSIVE CARE UNIT	7, 889	833		2, 332 468	0	31. 00
40. 00	1	SUBPROVI DER - I PF	40, 208	2, 812		870	0	40. 00
41.00	1	SUBPROVIDER - IRF	9, 680	937		308	0	41.00
43.00		NURSERY	0	350	1, 495	271	0	43.00
		LARY SERVICE COST CENTERS						
50.00	1	OPERATI NG ROOM	0	1, 613		3, 156	0	50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	0 345	- 1	0	0	51. 00 52. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	0	1, 064		1, 822	0	54. 00
56. 00	1	RADI OI SOTOPE	o	219		691	0	56. 00
60.00	06000	LABORATORY	0	1, 797	7, 676	26, 352	0	60.00
63. 00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5, 061	0	63. 00
64. 00	1	I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00	1	RESPI RATORY THERAPY	0	690	1	986	0	65. 00
66. 00 67. 00	1	PHYSI CAL THERAPY  OCCUPATI ONAL THERAPY	0	1, 284 370		135 O	0	66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY	0	136	1	0	0	68. 00
69. 00	1	ELECTROCARDI OLOGY	o	112		146	0	69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	43, 066	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	0	0		0	99, 704	73. 00
76. 00		CARDIAC REHAB TIENT SERVICE COST CENTERS	U	141	601	42	0	76. 00
88. 00		RURAL HEALTH CLINIC	0	598	0	66	0	88. 00
88. 01		RURAL HEALTH CLINIC II	o	825		216	0	88. 01
88. 02	08802	RURAL HEALTH CLINIC III	О	1, 161	0	187	0	88. 02
88. 04		RURAL HEALTH CLINIC V	0	660		261	0	88. 04
88. 05		RURAL HEALTH CLINIC VI	0	573		51	0	
90. 00 90. 01	1	CLI NI C ONCOLOGY	0	321 182		1, 170 81	0	90. 00 90. 01
90. 01		PAIN MANAGEMENT	0	233		0	0	90. 01
91. 00		EMERGENCY	o	1, 601		1, 052	0	91. 00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				·		92.00
93. 00		OTHER OUTPATIENT SERVICE COST CENTER	0	389	0	4	0	93. 00
00.40		REIMBURSABLE COST CENTERS			1	ما		00.40
99. 10	1	l .	0	0		0	0	99. 10 101. 00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	U	0	l U	U	U	101.00
113.00		INTEREST EXPENSE						113. 00
		HOSPI CE	О	423	1, 806	1, 337		116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86, 699	25, 508	64, 433	90, 330	99, 704	118. 00
400.5		I MBURSABLE COST CENTERS	-1	_		-1		400 00
	1	PHYSICIANS' PRIVATE OFFICES	0	2 010		0		192. 00
200.00		OTHER NONREIMBURSABLE AND PHYSICIAN Cross Foot Adjustments	٩	3, 018	١	260	0	194. 00 200. 00
200.00	1	Negative Cost Centers	n	0	0	o	0	200. 00
202.00	1	TOTAL (sum lines 118 through 201)	86, 699	28, 526		90, 590	99, 704	

Heal th	Financial Systems	DAVIESS COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
	NTION OF CAPITAL RELATED COSTS		Provider CCM	F	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II	pared:
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	I	16. 00	17. 00	24. 00	25. 00	26. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10. 00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON						11. 00 13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	179, 468					15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		1				17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 242	18	368, 127	7 0	368, 127	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 740	21	77, 920		77, 920	1
40. 00 41. 00	04000   SUBPROVI DER	11, 736 2, 667	1 1	269, 831 185, 477		269, 831 185, 477	
43. 00	04300 NURSERY	971		21, 775		21, 775	1
EO 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	12 102	el ol	E02 001	1 0	EO2 001	50.00
50. 00 51. 00	05100 RECOVERY ROOM	13, 102	1	502, 881 (		502, 881 0	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	958	1	181, 353		181, 353	1
54. 00 56. 00	05400  RADI OLOGY-DI AGNOSTI C   05600  RADI OI SOTOPE	29, 662 7, 248	1 1	800, 791 45, 944		800, 791 45, 944	1
60.00	06000 LABORATORY	31, 691	1	157, 275		157, 275	1
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	1, 120	1	10, 755 (		10, 755 0	1
65.00	06500 RESPI RATORY THERAPY	2, 991	1 1	95, 168		95, 168	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	4, 844 1, 929	1 1	135, 115 29, 39 <i>6</i>		135, 115 29, 396	1
68. 00	06800 SPEECH PATHOLOGY	470	0	20, 099	e o	20, 099	68. 00
69. 00 71. 00	06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 472 7, 552		20, 830 74, 32 <i>6</i>		20, 830 74, 326	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	688	0	1, 359	9 0	1, 359	72. 00
73. 00 76. 00	O7300   DRUGS CHARGED TO PATIENTS   O3020   CARDI AC REHAB	16, 686 281	1	145, 480 99, 72 <i>6</i>		145, 480 99, 726	
	OUTPATIENT SERVICE COST CENTERS						
88. 00 88. 01	O8800   RURAL HEALTH CLINIC   O8801   RURAL HEALTH CLINIC II	1, 387 1, 606		95, 522 70, 693		95, 522 70, 693	88. 00 88. 01
88. 02	08802 RURAL HEALTH CLINIC III	3, 046		135, 564		135, 564	1
88. 04 88. 05	O8803   RURAL HEALTH CLINIC V   O8804   RURAL HEALTH CLINIC VI	1, 844 920		47, 308 51, 158		47, 308 51, 158	1
90.00	09000 CLINIC	1, 733	1	73, 583		73, 583	
90. 01	09001 ONCOLOGY	2, 627	1 1	4, 144		4, 144	1
90. 02 91. 00	09002 PAIN MANAGEMENT 09100 EMERGENCY	675 12, 395		32, 062 168, 113		32, 062 168, 113	1
		770		105 72	o	105 722	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	770	21	105, 732	2  0	105, 732	93. 00
	09910 CORF 10100 HOME HEALTH AGENCY	0		(			99. 10 101. 00
101.00	SPECIAL PURPOSE COST CENTERS		ij O	(	را ار	0	1101.00
	11300 INTEREST EXPENSE	1 503	422	10 424		10 424	113.00
118.00	11600 HOSPICE 	1, 593 171, 646	1 1	19, 42 <i>6</i> 4, 046, 933		4, 046, 933	116. 00 118. 00
	NONREI MBURSABLE COST CENTERS						
	19200   PHYSICIANS' PRIVATE OFFICES   07951   OTHER NONREIMBURSABLE AND PHYSICIAN	7, 822	1	477 246, 873		477 246, 873	192. 00 194. 00
200.00	Cross Foot Adjustments			,	o	0	200. 00
201. 00 202. 00		179, 468	941	4, 294, 283	0 3 0	0 4, 294, 283	201. 00 202. 00
30	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	111,100		., 2, 200	, 9	.,, _ 50	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 DAVIESS COMMUNITY HOSPITAL Provider CCN: 15-0061 Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm CAPITAL RELATED COSTS

		Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
1.00   10100  NEW CAP   PELL COSTS-HUBLE SHIP   255,896   1.012,079   25,570,465   -7,853,142   45,992,086   -7,853,142   -7,853,142   -7,853,142   -7,853,142   -7,853,142		DENERAL DERIVISE COST DENTERO	1.00	2. 00	4. 00	5A	5. 00	
0.0000   DIADO   NEW CAP PILL COSTS - MONEL   EQUIP	1 00		225 806					1 00
4.00   00000   DUPLOYUNE BEWEIT S DEPARTMENT   540   3. 015   25,770,485   4.1,462   -7,853,142   4.5,802,026   4.00   6.00   000000			223, 690	1 012 679				•
0.000   0.00			549					
0.000   0.0700   0.0FEATION OF PLANT	5.00		12, 309				45, 892, 928	5. 00
0.00   00000   DUSTACEPING   1.546   3.052   448, 817   0   0   0   370, 390   8.0   0.00   0.0000   DETARY   4.054   10.902   85, 334   0   245, 196   10.00   10.00   10.000   DETARY   4.054   10.902   85, 334   0   245, 196   10.00   11.000					1			
0.000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000				0	·	0		1
10.00   01000 (DETARY   4.054   10.903   85.334   0   245.196   10.00   13.00 (DETERN   4.054   13.00   13.00 (DETERN   4.00   14.00 (DETERN   4.00 (DETER				3 053	ľ	0		•
13.00   01300   MURSING ADMINISTRATION   2,983   4,064   898, 421   0 1,061,046   13.00   14.00   14.00   01400   CENTRAL SERVICE S& SUPPLY   1,815   45,010   488, 304   0 999,702   15.00   17.00   01500   PHABMACY   1,815   45,010   488, 304   0 999,702   15.00   17.00   01500   PHABMACY   1,815   45,010   488, 304   0 999,702   15.00   17.00   01700   SOCIAL SERVICE   1,802   15.00   17.00								1
14. 00 0 10400 (EKTINAL SERVICES & SUPPLY				0		0	471, 258	11. 00
15.00   01500   PIARDHACY   1,815   45,010   448, 304   0   999, 702   15.00   17.00   01700   SOCIAL SERVICE COST CENTERS   0   48   91,009   0   110,775   17.00						0		1
16.00   01600   MEDICAL RECORDS & LIBRARY   9,808   1,872   455,885   0   779,274   16.00   17.00   17.00   0		1 I						1
17.00								1
INPATI ENT ROUTINE SERVICE COST CENTERS		1 I						1
31.00   03100   INTENSIVE CARE UNIT   2, 391   10, 741   620, 879   0   221, 462   31.00   40.00   04000   SUBPROVIDER - I.PF   9, 842   12, 418   1, 856, 293   0   21, 551, 040, 04.00   41.00   04100   SUBPROVIDER - I.RF   9, 842   12, 418   1, 856, 293   0   20, 652   0   370, 217   43.00   43.00   43200   MIRSERY   952   0   268, 592   0   370, 217   43.00   43.00   43200   MIRSERY   43.00   43.00   43200   MIRSERY   43.00   43.0								
40 00   04000 SUBPROVIDER - I PF								1
A1.00   O4100 SUBPROVIDER - IRF								1
ABOUND   MARCHERY   SERVICE COST CENTERS								•
50.00   05000  OFEATING ROOM   13,558   167,436   1,133,180   0   2,062,674   50.00   51.00   510.00   510.00   610.00   ECOVERY ROOM   0   0   0   0   51.00   510.00   510.00   610								1
15.0								
S2.00   OS200   OSE00   OSE00   PAT   LAROR ROOM   9, 856   3, 650   264, 976   0   475, 193   52.00								
54.00   OS-000   OS-000   OR-000   OR-0000   OR-00000				-			_	•
56.00   05600   RABIO II SOTOPE   1, 138   10, 878   226, 343   0   373, 373   56.00							1,0,1,0	
63.0 0 6300 BLOOD STORING, PROCESSING & TRANS. 199 0 0 0 0 201.678 63. 30 0 46.0 0 64.00 0 1000 INTRAVENDUS THERAPY 2 0 0 0 0 5 0 64.00 0 65.0 0 6500 RESPIRATORY THERAPY 2 2.617 29, 493 524, 936 0 7.63, 466 65 0 0 66.00 0 6600 PMYSICAL THERAPY 1, 437 0 289, 006 0 3.69, 033 67. 00 67.00 0CCUPATI ONAL THERAPY 1, 437 0 289, 006 0 3.69, 033 67. 00 6800 SPECH PATHOLOGY 1 1,018 52 124, 798 0 178, 198 68.00 6900 SPECH PATHOLOGY 1 1,018 52 124, 798 0 178, 198 68.00 6900 SPECH PATHOLOGY 1 1,018 52 124, 798 0 178, 198 68.00 6900 SPECH PATHOLOGY 1 1,018 52 124, 798 0 178, 198 68.00 171.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 11, 273 0 0 0 1, 473, 912 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 11, 273 0 0 0 1, 473, 912 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6, 174 0 0 2, 696, 241 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6, 174 0 0 0 2, 696, 241 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6, 174 0 0 0 2, 696, 241 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6, 174 0 0 0 2, 696, 241 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6, 174 0 0 0 2, 696, 241 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6, 174 0 0 0 2, 696, 241 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6, 174 0 0 0 2, 696, 241 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6, 174 0 0 0 2, 696, 241 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6, 174 0 0 0 2, 696, 241 73.00 07300 DRUGS CHARCH TO CHARCED TO PATIENTS 321 6, 174 0 0 100, 727 0 198, 80.00 880.00 88000 RURAL HEALTH CLINIC II 3, 484 1, 213 722, 690 0 1, 005, 771 88.01 88.01 880.00 8800 RURAL HEALTH CLINIC II 3, 484 1, 213 722, 690 0 1, 005, 771 88.01 88.01 880.00 RURAL HEALTH CLINIC II 3, 484 1, 213 722, 690 0 1, 005, 771 88.01 88.01 880.00 8800 RURAL HEALTH CLINIC II 3, 485 1, 120, 300 880.00 8800 RURAL HEALTH CLINIC II 3, 485 1, 245, 245, 285 880.00 800, 800 RURAL HEALTH CLINIC II 3, 485 1, 245, 245, 285 880.00 800 RURAL HEALTH CLINIC II 3, 485 1, 245, 245, 285 880.00 800 RURAL HEALTH CLINIC II 3, 485 1, 245, 245, 285 1, 245, 245, 245 1, 245, 245, 245, 245, 245, 245, 245, 245			1					•
64-00   06400   INTRAVENDUS THERAPY   0   0   0   0   0   0   0   0   0	60.00							1
65. 00   0.650				0	0	0		1
66.00   06600   PHYSI CAL THERAPY   6,745   2,301   1,066,665   0   1,489,620   66.00   67.00				o e	D 524 026	0		1
67.00   06700   0CCUPATIONAL THERAPY   1,437   0   289,006   0   369,033   87.00   68.00   06800   SPECH PATHOLOGY   1,018   582   124,798   0   178, 198   88.00   69.00   06900   ELECTROCARDIOLOGY   1,018   582   124,798   0   109,134   69.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   11,273   0   0   1,473,912   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   321   6,174   0   0   2,696,241   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   2,696,241   73.00   74.00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   2,696,241   73.00   75.00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   2,696,241   73.00   75.00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   0   70,749   75.00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   0   0   0   75.00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   0   0   0   75.00   07400   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   0   0   0   0   75.00   07400   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   0   0   0   0   0   75.00   07400   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   0   0   0   0   0   0   75.00   07400   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   0   0   0   0   0   0   75.00   07400   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   0   0   0   0   0   0   0								1
69.00   66900   ELECTROCARDIOLOGY   620   5,616   71,908   0   109,134   69,00   100,00   7100   M2DICAL SUPPLIES CHARGED TO PATIENTS   0   11,273   0   0   0   1,473,912   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   321   6,174   0   0   2,696,241   73.00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   2,696,241   73.00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   2,696,241   73.00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   2,696,241   73.00   07000   070,449   88.00   08000   070,449   88.00   08000   070,449   88.00   08000   070,449   88.00   08000   070,449   88.00   08000   070,449   88.00   08000   070,449   88.00   08000   070,449   88.00   08000   070,449   88.00   08000   070,449   88.00   08000   070,449   070,000   070,449   070,000   070,449   070,000   070,449   070,000   070,449   070,000   070,449   070,000   070,449   070,000   070,449   070,000   070,449   070,000   070,000   070,449   070,000   07								•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 11,273 0 0 72.00 1MPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 120,318 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 321 6,174 0 0 2,696,241 73.00 75.00 07300 DRUGS CHARGED TO PATIENTS 321 6,174 0 0 2,696,241 73.00 75.00 07300 DRUGS CHARGED TO PATIENTS 321 6,174 0 0 10,727 0 198,847 76.00 03020 CARDIAC REHAB 5,627 0 100,727 0 198,847 76.00 03020 CARDIAC REHAB 5,627 0 100,727 0 198,847 76.00 03020 CARDIAC REHAB 5,627 0 100,727 0 198,847 76.00 03020 CARDIAC REHAB 5,627 0 100,727 0 198,847 76.00 03020 CARDIAC REHAB 5,627 0 100,727 0 198,847 76.00 03020 CARDIAC REHAB 5,627 0 100,727 0 198,847 76.00 03020 CARDIAC REHAB 5,627 0 100,727 198,01 189,01 036801 RURAL HEALTH CLINIC III 3,484 1,213 722,690 0 1,005,771 88.01 88.01 8803 RURAL HEALTH CLINIC III 6,859 2,288 866,331 0 1,570,956 88.02 88.04 08803 RURAL HEALTH CLINIC V 1,942 2,555 882,873 0 1,243,362 88.04 88.05 08804 RURAL HEALTH CLINIC V 2,551 1,203 455,005 0 635,092 88.05 080804 RURAL HEALTH CLINIC V 2,551 1,203 455,005 0 635,092 88.05 09000 09000 CLINIC 3,759 2,174 410,127 0 352,594 90.00 09000 CLINIC 3,759 2,174 410,127 0 352,594 90.00 09000 CLINIC 0 0 0 0 0 260,472 90.02 90.00 09000 CLINIC 0 0 0 0 0 260,472 90.02 91.00 09100 EMERGENCY 0 0 0 0 0 0 260,472 90.02 91.00 09100 EMERGENCY 0 0 0 0 0 0 260,472 90.02 91.00 09100 EMERGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68. 00		1, 018	582	124, 798	0	178, 198	68. 00
72. 00   07200   IMPL DEV. CHARGED TO PATIENT   0   0   0   0   2,69e,241   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   321   6,174   0   0   2,69e,241   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   5,627   0   100,727   0   198,847   76. 00   70. 00   7			1			0		
73.00   07300   DRUGS CHARGED TO PATIENTS   321   6, 174   0   0   2, 696, 241   73.00     76.00   03020   CARDI AC REHAB   5, 627   0   100, 727   0   198, 847     76.00   03020   CARDI AC REHAB   5, 627   0   100, 727   0   198, 847     76.00   03020   CARDI AC REHAB   76.00     76.00   03020   CARDI AC REHAB   76.00     77.00   03020   CARDI AC REHAB   76.00     78.01   03080   RURAL HEALTH CLINI C   1   3, 484   1, 213   722, 690   0   1, 005, 771     88. 01   03800   RURAL HEALTH CLINI C   1   3, 484   1, 213   722, 690   0   1, 570, 956     88. 02   03802   RURAL HEALTH CLINI C   1   6, 859   2, 288   866, 331   0   1, 570, 956   88.02     88. 03   03804   RURAL HEALTH CLINI C   1   2, 551   1, 203   455, 005   0   635, 092     88. 05   03804   RURAL HEALTH CLINI C   1   2, 551   1, 203   455, 005   0   635, 092     88. 05   03804   RURAL HEALTH CLINI C   1   3, 759   2, 174   410, 127   0   352, 594   90, 00     90. 01   09000   00000   00000   0   0   0   0			- I	11, 2/3	0	0		1
76. 00   03020  CARDIAC REHAB   5,627   0   100,727   0   198,847   76. 00   100,727   0   198,847   76. 00   100,727   0   100,727   0   100,727   0   100,727   0   100,727   0   100,727   0   100,727   0   100,727   0   100,727   10				6. 174		0		1
OUTPATLENT SERVICE COST CENTERS		03020 CARDI AC REHAB				Ö		1
88. 01 08801 RURAL HEALTH CLINIC II		OUTPATIENT SERVICE COST CENTERS						
88. 02 08802 RURAL HEALTH CLINIC III 6,859 2,288 866,331 0 1,570,956 88. 02 88. 04 08803 RURAL HEALTH CLINIC V 1,942 2,555 882,873 0 1,243,362 88. 05 08804 RURAL HEALTH CLINIC VI 2,551 1,203 455,005 0 635,092 88. 05 90. 00 09000 CLINIC 3,759 2,174 410,127 0 352,594 90. 00 90. 01 09001 ONCOLOGY 0 0 162,946 0 210,880 90. 01 90. 01 09001 ONCOLOGY 0 0 162,946 0 210,880 90. 01 91. 00 9002 PAIN MANAGEMENT 1,714 0 0 0 0 0 260,472 90. 02 91. 00 9002 PAIN MANAGEMENT 1,714 0 0 0 0 0 260,472 90. 02 91. 00 99002 PAIN MANAGEMENT 1,714 0 0 0 0 0 260,472 90. 02 91. 00 99200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 99200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 99. 10 09100 CORF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
88. 04   08803 RURAL HEALTH CLINIC V						0		1
88.05   08804 RURAL HEALTH CLINIC VI   2,551   1,203   455,005   0   635,092   88.05   90.00   09000   CLINIC   3,759   2,174   410,127   0   352,594   90.00   90.01   09001   ONCOLOGY   0   0   162,946   0   210,880   90.01   90.02   09002   PAI N MANAGEMENT   1,714   0   0   0   260,472   90.02   91.00   09100   EMERGENCY   6,450   13,369   1,153,503   0   2,608,095   91.00   92.00   09200   OSERVATION BEDS (NON-DISTINCT PART)   92.00   93.00   04040   OTHER OUTPATIENT SERVICE COST CENTER   5,834   452   573,554   0   459,339   93.00   07HER REIMBURSABLE COST CENTERS   10.00   0   0   0   0   0   101.00   HOME   HEALTH AGENCY   0   0   0   0   0   0   101.00   07HER REIMBURSABLE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   11500   HOSPI CE   585   0   267,933   0   641,816   116.00   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   217,807   965,196   22,442,987   -7,853,142   40,626,855   118.00   192.00   19200   PHYSI CLANS* PRI VATE OFFI CES   0   345   0   0   5,265,599   194.00   200.00   Cross Foot Adjustments   200.00   201.00   201.00   Unit cost multiplier (Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   0.0171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   0.0171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   1.2021   256,142   204.00   205.00   205.00   205.00   205.00   205.00   205.00   205.00   205.00   205.00   205.00   205.00   205.00						0		
90. 00   090000   CLINI C   3,759   2,174   410,127   0   352,594   90. 00   90. 01   09001   0NCOLOGY   0 0 0   162,946   0   210,880   90. 01   90. 02   09002   PAIN MANAGEMENT   1,714   0 0 0   0 260,472   90. 02   91. 00   09100   EMERGENCY   6,450   13,369   1,153,503   0   2,608,095   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   93. 00   04040   OTHER OUTPATI ENT SERVICE COST CENTER   5,834   452   573,554   0   459,339   93. 00   0THER REI MBURSABLE COST CENTERS   99. 10   101. 00   10100   HOME   HEALTH AGENCY   0   0   0   0   0   0   0THER REI MBURSABLE COST CENTERS   113. 00   113. 00   11300   INTEREST EXPENSE   113. 00   116. 00   11600   HOSPI CE   585   0   267,933   0   641,816   116. 00   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   217,807   965,196   22,442,987   -7,853,142   40,626,855   118. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   345   0   0   474   192. 00   194. 00   07951   OTHER NONREI MBURSABLE AND PHYSI CI AN   8,089   47,138   3,127,498   0   5,265,599   194. 00   200. 00   Cross Foot Adj ustments   200. 00   201. 00   Negative Cost Centers   201. 00   202. 00   Cost to be allocated (per Wkst. B, 2,903,495   1,390,788   5,425,625   7,853,142   202. 00   203. 00   Unit cost multiplier (Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203. 00   204. 00   Cost to be allocated (per Wkst. B, 2,400,400   256,142   204. 00								
90. 02		09000 CLI NI C			410, 127	0	352, 594	90. 00
91. 00   09100   EMERGENCY   6, 450   13, 369   1, 153, 503   0   2, 608, 095   91. 00   92. 00   09200   0952000   095200   095200   0952000   095200   0952000   0952000   0952000   0952000   09520000   09520000   095200000   095200000000000000000000000000000000000				0	162, 946	0		
92. 00				12 260	1 152 502	0		1
93. 00			0,430	13, 309	1, 155, 505	0	2, 000, 095	
OTHER REIMBURSABLE COST CENTERS   O			5, 834	452	573, 554	0	459, 339	
101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   0   0   101. 00   0   0   101. 00   0   0   101. 00   0   0   0   0   0   101. 00   0   0   0   0   101. 00   0   0   0   0   0   0   0   0   101. 00   0   0   0   0   0   0   0   0   0								
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   585   0   267, 933   0   641, 816   116. 00								1
113. 00 116.00 116.00 116.00 116.00 118.00  SUBTOTALS (SUM OF LINES 1 through 117)  NONREI MBURSABLE COST CENTERS  192. 00 192.00 194. 00 19200 194. 00 195. 0	101.00		0	0	0	0	0	101.00
116. 00   11600   HOSPI CE   SUBTOTALS (SUM OF LINES 1 through 117)   217,807   965,196   22,442,987   -7,853,142   40,626,855   118.00   NONREI MBURSABLE COST CENTERS   0   345   0   0   474   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   345   0   0   5,265,599   194.00   200.00   Cross Foot Adjustments   Cross Foot Adjustments   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   205.01   206.00   20	113 0							113 00
NONREI MBURSABLE COST CENTERS   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   345   0   0   474   192.00   194.00   19			585	0	267, 933	0	641, 816	
192. 00	118.00		217, 807	965, 196	22, 442, 987	-7, 853, 142	40, 626, 855	118. 00
194. 00   07951   OTHER NONREIMBURSABLE AND PHYSICIAN   200. 00   Cross Foot Adjustments   201. 00   Negative Cost Centers   Cost to be allocated (per Wkst. B, Part I)   12. 853238   1. 373375   12. 12. 12. 12. 12. 12. 12. 12. 12. 12.	400.0			0.45		1		
200.00   Cross Foot Adjustments   200.00   201.00   Negative Cost Centers   202.00   Cost to be allocated (per Wkst. B, Part I)   203.00   Unit cost multiplier (Wkst. B, Part I)   12.853238   1.373375   0.212183   0.171119   203.00   204.00   Cost to be allocated (per Wkst. B, Part I)   205.00   204.00   205			0 000					
201. 00			0, 089	47, 138	J, 127, 498		5, 205, 599	
202. 00     Cost to be allocated (per Wkst. B, Part I)     2,903,495     1,390,788     5,425,625     7,853,142     202. 00       203. 00     Unit cost multiplier (Wkst. B, Part I)     12.853238     1.373375     0.212183     0.171119     203. 00       204. 00     Cost to be allocated (per Wkst. B,     256,142     204. 00								1
203.00 Unit cost multiplier (Wkst. B, Part I) 12.853238 1.373375 0.212183 0.171119 203.00 204.00 Cost to be allocated (per Wkst. B, 256, 142 204.00		Cost to be allocated (per Wkst. B,	2, 903, 495	1, 390, 788	5, 425, 625		7, 853, 142	1
204.00   Cost to be allocated (per Wkst. B,   12,021   256,142 204.00	202 2		10.050000	1 070075	0.040400		0.474410	202 22
			12. 853238	1.3/33/5				
	231.00	Part II)			12, 321		200, 142	

Health Financial Systems	DAVIESS COMMUNI	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2018		
				Го 12/31/2018	Date/Time Pre 5/29/2019 4:3	
	CAPITAL REL	ATED COSTS				
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	1.00	2. 00	4. 00	5A	5. 00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 00047	O	0. 005581	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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0061 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY (SQUARE (MEALS REPAI RS PLANT LINEN SERVICE (SQUARE (SQUARE (POUNDS OF FEET) SERVED) FFFT) FEET) LAUNDRY) 9. 00 10.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 206, 291 6.00 00700 OPERATION OF PLANT 43, 386 162, 905 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 467 467 341, 744 8.00 9.00 00900 HOUSEKEEPI NG 1,546 1.546 27, 132 160, 892 9.00 01000 DI ETARY 4,054 4, 054 2, 378 4,054 40, 628 10.00 10.00 1, 485 1, 485 1, 485 11.00 01100 CAFETERI A 11.00 0 Λ 01300 NURSING ADMINISTRATION 13.00 2,983 2, 983 0 2, 983 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 4, 485 4, 485 0 4, 485 0 14.00 01500 PHARMACY 1, 815 0 1, 815 15.00 15.00 1.815 0 01600 MEDICAL RECORDS & LIBRARY 0 16.00 9, 898 9, 898 9, 898 0 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 13, 553 30.00 03000 ADULTS & PEDIATRICS 9.473 9. 473 79. 964 9. 473 30.00 11, 890 31.00 03100 INTENSIVE CARE UNIT 2, 391 2, 391 2, 391 3, 697 31.00 40.00 04000 SUBPROVI DER - I PF 9,842 9, 842 45, 182 9,842 18, 842 40.00 04100 SUBPROVI DER - I RF 41.00 8,674 8, 674 14, 268 8,674 4,536 41.00 04300 NURSERY 43.00 952 952 952 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13, 558 13, 558 40, 426 13, 558 0 50.00 51 00 05100 RECOVERY ROOM 0 51 00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 9,856 9,856 0 9,856 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 12, 166 12, 166 79, 411 12, 166 0 54.00 05600 RADI OI SOTOPE 56.00 1, 138 1, 138 1, 138 0 56.00 0 06000 LABORATORY 60 00 3, 406 0 60 00 3, 406 3.406 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 199 199 0 199 0 63.00 06400 INTRAVENOUS THERAPY 64.00 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 2,617 2, 617 4. 756 2,617 0 65.00 06600 PHYSI CAL THERAPY 6, 745 6, 745 6, 745 66.00 66.00 0 0 67.00 06700 OCCUPATIONAL THERAPY 1,437 1, 437 0 1, 437 0 67.00 06800 SPEECH PATHOLOGY 1, 018 68.00 1.018 1,018 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 620 620 0 620 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 321 321 0 321 0 73.00 03020 CARDI AC REHAB 0 76.00 5,627 5, 627 5, 627 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 4,865 4, 865 C 4, 865 0 88.00 88. 01 08801 RURAL HEALTH CLINIC II 3, 484 3, 484 1,890 3, 484 0 88.01 6, 859 6, 859 6, 859 08802 RURAL HEALTH CLINIC III 88.02 88.02 0 0 88.04 08803 RURAL HEALTH CLINIC V 1,942 1, 942 960 1.942 0 88.04 88.05 08804 RURAL HEALTH CLINIC VI 2,551 2, 551 2, 551 0 88.05 90.00 09000 CLI NI C 3, 759 3, 759 2, 573 3, 759 0 90.00 09001 ONCOLOGY 90.01 90.01 Ω C 0 0 09002 PAIN MANAGEMENT 1,714 1,714 1,714 90.02 90.02 0 91.00 09100 EMERGENCY 6, 450 30, 914 6, 450 O 91.00 6.450 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 5,834 5,834 0 5,834 0 93.00 OTHER REIMBURSABLE COST CENTERS 99 10 09910 CORF 0 0 99. 10 0 101.00 10100 HOME HEALTH AGENCY n 0 101.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116.00 585 585 0 585 SUBTOTALS (SUM OF LINES 1 through 117) 198, 202 40, 628 118. 00 118.00 154, 816 341, 744 152, 803 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 194.00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 8.089 8,089 0 8. 089 0 194 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2,509,053 2, 116, 734 445, 519 870, 930 414, 183 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 12. 162688 12.993671 1.303663 5. 413134 10. 194521 203. 00 Cost to be allocated (per Wkst. B, 86, 699 204. 00 204.00 127, 848 592, 111 10,055 35, 456 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.619746 3.634701 0.029423 0.220371 2. 133972 205. 00 11)

Health Financial System	ns	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STAT	ISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2018		
					Γo 12/31/2018		
						5/29/2019 4:3	U pm
Cost Cente	r Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE	(MEALS	
		(SQUARE	(SQUARE	(POUNDS OF	FEET)	SERVED)	
		FEET)	FEET)	LAUNDRY)	·		
		6.00	7. 00	8. 00	9. 00	10.00	
206.00 NAHE adjus	tment amount to be allocated						206. 00
(per Wkst.	B-2)						
207. 00 NAHE uni t	cost multiplier (Wkst. D,						207. 00
Parts III	and IV)						

COST A	LLOCATION - STATISTICAL BASIS		Provider CC		eri od:	Worksheet B-1	
				T T	rom 01/01/2018 o 12/31/2018		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/29/2019 4: 3 MEDI CAL	O pm
	cost center bescription	(HOURS	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		PAID)		SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT	(COSTED		(GROSS	
		11.00	NRSI NG HRS) 13.00	REQUI S. ) 14. 00	15. 00	CHARGES) 16.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
5. 00 6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	770 100					10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	779, 139 23, 525					11. 00 13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	13, 427		3, 223, 922			14. 00
15. 00	01500 PHARMACY	13, 939		6, 702	100		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	22, 474		45	0	146, 759, 845	1
17. 00	01700 SOCIAL SERVICE	5, 581	0	359	0	0	17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	90 E40	80, 540	83, 004	0	2 451 214	30.00
30.00	03100   NTENSI VE CARE UNIT	80, 540 22, 757		16, 665	0	2, 651, 214 3, 057, 878	1
	04000 SUBPROVI DER - I PF	76, 803			-	9, 596, 328	
41. 00	04100 SUBPROVI DER - I RF	25, 592				2, 180, 321	1
43.00	04300 NURSERY	9, 556	9, 556	9, 631	0	794, 329	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	44.040	14.0(0	440.000	ام	40 740 045	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	44, 060	44, 060 0	112, 322 0	0	10, 713, 215 0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	9, 427	· -	0	0	783, 635	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	29, 055		64, 853	-	24, 253, 352	
56.00	05600 RADI OI SOTOPE	5, 994				5, 926, 006	56. 00
60.00	06000 LABORATORY	49, 078				25, 925, 850	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	180, 120		915, 867	1
64. 00 65. 00	06400   NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	18, 838	0	0 35, 104	0	0 2, 445, 339	
66. 00	06600 PHYSI CAL THERAPY	35, 075		4, 800		3, 961, 015	1
67. 00	06700 OCCUPATI ONAL THERAPY	10, 109	1	0	0	1, 577, 068	1
68. 00	06800 SPEECH PATHOLOGY	3, 721		0	0	384, 437	1
	06900 ELECTROCARDI OLOGY	3, 071	1	5, 193	0	1, 203, 364	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1, 532, 551 0	0	6, 175, 294 562, 748	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	0	100	13, 643, 191	1
76. 00	03020 CARDI AC REHAB	3, 844	3, 844	_	0		1
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	16, 331					
	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	22, 528 31, 698		7, 687 6, 653		1, 313, 326 2, 490, 952	
88. 04	08803 RURAL HEALTH CLINIC V	18, 015	1	9, 271	0	1, 507, 818	
88. 05	08804 RURAL HEALTH CLINIC VI	15, 638	1	1, 817	0	752, 444	
90.00	09000 CLI NI C	8, 762		41, 625	0	1, 417, 159	90.00
90. 01	09001 ONCOLOGY	4, 981	1	2, 879	0	2, 148, 353	
90. 02 91. 00	09002 PAIN MANAGEMENT 09100 EMERGENCY	6, 371	1	0	0	551, 806 10, 135, 041	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	43, 734	43, 734	37, 426	U	10, 135, 041	91.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER	10, 627	0	158	0	629, 813	
	OTHER REIMBURSABLE COST CENTERS						1
	09910 CORF	0		0			99. 10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300   INTEREST EXPENSE						113. 00
	11600 HOSPI CE	11, 549	11, 549	47, 596	0	1, 302, 840	
118.00		696, 700				140, 364, 473	
	NONREI MBURSABLE COST CENTERS		,				4
	19200 PHYSI CLANS' PRI VATE OFFI CES	02 420	0	0	0		192.00
200.00	07951 OTHER NONREIMBURSABLE AND PHYSICIAN Cross Foot Adjustments	82, 439	0	9, 243	0	6, 395, 372	200.00
200.00							201. 00
202.00		597, 296	1, 351, 834	924, 481	1, 227, 151	1, 232, 441	
	Part I)						
203.00		0. 766610	1		12, 271. 510000	0.008398	1
204.00	Cost to be allocated (per Wkst. B, Part II)	28, 526	64, 433	90, 590	99, 704	179, 468	204.00
205.00		0. 036612	0. 156395	0. 028099	997. 040000	0. 001223	205. 00
200.00	II)	3. 000012	3. 100070	3.020077	777.010000	3. 001220	
	·		<u> </u>		<u>'</u>		

Heal th Finar	ncial Systems	DAVIESS COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC	Provider CCN: 15-0061		Worksheet B-1	
					From 01/01/2018 To 12/31/2018	Doto/Time Dro	nanad.
					10 12/31/2018	Date/Time Pre 5/29/2019 4:3	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(HOURS	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		PAI D)		SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT	(COSTED		(GROSS	
			NRSING HRS)	REQUIS.)		CHARGES)	
		11. 00	13.00	14.00	15.00	16.00	
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)						

Health FinancialSystemsDAVIESS COMMUNITY HOSPITALIn Lieu of Form CMS-2552-10COST ALLOCATION - STATISTICAL BASISProvider CCN: 15-0061Period: From 01/01/2018Worksheet B-1

12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm Cost Center Description SOCIAL SERVICE (TIME SPENT) 17.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 5,580 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 107 30.00 31.00 03100 INTENSIVE CARE UNIT 124 31.00 40.00 04000 SUBPROVI DER - I PF 2, 175 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 5 04300 NURSERY 43.00 0 43 00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 51 00 05100 RECOVERY ROOM 00000000000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 05600 RADI OI SOTOPE 56.00 56.00 06000 LABORATORY 60 00 60 00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 06400 INTRAVENOUS THERAPY 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 03020 CARDI AC REHAB 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 88. 01 08801 RURAL HEALTH CLINIC II 0 0 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 88.04 08803 RURAL HEALTH CLINIC V 88.04 0 88.05 08804 RURAL HEALTH CLINIC VI 88.05 90.00 09000 CLI NI C 90.00 0 09001 ONCOLOGY 90.01 90.01 09002 PAIN MANAGEMENT 0 90.02 90.02 91.00 09100 EMERGENCY 538 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 122 93.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 99.10 101.00 10100 HOME HEALTH AGENCY 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 2.509 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 5, 580 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 194.00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 0 194 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 134, 112 202.00 Part I) 203.00 l203. 00 Unit cost multiplier (Wkst. B, Part I) 24.034409 Cost to be allocated (per Wkst. B, 204. 00 204.00 941 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.168638 205.00 11)

Heal th Finar	ncial Systems	DAVIESS COMMUNITY	/ HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der 0	CCN: 15-0061	Peri od:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	nared.
					12,01,2010	5/29/2019 4:3	
	Cost Center Description	SOCIAL SERVICE					
		/TIME					
		(TIME					
		SPENT)					
		17. 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)						

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0061	Period: Worksheet C From 01/01/2018 Part I
		To 12/31/2018 Date/Time Prepared

Cost Center Description					1	o 12/31/2018	Date/Time Pre 5/29/2019 4:3	pared:
NPATI ENT BOUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00				Title	XVIII	Hospi tal		о рііі
Total Costs				11 21 0	7,,,,,,			
INPATIENT ROUTINE SERVICE COST CENTERS   2,0   3,00   4,00   5,00   3,00   3,00   4,00   5,00   3,		Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
Near   Service   Near		occi contor boson per on			10101 00010		70141 00010	
INPATI ENT ROUTI NE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00				7.09		Di Gai i Gilanos		
INPAILENT ROUTI NE SERVICE COST CENTERS   3, 989, 193   3, 1989, 193   3, 1989, 1939, 199, 199, 199, 199, 199, 199, 1								
INPATIENT ROUTINE SERVICE COST CENTERS   3, 989, 193   0, 3, 989, 193   0, 00   300 00   300 00   AULTS & PEDIATRIC SS   3, 989, 193   0, 00   3, 989, 193   0, 00   3, 989, 193   0, 00   3, 989, 193   0, 00   3, 989, 193   0, 00   3, 989, 193   0, 00   3, 989, 193   0, 00   3, 989, 193   0, 00   3, 989, 193   0, 00   3, 989, 193   0, 00   41, 00   00   4000   SUPRPOVIDER - IPF   3, 528, 867   0, 3, 528, 867   0, 3, 528, 867   0, 15, 516, 375   1, 516, 375   0, 15, 516, 375   1, 516, 375   0, 15, 516, 375   1, 516, 375   0, 15, 516, 375   1,				2.00	3. 00	4. 00	5. 00	
30.00   03000   ADULTS & PEDIATRICS   3, 989, 193   3, 099, 193   30.00   3.00   3.00   3.00   117.85   NE CARE UNIT   1, 213, 868   1, 213, 868   0, 1, 213, 868   1, 213, 868   0, 1, 213, 868   1, 213, 868   1, 213, 868   0, 1, 213, 868   1, 213, 83   1, 213, 83   1, 213, 83   1, 213, 83   1,		INPATIENT ROUTINE SERVICE COST CENTERS						
31.00   03100   INTERSIVE CARE UNIT   1, 213, 868   3, 213, 868   0   1, 213, 868   31.00   04100   SUBPROVI DER - IPF   3, 528, 867   3, 528, 367   0   3, 528, 367   01.516, 375   41.00   41.00   41.00   SUBPROVI DER - IPF   1, 516, 375   5.1516, 375   0   1, 516, 375   41.00   43.00   42300   UNISCERY   50.00   50.00   SUBCOM UNISCERY   50.00   510, 785   43.00   43.00   42300   OPERATI IN GROOM   3, 183, 325   0   3, 183, 325   0   0, 3, 183, 325   50.00   51.00   51.00   05100   PERATINE ROOM   902, 541   50.00   51.00   52.00   05200   DELIVERY ROOM   64.00   6	30.00		3, 989, 193		3, 989, 193	ol ol	3, 989, 193	30.00
40.00   04000   04000   04000   04000   0500   0500   040000   040000   040000   040000   040000   040000   040000   0400000   040000000   0400000000								
1. 10.0   0.4100   0.4100   0.4100   0.4100   0.4100   0.4100   0.510, 785   0.51								1
A3 00   O4300   NURSERY   510,785   510,785   510,785   510,785   510,785   510,785   510,785   510,785   510,785   510,785   510,785   510,785   510,000   5200   05000   05000   05000   051000   051000   051000   051000   051000   051000   051000   051000   051000   051000   051000   051000								1
AMCILLARY SERVICE COST CENTERS   S			1					1
SOLID   CONTROL   CONTRO	101.00		0.07700		0.07.00	۹۱	0.07,00	10.00
51.00	50 00		3 183 325		3 183 325	ol ol	3 183 325	50.00
S2.00   05200   DELIVERY ROOM & LABOR ROOM   902, 541   902, 541   0   940, 541   52.00			1					1
S4-00   OS400 RADI OLOGY-DI ACNOSTIC   2,930,737   2,930,737   54.00					1		902 541	1
56.00   0500   CADO						١		1
60.00   06000   LABORATORY   3,901,306   3,901,306   0   3,901,306   63.00								
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   301, 614   301, 614   0   301, 614   63.00   64.00   06400   INTRAVENDUS THERAPY   1, 025, 353   0   1, 025, 353   0   1, 025, 353   0   66.00   06500   RESPIRATORY THERAPY   2, 012, 243   0   2, 012, 243   0   2, 012, 243   0   66.00   06600   PHYSI CAL THERAPY   2, 012, 243   0   2, 012, 243   0   67.00   06700   OCCUPATIONAL THERAPY   497, 105   0   68.00   06600   SPEECH PATHOLOGY   245, 894   0   245, 894   0   69.00   06600   SPEECH PATHOLOGY   245, 894   0   245, 894   0   69.00   06600   SPEECH PATHOLOGY   160, 711   160, 711   0   160, 711   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   2, 217, 456   0   2, 217, 456   0   2, 217, 456   72.00   07200   IMPL. DEV. CHARGED TO PATIENT   145, 633   145, 633   0   145, 633   72.00   73.00   07300   DRUGS CHARGED TO PATIENT   4, 509, 159   0   4, 509, 159   0   76.00   03020   CARDI AC REHAB   422, 810   422, 810   0   422, 810   0   76.00   03020   CARDI AC REHAB   422, 810   422, 810   0   422, 810   0   88.00   08800   RURAL HEALTH CLINIC   1   1, 317, 349   1, 317, 349   1, 317, 349   88. 01   88.01   08800   RURAL HEALTH CLINIC   1   2, 096, 580   80. 2, 096,								
64-00   06400   06400   NTEAVENOUS THERAPY   0   0   0   0   0   0   65.00     65.00   06500   RESPIRATORY THERAPY   1,025,353   0   1,025,353   0   0,025,3			1					ł
65.00   06500   RESPI RATORY THERAPY   1, 025, 353   0   1, 025, 353   0   1, 025, 353   65.00   66.00   06600   OFFICIAL THERAPY   2, 012, 243   0   2, 012, 243   0   2, 012, 243   0   66.00   06700   OCCUPATI ONAL THERAPY   497, 105   0   497, 105   0   497, 105   0   68.00   06800   SPEECH PATHOLOGY   245, 894   0   245, 894   0   245, 894   0   245, 894   0   69.00   06900   ELECTROCARDI OLOGY   160, 711   160, 711   0   160, 711   0   160, 711   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   2, 217, 456   2, 217, 456   0   2, 217, 456   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENT   145, 633   145, 633   0   145, 633   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   4, 509, 159   4, 509, 159   0   4, 509, 159   0   76.00   03020   CARDI AC REHAB   422, 810   422, 810   0   422, 810    88.00   08800   RURAL HEALTH CLINIC   1   1, 317, 349   1, 317, 349   0   1, 317, 349   88.01   08801   RURAL HEALTH CLINIC   1   1, 317, 349   1, 317, 349   0   1, 317, 349   88.02   08802   RURAL HEALTH CLINIC   1   2, 096, 580   2, 096, 580   0   2, 096, 580   0   88.04   08803   RURAL HEALTH CLINIC   1   840, 579   840, 579   840, 579   0   840, 579   80, 059   89.00   09000   CLINIC   C   561, 749   561, 749   7, 730   569, 479   90, 00   90.01   09000   CLINIC   C   561, 749   561, 749   7, 730   569, 479   90, 00   90.02   09000   CLINIC   C   561, 749   561, 749   7, 730   569, 479   90, 00   90.02   09000   CLINIC   C   561, 749   561, 749   7, 730   569, 479   90, 00   90.02   09000   CLINIC   C   561, 749   561, 749   7, 730   569, 479   90, 00   90.02   09000   CLINIC   C   561, 749   7, 730   569, 479   90, 00   90.03   09000   CLINIC   C   561, 749   7, 730   569, 479   90, 00   90.04   09000   CLINIC   C   561, 749   7, 730   569, 479   90, 00   90.05   09000   CLINIC   C   561, 749   7, 730   569, 479   90, 00   90.00   09000   CLINIC   C   561, 749   7, 730   569, 479   90, 00   90.00   09000   CLINIC   C   561, 749   7, 730   569, 479   90, 00   90.00   09000   CLINIC   C   561, 749		· ·						1
66.00   06600   PHYSI CAL THERAPY   2, 012, 243   0   2, 012, 243   0   2, 012, 243   0   0   0   0   0   0   0   0   0			_	_	1	1 1	_	
67. 00   06700   0CCUPATI ONAL THERAPY   497, 105   0   497, 105   0   497, 105   67. 00   68. 00   06800   SPEECH PATHOLOGY   245, 894   0   242, 810   0   22, 217, 456   71. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   4, 509, 159   4, 509, 159   0   4, 509, 159   73. 00   73.						_		
68.00 06800 SPEECH PATHOLOGY 245, 894 0 225, 894 0 69.00 66900 ELECTROCARDIOLOGY 160, 711 1 160, 711 0 1 145, 633 1 145, 633 0 145, 633 1 2.00 145, 633 172, 00 14					_, -, ,			•
69. 00   06900   ELECTROCARDI OLOGY   160, 711   160, 711   0   160, 711   69. 00   711. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   2, 217, 456   2, 217, 456   0   2, 217, 456   71. 00   713. 00   707. 00				0	,			•
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   2, 217, 456   2, 217, 456   0   2, 217, 456   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   145, 633   145, 633   0   145, 633   72. 00   73.			The state of the s	U				
72. 00								l
73. 00   07300   DRUGS CHARGED TO PATIENTS   4,509,159   4,509,159   0   4,509,159   76.00   03020   CARDI AC REHAB   422,810   0   422,810   0   422,810   76.00   00   0   0   0   0   0   0   0   0								1
76. 00 03020 CARDI AC REHAB 422, 810 422, 810 0 422, 810 0 422, 810 0 000 000 0000 CENTRY SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC C 1, 317, 349 1, 317, 349 0 1, 317, 349 88. 01 8800 RURAL HEALTH CLINIC III 1, 317, 349 1, 317, 349 0 1, 317, 349 88. 01 8802 RURAL HEALTH CLINIC III 2, 096, 580 2, 096, 580 0 2, 096, 580 0 2, 096, 580 0 8803 RURAL HEALTH CLINIC V 1, 545, 875 1, 545, 875 0 1, 545, 875 0 8804 RURAL HEALTH CLINIC V 1, 545, 875 1, 545, 875 0 1, 545, 875 80. 08804 RURAL HEALTH CLINIC V 1 840, 579 840, 579 0 840, 579 0 840, 579 90. 00 09000 CLINIC 561, 749 561, 749 7, 730 569, 479 90. 00 09000 CLINIC 561, 749 561, 749 7, 730 569, 479 90. 00 09000 PAIN MANAGEMENT 366, 958 366, 958 0 366, 958 0 0 366, 958 90. 02 09002 PAIN MANAGEMENT 366, 958 360, 958 0 366, 958 90. 02 09002 PAIN MANAGEMENT 366, 958 360, 958 0 366, 958 90. 02 09000 BERRYATION BEDS (NON-DISTINCT PART) 1, 340, 833 1, 340,							•	1
SERVICE COST CENTERS   SERVICE COST CENTER   SERVICE COST CENTERS   SE		1						•
88. 00   08800   RURAL HEALTH CLINIC   1, 234, 174   1, 234, 174   0   1, 234, 174   88. 00   88. 01   08801   RURAL HEALTH CLINIC   1   1, 317, 349   1, 317, 349   0   1, 317, 349   88. 01   88. 02   08802   RURAL HEALTH CLINIC   11   2, 096, 580   2, 096, 580   0   2, 096, 580   88. 02   88. 04   08803   RURAL HEALTH CLINIC   1, 545, 875   1, 545, 875   0   1, 545, 875   0   1, 545, 875   0   1, 545, 875   0   1, 545, 875   0   1, 545, 875   0   1, 545, 875   1, 545, 875   0   1, 545, 875   840, 579   840, 579   0   840, 579   88. 05   90. 00   09000   09000   00000   00000   00000   00000   00000   00000   00000   00000   000000	76.00		422,810		422, 810	)  0	422, 810	76.00
88. 01	00.00	OUTPATIENT SERVICE COST CENTERS	4 004 474		4 004 47		4 004 474	00.00
88. 02   08802   RURAL HEALTH CLINIC III   2, 096, 580   2, 096, 580   0   2, 096, 580   88. 02   88. 04   08803   RURAL HEALTH CLINIC V   1, 545, 875   1, 545, 875   0   1, 545, 875   88. 04   88. 05   08804   RURAL HEALTH CLINIC VI   840, 579   840, 579   0   840, 579   0   840, 579   88. 05   90. 00   09000   CLINIC   561, 749   561, 749   7, 730   569, 479   90. 00   90. 01   09001   0NCOLOGY   269, 652   269, 652   269, 652   0   269, 652   90. 01   90. 02   09002   PAIN MANAGEMENT   366, 958   366, 958   366, 958   0   366, 958   90. 02   91. 00   09100   EMERGENCY   3, 577, 670   3, 577, 670   0   3, 577, 670   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1, 340, 833   1, 340, 833   1, 340, 833   1, 340, 833   22. 00   93. 00   094040   OTHER OUTPATIENT SERVICE COST CENTER   732, 696   732, 696   8, 748   741, 444   93. 00   0THER REIMBURSABLE COST CENTERS   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   101. 00   11300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   113. 00   11600   HOSPICE   901, 166   901, 166   901, 166   116. 00   200. 00   Subtotal (see instructions)   48, 552, 886   0   48, 552, 886   16, 478   48, 569, 364   200. 00   201. 00   Less Observation Beds   1, 340, 833   1, 340, 833   201. 00								
88. 04								
88. 05			1					
90. 00								
90. 01			1		·		•	1
90. 02							•	1
91. 00			1		·		•	1
92. 00								
93. 00								1
OTHER REIMBURSABLE COST CENTERS   99. 10   099. 10   099. 10   101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   0   101. 00   101. 00   SPECI   AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   11600   HOSPI CE   901, 166   901, 166   901, 166   116. 00   200. 00   Subtotal (see instructions)   48, 552, 886   0   48, 552, 886   16, 478   48, 569, 364   200. 00   201. 00   Less Observation   Beds   1, 340, 833   1, 340, 833   1, 340, 833   201. 00   10								
99. 10	93. 00		732, 696		732, 696	8, 748	741, 444	93. 00
101. 00					T			
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   11600								
113. 00	101.00		0		[		0	101. 00
116. 00     11600     HOSPI CE     901, 166     901, 166     901, 166     901, 166     901, 166     116. 00       200. 00     Subtotal (see instructions)     48, 552, 886     0     48, 552, 886     16, 478     48, 569, 364     200. 00       201. 00     Less Observation Beds     1, 340, 833     1, 340, 833     1, 340, 833     1, 340, 833						,		
200. 00     Subtotal (see instructions)     48, 552, 886     0     48, 552, 886     16, 478     48, 569, 364     200. 00       201. 00     Less Observation Beds     1, 340, 833     1, 340, 833     1, 340, 833     1, 340, 833								•
201. 00 Less Observation Beds 1, 340, 833 1, 340, 833 1, 340, 833 201. 00			1					
		,						
202.00   Total (see instructions)   47,212,053  0  47,212,053  16,478  47,228,531 202.00			The state of the s					
	202.00		47, 212, 053	0	47, 212, 053	16, 478	47, 228, 531	202. 00

					To 12/31/2018	Date/Time Pre 5/29/2019 4:3	pared: O pm
-			Title	XVIII	Hospi tal	PPS	<u> </u>
			Charges		·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·	·	+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	2, 651, 214		2, 651, 21			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	3, 057, 878		3, 057, 87			31. 00
40. 00	04000 SUBPROVI DER - I PF	9, 596, 328		9, 596, 32			40. 00
41.00	04100 SUBPROVI DER – I RF	2, 180, 321		2, 180, 32			41.00
43. 00	04300 NURSERY	794, 329		794, 32	9		43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	2 (52 502	0.0/0.712	10 712 21	0 207140	0.000000	
50.00	05000 OPERATING ROOM	2, 652, 502	8, 060, 713			0.000000	
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	701, 997	01 (20		0.000000	0. 000000 0. 000000	1
52. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 824, 531	81, 638 20, 428, 821	783, 63 24, 253, 35		0. 000000	1
56. 00	05600 RADI OLOGY - DI AGNOSTI C	660, 795	5, 265, 211	5, 926, 00		0. 000000	•
60.00	06000 LABORATORY	6, 801, 401	19, 124, 449			0. 000000	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	527, 269	388, 598			0. 000000	•
64. 00	06400 I NTRAVENOUS THERAPY	327, 209	300, 340		0. 000000	0. 000000	1
65. 00	06500 RESPIRATORY THERAPY	1, 207, 359	1, 237, 980			0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	797, 212	3, 163, 803	3, 961, 01		0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	552, 183	1, 024, 885	1, 577, 06		0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	83, 788	300, 649	384, 43		0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	324, 880	878, 484	1, 203, 36		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 654, 246	4, 521, 048			0. 000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	220, 022	342, 726	562, 74		0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 497, 807	8, 145, 384			0. 000000	
76. 00	03020 CARDI AC REHAB	138	229, 842			0. 000000	76. 00
70.00	OUTPATIENT SERVICE COST CENTERS		22,7012	22,7,0	1, 000 10 1	0.00000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	1, 134, 490	1, 134, 49	o		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	o	1, 313, 326	1, 313, 32	6		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	ol	2, 490, 952				88. 02
88. 04	08803 RURAL HEALTH CLINIC V	o	1, 507, 818				88. 04
88. 05	08804 RURAL HEALTH CLINIC VI	o	752, 444				88. 05
90.00	09000 CLI NI C	56, 448	1, 360, 711	1, 417, 15	9 0. 396391	0.000000	90.00
90. 01	09001 ONCOLOGY	98	2, 148, 255			0.000000	90. 01
90. 02	09002 PAIN MANAGEMENT	o	551, 806	551, 80	6 0. 665013	0.000000	90. 02
91.00	09100 EMERGENCY	1, 446, 743	8, 688, 097	10, 134, 84	0. 353007	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	297, 442	1, 315, 568	1, 613, 01	0. 831261	0.000000	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	3, 166	626, 848	630, 01	4 1. 162984	0.000000	93. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0		0		99. 10
101.00	10100 HOME HEALTH AGENCY	0	0		0		101. 00
	SPECIAL PURPOSE COST CENTERS	· ·					
	11300 INTEREST EXPENSE				_		113. 00
	11600 H0SPI CE	0	1, 302, 840				116. 00
200.00		45, 590, 097	96, 387, 386	141, 977, 48	3		200.00
201.00		45 500 055	0/ 607 65	444 077 :-			201. 00
202.00	Total (see instructions)	45, 590, 097	96, 387, 386	141, 977, 48	<b>პ</b>		202. 00

Health Financial Systems	DAVIESS COMMUNITY	' HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0061	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 4:30 pm

					5/29/2019 4:30 pm
			Title XVIII	Hospi tal	PPS
Cost Center D	escription	PPS Inpatient			
		Ratio			
		11. 00			
	SERVICE COST CENTERS				
30.00  03000 ADULTS & PEDI					30.00
31.00  03100 INTENSIVE CAR	RE UNIT				31.00
40. 00   04000   SUBPROVI DER -	IPF				40. 00
41. 00   04100   SUBPROVI DER -	IRF				41. 00
43. 00   04300 NURSERY					43.00
ANCILLARY SERVICE (	COST CENTERS				
50.00 05000 OPERATING ROC	M	0. 297140			50. 00
51.00  05100 RECOVERY ROOM	1	0. 000000			51.00
52.00  05200 DELIVERY ROOM	1 & LABOR ROOM	1. 151736			52.00
54. 00   05400 RADI OLOGY-DI A	GNOSTI C	0. 120838			54.00
56. 00 05600 RADI 0I SOTOPE		0. 093339			56.00
60. 00 06000 LABORATORY		0. 150479			60.00
	, PROCESSING & TRANS.	0. 329321			63.00
64. 00   06400   NTRAVENOUS T		0. 000000			64. 00
65. 00   06500 RESPIRATORY T		0. 419309			65. 00
66. 00 06600 PHYSI CAL THER		0. 508012			66.00
67. 00 06700 OCCUPATI ONAL		0. 315208			67. 00
68. 00 06800 SPEECH PATHOL		0. 639621			68. 00
69. 00 06900 ELECTROCARDI 0		0. 133551			69. 00
	IES CHARGED TO PATIENTS	0. 359085			71. 00
72.00 07200 IMPL. DEV. CH		0. 258789			72. 00
73. 00 07300 DRUGS CHARGED		0. 330506			73. 00
76. 00 03020 CARDI AC REHAE		1. 838464			76. 00
OUTPATIENT SERVICE		1.030404			70.00
88. 00 08800 RURAL HEALTH					88. 00
88. 01   08801 RURAL HEALTH					88. 0
88. 02   08802   RURAL HEALTH					88. 02
88. 04   08803   RURAL HEALTH					88. 04
88. 05   08804 RURAL HEALTH					88. 05
90. 00 09000 CLINIC	CETIVIC VI	0. 401846			90.00
90. 01 09001 0NCOLOGY		0. 125516			90.0
90. 02   09002   PALN MANAGEME	NT	0. 665013			90.02
91. 00   09100   EMERGENCY	141	0. 353007			91.00
	BEDS (NON-DISTINCT PART)	0. 831261			92.00
	ENT SERVICE COST CENTER	1. 176869			93.00
OTHER REIMBURSABLE		1. 170009			93.00
99. 10 09910 CORF	COST CLIVIERS				99. 10
101.00 10100 HOME HEALTH A	CENCY				101. 00
SPECIAL PURPOSE COS					
113. 00 11300 I NTEREST EXPE					113. 00
116. 00 11600 HOSPI CE	INOL				116. 00
	instructions)				200. 00
	e instructions)				200. 00
201.00 Less Observat					201.00
202.00   Total (see in	isti uCti Ulis)				J202. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0061	Peri od:	Worksheet C
		From 01/01/2018	
		To 10/01/0010	Doto/Time Dropored.

			1	o 12/31/2018	Date/Time Pre 5/29/2019 4:3	pared: O nm
		Ti tl	e XIX	Hospi tal	Cost	Орш
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.	,				
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 989, 193		3, 989, 193	8 0	3, 989, 193	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 213, 868		1, 213, 868		1, 213, 868	
40. 00   04000   SUBPROVI DER - I PF	3, 528, 367		3, 528, 367		3, 528, 367	
41. 00   04100   SUBPROVI DER -   I RF	1, 516, 375		1, 516, 375		1, 516, 375	
43. 00   04300   NURSERY	510, 785	ł	510, 785		510, 785	
ANCILLARY SERVICE COST CENTERS				-1	2127122	
50. 00 05000 OPERATI NG ROOM	3, 183, 325		3, 183, 325	5 0	3, 183, 325	50.00
51. 00 05100 RECOVERY ROOM	0	i e	(	1	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	902, 541		902, 541		902, 541	52. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	2, 930, 737		2, 930, 737	-	2, 930, 737	54.00
56. 00   05600   RADI OI SOTOPE	553, 130		553, 130		553, 130	
60. 00   06000   LABORATORY	3, 901, 306		3, 901, 306		3, 901, 306	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	301, 614	ŀ	301, 614		301, 614	1
64. 00 06400 I NTRAVENOUS THERAPY	001,011		001,01		0	64. 00
65. 00 06500 RESPIRATORY THERAPY	1, 025, 353	0	1	ή	1, 025, 353	
66. 00 06600 PHYSI CAL THERAPY	2, 012, 243	l			2, 012, 243	
67. 00 06700 OCCUPATI ONAL THERAPY	497, 105	l			497, 105	1
68. 00 06800 SPEECH PATHOLOGY	245, 894	l .	245, 894		245, 894	
69. 00   06900   ELECTROCARDI OLOGY	160, 711	0	160, 711		160, 711	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 217, 456		2, 217, 456		2, 217, 456	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	145, 633	l	145, 633		145, 633	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 509, 159		4, 509, 159		4, 509, 159	
76. 00   03020   CARDI AC   REHAB	4, 504, 154		422, 810		4, 309, 139	1
OUTPATIENT SERVICE COST CENTERS	422,010		422,010	<u>/ </u>	422,010	70.00
88. 00 08800 RURAL HEALTH CLINIC	1, 234, 174		1, 234, 174	0	1, 234, 174	88. 00
88. 01   08801 RURAL HEALTH CLINIC II	1, 317, 349		1, 317, 349		1, 317, 349	88. 01
88. 02   08802 RURAL HEALTH CLINIC III	2, 096, 580		2, 096, 580		2, 096, 580	
88. 04   08803 RURAL HEALTH CLINIC V	1, 545, 875	l e	1, 545, 875		1, 545, 875	
88. 05   08804 RURAL HEALTH CLINIC VI	840, 579		840, 579		840, 579	
90. 00   09000   CLI NI C	561, 749	l e	561, 749		569, 479	
90. 01   09001   0NCOLOGY	269, 652		269, 652		269, 652	
90. 01   09001   0NCOLOGT 90. 02   09002   PALN MANAGEMENT	366, 958	l e	366, 958	1	366, 958	
91. 00   09100   EMERGENCY	3, 577, 670		3, 577, 670		3, 577, 670	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 340, 833	l e	1, 340, 833		1, 340, 833	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	732, 696		732, 696		741, 444	
OTHER REIMBURSABLE COST CENTERS	/32, 090		/32, 090	8, 748	741, 444	93.00
99. 10 09910 CORF	0				0	99. 10
101.00 10100 HOME HEALTH AGENCY						101.00
				)	U	101.00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	001 144		001 144		001 144	
	901, 166		901, 166		901, 166	
200.00 Subtotal (see instructions) 201.00 Less Observation Beds	48, 552, 886		48, 552, 88 <i>6</i> 1, 340, 833		48, 569, 364	
201.00 Less observation Beds 202.00 Total (see instructions)	1, 340, 833				1, 340, 833	
202.00    Total (See Histructions)	47, 212, 053	ı	47, 212, 053	16, 478	47, 228, 531	1202.00

				o 12/31/2018	Date/Time Pre 5/29/2019 4:3	
		Ti tl	e XIX	Hospi tal	Cost	о рііі
		Charges	<u> </u>	1100p1 tu	0001	
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
, , , , , , , , , , , , , , , , , , ,			+ col. 7)	Ratio	Inpati ent	
			,		Rati o	
	6.00	7.00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	2, 651, 214		2, 651, 214			30.00
31.00 03100 INTENSIVE CARE UNIT	3, 057, 878		3, 057, 878			31. 00
40. 00   04000   SUBPROVI DER - 1 PF	9, 596, 328		9, 596, 328			40. 00
41. 00   04100   SUBPROVI DER - I RF	2, 180, 321		2, 180, 321			41. 00
43. 00 04300 NURSERY	794, 329		794, 329			43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	2, 652, 502	8, 060, 713			0. 000000	50.00
51. 00   05100   RECOVERY ROOM	0	0	(	0.00000	0. 000000	1
52. 00   05200   DELI VERY ROOM & LABOR ROOM	701, 997	81, 638			0. 000000	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 824, 531	20, 428, 821	24, 253, 352		0. 000000	
56. 00   05600   RADI 01 SOTOPE	660, 795	5, 265, 211	5, 926, 006		0. 000000	
60. 00   06000   LABORATORY	6, 801, 401	19, 124, 449			0. 000000	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	527, 269	388, 598	915, 867		0. 000000	
64. 00   06400   I NTRAVENOUS THERAPY	0	0	(	0.000000	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	1, 207, 359	1, 237, 980			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	797, 212	3, 163, 803	3, 961, 015		0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	552, 183	1, 024, 885	1, 577, 068		0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY	83, 788	300, 649			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	324, 880	878, 484	1, 203, 364		0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 654, 246	4, 521, 048			0.000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	220, 022	342, 726			0.000000	
73. 00   07300   DRUGS CHARGED TO PATLENTS 76. 00   03020   CARDI AC REHAB	5, 497, 807	8, 145, 384			0.000000	73.00
OUTPATIENT SERVICE COST CENTERS	138	229, 842	229, 980	1. 838464	0. 000000	76. 00
88. 00 08800 RURAL HEALTH CLINIC	O	1, 134, 490	1, 134, 490	1. 087867	0. 000000	88. 00
88. 01   08801 RURAL HEALTH CLINIC   I	0	1, 134, 490			0.000000	88. 01
88. 02   08802 RURAL HEALTH CLINIC III	0	2, 490, 952	2, 490, 952		0.000000	88. 02
88. 04   08803   RURAL HEALTH CLINIC V	0	1, 507, 818			0.000000	
88. 05   08804 RURAL HEALTH CLINIC VI	0	752, 444			0.000000	
90. 00   09000   CLI NI C	56, 448	1, 360, 711	1, 417, 159		0.000000	
90. 01   09001 ONCOLOGY	98	2, 148, 255			0.000000	
90. 02   09002   PAI N MANAGEMENT	70	551, 806			0.000000	90.01
91. 00   09100   EMERGENCY	1, 446, 743	8, 688, 097			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	297, 442	1, 315, 568			0.000000	
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	3, 166	626, 848			0. 000000	
OTHER REIMBURSABLE COST CENTERS	3, 100	020, 040	030, 014	1. 102 704	0.000000	73.00
99. 10 09910 CORF	0	0	(			99. 10
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   NTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	0	1, 302, 840	1, 302, 840	)		116. 00
200.00 Subtotal (see instructions)	45, 590, 097	96, 387, 386				200.00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	45, 590, 097	96, 387, 386	141, 977, 483	s		202. 00
				'		

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-006	Peri od: Worksheet C From 01/01/2018 Part I Date/Ti me Prepared: 5/29/2019 4:30 pm

					5/29/2019 4:30 pm
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
INP	PATIENT ROUTINE SERVICE COST CENTERS				
30.00 030	000 ADULTS & PEDIATRICS				30.00
31.00 031	100 INTENSIVE CARE UNIT				31.00
40.00 040	000 SUBPROVI DER - I PF				40. 00
41.00 041	100 SUBPROVI DER - I RF				41.00
43.00 043	800 NURSERY				43. 00
ANC	CILLARY SERVICE COST CENTERS				
50.00 050	OOO OPERATING ROOM	0. 000000			50.00
51.00 051	100 RECOVERY ROOM	0. 000000			51.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54.00 054	100 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
56.00 056	600 RADI OI SOTOPE	0. 000000			56. 00
	000 LABORATORY	0. 000000			60.00
63. 00 063	BOO BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
	100 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 065	500 RESPIRATORY THERAPY	0. 000000			65. 00
	500 PHYSI CAL THERAPY	0. 000000			66. 00
•	700 OCCUPATIONAL THERAPY	0. 000000			67. 00
	BOO SPEECH PATHOLOGY	0. 000000			68.00
	POO ELECTROCARDI OLOGY	0. 000000			69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
	200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
	BOO DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	020 CARDI AC REHAB	0. 000000			76.00
	PATIENT SERVICE COST CENTERS	0.00000			70.00
	BOO RURAL HEALTH CLINIC	0. 000000			88. 00
	301 RURAL HEALTH CLINIC II	0. 000000			88. 0
	302 RURAL HEALTH CLINIC III	0. 000000			88. 02
1	303 RURAL HEALTH CLINIC V	0. 000000			88. 04
	304 RURAL HEALTH CLINIC VI	0. 000000			88. 05
	000 CLINIC	0. 000000			90.00
	001 ONCOLOGY	0. 000000			90. 0
	002 PAIN MANAGEMENT	0. 000000			90. 02
	100 EMERGENCY	0. 000000			91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
	040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			93. 00
	IER REI MBURSABLE COST CENTERS	0.000000			93.00
99. 10 099					99. 10
	100 HOME HEALTH AGENCY				101. 00
	CLIAL PURPOSE COST CENTERS				101.00
	BOO INTEREST EXPENSE				113. 00
	600 HOSPI CE				116. 00
200. 00	1				200. 00
200.00	Subtotal (see instructions) Less Observation Beds				200. 00
	1				
202. 00	Total (see instructions)	1			202. 00

Health Financial Systems	DAVIESS COM	MUNITY HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE S	SERVICE CAPITAL COSTS		]	Period: From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 4:30	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cos		Capi tal	Days	3 / col . 4)	
	(from Wkst.		Related Cost			
	Part II, co	1.	(col. 1 - col.			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COS						
30.00 ADULTS & PEDIATRICS	368, 1	27	0 368, 12		71. 48	
31.00 INTENSIVE CARE UNIT	77, 9	20	77, 920	726	107. 33	31.00
40. 00   SUBPROVI DER - I PF	269, 8	331	0 269, 83	1 6, 030	44. 75	40. 00
41. 00 SUBPROVI DER - I RF	185, 4	177	0 185, 47	7 1, 519	122. 10	41.00
43. 00 NURSERY	21, 7	775	21, 77	5 815	26. 72	43.00
200.00 Total (lines 30 through 199)	923, 1	30	923, 130	14, 240		200. 00
Cost Center Description	Inpatient	I npati ent				
	Program day	rs Program				
		Capital Cost				
		(col. 5 x col				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COS						
30.00 ADULTS & PEDIATRICS	1, 8					30. 00
31.00 INTENSIVE CARE UNIT		136 46, 79	6			31. 00
40. 00 SUBPROVI DER - I PF	5, (	)90 227, 77	8			40. 00
41.00 SUBPROVI DER - I RF	1, 2	265 154, 45	7			41. 00
43. 00 NURSERY		0	0			43.00
200.00 Total (lines 30 through 199)	8, 6	559, 26	8			200. 00

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre	pared:
					5/29/2019 4: 3	0 pm
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1 00	2 00	2 00	4 00	5 00	

				XVIII	ноѕргтаг	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	502, 881	10, 713, 215		699, 128	32, 817	50. 00
51. 00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	181, 353			0	0	52. 00
54.00	05400   RADI OLOGY-DI AGNOSTI C	800, 791	24, 253, 352		2, 146, 874	·	54. 00
56.00	05600 RADI 0I SOTOPE	45, 944			410, 267		56. 00
60.00	06000 LABORATORY	157, 275	25, 925, 850	0. 006066	3, 343, 842	20, 284	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	10, 755	915, 867	0. 011743	199, 029	2, 337	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0.000000	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	95, 168	2, 445, 339	0. 038918	638, 913	24, 865	65. 00
66.00	06600 PHYSI CAL THERAPY	135, 115	3, 961, 015	0. 034111	97, 385	3, 322	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	29, 396	1, 577, 068	0. 018640	22, 175	413	67. 00
68.00	06800 SPEECH PATHOLOGY	20, 099	384, 437	0. 052282	9, 798	512	68. 00
69.00	06900 ELECTROCARDI OLOGY	20, 830	1, 203, 364	0. 017310	160, 850	2, 784	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	74, 326	6, 175, 294	0. 012036	1, 121, 520	13, 499	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 359	562, 748	0. 002415	91, 102	220	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	145, 480	13, 643, 191	0. 010663	1, 315, 276	14, 025	73. 00
76.00	03020 CARDI AC REHAB	99, 726	229, 980	0. 433629	133	58	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	95, 522	1, 134, 490	0. 084198	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	70, 693	1, 313, 326	0. 053827	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	135, 564	2, 490, 952	0. 054423	0	0	88. 02
88. 04	08803 RURAL HEALTH CLINIC V	47, 308	1, 507, 818	0. 031375	0	0	88. 04
88. 05	08804 RURAL HEALTH CLINIC VI	51, 158	752, 444	0. 067989	0	0	88. 05
90.00	09000 CLI NI C	73, 583	1, 417, 159	0. 051923	56, 448	2, 931	90.00
90. 01	09001 ONCOLOGY	4, 144	2, 148, 353	0. 001929	0	0	90. 01
90. 02	09002 PAIN MANAGEMENT	32, 062	551, 806	0. 058104	0	0	90. 02
91.00	09100 EMERGENCY	168, 113	10, 134, 840	0. 016588	833, 848	13, 832	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	123, 733	1, 613, 010	0. 076709	197, 790	15, 172	92. 00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	105, 732	630, 014	0. 167825	0	0	93. 00
200.00	Total (lines 50 through 199)	3, 228, 110	122, 394, 573		11, 344, 378	221, 137	200. 00

	ncial Systems	DAVIESS COMMUN			In Lie	eu of Form CMS-	2552-10
APPORTI ONME	ENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	TS Provider C		Period: From 01/01/2018 Fo 12/31/2018		
			Title	e XVIII	Hospi tal	PPS	
	Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	·	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
		Adjustments		Adjustments		Education Cost	
		1A	1.00	2A	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	O ADULTS & PEDIATRICS	C	0	)	0	0	30.00
31.00 0310	O INTENSIVE CARE UNIT	C	0	)	0	0	31.00
40.00 04000	O SUBPROVIDER - IPF	C	ol o	)	0	0	40.00
41.00 0410	O SUBPROVI DER - I RF	l c	0		0	0	41.00
43.00 0430	O NURSERY		0	)	0	0	43.00
200. 00	Total (lines 30 through 199)				0	0	200.00
	Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	'	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
		Amount (see	1 through 3,				
		instructions)	minus col. 4)				
		4. 00	5. 00	6.00	7. 00	8. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00 03000	O ADULTS & PEDIATRICS	C	0	5, 150	0.00	1, 822	30.00
31.00 0310	O INTENSIVE CARE UNIT		0	720	0.00	436	31.00
40.00 04000	O SUBPROVIDER - IPF	C	0	6, 030	0.00	5, 090	40.00
41.00 0410	O SUBPROVI DER - I RF	C	0	1, 51	9 0.00	1, 265	41.00
43.00 0430	O NURSERY		0	81!	0.00	0	43.00
200. 00	Total (lines 30 through 199)		0	14, 240	O	8, 613	200.00
	Cost Center Description	I npati ent					
	·	Program					
		Pass-Through					
		Cost (col. 7 x					
		col. 8)					
		9. 00					
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDIATRICS	C	)				30.00
	O INTENSIVE CARE UNIT	C	)				31.00
	O SUBPROVIDER - IPF	C	)				40.00
	O SUBPROVIDER - IRF	C	)				41. 00
43.00 0430	0 NURSERY	C	)				43. 00
200. 00	Total (lines 30 through 199)	C	)				200. 00

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0061	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

						5/29/2019 4: 3	O pm
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(	0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	(	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 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	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	03020 CARDI AC REHAB	0	0		0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS		-		-1		1
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
	08802 RURAL HEALTH CLINIC III	0	0		0	0	88. 02
88. 04	08803 RURAL HEALTH CLINIC V	0	0		0	0	88. 04
	08804 RURAL HEALTH CLINIC VI	0	0		0	0	88. 05
	09000 CLINIC	0	0		0	0	90. 00
	09001 ONCOLOGY	0	0		0	0	90. 01
90. 02	09002 PAIN MANAGEMENT	0	0		0	0	90. 02
91. 00	09100 EMERGENCY	0	0		0	o o	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				n	92. 00
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	٥	93. 00
200.00		i o	Ö		0	n	200. 00
	1 ( )	, ,	,		-1	·	

Health Financial Systems	DAVIESS COMMUNITY	Y HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0061	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

				1	o 12/31/2018	Date/Time Prep 5/29/2019 4:30	
			Title	xVIII	Hospi tal	PPS	<u>o p</u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
		4.00	5. 00	and 4) 6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1. 00	0.00	0.00	7.00	0.00	
50.00	05000 OPERATI NG ROOM	0	0	(	10, 713, 215	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0.000000	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	783, 635	0.000000	52. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	(	24, 253, 352	0.000000	54.00
56.00	05600  RADI 0I SOTOPE	0	0	(	5, 926, 006	0.000000	56. 00
60.00	06000 LABORATORY	0	0	(	25, 925, 850	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	915, 867	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(	0	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	(	2, 445, 339	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(	3, 961, 015	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(	1, 577, 068	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	(	384, 437	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(	1, 203, 364	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	6, 175, 294	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(	562, 748	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	13, 643, 191	0.000000	73. 00
76.00	03020 CARDI AC REHAB	0	0	(	229, 980	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		., ,		
	08801 RURAL HEALTH CLINIC II	0	0	1	1, 313, 326		
	08802 RURAL HEALTH CLINIC III	0	0	(	2, 490, 952		1
	08803 RURAL HEALTH CLINIC V	0	0	(	1, 507, 818		
88. 05	08804 RURAL HEALTH CLINIC VI	0	0	(	752, 444		1
	09000 CLI NI C	0	0	(	1, 417, 159		
	09001 ONCOLOGY	0	0	(	2, 148, 353		
	09002 PAIN MANAGEMENT	0	0	(	551, 806		1
	09100 EMERGENCY	0	0	1	10, 134, 840		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	.,		1
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0				1
200. 00	Total (lines 50 through 199)	0	0	(	122, 394, 573	j l	200. 00

Hea	al th Financial	Systems		DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
	PPORTIONMENT OF ROUGH COSTS	I NPATI ENT/OUTPATI ENT	JTPATIENT ANCILLARY SERVICE OTHER PASS		S Provider C		Period: From 01/01/2018 To 12/31/2018		
					Ti tl e	e XVIII	Hospi tal	PPS	
	Cost	Center Description		Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through		Outpatient Program Pass-Through	

						5/29/2019 4:3	U pili
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0. 000000	699, 128		0 2, 613, 305	0	50.00
51.00 0	5100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52. 00 0	5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 146, 874		0 6, 105, 094	0	54.00
56. 00 0	5600 RADI OI SOTOPE	0. 000000	410, 267		0 1, 974, 344	0	56. 00
60.00 0	6000 LABORATORY	0. 000000	3, 343, 842		0 2, 560, 020	0	60.00
63. 00 0	6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	199, 029		0 126, 695	0	63.00
64. 00 0	6400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 0	6500 RESPI RATORY THERAPY	0. 000000	638, 913		0 611, 423	0	65. 00
66. 00 0	6600 PHYSI CAL THERAPY	0. 000000	97, 385		0 12, 427	0	66.00
67. 00 0	6700 OCCUPATIONAL THERAPY	0. 000000	22, 175		0 3, 906	0	67. 00
68. 00 0	6800 SPEECH PATHOLOGY	0. 000000	9, 798		0 395	0	68. 00
69. 00 0	6900 ELECTROCARDI OLOGY	0. 000000	160, 850		0 313, 569	0	69.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 121, 520		0 1, 118, 407	0	71. 00
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	91, 102		0 72, 886	0	72. 00
73. 00 0	7300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 315, 276		0 4, 103, 023	0	73. 00
76. 00 0	3020 CARDI AC REHAB	0. 000000	133		0 128, 819	0	76. 00
Ol	UTPATIENT SERVICE COST CENTERS					•	
88. 00 0	8800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
88. 01 0	8801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
88. 02 0	8802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88. 02
88. 04 0	8803 RURAL HEALTH CLINIC V	0. 000000	0		0 0	0	88. 04
88. 05   08	8804 RURAL HEALTH CLINIC VI	0. 000000	0		0 0	0	88. 05
90.00 0	9000 CLI NI C	0. 000000	56, 448		0 590, 999	0	90.00
90. 01 0	9001 ONCOLOGY	0. 000000	0		0 155, 277	0	90. 01
90. 02 0	9002 PAIN MANAGEMENT	0. 000000	0		0	0	90. 02
91. 00 0	9100 EMERGENCY	0. 000000	833, 848		0 1, 869, 066	0	91.00
92. 00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	197, 790		0 436, 379	0	92.00
93.00 0	4040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 616, 734	0	93. 00
200.00	Total (lines 50 through 199)		11, 344, 378		0 23, 412, 768	0	200. 00
'	,			•		•	•

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0061	Peri od:	Worksheet D

01/01/2018 | Part V 12/31/2018 | Date/Time Prepared: 5/29/2019 4:30 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 297140 2, 613, 305 776, 517 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 1 151736 52 00 0 0 05400 RADI OLOGY-DI AGNOSTI C 6, 105, 094 0 54.00 0.120838 737, 727 54.00 56.00 05600 RADI OI SOTOPE 0.093339 1, 974, 344 0 184, 283 56.00 0 60.00 06000 LABORATORY 0.150479 2, 560, 020 0 385, 229 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0.329321 126, 695 41, 723 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0.419309 611, 423 0 256, 375 65.00 06600 PHYSI CAL THERAPY 0.508012 12, 427 0 66 00 6, 313 66 00 67.00 06700 OCCUPATIONAL THERAPY 0.315208 3, 906 1, 231 67.00 68.00 06800 SPEECH PATHOLOGY 0.639621 395 0 253 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0.133551 313, 569 0 41,877 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 401, 603 71 00 0.359085 1, 118, 407 71 00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0. 258789 72, 886 0 0 18, 862 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 330506 4, 103, 023 2, 549 1, 356, 074 73.00 73.00 03020 CARDI AC REHAB 1.838464 128, 819 0 236, 829 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08801 RURAL HEALTH CLINIC II 0.000000 88.01 88. 01 0 08802 RURAL HEALTH CLINIC III 88.02 0.000000 0 88.02 08803 RURAL HEALTH CLINIC V 0.000000 88.04 0 88 04 88.05 08804 RURAL HEALTH CLINIC VI 0.000000 88.05 590, 999 90.00 09000 CLI NI C 0.396391 234, 267 90.00 09001 ONCOLOGY 0. 125516 155, 277 0 19, 490 90.01 90.01 09002 PAIN MANAGEMENT 90.02 0.665013 Λ 90.02 91.00 09100 EMERGENCY 0.353007 1,869,066 659, 793 91.00 0 o 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.831261 436, 379 362, 745 92.00 0 93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 717, 252 93.00 1.162984 616, 734 200.00 Subtotal (see instructions) 23, 412, 768 2, 549 6, 438, 443 200. 00 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 6, 438, 443 202. 00 23, 412, 768 2 549

Health Financial Systems	DAVI ESS COMMUNI	TY HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHE	ER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0061	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/29/2019 4:30 pm

				To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
		Ti tl e	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	0	C				50. 00
51.00   05100   RECOVERY ROOM	0	0				51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
56. 00   05600 RADI OI SOTOPE	0	0				56. 00
60. 00 06000 LABORATORY	0					60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	l 0	ol			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0					64.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	l o				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	l o				67. 00
68. 00 06800 SPEECH PATHOLOGY	0		1			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	Ö	1			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0		1			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	842	1			73. 00
76. 00 03020 CARDI AC REHAB	0					76.00
OUTPATIENT SERVICE COST CENTERS			1			70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	)			88. 00
88. 01   08801   RURAL HEALTH CLINIC II	Ö		1			88. 01
88. 02   08802   RURAL HEALTH CLINIC III	0		1			88. 02
88. 04   08803 RURAL HEALTH CLINIC V	0		1			88. 04
88. 05   08804 RURAL HEALTH CLINIC VI	0	ĺ	1			88. 05
90. 00   09000   CLINIC						90.00
90. 01   09001   0NCOLOGY						90.00
90. 02   09002   PAI N MANAGEMENT						90.02
91. 00   09100   EMERGENCY						91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1			92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER			1			93. 00
200.00 Subtotal (see instructions)		842				200.00
201.00 Less PBP Clinic Lab. Services-Program		042	-			200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	0	842	2			202. 00

Health Financial Systems	DAVIESS COMMUN		ON 45 00/4		eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Component	CN: 15-0061 CCN: 15-S061	Peri od: From 01/01/2018 To 12/31/2018		pared:
			× XVIII	Subprovi der - I PF	PPS	<u> </u>
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	502, 881				629	1
51. 00   05100   RECOVERY ROOM	0				0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	181, 353				0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	800, 791		•			1
56. 00   05600   RADI OI SOTOPE	45, 944				96	
60. 00 06000 LABORATORY	157, 275					1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	10, 755				0	
64. 00 06400 I NTRAVENOUS THERAPY	0				0	
65. 00 06500 RESPI RATORY THERAPY	95, 168					
66. 00   06600   PHYSI CAL THERAPY	135, 115				2, 688	1
67. 00 06700 OCCUPATI ONAL THERAPY	29, 396				82	1
68. 00 06800 SPEECH PATHOLOGY	20, 099		•		521	68. 00
69. 00 06900 ELECTROCARDI OLOGY	20, 830		•		749	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	74, 326				1, 003	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 359		•		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	145, 480					1
76. 00 03020 CARDI AC REHAB OUTPATI ENT SERVI CE COST CENTERS	99, 726	229, 980	0. 43362	29 0	0	76. 00
88. 00   08800   RURAL HEALTH CLINIC	95, 522	1, 134, 490	0. 08419	98 0	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC   I	70, 693				0	
88. 02   08802 RURAL HEALTH CLINIC III	135, 564				0	88. 02
88. 04   08803 RURAL HEALTH CLINIC V	47, 308				0	
88. 05   08804 RURAL HEALTH CLINIC VI	51, 158				0	88. 05
90. 00   09000   CLI NI C	73, 583				Ö	
90. 01   09001   0NCOLOGY	4, 144		•		0	
90. 02   09002   PAI N MANAGEMENT	32, 062				0	90. 02
91. 00 09100 EMERGENCY	168, 113		l		1	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	100, 113				2,031	1
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	105. 732		1		498	1
200.00   Total (lines 50 through 199)	3, 104, 377			2, 826, 550		200. 00

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0061	Peri od:	Worksheet D
THROUGH COSTS		Component CCN: 15-S061	From 01/01/2018 To 12/31/2018	Part IV   Date/Time Prepared:
				5/29/2019 4:30 pm
		Title XVIII	Subprovi der -	PPS

			Title	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School		Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1		•	•		
50.00	05000 OPERATI NG ROOM	0	0	C	0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	ol c	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	ol c	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	ol c	0	0	54.00
56.00	05600 RADI OI SOTOPE	0	0	ol c	0	0	56. 00
60.00	06000 LABORATORY	0	0	) c	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	) c	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	) c	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	) c	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	) c	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	) c	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	) c	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	) c	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	) c	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	) c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	ol c	0	0	73. 00
76.00	03020 CARDI AC REHAB	0	0	C	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	) c	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	) c	0	0	88. 02
88. 04	08803 RURAL HEALTH CLINIC V	0	0	) c	0	0	88. 04
88. 05	08804 RURAL HEALTH CLINIC VI	0	0	) c	0	0	88. 05
90.00	09000  CLI NI C	0	0	) c	0	0	90.00
90. 01	09001  ONCOLOGY	0	0	) c	0	0	90. 01
90. 02	09002 PAIN MANAGEMENT	0	0	) c	0	0	90. 02
91.00	09100 EMERGENCY	0	0	) c	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		[ C		0	92. 00
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	( C	0	0	70.00
200.00	Total (lines 50 through 199)	0	0	() C	0	0	200. 00

111 41-	Figure in Contains	DAVI FCC COMMUN	II TV. HOCDI TAI		1 11-		2552 40
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	DAVIESS COMMUN		CN: 15-0061	Peri od:	eu of Form CMS-2 Worksheet D	2552-10
	H COSTS	WIGE OTHER TAS			From 01/01/2018 To 12/31/2018	Part IV	
			Ti tl e	e XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	· · · · ·	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
		4.00	5.00	and 4) 6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50.00	05000 OPERATI NG ROOM	0		ol	0 10, 713, 215	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0			0 0		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 783, 635		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 24, 253, 352	0.000000	54.00
56.00	05600 RADI 0I SOTOPE	0	C		0 5, 926, 006	0.000000	56.00
60.00	06000 LABORATORY	0	C		0 25, 925, 850		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	)	0 915, 867		
64. 00	06400 I NTRAVENOUS THERAPY	0	C		0	0.00000	1
65. 00	06500 RESPI RATORY THERAPY	0	C	)	0 2, 445, 339	•	1
66. 00	06600 PHYSI CAL THERAPY	0	C	)	0 3, 961, 015	•	1
67. 00	06700 OCCUPATI ONAL THERAPY	0		)	0 1, 577, 068	•	1
68. 00	06800 SPEECH PATHOLOGY	0		)	0 384, 437	1	
69. 00 71. 00	06900  ELECTROCARDI OLOGY   07100  MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 1, 203, 364 0 6, 175, 294		
71.00	07200 I MPL. DEV. CHARGED TO PATIENT	0			0 562, 748		
73. 00	07300 DRUGS CHARGED TO PATTENTS	0			0 13, 643, 191		
76. 00	03020 CARDI AC REHAB	0		1	0 229, 980		
70.00	OUTPATIENT SERVICE COST CENTERS			1	227, 700	0.000000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	С		0 1, 134, 490	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	C		0 1, 313, 326		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	C		0 2, 490, 952	0. 000000	88. 02
88. 04	08803 RURAL HEALTH CLINIC V	0	C		0 1, 507, 818	0.000000	88. 04
88. 05	08804 RURAL HEALTH CLINIC VI	0	C	)	0 752, 444		
90.00	09000 CLI NI C	0	C	)	0 1, 417, 159		
90. 01	09001 ONCOLOGY	0	C		0 2, 148, 353	1	1
90. 02	09002 PAIN MANAGEMENT	0		)	0 551, 806	l l	1
91.00	09100 EMERGENCY	0	C	1	0 10, 134, 840		
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	C	1	0 1, 613, 010 0 630, 014	1	
93. 00 200. 00		0			0 630, 014 0 122, 394, 573		200. 00
200.00	Trotal (Tries 50 till bugli 177)	1	1	'I	0 122, 374, 373	I	<sub>1</sub> 200.00

	Financial Systems	DAVIESS COMMUNI	_			u of Form CMS-	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C	CN: 15-0061	Period: From 01/01/2018	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-S061	To 12/31/2018	Part IV Date/Time Pre 5/29/2019 4:3	pared: 80 pm
			Title	XVIII	Subprovi der -	PPS	
					IPF		
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	T	9. 00	10. 00	11.00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS		10.101	1			
50. 00	05000 OPERATING ROOM	0. 000000	13, 404		0 0	0	
51. 00	05100 RECOVERY ROOM	0. 000000	0		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	272, 659		0	0	
56.00	05600 RADI OI SOTOPE	0. 000000	12, 444		0	0	56. 00
60.00	06000 LABORATORY	0. 000000	920, 968		0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	98, 198		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	78, 792		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	4, 401		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	9, 963		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	43, 254		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	83, 295		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 163, 763		0 0	0	73.00
76.00	03020 CARDI AC REHAB	0. 000000	0		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS				•		
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88. 02
88. 04	08803 RURAL HEALTH CLINIC V	0. 000000	0		0 0	0	88. 04
88. 05	08804 RURAL HEALTH CLINIC VI	0. 000000	0		0 0	0	88. 05
90.00	09000 CLI NI C	0. 000000	0		0	0	1
90. 01	09001 ONCOLOGY	0. 000000	0		0	0	90. 01
90. 02	09002 PAIN MANAGEMENT	0. 000000	0		o o	Ö	
91. 00	09100 EMERGENCY	0. 000000	122, 444		0 0	0	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	.22, 111		0 0	0	
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	2, 965			0	
, 0. 00	Total (lines 50 through 199)	0.000000	2, 826, 550		0 0		200. 00

	Financial Systems	DAVIESS COMMUN		ON 45 00/4		u of Form CMS-	2552-10
APPORTI	ONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	IL COSTS	Provi der C	CN: 15-0061	Peri od: From 01/01/2018	Worksheet D Part II	
			Component	CCN: 15-T061	To 12/31/2018	Date/Time Pre 5/29/2019 4:3	pared: 0 pm
				e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26) 1. 00	2. 00	3.00	4. 00	5. 00	
Δ.	NCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	05000 OPERATING ROOM	502, 881	10, 713, 215	0. 04694	10 175	8	50.00
	05100 RECOVERY ROOM	0	10, 713, 213	•		0	
	05200 DELIVERY ROOM & LABOR ROOM	181, 353				0	1
	05400 RADI OLOGY-DI AGNOSTI C	800, 791	24, 253, 352			1, 487	54.00
	05600 RADI OI SOTOPE	45, 944	5, 926, 006			31	56. 00
	06000 LABORATORY	157, 275				968	1
63.00 0	06300 BLOOD STORING, PROCESSING & TRANS.	10, 755	915, 867			66	63.00
64.00 0	06400 INTRAVENOUS THERAPY	0	0	0.00000	00	0	64.00
65.00 0	06500 RESPIRATORY THERAPY	95, 168	2, 445, 339	0. 03891	18 164, 754	6, 412	65.00
	06600 PHYSI CAL THERAPY	135, 115	3, 961, 015			16, 180	
	06700 OCCUPATI ONAL THERAPY	29, 396	1, 577, 068			8, 087	
	06800 SPEECH PATHOLOGY	20, 099				1, 310	
	06900 ELECTROCARDI OLOGY	20, 830				30	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	74, 326	6, 175, 294			1, 512	
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 359				0	72.00
	07300 DRUGS CHARGED TO PATIENTS	145, 480				2, 440	1
	03020 CARDIAC REHAB DUTPATIENT SERVICE COST CENTERS	99, 726	229, 980	0. 43362	29 0	0	76. 00
	08800 RURAL HEALTH CLINIC	95, 522	1, 134, 490	0. 08419	98 0	0	88. 00
	08801 RURAL HEALTH CLINIC II	70, 693	1, 313, 326			0	88. 01
	08802 RURAL HEALTH CLINIC III	135, 564	2, 490, 952	1		0	1
	08803 RURAL HEALTH CLINIC V	47, 308				0	1
	08804 RURAL HEALTH CLINIC VI	51, 158		1	-	ő	88. 05
	09000 CLI NI C	73, 583		1		Ō	1
90. 01 0	09001 ONCOLOGY	4, 144	2, 148, 353	0. 00192	29 0	0	90. 01
90. 02 0	09002 PAIN MANAGEMENT	32, 062	551, 806	0. 05810	04 0	0	90. 02
91.00 0	09100 EMERGENCY	168, 113	10, 134, 840	0. 01658	38 0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
	04040 OTHER OUTPATIENT SERVICE COST CENTER	105, 732				0	
200. 00	Total (lines 50 through 199)	3, 104, 377	122, 394, 573	<b>3</b>	1, 668, 555	38, 531	200. 00

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0061 Component CCN: 15-T061	Peri od: From 01/01/2018 To 12/31/2018	
		Title XVIII	Subprovi der -	PPS

			Title	× XVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	cost center bescription	Anesthetist	Post-Stepdown		Post-Stepdown	Airred flear til	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS			2.00	0.1	0.00	
50.00	05000 OPERATING ROOM	0	0	1	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	1 0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	ıl c	o	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	·	o	0	54.00
56.00	05600 RADI OI SOTOPE	0	0	·	o	0	56. 00
60.00	06000 LABORATORY	0	0	·	o	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	·	o	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	·	o	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	·	o	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	·	o	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	·	o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	·	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	·	o	0	73. 00
76.00	03020 CARDI AC REHAB	0	0	·	o	0	76. 00
	OUTPATIENT 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. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	(	0	0	88. 02
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 CLI NI C	0	0	(	0	0	90.00
90. 01	09001 ONCOLOGY	0	0	(	0	0	90. 01
90. 02	09002 PAIN MANAGEMENT	0	0	(	0	0	90. 02
91.00	09100 EMERGENCY	0	0	(	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(		0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(	0	0	93. 00
200.00	Total (lines 50 through 199)	0	0	(	0	0	200. 00

	Financial Systems	DAVIESS COMMUN		ON 45 00/4		eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE UTHER PAS:		CCN: 15-0061	Peri od: From 01/01/2018	Worksheet D Part IV	nonod.
			Component	CCN: 15-T061	To 12/31/2018	Date/Time Pre 5/29/2019 4:3	pareu: O nm
			Title	e XVIII	Subprovi der -	PPS	о рііі
		1	T		I RF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,	to Charges (col. 5 ÷ col.	
		Education Cost	1, 2, 3, and 4)	Cost (sum or cols. 2, 3,		7)	
			4)	and 4)	0)	')	
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	0			0 10, 713, 215	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0			0 0	•	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0 783, 635		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0 24, 253, 352		54.00
56.00	05600 RADI OI SOTOPE	0			0 5, 926, 006	0.000000	56.00
60.00	06000 LABORATORY	0	(		0 25, 925, 850	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 915, 867	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	(		0 0	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	(		0 2, 445, 339	0.000000	65.00
66. 00	06600 PHYSI CAL THERAPY	0	(		0 3, 961, 015	0.000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	-		0 1, 577, 068		
68. 00	06800 SPEECH PATHOLOGY	0	(		0 384, 437		1
69. 00	06900 ELECTROCARDI OLOGY	0	(		0 1, 203, 364		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(		0 6, 175, 294		1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	`		0 562, 748		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			0 13, 643, 191		1
76. 00	03020 CARDI AC REHAB	0	(	<u> </u>	0 229, 980	0. 000000	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1 0	1 /	SI .	0 4 404 400	0.00000	00.00
88. 00	08800 RURAL HEALTH CLINIC	0			0 1, 134, 490		
88. 01	08801 RURAL HEALTH CLINIC II	0			0 1, 313, 326		
88. 02	08802 RURAL HEALTH CLINIC III	0	,		0 2, 490, 952		1
88. 04	08803 RURAL HEALTH CLINIC V	0	,	1	0 1, 507, 818		
88. 05 90. 00	08804 RURAL HEALTH CLINIC VI 09000 CLINIC	0			0 752, 444		
90.00	09000 CET NT C 09001 ONCOLOGY	0			0 1, 417, 159 0 2 148 353		
90.01	09001 ONCOLOGY	0			2, 1.0,000		1
91.00	09100 EMERGENCY		1		0 551, 806 0 10, 134, 840		
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 10, 134, 840		1
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER				0 630, 014		
200.00	· · · · · · · · · · · · · · · · · · ·				0 122, 394, 573		200. 00
200.00	Total (Tries 50 through 177)	1	1	1	0  122, 374, 373	ı	1200.00

Heal th	Financial Systems	DAVIESS COMMUNIT	TY HOSPITAL		In Lie	u of Form CMS-:	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der Co	CN: 15-0061	Peri od:	Worksheet D	2002 10
	H COSTS			CCN: 15-T061	From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre 5/29/2019 4:3	
			Title	XVIII	Subprovi der -	PPS	
					IRF		
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	10.00	x col. 10)	40.00	x col . 12)	
	ANOULL ARV CERVI OF COCT OFNITERS	9.00	10. 00	11. 00	12. 00	13. 00	
FO 00	ANCILLARY SERVICE COST CENTERS 05000  OPERATING ROOM	0.000000	175			0	F0 00
50.00		0.000000			0 0	0	
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	45, 033		0	0	54.00
56. 00	05600 RADI OI SOTOPE	0. 000000	3, 962		0	0	56. 00
60.00	06000 LABORATORY	0. 000000	159, 526		0 0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	5, 654		0 0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
65. 00	06500 RESPI RATORY THERAPY	0. 000000	164, 754		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	474, 340		0 0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	433, 877		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	25, 064		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 720		0 0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	125, 622		0 0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	228, 828		0 0	0	73. 00
76. 00	03020 CARDI AC REHAB	0. 000000	0		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000	0		0	0	
88. 04	08803 RURAL HEALTH CLINIC V	0. 000000	0		0	0	
88. 05	08804 RURAL HEALTH CLINIC VI	0. 000000	0		0	0	88. 05
90.00	09000  CLI NI C	0. 000000	0		0	0	90.00
90. 01	09001  ONCOLOGY	0. 000000	0		0	0	90. 01
90. 02	09002 PAIN MANAGEMENT	0. 000000	0		0	0	90. 02
91. 00	09100 EMERGENCY	0. 000000	0		0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92. 00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	
200.00	Total (lines 50 through 199)		1, 668, 555		0 0	0	200. 00

From 01/01/2018 Part V 12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 297140 146, 573 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 1 151736 0 1 484 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.120838 0 371, 471 0 54.00 56. 00 05600 RADI 0I SOTOPE 0.093339 95, 741 0 56.00 60.00 06000 LABORATORY 0.150479 0 347, 752 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0.329321 7,066 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 65.00 0.419309 22, 511 0 65.00 06600 PHYSI CAL THERAPY 0.508012 57, 546 66.00 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 0.315208 0 18,645 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.639621 5, 467 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.133551 0 15, 974 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 82, 209 0 71 00 0.359085 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0. 258789 0 6, 232 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 330506 148, 113 0 73.00 73.00 03020 CARDI AC REHAB 1.838464 <u>4,</u> 179 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1.087867 0 88.00 08801 RURAL HEALTH CLINIC II 1.003063 0 88.01 88. 01 08802 RURAL HEALTH CLINIC III 88. 02 88.02 0.841678 0 08803 RURAL HEALTH CLINIC V 1. 025240 88.04 0 88 04 88.05 08804 RURAL HEALTH CLINIC VI 1.117132 0 88.05 09000 CLI NI C 90.00 0.396391 25, 769 90.00 0 0 0 0 0 0 0

0. 125516

0.665013

0.353007

0.831261

1.162984

39, 063

10,034

159, 323

23, 922

10.114

0

1, 599, 188

1, 599, 188

0

0

90. 01

90. 02

93.00

0 200. 00

0 202.00

201.00

0

0

0 91.00

0 92.00

Ω

09001 ONCOLOGY

09100 EMERGENCY

09002 PAIN MANAGEMENT

Only Charges

09200 OBSERVATION BEDS (NON-DISTINCT PART)

04040 OTHER OUTPATIENT SERVICE COST CENTER

Net Charges (line 200 - line 201)

Less PBP Clinic Lab. Services-Program

Subtotal (see instructions)

90.01

90.02

91.00

92.00

93.00

200.00

201.00

202.00

Health Financial Systems	DAVIESS COMMUNI	TY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0061	From 01/01/2018	Worksheet D Part V Date/Time Prepared

				From 01/01/2018 To 12/31/2018	Part V   Date/Time Pre   5/29/2019 4:3	
		Ti tl	e XIX	Hospi tal	Cost	о рііі
	Cos	sts				
Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.) 7.00				
ANCLLIADY CEDVICE COCT CENTERS	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	42.552	0				F0 00
	43, 553					50.00
51. 00   05100   RECOVERY ROOM	0	-				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 709					52.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	44, 888					54.00
56. 00   05600   RADI 0I SOTOPE	8, 936					56. 00
60. 00   06000   LABORATORY	52, 329	0				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 327	0				63. 00
64. 00   06400   I NTRAVENOUS THERAPY	0	-				64. 00
65. 00  06500  RESPI RATORY THERAPY	9, 439					65. 00
66. 00 06600 PHYSI CAL THERAPY	29, 234					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 877	0				67. 00
68. 00   06800   SPEECH PATHOLOGY	3, 497					68. 00
69. 00   06900   ELECTROCARDI OLOGY	2, 133	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 520	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 613	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	48, 952	0				73.00
76. 00   03020   CARDI AC REHAB	7, 683	o				76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0				88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	o				88. 02
88.04 08803 RURAL HEALTH CLINIC V	0	o				88. 04
88.05 08804 RURAL HEALTH CLINIC VI	0	o				88. 05
90. 00   09000   CLI NI C	10, 215	o				90.00
90. 01   09001   0NCOLOGY	4, 903	o				90. 01
90. 02 09002 PALN MANAGEMENT	6, 673	o				90. 02
91. 00 09100 EMERGENCY	56, 242	o				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	19, 885					92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	11, 762	o				93.00
200.00 Subtotal (see instructions)	401, 370					200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)	401, 370	0				202. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0061	Period: From 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/29/2019 4:3	
	Title XVIII	Hospi tal	PPS	

		Title XVIII	Hospi tal	5/29/2019 4: 3 PPS	0 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			5, 150 5, 150	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	<i>y</i> ,	ivate room days,	0, 150	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 419	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)			0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n 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)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	1, 822	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private r	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI>			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
10.00	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0. 00	17. 00
18. 00				0. 00	18. 00
19. 00	Medicald 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	Total general inpatient routine service cost (see instructions			3, 989, 193	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December $x$ line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December $3 \times 1$ ine $20$ )	31 of the cost reporting	period (line 8	0	25. 00
26.00	Total swing-bed cost (see instructions)	'l' 04 ' l' 04)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			3, 989, 193	
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lin			0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	3, 989, 193	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			774.60	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			1, 411, 321 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39)	•		1, 411, 321	

	Financial Systems	DAVIESS COMMUNI		L 1E 00/1		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN		Period: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Prep 5/29/2019 4:30	
		T	Title		Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost		Average Per i em (col. 1	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00 0 0	5. 00	42. 00
12.00	Intensive Care Type Inpatient Hospital Units		<u> </u>				
43. 00 44. 00	INTENSIVE CARE UNIT	1, 213, 868	726	1, 671. 9	9 436	728, 988	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	·					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			6)		2, 768, 994 4, 909, 303	
49.00	PASS THROUGH COST ADJUSTMENTS	41 (111 Ough 46) (S	ee mstruction	5)		4, 909, 303	49.00
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from \	Wkst. D, sum	of Parts I and	177, 033	50. 00
51. 00		atient ancillarv	services (fro	m Wkst. D. s	um of Parts II	221, 137	51.00
	and IV)	,		,			
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-nhys	ician anesth	etist and	398, 170 4, 511, 133	
33.00	medical education costs (line 49 minus line	9 1				4, 311, 133	33.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge						55. 00
56.00	Target amount (line 54 x line 55)			F		0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (III	ne 56 minus	ine 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996, up	dated and co	mpounded by the	0. 00	•
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	ated by the ma	rket hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0.00	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(lines 54 x 6	0), or 1% of	the target		
62. 00	1	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
<b>.</b>	instructions)(title XVIII only)		04 6 11		1.76		, F 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 or the co	st reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 65	(title XVII	l only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 of	the cost re	porting period	0	67. 00
	(line 12 x line 19)	ŭ			0.		
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	cember 31 of t	he cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c	-		, ,			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v lin	o 3E)			72.00
74.00	Total Program general inpatient routine serv			e 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from Wo	rksheet B, P	art II, column		75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der records	)			78. 00 79. 00
80.00	Total Program routine service costs for comp	, ,		•	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81. 00 82. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (	,					82.00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PASS						00.00
87.00	Total observation bed days (see instructions	•	Line 2)			1, 731	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		11110 Z)			774. 60 1, 340, 833	
		-,				,	

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2018	Worksheet D-1	
				Γο 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	368, 127	3, 989, 193	0. 09228	1 1, 340, 833	123, 733	90.00
91.00 Nursing School cost	0	3, 989, 193	0.00000	1, 340, 833	0	91.00
92.00 Allied health cost	0	3, 989, 193	0.00000	1, 340, 833	0	92.00
93.00 All other Medical Education	0	3, 989, 193	0. 000000	1, 340, 833	0	93. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0061		Worksheet D-1
	Component CCN: 15-S061	From 01/01/2018 To 12/31/2018	
	Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			6, 030	
2.00	Inpatient days (including private room days, excluding swing-			6, 030	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		6, 030	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5. 00
	reporting period			_	
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	- 31 of the cost	0	7. 00
,, 00	reporting period	daye, t eag becombe.	0. 0. 1 0001	١	7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	a the Dresser (eveluding	r owing had and	5, 090	9. 00
9.00	newborn days)	o the Program (excruding	g swifig-bed and	5, 090	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days)	0	10. 00
	through December 31 of the cost reporting period (see instruc			_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11. 00
12. 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	3 .			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (exer daring smriig bed	days)	0	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6.11	2.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	or the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	the cost	0.00	20. 00
	reporting period	`		0.500.047	
21. 00 22. 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December		ting period (line	3, 528, 367 0	
22.00	5 x line 17)	or or the cost report	ing period (ine	١	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00
24. 00	X line 18)	s 21 of the cost reporti	ng poriod (line	0	24. 00
24.00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reporti	ng perrou (Trile	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
27.00	x line 20)				27.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 3, 528, 367	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(11110 21 11110 20)		0,020,00.	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	. line 20)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- IIIIe 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	ctions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 34 x line 35)	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fforontial (line	0 3, 528, 367	36. 00 37. 00
37.00	27 minus line 36)	and private room cost dr	Traientiai (TINE	5, 520, 507	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			505 11	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			585. 14 2, 978, 363	
40. 00	Medically necessary private room cost applicable to the Program			2, 478, 303	
	Total Program general inpatient routine service cost (line 39	,		2, 978, 363	

	Financial Systems	DAVIESS COMMUNIT				eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018 Fo 12/31/2018		nared·
			'	XVIII	Subprovi der -	5/29/2019 4: 3	0 pm
					I PF		
	Cost Center Description	Total Inpatient CostIn	Total Ipati ent Days	Average Per Diem (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	0					42.00
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 732, 672	48. 00
49. 00				ns)		3, 711, 035	
50. 00	Pass through costs applicable to Program inpol	atient routine se	ervices (from	Wkst. D, sum	of Parts I and	227, 778	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D, sı	um of Parts II	39, 118	51. 00
52. 00	Total Program excludable cost (sum of lines					266, 896	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		non-pny:	sician anestne	etist, and	3, 444, 139	53. 00
54. 00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and targ	get amount (I	ine 56 minus l	i ne 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	portina period er	ndi na 1996. u	pdated and cor	mpounded by the	0.00	58. 00 59. 00
(0.00	market basket	0 .		•	,	0.00	60. 00
61. 00	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
	amount (line 56), otherwise enter zero (see		(TIMES OF X	00), 01 1% 01	the target	_	
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	cost reportin	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6/	Inlus line 6	5)(title XVIII	only) For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing				-	0	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	-		·		0	
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient			•	9	0	
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID (	ONLY		_	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of						70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)					72. 00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.	•	•	ne 35)			73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service d	costs (from W	orksheet B, Pa	art II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· · · · · ·			ıs line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit	tati on	or rrim tatron	(11116 76 111111	25 11110 77)		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (	· · · · · · · · · · · · · · · · · · ·					82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	/			I	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			0.00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	•				89. 00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 4:30	
		Title	XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (			2. 20		0.00	
90.00 Capital -related cost	269, 831	3, 528, 367	0. 07647	5 0	0	90.00
91.00 Nursing School cost	0	3, 528, 367			0	91. 00
92.00 Allied health cost	0	3, 528, 367			0	92.00
93.00   All other Medical Education	0	3, 528, 367	0. 00000	0  0	0	93. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0061	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T061		
	Title XVIII	Subprovi der -	PPS
		IRE	

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			1, 519	
2.00	Inpatient days (including private room days, excluding swing-			1, 519	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 519	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5.00
4 00	reporting period	om dava) ofter December 1	01 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 265	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	o	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	Join dayo, ares.	Ĭ	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e 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 XI)	/ only (including private	room days)	o	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			٥	13.00
14.00	Medically necessary private room days applicable to the Progra			0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	o tili dagii becelliber o'i o'i	1110 0031	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		1, 516, 375	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18)   Swing-bed cost applicable to NF type services through December	31 of the cost reportir	na period (line	0	24. 00
2 00	7 x line 19)	e. e. e.e eeet repertr	ig por ou (i i io	Ĭ	2 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20)   Total swing-bed cost (see instructions)			o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 516, 375	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin	, ,	(ions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	10 01 <i>)</i>		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	1, 516, 375	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			998. 27	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 262, 812	39. 00
40.00	Medically necessary private room cost applicable to the Progra			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ II ne 4U)		1, 262, 812	41.00

	Financial Systems	DAVIESS COMMUNIT				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN Component CC	F	Period: From 01/01/2018 To 12/31/2018		
			Title )		Subprovi der -	5/29/2019 4: 3 PPS	0 pm
					I RF		
	Cost Center Description	Total Inpatient Cost In		Average Per iem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
40.00	Thurbos Div. (1) 11 - V. o. VIV 1	1.00	2.00	3. 00	4. 00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	<u> </u>	42. 00
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
40.00	Decree i goti et esitter e esit en esit (W	-+ 0.21 2	11: 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			s)		615, 545 1, 878, 357	
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from V	Wkst. D, sum	of Parts I and	154, 457	50. 00
51. 00	<pre>Pass through costs applicable to Program inpland IV)</pre>	atient ancillary	services (from	m Wkst. D, su	m of Parts II	38, 531	51. 00
52. 00	Total Program excludable cost (sum of lines					192, 988	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		ıted, non-physi	cian anesthe	etist, and	1, 685, 369	53. 00
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ing cost and targ	jet amount (lir	ne 56 minus l	ine 53)	ő	1
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported or	nding 1006 und	dated and com	pounded by the	0.00	
39.00	market basket	oortring perrou er	idi ilg 1996, upo	dated and con	ipourided by the	0.00	39.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				he amount by	0.00	
61.00	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see	n expected costs				0	61.00
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	(i ons)			0	63.00
64. 00	instructions)(title XVIII only)	3		·			64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after December	31 of the cos	st reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65)	(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through D	December 31 of	the cost rep	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	ember 31 of th	ne cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service of		ne 70 ÷ line 2)	)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		line 14 x line	e 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	•					74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service d	costs (from Wor	rksheet B, Pa	irt II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	, ,						78.00
79.00	Aggregate charges to beneficiaries for exces	· · · · · · · · · · · · · · · · · · ·			1. 70)		79. 00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		st limitation (	(iine 78 minu	is line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (	* .					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in						83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instructions					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86. 00
87.00	Total observation bed days (see instructions	)	: 2)			0	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	ine 2)			l .	88. 00 89. 00
		,					•

Health Financial Systems DAV	I LOO COMMUNICIAL	TY HOSPITAL		in Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component C		From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 4:30	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
				· ·	4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital -related cost	185, 477	1, 516, 375	0. 12231	6 0	0	90.00
91.00 Nursing School cost	0	1, 516, 375	0.00000	0 0	0	91.00
92.00 Allied health cost	o	1, 516, 375	0.00000	o o	0	92.00
93.00 All other Medical Education	0	1, 516, 375	0. 00000	이 이	0	93. 00

Health Financial Systems	DAVIESS COMMUNITY HOSP	PI TAL	In Lieu	ı of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Prov		From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prep 5/29/2019 4:30	
		Title XIX	Hospi tal	Cost	

		Title XIX	Hospi tal	5/29/2019 4: 30 Cost	0 pm
	Cost Center Description	THE XIX	позрі саг	0031	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		5, 150	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			5, 150	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be		21 of the cost	3, 419	4. 00 5. 00
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through becember	31 OF the Cost	ا	5.00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December 3	31 of the cost	o	6.00
	reporting period (if calendar year, enter 0 on this line)	3 ,			
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	i or the cost	ا	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	113	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		John days) arter	l	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(exer during eming zed i	aayo,	815	
16.00	Nursery days (title V or XIX only)			28	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
.0.00	reporting period				10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20.00	reporting period	<del></del> D 21 - <del></del>		0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	sarter becember 31 or tr	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		3, 989, 193	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
00.00	5 x line 17)	04 6 11			00.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)		5		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		3, 989, 193	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(		37.10.17.1.10	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	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: 20)		0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	FII ne 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	32.00
33. 00 34. 00	Average per diem private room charge differential (line 32 mir	ous line 22)(see instruct	tions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x lin		ons <i>)</i>	0.00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 989, 193	37.00
	27 minus line 36)	· · · · · · · · · · · · · · · · · · ·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTUENTO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			774 (0	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			774. 60 87, 530	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra	•		87,530	40.00
41. 00	1			87, 530	
	, J. J	,	l	2., 200	

	Financial Systems	DAVIESS COMMUN		CON 15 00/1		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-0061	Period: From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Innatient Day	Average Per		Program Cost (col. 3 x col.	
		Impatrent cost	inpatrent bay	col . 2)		4)	
12.00	NUDCEDY (+: +1 - V 0 VIV1.)	1.00	2.00	3.00	4. 00	5. 00	12.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	510, 785	81	5 626.	73 28	17, 548	42. 00
43.00	INTENSIVE CARE UNIT	1, 213, 868	72	1, 671.	99 25	41, 800	43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)		•				47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	I, line 200)			314, 176	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		461, 054	1
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	ationt routino	sorvices (fr	om Wkst D sui	m of Darte L and	I 0	50.00
30.00	[III]	attent routine	services (iii	JIII WKSt. D, Sui	ii Oi Faits i aliu		30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53.00	Total Program inpatient operating cost exclu	ding capital re	lated, non-ph	nysician anestl	hetist, and	0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00	Program discharges					0	54.00
	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raot amount /	lino 56 minus	lino 52)	0 0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and ta	irget allourt (	Title 50 millius	111le 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report ur	ndated by the	market hasket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line					0	1
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 )	( 60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	i iisti ucti oiis)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost report	ing period (See	T 0	64. 00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporting	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
/7.00	CAH (see instructions)		D 21	-6			/7.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	i December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69 00	(line 13 x line 20)  Total title V or XLX swing-bed NF inpatient	routine costs (	line 67 + lir	ne 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY		_	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				)		70.00
72.00	Program routine service cost (line 9 x line		THE 70 - TITLE	; 2)			72.00
73. 00	Medically necessary private room cost applic						73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		*	Part II column		74. 00 75. 00
75.00	26, line 45)	routine service	COSTS (110III	worksneet b, i	rait II, Corumn		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line   Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der recor	ds)			79. 00
	Total Program routine service costs for comp		ost limitatio	on (line 78 mi)	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (		* .				83. 00
84.00	Program inpatient ancillary services (see in		unc)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	· y/				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			1, 731	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•				1, 340, 833	

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	368, 127	3, 989, 193	0. 09228	1 1, 340, 833	123, 733	90.00
91.00 Nursing School cost	0	3, 989, 193	0.00000	1, 340, 833	0	91.00
92.00 Allied health cost	0	3, 989, 193	0.00000	1, 340, 833	0	92.00
93.00 All other Medical Education	0	3, 989, 193	0.00000	1, 340, 833	0	93. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0061	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-S061		
	Title XIX	Subprovi der -	Cost
		IPF	

		II the XIX	I PF	Cost	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		6, 030	1.00
2.00	Inpatient days (including private room days, excluding swing-b			6, 030	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		6, 030	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period		4 6 11		, ,,,
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF 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	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	254	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		om davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter O on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	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 XI)	Conly (including private	room days)	0	13. 00
.0.00	after December 31 of the cost reporting period (if calendar ye			· ·	10.00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed d	ays)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)				15. 00 16. 00
10.00	SWING BED ADJUSTMENT			20	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
10.00	reporting period	<del></del> D 21 +		0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	ne cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	e cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	6)		3, 528, 367	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
23.00	x line 18)	31 of the cost reporting	perrod (Trile 6	O	23.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24. 00
25 00	7 x line 19)	of the east manageting	noried (line 0	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (Tine 8	U	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		3, 528, 367	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation hed cha	rnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed end	1 gcs)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 -	Fline 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	i ons)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	,	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dif	rerential (line	3, 528, 367	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			585. 14	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			148, 626 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,		148, 626	
		•	'		•

	Financial Systems	DAVIESS COMMUNIT				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC Component C		Period: From 01/01/2018 To 12/31/2018		
			•	e XIX	Subprovi der -	5/29/2019 4: 3 Cost	
					I PF		1
	Cost Center Description	Total Inpatient CostIn	Total Ipati ent Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3. 00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	J 0	-1			0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0. 0	0	0	43. 00 44. 00
45. 00	1						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 25, 141	48. 00
49. 00				ns)		173, 767	
50.00	Pass through costs applicable to Program inpulli)	atient routine se	ervices (from	Wkst. D, sum	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (fro	om Wkst. D, s	um of Parts II	0	51. 00
52.00	Total Program excludable cost (sum of lines	,				0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		non-pnys	sician anestn	etist, and	0	53. 00
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ng cost and targ	get amount (Li	ine 56 minus	line 53)	0	1
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	portina period er	ndi na 1996. ui	odated and co	mpounded by the	0.00	
	market basket	0 .			,		
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by					0.00	1	
62. 00	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see Relief payment (see instructions)		(Tines 54 x 0	60), OF 1% OF	the target	0	62. 00
	Allowable Inpatient cost plus incentive payments	ent (see instruct	i ons)			0	
64. 00	j i	ts through Decemb	per 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	9 '	ts after December	31 of the co	ost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line 64	l plus line 6	5)(title XVII	l only). For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing		·			0	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of						70. 00 71. 00
72. 00 73. 00	Program routine service cost (line 9 x line		lino 14 v li	no 2E)			72. 00 73. 00
74. 00	Medically necessary private room cost applications and Program general inpatient routine services.		•	ne 35)			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)		costs (from Wo	orksheet B, Pa	art II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· · · · · · · · · · · · · · · · · · ·			us line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit	tati on		, 70 min	,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (	* .					82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<i>,</i>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			0.00	87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 4:30	
		Ti tl	e XIX	Subprovi der – I PF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	269, 831	3, 528, 367	0. 07647	'5 0	0	90.00
91.00 Nursing School cost	0	3, 528, 367	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 528, 367	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 528, 367	0. 00000	0 0	0	93.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0061	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T061		Date/Time Prepared: 5/29/2019 4:30 pm
	Title XIX	Subprovi der -	Cost
		IRF	

			IRF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	INPATIENT DAYS			4 540	4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			1, 519 1, 519	
3. 00	Private room days (excluding swing-bed and observation bed day	<b>3</b> ,	vate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		04 6 11	1, 519	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	m days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period	,.,,			
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	0	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on	v (including private ro	nom days)	0	10. 00
	through December 31 of the cost reporting period (see instruct	ons)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e 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 $$			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	ii (excluding swing-bed c	iays)	815	
	Nursery days (title V or XIX only)			28	
17 00	SWING BED ADJUSTMENT	through Docombon 21 of	the east	0.00	17. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period $$	s through becember 31 or	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s after December 31 of t	the cost	0. 00	18. 00
19. 00	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	after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	)		1, 516, 375	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe		ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	neriod (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reportir	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	ine 21 minus line 26)		1, 516, 375	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and abases set on had abs	, mass)	0	28. 00
29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	ir ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	20)		0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34. 00	Average per diem private room charge differential (line 32 min	us line 33)(see instruct	ions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line		*	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost dif	ferential (line	1, 516, 375	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	nstructions)		998. 27	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		0	39. 00
40.00	Medically necessary private room cost applicable to the Progra	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ IIne 4U)		0	41. 00

	Financial Systems	DAVIESS COMMUNIT				eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018 To 12/31/2018		nared·
			· ·	e XIX	Subprovi der -	5/29/2019 4: 3 Cost	
	Cook Contan December	T-+-1			I RF		
	Cost Center Description	Total Inpatient CostIn	Total patient Days	col . 2)	Program Days	Program Cost (col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0 0	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units	-					
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0.0	0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					15, 117	
49. 00	PASS THROUGH COST ADJUSTMENTS					15, 117	
50. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from	Wkst. D, sum	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (fr	om Wkst. D, s	um of Parts II	0	51. 00
52.00	Total Program excludable cost (sum of lines			_: _:	-4:-4	0	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		rtea, non-pny	sician anestn	etist, and	0	53. 00
54. 00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and targ	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period er	nding 1996, u	pdated and co	mpounded by the	0.00	58. 00 59. 00
(0.00	market basket						40.00
60. 00 61. 00	1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						60. 00 61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST			cost reporti	na period (See	0	64. 00
65. 00	instructions) (title XVIII only)	3		·	3 1	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)		•		•	0	
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	-				0	
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after Dec	cember 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ty/ICF/IID routi	ne service c	ost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line .	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applications	able to Program (	•	ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		orksheet B, P	art II, column		74. 00 75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		vider record	s)			79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		st limitation	(line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (						82. 00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in:						83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instructions					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86. 00
87. 00	Total observation bed days (see instructions)	)	ino 2)			0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	1116 Z)				88. 00 89. 00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Subprovi der – I RF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	185, 477	1, 516, 375	0. 12231	6 0	0	90.00
91.00 Nursing School cost	0	1, 516, 375	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	1, 516, 375	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	1, 516, 375	0. 00000	0 0	0	93. 00

	COMMUNITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15		Peri od:	Worksheet D-3	
			From 01/01/2018	D-+- /T: D	
			To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
	Title XVII	1	Hospi tal	PPS	Орш
Cost Center Description		o of Cost		Inpati ent	
oost conton bood ( ptron		Charges	Program	Program Costs	
		g		(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			835, 294		30. 00
31.00 03100 INTENSIVE CARE UNIT			2, 095, 641		31.00
40. 00   04000   SUBPROVI DER - 1 PF			0		40. 00
41. 00   04100   SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM		0. 297140	699, 128	207, 739	50.00
51. 00   05100   RECOVERY ROOM		0.000000	0	0	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM		1. 15173		0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 120838		259, 424	54.00
56. 00   05600   RADI 0I SOTOPE		0. 093339		38, 294	56. 00
60. 00   06000   LABORATORY		0. 150479		503, 178	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 32932		65, 544	63. 00
64. 00   06400   I NTRAVENOUS THERAPY		0.000000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 41930		267, 902	65. 00
66. 00   06600 PHYSI CAL THERAPY		0. 508012		49, 473	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 315208		6, 990	
68. 00 06800 SPEECH PATHOLOGY		0. 63962		6, 267	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 13355		21, 482	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 35908		402, 721	71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT		0. 258789		23, 576	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 33050		434, 707	73. 00
76. 00 03020 CARDI AC REHAB		1. 838464	4 133	245	76. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.000000		0	88. 00
88. 01   08801   RURAL HEALTH CLINIC II		0. 000000		0	88. 01
88. 02   08802   RURAL HEALTH CLINIC III		0. 000000		0	88. 02
88. 04   08803 RURAL HEALTH CLINIC V		0.000000		0	88. 04
88. 05   08804 RURAL HEALTH CLINIC VI		0.000000		0	88. 05

0. 401846

0. 125516

0.665013

0.353007

0. 831261

1. 176869

56, 448

833, 848

197, 790

11, 344, 378

90.00

0 90.01

92.00

93. 00

201. 00 202. 00

22, 683

294, 354

164, 415

0 90.02

0

2, 768, 994 200. 00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

90. 01

90.02

200.00

201.00

202.00

09001 ONCOLOGY

09002 PAIN MANAGEMENT

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER

Net charges (line 200 minus line 201)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61)

	Financial Systems DAVIESS COMMUNITY I NT ANCILLARY SERVICE COST APPORTIONMENT F		CN: 15-0061	Peri od:	wof Form CMS-2 Worksheet D-3	
		Component	CCN: 15-S061	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
		Title	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
- I	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDIATRICS			0		30.0
31.00	03100 INTENSIVE CARE UNIT			0		31.0
40.00	04000 SUBPROVI DER - I PF			8, 103, 900		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.0
	04300 NURSERY					43.0
	NCILLARY SERVICE COST CENTERS					
	D5000 OPERATI NG ROOM		0. 2971		3, 983	1
	D5100 RECOVERY ROOM		0.0000		0	
	D5200 DELIVERY ROOM & LABOR ROOM		1. 1517		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 1208		32, 948	1
	05600 RADI OI SOTOPE 06000 LABORATORY		0. 0933 0. 1504		1, 162 138, 586	
	06300 BLOOD STORING, PROCESSING & TRANS.		0. 1504		130, 300	
- 1	06400 INTRAVENOUS THERAPY		0. 0000		0	
	06500 RESPIRATORY THERAPY		0. 4193	99	41, 175	
1	06600 PHYSI CAL THERAPY		0. 5080		40, 027	
	06700 OCCUPATI ONAL THERAPY		0. 3152	· ·	1, 387	1
	06800 SPEECH PATHOLOGY		0. 6396		6, 373	68.0
69.00	06900 ELECTROCARDI OLOGY		0. 1335	51 43, 254	5, 777	69.0
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3590	85 83, 295	29, 910	71. C
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 2587	89 0	0	
	07300 DRUGS CHARGED TO PATIENTS		0. 3305		384, 631	
76.00	03020 CARDI AC REHAB		1. 8384	64 0	0	76.0
	OUTPATIENT SERVICE COST CENTERS		0.0000	00	0	
	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II		0.0000		0	
	08801 RURAL HEALTH CLINIC II		0.0000		0	88.0
	08803 RURAL HEALTH CLINIC V		0.0000		0	88.0
	08804 RURAL HEALTH CLINIC VI		0.0000		0	88. 0
	09000 CLINIC		0. 4018		0	1
	09001 ONCOLOGY		0. 1255		o o	
	09002 PAIN MANAGEMENT		0. 6650		Ō	90.0
	09100 EMERGENCY		0. 3530		43, 224	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8312		0	92.0
	04040 OTHER OUTPATIENT SERVICE COST CENTER		1. 1768	69 2, 965	3, 489	93.0
200.00	Total (sum of lines 50 through 94 and 96 through 98)			2, 826, 550	732, 672	200.0
201.00	Less PBP Clinic Laboratory Services-Program only charges (	line 61)		0		201. 0
202.00	Net charges (line 200 minus line 201)			2, 826, 550		202. 0

	ancial Systems DAVIESS COMMUNITY ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0061	Peri od:	worksheet D-3	
			CCN: 15-T061	From 01/01/2018 To 12/31/2018	Date/Time Pre	nared:
		Component	CCN. 15-1001		5/29/2019 4:3	
		Ti tl e	e XVIII	Subprovider - IRF	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	OO ADULTS & PEDI ATRI CS			0		30.00
	OO INTENSIVE CARE UNIT			0		31.00
40.00 0400	SUBPROVI DER - I PF			0		40.00
41.00 0410	OO SUBPROVI DER - I RF			1, 800, 728		41.00
	00 NURSERY					43.00
	LLARY SERVI CE COST CENTERS					
	OO OPERATI NG ROOM		0. 2971		1	1
	OO RECOVERY ROOM		0.0000			
	DO DELIVERY ROOM & LABOR ROOM		1. 1517		0	
	IO RADI OLOGY-DI AGNOSTI C IO RADI OI SOTOPE		0. 1208 0. 0933		5, 442 370	
	IO LABORATORY		0. 0933		24, 005	
	IO BLOOD STORING, PROCESSING & TRANS.		0. 1304			
	O I NTRAVENOUS THERAPY		0.0000		0	
	O RESPIRATORY THERAPY		0. 4193		69, 083	
	PHYSI CAL THERAPY		0. 5080			66.00
67. 00 0670	OO OCCUPATIONAL THERAPY		0. 3152	08 433, 877	136, 762	67.00
68. 00 0680	SPEECH PATHOLOGY		0. 6396	21 25, 064	16, 031	68. 00
	DO ELECTROCARDI OLOGY		0. 1335			
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3590			1
	O IMPL. DEV. CHARGED TO PATIENT		0. 2587		0	
	DO DRUGS CHARGED TO PATIENTS		0. 3305			
	OCARDIAC REHAB ATIENT SERVICE COST CENTERS		1. 8384	64 0	0	76. 00
	O RURAL HEALTH CLINIC		0.0000	00	0	88. 00
	1 RURAL HEALTH CLINIC II		0.0000		Ö	
	RURAL HEALTH CLINIC III		0.0000		0	88. 02
88. 04 0880	RURAL HEALTH CLINIC V		0.0000	00	0	88. 04
	14 RURAL HEALTH CLINIC VI		0.0000	00	0	88. 05
	DO CLINIC		0. 4018		0	
	ONCOLOGY		0. 1255		0	
	22 PAIN MANAGEMENT		0. 6650		0	
	OO EMERGENCY		0. 3530		0	
	OOOOBSERVATION BEDS (NON-DISTINCT PART) OOOTHER OUTPATIENT SERVICE COST CENTER		0.8312		1	
200. 00	Total (sum of lines 50 through 94 and 96 through 98)		1. 1768	1, 668, 555		
200.00	Less PBP Clinic Laboratory Services-Program only charges	(Line 61)		1,000,000	015, 545	200.00
202.00	Net charges (line 200 minus line 201)	(11110 01)		1, 668, 555		202. 00

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Period: From 01/01/2018	Worksheet D-3	
				To 12/31/2018	Date/Time Pre 5/29/2019 4:3	pared: O pm
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
INDATI ENT DOUTINE CEDVICE COCT CENTEDO						

		ii tie .	XIX	ноѕрі таі	Cost	
	Cost Center Description	Ra	atio of Cost	Inpatient	Inpati ent	
	<b>'</b>		To Charges	Program	Program Costs	
			3	Charges	(col. 1 x col.	
				g	2)	
			1. 00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00	03000 ADULTS & PEDI ATRI CS			107, 820		30. 00
31. 00	03100 I NTENSI VE CARE UNI T			124, 358		31. 00
	04000 SUBPROVI DER - I PF			124, 330		40. 00
41. 00	04100 SUBPROVIDER - TRF			0		41.00
				22 204		
43. 00	04300 NURSERY			32, 304		43. 00
	ANCILLARY SERVICE COST CENTERS		0.007440	407.070	00.050	
50. 00	05000 OPERATING ROOM		0. 297140	107, 872	32, 053	50. 00
51. 00	05100 RECOVERY ROOM		0. 000000	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1. 151736	28, 549	32, 881	52.00
54.00	05400  RADI OLOGY-DI AGNOSTI C		0. 120838	155, 536	18, 795	54.00
56.00	05600  RADI 0I SOTOPE		0. 093339	26, 873	2, 508	56.00
60.00	06000 LABORATORY		0. 150479	276, 599	41, 622	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 329321	21, 443	7, 062	63.00
64.00	06400 I NTRAVENOUS THERAPY		0.000000	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY		0. 419309	49, 101	20, 588	
66. 00	06600 PHYSI CAL THERAPY		0. 508012	32, 366	16, 442	
67. 00	06700 OCCUPATIONAL THERAPY		0. 315208	22, 455	7, 078	
68. 00	06800 SPEECH PATHOLOGY		0. 639621	3, 407	2, 179	
	06900 ELECTROCARDI OLOGY		0. 133551	13, 212	1, 764	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 359085	67, 275	24, 157	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 258789	8, 948	2, 316	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 330506	223, 585	73, 896	
76. 00	03020 CARDI AC REHAB		1. 838464	5	9	76. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		1. 087867	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		1. 003063	0	0	88. 01
88. 02	08802  RURAL HEALTH CLINIC III		0. 841678	0	0	88. 02
88. 04	08803 RURAL HEALTH CLINIC V		1. 025240	0	0	88. 04
88. 05	08804 RURAL HEALTH CLINIC VI		1. 117132	0	0	88. 05
90.00	09000 CLI NI C		0. 396391	0	0	90.00
90. 01	09001 0NC0L0GY		0. 125516	4	1	90. 01
90. 02	09002 PAI N MANAGEMENT		0. 665013	0	0	90. 02
91. 00	09100 EMERGENCY		0. 353007	58, 836	20, 770	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 831261	12, 096	10, 055	
93. 00	04040 OTHER OUTPATIENT SERVICE COST CENTER		1. 162984	12, 070	0,000	93. 00
200.00			1. 102 704	1, 108, 162	314, 176	
200.00		(Line 41)		1, 100, 102		
		(Title 61)		1 100 1/2		201. 00
202.00	Net charges (line 200 minus line 201)	1	l	1, 108, 162		202. 00

	Financial Systems DAVIESS COMMUNITY ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0061	Peri od:	u of Form CMS-: Worksheet D-3	
		Component	CCN: 15-S061	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Ti tl	e XIX	Subprovi der -	5/29/2019 4:3 Cost	о рііі
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Ü	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDIATRICS			0		30.00
31. 00	03100 INTENSIVE CARE UNIT			0		31.00
	04000 SUBPROVI DER - I PF			294, 192		40. 00
	04100 SUBPROVI DER – I RF			0		41.00
	04300 NURSERY			0		43. 00
	ANCILLARY SERVICE COST CENTERS 05000  OPERATING ROOM		0. 2971	40 0	0	50.00
	05100 RECOVERY ROOM		0. 2971		0	
	05200 DELIVERY ROOM & LABOR ROOM		1. 1517		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 1208		1, 074	
	05600 RADI OI SOTOPE		0. 0933	· ·	45	1
60.00	06000 LABORATORY		0. 1504		4, 738	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 3293	21 77	25	63. 00
	06400 I NTRAVENOUS THERAPY		0.0000		0	
	06500 RESPI RATORY THERAPY		0. 4193	· ·	2, 360	
	06600 PHYSI CAL THERAPY		0. 5080		1, 309	1
	06700 OCCUPATI ONAL THERAPY		0. 3152		53	
	06800 SPEECH_PATHOLOGY 06900 ELECTROCARDI OLOGY		0. 6396 0. 1335		205 218	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1333	· ·	463	
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 2587		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 3305		12, 907	
	03020 CARDI AC REHAB		1. 8384	· ·	0	1
	OUTPATIENT SERVICE COST CENTERS					]
	08800 RURAL HEALTH CLINIC		1. 0878		0	1
	08801 RURAL HEALTH CLINIC II		1.0030		0	
	08802 RURAL HEALTH CLINIC III		0. 8416		0	
	08803 RURAL HEALTH CLINIC V		1. 0252		0	
	08804  RURAL HEALTH CLINIC VI 09000  CLINIC		1. 1171 0. 3963		0	
	09001 ONCOLOGY		0. 3703		0	
	09002 PALN MANAGEMENT		0. 1255		0	
	09100 EMERGENCY		0. 3530		1, 510	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8312		0	1
	04040 OTHER OUTPATIENT SERVICE COST CENTER		1. 1629		234	1
200.00	Total (sum of lines 50 through 94 and 96 through 98)			96, 071	25, 141	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			96, 071		202. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0061	Peri od:	Worksheet D-3	
	Component	CCN: 15-T061	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 4:3	pared 0 pm
	Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description	<del>-</del>	Ratio of Cos	t Inpatient	I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				2.22	
0.00 03000 ADULTS & PEDIATRICS			0		30.
1.00 03100 INTENSIVE CARE UNIT			0		31.
0. 00   04000   SUBPROVI DER - 1 PF			0		40.
1. 00   04100   SUBPROVI DER - I RF			47, 979		41.
3. 00   04300  NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS		0.2071	10 11	2	-
0.00 05000 OPERATING ROOM		0. 2971		3	
1.00   05100   RECOVERY ROOM 2.00   05200   DELIVERY ROOM & LABOR ROOM		0.0000		0	
4. 00   05400   RADI OLOGY-DI AGNOSTI C		1. 1517 0. 1208		147	1
6. 00   05600   RADI 01 SOTOPE		0. 1208		147	
0. 00   06000   LABORATORY		0. 0733		564	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 3293		150	
4. 00   06400   I NTRAVENOUS THERAPY		0.0000		0	1
5. 00 06500 RESPIRATORY THERAPY		0. 4193		2, 370	65.
6. 00 06600 PHYSI CAL THERAPY		0. 5080	12 11, 753	5, 971	66.
7. 00 06700 OCCUPATI ONAL THERAPY		0. 3152	08 10, 617	3, 347	67.
8.00 06800 SPEECH PATHOLOGY		0. 6396	21 614	393	68.
9. 00   06900   ELECTROCARDI OLOGY		0. 1335		7	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3590		222	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 2587		0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3305		1, 933	
6. 00 03020 CARDI AC REHAB		1. 8384	64 0	0	76.
OUTPATIENT SERVICE COST CENTERS 8. 00   08800   RURAL HEALTH CLINIC		1. 0878	67 0	0	88.
8. 01   08801 RURAL HEALTH CLINIC II		1. 0070		0	
8. 02 08802 RURAL HEALTH CLINIC III		0. 8416		0	
8. 04   08803 RURAL HEALTH CLINIC V		1. 0252		0	
8.05 08804 RURAL HEALTH CLINIC VI		1. 1171		0	
0. 00   09000   CLI NI C		0. 3963		0	90.
0. 01   09001   0NCOLOGY		0. 1255	16 0	0	90.
O. O2 O9OO2 PAIN MANAGEMENT		0. 6650	13 0	0	90.
1.00   09100   EMERGENCY		0. 3530		0	1
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8312		0	
3.00 04040 OTHER OUTPATIENT SERVICE COST CENTER		1. 1629		0	
00.00 Total (sum of lines 50 through 94 and 96 through 98			40, 690	15, 117	1
01.00 Less PBP Clinic Laboratory Services-Program only ch	narges (line 61)		0		201.
02.00   Net charges (line 200 minus line 201)			40, 690		202.

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061		Worksheet E Part A Date/Time Prepared: 5/29/2019 4:30 pm

	Title XVIII Hospital	5/29/2019 4: 30 PPS	O pm
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1. 00	
1.00	DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2, 899, 502	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see linstructions)	910, 642	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octob 1 (see instructions)	per 0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	5, 965 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	1
3.00	Managed Care Simulated Payments	308, 129	3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment	37. 18	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending or before 12/31/1996. (see instructions)	on 0.00	5. 00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap 1 new programs in accordance with 42 CFR 413.79(e)	for 0.00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR $\$412.105(f)(1)(iv)(B)(1)$ ACA $\$5503$ reduction amount to the IME cap as specified under 42 CFR $\$412.105(f)(1)(iv)(B)(2)$ If the specified under 42 CFR $\$412.105(f)(1)(iv)(B)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)$	0.00 ne 0.00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions.  Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1202)	0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the co	ost 0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions.  The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital		8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see		9. 00
10. 00	instructions)  FTE count for allopathic and osteopathic programs in the current year from your records	0.00	1
11. 00 12. 00	FTE count for residents in dental and podiatric programs.		11. 00 12. 00
13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.	0.00	•
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 199 otherwise enter zero.		•
15. 00		0.00	15. 00
	Adjustment for residents in initial years of the program	l .	16. 00
	Adjustment for residents displaced by program or hospital closure	l .	17. 00
	Adjusted rolling average FTE count	0.00000	18. 00 19. 00
	Current year resident to bed ratio (line 18 divided by line 4).  Prior year resident to bed ratio (see instructions)	0.00000	
21. 00	Enter the Lesser of Lines 19 or 20 (see instructions)	0.000000	
	IME payment adjustment (see instructions)	0.000000	22. 00
	IME payment adjustment - Managed Care (see instructions)	0	1
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$ .	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	1
	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	
26. 00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	1
27. 00	IME payments adjustment factor (see instructions)	0. 000000	•
28. 00	IME add-on adjustment amount (see instructions)	0	•
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	•
29. 00	Total IME payment ( sum of lines 22 and 28)	0	29. 00
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	0	29. 01
	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3. 33	1
31. 00	Percentage of Medicaid patient days (see instructions)	27. 77	
32.00	Sum of lines 30 and 31	31. 10	
33. 00	Allowable disproportionate share percentage (see instructions)	12.00	1
34. 00	Disproportionate share adjustment (see instructions)	114, 304	34.00

ALCUL	Financial Systems DAVIESS COMMUNI ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Peri od:	Worksheet E	
			From 01/01/2018 To 12/31/2018	Part A Date/Time Pre	pare
		Title XVIII	Hospi tal	5/29/2019 4: 3 PPS	U pm
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
5. 00	Total uncompensated care amount (see instructions)		6, 766, 695, 164	8, 272, 872, 447	35.
5. 01	Factor 3 (see instructions)		0. 000052342	0. 000053319	
5. 02	Hospital uncompensated care payment (If line 34 is zero, entinstructions)	er zero on this line) (se	e 354, 184	441, 099	35.
5. 03	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	264, 910	111, 181	35.
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.		376, 091		36.
0. 00	Additional payment for high percentage of ESRD beneficiary d Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46) 0		40.
). 00	652, 682, 683, 684 and 685 (see instructions)	discharges for M3-DRGS			40.
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.
. 01	instructions) Total ESRD Medicare covered and paid discharges excluding MS	DDCc 452 402 402 404	0		41.
. 01	an 685. (see instructions)	, DNO3 002, 002, 003, 004			+1.
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qual	,	0.00		42
. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6 instructions)	82, 683, 684 an 685. (see	0		43
. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44
00	days)	`	0.00		۱.,
. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line 4	•	0.00		45 46
. 00	Subtotal (see instructions)		4, 306, 504		47
. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)			Amount	
				1. 00	
. 00	Total payment for inpatient operating costs (see instruction	•		4, 306, 504	
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a Exception payment for inpatient program capital (Wkst. L, Pt			305, 063 0	
. 00	Direct graduate medical education payment (from Wkst. E-4, I			0	
. 00	Nursing and Allied Health Managed Care payment			0	
. 00 . 01	Special add-on payments for new technologies Islet isolation add-on payment			0	
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	
. 00	Cost of physicians' services in a teaching hospital (see int			0	
. 00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.		hrough 35).	0	
. 00	Total (sum of amounts on lines 49 through 58)	TV, Cot. 11 Title 200)		4, 611, 567	
. 00	Pri mary payer payments			0	1
. 00	Total amount payable for program beneficiaries (line 59 minu	s line 60)		4, 611, 567	
. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			612, 260 9, 715	
	Allowable bad debts (see instructions)			86, 627	
. 00	Adjusted reimbursable bad debts (see instructions)			56, 308	1
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		47, 187	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	annlicable to MS-DRGs (s	ee instructions)	4, 045, 900 0	1
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50 . 87	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration	, ,	instructions)	0	1
. 88	SCH or MDH volume decrease adjustment (contractor use only)	•		0	
. 89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)			70
). 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
). 91 ). 92	HSP bonus payment HRR adjustment amount (see instructions)			0	1
). 92 ). 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			-171	1
). 94	HRR adjustment amount (see instructions)			-8, 605	1
	Recovery of accelerated depreciation			0	70

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-0061	Peri od: From 01/01/2018 To 12/31/2018		
		Ti tl	e XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal yea the corresponding federal year for the perio		n column 0		2018	495, 340	70. 96
70.97 Low volume adjustment for federal fiscal year the corresponding federal year for the perior				2019	222, 746	70. 97

		0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	2018	495, 340	70. 96
	the corresponding federal year for the period prior to 10/1)			
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	2019	222, 746	70. 97
	the corresponding federal year for the period ending on or after 10/1)			
70. 98	Low Volume Payment-3		0	70. 98
70. 99	HAC adjustment amount (see instructions)		0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4, 755, 210	71.00
71. 01	Sequestration adjustment (see instructions)		95, 104	71. 01
71. 02	Demonstration payment adjustment amount after sequestration		0	71. 02
72.00	Interim payments		4, 590, 694	72. 00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		69, 412	74. 00
	73)			
75.00	Protested amounts (nonallowable cost report items) in accordance with		0	75. 00
	CMS Pub. 15-2, chapter 1, §115.2			
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90. 00
	plus 2.04 (see instructions)			
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92. 00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93. 00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94. 00
95. 00	Time value of money for operating expenses (see instructions)		0	95. 00
96.00	Time value of money for capital related expenses (see instructions)		0	96. 00
		Prior to 10/1	On/After 10/1	
		1. 00	2. 00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100. 00
	HVBP Adjustment for HSP Bonus Payment			
	HVBP adjustment factor (see instructions)	0. 00000000	<b>I</b>	
102.00	NUMBD adjustment amount for USD benus normant (see instructions)			
	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102. 00
	HRR Adjustment for HSP Bonus Payment			
	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	0.000	0.0000	103. 00
	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)	0.000	0.0000	
104.00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus	0.000	0.0000	103. 00 104. 00
104.00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th	0.000	0.0000	103. 00
104.00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th  Century Cures Act? Enter "Y" for yes or "N" for no.	0.000	0.0000	103. 00 104. 00
104. 00 200. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement	0.000	0.0000	103. 00 104. 00 200. 00
104. 00 200. 00 201. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)	0.000	0.0000	103. 00 104. 00 200. 00 201. 00
200. 00 201. 00 202. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)	0.000	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00
200. 00 201. 00 202. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00
200. 00 201. 00 202. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00
200. 00 201. 00 202. 00 203. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o period)	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
200. 00 201. 00 202. 00 203. 00 204. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o period)  Medicare target amount	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year operiod)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year operiod)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o 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	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o 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 instructions)	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o 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 instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o 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  Drogram reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o 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 instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year operiod)  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 instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use  Total adjustment to Medicare IPPS payments (see instructions)	0.000 itment ne 21st	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o 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 instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  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	0.000 itment ne 21st	0 0.0000 0 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o period)  Medicare target amount  Case-mix adjustment factor (see instructions)  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 instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use  Total adjustment to Medicare Part A IPPS payments (from line 211)	0.000 itment ne 21st	0 0.0000 0 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00
104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 211.00 212.00 213.00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o 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  Deficial Program reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use  Total adjustment to Medicare Part A IPPS payments (from line 211)  Comparision of PPS versus Cost Reimbursement  Descriptions  Total adjustment to Medicare Part A IPPS payments (from line 211)  Low-volume adjustment (see instructions)	0.000  Itment  De 21st  Of the current 5-year demons	0 0.0000 0 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00
104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 210.00 211.00 212.00 213.00	HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus  Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)  Medicare discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year o period)  Medicare target amount  Case-mix adjustment factor (see instructions)  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 instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use  Total adjustment to Medicare Part A IPPS payments (from line 211)	0.000  Itment  De 21st  Of the current 5-year demons	0 0.0000 0 0	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2018 | Part A Exhibit 4 | To 12/31/2018 | Date/Time Prepared: 5/29/2019 4:30 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0061

						0 12/01/2010	5/29/2019 4: 30	
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
	1	0	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	2, 899, 502	0	2, 899, 502		2, 899, 502	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier	1. 02	910, 642	0		910, 642	910, 642	1. 02
1.02	payments for discharges occurring on or after October 1	1. 02	710, 042	O		710, 042	710, 042	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	5, 965	0	5, 965	0	5, 965	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	308, 129	0	308, 129	0	308, 129	4. 00
F 00	Indirect Medical Education Adju		0.000000	0.000000	0.00000	0.000000		F 00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0.000000	0. 000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
7. 00	instructions) Indirect Medical Education Adju IME payment adjustment factor	ustment for the 27.00	2 Add-on for Se 0.000000	ction 422 of t 0.000000		0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
9. 00	for managed care (see instructions)	20.00	0	0	0	0	0	0.00
9. 00	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29. 00 29. 01	0	0	0	0	0	9. 00 9. 01
7.01	care (sum of lines 6.01 and 8.01)	27.01	J	O		Ü	0	7. 01
	Di sproporti onate Share Adjustm							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10. 00
11. 00	instructions) Disproportionate share	34. 00	114, 304	0	86, 985	27, 319	114, 304	11. 00
11. 01	adjustment (see instructions) Uncompensated care payments	36. 00	376, 091	0	264, 909	111, 182	376, 091	11. 01
10.00	Additional payment for high per		ש beneficiary		_			12.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	O	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	4, 306, 504 0	0		1, 049, 143 0	4, 306, 504 0	13. 00 14. 00
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see	49. 00	4, 306, 504	0	3, 257, 361	1, 049, 143	4, 306, 504	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	305, 063	0	-76, 273	381, 336	305, 063	16. 00
17. 00	if applicable) Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17. 01 17. 02

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL		In Lie	u of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provi der Co	CN: 15-0061	From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2019 4:30 pm

					Т	o 12/31/2018	Date/Time Pre 5/29/2019 4:3	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	С	0	0	10.00
19. 00	SUBTOTAL			0	3, 181, 088	1, 430, 479	4, 611, 567	19. 00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	304, 234	0	-76, 684	380, 918	304, 234	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	829	0	620	209	829	20. 01
21.00	Capital DRG outlier payments	2. 00	0	0	-209	209	0	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	C	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0. 0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	0	C	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	305, 063	0	-76, 273	381, 336	305, 063	26. 00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 155714	0. 155714		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			495, 340		495, 340	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				222, 746	222, 746	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Heal th Financial SystemsDAVIESS COMMUNIHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Peri od: Worksheet E From 01/01/2018 Part A Exhi bit 5 To 12/31/2018 Date/Ti me Prepared: 5/29/2019 4: 30 nm Provider CCN: 15-0061

				'	0 12/31/2010	5/29/2019 4: 30	
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	2, 899, 502	2, 899, 502		2, 899, 502	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	910, 642		910, 642	910, 642	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	C		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00	5, 965	5, 965	0	5, 965	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	c	0	0	2. 01
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0 308, 129	C C		0	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0.000000	0. 000000		5. 00
6. 00	(see instructions) IME payment adjustment (see instructions)	22. 00	0	C	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	C		0	6. 01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000				7. 00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0	C C	0	0	8. 00 8. 01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0	C	0	0 0	9. 00 9. 01
	lines 6.01 and 8.01) Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33.00	0. 1200	0. 1200	0. 1200		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	114, 304				11. 00
	instructions) Uncompensated care payments	36. 00	376, 091			376, 091	11. 01
	Additional payment for high percentage of ESF						
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	С	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47. 00 48. 00	4, 306, 504 0	3, 257, 362 C	1, 049, 142 0	4, 306, 504 0	13. 00 14. 00
15. 00	instructions) Total payment for inpatient operating costs (see instructions)	49. 00	4, 306, 504	3, 257, 362	1, 049, 142	4, 306, 504	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	305, 063	-76, 273	381, 336	305, 063	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	0	C	0	0	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	C		0	18. 00
19. 00	SUBTOTAL			3, 181, 089	1, 430, 478	4, 611, 567	19. 00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
From 01/01/2018 To 12/31/2018				Worksheet E Part A Exhibi Date/Time Pre 5/29/2019 4:3	pared:	
		Title	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	304, 234	-76, 68	4 380, 918	304, 234	20. 00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	829	62	0 209	829	20. 01
21.00 Capital DRG outlier payments	2.00	0	-20	9 209	0	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0. 0000		22. 00
23 00 Indirect medical education adjustment (see	6.00	٥			Λ .	23 00

		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	304, 234	-76, 684	380, 918	304, 234	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	829	620	209	829	20. 01
21.00	Capital DRG outlier payments	2.00	0	-209	209	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	0.0000	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. 0000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	0	0	25. 00
26. 00	1	12.00	305, 063	-76, 273	381, 336	305, 063	26. 00
	1	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	495, 340	495, 340		495, 340	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	222, 746		222, 746	222, 746	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-171	-128	-43	-171	30. 00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-8, 605	-6, 436	-2, 169	-8, 605	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(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	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der (	CCN: 15-0061	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 4:30 pm

NATE 8 - MEDICAL AND OTHER HEALTH SERVICES   1.00				12/31/2010	5/29/2019 4:3	
MART S - MEDICAL AND OTHER PRACTICS SEA INSTRUCTIONS   8,42   1.00			Title XVIII	Hospi tal		
MART S - MEDICAL AND OTHER PRACTICS SEA INSTRUCTIONS   8,42   1.00						
Medical and other services (see Instructions)   842   1.00					1. 00	
Medical and other services relaburated under 0PPS (see Instructions)					0.40	
3.00   OPPS payments   5,719,788   3.00   0.00			ti ana)			1
0.011 or payment (see instructions)			LI OIIS)			•
0.00   0.01   1.01   1.02						1
Enter the hospit plat space   Fire payment to cost ratio (see Instructions)   0.000   5.00						1
Sum of Times 3, 4, and 4, 01, divided by Time 6   0.00   7.00		· · · · · · · · · · · · · · · · · · ·	ctions)		0.000	1
Transit tional corridor payment (see instructions)   0   8   0   0   0   0   0   0   0   0	6.00	Line 2 times line 5			0	6. 00
Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200   0   9, 00   10, 00   00   00   00   00   00						1
10.00   Organ acquist it ons   10.00						
10.70   Oxal cost (sum of lines 1 and 10) (see instructions)   842   10.00			V, col. 13, line 200			1
Communation for ELESSER OF COST OR CHARGES		9				1
Reasonable charges   2, 549   12, 00   April 1 ary service charges   2, 549   12, 00   13, 00   0 rigan acquisition charges (From West. D-4, Pt. IIII, col. 4, line 69)   0 13, 00   13, 00   13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 13, 00   0 14, 00   0 14, 00   0 15, 00	11.00				042	11.00
12.00   Ancillary service charges   2.549   12.00						
13.00   Organ acquisition charges (From Wixst. D-4, Pt. III., col. 4, line 69)   0   13.00	12. 00				2, 549	12.00
Customary_charges			ne 69)			1
15.00   Aggregate amount actually collected from patients   Iable for payment for services on a charge basis   0   16.00   Amounts that would have been reade in accordance with 42 CFR §413.13(e)   0.000000   17.00   18.00   17.00   18.00   17.00   18.00   18.00   17.00   18.00   17.00   18.0	14.00	Total reasonable charges (sum of lines 12 and 13)			2, 549	14. 00
16.00   Amounts that would have been realized from patients   1able for payment for services on a chargebasis   had such payment been made in accordance with 42 CFR \$413.13(e)   17.00   17						
had such payment been made in accordance with 42 CFR \$413.13(e)						•
17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00   2.549   18.00   17.00   2.549   18.00   17.00   2.549   18.00   17.00   2.549   18.00	16.00	<u>'</u>	1 3	cnargebasis	0	16.00
18.00   Total customery charges (see instructions)   2,549   18.00   1,707   19.00   20.00	17 00		=)		0.000000	17 00
19.00   Excess of customary Charges over reasonable cost (complete only if line 18 exceeds line 11) (see   1,707   19.00						1
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00			y if line 18 exceeds line	11) (see		1
Instructions		instructions)				
2.1 0.0   Lesser of cost or charges (see instructions)   0.2 0.0	20. 00		y if line 11 exceeds line	18) (see	0	20. 00
22. 00   Interns and residents (see instructions)   0   22. 00   23. 00	21 00				0.40	21 00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   5.24.00		g ,				1
Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9)   5, 249, 952   24, 00		· · · · · · · · · · · · · · · · · · ·	ructions)			1
COMPUTATION OF REIMBURSEMENT SETTLEMENT   COMPUTATION OF REIMBURSEMENT SETTLEMENT   Computation		, , , , , , , , , , , , , , , , , , , ,	detrons)		-	1
26. 00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   1, 037, 246   26. 00				·		
27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   10   10   10   10   10   10   10   1	25.00	Deductibles and coinsurance amounts (for CAH, see instructions	5)		0	25. 00
Instructions						
28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   28. 00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29. 00   2	27. 00		olus the sum of lines 22 an	d 23] (see	4, 213, 549	27. 00
9.9 00         ESRD direct medical education costs (from Wkst. E-4, line 36)         29, 00           30. 00         Subtotal (sum of lines 27 through 29)         4, 213, 549         30. 00           31. 00         Primary payer payments         173         31. 00           32. 00         Autotal (line 30 minus line 31)         4, 213, 376         32. 00           33. 00         Composite rate ESRD (from Wkst. I-5, line 11)         0         33. 00           34. 00         All owable bad debts (see instructions)         253, 047         34. 00           36. 00         All owable bad debts (see instructions)         164, 481         35. 00           36. 00         All owable bad debts for dual eligible beneficiaries (see instructions)         213, 648         36. 00           36. 00         All owable bad debts for dual eligible beneficiaries (see instructions)         213, 648         36. 00           37. 00         MSP-LCC reconciliation amount from PS&R         1, 277         38. 00           39. 00         THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         0         39. 50           39. 97         Permostration payment adjustment amount before sequestration         0         39. 50           39. 98         Partial or full credits received from manufacturers for replaced devices (see instructions)         0         39. 99      <	20 00	l	no E0)		0	20 00
30.00   Subtotal (sum of lines 27 through 29)   173   30.00   31.00   71 mary payer payments   173   31.00   31.00   71 mary payer payments   173   31.00			ne 30)			1
31.00   Primary payer payments   173   31.00   32.00   Subtotal (line 30 minus line 31)   4,213,376   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   32.00   Composite rate ESRD (from Wist. 1-5, line 11)   5.00   33.00   Allowable bad debts (see instructions)   553,047   34.00   34.00   Allowable bad debts (see instructions)   164,481   35.00   36.00   Allowable bad debts (see instructions)   213,648   36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   213,648   36.00   37.00   Subtotal (see instructions)   4,377,875   37.00   37.00   Subtotal (see instructions)   39.00		· · · · · · · · · · · · · · · · · · ·				1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33. 00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   33. 00   34. 00   All owable bad debts (see instructions)   253, 047   34. 00   35. 00   Adjusted reimbursable bad debts (see instructions)   164, 481   35. 00   36. 00   All lowable bad debts for dual eligible beneficiaries (see instructions)   213, 648   36. 00   213, 648   36. 00   38. 00   MSP-LCC reconciliation amount from PS&R   4, 377, 857   37. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00   0   0   0   0   0   0   0   0   0	31.00	,				1
33.00       Composite rate ESRD (from Wkst. I-5, line 11)       0       33.00       33.00       253,047       34.00         34.00       All lowable bad debts (see instructions)       164,481       35.00       36.00       All justed reimbursable bad debts (see instructions)       213,648       36.00         35.00       All lowable bad debts for dual eligible beneficiaries (see instructions)       213,648       36.00         37.00       Subtotal (see instructions)       4,377,857       37.00         39.00       MSP-LCC reconciliation amount from PS&R       1,277       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.97       Pioneer ACO demonstrati on payment adjustment (see instructions)       39.50         39.97       Pemonstrati on payment adjustment amount before sequestration       0       39.97         39.98       RECOVERY OF ACCELERATED DEPRECIATION       39.97         40.00       Subtotal (see instructions)       4,376,580       40.00         40.01       Demonstration payment adjustment amount after sequestration       87,532       40.01         40.02       Interim payments       4,252,844       41.00         42.00       Tentative settlement (for contractors use only)       36,204       43.00	32.00				4, 213, 376	32. 00
34.00			CES)			
35. 00						
36.00		, ,				1
37.00   Subtotal (see instructions)   4,377,857   37.00   38.00   MSP-LCC reconciliation amount from PS&R   1,277   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   39.97   Demonstration payment adjustment amount before sequestration   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99   40.00   Subtotal (see instructions)   4,376,580   40.00   40.02   Demonstration payment adjustment amount after sequestration   4,376,580   40.00   40.01   40.02   Demonstration payment adjustment amount after sequestration   40.02   Demonstration payment adjustment amount after sequestration   40.02   Demonstration payment adjustment amount after sequestration   40.02   40.02   40.02   40.02   40.02   40.03   40.03   40.04			ructions)			•
38. 00       MSP-LCC reconciliation amount from PS&R       1, 277       38. 00         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39. 00         39. 50       Pioneer ACO demonstration payment adjustment (see instructions)       39. 50         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 95         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       4, 376, 580       40. 00         40. 01       Sequestration adjustment (see instructions)       87, 532       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 20         41. 00       Interim payments       4, 252, 844       41. 00         42. 00       Tentative settlement (for contractors use only)       0       42. 00         43. 00       Balance due provider/program (see instructions)       36, 204       43. 00         44. 00       Filts. 2       TO BE COMPLETED BY CONTRACTOR       0       90. 00         90. 00       Original outlier amount (see instructions)       0       90. 00			deti ons)			
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   90.00   39.50   90.00   39.50   90.00   39.50   90.00		· · · · · · · · · · · · · · · · · · ·				1
39. 97 39. 98 39. 99 Recovery of accelerated Deprectations of the sequestration of the seques	39.00					39. 00
39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       4, 376, 580       40. 00         40. 01       Sequestration adjustment (see instructions)       87, 532       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         41. 00       Interim payments       4, 252, 844       41. 00         42. 00       Tentative settlement (for contractors use only)       0       42. 00         43. 00       Balance due provider/program (see instructions)       36, 204       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00         5115. 2       To BE COMPLETED BY CONTRACTOR       0       90. 00         90. 00       Original outlier amount (see instructions)       0       91. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       91. 00         92. 00       The rate used to calculate the Time Value of Money       0. 00       92. 00         93. 00       Time Value of Money (see instructions)       0       93. 00	39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			1
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99						•
40.00       Subtotal (see instructions)       4, 376, 580       40.00         40.01       Sequestration adjustment (see instructions)       87, 532       40.01         40.02       Demonstration payment adjustment amount after sequestration       0 40.02         41.00       Interim payments       4, 252, 844       41.00         42.00       Tentative settlement (for contractors use only)       42.00       0 42.00         43.00       Balance due provider/program (see instructions)       36, 204       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0 44.00         90.00       Original outlier amount (see instructions)       0 90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0 91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0 93.00		·	ced devices (see instructio	ns)		•
40.01       Sequestration adjustment (see instructions)       87,532       40.01         40.02       Demonstration payment adjustment amount after sequestration       0 40.02         41.00       Interim payments       4,252,844       41.00         42.00       Tentative settlement (for contractors use only)       0 42.00         43.00       Bal ance due provider/program (see instructions)       36,204       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0 44.00         70 BE COMPLETED BY CONTRACTOR       0 90.00         91.00       Original outlier amount (see instructions)       0 90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0 91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0 93.00						•
40.02       Demonstration payment adjustment amount after sequestration       0       40.02         41.00       Interim payments       4,252,844       41.00         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Balance due provider/program (see instructions)       36,204       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0       44.00         70 BE COMPLETED BY CONTRACTOR       0       90.00       90.00       91.00       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0       93.00		,				1
41.00   Interim payments   4, 252, 844   41.00   42.00   Tentative settlement (for contractors use only)   0   42.00   43.00   Balance due provider/program (see instructions)   36, 204   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   §115.2   TO BE COMPLETED BY CONTRACTOR   0   0   0   0   0   0   0   0   0						1
42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 42.00  44.00 43.00  44.00 90.00  90.00  90.00  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 Time Value of Money (see instructions)  93.00				ļ		•
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f		Tentative settlement (for contractors use only)				1
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions)						1
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)	44. 00	, , , , , , , , , , , , , , , , , , ,	nce with CMS Pub. 15-2, cha	pter 1,	0	44. 00
90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00 Time Value of Money (see instructions)	90 00				0	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00 Time Value of Money (see instructions)		,				1
93.00 Time Value of Money (see instructions) 0 93.00		1		ļ		1
94.00   Total (sum of lines 91 and 93) 0   94.00		1				1
	94. 00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061	Peri od: From 01/01/2018	Worksheet E
	Component CCN: 15-S061		
	Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovider -	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)			0	1. 00 2. 00
2. 00 3. 00	OPPS payments			0	3.00
4. 00	Outlier payment (see instructions)			0	4. 00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions	;)		0. 000	5. 00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co	ol. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges				
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69	<i>'</i> )		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for paymen			0	
16. 00	Amounts that would have been realized from patients liable for paym had such payment been made in accordance with 42 CFR §413.13(e)	ient for services of	n a chargebasis	U	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	0	19. 00
20.00	instructions)  Every of reasonable cost over sustantial charges (complete only if	Line 11 evenede Li	no 10) (coo	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete only if instructions)	Time it exceeds iti	ne 18) (See	U	20. 00
21. 00	Lesser of cost or charges (see instructions)			0	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructio	ns)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (	for CAH, see instr	uctions)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus t			0	27. 00
	instructions)				
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50 ESRD direct medical education costs (from Wkst. E-4, line 36)	1)		0	28. 00 29. 00
30. 00	Subtotal (sum of lines 27 through 29)			0	30.00
31. 00	Primary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31)			0	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		1		
33.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
	Allowable bad debts for dual eligible beneficiaries (see instructio	ons)		0	36. 00
37. 00				0	37. 00
	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 00 39. 50
39. 50 39. 97	Demonstration payment adjustment amount before sequestration			0	39. 50 39. 97
39. 98	Partial or full credits received from manufacturers for replaced de	evices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	, i	0	39. 99
40.00	Subtotal (see instructions)			0	40. 00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02 41. 00	Demonstration payment adjustment amount after sequestration Interim payments			0	40. 02 41. 00
42.00	Tentative settlement (for contractors use only)			0	41.00
43. 00	Balance due provider/program (see instructions)			0	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR		T	0	00.00
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92. 00	The rate used to calculate the Time Value of Money				92.00
93. 00	Time Value of Money (see instructions)			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Provider CCN: 15-0061

Interfim 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.						5/29/2019 4:30	) pm
Total interim payments paid to provider							
1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00			Inpatien	t Part A	Par	rt B	
1.00   Total interim payments paid to provider   4,590,694   4,252,844   4,252,841   1,2			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interfim 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.				2.00	3. 00	4. 00	
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If hone, write "NONE" or enter a zero	1.00	Total interim payments paid to provider		4, 590, 69	4	4, 252, 844	1. 00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero tist 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)	2.00	Interim payments payable on individual bills, either			0	0	2.00
Write "NONE" or enter a zero							
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)							
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02   0   0   0   3.0     3.03   3.04   0   0   0   3.0     3.05   0   0   0   3.0     3.06   0   0   0   3.0     3.07   3.08   0   0   0   3.0     3.08   3.09   3.50   0   0   0     3.51   3.52   0   0   0   3.5     3.53   3.54   0   0   0   3.5     3.54   0   0   0   3.5     3.55   0   0   0   3.5     3.56   3.59   0   0   0   3.5     3.57   3.59   0   0   0   3.5     3.59   3.50   3.99     4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4.590,694   4.252,844   4.0     4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4.590,694   4.252,844   4.0     5.01   Total interim payments (sum of lines 1, 2, and 3.99)   5.0     5.02   Total interim payments (sum of lines 1, 2, and 3.99)   5.0     5.03   Total interim payments (sum of lines 1, 2, and 3.99)   5.0     6.00   Total interim payments (sum of lines 1, 2, and 3.99)   6.0     7.00   Total interim payments (sum of lines 3.01-3.49 minus sum of lines 4.0   0   0   0     7.00   Total interim payments (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   0   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0   0   0   0     7.00   Total Medicare program liability (see instructions)   0   0	3 01						3. 01
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR  5.01 TENTATIVE TO PROGRAM  TENTATIV		ADJUSTIMENTS TO TROVIDER					3. 02
3.04   0   0   0   3.6     3.05					-	- 1	3. 03
3.50   Provider to Program					-		3. 04
Provider to Program							3. 05
3.50   ADJUSTMENTS TO PROGRAM	0.00	Provider to Program			<u> </u>	J	0.00
3.51   3.52   3.53   0	3.50				o	0	3. 50
3.53   3.54   3.54   3.59   3.50-3.98   0   0   0   3.50-3.98   3.50-3.98   4.590,694   4.252,844   4.00   7.50					Ö	0	3. 51
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4.590,694   4.252,844   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	3.52				o	0	3. 52
3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   4,590,694   4,252,844   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4,590,694   4,252,844   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4,590,694   4,252,844   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4,590,694   4,252,844   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4,590,694   4,252,844   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4,590,694   4,252,844   4.00   Total Medicare program to Provider   5.00   Total Medicare program to Provider to Program to Provider   5.00   Total Medicare program liability (see instructions)   5.00   Total Medicare program liability (see instructions)   4,660,106   4,289,048   7.00   7	3.53				o	0	3. 53
3. 50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)	3.54				o	0	3. 54
4.00   Total interim payments (sum of lines 1, 2, and 3.99)   4,590,694   4,252,844   4.0	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)       10 BE COMPLETED BY CONTRACTOR         5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00         Frogram to Provider       0       0       5.00         5.01 TENTATIVE TO PROVIDER       0       0       5.00         5.02 5.03		1					
appropriate   TO BE COMPLETED BY CONTRACTOR	4.00			4, 590, 69	4	4, 252, 844	4. 00
TO BE COMPLÉTED BY CONTRACTOR							
5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	F 00			Ι			F 00
Write "NONE" or enter a zero. (1)   Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER		Program to Provider					
5.02   0	5 01				0	0	5. 01
5.03   Provider to Program   S.50   TENTATIVE TO PROGRAM   O   O   S.50     5.51   O   O   O   S.50     5.52   O   O   O   S.50     5.52   O   O   O   S.50     5.59   Subtotal (sum of lines 5.01-5.49 minus sum of lines   S.50-5.98)   O   O   S.50     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   O   O   O   O     6.01   SETTLEMENT TO PROVIDER   O   O   O   O     6.02   SETTLEMENT TO PROGRAM   O   O   O   O     7.00   Total Medicare program liability (see instructions)   O   O   O   O     7.00   Total Medicare program liability (see instructions)   O   O   O     8.00   O   O   O   O     8.00   O   O     8.00   O   O   O     8.00   O     8.00   O   O     8.00   O   O     8.00   O   O     8.00   O     8.00   O   O     8.00   O   O     8.00   O     8.00   O   O     8.00   O   O     8.00		TERMINE TO TROTTEE					5. 02
TENTATI VE TO PROGRAM   0						0	5. 03
5.51   0		Provider to Program		•	•		
5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   69,412   36,204   6.00   Contractor Number   6.00   Contractor Nu	5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 69,412 36,204 6.00 6.02 SETTLEMENT TO PROGRAM 0 0 0 6.00 7.00 Total Medicare program liability (see instructions) 4,660,106 4,289,048 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.51				0	0	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00						- 1	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	5. 99	`			0	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  6.01 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  6.01 SETTLEMENT TO PROGRAM 7.00 Contractor NPR Date (Mo/Day/Yr) 8.00 NPR Date (Mo/Day/Yr) 9.00 NPR Date (Mo/Day/Yr) 1.00 2.00		1					_
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1. 00 2. 00	6. 00	` '					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	. 01			/0.44		2/ 22/	/ 01
7.00 Total Medicare program liability (see instructions)  4,660,106  Contractor Number (Mo/Day/Yr)  0 1.00 2.00							6. 01
Contractor NPR Date (Mo/Day/Yr)           0         1.00         2.00					-		
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Total Medicare program Hability (see Instructions)		4, 660, 10			7.00
0 1.00 2.00							
				)			
o.vv inductor contractor	8. 00	Name of Contractor			1.00	2.00	8. 00

Health Financial Systems	DAVIESS COMMUNITY	Y HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVICES RENDERED	Provider CCN: 15-0061		Worksheet E-1
			From 01/01/2018	
		Component CCN, 1E CO/1	To 10/01/0010	Data /Tima Dranarad.

| Component CCN: 15-S061 | To | 12/31/2018 | Date/Time Prepared: | 5/29/2019 4:30 pm | | Title XVIII | Subprovider - | PPS |

		Title	XVIII	Subprovi der - I PF	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	T	1.00	2.00	3. 00	4. 00	
1.00	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		4, 577, 41 <i>6</i>		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER			)	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	ADJUSTMENTS TO PROGRAM		C	)	0	3. 50
3. 51			(		0	
3.52			(		0	
3.53			(		0	3. 53
3.54			(	)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		(		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR		4, 577, 416		0	4.00
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5.03			(	)	0	5.03
	Provi der to Program	1	_		_	
5. 50	TENTATI VE TO PROGRAM		(		0	
5. 51					0	
5. 52 5. 99	Colotatal (sum of lines 5 01 5 40 minus sum of lines				0	
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			,	0	
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		22, 947		0	6.01
6. 02	SETTLEMENT TO PROGRAM			2	0	
7. 00	Total Medicare program liability (see instructions)		4, 600, 363		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor	I				8.00

Health Financial Systems	DAVIESS COMMUNIT	Y HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	R SERVICES RENDERED	Provider CCN: 15-0061		Worksheet E-1
			From 01/01/2018	
		Component CCN: 15 TO61	To 12/21/2010	Data/Tima Droparod

 Component CCN: 15-T061
 To
 12/31/2018
 Date/Time Prepared: 5/29/2019 4: 30 pm

 Title XVIII
 Subprovider PPS

			XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	I=	1.00	2.00	3. 00	4. 00	
1. 00 2. 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		1, 946, 511		0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		(		0	3. 01
3. 02					o	3. 02
3.03					0	3. 03
3.04					0	3. 04
3.05					0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3.51			(		0	3. 51
3.52			(		0	3. 52
3.53			(		0	3. 53
3.54			(		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		(	D	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 946, 511	1	0	4. 00
	TO BE COMPLETED BY CONTRACTOR	ı		1		
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5.02			(		0	5. 02
5.03			(		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51			(		0	5. 51
5. 52			(		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		(		0	6. 01
6.02	SETTLEMENT TO PROGRAM		1, 053		0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 945, 458		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor					8.00

					5/29/2019 4: 30	0 pm
			XVIII	Swing Beds - SNF		
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider			0	0	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		Г	_1	_	
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3. 04				0	0	3. 04
3. 05				0	0	3. 05
2 50	Provider to Program					2 50
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				-		3. 51
3. 52				0	0	3. 52
3.53				0		3. 53
3. 54 3. 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines			0	0	3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			U	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)			0	0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as			O .		4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
,	the cost report. (1)				_	,
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	0	7. 00
				Contractor	NPR Date	
		,	)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		,	1.00	2.00	8. 00
5. 50	Tham of solition			1	1	0.00

Heal th	Financial Systems DAVIESS COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0061 Period: Worksheet From 01/01/2018 Part II To 12/31/2018 Date/Time 5/29/2019					epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst		e 14		1. 00
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00 3. 00
	3.00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)				30.00
31.00					31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32. 00

Health Financial Systems	DAVIESS COMMUNITY	′ HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-0061	Period: From 01/01/2018	
		Component CCN: 15-U061		Date/Time Prepared: 5/29/2019 4:30 pm

				5/29/2019 4: 30	0 pm
		Title XVIII	wing Beds - SNF	PPS	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1		
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, a				3. 00
4 00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruct			0.00	4 00
4. 00	Per diem cost for interns and residents not in approved teaching pr	rogram (see		0. 00	4. 00
E 00	instructions)			0	F 00
5.00	Program days	ations)	0	0	5.00
6. 00 7. 00	Interns and residents not in approved teaching program (see instructional utilization review - physician compensation - SNF optional method of	only		U	6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	on y		0	8.00
9. 00	Primary payer payments (see instructions)			0	9. 00
10. 00	Subtotal (line 8 minus line 9)		0	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	to physician	0	0	11. 00
11.00	professional services)	to physician		Ö	11.00
12.00	Subtotal (line 10 minus line 11)		o	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records) (exc	clude coinsurance	O	0	13. 00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	14. 00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0	15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstration	n) payment	0		16. 55
	adjustment (see instructions)			_	
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		0	0	17.00
	Adjusted reimbursable bad debts (see instructions)	>	0	0	17. 01
	Allowable bad debts for dual eligible beneficiaries (see instruction Total (see instructions)	ons)	0	0	18. 00 19. 00
	Sequestration adjustment (see instructions)		0	0	19.00
	Demonstration payment adjustment amount after sequestration)			0	19.01
	Interim payments			0	20.00
	Tentative settlement (for contractor use only)		0	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and 2°	1)	0	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance wi	•	0	0	23. 00
	chapter 1, §115.2			_	
	Rural Community Hospital Demonstration Project (§410A Demonstration	n) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period ι	under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201. 00	Medicare swing-bed SNF inpatient routine service costs (from Wkst.	D-1, Pt. II, line			201. 00
202 00	66 (title XVIII hospital))	+ D 21 2 1:			202 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wks <sup>1</sup> 200 (title XVIII swing-bed SNF))	t. D-3, COL. 3, TINE			202. 00
202 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				203.00
204.00	Computation of Demonstration Target Amount Limitation (N/A in first	t year of the current	5-vear demonst	ration	204.00
	period)	year or the earrent	. o year demonst	1 4 1 7 011	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times I	ine 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement	t			
207.00	Program reimbursement under the §410A Demonstration (see instruction	ons)			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col	. 1, sum of lines 1			208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructions	s)			209. 00
210. 00	Reserved for future use				210. 00
045 66	Comparision of PPS versus Cost Reimbursement	1! 242) (			015 00
∠15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plinstructions)	us line 210) (see			215. 00
			1		I

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061	From 01/01/2018	
	Component CCN: 15-S061	To 12/31/2018	Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Subprovi der -	PPS

	IPF		
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	4, 959, 422	1. 00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	3, 437	3.00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4. 01
5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6. 00
7. 00	Current year's unweighted L&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7. 00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9.00	Average Daily Census (see instructions)	16. 520548	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	10.00
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	0	11. 00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	4, 962, 859	
13. 00	Nursing and Allied Health Managed Care payment (see instruction)	0	
14. 00	Organ acquisition (DO NOT USE THIS LINE)		14. 00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	
16.00	Subtotal (see instructions)	4, 962, 859	
17. 00	Primary payer payments	0	
18.00	Subtotal (line 16 less line 17).	4, 962, 859	•
19.00	Deductibles	203, 464	
20. 00 21. 00	Subtotal (line 18 minus line 19) Coinsurance	4, 759, 395 88, 559	
22. 00 23. 00	Subtotal (line 20 minus line 21) Allowable bad debts (exclude bad debts for professional services) (see instructions)	4, 670, 836 36, 019	
24. 00	Adjusted reimbursable bad debts (see instructions)	23, 412	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26, 313	
26. 00	Subtotal (sum of lines 22 and 24)	4, 694, 248	
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	4, 094, 248	
28. 00	Other pass through costs (see instructions)	0	
29. 00	Outlier payments reconciliation	0	
30. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
30. 99	Demonstration payment adjustment amount before sequestration	l ő	
31. 00	Total amount payable to the provider (see instructions)	4, 694, 248	
31. 01	Sequestration adjustment (see instructions)	93, 885	
31. 02	Demonstration payment adjustment amount after sequestration	0	
32.00	Interim payments	4, 577, 416	32.00
33.00	Tentative settlement (for contractor use only)	0	33. 00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	22, 947	34.00
35. 00	Protested amounts (nonal owable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
50. 00		0	50.00
51. 00	Outlier reconciliation adjustment amount (see instructions)	0	
52. 00	The rate used to calculate the Time Value of Money	0.00	
53.00	Time Value of Money (see instructions)	0	53. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Peri od: From 01/01/2018	Worksheet E-3
	Component CCN: 15-T061		Date/Time Prepared: 5/29/2019 4:30 pm
	Title XVIII	Subprovi der -	PPS
		LDE	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1. 00	Net Federal PPS Payment (see instructions)	1, 972, 513	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0195	1
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	30, 377	3. 00
4. 00	Outlier Payments	1, 698	ł
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prid	1	1
0.00	to November 15, 2004 (see instructions)		0.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	/ 00
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new transhing program" (see instructions)	w 0.00	7. 00
8. 00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	w 0.00	8. 00
6.00	teaching program" (see instructions)	0.00	0.00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10. 00	Average Daily Census (see instructions)	4. 161644	1
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	1
12. 00	Teaching Adjustment (see instructions)	0.000000	12.00
13. 00	Total PPS Payment (see instructions)	2, 004, 588	
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	2, 004, 500	
15. 00	Organ acquisition (DO NOT USE THIS LINE)	١	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	o	ł
17. 00	Subtotal (see instructions)	2, 004, 588	
18. 00	Primary payer payments	2, 00 1, 000	ł
19. 00	Subtotal (line 17 less line 18).	2, 004, 588	
20. 00	Deducti bl es	25, 412	
21. 00	Subtotal (line 19 minus line 20)	1, 979, 176	
22. 00	Coinsurance	0	22. 00
23. 00		1, 979, 176	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9, 208	
25. 00	Adjusted reimbursable bad debts (see instructions)	5, 985	
26. 00	, ,	6, 604	•
27. 00	Subtotal (sum of lines 23 and 25)	1, 985, 161	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	0	
30.00	Outlier payments reconciliation	0	30. 00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	1, 985, 161	32. 00
32. 01	Sequestration adjustment (see instructions)	39, 703	32. 01
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33.00	Interim payments	1, 946, 511	33. 00
34.00	Tentative settlement (for contractor use only)	0	34. 00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-1, 053	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	1, 698	•
	Outlier reconciliation adjustment amount (see instructions)	0	
52.00	The rate used to calculate the Time Value of Money	1	52.00
53.00	Time Value of Money (see instructions)	0	53. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2019 4:30 pm
	Ti +Lo VIV	⊎osni tal	Cost

Part VII. CALCULATION OF RETURNINGSMENT ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES   1.00   2.00				10 12/31/2018	5/29/2019 4:3	
PART VII - CALCULATION OF RETMOURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		
PART VIT - CACCULATION OF RET INSURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   Inpatient hospital of SNF/MF Services   401,004   401,307   2.00   2.00   Medical and other services   401,307   2.00   3.00   0 grap acquisit into (certified transplant centers only)   3.00   0 grap acquisit into (certified transplant centers only)   401,004   401,307   4.00   3.00   4.00   5.00   Inpatient pri mary payer payments   401,004   401,307   4.00   6.00   0 cutpatient pri mary payer payments   401,004   401,307   7.00   0 cutpatient pri mary payer payments   401,004   401,307   7.00   0 cutpatient pri mary payer payments   5.00   6						
Inpatient hospital/SNF/NF services		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	X SERVICES		
Inpatient hospital/SNF/NF services		COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00   Organ acquisition (certified transplant centers only)	1.00			461, 054		1.00
Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services			401, 370	2. 00
Inpat   Inpa	3.00	Organ acquisition (certified transplant centers only)		0		3.00
Outpatient primarry payer payments   0   0   6.00	4.00	Subtotal (sum of lines 1, 2 and 3)		461, 054	401, 370	4.00
2.00   Subtotal (line 4 less sum of lines 5 and 6)	5.00	Inpatient primary payer payments		0		5. 00
COMPUTATION OF LESSER OF COST OR CHARGES	6.00	Outpatient primary payer payments			0	6. 00
Reasonable Charges	7.00	Subtotal (line 4 less sum of lines 5 and 6)		461, 054	401, 370	7.00
8.00   Routine service charges   0   1, 199, 188   0.0   0.00   Another service charges   1, 108, 162   1, 599, 188   0.0   0.00   0   0   0   0   0   0						
0.00   Ancillary service charges   1,108,162   1,599,188   9.00   10.00   15.00   16						
10.00   Organ acquisition charges, net of revenue   10.00		Routine service charges		0		8. 00
11.00   Incentive from target amount computation   11.00   1,008,162   1,509,188   12.00   Total reasonable charges (sum of lines 8 through 11)   1,008,162   1,509,188   12.00   13				1, 108, 162	1, 599, 188	1
12.00   Total reasonable charges (sum of lines 8 through 11)   1,108,162   1,599,188   12.00				0		1
CUSTOMARY CHARGES				0		
13. 00   Amount actually collected from patients	12. 00			1, 108, 162	1, 599, 188	12.00
basis						
14. 00   Amounts that would have been realized from patients Liable for payment for services on a rarge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15. 00   16. 00   17. 00   1	13. 00		services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)  10. 00 Tatio of line 13 to line 14 (not to exceed 1.000000)  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 00000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 000000  10. 0000000  10. 0000000  10. 0000000  10. 000000000  10. 0000000000						
15. 00	14. 00			0	0	14.00
16.00	15 00		12 CFR §413. 13(e)	0.000000	0.000000	15 00
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   11.00   11.00   11.00   11.00   11.00   12.00		,				
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   18.00   10)   100   10			wifling 14 avecade			
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   19.00   19.0	17.00		y IT TIME TO exceeds	647, 108	1, 197, 818	17.00
16) (see instructions)	10 00		vifling 4 exceeds line	0	0	10 00
19.00   Interns and Residents (see instructions)   0   0   19.00   20.00   2	10.00		y IT TITLE 4 exceeds TITLE	0	U	10.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   Cost of covered services (enter the lesser of line 4 or line 16)   Main 10,054   Main 1	10 00			0	0	10 00
21.00   Cost of covered services (enter the lesser of line 4 or line 16)   RROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.   O			ructions)	Ĭ	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				١	-	
22.00   Other than outlier payments   0   0   0   22.00	21.00				401, 370	21.00
23.00       Outlier payments       0       0       23.00         24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0       26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       461,054       401,370       29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30.00       Excess of reasonable cost (from line 18)       0       0       30.00         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       461,054       401,370       31.00         32.00       Deductibles       0       0       32.00         33.00       All lowable bad debts (see instructions)       0       0       33.00         34.00       All lowable bad debts (see instructions)       0       34.00         35.00       Utilitzation review       0       35.00         36.00       Other anal color of t	22 00		Compressed for 115 provide		0	22 00
24. 00       Program capital payments       0       24. 00         25. 00       Capital exception payments (see instructions)       0       25. 00         26. 00       Routine and Ancillary service other pass through costs       0       0       26. 00         27. 00       Subtotal (sum of lines 22 through 26)       0       0       27. 00         28. 00       Customary charges (title V or XIX PPS covered services only)       0       0       28. 00         29. 00       Titles V or XIX (sum of lines 21 and 27)       461,054       401,370       29. 00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       461,054       401,370       31. 00         32. 00       Deductible s       0       0       0       32. 00         33. 00       Coinsurance       0       0       33. 00         34. 00       Allowable bad debts (see instructions)       0       0       34. 00         35. 00       Utilization review       0       0       35. 00         36. 00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       461,054       401,370       35. 00         37. 00       Othera Apulustments       -461,054       -401,370		1 3		-		
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Interim payments 40. 00 43. 00 41. 00 Interim payments 45. 00 0 0 43. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 46. 00 0 26. 00 0 0 26. 00 0 0 27. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 28. 00 0 0 40. 00 0 40. 00 0 0 0 0 0 30. 00 0 30. 00 0 0 0 30. 00 0 0 0 30. 00 0 0 0 0 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-	ŭ	
26.00 Routine and Ancillary service other pass through costs 0 0 26.00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 7 Titles V or XIX (sum of lines 21 and 27) 461,054 401,370  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 461,054 401,370 31.00 32.00 Deductibles 0 0 0 33.00 33.00 Coinsurance 0 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 461,054 401,370 36.00 37.00 OTHER ADJUSTMENTS 461,054 401,370 37.03 38.00 Subtotal (line 36 ± line 37) 0 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 0 40.00 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00		9   1   3		0		
27. 00 Subtotal (sum of lines 22 through 26) 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 461,054 401,370 29. 00  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 461,054 401,370 31. 00 31. 00 Deductibles 0 0 0 32. 00 32. 00 Deductibles 0 0 0 33. 00 33. 00 Coi nsurance 0 0 0 34. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 461,054 401,370 36. 00 37. 00 OTHER ADJUSTMENTS -461,054 -401,370 37. 00 38. 00 Subtotal (line 36 ± line 37) 0 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 0 40. 00 41. 00 Interim payments 0 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00				0	0	
29. 00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				0	0	
29. 00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29.00	Titles V or XIX (sum of lines 21 and 27)		461, 054	401, 370	29. 00
31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32. 00 Deductibles  33. 00 Coinsurance  34. 00 Allowable bad debts (see instructions)  35. 00 Utilization review  36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37. 00 OTHER ADJUSTMENTS  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  401, 054  401, 370  401, 370  401, 370  401, 370  401, 370  401, 370  401, 370  402, 00  403, 00  404, 00  405, 00  407, 00  408, 00  409,		COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
32. 00 Deductibles 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 461,054 401,370 36. 00 37. 00 OTHER ADJUSTMENTS -461,054 -401,370 37. 00 38. 00 Subtotal (line 36 ± line 37) 0 0 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 0 0 40. 00 41. 00 Interim payments 0 0 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) 0 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	30.00	Excess of reasonable cost (from line 18)		0	0	30.00
33. 00   Coinsurance   0   0   33. 00   34. 00   Allowable bad debts (see instructions)   0   34. 00   35. 00   Utilization review   0   35. 00   36. 00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   461,054   401,370   37. 00   OTHER ADJUSTMENTS   -461,054   -401,370   37. 00   38. 00   Subtotal (line 36 ± line 37)   0   0   0   39. 00   Direct graduate medical education payments (from Wkst. E-4)   0   0   38. 00   39. 00   Total amount payable to the provider (sum of lines 38 and 39)   0   0   40. 00   41. 00   Interim payments   0   0   41. 00   42. 00   Balance due provider/program (line 40 minus line 41)   0   0   42. 00   43. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43. 00	31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	461, 054	401, 370	31.00
34.00   Allowable bad debts (see instructions)	32.00	Deducti bl es		0	0	32.00
35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 461, 054 401, 370 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 40. 00 Interim payments 41. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 45. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 461, 054 401, 370 461, 054 401, 370 461, 054 401, 370 401, 370 9 0 0 0 38. 00 39. 00 0 0 0 0 40. 00 41. 00 42. 00 43. 00	33.00	Coi nsurance		0	0	33. 00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Hoterim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  401, 054  401, 370  401, 370  401, 370  37.00  38.00  39.00  0  0  0  41.00  42.00	34.00	Allowable bad debts (see instructions)		0	0	34. 00
37. 00 OTHER ADJUSTMENTS  38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 17. 00 1 37. 00 38. 00  0 39. 00  0 40. 00  0 41. 00  0 42. 00  43. 00	35.00	Utilization review		0		35. 00
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 38.00 39.00 40.00 41.00 41.00 42.00 43.00	36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)		401, 370	36. 00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  39.00 40.00 41.00 41.00 42.00 43.00	37.00	OTHER ADJUSTMENTS		-461, 054	-401, 370	37. 00
40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 40.00  0 40.00  0 41.00  0 42.00  42.00  43.00				0	0	
41.00 Interim payments  0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				٩		
42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0		
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00		1 3		-		
chapter 1, §115.2	43.00		nce with CMS Pub 15-2,	0	0	43.00
		cnapter 1, §115.2				I

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0061	Peri od: From 01/01/2018	Worksheet E-3
	Component CCN: 15-S061		
	Title XIX	Subprovi der -	Cost
		IPF	

		I PF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	173, 767		1.00
2.00	Medical and other services		0	2. 00
3.00	Organ acquisition (certified transplant centers only)	0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)	173, 767	0	4. 00
5.00	Inpatient primary payer payments	0		5. 00
6.00	Outpatient primary payer payments		0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	173, 767	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routi ne servi ce charges	0		8. 00
9.00	Ancillary service charges	96, 071	0	
10.00	Organ acquisition charges, net of revenue	0		10.00
11. 00	Incentive from target amount computation	0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)	96, 071	0	12.00
	CUSTOMARY CHARGES			
13. 00	Amount actually collected from patients liable for payment for services on a charge	0	0	13. 00
	basis	_	_	
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0. 000000	
16.00	Total customary charges (see instructions)	96, 071	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	0	0	17. 00
40.00	line 4) (see instructions)	77 (0)	0	40.00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	77, 696	0	18. 00
19. 00	16) (see instructions)   Interns and Residents (see instructions)	0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	•
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	96, 071	0	21. 00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide	<del></del>	U	21.00
22. 00	Other than outlier payments	0	0	22. 00
23. 00	Outlier payments		0	23. 00
24. 00	Program capital payments		O	24. 00
25. 00	Capital exception payments (see instructions)			25. 00
26. 00	Routine and Ancillary service other pass through costs		0	
27. 00	Subtotal (sum of lines 22 through 26)		0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	
29. 00	Titles V or XIX (sum of lines 21 and 27)	96, 071	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	70, 07 1		27.00
30. 00	Excess of reasonable cost (from line 18)	77, 696	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	96, 071	0	31.00
32. 00	Deductibles	0	0	
33. 00	Coinsurance	0	0	33. 00
34. 00	Allowable bad debts (see instructions)	0	0	
35. 00	Utilization review	0	_	35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	96, 071	0	36.00
37. 00	OTHER ADJUSTMENTS	-96, 071	0	37. 00
38. 00	Subtotal (line 36 ± line 37)	0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	o	Ü	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)	o	0	
41. 00	Interim payments	o	0	
42. 00	Balance due provider/program (line 40 minus line 41)	o	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	O	0	43.00
	chapter 1, §115.2			
				•

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0061	Peri od: From 01/01/2018	Worksheet E-3 Part VII
	Component CCN: 15-T061	To 12/31/2018	Date/Time Prepared: 5/29/2019 4:30 pm
	Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX	1	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	. 020 . 010 . 1 . 1 . 2 . 0 . 0 . 0 . 0 . 0 . 0 . 0 . 0 . 0	. 02.111.020		
1.00	Inpatient hospital/SNF/NF services		15, 117		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0	_	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		15, 117	0	4. 00
5. 00	Inpatient primary payer payments		0	-	5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		15, 117	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		127	-	
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		40, 690	0	9. 00
10. 00	Organ acquisition charges, net of revenue		0	· ·	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		40, 690	0	12. 00
	CUSTOMARY CHARGES		1 12/ 2/ 2	-	
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis	g-		-	
14.00	Amounts that would have been realized from patients liable for	payment for services on	o	0	14.00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		40, 690	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	25, 573	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16	)	15, 117	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23.00
24. 00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		15, 117	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		15, 117	0	31. 00
32.00	Deducti bl es		0	0	32.00
33. 00	Coi nsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	15, 117	0	36. 00
37. 00	OTHER ADJUSTMENTS		-15, 117	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. 00
41. 00	Interim payments		0	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		

Health Financial Systems

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

Provider CCN: 15-0061 Period: From 01/01

Offi y)					5/29/2019 4:3	O pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
	I	1.00	2. 00	3. 00	4. 00	
4 00	CURRENT ASSETS	1 110 70	1	ام		
1.00	Cash on hand in banks	1, 119, 794		0	0	
2.00	Temporary investments	0	0	0	0	•
3.00	Notes receivable	0	_	0	0	•
4.00	Accounts receivable	18, 654, 265		0	0	4. 00
5.00	Other receivable	541, 816		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-10, 953, 493		0	0	6.00
7.00	Inventory	1, 380, 441		0	0	7. 00
8.00	Prepai d expenses	538, 775		0	0	
9.00	Other current assets	524, 000		0	0	
10.00	Due from other funds	0		0	0	•
11. 00	Total current assets (sum of lines 1-10)	11, 805, 598	0	0	0	11. 00
12 00	FIXED ASSETS	1 200 055		0	0	12 00
12.00	Land	1, 280, 955		0	0	•
13.00	Land improvements	687, 865		0	0	13.00
14.00	Accumulated depreciation	-683, 509		0	0	14.00
15. 00 16. 00	Buildings	64, 509, 458 -43, 968, 796		0	0	15. 00 16. 00
17. 00	Accumulated depreciation			0	0	•
18. 00	Leasehold improvements	39, 119		0	0	18.00
19. 00	Accumulated depreciation Fixed equipment	-35, 528 7, 765, 420		0	0	19.00
	Accumulated depreciation	-4, 857, 078		0	0	20.00
20. 00 21. 00	Automobiles and trucks	-4,037,070	0	0	0	21.00
21.00	Accumulated depreciation		0	0	0	21.00
	•	29, 886, 514		0	0	23. 00
23. 00	Major movable equipment			0	0	•
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-27, 044, 089	0	0	0	
26. 00	Accumulated depreciation		0	0	0	
27. 00	HIT desi gnated Assets		0	0	0	27.00
28. 00	Accumulated depreciation		0	0	0	28.00
29. 00	·		0	0	0	29.00
30. 00	Minor equipment-nondepreciable	27 500 221		-	0	ł
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	27, 580, 331	0	U	U	30.00
31. 00	Investments	3, 367, 670	0	0	0	31.00
32. 00	Deposits on Leases	3,307,070	0	0	0	
33. 00	Due from owners/officers		0	0	0	
34. 00	Other assets	2, 540, 970		0	0	1
35. 00	Total other assets (sum of lines 31-34)	5, 908, 640		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	45, 294, 569		-	0	•
30.00	CURRENT LIABILITIES	45, 274, 507	0	U <sub>I</sub>	U	30.00
37. 00	Accounts payable	2, 397, 010	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	713, 090		0	0	38.00
39. 00	Payroll taxes payable	203, 836		0	0	•
40. 00	Notes and Loans payable (short term)	24, 940, 654		0	0	
41. 00	Deferred income	24, 740, 034		0	0	41.00
42. 00	Accel erated payments		0	O	O	42.00
43. 00	Due to other funds		0	0	0	1
44. 00	Other current liabilities	2, 395, 318		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	30, 649, 908				1
45.00	LONG TERM LIABILITIES	30, 047, 700	0	U U	0	45.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable				0	1
48. 00	Unsecured Loans			o	0	
49. 00	Other long term liabilities	16, 824, 270		0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	16, 824, 270		o	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	47, 474, 178		-	0	51.00
31.00	CAPITAL ACCOUNTS	1 47, 474, 170		<u> </u>	0	31.00
52. 00	General fund balance	-2, 179, 609				52. 00
53. 00	Specific purpose fund	2,177,007	0			53. 00
54. 00	Donor created - endowment fund balance - restricted		١	0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			١	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	•
56.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	-2, 179, 609	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	45, 294, 569		0	0	
55. 66	[59]	.5, 2, 4, 507				55.50
		•		. '		•

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0061

Period: Worksheet G-1 From 01/01/2018

12/31/2018 Date/Time Prepared: 5/29/2019 4:30 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 12, 318, 796 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -2, 637, 385 2.00 Total (sum of line 1 and line 2) 3.00 9, 681, 411 0 3.00 4.00 TRANSFER TO LTC OPERATIONS -11, 861, 018 0 0 4.00 5.00 0 5.00 0000 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) -11, 861, 018 10.00 Subtotal (line 3 plus line 10) -2, 179, 607 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 0 12.00 00000 13.00 13.00 14.00 0 14.00 0 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance -2, 179, 607 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 TRANSFER TO LTC OPERATIONS 4.00 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00

Health Financial Systems DATATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0061

			To	12/31/2018	Date/Time Prep 5/29/2019 4:30	
	Cost Center Description	Inpati	ent	Outpati ent	Total	<b>У</b> РШ
		1.0		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	6, 5	47, 390		6, 547, 390	1.00
2.00	SUBPROVI DER - I PF		09, 134		10, 609, 134	2.00
3.00	SUBPROVI DER - I RF		26, 924		2, 326, 924	3.00
4.00	SUBPROVI DER		•			4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	19, 4	83, 448		19, 483, 448	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3, 5	12, 422		3, 512, 422	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of li	nes 3, 5	12, 422		3, 512, 422	16.00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		95, 870		22, 995, 870	
18. 00	Ancillary services	26, 7	84, 926	86, 256, 658	113, 041, 584	
19. 00	Outpati ent servi ces		0	947, 770	947, 770	19. 00
20. 00	RURAL HEALTH CLINIC		0	1, 134, 490	1, 134, 490	
20. 01	RURAL HEALTH CLINIC II		0	1, 313, 326	1, 313, 326	
20. 02	RURAL HEALTH CLINIC III		0	2, 375, 673	2, 375, 673	
20. 04	RURAL HEALTH CLINIC V		0	1, 403, 909	1, 403, 909	
20. 05	RURAL HEALTH CLINIC VI		0	752, 444	752, 444	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY			0	0	22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC		_	_	_	24. 00
24. 10	CORF		0	0	0	
25. 00	AMBULATORY SURGICAL CENTER (D. P. )			4 000 040	4 000 040	25. 00
26. 00	HOSPICE		0	1, 302, 840	1, 302, 840	
27. 00	OTHER		0 704	6, 625, 456	6, 625, 456	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	D WKST.   49, /	80, 796	102, 112, 566	151, 893, 362	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		I	62, 855, 065		29. 00
30.00	ADD (SPECIFY)		0	02, 000, 000		30.00
31. 00	ADD (SPECIFF)		0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		J	О		36. 00
37. 00	DEDUCT (SPECIFY)		0	ď		37. 00
38. 00	DEDUCT (SECOTET)		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		3	n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		62, 855, 065		43. 00
	to Wkst. G-3, line 4)			==, 500, 000		
		'	1	'	'	

	Financial Systems DAVIESS COMMUNITY			u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0061	Peri od: From 01/01/2018	Worksheet G-3	
			To 12/31/2018	Date/Time Pre	pared:
	<u> </u>			5/29/2019 4: 30	O pm
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			151, 893, 362	
2.00	Less contractual allowances and discounts on patients' accoun	ts		92, 998, 213	
3.00	Net patient revenues (line 1 minus line 2)			58, 895, 149	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		62, 855, 065	•
5.00	Net income from service to patients (line 3 minus line 4)			-3, 959, 916	5. 00
	OTHER I NCOME			000	
6.00	Contributions, donations, bequests, etc			-902	
7.00	Income from investments			59, 745	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts				10.00
11.00	Rebates and refunds of expenses				11.00
12.00	Parking lot receipts				12.00
13.00	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and guests			277, 512	
15. 00	Revenue from rental of living quarters				15. 00
16. 00	Revenue from sale of medical and surgical supplies to other the	han patients		0	1
17. 00	Revenue from sale of drugs to other than patients			520, 012	
18. 00	Revenue from sale of medical records and abstracts			13, 208	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			143, 622	
23. 00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUE			303, 279	
25.00	Total other income (sum of lines 6-24)			1, 322, 531	
	Total (line 5 plus line 25)			-2, 637, 385	
	OTHER EXPENSES (SPECIFY)			0	
	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)			-2, 637, 385	29. 00

5/29/2019 4:30 pm Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSIFI -SUBTOTAL CATI ONS 1 plus col 2.00 5. 00 1 00 3 00 4 00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT\* 1.00 0 0 0 2.00 CAP REL COSTS-MVBLE EQUIP\* 0 0 2.00 EMPLOYEE BENEFITS DEPARTMENT 3 00 0 3 00 0 4.00 ADMINISTRATIVE & GENERAL\* 114, 115 77, 626 191, 741 0 191, 741 4.00 PLANT OPERATION & MAINTENANCE\* 0 5.00 5.00 0 6.00 LAUNDRY & LINEN SERVICE\* 0 0 0 6.00 HOUSEKEEPI NG\* 0 0 0 7.00 C 0 7 00 8.00 DI ETARY\* 0 0 0 0 8.00 9.00 NURSING ADMINISTRATION\* 0 Ω 0 0 0 9 00 0 0 10.00 ROUTINE MEDICAL SUPPLIES\* 0 10 00 C 0 0 0 11.00 MEDICAL RECORDS\* 0 Ω 11.00 12.00 STAFF TRANSPORTATION\* 0 13, 689 13,689 0 13, 689 12.00 0 0 VOLUNTEER SERVICE COORDINATION\* 13.00 13.00 C 0 PHARMACY\* 0 14.00 C 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES\* 0 0 0 0 0 15.00 16.00 OTHER GENERAL SERVICE\* 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 DIRECT PATIENT CARE SERVICE COST CENTERS INPATIENT CARE-CONTRACTED\*\* 25.00 0 25.00 26.00 PHYSICIAN SERVICES\*\* 0 12,000 12,000 3, 470 15, 470 26.00 NURSE PRACTITIONER\*\* 27.00 0 C 0 27.00 REGISTERED NURSE\*\* 28.00 88.598 202, 728 291, 326 0 291, 326 28.00 29.00 LPN/LVN\*\* 0 0 0 29.00 0 PHYSI CAL THERAPY\*\* 30.00 0 0 30.00 0 OCCUPATIONAL THERAPY\*\* 0 31.00 C 0 Λ 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY\*\* 0 C 0 0 0 32.00 MEDICAL SOCIAL SERVICES\*\* 0 33.00 0 0 0 0 33.00 0 34.00 SPIRITUAL COUNSELING\* 0 0 0 34.00 DI ETARY COUNSELING\*\* 0 35, 00 C 0 Ω 35, 00 36.00 COUNSELING - OTHER\*\* 0 0 0 36.00 37.00 HOSPICE AIDE & HOMEMAKER SERVICES\*\* 55, 264 55, 264 0 55, 264 37.00 38 00 DURABLE MEDICAL EQUIPMENT/OXYGEN\*\* 38 00 0 C 0 0 39.00 PATIENT TRANSPORTATION\*\* 0 0 39.00 40.00 IMAGING SERVICES\* 0 0 0 40.00 0 0 0 41.00 LABS & DIAGNOSTICS\*\* 0 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE\*\* 0 42.00 C Λ 42.00 0 42.50 DRUGS CHARGED TO PATIENTS\*\* 0 0 0 0 42.50 0 0 43.00 OUTPATIENT SERVICES\*\* 0 0 43.00 44 00 PALLIATIVE RADIATION THERAPY\*\* 0 Ω 0 44 00 0 0 45.00 PALLIATIVE CHEMOTHERAPY\*\* 0 0 0 Ω 45.00 OTHER PATIENT CARE SERVICES (SPECIFY) \*\* 9, 956 9, 956 9, 956 46.00 46.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 0 60 00 60 00 0 0 61.00 VOLUNTEER PROGRAM \* 0 0 0 0 61.00 62.00 FUNDRAI SI NG\* 0 0 0 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS\* 0 0 0 63.00 63.00 0 PALLIATIVE CARE PROGRAM\* 64.00 Ω 0 64.00 0 0 65.00 OTHER PHYSICIAN SERVICES\* 0 0 0 65.00 RESIDENTIAL CARE\* 0 66.00 66.00 0 0 0 0 67.00 ADVERTI SI NG 67.00 0 TELEHEALTH/TELEMONI TORI NG\* 68 00 C 0 0 0 68 00 69.00 THRIFT STORE\* 0 0 0 69.00 0 70 00 NURSING FACILITY ROOM & BOARD\* 0 0 0 0 70.00 OTHER NONREIMBURSABLE (SPECIFY)\* 71.00 0 0 0 71.00

267, 933

306, 043

573, 976

3, 470

577, 446 100. 00

100.00 TOTAL

 $<sup>^{\</sup>star}$  Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

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

			·		5/29/2019 4:3	30 pm
				Hospi ce I		
		ADJUSTMENTS	TOTAL (col. 5			
			± col. 6)			
	CENEDAL CEDALOE COCT CENTEDO	6. 00	7.00			
1. 00	GENERAL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FLXT*	1 0	ol			1.00
2. 00	CAP REL COSTS-BLDG & FIXT		1			2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*		1			3. 00
4. 00	ADMINISTRATIVE & GENERAL*		1			4. 00
5. 00	PLANT OPERATION & MAINTENANCE*		171, 741			5. 00
6. 00	LAUNDRY & LINEN SERVICE*					6.00
7. 00	HOUSEKEEPI NG*					7. 00
8. 00	DI ETARY*					8. 00
9. 00	NURSING ADMINISTRATION*					9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*					10.00
11. 00	MEDI CAL RECORDS*		1			11. 00
12. 00	STAFF TRANSPORTATION*					12. 00
13. 00	VOLUNTEER SERVICE COORDINATION*		0			13. 00
14. 00	PHARMACY*					14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*		ol ol			15. 00
16. 00	OTHER GENERAL SERVICE*	0				16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS	'	'			
25.00	I NPATI ENT CARE-CONTRACTED**	0	0			25. 00
26.00	PHYSI CI AN SERVI CES**	0	15, 470			26. 00
27.00	NURSE PRACTITIONER**	0	o			27. 00
28.00	REGI STERED NURSE**	0	291, 326			28. 00
29. 00	LPN/LVN**	0	ol ol			29. 00
30.00	PHYSI CAL THERAPY**	0	o			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				37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0				38. 00
39. 00	PATIENT TRANSPORTATION**	0				39. 00
40.00	I MAGI NG SERVI CES**	0	1			40.00
41. 00	LABS & DI AGNOSTI CS**	0	1			41. 00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0			42. 00
42. 50	DRUGS CHARGED TO PATIENTS**	0				42. 50
43. 00	OUTPATIENT SERVICES**	0				43. 00
44. 00	PALLIATIVE RADIATION THERAPY** PALLIATIVE CHEMOTHERAPY**	0				44. 00
45. 00		0				45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	9, 956			46. 00
60. 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM *	0	0			60.00
61.00	VOLUNTEER PROGRAM *		1			61.00
62. 00	FUNDRAI SI NG*		1			62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*		1			63.00
64. 00	PALLIATIVE CARE PROGRAM*		1			64.00
65. 00	OTHER PHYSICIAN SERVICES*		1			65. 00
66. 00	RESI DENTI AL CARE*		1			66.00
67. 00						67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*					68. 00
69. 00	THRIFT STORE*		1			69.00
70. 00	NURSING FACILITY ROOM & BOARD*		1			70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*					71.00
	TOTAL		1			100.00
		·				

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Hospi ce CCN: 15-1553

Peri od: Worksheet 0-2 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

5/29/2019 4:30 pm Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 12,000 12,000 26.00 0 3, 470 15, 470 26.00 NURSE PRACTITIONER 27.00 0 27.00 0 0 28.00 REGISTERED NURSE 88, 598 202, 728 291, 326 0 291, 326 28.00 29.00 LPN/LVN 0 29.00 0 30.00 PHYSI CAL THERAPY 0 0 0 0 30.00 OCCUPATIONAL THERAPY 0 0 0 31.00 0 0 31.00 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 0 0 0 0 33.00 0 SPIRITUAL COUNSELING 0 34.00 0 34.00 0 0 35.00 DIETARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 0 0 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 37.00 55, 264 55, 264 55, 264 37.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38.00 38.00 0 39. 00 PATIENT TRANSPORTATION 0 0 0 39.00 40.00 I MAGING SERVICES 0 0 40.00 0 LABS & DIAGNOSTICS 0000 0 0 41.00 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 42.50 OUTPATIENT SERVICES 0 0 0 43.00 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 9, 956 9, 956 9, 956 46.00 100.00 TOTAL \* 372, 016 100. 00 153.818 214, 728 368, 546 3.470

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATIENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	15, 470	26. 00
27.00	NURSE PRACTITIONER	0	0	27. 00
28.00	REGI STERED NURSE	0	291, 326	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	o	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	o	34.00
35.00	DI ETARY COUNSELI NG	0	o	35. 00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	55, 264	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	ol ol	38. 00
39.00	PATI ENT TRANSPORTATION	0	ol ol	39.00
40.00	I MAGI NG SERVI CES	0	ol ol	40.00
41.00	LABS & DIAGNOSTICS	0	ol ol	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	ol ol	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	ol ol	42. 50
43.00	OUTPATIENT SERVICES	0	ol ol	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	ol ol	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	ol ol	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	9, 956	46.00
100.00	TOTAL *	0	372, 016	100.00

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

	Financial Systems DAVIESS COMMUN		011 45 00/2		u of Form CMS-2	
	NLLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET SES FOR ALLOCATION	Provider C	CN: 15-0061	Peri od: From 01/01/2018	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION	Hospi ce CC	N: 15-1553	To 12/31/2018	Date/Time Pre 5/29/2019 4:3	pared: O pm
				Hospi ce I		
	Descriptions		HOSPI CE DI REC		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
			instructions	) EXPENSES FROM WKST B PART I	1 + 2)	
				(see		
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 7, 519	7, 519	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 56, 851	56, 851	3. 00
4.00	ADMINISTRATIVE & GENERAL		191, 74		325, 138	
5.00	PLANT OPERATION & MAINTENANCE			0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE			0	0	6. 00
7. 00	HOUSEKEEPI NG			0 3, 167	3, 167	7. 00
8.00	DI ETARY			0 0	0	
9.00	NURSI NG ADMI NI STRATI ON			0 37, 895		1
10.00	ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS			0 13, 648		
11. 00 12. 00	STAFF TRANSPORTATION		13, 68	0 10, 941	10, 941 13, 689	
13. 00	VOLUNTEER SERVICE COORDINATION		13,00	0	13,009	13.00
14. 00	PHARMACY			0 0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	15.00
16. 00	OTHER GENERAL SERVICE			0 0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			60, 302	60, 302	17. 00
	LEVEL OF CARE		1			
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		372, 01	6	372, 016	51.00
52.00	HOSPICE INPATIENT RESPITE CARE			0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE			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 64. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM			0	0	63.00
65.00	OTHER PHYSICIAN SERVICES			0	0	64. 00 65. 00
66.00	RESI DENTI AL CARE			0	0	66.00
67. 00	ADVERTI SI NG			0	0	67.00
	TELEUENI TU/TELEMONI TODI NC				0	

68. 00

69. 00 70. 00 0 0

71. 00 99. 00 0

901, 166 100. 00

323, 720

68. 00 | TELEHEALTH/TELEMONI TORI NG

100. 00 TOTAL

69.00 THELEHEALTH TELEMONTTORING
69.00 THRIFT STORE
70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)
99.00 NEGATIVE COST CENTER

Health Financial Systems	DAVIESS COMMUNITY	Y HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC	E GENERAL SERVICE COSTS	Provider CCN: 15-0061	Peri od:	Worksheet 0-6

From 01/01/2018 To 12/31/2018 Part I Date/Time Prepared: Hospi ce CCN: 15-1553 5/29/2019 4:30 pm Hospi ce I TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions FIX EQUI P **BENEFITS** DEPARTMENT 1.00 2.00 0 ЗА 3.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 7, 519 7, 519 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 3.00 EMPLOYEE BENEFITS DEPARTMENT 56, 851 56, 851 3.00 4.00 ADMINISTRATIVE & GENERAL 325, 138 33, 835 358, 973 4.00 0 5.00 PLANT OPERATION & MAINTENANCE 0 5.00 0 0 LAUNDRY & LINEN SERVICE 0 6.00 0 0 0 0 6.00 7.00 HOUSEKEEPI NG 3, 167 0 3, 167 7.00 8.00 DI ETARY 0 0 0 0 0 0 0 0 8.00 NURSING ADMINISTRATION 0 9.00 37.895 0 37, 895 9.00 ROUTINE MEDICAL SUPPLIES 0 10.00 13,648 13, 648 10.00 0 11.00 MEDICAL RECORDS 10, 941 10, 941 11.00 12.00 STAFF TRANSPORTATION 13, 689 13, 689 12.00 VOLUNTEER SERVICE COORDINATION 0 13.00 13.00 0 0 0 14.00 PHARMACY 0 C 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15.00 OTHER GENERAL SERVICE 0 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 60, 302 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 372, 016 395, 032 51.00 23, 016 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 0 C 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM n 0 0 n 60.00 00000000000 0 VOLUNTEER PROGRAM 0 0 0 0 0 0 0 61.00 0 61.00 62.00 FUNDRAI SI NG 0 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 63.00 0 63.00 0 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 RESIDENTIAL CARE 0 0 66.00 0 66.00 67 00 ADVERTI SI NG Ω 0 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 0 68.00 69.00 THRIFT STORE C 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 0 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71 00 0 71.00

0

901, 166

7.519

7, 519

0

56, 851

0

7.519

901, 166 100. 00

99.00

99.00 NEGATIVE COST CENTER

100.00 TOTAL

			nospi ce coi	N. 13-1333	10 12/31/2010	5/29/2019 4:	
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	358, 973					4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0	)			5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	)	0		6. 00
7.00	HOUSEKEEPI NG	2, 097	0	)	5, 264		7. 00
8.00	DI ETARY	0	0	)	0	(	8.00
9.00	NURSI NG ADMI NI STRATI ON	25, 089	0	)	0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	9, 036	0	)	0		10.00
11.00	MEDI CAL RECORDS	7, 244	0	1	0		11. 00
12.00	STAFF TRANSPORTATION	9, 063	0	1	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	o	0	)	0		13. 00
14.00	PHARMACY	o	0	)	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0	)	o		15. 00
16.00	OTHER GENERAL SERVICE	ol	0	)	o		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	39, 925	0	)	o		17. 00
	LEVEL OF CARE			•	'		
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	261, 541					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	O	0	1	o o	(	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	O	0	1	o o	(	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0	)	0		61. 00
62.00	FUNDRAI SI NG	0	0	)	0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	O	0	1	0		63. 00
64.00	PALLIATIVE CARE PROGRAM	o	0	1	0		64.00
65.00	OTHER PHYSICIAN SERVICES	o	0	)	0		65. 00
66.00	RESI DENTI AL CARE	o	0	)	ol ol	(	66.00
67.00	ADVERTI SI NG	o	0	)	0		67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	o	0	)	0		68. 00
69. 00	THRI FT STORE	0	0		o		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	4, 978	0		0 5, 264	(	71.00
99. 00	NEGATI VE COST CENTER	o	0		ol ol	(	99.00
100.00	4	358, 973	0		0 5, 264	(	100.00
	*			•			•

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BA	SED HOSPICE GENERAL SERVICE COSTS	Provider CCN: 15-0061	Peri od:	Worksheet 0-6

01/01/2018 12/31/2018 From To Part I Date/Time Prepared: Hospi ce CCN: 15-1553 5/29/2019 4:30 pm Hospi ce I Descriptions NURSI NG ROUTI NE MEDI CAL VOLUNTEER STAFF MEDI CAL RECORDS SERVI CE ADMI NI STRATI ON TRANSPORTATI ON COORDI NATI ON **SUPPLIES** 9. 00 11. 00 12.00 10.00 13.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 62, 984 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 22, 684 10.00 11.00 MEDICAL RECORDS 0 18, 185 11.00 12.00 STAFF TRANSPORTATION 0 0 22, 752 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 0 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15.00 OTHER GENERAL SERVICE 0 o 16.00 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 50.00 HOSPICE ROUTINE HOME CARE 18, 185 51.00 62, 984 22, 684 22, 752 0 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 C 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 60.00 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 0 0 0 0 0 0 0 61.00 0 61.00 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 64.00 0 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 66.00 0 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 0 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 Ω 71.00 0 99.00 NEGATIVE COST CENTER 0 0 99.00 100.00 TOTAL 62, 984 22, 684 18, 185 22, 752 0 100.00

Heal th Financial	Systems	DAVIESS COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10	
COST ALLOCATION	- HOSPI TAL-BASED	HOSPI CE GENERAL	SERVICE COSTS	Provider CCN: 15-0061	Peri od:	Worksheet 0-6

From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Hospi ce CCN: 15-1553 5/29/2019 4:30 pm Hospi ce I Descriptions PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL ADMI NI STRATI VE SERVI CE RESI DENTI AL SERVI CES CARE SERVICES 14. 00 16. 00 18.00 15.00 17.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 9.00 NURSING ADMINISTRATION 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 13.00 VOLUNTEER SERVICE COORDINATION 13.00 14.00 PHARMACY 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 100, 227 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 50.00 0 0 0 0 HOSPICE ROUTINE HOME CARE 783, 178 51.00 0 0 0 0 51.00 HOSPICE INPATIENT RESPITE CARE 0 52.00 0 Λ 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 n 60.00 0 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 61.00 0 61.00 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 63.00 PALLIATIVE CARE PROGRAM 0 64.00 64.00 0 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 0 117, 988 71.00 100, 227 99.00 NEGATIVE COST CENTER 0 99.00 0 0

100, 227

901, 166 100. 00

100.00 TOTAL

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GE STATISTICAL BASIS	NERAL SERVICE COSTS	Provider CCN:	15-0061 15-1553	Peri od: From 01/01/2018 To 12/31/2018	Worksheet 0-6 Part II Date/Time Prepared: 5/29/2019 4:30 pm

			Hospi ce cci	I: 15-1553   I	0 12/31/2018	5/29/2019 4: 3	
					Hospi ce I	0,2,,201, 110	о р
	Cost Center Descriptions	CAP REL BLDG & C	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
		FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (I	DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
		(	, , , , , , , , , , , , , , , , , , ,	(GROSS		COSTS)	
				SALARI ES)			
		1.00	2. 00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	11.00					
1.00	CAP REL COSTS-BLDG & FLXT	585					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0	191, 741			3. 00
4.00	ADMINISTRATIVE & GENERAL	0	0	114, 115		542, 193	1
5. 00	PLANT OPERATION & MAINTENANCE	Ŏ	0	111, 110	000, 770	012, 170	5. 00
6. 00	LAUNDRY & LINEN SERVICE		0	0	0	0	1
7. 00	HOUSEKEEPI NG		0	0	0	3, 167	7. 00
8.00	DI ETARY		0	0	0	3, 107	1
9. 00			0	0	0	-	1
	NURSI NG ADMINI STRATI ON		٥	0	U	37, 895	1
10.00	ROUTINE MEDICAL SUPPLIES		0	0	0	13, 648	1
11. 00	MEDI CAL RECORDS	0	0	0	0	10, 941	1
12. 00	STAFF TRANSPORTATION	0	0	0	0	13, 689	1
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13. 00
14. 00	PHARMACY	0	0	0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	60, 302	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50. 00
51.00	HOSPICE ROUTINE HOME CARE			77, 626	0	395, 032	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	o	. 0	o	0	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	o	0	0	0	
	NONREI MBURSABLE COST CENTERS		-1	-	-1		
60.00	BEREAVEMENT PROGRAM	0	0	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	Ŏ	0	0	0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM		0	0	0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES		0	0	0	0	65. 00
66. 00	RESI DENTI AL CARE		0	0	0	0	66. 00
			0	0	0	0	1
67. 00	ADVERTI SI NG		0	0	U	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		0	0	U	0	68. 00
69. 00	THRIFT STORE	١	U	Ü	0	Ü	69.00
	NURSING FACILITY ROOM & BOARD		_	_	0		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	585	0	0	0	7, 519	1
	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0	56, 851		358, 973	
101. 00	UNIT COST MULTIPLIER	12. 852991	0. 000000	0. 296499		0. 662076	101. 00

	Financial Systems	DAVIESS COMMUN				eu of Form CMS-	
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSIS	Provi der C	CN: 15-0061	Peri od: From 01/01/2018	Worksheet 0-6	
STATES	TICAL BASIS		Hospi ce CC	N: 15-1553	To 12/31/2018	Date/Time Pre	pared:
						5/29/2019 4: 3	0 pm
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NO	Hospice I  B DIETARY	NURSI NG	
	cost center bescriptions	OPERATION &	LI NEN SERVI CE			ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY	(OGOTINE TEET	DAYS)	ADMIT IN STRUCTION	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
						HRS. )	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS		T			T	
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00 4. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						3. 00 4. 00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG			58	35		7. 00
8.00	DI ETARY				0 0		8.00
9. 00	NURSING ADMINISTRATION	0			0	11, 549	
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	1
11.00	MEDI CAL RECORDS	0			0	0	11. 00
12.00	STAFF TRANSPORTATION	0	)		0	0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0	)		0	0	13. 00
14. 00	PHARMACY	0	)		0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	1		0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0	l l		0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	)	L	0	l .	17. 00
50. 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE					0	50.00
50.00	HOSPICE CONTINUOUS HOME CARE					11, 549	
52. 00	HOSPICE INPATIENT RESPITE CARE	0			0 0	1	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE			•		1	53.00
00.00	NONREI MBURSABLE COST CENTERS		1	1	<u> </u>	<u> </u>	00.00
60.00	BEREAVEMENT PROGRAM	0	)		0	0	60.00
61.00	VOLUNTEER PROGRAM	0	)		0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	)		0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM	0	)		0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	)		0	0	65. 00
66. 00	RESI DENTI AL CARE	0	) C	)	0	0	66. 00
67. 00	ADVERTI SI NG	0	)		0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	(		U	0	68.00
69.00	THRIFT STORE		'		U	0	69.00

0.000000

0.000000

70.00

71.00

99.00

62, 984 100. 00 5. 453632 101. 00

585

0.000000

5, 264

8. 998291

70.00 NURSING FACILITY ROOM & BOARD 71.00 OTHER NONREIMBURSABLE (SPECIFY)

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)
101.00 UNIT COST MULTIPLIER

99.00 NEGATIVE COST CENTER

Health Financial Systems DAVIESS COMMUNITY HOSPITAL				In Lie	u of Form CMS-	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der CCN	N: 15-0061	Peri od:	Worksheet 0-6	
STATI STI CAL BASI S				From 01/01/2018		
		Hospi ce CCN:	15-1553	To 12/31/2018		
		·			5/29/2019 4:3	O pm
				Hospi ce I		
Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	

			Hospi ce CC	N: 15-1553   1	0 12/31/2018	5/29/2019 4: 3	
					Hospi ce I		<u> </u>
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	<b>'</b>	MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON	· ´	
		(PATIENT DAYS)	(	(MI LEAGE)	(HOURS OF		
				, ,	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	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	5, 337					10.00
11. 00	MEDICAL RECORDS	5, 557	5, 337	,			11.00
12. 00	STAFF TRANSPORTATION		5, 337	13, 689			12.00
13. 00	VOLUNTEER SERVICE COORDINATION			13,007			13.00
					0	0	1
14.00	PHARMACY				0	0	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	
16. 00	OTHER GENERAL SERVI CE			C	O O	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	- 00	0		0	
51. 00	HOSPICE ROUTINE HOME CARE	5, 337	5, 337			0	1
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	-	0	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	) <u> </u>	0	0	53. 00
	NONREI MBURSABLE COST CENTERS		Г	Г	T		
60. 00	BEREAVEMENT PROGRAM			0		0	
61. 00	VOLUNTEER PROGRAM			0		0	1
62. 00	FUNDRAI SI NG			0	0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	1
64.00	PALLIATIVE CARE PROGRAM			0	0	0	
65. 00	OTHER PHYSICIAN SERVICES			0	0	0	65. 00
66. 00	RESI DENTI AL CARE			0	0	0	66. 00
67.00	ADVERTI SI NG			C	0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	0	68. 00
69.00	THRI FT STORE			0	O	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	o	0	71.00
99. 00	NEGATI VE COST CENTER						99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	22, 684	18, 185	22, 752	0	0	100.00
	UNIT COST MULTIPLIER	4. 250328				0. 000000	101.00
	1	1	1	1			

Health Financial Systems	ITY HOSPITAL		In Lieu of Form CMS-2552-10			
		Provi der Co			Worksheet 0-6	
STATISTICAL BASIS		Hospi ce CCI		From 01/01/2018 To 12/31/2018		
				Hospi ce I		
Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
	ADMI NI STRATI VE		RESIDENTI AL			

					Hospi ce I	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/		
		ADMI NI STRATI VE		RESI DENTI AL		
		SERVI CES	(SPECI FY	CARE SERVICES		
		(PATIENT DAYS)	BASIS)	(IN-FACILITY		
				DAYS)		
	T	15. 00	16. 00	17. 00		
	GENERAL SERVICE COST CENTERS		T	T	T	4
1.00	CAP REL COSTS-BLDG & FIXT					1. 00
2.00	CAP REL COSTS-MVBLE EQUIP					2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT					3. 00
4.00	ADMINISTRATIVE & GENERAL					4. 00
5.00	PLANT OPERATION & MAINTENANCE					5. 00
6.00	LAUNDRY & LINEN SERVICE					6. 00
7.00	HOUSEKEEPI NG					7. 00
8.00	DI ETARY					8. 00
9.00	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					14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15. 00
16. 00	OTHER GENERAL SERVICE		0	)		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			1		17. 00
	LEVEL OF CARE		1		I	4
50.00	HOSPICE CONTINUOUS HOME CARE	0		•		50.00
51. 00	HOSPICE ROUTINE HOME CARE	0	_	•		51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0			52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53. 00
(0.00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM			<b>.</b>	I	40.00
60. 00 61. 00	VOLUNTEER PROGRAM		0	1		60.00
62. 00						62.00
	FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS					
63. 00 64. 00						63. 00 64. 00
65. 00	PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES					65. 00
66. 00						
67. 00	RESI DENTI AL CARE ADVERTI SI NG					66. 00 67. 00
68. 00 69. 00	TELEHEALTH/TELEMONI TORI NG THRI FT STORE					68. 00 69. 00
	NURSING FACILITY ROOM & BOARD			ή		70.00
70.00	l .			1		
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		1	'		71. 00
	NEGATIVE COST CENTER			100 227		99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part UNIT COST MULTIPLIER	0. 000000	0 000000	100, 227 100, 227. 000000		100. 00 101. 00
101.00	NOMI COSI MULTIFLILA	1 0.00000	0.00000	1100, 227. 000000	T .	1101.00

Heal th	Financial Systems	DAVIESS COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY				CN: 15-0061	Peri od:	Worksheet 0-7	
LEVEL OF CARE			Hospi ce CCM	N: 15-1553	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 4:3	pared: O pm
					Hospi ce I		
				Charges by LOC (from Provider Records)			
	Cost Center Descriptions	From Wkst. C, ( Part I, Col. 9 line	Ratio		HRHC	HI RC	
	AMOULLARY CERVICE COCT CENTERS	0	1.00	2.00	3. 00	4. 00	
1 00	ANCI LLARY SERVI CE COST CENTERS	// 00	0. 500012			0	1 00
1. 00 2. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00	0. 508012 0. 315208		0 0	0	1. 00 2. 00
3. 00	SPEECH PATHOLOGY	68. 00	0. 313208			0	
4. 00	DRUGS CHARGED TO PATIENTS	73. 00	0. 330506			0	
5. 00	DURABLE MEDICAL EQUIP-RENTED	96.00	0. 330300		9	O	5.00
6. 00	LABORATORY	60.00	0. 150479		ol ol	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0. 359085		o o	0	1
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00	1. 162984		0 0	0	1
9.00	RADI OLOGY-THERAPEUTI C	55. 00					9. 00
10.00	CARDI AC REHAB	76. 00	1. 838464		0 0	0	10.00
11. 00	Totals (sum of lines 1-11)						11. 00
	Charges by LOC Shared Service Costs by LOC (from Provider Records)						
	Cost Center Descriptions				xHIRC (col. 1 x		
		5.00	col . 2) 6.00	col. 3) 7.00	col . 4) 8.00	col . 5) 9.00	
	ANCILLARY SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1. 00	PHYSI CAL THERAPY	0	0		ol ol	0	1.00
2. 00	OCCUPATIONAL THERAPY	o	0		ol ol	Ö	
3. 00	SPEECH PATHOLOGY	o	0		o o	Ō	3. 00
4.00	DRUGS CHARGED TO PATIENTS	0	0		o o	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED						5. 00
6.00	LABORATORY	0	0		0 0	0	6. 00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	7. 00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	
9. 00	RADI OLOGY-THERAPEUTI C				_		9. 00
10.00	CARDI AC REHAB	0	0		0 0	0	
11.00	Totals (sum of lines 1-11)	1 1	0	I	0 0	0	11. 00

Health Financial Systems	DAVIESS COMMUNIT	Y HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM C	OST	Provi der CCN:	15-0061	Peri od: From 01/01/2018	Worksheet 0-8
		Hospi ce CCN:	15-1553		Date/Time Prepared:

		nospi ce con	. 10 1000   1	12/01/2010	5/29/2019 4: 30	
				Hospi ce I		
	· · · · · · · · · · · · · · · · · · ·		TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1. 00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)				0. 00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	e 10)	0	0		4. 00
5.00	Program cost (line 3 times line 4)		0	0		5. 00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			783, 178	6. 00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				5, 337	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				146. 74	
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)	4, 620			9. 00
10.00	Program cost (line 8 times line 9)		677, 939	0		10. 00
	HOSPICE INPATIENT RESPITE CARE					
11. 00		7, col. 8,			0	11. 00
	line 11)					
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12. 00
	Total average cost per diem (line 11 divided by line 12)				0. 00	13. 00
	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 12)	0	0		14. 00
15. 00	Program cost (line 13 times line 14)		0	0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7, col. 9,			0	16. 00
47.00	line 11)					47.00
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17. 00
	Total average cost per diem (line 16 divided by line 17)	>	_	_	0.00	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 13)	0	0		19. 00
20.00	Program cost (line 18 times line 19)		0	O <sub>I</sub>		20. 00
	TOTAL HOSPICE CARE					
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				783, 178	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				5, 337	
23. 00	Average cost per diem (line 21 divided by line 22)				146. 74	23.00

CALCIII		MUNI TY HOSPI TAL		u of Form CMS-2	2552-10
CALCUI	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0061	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Pre 5/29/2019 4:30	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPI TAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			304, 234	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			829	1. 01
2.00	Capital DRG outlier payments			0	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the consumber of interns & residents (see instructions)	ost reporting period (see inst	ructions)	12. 08 0. 00	3. 00 4. 00
4. 00 5. 00	Indirect medical education percentage (see instructions)			0.00	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 l		columns 1 and	0.00	6. 00
0.00	1.01) (see instructions)	by the sam of fines fand for	, corumns r and	O	0. 00
7.00	Percentage of SSI recipient patient days to Medicare Par	rt A patient days (Worksheet E	, part A line	0.00	7. 00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see i	nstructions)		0.00	8. 00
9.00	Sum of lines 7 and 8			0.00	9. 00
10.00	Allowable disproportionate share percentage (see instruc	ctions)		0.00	10. 00 11. 00
11. 00 12. 00				0 305, 063	
12.00	Total prospective capital payments (see mistructions)			303, 003	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions	•		0	1. 00
2.00	Program inpatient ancillary capital cost (see instruction			0	2. 00 3. 00
3.00		Total inpatient program capital cost (line 1 plus line 2)			
4.00	Capital cost payment factor (see instructions)				4 00
$F \cap \cap$				0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)				
	Total inpatient program capital cost (line 3 x line 4)  PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	5. 00
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)	wetaness (see instructions)		1.00	1. 00
1. 00 2. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum	,		1.00	1. 00 2. 00
1. 00 2. 00 3. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2	,		1.00	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circuments in the cost of	2)		1.00	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2	2)		0 1.00 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circuments in the capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	2) 4) see instructions)	( line 6)	0 1.00 0 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (see instructions) Capital minimum payment level for extraordinary circumstances (see instructions)	2) 4) see instructions) dinary circumstances (line 2 x	(line 6)	0 1.00 0 0 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)  Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (see instructions)  Adjustment to capital minimum payment level for extraordinary circumstances (see instructions)  Capital minimum payment level (line 5 plus line 7)  Current year capital payments (from Part I, line 12, as	2) 4) see instructions) dinary circumstances (line 2 x applicable)	ŕ	0 1.00 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (see instructions)  Adjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7)  Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level	2) 4) see instructions) dinary circumstances (line 2 x applicable) to capital payments (line 8	less line 9)	0 1.00 0 0 0.00 0.00 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)  Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circuments (see instructions)  Applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line appropriate percentage adjustment for extraordinary circumstances (see instructions)  Capital minimum payment level (line 5 plus line 7)  Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level (Carryover of accumulated capital minimum payment level (Worksheet L, Part III, line 14)	2) 4) see instructions) dinary circumstances (line 2 x applicable) to capital payments (line 8 over capital payment (from pri	less line 9) or year	0 1.00 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circuments (see instructions) Reprogram inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 2 Representage adjustment for extraordinary circumstances (see instructions) Capital minimum payment level (line 5 plus line 7) Current year capital minimum payment level (line 5 plus line 7) Current year comparison of capital minimum payment level (Carryover of accumulated capital minimum payment level (Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	2) 4) see instructions) dinary circumstances (line 2 x applicable) to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus lin	less line 9) or year ne 11)	0 1.00 0 0 0.00 0 0.00 0 0 0	1. 00 2. 000 3. 000 4. 000 5. 000 7. 000 8. 000 9. 000 11. 000 12. 000
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 2 Percentage adjustment for extraordinary circumstances (3 Adjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level (Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive,	2)  4)  See instructions)  dinary circumstances (line 2 x  applicable)  to capital payments (line 8  over capital payment (from pri  tal payments (line 10 plus line enter the amount on this line	less line 9) or year ne 11)	0 1.00 0 0 0.00 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00
3. 00 4. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)  Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary circumstances (see Instructions)  Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (see Instructions)  Capital minimum payment level (line 5 plus line 7)  Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level (Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level of capital minimum payment l	2)  4)  See instructions)  dinary circumstances (line 2 x  applicable)  to capital payments (line 8  over capital payment (from pri  tal payments (line 10 plus line enter the amount on this line	less line 9) or year ne 11)	0 1.00 0 0 0.00 0 0.00 0 0 0	1. 00 2. 00 3. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00
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	PART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)  Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circum (see the program inpatient capital costs (line 1 minus line 1)  Applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line 1)  Percentage adjustment for extraordinary circumstances (see instructions)  Capital minimum payment level (line 5 plus line 7)  Current year capital minimum payment level for extraordinary circumstances (see instructions)  Capital minimum payment level (line 5 plus line 7)  Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level (Carryover of accumulated capital minimum payment level (worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line)	A)  see instructions)  dinary circumstances (line 2 x  applicable)  to capital payments (line 8  over capital payment (from pri  tal payments (line 10 plus line  enter the amount on this line  over capital payment for the f	less line 9) or year ne 11)	0 1.00 0 0 0.00 0 0.00 0 0 0	4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS  Program inpatient capital costs (see instructions)  Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circum (see instructions)  Applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line applicable exception percentage (see instructions)  Capital cost for comparison to payment level for extraordinary circumstances (see instructions)  Capital minimum payment level (line 5 plus line 7)  Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level (carryover of accumulated capital minimum payment level to capital current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line)  Current year allowable operating and capital payment (see current year allowabl	2)  4) see instructions) dinary circumstances (line 2 x applicable) to capital payments (line 8 over capital payment (from pri tal payments (line 10 plus line enter the amount on this line over capital payment for the f	less line 9) or year ne 11)	0 1.00 0 0 0.00 0.00 0 0.00 0	1. 00 2. 000 3. 000 4. 000 5. 000 6. 000 7. 000 8. 000 10. 000 11. 000 12. 000 13. 000

	Financial Systems	DAVIESS COMMUN		011 45 00/4		u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-0061	Period: From 01/01/2018	Worksheet M-1	
			Component		Γο 12/31/2018	Date/Time Pre 5/29/2019 4:3	
					RHC I	Cost	
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS		_				
1. 00	Physi ci an	238, 888	0			238, 888	1
2.00	Physician Assistant	0	0	1	0	0	
3. 00	Nurse Practitioner	158, 611	0	158, 61	1 0	158, 611	
4.00	Visiting Nurse	0	0		0	0	
5. 00	Other Nurse	0	0	(	0	0	
6. 00	Clinical Psychologist	0	0	(	0	0	1 0.00
7. 00	Clinical Social Worker	0	0	(	0	0	1
8. 00	Laboratory Techni ci an	0	0		0	0	0.00
9. 00	Other Facility Health Care Staff Costs	114, 680	0	114, 680		114, 680	
10.00	Subtotal (sum of lines 1 through 9)	512, 179	0	512, 179		512, 179	
11. 00	Physician Services Under Agreement	0	78, 589			78, 589	
12. 00	Physician Supervision Under Agreement	0	0	1	0	0	
13. 00		0	0	1	0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	78, 589			78, 589	1
15. 00	Medical Supplies	0	12, 772	1		12, 772	1
16.00	Transportation (Health Care Staff)	0	0	1	0	0	
17. 00		0	0	1	0	0	
18.00	,	0	0	1	0	0	
19. 00		0	0	1	0	0	1 . ,
20.00	Allowable GME Costs	_					20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	12, 772	1		12, 772	
22. 00	Total Cost of Health Care Services (sum of	512, 179	91, 361	603, 540	0	603, 540	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES				1		
23. 00		O	0	ı ,	0	0	23. 00
24. 00	Dental	0	0	1		0	
25. 00		0	0	1		0	1
25. 00	Optometry Tel eheal th	0	0			0	1
25. 01	Chronic Care Management		0	] :		0	1
26. 00	All other nonreimbursable costs	0	0			0	1
27. 00	Nonallowable GME costs	"	0	1		0	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	_		0	0	
20.00	through 27)			Ί '			20.00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	35, 935	35, 93!	5 0	35, 935	29. 00
	Administrative Costs	76, 670	0 0	1			
	Total Facility Overhead (sum of lines 29 and	76, 670	35, 935			-	

76, 670

588, 849

Total Facility Overhead (sum of lines 29 and

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

112, 605

716, 145

35, 935

127, 296

112, 605

716, 145

31.00

32.00

31.00

32.00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-0061	Peri od: From 01/01/2018	Worksheet M-1
		Component CCN: 15-8500	To 12/31/2018	Date/Time Prepared: 5/29/2019 4:30 pm
			RHC I	Cost
	Adjustments	Net Expenses		

						5/29/2019 4:	30 pm
					RHC I	Cost	
		Adjustments	Net	Expenses			
		•	for A	Allocation			
				5 + col.			
			(00	6)			
		6. 00		7. 00			
	FACILITY HEALTH CADE STAFF COSTS	0.00		7.00			
4 00	FACILITY HEALTH CARE STAFF COSTS		٦.	000 000			4 00
1. 00	Physi ci an	0	2	238, 888			1.00
2.00	Physician Assistant	0		0			2. 00
3.00	Nurse Practitioner	0	기	158, 611			3. 00
4.00	Visiting Nurse	0		0			4. 00
5.00	Other Nurse	0	ol	0			5. 00
6.00	Clinical Psychologist	0	ol	o			6.00
7. 00	Clinical Social Worker	0	<u> </u>	0			7. 00
8. 00	Laboratory Techni ci an	0	า	0			8.00
9. 00		0	3	- 1			
	Other Facility Health Care Staff Costs	0	2	114, 680			9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	ار	512, 179			10.00
11. 00	Physician Services Under Agreement	0	기	78, 589			11. 00
12.00	Physician Supervision Under Agreement	0		0			12. 00
13.00	Other Costs Under Agreement	0	ol	0			13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	ol	78, 589			14.00
15. 00	Medical Supplies	0		12, 772			15. 00
16. 00	Transportation (Health Care Staff)	0	วไ	0			16. 00
17. 00	Depreciation-Medical Equipment	0	Š.	0			17. 00
18. 00	Professional Liability Insurance	0		0			18.00
	1	0		- 1			
19. 00	1	Ü	ار	0			19. 00
20. 00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	기	12, 772			21. 00
22.00	Total Cost of Health Care Services (sum of	0	[כ	603, 540			22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	)	0			23. 00
24.00	Dental	0	ol	o			24. 00
25. 00	Optometry	0		0			25. 00
25. 01	Tel eheal th	0	5	0			25. 01
25. 02	Chronic Care Management	0	า	0			25. 02
26. 00	, and the second	0		0			26. 00
	All other nonreimbursable costs	Ü	ار	U			
27. 00	Nonallowable GME costs	_		_			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	)	0			28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0		35, 935			29. 00
30.00	Administrative Costs	0	ol	76, 670			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	n	ol	112, 605			31.00
	30)	· ·		, _ 500			1
32. 00	Total facility costs (sum of lines 22, 28	0		716, 145			32. 00
32. 00	and 31)	0	1	, 10, 140			1 52. 50
	10.00 0.7		1	'			1

	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	DAVIESS COMMUNI		CN: 15-0061	Peri od:	worksheet M-1	
			Component		From 01/01/2018 To 12/31/2018		nared:
			Component	0014. 10 0777		5/29/2019 4: 3	
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassificati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2.00	2.00	4.00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2. 00	3. 00	4. 00	5.00	
1.00	Physician	231, 060	C	231, 06	0 0	231, 060	1.00
2.00	Physician Assistant	231,000	C	1	0 0		1
3.00	Nurse Practitioner	190, 740		1		190, 740	
4.00	Visiting Nurse	170,740		1	0 0	0	1
5.00	Other Nurse				0 0	0	1
6.00	Clinical Psychologist				0 0	0	1
7. 00	Clinical Social Worker				0 0	0	7.00
8. 00	Laboratory Techni ci an				0 0	0	
9. 00	Other Facility Health Care Staff Costs	180, 925		180, 92	0	180, 925	
10. 00	Subtotal (sum of lines 1 through 9)	602, 725	C	1		602, 725	
11. 00	Physician Services Under Agreement	002, 725		002, 72	0 0	002, 723	1
12. 00	Physician Supervision Under Agreement				0 0	0	
13. 00					0 0	0	1
14. 00	Subtotal (sum of lines 11 through 13)				0 0	0	
15. 00	,		44, 528	44, 52	0	44, 528	
16. 00			44, 320	77, 32	0 0	0	1
17. 00		o o	Č		0 0	o o	
18. 00	The second secon	o o	Č		0 0	o o	1
19. 00		o o	Č		0 0	o o	
20. 00	Allowable GME Costs		_	1		Ĭ	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	44, 528	44, 52	8 0	44, 528	1
22. 00	Total Cost of Health Care Services (sum of	602, 725	44, 528	1			
22.00	lines 10, 14, and 21)	002,720	, 020	]	3	017,200	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				<b>"</b>	!	1
23.00		0	С		0 0	0	23. 00
24.00	Dental	o	C		0 0	0	24. 00
25.00	Optometry	o	C		0 0	0	25. 00
25. 01	Tel eheal th	0	C		0 0	0	25. 01
25. 02	Chronic Care Management	0	C		0 0	0	25. 02
26.00	All other nonreimbursable costs	O	C		0 0	0	26. 00
27.00	Nonallowable GME costs						27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	O	C		0 0	0	28. 00
	through 27)						]
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	38, 763	1		38, 763	
	Administrative Costs	119, 965	C	1,			
31. 00	Total Facility Overhead (sum of lines 29 and	119, 965	38, 763	158, 72	8 0	158, 728	31.00

119, 965

722, 690

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

158, 728

805, 981

38, 763

83, 291

158, 728

805, 981

31.00

32.00

31.00

32.00

and 31)

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-0061	Peri od: From 01/01/2018	Worksheet M-1
	Component CCN: 15-399		
		DHC 11	Cost

	5/29/2019 4: 30 pm
RHC I I	Cost
Adjustments Net Expenses	
for Allocation	
(col. 5 + col.	
6)	
6.00 7.00	
FACILITY HEALTH CARE STAFF COSTS	
1. 00   Physi ci an 0 231, 060	1.00
2.00 Physician Assistant 0 0	2. 00
3.00 Nurse Practitioner 0 190,740	3. 00
4.00   Visiting Nurse   0   0	4. 00
5.00 Other Nurse 0 0	5. 00
6.00 Clinical Psychologist 0 0	6. 00
7.00 Clinical Social Worker 0 0	7. 00
8.00 Laboratory Technician 0 0	8. 00
9.00 Other Facility Health Care Staff Costs 0 180,925	9. 00
10.00   Subtotal (sum of lines 1 through 9) 0 602,725	10.00
11.00 Physician Services Under Agreement 0 0	11.00
12.00 Physician Supervision Under Agreement 0 0	12. 00
13.00 Other Costs Under Agreement 0 0	13.00
14.00 Subtotal (sum of lines 11 through 13) 0 0	14. 00
15.00 Medical Supplies 0 44,528	15. 00
16.00 Transportation (Health Care Staff) 0 0	16. 00
17.00 Depreciation-Medical Equipment 0 0	17. 00
18.00 Professional Liability Insurance 0 0	18. 00
19.00 Other Health Care Costs 0 0	19. 00
20.00 Allowable GME Costs	20. 00
21.00   Subtotal (sum of lines 15 through 20) 0 44,528	21. 00
22.00 Total Cost of Health Care Services (sum of 0 647, 253	22. 00
lines 10, 14, and 21)	
COSTS OTHER THAN RHC/FQHC SERVICES	
23.00   Pharmacy 0 0	23. 00
24. 00   Dental   0   0	24. 00
25.00   Optometry 0 0	25. 00
25. 01   Tel eheal th 0 0 0	25. 01
25.02 Chronic Care Management 0 0	25. 02
26.00 All other nonreimbursable costs 0 0	26. 00
27.00 Nonallowable GME costs	27. 00
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0	28. 00
through 27)	
FACILITY OVERHEAD	
29. 00 Facility Costs 0 38, 763	29. 00
30.00 Administrative Costs 0 119,965	30.00
31.00 Total Facility Overhead (sum of lines 29 and 0 158,728	31.00
30)	
32.00   Total facility costs (sum of lines 22, 28   0   805, 981	32. 00
and 31)	I

	Financial Systems	DAVIESS COMMUN				eu of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-0061	Peri od:	Worksheet M-1	
			Component	CCN: 15-8501	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
					RHC III	Cost	
	·	Compensation	Other Costs	Total (col.	1 Reclassi ficati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS				1		
1.00	Physi ci an	33, 103	C	1,			
2. 00	Physician Assistant	0	C	1	0 0	0	
3. 00	Nurse Practitioner	477, 806	C	477, 80		477, 806	
4. 00	Visiting Nurse	0	C	)	0 0	0	
5. 00	Other Nurse	0	C	)	0	0	0.00
6. 00	Clinical Psychologist	0	C	)	0	0	0.00
7. 00	Clinical Social Worker	0	C	)	0	0	7. 00
8. 00	Laboratory Techni ci an	0	C	)	0 0	0	
9. 00	Other Facility Health Care Staff Costs	264, 038	C	264, 03		264, 038	1
10. 00	Subtotal (sum of lines 1 through 9)	774, 947	(	774, 94		774, 947	
11. 00	Physician Services Under Agreement	0	127, 955	127, 95		127, 955	
12. 00	Physician Supervision Under Agreement	0	(	)	0 0	1	
13. 00	3	0	203, 423	•		203, 423	
14. 00	Subtotal (sum of lines 11 through 13)	0	331, 378	1			
15. 00	Medical Supplies	0	23, 774	23, 77		23, 774	
16. 00	Transportation (Health Care Staff)	0	(	2	0	0	
17. 00	Depreciation-Medical Equipment	0	(	2	0	0	1
18.00	1	0	(	2	0	0	
19.00	Other Health Care Costs	0	(	7	0	0	1
20.00	Allowable GME Costs		00.77				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	23, 774	•		23, 774	
22. 00	Total Cost of Health Care Services (sum of	774, 947	355, 152	1, 130, 09	0	1, 130, 099	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00		0	(	\	0 0	0	23. 00
24. 00	Dental	0		1	0 0	0	
25. 00	Optometry	0			0 0	0	1
25. 00	Tel eheal th	0				0	
25. 01	Chronic Care Management	0				0	
26. 00	All other nonreimbursable costs	0				0	
27. 00	Nonal I owable GME costs	o o		1		0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	r		0	0	1
20.00	through 27)			1	ا		20.00
	FACILITY OVERHEAD			1	1		1
29. 00		0	74, 350	74, 35	50 0	74, 350	29. 00
30.00	Administrative Costs	91, 384		1			
	Total Facility Overhead (sum of lines 29 and			•			

866, 331

1, 295, 833

429, 502

1, 295, 833

32.00

32.00

and 31)

Total facility costs (sum of lines 22, 28

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Li€	eu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-006	1 Peri od: From 01/01/2018	Worksheet M-1
	Component CCN: 15-85		Date/Time Prepared: 5/29/2019 4:30 pm

			Componen	t con	v. 13-0301	10	12/31/2010	5/29/2019 4:	
							RHC III	Cost	
		Adjustments	Net Expense	s				•	
		•	for Allocati	on					
			(col. 5 + co	١.					
			6)						
		6.00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	33, 1	03					1. 00
2.00	Physician Assistant	0		0					2. 00
3.00	Nurse Practitioner	0	477, 8	06					3. 00
4.00	Visiting Nurse	0		0					4. 00
5.00	Other Nurse	0		0					5. 00
6.00	Clinical Psychologist	0		0					6. 00
7.00	Clinical Social Worker	0		0					7. 00
8.00	Laboratory Techni ci an	0		0					8. 00
9.00	Other Facility Health Care Staff Costs	0	264, 0	38					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	774, 9	47					10.00
11.00	Physician Services Under Agreement	0	127, 9	55					11. 00
12.00	Physician Supervision Under Agreement	0		o					12. 00
13.00	Other Costs Under Agreement	0	203, 4	23					13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	331, 3	78					14. 00
15.00	Medical Supplies	0	23, 7	74					15. 00
16.00	Transportation (Health Care Staff)	0		0					16. 00
17.00	Depreciation-Medical Equipment	0		0					17. 00
18.00	Professional Liability Insurance	0		0					18. 00
19.00	Other Health Care Costs	0		0					19. 00
20.00	Allowable GME Costs								20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	23, 7	74					21. 00
22.00	Total Cost of Health Care Services (sum of	0	1, 130, 0	99					22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								
23. 00	1	0		0					23. 00
24. 00	Dental	0		0					24. 00
25. 00	Optometry	0		0					25. 00
25. 01	Tel eheal th	0		0					25. 01
25. 02	Chronic Care Management	0		0					25. 02
26. 00	All other nonreimbursable costs	0		0					26. 00
27. 00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		0					28. 00
	through 27)								
	FACILITY OVERHEAD								
29. 00	Facility Costs	0	74, 3						29. 00
30.00	Administrative Costs	0	91, 3						30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	165, 7	34					31. 00
22.00	30)	_	1 005 0	22					22.00
32. 00	Total facility costs (sum of lines 22, 28	O	1, 295, 8	33					32. 00
	and 31)	l		- 1					I

	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	DAVIESS COMMUN	Provider Co	^N: 15 0061	In Lie Period:	u of Form CMS-2 Worksheet M-1	2552-10
ANALTS	13 OF HOSFITAL-BASED KIROTIGHE COSTS			1	From 01/01/2018 To 12/31/2018	Date/Time Pre	
					RHC V	5/29/2019 4: 3 Cost	0 pm
		Compensation	Other Costs	Total (col 1	Reclassificati	Reclassi fi ed	
		Compensation	other costs	+ col . 2)	ons	Trial Balance	
				1 001. 2)	0115	(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	535, 153	0	535, 153	0	535, 153	1. 00
2.00	Physici an Assistant	0	0		1	0	2. 00
3.00	Nurse Practitioner	166, 145	0	166, 14!	0	166, 145	3. 00
4.00	Visiting Nurse	0	0	(	0	0	4. 00
5.00	Other Nurse	0	0	(	0	0	5. 00
6. 00	Clinical Psychologist	0	0	(	0	0	6.00
7.00	Clinical Social Worker	0	0	9	0	0	7. 00
8.00	Laboratory Technician	110 100	0	110 10	0	0	8.00
9.00	Other Facility Health Care Staff Costs	118, 188	0			118, 188	9.00
10.00	Subtotal (sum of lines 1 through 9)	819, 486	0	819, 486	0	819, 486	10. 00 11. 00
11. 00 12. 00	Physician Services Under Agreement Physician Supervision Under Agreement	0	0	)	0	0	12.00
13. 00	Other Costs Under Agreement	0	0	)		0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0			0	14.00
15. 00	Medical Supplies	0	100, 865	100, 86!		100, 865	
16. 00	Transportation (Health Care Staff)	0	00,009	100,000		0	16.00
17. 00	Depreciation-Medical Equipment	Ö	0	ĺ		Ö	17. 00
18. 00	Professional Liability Insurance	0	0			Ö	18. 00
19. 00	Other Health Care Costs	0	0		0	0	19. 00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	100, 865	100, 86!	0	100, 865	21.00
22.00	Total Cost of Health Care Services (sum of	819, 486	100, 865	920, 35°	0	920, 351	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0			0	23. 00
24. 00	Dental	0	0		·	0	24. 00
25. 00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01 25. 02
25. 02 26. 00	Chronic Care Management All other nonreimbursable costs	0	0	)	0	0	26.00
27. 00	Nonallowable GME costs	U	U			0	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	(	0	0	28.00
20.00	through 27)	o o	O	· `			20.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	43, 823	43, 823	3 0	43, 823	29. 00
30.00	Administrative Costs	63, 387	0				30.00
31.00	Total Facility Overhead (sum of lines 29 and	63, 387	43, 823	107, 210	0	107, 210	31. 00
	30)						

882, 873

1, 027, 561

144, 688

1, 027, 561

32.00

32.00

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

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS		Provi der C	CN: 15-0061	Peri od: From 01/01/2018	Worksheet M-1	
		Component	CCN: 15-8503	To 12/31/2018	Date/Time Prep 5/29/2019 4:30	
				RHC V	Cost	
	Adjustments	Net Expenses				
		for Allocation	1			

					RHC V	Cost
		Adjustments	Net Expenses		I KIIC V	COST
		Auj us tillerits	for Allocation			
			(col. 5 + col.			
			6)			
	FACILLETY HEALTH CARE CTAFE COCTO	6. 00	7. 00			
	FACILITY HEALTH CARE STAFF COSTS		505.450			
1.00	Physi ci an	0	535, 153			1.00
2.00	Physi ci an Assi stant	0	0	l .		2. 00
3.00	Nurse Practitioner	0	166, 145			3.00
4.00	Visiting Nurse	0	0			4.00
5.00	Other Nurse	0	0			5. 00
6.00	Clinical Psychologist	0	0			6. 00
7.00	Clinical Social Worker	0	0			7. 00
8.00	Laboratory Techni ci an	0	0			8. 00
9.00	Other Facility Health Care Staff Costs	0	118, 188			9.00
10.00	Subtotal (sum of lines 1 through 9)	0	819, 486	1		10.00
11. 00	Physician Services Under Agreement	0	0			11.00
12. 00	Physician Supervision Under Agreement	0	0			12.00
13. 00	Other Costs Under Agreement	0	l o			13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0			14.00
15. 00	Medical Supplies	0	100, 865			15.00
16. 00	Transportation (Health Care Staff)	0	0 100, 809			16.00
17. 00	Depreciation-Medical Equipment	0				17.00
18. 00	Professional Liability Insurance	0				18.00
19. 00	Other Health Care Costs	0				19.00
		Ü	0			
20. 00	Allowable GME Costs	_				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	100, 865			21. 00
22. 00	Total Cost of Health Care Services (sum of	0	920, 351			22. 00
	lines 10, 14, and 21)					
	COSTS OTHER THAN RHC/FQHC SERVICES		T	r		
23. 00	Pharmacy	0	0			23. 00
24. 00	Dental	0	0			24. 00
25. 00	Optometry	0	0			25. 00
25. 01	Tel eheal th	0	0			25. 01
25. 02	Chronic Care Management	0	0			25. 02
26.00	All other nonreimbursable costs	0	0			26. 00
27.00	Nonallowable GME costs					27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0			28. 00
	through 27)					
	FACILITY OVERHEAD		•			
29. 00	Facility Costs	0	43, 823			29. 00
30.00	Administrative Costs	0	63, 387			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	107, 210			31.00
550	30)	O	.37,210			31.66
32. 00	Total facility costs (sum of lines 22, 28	0	1, 027, 561			32.00
52. 50	and 31)	O	1,027,001			32.00
	10		I	ı		T .

	Financial Systems	DAVIESS COMMUNI				eu of Form CMS-	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-0061	Peri od:	Worksheet M-1	
			Component	CCN: 15-8506	From 01/01/2018 To 12/31/2018		
					RHC VI	Cost	
		Compensation	Other Costs		1 Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1.00	Physi ci an	64, 140	C	64, 14	10 0	64, 140	1.00
2.00	Physi ci an Assi stant	0	C		0 0	0	2. 00
3.00	Nurse Practitioner	175, 613	C	175, 6°	13 0	175, 613	3. 00
4.00	Visiting Nurse	o	C		0 0	0	4. 00
5.00	Other Nurse	0	C		0 0	0	5. 00
6.00	Clinical Psychologist	0	C		0	0	6. 00
7.00	Clinical Social Worker	0	C	)	0	0	
8.00	Laboratory Techni ci an	0	C	)	0	0	0.00
9.00	Other Facility Health Care Staff Costs	171, 412	C	1, .		171, 412	1
10.00	Subtotal (sum of lines 1 through 9)	411, 165	(	411, 10	55 0	411, 165	
11.00	Physician Services Under Agreement	0	(	2	0	0	
12.00	Physician Supervision Under Agreement	0	(	)	0	0	
13.00	Other Costs Under Agreement	0	(			0	
14. 00 15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	23, 227	23, 22	0	0 23, 227	
16. 00	Transportation (Health Care Staff)	0	23, 221	23, 24	0 0	23, 227	1
17. 00		0	(		0	0	
18. 00	Professional Liability Insurance				0 0	0	
19. 00		0	(	ó	0 0	0	
20. 00	Allowable GME Costs			1			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	23, 227	23. 22	27 0	23, 227	
22. 00	Total Cost of Health Care Services (sum of	411, 165	23, 227		92 0	434, 392	22. 00
	lines 10, 14, and 21)					·	
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	C		0 0		
24. 00	Dental	0	C		0	0	
25. 00	Optometry	0	(	)	0 0	0	0.00
25. 01	Tel eheal th	0	(	2	0	0	
25. 02	Chronic Care Management	0	(	)	0 0	0	
26. 00 27. 00	All other nonreimbursable costs	U	C	7	0 0	0	26. 00 27. 00
28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23				0 0	0	
20.00	through 27)			Ί		0	20.00
	FACILITY OVERHEAD			1			-
29. 00		O	25, 875	25, 8	75 0	25, 875	29. 00
30.00	Administrative Costs	43, 840	23,376	43, 84		43, 840	
31. 00	Total Facility Overhead (sum of lines 29 and	43, 840	25, 875			69, 715	
	30)						1

455, 005

504, 107

49, 102

504, 107

32.00

32.00

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

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-0061	Peri od: From 01/01/2018	Worksheet M-1
	Component CCN: 15-850		
		DHC M	Cost

			Component	CCIV. I	3-0300	10	12/31/2010	5/29/2019 4:3	
							RHC VI	Cost	
	·	Adjustments	Net Expenses						
			for Allocation	ո					
			(col. 5 + col.	.					
			6)						
		6. 00	7.00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	64, 140	)  C					1. 00
2.00	Physician Assistant	0		)  C					2. 00
3.00	Nurse Practitioner	0	175, 613	3					3. 00
4.00	Visiting Nurse	0	(	)  C					4. 00
5.00	Other Nurse	0	(	) 					5. 00
6.00	Clinical Psychologist	0	(	) 					6. 00
7.00	Clinical Social Worker	0		) 					7. 00
8.00	Laboratory Techni ci an	0		) 					8. 00
9.00	Other Facility Health Care Staff Costs	0	171, 412						9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	411, 165	5					10. 00
11. 00	Physician Services Under Agreement	0	(	) 					11. 00
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		) )					14. 00
15. 00	Medical Supplies	0	23, 227	7					15. 00
16. 00	Transportation (Health Care Staff)	0	(	) )					16. 00
17. 00	Depreciation-Medical Equipment	0		) 					17. 00
18. 00	Professional Liability Insurance	0		0					18. 00
19. 00	Other Health Care Costs	0	(	0					19. 00
20. 00	Allowable GME Costs								20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	23, 227						21. 00
22. 00	Total Cost of Health Care Services (sum of	0	434, 392	2					22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES			al .					
23. 00	Pharmacy	0							23. 00
24. 00	Dental	0	-	0					24. 00
25. 00	Optometry	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	Ü	(	0					26. 00
27. 00	Nonallowable GME costs		,						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	(	)					28. 00
	through 27)								
20.00	FACILITY OVERHEAD	0	25, 875	-1					20.00
29. 00	Facility Costs	0							29. 00
30.00	Administrative Costs	0	43, 840						30.00
31. 00	Total Facility Overhead (sum of lines 29 and	U	69, 715	7					31. 00
32. 00	30) Total facility costs (sum of lines 22, 29	0	504 10	7					32. 00
32.00	Total facility costs (sum of lines 22, 28 and 31)	U	504, 107	<b>'</b>					32.00
	Jana 51)		ı	1					1

	Financial Systems	DAVIESS COMMUN				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		Period: From 01/01/2018	Worksheet M-2	
			Component		Fo 12/31/2018		
					RHC I	5/29/2019 4: 30 Cost	U pm
		Number of FTE	Total Visits	Productivi tv	Minimum Visits		
		Personnel	local visits		(col. 1 x col.		
		1 CI Sollici		Standard (1)	3)	4	
		1, 00	2, 00	3.00	4.00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 96					1.00
2. 00	Physici an Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 97			2, 037		3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 93			6, 069	6, 069	
5. 00	Visiting Nurse	0. 00				0	5.00
5. 00	Clinical Psychologist	0. 00				0	6.00
7. 00	Clinical Social Worker	0. 00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00				0	7.01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	1. 93	5, 810			6, 069	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
	DETERMINATION OF ALLOWARIE COCT APPLICABLE	TO HOODITAL DAGE	D DUO (FOUR CER	VII 050		1. 00	
10 00	DETERMINATION OF ALLOWABLE COST APPLICABLE Total costs of health care services (from V			VICES		603, 540	   10. 00
10.00	Total nonreimbursable costs (from Wkst. M-1						l
12. 00	Cost of all services (excluding overhead) (					0 603, 540	
13. 00	Ratio of hospital -based RHC/FQHC services (					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (1			no 21)		112, 605	
15. 00	Parent provider overhead allocated to facil			116 31)		518, 029	
16. 00	Total overhead (sum of lines 14 and 15)	ity (See Ilistiu	0113)			630, 634	
17. 00						030, 034	
	Enter the amount from line 16					630, 634	
	Overhead applicable to hospital-based RHC/F	FOHC services (Li	ne 13 x line 1	8)		630, 634	

Heal th	Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2018 To 12/31/2018		nared:
			Component	0014. 13 3777	10 12/31/2010	5/29/2019 4: 3	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	2.00	2.00	3) 4. 00	5. 00	
	VISITS AND PRODUCTIVITY	1.00	2. 00	3.00	4.00	5.00	
	Positions						
1. 00	Physi ci an	1. 02	4, 091	4, 20	0 4, 284		1.00
2. 00	Physician Assistant	0.00			·		2.00
3. 00	Nurse Practitioner	1. 67					3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 69			7, 791		4.00
5. 00	Visiting Nurse	0.00	0			0	5. 00
6. 00	Clinical Psychologist	0.00	0			0	6.00
7. 00	Clinical Social Worker	0.00	0			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0. 00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	2. 69	7, 116			7, 791	8.00
9. 00	through 7)		0			0	9.00
9.00	Physician Services Under Agreements					U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL-BASE	D RHC/FOHC SER	VLCES		1.00	
10. 00						647, 253	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1					0	11. 00
12. 00	Cost of all services (excluding overhead) (	sum of lines 10	and 11)			647, 253	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (	line 10 divided	by line 12)			1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (f			ne 31)		158, 728	14.00
15. 00	Parent provider overhead allocated to facil	ity (see instruc	ctions)			511, 368	
16. 00	Total overhead (sum of lines 14 and 15)					670, 096	
17. 00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16		40 11 -	2)		670, 096	
	Overhead applicable to hospital-based RHC/F					670, 096	
20. 00	Total allowable cost of hospital-based RHC/	FUHC services (s	sum of lines 10	and 19)		1, 317, 349	20.00

Heal th	Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Period: From 01/01/2018	Worksheet M-2	
			Component	CCN: 15-8501	Го 12/31/2018	Date/Time Prep 5/29/2019 4:30	
					RHC III	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4	
		1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 55					1. 00
2.00	Physician Assistant	0. 00					2. 00
3.00	Nurse Practitioner	4. 78		· ·			3. 00
4.00	Subtotal (sum of lines 1 through 3)	5. 33			12, 348	· ·	
5.00	Visiting Nurse	0.00				0	5. 00
6.00	Clinical Psychologist	0.00				0	6. 00
7.00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5. 33	14, 024			14, 024	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
7. 00	Triysi et all sel vi ees under Agreements					0	7. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			1, 130, 099	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			1, 130, 099	12. 00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. N	M-1, col. 7, li	ne 31)		165, 734	14. 00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			800, 747	15. 00
16.00	Total overhead (sum of lines 14 and 15)					966, 481	16. 00
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					966, 481	
	Overhead applicable to hospital-based RHC/FC					966, 481	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		2, 096, 580	20.00

Heal th	Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Peri od: From 01/01/2018	Worksheet M-2	
			Component		To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
					RHC V	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4	
		1.00	2.00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 92	3, 683	4, 20	0 3, 864		1. 00
2.00	Physi ci an Assi stant	0.00	0	2, 10	0 0		2. 00
3.00	Nurse Practitioner	1. 30		2, 10			3. 00
4.00	Subtotal (sum of lines 1 through 3)	2. 22			6, 594	7, 530	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0. 00				0	
7.00	Clinical Social Worker	0.00	l e			0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2. 22	7, 530			7, 530	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	Trifysi Ci air Sei vi ces under Agreements					0	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			920, 351	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11. 00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			920, 351	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		107, 210	14. 00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			518, 314	15. 00
16.00	Total overhead (sum of lines 14 and 15)					625, 524	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					625, 524	
	Overhead applicable to hospital-based RHC/FC					625, 524	
20. 00	Total allowable cost of hospital-based RHC/F	OHC services (s	sum of lines 10	and 19)		1, 545, 875	20.00

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der (		Peri od: From 01/01/2018	Worksheet M-2	
			Component		To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
					RHC VI	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col.	
		1.00	2.00	3.00	4.00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 10	400	4, 20	0 420		1. 00
2.00	Physi ci an Assi stant	0.00		2, 10	0 0		2. 00
3.00	Nurse Practitioner	1. 49	3, 97	2, 10	0 3, 129		3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 59	4, 37	9	3, 549	4, 379	4. 00
5.00	Visiting Nurse	0.00		o		0	5. 00
6.00	Clinical Psychologist	0.00	(	o l		0	6. 00
7.00	Clinical Social Worker	0.00		O		0	7. 00
7.01	Medical Nutrition Therapist (FQHC only)	0.00		)		0	7. 01
7.02	Diabetes Self Management Training (FQHC	0.00		o		0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	1. 59	4, 37	9		4, 379	8. 00
	through 7)			_		_	
9.00	Physician Services Under Agreements			0		0	9. 00
						4.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	FO HOCDITAL DACE	D DUC/FOUR CE	DVI CEC		1. 00	
10 00	Total costs of health care services (from W			RVICES		434, 392	10 00
11. 00	1					434, 392	
12. 00	Cost of all services (excluding overhead) (					434, 392	
13. 00	Ratio of hospital -based RHC/FQHC services (					1, 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fi			ine 31)		69, 715	
15. 00	Parent provider overhead allocated to facili			1116 31)		336, 472	
16. 00	Total overhead (sum of lines 14 and 15)	ity (see instruc	211 0113)			406, 187	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					406, 187	
	Overhead applicable to hospital-based RHC/FG	QHC services (li	ne 13 x line	18)		406, 187	
	Total allowable cost of hospital-based RHC/					840, 579	
				,			

Heal th	Financial Systems DAVIESS COMMUNITY	Y HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0061	Peri od:	Worksheet M-3	
SERVI (	ES	Component CCN: 15-8500	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
		Title XVIII	RHC I	Cost	O piii
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		1, 234, 174	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		1, 904	2. 00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 232, 270	3.00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	6, 069 0	4. 00 5. 00		
6. 00	Total adjusted visits (line 4 plus line 5)	11116 7)		6, 069	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			203. 04	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	82. 30	83. 45	8. 00
9.00	Rate for Program covered visits (see instructions)		203. 04	203. 04	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	,	0	1, 927	10.00
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr.		0	391, 258 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x li		0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions	,	0	0	14. 00
15.00	Graduate Medical Education Pass Through Cost (see instruction	is)			15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	*	0	391, 258	
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		379, 807	
16. 02	Total program preventive charges (see Histractions) (Homeprov Total program preventive costs ((line 16.02/line 16.01) times	•		41, 506 42, 757	16. 02
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	-		254, 440	1
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	297, 197	16. 05
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 30, 451	17. 00 18. 00
10. 00	records)	(11 om contractor		30, 431	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		61, 573	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			297, 197	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		819	•
22. 00	Total reimbursable Program cost (line 20 plus line 21)			298, 016	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
25. 00	,			0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
	Demonstration payment adjustment amount before sequestration			0	
26. 00 26. 01	, ,			298, 016 5, 960	1
26. 01	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			5, 960	l
27. 00	, , , , , , , , , , , , , , , , , , , ,			307, 352	
28. 00	, , ,			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.01)	•		-15, 296	
30. 00	Protested amounts (nonallowable cost report items) in accorda	ince with CMS Pub. 15-II,		0	30.00

пеат п	Financial Systems DAVIESS COMMUNITY	Y HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0061	Peri od:	Worksheet M-3	
SERVI (	EES	Component CCN: 15-3999	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		1, 317, 349	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		3, 525	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 313, 824	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		7, 791 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	7)		7, 791	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			168. 63	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	1. 00	2. 00 83. 45	8. 00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	168. 63	168. 63	
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	contractor records)	0	2, 295	
11.00	Program cost excluding costs for mental health services (line		0	387, 006	1
12.00	Program covered visits for mental health services (from contra	*	0	0	12.00
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions	•	0	0	13. 00 14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instruction			O	15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	387, 006	
16. 01	Total program charges (see instructions)(from contractor's re	•		462, 560	
16. 02	Total program preventive charges (see instructions) (from prov	-		0	16. 02
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0)	•		0 272, 681	16. 03 16. 04
10.04	(Titles V and XIX see instructions.)	3 and 16) times .60)		272,001	10.04
16. 05	Total program cost (see instructions)		0	272, 681	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		46, 155	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		83, 284	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			272, 681	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		1, 884	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		274, 565	
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	24. 00 25. 00
25. 50		s)		0	
	Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions)			274, 565	26. 00
26. 01	Sequestration adjustment (see instructions)			5, 491	
26. 02 27. 00				0 227, 658	
28. 00	1 3			227, 658	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		41, 416	
29.00		nce with CMS Pub. 15-II,	1	0	

Heal th	Financial Systems DAVIESS COMMUNITY	Y HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0061	Peri od:	Worksheet M-3	
SERVIC	ES	Component CCN: 15-8501	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
		Title XVIII	RHC III	Cost	. p
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			2, 096, 580	•
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		939	2.00
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			2, 095, 641 14, 024	3. 00 4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		14, 024	5.00
6.00	Total adjusted visits (line 4 plus line 5)	,		14, 024	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			149. 43	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or vour contractor)	82. 30	83. 45	8. 00
9.00	Rate for Program covered visits (see instructions)		149. 43	149. 43	l
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		0	1, 994	10.00
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr.		0	297, 963 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x li	*	0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions	•	0	0	14. 00
15.00	Graduate Medical Education Pass Through Cost (see instruction	s)			15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	297, 963	•
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		382, 564 16, 243	
16. 02	Total program preventive charges (see Histractions) (110m prov Total program preventive costs ((line 16.02/line 16.01) times	-		12, 651	16. 02
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	•		196, 611	16. 04
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	209, 262	
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 39, 548	17. 00 18. 00
10.00	records)	(11 om contractor		37, 340	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		65, 356	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			209, 262	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		606	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			209, 868	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	25. 00
25. 50		s)		0	
	Demonstration payment adjustment amount before sequestration			0	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			209, 868 4, 197	
26. 02				4, 197	ı
27. 00	, , , , , , , , , , , , , , , , , , , ,			228, 052	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			-22, 381	29.00
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II,		0	30.00

	Financial Systems DAVIESS COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC				2552-10
SERVI CI	THE OF THE MEDITORIES OF THE MENT TON TOOT TIME BROED MITOT AND	Provider CCN: 15-0061	Peri od:	Worksheet M-3	
	ES Control of the con	Component CCN: 15-8503	From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 4:30	
		Title XVIII	RHC V	Cost	
				1 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1. 00	
	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2. line 20)		1, 545, 875	1.00
	Cost of vaccines and their administration (from Wkst. M-4, li			0	2. 00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	•		1, 545, 875	3. 00
	Total Visits (from Wkst. M-2, column 5, line 8)			7, 530	4. 00
	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
	Total adjusted visits (line 4 plus line 5)			7, 530	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	205.30 of Limit (1)	7. 00
			Carcuration	OI LIIII ( I)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	1. 00	2. 00 83. 45	8. 00
	Rate for Program covered visits (see instructions)	. o or your contractor)	205. 30	205. 30	ı
	CALCULATION OF SETTLEMENT		200.00	200.00	7.00
	Program covered visits excluding mental health services (from	contractor records)	0	6	10.00
11. 00	Program cost excluding costs for mental health services (line	9 x line 10)	0	1, 232	11. 00
1	Program covered visits for mental health services (from contra		0	0	
1	Program covered cost from mental health services (line 9 x li	•	0	0	13. 00
1	Limit adjustment for mental health services (see instructions)		0	0	14.00
1	Graduate Medical Education Pass Through Cost (see instruction: Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	1, 232	15. 00 16. 00
4	Total program charges (see instructions) (from contractor's re	•		954	•
4	Total program preventive charges (see instructions)(from provi	•		0	16. 02
4	Total program preventive costs ((line 16.02/line 16.01) times			0	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0)	3 and 18) times .80)		622	16. 04
	(Titles V and XIX see instructions.)				
	Total program cost (see instructions)		0	622	
	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 454	17. 00 18. 00
16.00	records)	(110m contractor		454	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		100	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			622	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	21. 00
1	Total reimbursable Program cost (line 20 plus line 21)			622	•
1	Allowable bad debts (see instructions)			0	23. 00
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	munti ana)		0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	24. 00 25. 00
	Pioneer ACO demonstration payment adjustment (see instruction:	s)		0	25. 50
	Demonstration payment adjustment amount before sequestration	-,		0	
	Net reimbursable amount (see instructions)			622	
1	Sequestration adjustment (see instructions)			12	
	Demonstration payment adjustment amount after sequestration			0	ı
	Interim payments			344	1
	Tentative settlement (for contractor use only)	02 27 and 20)		0	ı
	Balance due component/program (line 26 minus lines 26.01, 26.0 Protested amounts (nonallowable cost report items) in accordance			266 0	
	riotestea amounts (nonarrowable cost report riells) ill accorda	nee with own rub. 13-11,	1	U	1 30.00

Heal th	Financial Systems DAVIESS COMMUNITY	Y HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0061	Peri od:	Worksheet M-3	
SERVIC	ES	Component CCN: 15-8506	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 4:3	
		Title XVIII	RHC VI	Cost	, p
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		840, 579	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		1, 618	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			838, 961	3.00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		4, 379 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	7)		4, 379	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			191. 59	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2) 2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or your contractor)	82. 30	83. 45	8. 00
9.00	Rate for Program covered visits (see instructions)		191. 59	191. 59	
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	-	0	1, 842	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr.		0	352, 909 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x li	•	0	0	13. 00
14. 00	Limit adjustment for mental health services (see instructions	,	0	0	14. 00
15.00	Graduate Medical Education Pass Through Cost (see instruction	s)			15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	352, 909	
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		344, 072 202	1
16. 02	Total program preventive charges (see Histractions) (Tom prov Total program preventive costs ((line 16.02/line 16.01) times			202	16. 02
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	-		248, 970	
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	249, 177	
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 41, 490	17. 00 18. 00
10.00	records)	(11 om contractor		41, 470	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		60, 479	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			249, 177	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		872	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			250, 049	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	25. 00
25. 50		s)		0	
	Demonstration payment adjustment amount before sequestration			250,040	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			250, 049 5, 001	
26. 02	, ,			5,001	1
27. 00	, , , , , , , , , , , , , , , , , , , ,			212, 039	
28. 00	,			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			33, 009	
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II,		0	30.00

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0061	Peri od: From 01/01/2018	Worksheet M-4
VACCINE COST		Component CCN: 15-8500	To 12/31/2018	Date/Time Prepared: 5/29/2019 4:30 pm
•		Title XVIII	RHC I	Cost

		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		512, 179	512, 179	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	al health care staff time	0. 000122	0. 001424	2. 00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	ne 1 x line 2)	62	729	3. 00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	rom your records)	93	47	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	155	776	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	eet M-1, col. 7, line 22)	603, 540	603, 540	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)		630, 634	630, 634	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	tal direct cost (line 5	0. 000257	0. 001286	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	162	811	9. 00
10. 00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	317	1, 587	10. 00
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	15	227	11. 00
12. 00	Cost per pneumococcal and influenza vaccine injection (line 10		21. 13		12. 00
13. 00	Number of pneumococcal and influenza vaccine injections admini		8	93	13. 00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (th	neir) administration	169	650	14.00
	(line 12 x line 13)				
15. 00		,		1, 904	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	` ,		819	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)		1		

Health Financial Systems	DAVIESS COMMUNITY	′ HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC I	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0061	Period: From 01/01/2018	Worksheet M-4
VACCINE COST		Component CCN: 15-3999	To 12/31/2018	Date/Time Prepared: 5/29/2019 4:30 pm
		Title XVIII	RHC LL	Cost

Title XVIII RRC II Cost    Pneumococcal Influenza					3/27/2017 4.30	o piii
1.00   Heal th care staff cost (from Wkst. M-1, col. 7, line 10)   1.00   2.00   602,725   602,725   1.00   602,725   1.00   602,725   1.00   602,725   1.00   602,725   1.00   602,725   1.00   602,725   1.00			Title XVIII	RHC II	Cost	
1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 2.00 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time 0.002208 0.000433 2.00 4.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 1,331 261 3.00 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 93 47 4.00 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 1,424 308 5.00 6.00 Total direct cost of the hospital -based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 647,253 647,253 6.00 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 670,096				Pneumococcal	I nfl uenza	
2.00 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time 3.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 11.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections (from your records) 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of line 12 x line 13) 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)				1. 00	2. 00	
3.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 11, 474 10, 00 11, 00 Total pneumococcal and influenza vaccine (line 7 x line 8) 11, 474 11,	1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		602, 725	602, 725	1.00
4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 6.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 002208	0.000433	2.00
5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 11.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 73 372 11.00 73.00 Number of pneumococcal and influenza vaccine injections (from your records) 74.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of line 12 x line 13) 75.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	1, 331	261	3. 00
Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)  Total overhead (from Wkst. M-2, line 19)  Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)  Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)  Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)  Total number of pneumococcal and influenza vaccine injections (from your records)  Cost per pneumococcal and influenza vaccine injections (line 10/line 11)  Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries  Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	93	47	4.00
Total overhead (from Wkst. M-2, line 19)  8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)  9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)  10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)  11.00 Total number of pneumococcal and influenza vaccine injections (from your records)  12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11)  13.00 Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	1, 424	308	5. 00
8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	647, 253	647, 253	6. 00
divided by line 6)  9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)  1,474 319 9.00  Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)  11.00 Total number of pneumococcal and influenza vaccine injections (from your records)  12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11)  13.00 Number of pneumococcal and influenza vaccine injections administered to Program  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration  15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	7.00	Total overhead (from Wkst. M-2, line 19)		670, 096	670, 096	7. 00
9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0.002200	0.000476	8. 00
Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)  Total number of pneumococcal and influenza vaccine injections (from your records)  Cost per pneumococcal and influenza vaccine injection (line 10/line 11)  Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)  Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)		divided by line 6)				
lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Total number of pneumococcal and influenza vaccine injections (from your records) Total number of pneumococcal and influenza vaccine injection (line 10/line 11) Total cost per pneumococcal and influenza vaccine injections administered to Program Deneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	1, 474	319	9. 00
11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	2, 898	627	10.00
12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11)  13.00 Number of pneumococcal and influenza vaccine injections administered to Program  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration  15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,		lines 5 and 9)				
13.00 Number of pneumococcal and influenza vaccine injections administered to Program  39 199 13.00 beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration  15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	73	372	11. 00
beneficiaries  14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration  15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	39. 70	1. 69	12.00
14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration  1,548 336 14.00  (line 12 x line 13)  Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	39	199	13.00
(line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,		benefi ci ari es				
15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	14.00	Program cost of pneumococcal and influenza vaccine and its (t	neir) administration	1, 548	336	14.00
of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)  16.00 Total Program cost of pneumococcal and influenza vaccine and its (their)  administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,						
16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	15. 00				3, 525	15. 00
administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,						
	16. 00		` ,		1, 884	16. 00
lling 21)			amount to Wkst. M-3,			
Title 21)		line 21)				

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0061	From 01/01/2018	
		Component CCN: 15-8501	To 12/31/2018	Date/Time Prepared: 5/29/2019 4:30 pm
· · · · · · · · · · · · · · · · · · ·		Ti +Lo VVIII	DUC III	Cost

				3/29/2019 4.30	J PIII
		Title XVIII	RHC III	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		774, 947	774, 947	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 000016	0. 000457	2. 00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	ne 1 x line 2)	12	354	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	rom your records)	93	47	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	105	401	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	eet M-1, col. 7, line 22)	1, 130, 099	1, 130, 099	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)		966, 481	966, 481	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	tal direct cost (line 5	0. 000093	0. 000355	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	90	343	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	195	744	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		2		11. 00
12. 00	Cost per pneumococcal and influenza vaccine injection (line 10		97. 50		12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	2	58	13.00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (th	neir) administration	195	411	14.00
	(line 12 x line 13)				
15. 00				939	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,	•			
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	,		606	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	DAVIESS COMMUNITY	′ HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provi der CCN: 15-0061	Peri od: From 01/01/2018	Worksheet M-4
VACCINE COST		Component CCN: 15-8506	To 12/31/2018	Date/Time Prepared: 5/29/2019 4:30 pm
		Title XVIII	RHC VI	Cost

				3/27/2017 4.30	J PIII
		Title XVIII	RHC VI	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		411, 165	411, 165	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 000488	0. 001204	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	ne 1 x line 2)	201	495	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	93	47	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	294	542	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	434, 392	434, 392	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		406, 187	406, 187	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 000677	0. 001248	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	275	507	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	569	1, 049	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	34	210	11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10		16. 74	5. 00	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	30	74	13.00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (the	neir) administration	502	370	14.00
	(line 12 x line 13)				
15. 00				1, 618	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	,		872	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-0061 Component CCN: 15-8500	Peri od: From 01/01/2018 To 12/31/2018	
			t	

		Component CCN: 15-8500	10 12/31/2018	5/29/2019 4:30	
			RHC I	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
	Fotal interim payments paid to hospital-based RHC/FQHC			307, 352	1.
	nterim payments payable on individual bills, either submit			0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
- 1	'NONE" or enter a zero				_
	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period.				3
	payment. If none, write "NONE" or enter a zero. (1)	AISO SHOW date of each			
P	Program to Provider				
1	Togram to Trovider			0	3
2				l ol	3
3				l ol	3
4					3
5				0	3
Р	rovider to Program				
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		307, 352	4
	27) O BE COMPLETED BY CONTRACTOR				
	ist separately each tentative settlement payment after des	k review. Also show date of	•		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	rogram to Provider		<u>'</u>		
1				0	5
2				0	5
3				0	5
	rovider to Program				_
0				0 0	5
1				0	5
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	08)		0	5
	Determined net settlement amount (balance due) based on the	,			6
	SETTLEMENT TO PROVIDER	332 Topol C. (1)		0	6
	SETTLEMENT TO PROGRAM			15, 296	6
	Fotal Medicare program liability (see instructions)			292, 056	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
	Name of Contractor				8

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-0061 Component CCN: 15-3999		Worksheet M-5 Date/Time Prepared: 5/29/2019 4:30 pm

				5/29/2019 4: 30	0 pm
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			227, 658	
2. 00	Interim payments payable on individual bills, either submit			0	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3. 0
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
0.1	Program to Provider				١
. 01				0	3. (
. 02				0	3. (
. 03				0	3.
3. 04				0	3.
8. 05	Describer to Describe			0	3.
. 50	Provider to Program			0	3.
. 50 . 51					3. 3.
52					3.
53					3.
. 54					3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	08)			3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			227, 658	4.
. 00	27)	Tel to worksheet w o, Title		227,000	١.
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	k review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	5.
. 02				0	5.
. 03				0	5.
	Provider to Program			1	_
50				0	5.
51				0	5.
52	Cultural (	00)		0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.
00	Determined net settlement amount (balance due) based on the	e cost report. (1)		41 41/	6.
01	SETTLEMENT TO PROVIDER			41, 416	6.
02	SETTLEMENT TO PROGRAM			ı	6.
. 00	Total Medicare program liability (see instructions)		Contract	269, 074 NPR Date	7.
			Contractor Number		
		0	1. 00	(Mo/Day/Yr) 2.00	

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-0061 Component CCN: 15-8501	Peri od: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 4:30 pm

ŭ	omponent con. 13-0301	10 12/31/2010	5/29/2019 4: 30	
		RHC III	Cost	
		Par	t B	
		mm/dd/yyyy	Amount	
		1, 00	2, 00	
O Total interim payments paid to hospital-based RHC/FQHC			200, 052	1
O Interim payments payable on individual bills, either submitted of	or to be submitted to		0	2
the contractor for services rendered in the cost reporting period				
"NONE" or enter a zero				
O List separately each retroactive lump sum adjustment amount base	ed on subsequent			1 3
revision of the interim rate for the cost reporting period. Also				
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				1
1		08/09/2018	28, 000	1 :
2			0	:
3			0	:
4			l ol	1 :
5			ol	1 :
Provider to Program				1
0			0	1 :
1			0	
2			o	
3			o	
4			o	
9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			28, 000	
O Total interim payments (sum of lines 1, 2, and 3.99) (transfer t	to Worksheet M-3, line		228, 052	١.
27)				
TO BE COMPLETED BY CONTRACTOR				
O List separately each tentative settlement payment after desk rev	view. Also show date o	f		
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
1			0	
2			0	
3			0	
Provider to Program				
0			0	
1			0	
2			0	!
9 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	
Determined net settlement amount (balance due) based on the cost	t report. (1)			
1 SETTLEMENT TO PROVIDER			0	'
2 SETTLEMENT TO PROGRAM			22, 381	(
O Total Medicare program liability (see instructions)			205, 671	
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1. 00	2.00	
0 Name of Contractor		(		8

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-0061 Component CCN: 15-8503	Peri od: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/29/2019 4:30 pm

	component con. 13-6303	10 12/31/2010	5/29/2019 4: 30	
		RHC V	Cost	
		Par	t B	
		mm/dd/yyyy	Amount	
		1. 00	2.00	
O Total interim payments paid to hospital-based RHC/FQHC			344	1
Unterim payments payable on individual bills, either submitted	or to be submitted to		0	2
the contractor for services rendered in the cost reporting period				
"NONE" or enter a zero				
O List separately each retroactive lump sum adjustment amount base	ed on subsequent			1 3
revision of the interim rate for the cost reporting period. Also				
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				1
1			0	] 3
2			0	3
3			0	3
14			o	3
15			o	3
Provider to Program		<u>'</u>		
0			0	1 :
1			0	1
2			0	1
3			0	1
4			0	1
9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	1
Total interim payments (sum of lines 1, 2, and 3.99) (transfer	to Worksheet M-3, line		344	4
27)				
TO BE COMPLETED BY CONTRACTOR				
O List separately each tentative settlement payment after desk re	view. Also show date o	f		
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
11			0	
2			0	
3			0	5
Provider to Program				
0			0	
1			0	5
2			0	
9 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	
Determined net settlement amount (balance due) based on the cos	t report. (1)			1
1 SETTLEMENT TO PROVIDER			266	6
2 SETTLEMENT TO PROGRAM			0	6
O Total Medicare program liability (see instructions)		0 1	610	7
		Contractor	NPR Date	
	0	Number	(Mo/Day/Yr)	
Name of Contractor	0	1. 00	2. 00	8
0 Name of Contractor				. ⊱

Health Financial Systems	DAVIESS COMMUNITY	/ HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-0061 Component CCN: 15-8506		Worksheet M-5 Date/Time Prepared: 5/29/2019 4:30 pm

				5/29/2019 4: 30	0 pm
			RHC VI	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			212, 039	1.0
2. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
. 00	List separately each retroactive lump sum adjustment amount	based on subsequent			3. 0
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	3. (
. 02				0	3. (
. 03				0	3.
. 04				0	3.
. 05				0	3.
	Provider to Program				
. 50				0	3.
51				0	3.
52				0	3.
53				0	3.
. 54				0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		212, 039	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	k review. Also show date of	,		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	5.
. 02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
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 PROVI DER			33, 009	6.
02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)	<u> </u>		245, 048	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
3. 00	Name of Contractor			1	8. (