	required by law (42 USC 1395) since the beginning of the co					FORM APPROVING NO. 093 EXPIRES 03-	38-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX CO SUMMARY	OST REPORT CERTIFICATION	Provider CCN: 15-13		od: 10/01/2018 09/30/2019		Prepared:
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically filed	cost report		[Date: 2/25/202	20 Time:	4: 21 pm
use only	2. [] Manually submitted co	st report					
	3. [0] If this is an amended 4. [F] Medicare Utilization.	report enter the number Enter "F" for full or "L	of times the provid _" for low.	der resubm	itted this c	ost report	
Contractor use only	(2) Settled without Audit	7. Contractor No.	or this Provider CCN	12. [0]I	ctor's Vendo	lumn 1 is 4	

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 GIBSON GENERAL HOSPITAL (15-1319) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 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
Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-129, 652	-54, 115	0	20, 575	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-298, 659	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		5, 841		0	10.00
200.00	Total	0	-428, 311	-48, 273	0	20, 575	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1319 Peri od: Worksheet S-2 From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 4:21 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1800 SHERMAN DRIVE 1.00 PO Box: 1.00 State: IN 2.00 City: PRINCETON Zi p Code: 47670-County: GIBSON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal GIBSON GENERAL HOSPITAL 151319 99915 12/16/2003 N 0 0 3.00 Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF GIBSON GENERAL SWING 15Z319 99915 12/16/2003 N 0 Ν 7.00 BFD 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA GIBSON HOME HEALTH 157445 99915 10/19/1995 Ν Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC GIBSON GENERAL FAMILY 158524 99915 09/11/2017 O 15.00 N 0 15.00 MEDI CI NE Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1 00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2018 09/30/2019 20.00 21.00 Type of Control (see instructions) 21.00 2 1.00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for N 22.00 N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		pai d days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00	If this provider is an IPPS hospital, enter the	0	0	0	0	0	0	24.00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							

	Financial Systems GIBSON -AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	I GENERAL HO ATA I	Provider CC	CN: 15-1319	Peri od:	4 (0040		eet S-2)
					From 10/0 To 09/3	0/2018	Date/T	ime Pre 1020 4:2	epared 21 pm
		In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medica HMO da	aid (Other di cai d	
		paid days	el i gi bl e unpai d	Medicaid paid days	Medi cai d el i gi bl e			days	
		1.00	days 2. 00	3. 00	unpai d 4. 00	5. 00)	6. 00	-
. 00	If this provider is an IRF, enter the in-state	0	0		0	0, 0,	0	0.00	25.
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid								
	HMO paid and eligible but unpaid days in column 5.				Heban /D	ural C	Doto o	F Coogn	
	T-	<u> </u>			Urban/R			00	
. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the be	ginning of t	the	2	!		26.
. 00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	r"2" for r	ural. If a		st	2			27.
. 00	If this is a sole community hospital (SCH), enter the leffect in the cost reporting period.			CH status in	ר	C)		35.
	period. In the cost reporting period.				Begi nr			i ng: 00	
. 00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for numb			2.	00	36.
. 00	If this is a Medicare dependent hospital (MDH), ente		r of perio	ds MDH statu	ıs	C			37.
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f								37.
. 00	<pre>instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o</pre>								38.
	enter subsequent dates.				Y/	N	Y,	/N	
. 00	Does this facility qualify for the inpatient hospita	l normont c	di uotmont	for law valu	1. (00 N	39.
. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i), (ii), or the mileage	(iii)? En requireme	ter in colur nts in	nn		'	N	39.
. 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	ber 1. Ente	r "Y" for				ı	N	40.
	no in column 2, for discharges on or after October 1	. (see inst	ructions)			V	XVIII		
	Prospective Payment System (PPS)-Capital					1.00	0 2.00	3. 00	
. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti ona	te share in	accordance	· N	N	N	45.
. 00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46.
00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS					N	N	N	47.
	Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in		7			N	N	N	48. 56.
. 00	UNII for		ng which r			1			57.
. 00	or "N" for no. If line 56 is yes, is this the first cost reporting CMF programs trained at this facility? Fotor "Y" fo		" for no i	n column 1	i i coi aiiii				
00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	ryes or "N th of this Y", complet	cost repor e Workshee	ting period		·"			
. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim	or yes or "N th of this Y", complet I, if appli bursement f	cost repor e Workshee cable. or physici	ting periodí t E-4. If co	olumn 2 is	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			58.
. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes or "N th of this Y", complet I, if appli bursement f complete W	cost repor e Workshee cable. or physici kst. D-5.	ting period' t E-4. If co ans' service , Pt. I.	olumn 2 is	N			
. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	or yes or "N th of this Y", complet I, if appli bursement f complete W	cost repor e Workshee cable. or physici kst. D-5.	ting periodí t E-4. If co ans' service	olumn 2 is	N eet A	Qualifi Crite	hrough i cati on eri on	58. 59.
3. 00 5. 00 7. 00 3. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ryes or "N th of this Y", complet I, if appli bursement f complete W s, complete	cost repor e Workshee cable. or physici kst. D-5. Wkst. D-2	ting period't E-4. If co ans' service , Pt. I. NAHE 413.8	olumn 2 is es as 85 Worksh	N eet A	Qualifi Crite Cc	i cati on	

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1319 Peri od: Worksheet S-2 From 10/01/2018 Part I Date/Time Prepared: 09/30/2019 2/25/2020 4:21 pm Y/N IME Direct GME IME Direct GME 3. 00 5.00 1.00 2.00 4.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 Ν 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, 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 instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61 05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unwei ghted Unwei ghted Program Name IME FTE Count Direct GME FTE Count 1. 00 2.00 3. 00 4. 00 0.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62. 01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 1/ (col. 1 + Nonprovi der Hospi tal col. 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting

0.00

0.00

0.000000 64.00

period that begins on or after July 1, 2009 and before June 30, 2010.

in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

Enter in column 1, if line 63 is yes, or your facility trained residents

64.00

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1319 Peri od: Worksheet S-2 From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 4:21 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal 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/ (col . 1 + col . 2)) FTEs in FTFs Nonprovi der Hospi tal 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 Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?	N			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most			0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.				
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75.00
subprovider? Enter "Y" for yes and "N" for no.				

Health Financial Systems GIBSON GENERAL F	HOSPI TAL	Li	n Lieu	of For	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-1319	Period: From 10/01/ To 09/30/	′2018 ′2019	Workshe Part I Date/Ti 2/25/20	et S-2 me Pre	pared:
			1.00	2.00	3. 00	
76.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teach CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. (indicate which program year began during this cost reporting periods.	2004? Enter "Y" for yes hing program in accordan Column 3: If column 2 is	or "N" for ce with 42 Y,			0	76.00
				1.0	00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a 81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.	1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 6.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified under section	n		N		87. 00
1000(0)(1)(0)(W). Enter 1 101 yes of W 101 no.		V 1. 00		XI :		
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital	convices? Enter "V" for			Υ Υ		90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the		N		Υ		91.00
full or in part? Enter "Y" for yes or "N" for no in the applicable column. OD Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see						92.00
93.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		N		N		93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, ar applicable column.	nd "N" for no in the	N		N		94.00
95.00 If line 94 is "Y", enter the reduction percentage in the appli 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes of applicable column.		0. 00 N		O. C N		95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appli 98.00 Does title V or XIX follow Medicare (title XVIII) for the inte stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	erns and residents post	0. 00 Y		0. C Y		97. 00 98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl				Υ		98. 01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.		Y		Υ		98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes				N		98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reoutpatient services cost: Enter "Y" for yes or "N" for no in column 2 for title XIX		N N		N		98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col				Υ		98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost represented by the cost of the column 2 for title XIX. Rural Providers		Y		Y		98.06
105. 00 Does this hospital qualify as a CAH? 106. 00 If this facility qualifies as a CAH, has it elected the all-ir	nclusive method of navmo	rnt N				105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost retaining programs? Enter "Y" for yes or "N" for no in column of the cost	reimbursement for I&R	N				107.00
yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2 reimbursed. If yes complete Wkst. D-2, Pt. II.	25 and the program is co	st				100.00
108.00 Is this a rural hospital qualifying for an exception to the CF CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	кіva тее schedule? See 4	.2 N				108. 00

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1319 Peri od: Worksheet S-2 From 10/01/2018 Part I Date/Time Prepared: 09/30/2019 2/25/2020 4:21 pm Physi cal Occupati onal Speech Respi ratory 1. 00 2. 00 3. 00 4. 00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν 109.00 therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes 110 00 N complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1.00 2.00 111.00|f this facility qualifies as a CAH, did it participate in the Frontier Community Ν 111.00 Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 Miscellaneous Cost Reporting Information 115.00|Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 Ν 0 115.00 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. Ν 116.00 117.00|s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Υ 117.00 no. 118.00 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. Premi ums Losses Insurance 1. 00 2.00 3.00 0118.01 118.01 List amounts of mal practice premiums and paid losses: 60, 536 1. 00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119 00 120.00|s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Ν Ν 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or 'N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00|Did this facility incur and report costs for high cost implantable devices charged to 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Ν 122.00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If Ν 125.00 yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare certified kidney transplant center, enter the certification date 126.00 in column 1 and termination date, if applicable, in column 2. 127.00|If this is a Medicare certified heart transplant center, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00 of this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|If this is a Medicare certified lung transplant center, enter the certification date in 129, 00 column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 of this is an organ procurement organization (OPO), enter the OPO number in column 1 134 00 and termination date, if applicable, in column 2. All Providers

		NERAL HOSPITAL Provider CO	N. 15 1210	Peri od		u of Form CMS Worksheet S-	
OSPITAL AND HOSPITAL HEALTH CARE COMPLE)	TIDENTIFICATION DATA	Provider CC	.N: 15-1319	From 1	0/01/2018 9/30/2019	Part I Date/Time Pr 2/25/2020 4:	epared
					1. 00	2.00	_
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "I are claimed, enter in column 2 the	N" for no in column 1	. If yes, and home	office co	,	Y	HB0778	140.0
1. 00		2. 00			3. 00		
If this facility is part of a chai			ough 143 th	ne name ar	nd address	of the home	
office and enter the home office control Name: DEACONESS HEALTH SYSTEM	Contractor's Name	e: WISCONSIN PHYSIC SERVICES	I ANS Contra	actor's Nu	ımber: 0810	1	141. (
22.00 Street: 600 MARY STREET	PO Box:		7. 0		4774		142.
3. 00 Ci ty: EVANSVI LLE	State:	I N	Zip Co	ode:	4771		143.
						1. 00	1
4.00 Are provider based physicians' cos	ts included in Worksh	eet A?				Υ	144.
							4
5.00 f costs for renal services are cla	aimad an Wkst A lin	a 74 are the cost	c for		1. 00	2. 00	145.
inpatient services only? Enter "Y" no, does the dialysis facility incle period? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	for yes or "N" for no lude Medicare utiliza for no in column 2. y changed from the pro column 1. (See CMS Po	o in column 1. If tion for this cost eviously filed cos	column 1 i reporting t report?		N		146.
The state of the s	. , , , , , ,						
						1. 00	
7.00 Was there a change in the statistic						N	147.
3.00 Was there a change in the order of 9.00 Was there a change to the simplifio	allocation? Enter Y ed cost finding metho	ror yes or N r d2 Enter "V" for v	or no. es or "N"	for no		N N	148. 149.
7. solvas there a change to the simplifit	sa cost irriaring metrio	Part A	Part [itle V	Title XIX	177.
		1.00	2. 00		3. 00	4. 00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or " 5.00Hospi tal	N for no for each co	N N	and Part	B. (See 4	N N	3. 13) N	155.
6.00Subprovider - IPF		N	N N		N	N N	156.
7.00 Subprovi der – IRF		N	N		N	N	157.
8. 00 SUBPROVI DER		N.	, ,		NI.		158.
9.00 SNF 0.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 160.
1. OOCMHC		IV	l N		N	N N	161.
						1. 00	
he							
Multicampus 5.00 s this hospital part of a Multican Enter "Y" for yes or "N" for no.	npus hospital that ha	s one or more camp	uses in di	fferent C	BSAs?	N	165.
5.00 <mark>ls this hospital part of a Multica</mark>	Name	County	State	Zi p Code	CBSA	FTE/Campus	165.
5.00 Is this hospital part of a Multican Enter "Y" for yes or "N" for no.		<u> </u>				FTE/Campus 5.00	
5.00 is this hospital part of a Multican Enter "Y" for yes or "N" for no.	Name	County	State	Zi p Code	CBSA	FTE/Campus 5.00	
5.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	County	State	Zi p Code	CBSA	FTE/Campus 5.00 0.0	
5.00 is this hospital part of a Multical Enter "Y" for yes or "N" for no. 6.00 if line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	Name 0	County 1.00	State 2.00	Zi p Code 3. 00	CBSA	FTE/Campus 5.00	
6.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10)	Name 0) incentive in the Am under §1886(n)? Ent. 5 is "Y") and is a me.	County 1.00 nerican Recovery arer "Y" for yes oreaningful user (lin	State 2.00	Zi p Code 3.00	CBSA 4.00	FTE/Campus 5.00 0.0	00 166.
5.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 If this provider is a CAH and is not contact the second s	Name 0) incentive in the Am under §1886(n)? Ento 5 is "Y") and is a mea IT assets (see instru- ot a meaningful user,	County 1.00 nerican Recovery arer "Y" for yes or aningful user (linctions) does this provide	State 2.00 and Reinvest "N" for no e 167 is "	Zip Code 3.00 tment Act Y"), ente	CBSA 4.00	FTE/Campus 5.00 0.0	00 166. 167. 168.
15.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no. 16.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 7.00 Is this provider a meaningful user 88.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 1f this provider is a CAH and is no exception under §413.70(a) (6) (ii)? 9.00 If this provider is a meaningful user 19.00 Is this provider 1	Name 0 incentive in the Am under §1886(n)? Ento 5 is "Y") and is a mel IT assets (see instruot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y")	County 1.00 nerican Recovery arer "Y" for yes or aningful user (linuctions) does this provide "N" for no. (see	State 2.00 and Reinvest "N" for note 167 is " r qualify instruction	Zi p Code 3.00 tment Act D. Y"), ente for a harons)	CBSA 4.00	FTE/Campus 5.00 0.0	167. 168.
15.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no. 16.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 77.00 Is this provider a meaningful user 18.00 If this provider is a CAH (line 10.18.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)?	Name 0 incentive in the Am under §1886(n)? Ento 5 is "Y") and is a mel IT assets (see instruot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y")	County 1.00 nerican Recovery arer "Y" for yes or aningful user (linuctions) does this provide "N" for no. (see	State 2.00 and Reinvest "N" for note 167 is " r qualify instruction	zip Code 3.00 tment Act Y"), ente for a har ons) is "N"),	CBSA 4.00	FTE/Campus 5.00 0.0	165. 1
15.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no. 16.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 7.00 Is this provider a meaningful user 88.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 1f this provider is a CAH and is no exception under §413.70(a) (6) (ii)? 9.00 If this provider is a meaningful user 19.00 Is this provider 1	Name 0 incentive in the Am under §1886(n)? Ento is "Y") and is a medit assets (see instruction of a meaningful user, Enter "Y" for yes or ser (line 167 is "Y") ns)	County 1.00 1.00 1.00 Derican Recovery arer "Y" for yes or aningful user (linuctions) does this provide "N" for no. (see and is not a CAH	d Reinvest "N" for no e 167 is " r qualify instructic (line 105	tment Act Y"), ente for a har ons) is "N"),	r the dshi p enter the	FTE/Campus 5.00 0.0	167. 168.

Health Financial Systems GIBS	In Lie	of Form CN	MS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1319 Peri				Worksheet	S-2
			From 10/01/2018 To 09/30/2019		
				27 207 2020	1. 21 piii
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any day section 1876 Medicare cost plans reported on Wkst.	N		0 171. 00		
"Y" for yes and "N" for no in column 1. If column 1876 Medicare days in column 2. (see instructions)	on				

	Financial Systems GIBSON GENERA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	worksheet S-2	
		1	F	rom 10/01/2018 o 09/30/2019	Part II	
				V (1)	2/25/2020 4: 2	2 <u>1 pm</u>
				Y/N 1. 00	<u>Date</u> 2.00	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	esponses Ente			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation		46	N		1
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.
	proporting period. It yes, enter the date of the change in	301 Giiii 2. (300	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home 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)	offices, drug der or its of the board	N			3. (
	rerationships: (see Thati dottons)		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Cer-Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.0
. 00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit re	conciliation.		\/ /N		
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider is	N		6.0
	the legal operator of the program?			N		
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		7. (8. (
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. (
0. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	N		10. (
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.
					Y/N	
					1. 00	
2. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s soo instruc	tione		Y	12.
3. 00				st reporting	N N	13.
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	f yes, see ins	tructi ons.	N	14.
5. 00	Did total beds available change from the prior cost reporti	ing period? If	yes, see inst	ructions.	N	15.
			t A		t B	
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2. 00	3. 00	4. 00	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Υ	01/03/2020	Y	01/03/2020	16.0
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17.
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.
9. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.

Health Financial Systems	GI BSON GENER				u of Form CMS		
HOSPITAL AND HOSPITAL HEALTH CARE RE	I MBURSEMENT QUESTI ONNAI RE	Provi der CC	CN: 15-1319	Peri od: From 10/01/2018 To 09/30/2019		repared:	
		Descri	ption	Y/N	Y/N	. 21 piii	
		C)	1. 00	3. 00		
20.00 If line 16 or 17 is yes, were Report data for Other? Descri				N	N	20. 00	
		Y/N	Date	Y/N	Date		
24. 22 W		1.00	2. 00	3.00	4. 00	04.00	
21.00 Was the cost report prepared records? If yes, see instruct		N		N		21. 00	
					1. 00		
COMPLETED BY COST REIMBURSED A	AND TEERA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	OSPLTALS)		1.00		
Capital Related Cost	(======================================						
22.00 Have assets been relifed for	Medicare purposes? If yes, so	ee instructions			N	22. 00	
23.00 Have changes occurred in the reporting period? If yes, see		e due to apprais	sals made du	uring the cost	N	23. 00	
24.00 Were new leases and/or amendm If yes, see instructions	ents to existing leases enter	red into during	this cost r	reporting period?	N	24.00	
25.00 Have there been new capitaliz	ed Leases entered into during	g the cost repor	ting period	l? If yes, see	N	25. 00	
instructions. 26.00 Were assets subject to Sec. 23 instructions.	14 of DEFRA acquired during	the cost reporti	ng period?	If yes, see	N	26. 00	
27.00 Has the provider's capitaliza copy.	tion policy changed during th	he cost reportir	ng period? I	f yes, submit	N	27. 00	
Interest Expense	Interest Expense						
	period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)						
	treated as a funded depreciation account? If yes, see instructions O Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see						
instructions. 31.00 Has debt been recalled before instructions.	00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see						
Purchased Services 32.00 Have changes or new agreement	s occurred in patient care s	ervices furnishe	ed through c	contractual	N	32.00	
arrangements with suppliers o 33.00 If line 32 is yes, were the r	of services? If yes, see insti	ructi ons.				33.00	
no, see instructions. Provider-Based Physicians		•	<u> </u>				
34.00 Are services furnished at the If yes, see instructions.	provider facility under an a	arrangement with	n provi der-b	based physicians?	Y	34.00	
35.00 If line 34 is yes, were there physicians during the cost re	new agreements or amended exporting period? If yes, see	xisting agreemer instructions.	nts with the	e provi der-based	N	35. 00	
				Y/N	Date		
U				1. 00	2. 00		
Home Office Costs	ed on the cost senset?			N1		24 00	
36.00 Were home office costs claime 37.00 If line 36 is yes, has a home		nranarad by the	home office	N 2? N		36. 00 37. 00	
If yes, see instructions.	·						
38.00 If line 36 is yes, was the f the provider? If yes, enter i	n column 2 the fiscal year en	nd of the home o	offi ce.			38.00	
39.00 If line 36 is yes, did the prosecutions.		•	,	·		39.00	
40.00 If line 36 is yes, did the print instructions.	ovider render services to the	e nome office?	ii yes, see	P N		40.00	
		1. (00	2.	00		
	Cost Report Preparer Contact Information						
41.00 Enter the first name, last name	me and the title/position	AUSTIN		FISHER		41.00	
held by the cost report prepa	in ci i i i coi aiii i s i, z, ana s,					III .	
		BLUE & CO.				42. 00	

Health Financial Systems	Systems GIBSON GENERAL HOSPITAL					2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	TI ONNAI RE	Provi der		Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Pre 2/25/2020 4:2	pared:
		3	. 00			
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/	/position N	MANAGER				41.00
held by the cost report preparer in columns 1, respectively.	2, and 3,					
42.00 Enter the employer/company name of the cost re	eport					42.00
preparer.						
43.00 Enter the telephone number and email address o						43.00
report preparer in columns 1 and 2, respective	el y.					

Heal th Fi nancial SystemsGIBSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1319

					T	o 09/30/2019	Date/Time Pre 2/25/2020 4:2	
							1/P Days /	I DIII
							0/P Visits /	
							Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	oomponent	Line Number	110.	or beas	Avai I abl e	O/III TIOUT S	11 210 1	
		1. 00	2	2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		20	7, 300	21, 120. 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			20	7, 300	21, 120. 00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31.00	ol .	5	1, 825	2, 112. 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							13.00
14. 00	Total (see instructions)			25	9, 125	23, 232. 00	0	
15. 00	CAH visits				.,		0	15.00
16. 00	SUBPROVIDER - IPF						_	16.00
17. 00	SUBPROVIDER - IRF							17. 00
18. 00	SUBPROVI DER							18.00
19. 00	SKILLED NURSING FACILITY	44. 00		o	0		0	
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							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC	88. 00					0	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			25			_	27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambulance Trips						_	29.00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room			Ĭ				32.01
52. 51	outpatient days (see instructions)							52.01
33. 00	LTCH non-covered days							33.00
	LTCH site neutral days and discharges							33. 01
	,	ı	'	'		1		

Heal th Financial SystemsGIBSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1319

Peri od: Worksheet S-3 From 10/01/2018 Part I To 09/30/2019 Date/Ti me Prepared:

						2/25/2020 4: 2	1 pm
	·	I/P Days	/ O/P Visits	/ Tri ps	Full Time I		
				•		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	513	15	880			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)	195	49				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	o	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	1, 417	0	1, 417			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	.,	0	.,			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 930	15				7.00
7.00	beds) (see instructions)	1, ,00	10	0,000			7.00
8. 00	INTENSIVE CARE UNIT	23	0	88			8.00
9. 00	CORONARY CARE UNIT	2.5	J				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)	1, 953	15	3, 118	0.00	237. 29	1
15. 00	CAH visits	1, 755	0		0.00	231.29	15.00
16. 00	SUBPROVIDER - IPF	٥	U	U			16.00
17. 00	SUBPROVIDER - I PF						17.00
18. 00	SUBPROVI DER						18.00
		٥	0	0	0.00	0.00	
19.00	SKILLED NURSING FACILITY	٥	U	U	0. 00	0.00	•
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	2 0/4	25	4 007	0.00	, ,,	21.00
22. 00	HOME HEALTH AGENCY	2, 864	35	4, 926	0. 00	6. 63	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC				6 66		25.00
26.00	RURAL HEALTH CLINIC	167	0		0.00		1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			•
27. 00	Total (sum of lines 14-26)		_		0. 00	246. 86	l .
28. 00	Observation Bed Days	_	0	633			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	_			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0				l	33. 01

Provider CCN: 15-1319

				10	09/30/2019	Date/IIMe Pre 2/25/2020 4:2	
		Full Time	<u> </u>	Di sch	arges		
		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	181	6	284	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)			48	20		2.00
3. 00	HMO IPF Subprovider				0		3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	0	181	6	284	•
15. 00	CAH visits						15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0.00					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						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27. 00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01

Heal th	Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOME H	EALTH AGENCY STATISTICAL DATA			F	eriod: rom 10/01/2018		
			Component	CCN: 15-7445 T		2/25/2020 4:2	
					Home Health Agency I	PPS	
					1.	00	
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	LIOME LIEALTH ACENCY STATISTICAL DATA	1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	1	1			1. 00
2. 00	Unduplicated Census Count (see instructions)	0.00	107.00		0.00 oyees (Full Ti		2. 00
		Enter the numb	er of hours in	Staff	Contract	Total	
			l work week	Starr	Contract	Total	
			0	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00				3. 00
4.00	Director(s) and Assistant Director(s)		40.00	1. 12	0.00	1. 12	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			0. 00 3. 56			5. 00 6. 00
7. 00	Nursi ng Supervi sor			0.00	0. 00	0.00	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			0. 76 0. 00			8. 00 9. 00
10.00	Occupational Therapy Service			0. 15	0. 00	0. 15	10.00
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. 00 0. 04			11. 00 12. 00
13.00	Speech Pathology Supervisor			0.00			
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0.00			
16.00	Home Health Aide			1.00	0. 00	1. 00	16. 00
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. 00 0. 00			
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where			1			19. 00
17.00	you provided services during the cost			'			19.00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			99915			20. 00
	during this cost reporting period (line 20 contains the first code).						
	contains the first code).		pi sodes	LUDA Estas las	DED 0.1	Tabala Casha	
		Wi thout Outliers		LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
	PPS ACTIVITY DATA	1. 00	2. 00	3.00	4. 00	5. 00	
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	1, 310 209, 232					21. 00 22. 00
23. 00	Physical Therapy Visits	921				235, 571 946	
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	188, 805 175		1, 640	1, 435	193, 930 180	24. 00 25. 00
26. 00	Occupational Therapy Visit Charges	35, 875		205	615		26.00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	23 4, 715				23 4, 715	27. 00 28. 00
29. 00	Medical Social Service Visits	0	0	Ō	0	0	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	0 221	1	1		0 240	30. 00 31. 00
32.00	Home Health Aide Visit Charges	16, 572	975	0	450	17, 997	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 650	138	48	28	2, 864	33.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 455, 199	21, 470	_	_	_	34.00 35.00
	30, 32, and 34)						
36. 00	outlier)	141		20	3	164	36. 00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	23, 607	5, 779	476	0		37. 00 38. 00

Heal th	n Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1319	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8524	From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:2	
					RHC I	Cost	
					1	00	-
	Clinic Address and Identification				1.	00	
1. 00	Street		1		7851 S. PROFES		1.00
				00	State 2.00	ZIP Code 3.00	
2. 00	City, State, ZIP Code, County		FORT BRANCH	00		47648	2.00
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for	urban		1.00	3.00
3.00	HOSPITAL-BASED FUNCS UNLT. DESIGNATION - ENT	ei k ioi iui	ai 0i 0 10i		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds						
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4.00
6. 00	Health Services for the Homeless (Section 34						6.00
7. 00	Appal achi an Regi onal Commi ssi on						7.00
8. 00 9. 00	Look-Alikes						8. 00 9. 00
9.00	OTHER (SPECIFY)						9.00
					1.00	2. 00	
10.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column		0	10.00
	Tiours.)	Sun	iday	T 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)			08: 00	17: 00	08: 00	11.00
	Joenn 0	l.		100.00		00.00	11100
	Tu				1.00	2. 00	
12. 00 13. 00		ed in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N N	0	12. 00 13. 00
				Prov	ider name	CCN number	
11.00	DUO (FOUO				1. 00	2. 00	44.00
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
				unty			
2. 00	City, State, ZIP Code, County		GI BSON	00			2.00
2.00	Jointy, State, Zir Code, County	Tuesday		esday	Thur	sday	2.00
		to	from	to	from	to	
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
11 00	Facility hours of operations (1)	17: 00	he. oo	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	GIBSON GENER	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
		Component		From 10/01/2018 To 09/30/2019	Date/Time Pre	
		·			2/25/2020 4: 2	1 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

	Financial Systems GIBSON GENERAL HOSTAL UNCOMPENSATED AND INDIGENT CARE DATA P	SPLIAL rovider CCN: 15-131	19 Peri od		u of Form CMS-2 Worksheet S-1	
105PI	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 15-13		a: 10/01/2018	worksneet 5-1	U
				09/30/2019	Date/Time Pre	pared:
					2/25/2020 4: 2	1 pm
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202 c	olumn 8)		0. 475575	1.0
	Medicaid (see instructions for each line)				2 (00 22(, ,
. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				2, 680, 236 N	2. C
. 00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments from M	ledi cai d?		IN	4.0
. 00	If line 4 is no, then enter DSH and/or supplemental payments fr				0	5.0
. 00	Medi cai d charges				7, 557, 100	6.0
. 00	Medicaid cost (line 1 times line 6)				3, 593, 968	
. 00	Difference between net revenue and costs for Medicaid program (and 5; if	913, 732	8.0		
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	s each line)				
. 00	Net revenue from stand-alone CHIP	each Title)			0	9.0
	Stand-alone CHIP charges				0	
1. 00	Stand-alone CHIP cost (line 1 times line 10)		0	11.0		
2. 00	,	line 11 minus line	9; if < z	ero then	0	12.0
	enter zero)		1:>			ŀ
3. 00	Other state or local government indigent care program (see instance) Net revenue from state or local indigent care program (Not incl			I	0	13. (
	Charges for patients covered under state or local indigent care			nes 6 or	0	
1. 00	10)	program (Not Ther	aaca III II	1103 0 01	G	' ' ' '
5.00	1 ()			0	15.0
6. 00		minus line	. 0	16. (
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHII) / /			(
	instructions for each line)	and State/Tocal	rnargent c	are progra	IIIS (See	
7. 00	Private grants, donations, or endowment income restricted to fu	nding charity care			0	17. C
8. 00	Government grants, appropriations or transfers for support of h	ospital operations	i		0	18.0
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent care pro	grams (sum	n of lines	913, 732	19.0
	8, 12 and 16)	Uni nsu	rod I	nsured	Total (agl 1	
		patier		ati ents	Total (col. 1 + col. 2)	
		1.00		2. 00	3. 00	
	Uncompensated Care (see instructions for each line)					
0. 00		ility 12	28, 075	0	128, 075	20.0
1. 00	(see instructions) Cost of patients approved for charity care and uninsured discou	ate (soo	50, 909	o	60, 909	21. (
1.00	instructions)	113 (366	50, 909	٩	00, 707	21.0
2. 00	Payments received from patients for amounts previously written	off as	О	o	0	22.0
	charity care					
3.00	Cost of charity care (line 21 minus line 22)		50, 909	0	60, 909	23.0
					1 00	
4. 00	Does the amount on line 20 column 2, include charges for patien	t days beyond a Le	nath of st	av limit	1. 00 N	24.0
4. 00	imposed on patients covered by Medicaid or other indigent care		ingtil of st	ay IIIII t	14	27.0
5. 00	If line 24 is yes, enter the charges for patient days beyond th		ogram's le	ength of	0	25.0
	stay limit					
6.00	Total bad debt expense for the entire hospital complex (see ins		`		2, 874, 185	
7. 00	Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (s	•	7		230, 262 354, 250	1
7 (11	1	ee mistructions)				
	INON-Medicare bad debt expense (see instructions)				2, 519, 935	
28. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instruct	i ons)		2, 519, 935 1, 322, 406	
27. 01 28. 00 29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instruct	i ons)		2, 519, 935 1, 322, 406 1, 383, 315 2, 297, 047	29. 0 30. 0

Heal th	Financial Systems	GIBSON GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:2	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1. 00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT		1, 299, 906	1, 299, 906	265, 560	1, 565, 466	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0	,,,		0	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	209, 379	848. 969	1	1	631, 626	
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 441, 659	4, 270, 152	,		5, 980, 296	
7. 00	00700 OPERATION OF PLANT	217, 635	914, 748			1, 329, 732	1
8.00	00800 LAUNDRY & LINEN SERVICE	45, 699	37, 517			88, 450	1
9. 00	00900 HOUSEKEEPI NG	273, 143	108, 015	1		397, 737	
10.00	01000 DI ETARY	427, 141	373, 718			373, 829	1
11. 00	01100 CAFETERI A	0	0	1		461, 135	1
13. 00	01300 NURSING ADMINISTRATION	42, 532	-7, 075	35, 457		34, 783	1
14.00	01400 CENTRAL SERVI CE & SUPPLY	177, 028	129, 022			316, 383	1
15. 00	01500 PHARMACY	138, 162	462, 292			606, 229	1
	01600 MEDICAL RECORDS & LIBRARY	266, 192	119, 145	1		398, 086	1
	INPATIENT ROUTINE SERVICE COST CENTERS				, ,		1
30.00	03000 ADULTS & PEDIATRICS	1, 426, 220	1, 079, 618	2, 505, 838	-25, 533	2, 480, 305	30.00
31.00	03100 INTENSIVE CARE UNIT	6, 378	1, 065			7, 416	1
44.00	04400 SKILLED NURSING FACILITY	0	0		ol ol	0	44.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	831, 831	845, 942	1, 677, 773	-152, 134	1, 525, 639	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	695, 556	765, 230	1, 460, 786	21, 123	1, 481, 909	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	155, 980	155, 980	o	155, 980	54.03
60.00	06000 LABORATORY	795, 254	903, 953	1, 699, 207	23, 611	1, 722, 818	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	45, 637	45, 637	0	45, 637	62.00
65.00	06500 RESPI RATORY THERAPY	419, 746	437, 342	857, 088	6, 874	863, 962	65.00
66.00	06600 PHYSI CAL THERAPY	664, 442	276, 094	940, 536	20, 936	961, 472	66.00
67.00	06700 OCCUPATI ONAL THERAPY	250, 479	42, 196	292, 675	4, 063	296, 738	67.00
68.00	06800 SPEECH PATHOLOGY	91, 328	11, 999	103, 327	7 0	103, 327	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(148, 295	148, 295	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(553, 194	553, 194	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 068, 408	1, 068, 408	8 0	1, 068, 408	
76.00	03480 I NFUSI ON THERAPY	81, 343	66, 137	147, 480	1, 415	148, 895	76.00
	OUTPATIENT SERVICE COST CENTERS			1			
88. 00	08800 RURAL HEALTH CLINIC	191, 410	112, 995	1		292, 699	
90.00	09000 CLINIC	0	0	(1 4	0	
90. 01	09001 DI ABETES	0	3, 775	3, 775	-1, 815	1, 960	
90. 02	09002 OP PSYCH	0	0	(0	0	
90. 03	09003 PAIN MANAGEMENT	205, 431	391, 161			384, 685	
91.00	09100 EMERGENCY	804, 383	1, 598, 236	2, 402, 619	11, 023	2, 413, 642	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
404.00	OTHER REIMBURSABLE COST CENTERS	440 774	00/ 007	/00 /04	10.000	/00 5/4	101 00
101.00	10100 HOME HEALTH AGENCY	413, 774	206, 907	620, 681	18, 880	639, 561	1101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		266, 159	266, 159	-266, 159		113.00
	1 1	10 114 145					•
118.00		10, 116, 145	16, 835, 243	26, 951, 388	528, 906	27, 480, 294	1118.00
104 00	NONREI MBURSABLE COST CENTERS	2 021 402	1 0/1 104	1 772 470	-545, 775	4 224 002	104 00
	07950 MOB 07951 FOUNDATI ON	2, 931, 482 52, 619	1, 841, 196 4, 379			4, 226, 903 56, 908	194.00
	07951 FOUNDATT ON 207952 ASC	52, 619	4, 3/9	1			194.01
174. UZ	07952 ASC 07953 SNF - PERRY CO.	907, 577	426, 460			1, 350, 906	
200.00		14, 007, 823	19, 107, 278				
200.00	1. The (Som of Elikes 110 through 177)	11,007,020	17, 107, 270	33, 113, 10	· ₁	55, 115, 101	

 Health Financial
 Systems
 GIBSON GEN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provi der CCN: 15-1319

				2/25/2020 4:21 pm	<u>m</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-115, 553	1, 449, 913	1.	. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	0	2.	. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 211, 985	1, 843, 611	4.	. 00
5.00	00500 ADMINI STRATI VE & GENERAL	1, 088, 273	7, 068, 569	5.	. 00
7.00	00700 OPERATION OF PLANT	473, 803	1, 803, 535	7.	. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	88, 450		. 00
9.00	00900 HOUSEKEEPI NG	190, 412	588, 149		. 00
10.00	01000 DI ETARY	104, 677	478, 506		. 00
11. 00	01100 CAFETERI A	-145, 585	315, 550		. 00
13. 00	01300 NURSING ADMINISTRATION	177, 744	212, 527		. 00
14. 00	01400 CENTRAL SERVICE & SUPPLY	0	316, 383		. 00
15. 00	01500 PHARMACY	323, 733	929, 962		. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	79, 874	477, 960		. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	17,014	477,700	10.	. 00
30. 00	03000 ADULTS & PEDIATRICS	-393, 018	2, 087, 287	20	. 00
31. 00	03100 INTENSIVE CARE UNIT	-343,018	7, 416		. 00
44. 00	04400 SKILLED NURSING FACILITY	0	7,410		. 00
44.00	ANCILLARY SERVICE COST CENTERS	0	U	44.	. 00
E0 00	05000 OPERATING ROOM	-661, 893	863, 746	FO	
50. 00 54. 00		•			. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	1, 481, 909		. 00
54. 03	05401 NUCLEAR MEDICINE-DI AGNOSTI C	0	155, 980		. 03
60.00	06000 LABORATORY	0	1, 722, 818		. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	45, 637		. 00
65.00	06500 RESPI RATORY THERAPY	-81, 201	782, 761	1	. 00
66.00	06600 PHYSI CAL THERAPY	0	961, 472	1	. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	296, 738		. 00
68. 00	06800 SPEECH PATHOLOGY	0	103, 327		. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	148, 295		. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	553, 194		. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-11, 195	1, 057, 213		. 00
76.00	03480 I NFUSI ON THERAPY	-23, 052	125, 843	76.	. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0	292, 699		. 00
90.00	09000 CLI NI C	0	0		. 00
90. 01	09001 DI ABETES	0	1, 960		. 01
90. 02	09002 OP PSYCH	0	0	90.	. 02
90. 03	09003 PAIN MANAGEMENT	0	384, 685	90.	. 03
91.00	09100 EMERGENCY	0	2, 413, 642	91.	. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.	. 00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	639, 561	101.	. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 I NTEREST EXPENSE	0	0	113.	. 00
118.00		2, 219, 004	29, 699, 298		. 00
	NONREI MBURSABLE COST CENTERS				
194 00	07950 MOB	0	4, 226, 903	194	. 00
	07951 FOUNDATION	0	56, 998		
	07952 ASC	0	0		. 02
	07953 SNF - PERRY CO.	0	1, 350, 906		
200.00		2, 219, 004		1	
200.00	1 1.2 (30 31. 223 1.73 2 3ugii 177)	2,2.,,001	55,55.,100	1 200.	

Provider CCN: 15-1319

Peri od: From 10/01/2018 To 09/30/2019 Date/Ti me Prepared: 2/25/2020 4: 21 pm

					2/25/2020 4: 21 p	<u></u>
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	C - CAFETERIA					
1. 00	CAFETERI A	1100	24 <u>5, 9</u> 48	21 <u>5, 1</u> 87	1	1. 00
	0		245, 948	215, 187		
	D - MED SUPPLY CHG PTS					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	148, 295	1	1. 00
	PATI ENT					
2.00	I MPL. DEV. CHARGED TO	72. 00	0	553, 194	2	2.00
	PATI ENTS					
3. 00		0.00	0	0		3. 00
4.00		0. 00	0	0		4. 00
5.00		0. 00	0	0		5. 00
6.00		0.00	0	0	6	6. 00
7.00		0. 00	0	0		7. 00
8.00		0. 00	0	0		8. 00
9.00		0. 00	0	0	9	9. 00
10.00		0. 00	0	0	10	0. 00
11.00		0.00	0	0	11	1. 00
12.00		0.00	0	0	12	2.00
13.00		0.00	0	0	13	3.00
14.00		0.00	0	0	14	4. 00
15. 00		0.00	0_	0	15	5.00
	0		0	701, 489		
	F - BUSINESS HEALTH SER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	86, 472	32, 630	1	1. 00
	0		86, 472	32, 630		
	G - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	265, 560	1	1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	599	2	2.00
	0 — — — — — —	T		266, 159		
	I - QUALITY SERVICES					
1.00	ADMINISTRATIVE & GENERAL	5. 00	67, 012	28, 935	1	1.00
	0 — — — — — —	T	67, 012	28, 935		
	J - HEALTH INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	81, 966	1	1.00
2.00	OPERATION OF PLANT	7. 00	0	7, 505		2.00
3.00	LAUNDRY & LINEN SERVICE	8. 00	0	5, 234	3	3.00
4.00	HOUSEKEEPI NG	9. 00	o	16, 579		4. 00
5.00	DI ETARY	10.00	0	34, 105	5	5. 00
6.00	NURSING ADMINISTRATION	13. 00	o	987	6	6. 00
7.00	MEDICAL RECORDS & LIBRARY	16. 00	o	12, 749		7. 00
8.00	ADULTS & PEDIATRICS	30.00	o	72, 532		8. 00
9.00	OPERATING ROOM	50.00	o	27, 339		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	o	21, 123	ı	0.00
11.00	LABORATORY	60.00	o	23, 611	11	1.00
12.00	RESPI RATORY THERAPY	65. 00	o	15, 870	12	2.00
13.00	PHYSI CAL THERAPY	66.00	o	30, 374	13	3. 00
14.00	OCCUPATI ONAL THERAPY	67. 00	o	4, 128		4. 00
15.00	CENTRAL SERVICE & SUPPLY	14. 00	0	10, 474	15	5. 00
16.00	PHARMACY	15. 00	O	5, 846		6. 00
17.00	INFUSION THERAPY	76. 00	0	2, 474		7. 00
18.00	RURAL HEALTH CLINIC	88. 00	o	6, 220		8. 00
19. 00	PAIN MANAGEMENT	90. 03	ol	5, 829		9. 00
20.00	EMERGENCY	91. 00	o	19, 704		0.00
21. 00	HOME HEALTH AGENCY	101.00	ol	19, 069		1.00
22.00	мов	194. 00	o	97, 242		2.00
23. 00	SNF - PERRY CO.	194. 03	o	43, 162		3. 00
_5.50	0	— · <i>/</i> ···	 	564, 122		
	K - WELLNESS CENTER		٥	55 1, 122		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	265	18, 033	1	1. 00
50	0	— — »+	$ \frac{265}{265}$	18, 033	'	50
	M - SNF OPERATION OF PLANT		200	10, 000		
1. 00	OPERATION OF PLANT	7. 00	23, 157	0	1	1. 00
	0	<u> </u>		— — <u>ŏ</u>	'	. 50
	N - MALPRACTICE		20, 10,	0		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	46, 543		1. 00
2. 00		0.00	o	0		2. 00
3. 00		0.00	o	0	•	3. 00
4. 00		0.00	o	0		4. 00
5. 00		0.00	o	n		5. 00
0.00			— — —	46, 543	~	5. 50
	O - MOB COLLECTION EXPENSE		U	40, 543		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	ol	3, 577	1	1. 00
2. 00	ADMINISTRATIVE & GENERAL	0. 00	o	3, 377		2.00
3. 00		0.00	o	0	•	3.00
3.00	l .	0.00	·	U	3	5.00

Heal th Financial Systems

GIBSON GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1319
Period: From 10/01/2018
To 09/30/2019 Prepared:

					2/25/2020 4:2	epareu: 21 nm
		Increases			2, 20, 2020 11.	- P
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	0		0	3, 577		
	Q - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7. 00	0	166, 687		1.00
2.00		0. 00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0. 00	0	0		6. 00
	0		0	166, 687		
	R - HRS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	95, 140		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
	TOTALS		0	95, 140		
500.00	Grand Total: Increases		422, 854	2, 138, 502		500.00

Provi der CCN: 15-1319

Peri od: From 10/01/2018 To 09/30/2019

Date/Time Prepared: 2/25/2020 4:21 pm

		D				2/25/2020 4:	21 pm
	C+ C+	Decreases "	Callani	0+1	WI+ A 7 D-E		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	C - CAFETERI A	7.00	6.00	9.00	10.00		_
1. 00	DIETARY	10.00	245, 948	215, 187	0		1.00
1.00	0		245, 948	215, 187	— — ^Ч		1.00
	D - MED SUPPLY CHG PTS		243, 740	213, 107			-
1.00	CENTRAL SERVICE & SUPPLY	14. 00	O	141	0		1.00
2. 00	ADULTS & PEDIATRICS	30.00	o	2, 118			2.00
3. 00	INTENSIVE CARE UNIT	31.00	o	27	0		3. 00
4. 00	OPERATING ROOM	50. 00	o	127, 858			4. 00
5. 00	RESPI RATORY THERAPY	65. 00	ol	8, 996			5.00
6. 00	PHYSI CAL THERAPY	66.00	ol	922	o		6.00
7. 00	OCCUPATIONAL THERAPY	67.00	O	65	0		7.00
8.00	PHARMACY	15. 00	O	71	o		8.00
9.00	INFUSION THERAPY	76. 00	О	1, 059	0		9. 00
10.00	RURAL HEALTH CLINIC	88. 00	o	9, 955	0		10.00
11.00	PAIN MANAGEMENT	90. 03	O	216, 938	0		11.00
12.00	EMERGENCY	91. 00	0	8, 681	0		12.00
13.00	HOME HEALTH AGENCY	101. 00	0	189	0		13.00
14.00	MOB	194. 00	0	324, 391	0		14.00
15.00	SNF - PERRY CO.	194. 03	0	78			15. 00
	0		0	701, 489			
	F - BUSINESS HEALTH SER						
1.00	MOB	1 <u>94.</u> 00	8 <u>6, 4</u> 72	3 <u>2, 6</u> 30			1.00
	0		86, 472	32, 630			
	G - INTEREST						
1. 00	I NTEREST EXPENSE	113. 00	0	266, 159			1.00
2.00		0.00	•	0			2.00
	0		0	266, 159			
	I - QUALITY SERVICES						
1. 00	ADULTS & PEDIATRICS	<u>30.</u> 00	67, 012	<u>28, 935</u>			1.00
	0		67, 012	28, 935			_
4 00	J - HEALTH INSURANCE	4 00	ما	E(4,400			1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	564, 122	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0	0 0		4. 00 5. 00
6. 00		0.00	0	0	0		6.00
7. 00		0.00	o	0	0		7.00
8. 00		0.00	o	0	0		8.00
9. 00		0.00	Ö	0	0		9. 00
10. 00		0.00	Ö	0	o		10.00
11. 00		0. 00	o	0	0		11.00
12. 00		0. 00	Ö	0	0		12.00
13. 00		0. 00	Ö	0	Ö		13.00
14. 00		0.00	o	0	o		14. 00
15. 00		0.00	o	0	0		15.00
16. 00		0.00	o	0	0		16.00
17. 00		0.00	O	0	0		17.00
18.00		0.00	0	0	O		18.00
19.00		0.00	0	0	O		19.00
20.00		0.00	0	0	o		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	O	0	0		22.00
23.00		0. 00	0	0	0		23. 00
	0		0	564, 122			
	K - WELLNESS CENTER						
1.00	MOB	194. 00	265	1 <u>8, 0</u> 33			1.00
	0		265	18, 033			_
	M - SNF OPERATION OF PLANT						
1.00	SNF - PERRY CO.	1 <u>94.</u> 03	2 <u>3, 1</u> 57	0	0		1.00
	0		23, 157	0			
	N - MALPRACTICE						4
1.00	OPERATING ROOM	50.00	0	7, 451			1.00
2.00	RURAL HEALTH CLINIC	88. 00	0	1, 588			2.00
3. 00	PAIN MANAGEMENT	90. 03	0	574			3.00
4.00	MOB	194. 00	0	33, 872			4.00
5. 00	SNF - PERRY CO.	194.03	•	3,058			5. 00
	O MOD COLLECTION SYDENCE		0	46, 543			-
1 00	O - MOB COLLECTION EXPENSE	00.00	ما	00	21		1 00
1.00	RURAL HEALTH CLINIC	88.00	0	20			1.00
2.00	MOB OPERATING ROOM	194. 00	0	3, 281			2.00
3. 00	OPERATING ROOM	5000		$\frac{276}{3,577}$	0		3.00
	Io		Ч	3, 5//	l l		1

Health Financial Systems RECLASSIFICATIONS GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1319

Peri od: From 10/01/2018 To 09/30/2019 Date/Ti me Prepared: 2/25/2020 4: 21 pm

						2, 20, 2020 .	· - · ~
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	Q - UTILITIES RECLASS						
00	ADMINISTRATIVE & GENERAL	5. 00	0	55, 287	0		1
00	NURSING ADMINISTRATION	13. 00	0	1, 661	0		2
00	OPERATING ROOM	50.00	0	42, 786	0		3
00	PHYSI CAL THERAPY	66.00	0	8, 516	0		4
00	DI ABETES	90. 01	0	1, 815	0		5
00	MOB	194. 00	0	56, 622	0		1 6
	0			166, 687			
	R - HRS RECLASS						
00	RURAL HEALTH CLINIC	88. 00	0	6, 363	0		1
00	PAIN MANAGEMENT	90. 03	0	224	0		2
00	MOB	194. 00	0	87, 451	0] 3
00	OPERATI NG ROOM	50.00	0	1, 102	0		4
	TOTALS		0	95, 140			
00.00	Grand Total: Decreases		422, 854	2, 138, 502			500

Provider CCN: 15-1319

| Peri od: | Worksheet A-7 | From 10/01/2018 | Part | To 09/30/2019 | Date/Time Prepared:

				'	0 09/30/2019	2/25/2020 4: 2	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	680, 034	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3. 00	Buildings and Fixtures	19, 707, 979	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5. 00	Fixed Equipment	13, 638, 960	3, 731, 561	0	3, 731, 561	9, 546	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	34, 026, 973	3, 731, 561	0	3, 731, 561	9, 546	1
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34, 026, 973	3, 731, 561	0	3, 731, 561	9, 546	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_				
1.00	Land	680, 034	0				1.00
2. 00	Land Improvements	0	0				2.00
3. 00	Buildings and Fixtures	19, 707, 979	0				3.00
4. 00	Building Improvements	0	0				4.00
5.00	Fi xed Equipment	17, 360, 975	0				5.00
6.00	Movable Equipment	0	0				6.00
7. 00	HIT designated Assets	0	0				7.00
8. 00	Subtotal (sum of lines 1-7)	37, 748, 988	0				8. 00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	37, 748, 988	0				10.00

Heal th	n Financial Systems	GI BSON GENERAL HOSPI TAL			In Lieu of Form CMS-2552-10			
	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-1319	Period: From 10/01/2018	Worksheet A-7		
						Date/Time Pre 2/25/2020 4:2		
	SUMMARY OF CAPITAL							
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see instructions)	instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	CAP REL COSTS-BLDG & FIXT	1, 128, 154	0		0 152, 917	18, 835	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00	
3.00	Total (sum of lines 1-2)	1, 128, 154	0		0 152, 917	18, 835	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 299, 906				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
0 00	T-1-1 (C 11 1 0)	1	4 000 00/	I			0 00	

0 0 0

1, 299, 906

1.00 2.00 3.00

3.00 Total (sum of lines 1-2)

Provider CCN: 15-1319	Heal th	n Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL	RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1319	Peri od:	Worksheet A-7	
COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL								nared·
Cost Center Description							2/25/2020 4: 2	
Leases for Ratio (col 1 - col 2)			COME	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL				
Leases for Ratio (col 1 - col 2)		Cost Contor Doscription	Cross Assats	Cani tal i zod	Gross Assots	Patio (soo	Lncuranco	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.000		cost center bescription	01033 A33613	•			Trisui ance	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS				Loudes		Thistractions)		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.000000					col . 2)			
1.00 CAP REL COSTS-BLDG & FIXT 37,748,988 0 37,748,988 1.000000 0 2.00				2.00	3.00	4. 00	5. 00	
2.00 CAP REL COSTS-MVBLE EQUIP 37,748,988 0 0 0 0 0 0 0 0 0								
3.00 Total (sum of lines 1-2) 37,748,988 0 37,748,988 1.000000 0 3.00			37, 748, 988	0	37, 748, 98			
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL			0	0)			
Cost Center Description	3. 00	Total (sum of lines 1-2)						3.00
Capital -Rel at ed Costs through 7) 6.00 7.00 8.00 9.00 10.00			ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	OF CAPITAL	
PART - RECONCILIATION OF CAPITAL COSTS CENTERS		Cost Center Description		Other	Total (sum o	f Depreciation	Lease	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS		·		Capi tal -Rel at	col s. 5			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS				ed Costs	through 7)			
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1, 128, 154 150, 007 1.00 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 1, 128, 154 150, 007 3.00 3.00 Total (sum of lines 1-2) 0 0 0 0 1, 128, 154 150, 007 3.00 3.00 SUMMARY OF CAPITAL				7. 00	8. 00	9. 00	10.00	
2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 0 0 0			ENTERS					
Total (sum of lines 1-2)			0	0)	0 1, 128, 154	150, 007	
Cost Center Description			0	0)	0		
Cost Center Description	3.00	Total (sum of lines 1-2)	0)		150, 007	3.00
Capital - Related Costs (see instructions) Capital - Related Costs (see instructions) Capital - Related Costs (see instructions) PART III - RECONCILIATION OF CAPITAL COSTS CENTERS Capital - Related Costs (see instructions) 11.00 12.00 13.00 14.00 15.00				Sl	JMMARY OF CAPI	TAL		
instructions ed Costs (see instructions) ed Costs (see instr		Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
11.00 12.00 13.00 14.00 15.00		·		(see	instructions	Capi tal -Rel at	(sum of cols.	
11.00 12.00 13.00 14.00 15.00				instructions)		ed Costs (see	9 through 14)	
PART - RECONCILIATION OF CAPITAL COSTS CENTERS						instructions)		
1. 00 CAP REL COSTS-BLDG & FIXT 0 152, 917 18, 835 0 1, 449, 913 1.00 2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 2.00				12. 00	13. 00	14. 00	15. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2. 00			ENTERS					
			_					
			_	1	1	-	-	
3. 00 Total (sum of lines 1-2) 0 152, 917 18, 835 0 1, 449, 913 3. 00	3. 00	Total (sum of lines 1-2)	0	152, 917	' 18, 83	5 0	1, 449, 913	3.00

Provi der CCN: 15-1319 Worksheet A-8 From 10/01/2018 09/30/2019 Date/Time Prepared: 2/25/2020 4:21 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -115,553 CAP REL COSTS-BLDG & FIXT 1. 00 10 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 -3.017 OPERATION OF PLANT 7 00 7.00 Α stations excluded) (chapter 8.00 Television and radio service -170 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 9.00 0.00 Provi der-based physici an -852, 068 10.00 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 4, 849, 475 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -145, 585 CAFETERI A 14.00 В 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and -6, 788 MEDICAL RECORDS & LIBRARY 18.00 В 16.00 18.00 abstracts 19.00 Nursing and allied health 0 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) 0 *** Cost Center Deleted *** 25.00 25.00 Utilization review 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FIXT

OCAP REL COSTS-MVBLE EQUIP

O OCCUPATIONAL THERAPY

OADULTS & PEDIATRICS

0 *** Cost Center Deleted ***

2.00

19.00

0.00

67.00

30.00

27.00

28.00

29 00

30.00

30.99

Depreciation - CAP REL

Non-physician Anesthetist Physicians' assistant

Adjustment for occupational

therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see A-8-3

COSTS-MVBLE EQUIP

instructions)

27.00

28.00

29 00

30.00

30.99

Heal th	Financial Systems		GIBSON GENERA	AL HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:2		
				Expense Classification on	Worksheet A			
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7		
	cost center beserretron	(2)	Alloure	Cost center	Line "	Ref.		
		1. 00	2. 00	3.00	4. 00	5. 00		
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00	
	pathology costs in excess of							
	limitation (chapter 14)							
32.00	CAH HIT Adjustment for		0		0.00	0	32.00	
	Depreciation and Interest							
33. 00	MISC INCOME	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33.00	
33. 02	PHYSICIAN RECRUITING	A		EMPLOYEE BENEFITS DEPARTMENT		0	33. 02	
33. 03	ADVERTI SI NG	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03	
33. 04	HAF FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 04	
34.00	LOBBYING	A		ADMINISTRATIVE & GENERAL	5. 00	0	34.00	
34. 01	340B	A		DRUGS CHARGED TO PATIENTS	73. 00	0	34. 01	
35.00	CRNA	A		OPERATING ROOM	50.00	0	35.00	
50. 00	TOTAL (sum of lines 1 thru 49)		2, 219, 004				50.00	

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(Transfer to Worksheet A,

⁽¹⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-1319

Worksheet A-8-1

From 10/01/2018 | To 09/30/2019 | Date/Time Prepared:

				10 07/30/2017	2/25/2020 4: 2	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	·
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4.00	5. 00	
	A. COSTS INCURRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OF	₹ CLAIMED HOME	
	OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1, 237, 590	0	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2, 365, 123	0	2.00
3.00	7. 00	OPERATION OF PLANT	HOME OFFICE	476, 990	0	3.00
3. 01	9.00	HOUSEKEEPI NG	HOME OFFICE	190, 412	0	3. 01
3.02	10.00	DI ETARY	HOME OFFICE	104, 677	0	3.02
4.00	13. 00	NURSING ADMINISTRATION	HOME OFFICE	75, 932	0	4.00
4. 01	15. 00	PHARMACY	HOME OFFICE	323, 733	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	86, 662	0	4.02
4.03	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	174, 385	0	4.03
4.04	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	527, 501	838, 129	4.04
4.05	13.00	NURSING ADMINISTRATION	HOME OFFICE	101, 812	0	4.05
4.06	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	117, 927	95, 140	4.06
5.00	TOTALS (sum of lines 1-4).			5, 782, 744	933, 269	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
4 TI.			1 C 1 1 . 1			

* 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.

 or seen person to normanier in and or an anounce arronage of seal a so that dated the contains the farth									
			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 RELATED 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.

G		0.00	DEACONESS HOSP	100.00	6.00
G		0.00	HRS	100.00	7. 00
		0.00		0.00	8.00
		0.00		0.00	9. 00
		0.00		0.00	10.00
Other (financial or	HOME OFFICE				100.00
n-financial) specify:					
	•	`	G 0.00 0.00 0.00 0.00 0.00 Other (financial or HOME OFFICE	· ·	G 0.00 HRS 100.00 0.00 0.00 0.00 0.00 0.00 0.00 0

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

Heal th	Financial Syste	ems	GI BSON GENER	AL HOSPITAL	In Lieu	of Form CMS-	2552-10
STATEME OFFI CE		SERVICES FROM	M RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1319	Peri od: From 10/01/2018 To 09/30/2019	Worksheet A-B Date/Time Pro 2/25/2020 4:2	epared:
	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.					
			MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1.00	1, 237, 590	0					1.00
2.00	2, 365, 123	0					2.00
3.00	476, 990	0					3.00
3. 01	190, 412	0					3. 01
3.02	104, 677	0)				3. 02
4.00	75, 932	0					4.00
4.01	323, 733	0					4. 01
4.02	86, 662	0)				4. 02
4.03	174, 385	0)				4.03
4.04	-310, 628)				4.04
4.05	101, 812	0)				4. 05
4.06	22. 787	0)				4.06

* 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.

5.00

1100 1101	boon postou to normande m	oct amino i ana, ci 2, the amount arrowable choard be that eated in coramin i ci the parti	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6, 00		
	1 11		
	B. INTERRELATIONSHIP TO RELATE	TED 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.

	To this discontinuo and of the ATTT.								
	HOME OFFICE	6.00							
7.00	PFS	7.00							
8. 00 9. 00		8.00							
9.00		9.00							
10. 00 100. 00		10.00							
100.00		100.00							

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

5.00

4, 849, 475

GI BSON GENERAL HOSPI TAL

Provi der CCN: 15-1319 Peri od:
From 10 Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

TROVIDE	LIC DASED TITISTO	TAN ADSOSTMENT		Trovider		From 10/01/2018 To 09/30/2019		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component		Physi ci an/Prov i der Component	
		i deliti i i ei	Remuner at 1 on	Component	Component		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6, 00	7. 00	
1. 00		ADULTS & PEDIATRICS	393, 018	393, 018			0	1. 00
2. 00		OPERATING ROOM	354, 797	354, 797	C	o	o	2. 00
3. 00		LABORATORY	40,000	0	40, 000	o	ol	3. 00
4. 00		RESPIRATORY THERAPY	81, 201	81, 201	C		ol	4.00
5. 00		INFUSION THERAPY	23, 052	23, 052	C	o	ol	5. 00
6. 00		EMERGENCY	1, 144, 247	0	1, 144, 247	O	ol	6.00
7. 00	0.00		0	0		o	ol	7. 00
8. 00	0.00		o	0	C	o	ol	8. 00
9. 00	0.00		O	0	C	o	l o	9. 00
10.00	0.00		0	0	C	o	o	10.00
200.00			2, 036, 315	852, 068	1, 184, 247		o	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		I denti fi er	,	Unadjusted RCE	Memberships &		of Mal practice	
				Li mi t	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12.00	13.00	14.00	
1. 00	30.00	ADULTS & PEDIATRICS	0	0	C	0	0	1.00
2. 00	50.00	OPERATING ROOM	0	0	C	0	0	2.00
3. 00	60.00	LABORATORY	0	0	C	0	0	3.00
4. 00	65. 00	RESPI RATORY THERAPY	0	0	C	0	0	4.00
5. 00	76. 00	INFUSION THERAPY	0	0	C	0	0	5.00
6. 00	91. 00	EMERGENCY	0	0	C	0	0	6.00
7. 00	0.00		0	0	C	0	0	7.00
8. 00	0.00		0	0	C	0	0	8. 00
9. 00	0.00		0	0	C	0	0	9. 00
10.00	0.00		0	0	C	0	0	10.00
200.00			0	0	C	0	O	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
			14					
1 00	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		4 00
1.00		ADULTS & PEDIATRICS	0	0	C			1.00
2.00		OPERATING ROOM	0	0	C	001,777		2.00
3. 00		LABORATORY	0	0	C			3.00
4.00		RESPI RATORY THERAPY	0	0	C			4.00
5.00		I NFUSI ON THERAPY	0	0	C	23, 052		5.00
6. 00		EMERGENCY	0	0	C	0		6.00
7.00	0.00		0	0	C	0		7.00
8.00	0.00	1	0	0	C	0		8.00
9.00	0.00		0	0	C	0		9.00
10.00	0. 00		0	0	C	0 0 0 0 0		10.00
200.00			0	0	C	852, 068	ı l	200.00

Period: Worksheet B
From 10/01/2018 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1319

COST Center Description						To	09/30/2019	Date/Time Pre	pared:
CONT Center Description					CAPITAL REI	ATED COSTS		2/25/2020 4: 2	1 pm
All Coast In					ON TIME REE	54120 00010			
CALL DOCAD CAL		Cost	t Center Description		BLDG & FIXT	MVBLE EQUIP		Subtotal	
SENERAL SERVICE COST CENTERS									
COLUMN C							DEPARTMENT		
SENERAL SERVICE COST CENTERS 1.00 2.00 4.00 4A									
1.00					1.00	2.00	4. 00	4A	
2.00 00200 CAP PEL COSTS-MMBLE COUP 0 1, 885, 304 2, 00 0.									
4.00 00000 BAPLOTER BENEFITS DEPARTMENT 1,843, 611 11,692 0 204,135 1,342,470 5.00 7.00 00000 ADMIN STRATILE & GENERAL 7,008, 569 69,766 0 204,135 7,342,470 5.00 7.00 00000 ADMIN STRATILE & GENERAL 7,008, 569 69,766 0 204,135 2,144,185 7,008 7,000 00000 DEPARTY 1,803,535 308,069 0 32,581 2,144,185 7,008 7,000 00000 DEPARTY 1,803,535 308,069 0 32,581 2,144,185 7,000 7,000 00000 DEPARTY 478,506 37,623 0 24,517 540,046 10.00 11.00 01000 DEFARY 478,506 37,623 0 24,517 540,046 10.00 11.00 01000 DEFARY 478,506 37,623 0 24,517 540,046 10.00 11.00 01000 DEFARY 478,506 37,633 11.00 0 33,779 376,539 11.00 11.00 133,779 376,539 11.00 133,779 376,539 11.00 376,539 3				1, 449, 913	1, 449, 913				
5.00 00500 ADMINISTRATIVE & CENERAL 7,068,569 69,766 0 204,135 7,342,470 5 0.0 8.00 00800 LAUNDRY & LINEN SERVICE 88,8,450 25,446 0 6,183 120,079 8 0.0 8.00 00800 LAUNDRY & LINEN SERVICE 88,450 25,446 0 6,183 120,079 8 0.0 9.00 00800 DUSKEEPING 478,506 37,623 0 24,517 540,646 10 0.0 10.00 01000 DIETARY 478,506 37,623 0 24,517 540,646 10 0.0 13.00 01000 CAFETERIA 315,550 27,710 0 33,279 376,539 11 0.0 13.00 01300 CUSTRAL SERVICE & SUPPLY 316,583 0 0 23,953 340,338 40 0.0 15.00 01300 CUSTRAL SERVICE & SUPPLY 316,583 0 0 23,953 340,338 40 0.0 15.00 01500 PURROLUCE 48,050 15,000 16,600 48,655 15,000 15.00 01500 PURROLUCE 48,050 15,000 16,000 183,912 2,98,929 30 0.0 15.00 03000 ADULTS & PEDIATRICS 2,087,287 127,730 36,018 353,768 16,000 16.00 03000 ADULTS & PEDIATRICS 2,087,287 127,730 36,018 353,768 16,000 16.00 03000 ADULTS & PEDIATRICS 2,087,287 127,730 3,000 30,000 3,000				1 843 611	11 603		1 855 304		
7.00 007000 Depart On OF PLANT 1,803,535 308,069 0 32,581 2,14,185 7.00 8.00 9.00 00900 LAINDRY & LISHES SERVICE 88,450 25,446 0 6,183 120,079 8.00 9.00 00900 HOUSEKEEPING 588,149 14,362 0 36,988 639,469 9.00 11.00 01100 CAFETERI A 315,550 277,710 0 33,279 376,539 113.00 14.00 01400 CAFETERI A 315,550 277,710 0 5,375 322,591 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 316,383 3 0 0 23,953 340,336 14.00 16.00 01600 PHARMACY 477,960 20,810 38,6,018 534,788 16.00 30.00 03000 ABULTS & SERVICE OST CENTERS 2,087,287 127,730 0 183,912 2,398,929 30 31.00 03000 ABULTS & PEDIATRICS 2,087,287 127,730 0 183,541 19.55,939 41,000 43,								7. 342. 470	
9.00 000000 HOUSEKEPING									
10. 00 10000 DIETARY 478, 506 37, 623 0 24, 517 540, 646 10. 00 13. 00 1000 CAFETERIA 315, 550 27, 710 0 33, 279 376, 539 11. 00 11. 00 1100 CAFETERIA 315, 550 27, 710 0 35, 755 222, 591 13. 00 0 23, 953 340, 336 14. 00 14. 00 1400 CENTRAL SERVICE & SUPPLY 316, 383 0 0 0 23, 953 340, 336 14. 00 15. 00 1500 DHARMACY 929, 962 0 0 18, 694 948, 656 15. 00 18. 00 MEDICAL RECORDS & LIBRARY 477, 960 20, 610 0 36, 018 534, 788 16. 00 18. 00 MEDICAL RECORDS & LIBRARY 477, 960 20, 610 0 36, 018 534, 788 16. 00 10. 00 0 0 0 0 0 0 0 0	8.00	00800 LAUN	NDRY & LINEN SERVICE	88, 450	25, 446	0	6, 183	120, 079	8.00
11.00 01100 CAFETERIA 315,550 27,710 0 32,279 376,599 11.00 13.00 01300 NURSI NA GAMINI STRATI ON 212,527 4,309 0 0 22,953 340,326 14.00 14.00 01400 CENTRAL SERVICE & SUPPLY 929,962 0 0 18,694 9948,656 15.00 1500 01500 PHAMACY 929,962 0 0 36,018 534,788 16.00 1787 TENTRO TRUTHE SERVICE COST CENTERS		1 1							
13. 00 01300 NURSIN G ADMINISTRATION 212, 527 4, 300 0 5, 755 222, 591 13. 00									
14. 00 01400 CHITRAL SERVICE & SUPPLY 316, 3813 0 0 23, 953 340, 336 14. 00 16. 00 01000 PHARMACY 929, 962 0 0 0 30, 018 534, 788 16. 00 17000									
15. 00 01500 PHARMACY 929, 962 0 0 18, 694 948, 656 15. 00 10. 0						1			
16. 00					-				
30.00 03000 ADULTS & PEDIATRICS 2,087,287 127,730 0 183,912 2,398,929 30.00 31.00 03100	16.00				20, 810	0			16.00
31. 00 03100 INTENSIVE CARE UNIT 7, 416 30, 223 0 863 38, 502 31, 00 44.									
ALC 0 0 0 0 0 0 0 0 0					· ·				
ANCILLARY SERVICE COST CENTERS S0.00							•		
SOLO	44.00			U	U	U	U	U	44.00
54.00 05400 RADIOLOGY-DI AGNOSTIC 1.481,909 54,576 0 94,114 1,630,599 54,03	50. 00			863, 746	79, 679	0	112, 553	1, 055, 978	50.00
60.00 06000 LABORATORY 1,722,818 23,885 0 107,604 1,854,307 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 45,637 0 0 0 0 45,637 62.00 65.00 06500 RESPIRATORY THERAPY 782,761 25,165 0 56,795 864,721 65.00 66.00 06500 RESPIRATORY THERAPY 782,761 25,165 0 56,795 864,721 65.00 66.00 06500 RESPIRATORY THERAPY 961,472 43,883 0 89,904 1,095,259 66.00 67.00 6700 00 0 33,892 343,400 67.00 67.00 06700 00 0 0 33,892 343,400 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.0				·	· ·				
62.00 06200 MPOLE BLOOD & PACKED RED BLOOD CELLS 45, 637 0 0 0 0 45, 637 62.00 65.00 06500 RESPI RATORY THERAPY 782, 761 25, 165 0 56, 795 864, 721 65.00 66.00 06600 PHYSI CAL THERAPY 961, 472 43, 883 0 89, 904 1, 095, 259 66.00 67.00 06700 0CCUPATI ONAL THERAPY 296, 738 12, 770 0 33, 892 343, 400 67.00 68.00 06800 SPEECH PATHOLOGY 103, 327 968 0 12, 357 1116, 652 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 67.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 148, 295 56, 028 0 0 0 0 204, 323 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 533, 194 0 0 0 0 553, 194 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1,057, 213 15, 798 0 0 1,073, 011 73.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 1,258, 213 16, 657 0 11,006 153,506 76.00 03480 INFUSI ON THERAPY 125,843 16, 657 0 11,006 153,506 76.00 03480 INFUSI ON THERAPY 125,843 16, 657 0 10,006 153,506 79.00 09000 CLI NI C 0 0 0 0 0 0 0 79.01 09001 DABETES 1,960 0 0 0 0 0 0 79.02 09002 OP SYCH 0 0 0 0 0 0 79.03 09003 PAIN MANAGEMENT 384,685 24,587 0 27,796 437,068 90.03 79.00 09000 OSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0 55,987 703,432 70.00 07900 DEBERGENCY 384,685 24,587 0 27,796 437,068 90.03 79.00 09000 OSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0 0 0 70.01 OTION OTION 0 0 0 0 0 0 70.02 OTION OTION OTION 0 0 0 0 0 70.03 OTION OTION 0 0 0 0 0 0 70.04 OTION 0 0 0 0 0 0 0 70.05 OTION 0 0 0 0 0 0 0 70.07 0 0 0 0 0 0 0 0 70.07 0 0 0 0 0 0 0 0 70.08 0 0 0 0 0 0 0 0 70.09 0 0 0 0 0 0 0 0 70.00 0 0 0 0 0 0 0 70.00 0 0 0 0 0 0 0 7				155, 980			O	162, 537	54.03
65.00 06500 RESPIRATORY THERAPY 782,761 25,165 0 56,795 864,721 65.00 66.00 06600 PHYSICAL THERAPY 961,472 43,883 0 89,904 1,095,259 66.00 67.00 06700 0CCUPATI ONAL THERAPY 296,738 12,770 0 33,892 343,400 67.00 68.00 06800 SPEECH PATHOLOGY 103,327 968 0 12,357 116,652 68.00 69.00 06900 LECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0		1 1							
66.00 06600 PHYSICAL THERAPY 961, 472 43, 883 0 89, 904 1, 095, 259 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 296, 738 12, 770 0 33, 892 343, 400 67. 00 68.00 06800 SPEECH PATHOLOGY 103, 327 968 0 12, 357 116, 652 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 148, 295 56, 028 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 553, 194 0 0 0 0 553, 194 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 057, 213 15, 798 0 0 1, 073, 011 73. 00 76. 00 03480 INFUSION THERAPY 125, 843 16, 657 0 11, 006 153, 506 76. 00 03480 INFUSION THERAPY 125, 843 16, 657 0 11, 006 153, 506 76. 00 04800 RURAL HEALTH CLINIC 292, 699 0 0 25, 899 318, 598 80. 00 77. 00 09000 CLINIC 0 0 0 0 0 0 0 78. 00 09000 DRUGS CHARGED TO PATIENTS 1, 960 0 0 0 0 0 79. 01 09001 DIABETES 1, 960 0 0 0 0 0 0 0 79. 02 09002 0P PSYCH 0 0 0 0 0 0 0 0 79. 03 09003 PAIN MANAGEMENT 384, 685 24, 587 0 27, 796 437, 068 90. 03 791. 00 09100 EMERGENCY 2, 413, 642 138, 143 0 108, 839 2, 660, 624 91. 00 792. 00 09000 0500 0500 0500 0500 0500 0500 70 00 00 00 00 00 0 0 70 00 0					-		-		
67. 00 06700 0CCUPATI ONAL THERAPY 296, 738 12, 770 0 33, 892 343, 400 67. 00 68. 00 06800 SPEECH PATHOLOGY 103, 327 968 0 12, 357 116, 652 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CALL SUPPLIES CHARGED TO PATI ENT 148, 295 56, 028 0 0 0 0 204, 323 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 553, 194 0 0 0 0 553, 194 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 1, 057, 213 15, 798 0 0 11, 073, 011 73. 00 74. 00 03480 INFUSI ON THERAPY 125, 843 16, 657 0 11, 000 153, 506 75. 00 03480 INFUSI ON THERAPY 125, 843 16, 657 0 11, 000 153, 506 76. 00 09000 000 000 000 000 00 00 00 00 76. 00 09000 000 000 000 00 00									
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69.00 669.00 ELECTROCARDI OLOGY 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 148, 295 56, 028 0 0 204, 323 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 553, 194 0 0 0 553, 194 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,057, 213 15,798 0 0 0 1,073, 011 73.00 07300 DRUGS CHARGED TO PATIENTS 1,057, 213 15,798 0 0 0 1,073, 011 73.00 07300 DRUGS CHARGED TO PATIENTS 1,057, 213 15,798 0 0 0 1,000 76.00 073480 INFUSION THERAPY 125,843 16,657 0 11,006 153,506 76.00 07400 DRUGS CHARGED TO PATIENTS 125,843 16,657 0 11,006 153,506 76.00 07400 DRUGS CHARGED TO PATIENTS 125,843 16,657 0 11,006 153,506 76.00 DRUGS CHARGED TO PATIENTS 125,843 16,657 0 11,006 153,506 76.00 DRUGS CHARGED TO PATIENTS 125,843 16,657 0 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 125,843 16,657 0 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 125,843 16,657 0 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 292,699 0 0 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 292,699 0 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 292,699 0 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 292,699 0 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 0 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 294,699 294,596 138,143 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 294,699 134,645 24,587 0 0 0 76.00 DRUGS CHARGED TO PATIENTS 294,699 294,699 294,596 294,596 294,596 294,596									
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 553, 194 0 0 0 0 553, 194 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 057, 213 15, 798 0 0 1, 073, 011 73. 00 76. 00 03480 INFUSI ON THERRPY 125, 843 16, 657 0 11, 006 153, 506 76. 00 00 00 00 00 00 00 00	69. 00			o	0	0		0	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 1,057,213 15,798 0 1,006 1,073,011 73.00 76. 00 03480 INFUSION THERAPY 125,843 16,657 0 11,006 153,506 88. 00 08800 RURAL HEALTH CLINIC 292,699 0 0 25,899 318,598 88.00 90. 00 09000 CLINIC 0 0 0 0 0 0 0 90.00 90. 01 09001 DI ABETES 1,960 0 0 0 0 0 0 90.01 90. 02 09002 OP PSYCH 0 0 0 0 0 0 0 0 90. 03 09003 PAI N MANAGEMENT 384,685 24,587 0 27,796 437,068 90.03 91. 00 09100 EMERGENCY 2,413,642 138,143 0 108,839 2,660,624 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 55,987 703,432 101. 00 10100 HOME HEALTH AGENCY 639,561 7,884 0 55,987 703,432 113. 00 11300 INTEREST EXPENSE 113.00 114. 00 NONREI MBURSABLE COST CENTERS 113.00 1194. 01 07950 MOB 4,226,903 133,506 0 384,921 4,745,330 194.00 194. 01 07951 FOUNDATION 56,998 20,435 0 7,120 84,553 194.01 194. 02 07952 ASC 0 0 0 0 0 0 0 100 00							0		
76. 00 03480 NFUSION THERAPY 125, 843 16, 657 0 11, 006 153, 506 76. 00 OUTPATI ENT SERVI CE COST CENTERS 8. 00 08800 RURAL HEALTH CLINI C 292, 699 0 0 0 25, 899 318, 598 88. 00 90. 00 09000 CLINI C 0 0 0 0 0 0 0 90. 01 09001 DI ABETES 1, 960 0 0 0 0 0 0 90. 02 09002 OP PSYCH 0 0 0 0 0 0 0 90. 03 09003 PAIN MANAGEMENT 384, 685 24, 587 0 27, 796 437, 068 90. 03 91. 00 09100 EMERGENCY 2, 413, 642 138, 143 0 108, 839 2, 660, 624 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 OTHER REI MBURSABLE COST CENTERS 101. 00 11300 INTEREST EXPENSE 113. 00 1300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 29, 699, 298 1, 184, 321 0 1, 343, 594 28, 921, 996 194. 00 07950 MOB 4, 226, 903 133, 506 0 384, 921 4, 745, 330 194. 00 194. 01 07951 FOUNDATION 56, 998 20, 435 0 7, 120 84, 553 194. 01 194. 02 07952 ASC 0 0 0 0 0 0 0 200. 00 Cross Foot Adjustments 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 111, 00 119, 669 1, 582, 226 194. 03 100. 00 0 0 0 0 0 101, 00 0 0 0 0 102, 00 0 0 0 0 102, 00 0 0 0 103, 00 0 0 0 104, 01 07951 0700 0700 0700 105, 00 0 0 0 106, 00 0 0 0 107, 00 0 0 108, 00 0 0 109, 00 0 0 109, 00 0 0 109, 00 0 0 100, 00 0 0 100, 00 0 0 100, 00 0 0 100, 00 0 0 100, 00 0 0 100, 00 0 0 100, 00 0 100, 00 0 0 100, 00 0 0 100, 00 0					-		-		
SECOND CONTINUE									
88. 00	76.00			125, 843	10, 007	U	11,006	153, 506	76.00
90. 00	88. 00	08800 RURA	AL HEALTH CLINIC	292, 699	0	0	25, 899	318, 598	88. 00
90. 02	90.00			o	0	0	0		90.00
90. 03				1, 960	0	0	0	1, 960	
91. 00				0	0		0	- 1	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 92. 00 0THER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 639, 561 7, 884 0 55, 987 703, 432 101. 00 1300 INTEREST EXPENSE 113. 00 1300 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 29, 699, 298 1, 184, 321 0 1, 343, 594 28, 921, 996 118. 00 194. 01 07950 MOB 4, 226, 903 133, 506 0 384, 921 4, 745, 330 194. 00 194. 01 07951 FOUNDATION 56, 998 20, 435 0 7, 120 84, 553 194. 01 194. 02 07952 ASC 0 0 0 0 0 0 194. 02 194. 03 07953 SNF - PERRY CO. 1, 350, 906 111, 651 0 119, 669 1, 582, 226 194. 03 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0				·			·		
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 639, 561 7, 884 0 55, 987 703, 432 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 29, 699, 298 1, 184, 321 0 1, 343, 594 28, 921, 996 118.00 NONREI MBURSABLE COST CENTERS 28, 921, 996 118.00 NONREI MBURSABLE COST CENTERS 133, 506 0 384, 921 4, 745, 330 194.00 194.01 07951 FOUNDATION 56, 998 20, 435 0 7, 120 84, 553 194.01 194.02 07952 ASC 0 0 0 0 0 0 194.02 194.03 07953 SNF - PERRY CO. 1, 350, 906 111, 651 0 119, 669 1, 582, 226 194.03 200.00 Cross Foot Adjustments 0 200.00 0 0 0 0 0 0 0 201.00 0 0 0 0 0 0 0 0 0				2,413,042	138, 143	U	108, 839		
101. 00 10100 HOME HEALTH AGENCY 639, 561 7, 884 0 55, 987 703, 432 101. 00 113. 00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 29, 699, 298 1, 184, 321 0 1, 343, 594 28, 921, 996 118. 00 NONREI MBURSABLE COST CENTERS	72.00								72.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 29,699,298 1,184,321 0 1,343,594 28,921,996 118.00 NONREI MBURSABLE COST CENTERS 133,506 0 384,921 4,745,330 194.00 194.01 07951 FOUNDATION 56,998 20,435 0 7,120 84,553 194.01 194.02 07952 ASC 0 0 0 0 0 0 0 194.02 194.03 07953 SNF - PERRY CO. 1,350,906 111,651 0 119,669 1,582,226 194.03 200.00 Cross Foot Adjustments 0 200.00 Negative Cost Centers 0 0 0 0 0 0 201.00	101.00			639, 561	7, 884	0	55, 987	703, 432	101. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 29,699,298 1,184,321 0 1,343,594 28,921,996 118.00									
NONRE MBURSABLE COST CENTERS 194. 00 07950 MOB 4, 226, 903 133, 506 0 384, 921 4, 745, 330 194. 00 194. 01 07951 FOUNDATI ON 56, 998 20, 435 0 7, 120 84, 553 194. 01 194. 02 07952 ASC 0 0 0 0 0 0 0 194. 02 194. 03 07953 SNF - PERRY CO. 1, 350, 906 111, 651 0 119, 669 1, 582, 226 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 0 0 0		1 1							
194. 00 07950 M0B 4, 226, 903 133, 506 0 384, 921 4, 745, 330 194. 00 194. 01 07951 FOUNDATI ON 56, 998 20, 435 0 7, 120 84, 553 194. 01 194. 02 07952 ASC 0 0 0 0 0 0 194. 02 194. 03 07953 SNF - PERRY CO. 1, 350, 906 111, 651 0 119, 669 1, 582, 226 194. 03 200. 00 Cross Foot Adjustments Negati ve Cost Centers 0 0 0 0 0 0 200. 00	118.00			29, 699, 298	1, 184, 321	0	1, 343, 594	28, 921, 996	118. 00
194. 01 07951 FOUNDATION 56, 998 20, 435 0 7, 120 84, 553 194. 01 194. 02 07952 ASC 0 0 0 0 0 0 194. 02 194. 03 07953 SNF - PERRY CO. 1, 350, 906 111, 651 0 119, 669 1, 582, 226 194. 03 200. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00	104 00		RSABLE COST CENTERS	4 226 002	122 506		204 021	4 745 220	104 00
194. 02 07952 ASC 0 0 0 0 0 194. 02 194. 03 07953 SNF - PERRY CO. 1, 350, 906 111, 651 0 119, 669 1, 582, 226 194. 03 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 201. 00			NDATI ON						
194. 03 07953 SNF - PERRY CO. 1, 350, 906 111, 651 0 119, 669 1, 582, 226 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 201. 00									
201.00 Negative Cost Centers 0 0 0 0 201.00			- PERRY CO.	1, 350, 906	-		119, 669	1, 582, 226	194. 03
		1 1							
202.00				05 004 455	-				
	202.00	ן וווון וי	AL (Sull Lines ITO Enrough 201)	35, 334, 105	1, 449, 913	ا ا	1, 855, 304	35, 334, 105	202.00

Provider CCN: 15-1319

| Peri od: | Worksheet B | From 10/01/2018 | Part | To 09/30/2019 | Date/Time Prepared: 2/25/2020 4: 21 pm

2/25/2020 4: 21							1 pm
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	E & GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
GE	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMI NI STRATI VE & GENERAL	7, 342, 470					5.00
	0700 OPERATION OF PLANT		2 704 424				7.00
		562, 439	2, 706, 624				
	0800 LAUNDRY & LINEN SERVICE	31, 498	64, 951	216, 528			8.00
	0900 HOUSEKEEPI NG	167, 738	36, 659		0.0,000		9. 00
	1000 DI ETARY	141, 816	96, 032	•			10.00
	1100 CAFETERI A	98, 770	70, 729	0	22, 912	0	11.00
13.00 0	1300 NURSING ADMINISTRATION	58, 388	10, 998	0	3, 563	0	13.00
	1400 CENTRAL SERVICE & SUPPLY	89, 273	0	0	0	0	14.00
15. 00 0°	1500 PHARMACY	248, 841	0	0	o	0	15. 00
	1600 MEDICAL RECORDS & LIBRARY	140, 280	53, 116	0	17, 206	0	16.00
LN	NPATIENT ROUTINE SERVICE COST CENTERS	1,		<u>-</u>	, =	-	1
	3000 ADULTS & PEDIATRICS	629, 261	326, 030	53, 997	105, 614	201, 895	30.00
	3100 I NTENSI VE CARE UNI T	10, 099	77, 144			7, 735	31.00
	4400 SKILLED NURSING FACILITY	10, 044	77, 144			7, 735	44.00
		l U	0	10	U	0	44.00
	NCILLARY SERVICE COST CENTERS	07/ 000	202 202	1 0	/F 000		F0 00
	5000 OPERATING ROOM	276, 993	203, 380			0	50.00
	5400 RADI OLOGY-DI AGNOSTI C	427, 721	139, 306			0	54.00
	5401 NUCLEAR MEDICINE-DIAGNOSTIC	42, 635	16, 736			0	54.03
	6000 LABORATORY	486, 401	60, 966	0	19, 749	0	60.00
62.00 06	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	11, 971	0	0	0	0	62.00
65.00 06	6500 RESPIRATORY THERAPY	226, 824	64, 234	0	20, 808	0	65.00
66.00 06	6600 PHYSI CAL THERAPY	287, 296	112, 011	l 0	36, 285	0	66.00
	6700 OCCUPATI ONAL THERAPY	90, 077	32, 595	0		0	67.00
	6800 SPEECH PATHOLOGY	30, 599	2, 471	0	· · · · · · · · · · · · · · · · · · ·	0	68.00
	6900 ELECTROCARDI OLOGY	0	2, 7/1	0		Ö	69.00
		-1	142 012			0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	53, 596	143, 012		46, 327		71.00
	7200 I MPL. DEV. CHARGED TO PATIENTS	145, 108	0	0		0	72.00
	7300 DRUGS CHARGED TO PATIENTS	281, 460	40, 325			0	73.00
	3480 INFUSION THERAPY	40, 266	42, 517	0	13, 773	0	76. 00
	UTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	83, 571	0	0	0	0	88. 00
90.00	9000 CLI NI C	0	0	0	0	0	90.00
90. 01 09	9001 DI ABETES	514	0	0	o	0	90. 01
	9002 OP PSYCH	l ol	0	0	o	0	90. 02
	9003 PAIN MANAGEMENT	114, 647	62, 759	0	20, 330	0	90. 03
	9100 EMERGENCY	697, 906	352, 609		114, 223	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	077, 700	332, 009	١	114, 223	, o	92.00
	THER REIMBURSABLE COST CENTERS						72.00
		104 547	00.400	1 0	(540		100 00
	0100 HOME HEALTH AGENCY	184, 517	20, 123	0	6, 519	0	101.00
	PECIAL PURPOSE COST CENTERS	1		T			
	1300 I NTEREST EXPENSE					 -	113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 660, 505	2, 028, 703	56, 066	624, 260	209, 630	118. 00
	ONREIMBURSABLE COST CENTERS						l
194. 00 0	7950 MOB	1, 244, 754	340, 774	0	110, 390	0	194. 00
	7951 FOUNDATI ON	22, 179	52, 160	l 0		0	194. 01
194. 02 0		0	0	l o			194. 02
	7953 SNF - PERRY CO.	415, 032	284, 987	-	_	599, 972	1
200.00	Cross Foot Adjustments	+13,032	204, 707	100, 402	72, 317	J77, 712	200.00
200.00	Negative Cost Centers		^	_			200.00
		7 242 470	2 704 424	214 520	042 04		
202.00	TOTAL (sum lines 118 through 201)	7, 342, 470	2, 706, 624	216, 528	843, 866	809, 602	_J 2U2. UU

Peri od: Worksheet B From 10/01/2018 Part I To 09/30/2019 Date/Ti me Prepared: 2/25/2020 4: 21 pm Provider CCN: 15-1319

2/25/2020 4: 21 pm								
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
			ADMI NI STRATI O	SERVICE &		RECORDS &		
			N	SUPPLY		LI BRARY		
		11. 00	13. 00	14. 00	15. 00	16.00		
	GENERAL SERVICE COST CENTERS				1			
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00	
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00	
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00	
9. 00	00900 HOUSEKEEPI NG						9.00	
10.00	01000 DI ETARY						10.00	
11. 00	01100 CAFETERI A	568, 950					11.00	
13. 00	01300 NURSING ADMINISTRATION	2, 659	298, 199				13.00	
14. 00	01400 CENTRAL SERVI CE & SUPPLY	2,037	270, 177	429, 609			14.00	
15. 00	01500 PHARMACY	0	0	1, 445	1, 198, 942		15.00	
16. 00	01600 MEDICAL RECORDS & LIBRARY	16, 641	o	13	0	762, 044	16.00	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	10,011	<u> </u>	10	9	702,011	10.00	
30.00	03000 ADULTS & PEDIATRICS	84, 967	117, 925	11, 422	0	40, 771	30.00	
31. 00	03100 INTENSIVE CARE UNIT	399	771	0	o	1, 274	31. 00	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	o	0	44.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	52, 002	24, 344	48, 449	0	52, 982	50.00	
54.00	05400 RADI OLOGY-DI AGNOSTI C	43, 483	0	8, 257	0	131, 271	54.00	
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	9, 740	0	4, 731	54.03	
60.00	06000 LABORATORY	49, 715	0	115, 024	0	86, 504	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	10, 284	0	977	62.00	
65.00	06500 RESPI RATORY THERAPY	26, 240	6, 956	2, 236	0	37, 185	65.00	
66.00	06600 PHYSI CAL THERAPY	41, 538	0	7, 989	0	66, 898	66. 00	
67.00	06700 OCCUPATI ONAL THERAPY	15, 659	0	132	0	23, 807	67.00	
68. 00	06800 SPEECH PATHOLOGY	5, 709	0	0	0	8, 012		
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	34, 628	0	5, 296	71. 00	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	129, 393	0	10, 866	72.00	
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 637	6, 032		1, 198, 942	65, 850	73.00	
76. 00	03480 I NFUSI ON THERAPY	5, 085	9, 800	0	0	3, 288	76. 00	
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	399	0	3, 368	88. 00	
90.00	09000 CLINIC	0	0	399	0	3, 308 0	90.00	
90. 00	09001 DI ABETES	0	0	0	0	89	90.00	
90. 01	09002 OP PSYCH	0	0	0	0	0	90.01	
90. 03	09003 PAIN MANAGEMENT	8, 039	14, 820	2, 642	0	27, 480	90.03	
91. 00	09100 EMERGENCY	50, 286		16, 502	0	87, 038	91.00	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	00, 200	07, 170	10, 002	Ĭ	07,000	92.00	
,2.00	OTHER REIMBURSABLE COST CENTERS						72.00	
101.00	10100 HOME HEALTH AGENCY	25, 867	30, 073	2, 528	0	9, 608	101.00	
	SPECIAL PURPOSE COST CENTERS							
113.00	11300 I NTEREST EXPENSE						113.00	
118. 00		436, 926	298, 199	405, 847	1, 198, 942	667, 295	118. 00	
	NONREI MBURSABLE COST CENTERS	•						
	07950 MOB	73, 445	0	17, 435	0	82, 367	•	
	07951 FOUNDATI ON	3, 289	0	0	0		194. 01	
	07952 ASC	0	0	0	0		194. 02	
	07953 SNF - PERRY CO.	55, 290	0	6, 327	0	12, 382	194. 03	
200.00		_	ا			^	200.00	
201.00	S S S S S S S S S S S S S S S S S S S	568, 950	0 298, 199	429, 609	1, 198, 942	762, 044	201.00	
202. 00		1 300, 930	270, 199	427, 009	1, 170, 742	102, 044	202.00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS GI BSON GENERAL HOSPI TAL

Provider CCN: 15-1319

						To	09/30/2019 Date/Time P 2/25/2020 4	
		Cost Center Description	Subtotal	Intern &	Tota		272372020 4	. 21 piii
		2001 201101 20001 21 011	oub to tu.	Resi dents				
				Cost & Post				
				Stepdown				
				Adjustments		_		
	CENED	AL CEDVICE COST CENTERS	24. 00	25. 00	26.0	0		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
2. 00		CAP REL COSTS-MVBLE EQUIP						2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00		ADMINISTRATIVE & GENERAL						5. 00
7.00	00700	OPERATION OF PLANT						7. 00
8.00		LAUNDRY & LINEN SERVICE						8. 00
9. 00		HOUSEKEEPI NG						9.00
10.00		DIETARY						10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION						11. 00 13. 00
14. 00		CENTRAL SERVICE & SUPPLY						14.00
15. 00		PHARMACY						15. 00
16. 00		MEDICAL RECORDS & LIBRARY						16. 00
		ENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	3, 970, 811	0	3, 9	70, 811		30. 00
31. 00		INTENSIVE CARE UNIT	162, 983	0	16	52, 983		31.00
44. 00		SKILLED NURSING FACILITY	0	0		0		44. 00
FO 00		LARY SERVICE COST CENTERS	1 700 011		1 7	00 011		F0.00
50. 00 54. 00		OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	1, 780, 011 2, 425, 764	0		30, 011 25, 764		50. 00 54. 00
54. 03	1	NUCLEAR MEDICINE-DIAGNOSTIC	2, 423, 704	0		41, 800		54.00
60.00	1	LABORATORY	2, 672, 666	0		72, 666		60.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	68, 869	0		58, 869		62.00
65.00		RESPI RATORY THERAPY	1, 249, 204	0		19, 204		65. 00
66.00		PHYSI CAL THERAPY	1, 647, 276	0		17, 276		66. 00
67.00		OCCUPATI ONAL THERAPY	516, 229	0		16, 229		67. 00
68.00		SPEECH PATHOLOGY	164, 243	0	16	54, 243		68.00
69.00		ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENT	407 100	0	10	0		69. 00 71. 00
71. 00 72. 00		IMPL. DEV. CHARGED TO PATIENTS	487, 182 838, 561	0		37, 182 38, 561		71.00
73. 00		DRUGS CHARGED TO PATIENTS	2, 692, 084	0		92, 084		73.00
76. 00		INFUSION THERAPY	268, 235	0		58, 235		76. 00
		TIENT SERVICE COST CENTERS	•					
88.00		RURAL HEALTH CLINIC	405, 936	0	40	05, 936		88. 00
90.00		CLINIC	0	0		0		90.00
90. 01		DI ABETES	2, 563	0		2, 563		90. 01
90. 02 90. 03		OP PSYCH PAIN MANAGEMENT	687, 785	0	40	0 37, 785		90. 02 90. 03
91.00		EMERGENCY	4, 066, 666	0		56, 666		91.00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART	4, 000, 000	0	4, 00	30, 000		92.00
72.00		REIMBURSABLE COST CENTERS						72.00
101.00		HOME HEALTH AGENCY	982, 667	0	98	32, 667		101.00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25, 331, 535	0	25, 33	31, 535		118. 00
104 00	NONRE 07950	MBURSABLE COST CENTERS	6, 614, 495	0	۷.	14, 495		194. 00
		FOUNDATI ON	179, 078	0		79, 078		194.00
	07952		0,7,070	0	1.	0,070		194. 01
		SNF - PERRY CO.	3, 208, 997	0	3, 20	08, 997		194. 03
200.00		Cross Foot Adjustments	o	0		0		200. 00
201.00		Negative Cost Centers	0	0		0		201. 00
202.00)	TOTAL (sum lines 118 through 201)	35, 334, 105	0	35, 33	34, 105		202. 00

| Peri od: | Worksheet B | From 10/01/2018 | Part II | To 09/30/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1319

					То	09/30/2019	Date/Time Pre 2/25/2020 4:2	
				CAPI TAL REI	LATED COSTS		272372020 4.2	Pill
	(Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New				BENEFITS	
			Capi tal Related Costs				DEPARTMENT	
			0	1.00	2.00	2A	4. 00	
	GENERA	L SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	11, 693		11, 693	11, 693	4. 00
5. 00		ADMINISTRATIVE & GENERAL	0	69, 766		69, 766	1, 287	5. 00
7.00		OPERATION OF PLANT	0	308, 069		308, 069	205	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	25, 446		25, 446	39	8.00
9.00		HOUSEKEEPI NG	0	14, 362		14, 362	233	9.00
10. 00 11. 00		DI ETARY CAFETERI A	0	37, 623 27, 710		37, 623 27, 710	155 210	10. 00 11. 00
13.00		NURSING ADMINISTRATION	0	4, 309		4, 309	36	13.00
14. 00		CENTRAL SERVICE & SUPPLY	0	4, 309		4, 309	151	14.00
15. 00		PHARMACY	0	0	- 1	ol Ol	118	15.00
16. 00		MEDICAL RECORDS & LIBRARY	0	20, 810		20, 810	227	16. 00
		ENT ROUTINE SERVICE COST CENTERS		==1, = : =	-1	==, =		
30.00	03000	ADULTS & PEDIATRICS	0	127, 730	0	127, 730	1, 159	30.00
31.00	03100 1	INTENSIVE CARE UNIT	0	30, 223	0	30, 223	5	31.00
44.00	04400 \$	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	0	79, 679		79, 679	710	
54.00		RADI OLOGY-DI AGNOSTI C	0	54, 576		54, 576	593	54.00
54. 03		NUCLEAR MEDICINE-DIAGNOSTIC	0	6, 557		6, 557	0	54. 03
60.00		LABORATORY	0	23, 885		23, 885	678	60.00
62. 00 65. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY	0	0 25, 165		0 25, 165	0 358	62. 00 65. 00
66.00		PHYSI CAL THERAPY	0	43, 883		43, 883	567	66.00
67. 00		OCCUPATI ONAL THERAPY	0	12, 770		12, 770	214	
68. 00		SPEECH PATHOLOGY	0	968		968	78	68. 00
69. 00		ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	56, 028	O	56, 028	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	15, 798	0	15, 798	0	73.00
76.00		INFUSION THERAPY	0	16, 657	0	16, 657	69	76. 00
		LENT SERVICE COST CENTERS						
88. 00		RURAL HEALTH CLINIC	0	0		0	163	88. 00
90.00			0	0	- 1	0	0	90.00
90. 01		DI ABETES OP PSYCH	0	0	_	0	0	90. 01
90. 02 90. 03		PAIN MANAGEMENT	0	0 24, 587		24, 587	0 175	90. 02 90. 03
91.00		EMERGENCY	0	138, 143		138, 143	686	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	0	130, 143		130, 143	000	92.00
72.00		REIMBURSABLE COST CENTERS				<u></u>		72.00
101.00		HOME HEALTH AGENCY	0	7, 884	0	7, 884	353	101. 00
		L PURPOSE COST CENTERS		.,,,,,	-1	.,		
113.00		INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 184, 321	0	1, 184, 321	8, 469	118. 00
		MBURSABLE COST CENTERS						
	07950		0	133, 506		133, 506		194. 00
		FOUNDATI ON	0	20, 435		20, 435		194. 01
	2 07952		0	0	-	0		194. 02
		SNF - PERRY CO.	0	111, 651	0	111, 651	/54	194. 03
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers		^		0	^	200. 00 201. 00
201.00		TOTAL (sum lines 118 through 201)	0	1, 449, 913	0	1, 449, 913	11, 693	
202.00	- ₁ Ι	TOTAL (Sum TITIOS TTO LITTOUGH 201)	١	1,447,713	١	1, 777, 713	11, 073	1202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1319

Peri od: Worksheet B From 10/01/2018 Part II To 09/30/2019 Date/Time Prepared:

2/25/2020 4:21 pm Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 10.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 71,053 5.00 7.00 00700 OPERATION OF PLANT 5, 442 313, 716 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 305 7, 528 33, 318 8.00 00900 HOUSEKEEPI NG 1,623 4, 249 20, 467 9 00 9 00 0 10.00 01000 DI ETARY 1, 372 11, 131 0 755 51,036 10.00 8, 198 01100 CAFETERI A 956 0 11.00 556 0 11.00 13.00 01300 NURSING ADMINISTRATION 565 1, 275 0 86 0 13.00 01400 CENTRAL SERVICE & SUPPLY 0 14.00 14 00 864 C 0 0 0 15.00 01500 PHARMACY 2, 408 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 357 6, 157 0 417 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 6.088 37.789 8.309 2.562 12, 727 8, 942 31.00 03100 INTENSIVE CARE UNIT 98 318 606 488 31.00 04400 SKILLED NURSING FACILITY 44.00 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 50.00 05000 OPERATING ROOM 2,680 23, 573 0 1,598 0 05400 RADI OLOGY-DI AGNOSTI C 4, 138 16, 147 0 1, 094 0 54.00 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 54.03 413 1, 940 131 0 54.03 4, 706 0 06000 LABORATORY 479 60.00 7,066 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 116 0 0 62.00 65.00 06500 RESPIRATORY THERAPY 2, 195 7, 445 0 505 0 65.00 06600 PHYSI CAL THERAPY 2, 780 0 12.983 880 66.00 0 66,00 0 06700 OCCUPATI ONAL THERAPY 67.00 872 3,778 256 0 67.00 06800 SPEECH PATHOLOGY 296 286 0 19 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 519 16, 576 0 1, 124 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 1, 404 Ω 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,723 4,674 0 317 0 73.00 03480 INFUSION THERAPY 0 76.00 390 4, 928 0 76.00 334 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 809 0 0 0 88.00 09000 CLI NI C 0 0 0 90.00 90.00 0 C 09001 DI ABETES 90.01 5 0 0 90.01 0 0 09002 OP PSYCH 0 90.02 90.02 0 0 0 09003 PAIN MANAGEMENT 90.03 1, 109 7, 274 0 493 0 90.03 91.00 09100 EMERGENCY 6,753 40, 869 0 2,771 0 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 1, 785 2, 332 0 158 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 54, 771 235, 140 8,627 15, 141 13, 215 118. 00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MOB 12, 051 39, 498 0 194. 00 0 2.677 194. 01 07951 FOUNDATI ON 0 194 01 0 215 6,046 410 194. 02 07952 ASC 0 0 194.02 194. 03 07953 SNF - PERRY CO. 4,016 33, 032 24, 691 2, 239 37, 821 194. 03 200.00 200 00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 71, 053 313, 716 33, 318 20, 467 51, 036 202. 00

Provider CCN: 15-1319

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 10/01/2018 | Part II |
| To 09/30/2019 | Date/Time Prepared: 2/25/2020 4:21 pm

				07/30/2017	2/25/2020 4: 2	1 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMINISTRATIO	SERVICE &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 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						10.00
11. 00 01100 CAFETERI A	27 420					
	37, 630	l				11.00
	176	6, 447	1 015			13.00
14. 00 01400 CENTRAL SERVI CE & SUPPLY	0	0	1, 015	0 500		14.00
15. 00 01500 PHARMACY	0	0	3	2, 529	00.010	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 101	0	0	0	30, 069	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				-1		
30. 00 03000 ADULTS & PEDI ATRI CS	5, 617	2, 551	27	0	1, 608	30.00
31. 00 03100 INTENSIVE CARE UNIT	26		0	0	50	31.00
44.00 O4400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 440	526	115	0	2, 089	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 876	0	20	0	5, 194	54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	23	0	187	54.03
60. 00 06000 LABORATORY	3, 288	0	272	0	3, 411	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	24	0	39	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 736	150	5	0	1, 466	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 747	0	19	0	2, 638	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 036	0	0	0	939	67.00
68.00 06800 SPEECH PATHOLOGY	378	o	0	0	316	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	o	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	82	O	209	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	306	0	428	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	571	130	11	2, 529	2, 597	73.00
76.00 03480 INFUSION THERAPY	336	212	0	0	130	76. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	1	0	133	88. 00
90. 00 09000 CLI NI C	0	l ol	0	o	0	90.00
90. 01 09001 DI ABETES	0	o	0	0	4	90. 01
90. 02 09002 OP PSYCH	0	o	0	0	0	90. 02
90. 03 09003 PAI N MANAGEMENT	532	320	6	0	1, 084	90. 03
91. 00 09100 EMERGENCY	3, 326	1, 891	39	o l	3, 432	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 320	1,071	37	٩	3, 432	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	1, 711	650	6	0	379	101. 00
SPECIAL PURPOSE COST CENTERS	1,711	000	<u> </u>	<u> </u>	377	101.00
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	28, 897	6, 447	959	2, 529	26, 333	
NONREI MBURSABLE COST CENTERS	20,077	0, 117	,,,,	2,027	20, 000	110.00
194. 00 07950 MOB	4, 858	ol	41	0	3 248	194. 00
194. 01 07951 FOUNDATI ON	218	l ol	0	0	·	194. 01
194. 02 07952 ASC	0		Ö	n		194. 02
194. 03 07953 SNF - PERRY CO.	3, 657	ا م	15	n		194. 03
200.00 Cross Foot Adjustments	3,037		13	9	400	200.00
201.00 Negative Cost Centers	0	ا	n	n	Λ	201.00
202.00 TOTAL (sum lines 118 through 201)	37, 630	6, 447	1, 015	2, 529	30, 069	
202. 00 [101/12 (30iii 111/03 110 till 00gil 201)	37,030	0, 447	1,015	2, 527	30, 007	_02.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2018 | Part II | To 09/30/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1319

					To 09/30/2019	
	Cost Center Description	Subtotal	Intern &	Total		2/25/2020 4: 21 pm
	oost conten bescription	Subtotal	Resi dents	lotai		
			Cost & Post			
			Stepdown			
			Adjustments			
	CENEDAL CEDALCE COCT CENTEDS	24. 00	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL					5.00
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					10.00
11.00	01100 CAFETERI A					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
14.00	01400 CENTRAL SERVICE & SUPPLY					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					18.00
30. 00	03000 ADULTS & PEDIATRICS	206, 167	0	206, 16	.7	30.00
	03100 I NTENSI VE CARE UNI T	40, 773	Ö			31.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0	44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	114, 410	0			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	84, 638	0			54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	9, 251	0			54. 03
60. 00 62. 00	O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	43, 785	0			60. 00 62. 00
65. 00	06500 RESPIRATORY THERAPY	179 39, 025	0	17 39, 02		65.00
66. 00	06600 PHYSI CAL THERAPY	66, 497	0	66, 49		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	19, 865	0	1		67.00
68. 00	06800 SPEECH PATHOLOGY	2, 341	0			68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	74, 538	0	74, 53	8	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 138	0	, ,		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	29, 350	0	,		73.00
76. 00	03480 I NFUSI ON THERAPY	23, 056	0	23, 05	6	76. 00
00 NN	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1, 106	0	1, 10	16	88. 00
90.00	09000 CLINIC	1, 100	0		0	90.00
90. 01	09001 DI ABETES	9	0		9	90. 01
90. 02	09002 OP PSYCH	O	0	,	0	90. 02
90. 03	09003 PAIN MANAGEMENT	35, 580	0	35, 58	0	90. 03
91.00	09100 EMERGENCY	197, 910	0	197, 91	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
404.00	OTHER REIMBURSABLE COST CENTERS	45.050		1 45 05	-al	101.00
101.00	10100 HOME HEALTH AGENCY	15, 258	0	15, 25	8	101.00
112 00	SPECIAL PURPOSE COST CENTERS					113. 00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 005, 876	0	1, 005, 87	6	118.00
110.00	NONREI MBURSABLE COST CENTERS	1,000,070		1,000,07	<u> </u>	110.00
194.00	07950 MOB	198, 304	0	198, 30	14	194.00
	07951 FOUNDATI ON	27, 369	0	1		194. 01
	07952 ASC	0	0		0	194. 02
	07953 SNF - PERRY CO.	218, 364	0	218, 36		194. 03
200.00		0	0	1	0	200.00
201. 00 202. 00		1 440 013	0	1	0	201. 00 202. 00
202.00	TOTAL (Suill Filles 110 till Ough 201)	1, 449, 913	0	1, 449, 91	ار	1202.00

		TION - STATISTICAL BASIS	OI DOON GENERO	Provi der C	CN: 15-1319 P	eri od:	Worksheet B-1	
					F T	rom 10/01/2018 o 09/30/2019	Date/Time Pre	epared:
							2/25/2020 4: 2	21 pm
			CAPITAL REI	LATED COSTS				
		Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
		<u>'</u>	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
					DEPARTMENT		(ACCUM. COST)	
					(GROSS			
			1. 00	2.00	SALARI ES) 4. 00	5A	5. 00	
	GENER	AL SERVICE COST CENTERS	1.00	2.00	1. 00	071	0.00	
1.00		CAP REL COSTS-BLDG & FLXT	92, 877					1.00
2. 00	1	CAP REL COSTS-MVBLE EQUIP		92, 877	1			2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	749 4, 469				27, 991, 635	4. 00 5. 00
7. 00		OPERATION OF PLANT	19, 734				1	1
8. 00		LAUNDRY & LINEN SERVICE	1, 630		1		1	
9.00		HOUSEKEEPI NG	920				1	1
10.00	1	DI ETARY	2, 410				•	
11.00		CAFETERI A	1, 775					
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICE & SUPPLY	276	•	1		, , , , ,	1
		PHARMACY	0	1	1			1
		MEDICAL RECORDS & LIBRARY	1, 333				•	1
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	8, 182					1
31.00		INTENSIVE CARE UNIT	1, 936					1
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0	0	0	44.00
50.00	05000	OPERATING ROOM	5, 104	5, 104	831, 831	0	1, 055, 978	50.00
54.00		RADI OLOGY-DI AGNOSTI C	3, 496		1			1
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	420		_	162, 537	54.03
60.00	1	LABORATORY	1, 530		1			
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1	1	_		
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	1, 612 2, 811					
67. 00		OCCUPATI ONAL THERAPY	818					
68.00		SPEECH PATHOLOGY	62	62	1		1	
		ELECTROCARDI OLOGY	0	1	1	-		
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	3, 589		i	-		
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	1 013	1	_	0		
76.00		INFUSION THERAPY	1, 012 1, 067		l .			1
70.00		TIENT SERVICE COST CENTERS	1,007	1,007	01,010		100,000	70.00
88.00		RURAL HEALTH CLINIC	0	0	191, 410	0	318, 598	88. 00
		CLINIC	0	0	0		l .	
90. 01	1	DI ABETES	0	0	0	0		1
90. 02		OP PSYCH PAIN MANAGEMENT	1, 575	1, 575	205, 431	0		
		EMERGENCY	8, 849					
		OBSERVATION BEDS (NON-DISTINCT PART		, , , , ,			_, _,,	92.00
	OTHER	REIMBURSABLE COST CENTERS						
101.00		HOME HEALTH AGENCY	505	505	413, 774	0	703, 432	101.00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE	I	I	1	I		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75, 864	75, 864	9, 929, 923	-7, 342, 470	21, 579, 526	
110.00		IMBURSABLE COST CENTERS	73,004	13,004	7, 727, 723	7, 542, 470	21, 377, 320	1110.00
194.00			8, 552	8, 552	2, 844, 745	0	4, 745, 330	194. 00
		FOUNDATI ON	1, 309		1			194. 01
194. 02			0		_ ~	-		194. 02
200.00		SNF - PERRY CO. Cross Foot Adjustments	7, 152	7, 152	884, 420	0	1, 582, 226	200.00
200.00	1	Negative Cost Centers						201.00
202.00	1	Cost to be allocated (per Wkst. B,	1, 449, 913	0	1, 855, 304		7, 342, 470	
		Part I)						
203.00	1	Unit cost multiplier (Wkst. B, Part I)	15. 611109	0. 000000	1		0. 262309	
204.00	ן	Cost to be allocated (per Wkst. B,			11, 693		71, 053	204.00
205. 00		Part II) Unit cost multiplier (Wkst. B, Part			0. 000853		0. 002538	205 00
200.00	1				0.000033		0.002338	200.00
206.00	o	NAHE adjustment amount to be allocated						206.00
0		(per Wkst. B-2)						00- 00
207. 00	וי	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	I	prants III anu IV)	I	I	I	I	I	1

	Financial Systems	GIBSON GENERA				u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 10/01/2018 To 09/30/2019	Worksheet B-1 Date/Time Pre 2/25/2020 4:2	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A (GROSS SALARI ES)	
		7. 00	8. 00	9. 00	10.00	11. 00	
4 00	GENERAL SERVICE COST CENTERS	1	T	T	1		
1. 00 2. 00 4. 00 5. 00 7. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	67, 925					1.00 2.00 4.00 5.00 7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	1, 630 920	9, 211	65, 375			8. 00 9. 00
10.00	01000 DI ETARY	2, 410	0	2, 410	9, 211		10.00
11. 00	01100 CAFETERI A	1, 775		1, 775		9, 101, 074	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	276	l .	276		42, 532	1
14.00	01400 CENTRAL SERVICE & SUPPLY	0	_			0	
15.00	01500 PHARMACY	0	_	1 222	_	0	
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	1, 333		1, 333	0	266, 192	16.00
30. 00	03000 ADULTS & PEDIATRICS	8, 182	2, 297	8, 182	2, 297	1, 359, 208	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 936				6, 378	1
44.00	04400 SKILLED NURSING FACILITY	0				0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 104	l .			831, 831	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 496		3, 496		695, 556	1
54. 03	05401 NUCLEAR MEDICINE-DI AGNOSTI C	420		420		705.054	
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 530 0		1, 530		795, 254 0	1
65.00	06500 RESPIRATORY THERAPY	1, 612	_	1, 612		419, 746	
66. 00	06600 PHYSI CAL THERAPY	2, 811		2, 811		664, 442	
67. 00	06700 OCCUPATI ONAL THERAPY	818		818		250, 479	
68.00	06800 SPEECH PATHOLOGY	62	0	62	0	91, 328	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	·	C	1	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 589		3, 589		0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	_	1 016	0	0	
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03480 INFUSION THERAPY	1, 012 1, 067		1, 012 1, 067		138, 162 81, 343	1
70.00	OUTPATIENT SERVICE COST CENTERS	1,007	0	1,007	<u> </u>	01, 343	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
90.00	09000 CLI NI C	0	0	Ċ		0	1
90. 01	09001 DI ABETES	0	0	C	o	0	90. 01
90. 02	09002 OP PSYCH	0	0	C	0	0	
90. 03	09003 PAIN MANAGEMENT	1, 575		1, 575		128, 595	
91.00	09100 EMERGENCY	8, 849	0	8, 849	0	804, 383	1
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	505	0	505	ol ol	413, 774	101.00
	SPECIAL PURPOSE COST CENTERS		-		-1		1
113.00	11300 INTEREST EXPENSE						113. 00
118.00	3 /	50, 912	2, 385	48, 362	2, 385	6, 989, 203	118. 00
404.00	NONREI MBURSABLE COST CENTERS	0.550	1	0 550	ا	4 474 000	104.00
	07950 MOB 07951 FOUNDATI ON	8, 552 1, 309		8, 552 1, 309		1, 174, 832	194.00
	07951 FOUNDATT ON 07952 ASC	1, 309	0	1, 309			194. 01
	07953 SNF - PERRY CO.	7, 152	6, 826			884, 420	
200.00		1, 1, 1, 1	, , , , ,	.,	3, 323	,	200.00
201.00							201.00
202.00	Part I)	2, 706, 624			809, 602	568, 950	202. 00
203.00		39. 847243			87. 895125	0. 062515	1
204.00		313, 716	33, 318	20, 467	51, 036	37, 630	204.00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	4. 618565	3. 617197	0. 313071	5. 540766	0. 004135	205. 00
206. 00							206. 00
207. 00	(per Wkst. B-2)						207. 00
207.00	Parts III and IV)						207.00

Heal th	Financial Systems	GIBSON GENERA	L HOSPITAL		In Lie	u of Form CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-1319	Peri od:	Worksheet B-1
				<u> </u>	From 10/01/2018 To 09/30/2019	Date/Time Prepared:
						2/25/2020 4:21 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVI CE &	(COSTED REQUIS.)	RECORDS &	
		N (NURSE	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	
		SALARI ES)	REQUIS.)		PATI ENT	
		SALARI ES)	REQUIS.)		REVENUE)	
		13. 00	14. 00	15. 00	16.00	
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE					7.00
9. 00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11.00
13.00	01300 NURSING ADMINISTRATION	2, 465, 907				13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	1, 836, 716	,		14.00
15.00	01500 PHARMACY	0	6, 178	1, 068, 408	3	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	56)	60, 828, 043	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1		
30.00	03000 ADULTS & PEDIATRICS	975, 167	48, 831	•	3, 254, 395	
31.00	03100 INTENSIVE CARE UNIT	6, 378	0		101, 660	
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	U	'	0	44.00
50.00	05000 OPERATING ROOM	201, 306	207, 134	1	4, 229, 121	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	201, 300	35, 301	1	10, 478, 914	
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	41, 643	1	377, 611	54. 03
60.00	06000 LABORATORY	0	491, 762		6, 904, 889	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	43, 967		77, 995	
65.00	06500 RESPIRATORY THERAPY	57, 523	9, 561		2, 968, 161	65.00
66.00	06600 PHYSI CAL THERAPY	0	34, 156		5, 339, 892	
67. 00	06700 OCCUPATI ONAL THERAPY	0	565		1, 900, 320	
68. 00	06800 SPEECH PATHOLOGY	0	0		639, 531	68.00
69.00	06900 ELECTROCARDI OLOGY	0	140.047)) 422.754	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	148, 047 553, 194		0 422, 754 0 867, 308	
73.00	07300 DRUGS CHARGED TO PATIENTS	49, 877	20, 366	1		
	03480 I NFUSI ON THERAPY	81, 038	20, 300		262, 429	
	OUTPATIENT SERVICE COST CENTERS			'		
88.00	08800 RURAL HEALTH CLINIC	0	1, 706)	268, 843	88.00
90.00	09000 CLI NI C	0	0)	0	90.00
	09001 DI ABETES	0	0)	7, 128	
90. 02	09002 OP PSYCH	0	0		0	90.02
	09003 PAIN MANAGEMENT	122, 553	11, 295	1	2, 193, 513	
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	723, 383	70, 552	(6, 947, 475	91.00
72.00	OTHER REIMBURSABLE COST CENTERS					92.00
101 00	10100 HOME HEALTH AGENCY	248, 682	10, 810		766, 887	101.00
	SPECIAL PURPOSE COST CENTERS	2 107 002	10,010		, , , , , , , , , , , , , , , , , , , ,	.555
113.00	11300 INTEREST EXPENSE					113.00
118. 00	, ,	2, 465, 907	1, 735, 124	1, 068, 40	53, 265, 079	118.00
	NONREI MBURSABLE COST CENTERS					
	07950 MOB	0	74, 542		6, 574, 611	
	07951 FOUNDATI ON	0	0	1	0	194. 01
	07952 ASC 07953 SNF - PERRY CO.	0	27, 050		0 988, 353	
200.00		0	27,030	'l	900, 333	200.00
201.00						201.00
202.00		298, 199	429, 609	1, 198, 94	762, 044	
	Part I)		,	.,,	1	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 120929	0. 233901	1. 12217	6 0. 012528	203.00
204.00	Cost to be allocated (per Wkst. B,	6, 447	1, 015	2, 52	9 30, 069	204.00
	Part II)					
205. 00		0. 002614	0. 000553	0. 00236	7 0. 000494	205. 00
204 00	NAME adjustment amount to be allegated			1		207.00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)			1		206.00
207. 00						207. 00
_07.00	Parts III and IV)					207.00
		. '		•		1

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1319	Peri od: Worksheet C From 10/01/2018 Part I To 09/30/2019 Date/Time Prepared: 2/25/2020 4:21 pm

					To 09/30/2019	Date/Time Pre 2/25/2020 4:2	pared: 1 nm
			Title	XVIII	Hospi tal	Cost	ГРШ
			1		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	.,				
		col. 26)					
		1.00	2.00	3.00	4.00	5. 00	
ΙN	PATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03	000 ADULTS & PEDIATRICS	3, 970, 811		3, 970, 81	1 0	0	30.00
31.00 03	100 INTENSIVE CARE UNIT	162, 983		162, 98		0	31.00
44.00 04	400 SKILLED NURSING FACILITY	o			o	0	44.00
AN	CILLARY SERVICE COST CENTERS						
50.00 05	000 OPERATING ROOM	1, 780, 011		1, 780, 01	1 0	0	50.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	2, 425, 764		2, 425, 76	4 0	0	54.00
54. 03 05	401 NUCLEAR MEDICINE-DIAGNOSTIC	241, 800		241, 80	0 0	0	54.03
60.00 06	000 LABORATORY	2, 672, 666		2, 672, 66	6 0	0	60.00
62.00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	68, 869		68, 86	9 0	0	62.00
65. 00 06	500 RESPI RATORY THERAPY	1, 249, 204	0	1, 249, 20	4 0	0	65.00
66. 00 06	600 PHYSI CAL THERAPY	1, 647, 276	0	1, 647, 27	6 0	0	66.00
67. 00 06	700 OCCUPATI ONAL THERAPY	516, 229	0	516, 22	9 0	0	67.00
68. 00 06	800 SPEECH PATHOLOGY	164, 243	0	164, 24	3 0	0	68. 00
69.00 06	900 ELECTROCARDI OLOGY	0			0	0	69.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	487, 182		487, 18	2 0	0	71.00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS	838, 561		838, 56	1 0	0	72.00
73.00 07	300 DRUGS CHARGED TO PATIENTS	2, 692, 084		2, 692, 08	4 0	0	73.00
76.00 03	480 INFUSION THERAPY	268, 235		268, 23	5 0	0	76.00
	TPATIENT SERVICE COST CENTERS						
	800 RURAL HEALTH CLINIC	405, 936		405, 93	6 0	0	88. 00
	000 CLI NI C	0			0	0	90.00
	001 DI ABETES	2, 563		2, 56	3 0	0	90. 01
	002 OP PSYCH	0			0	0	90. 02
90. 03 09	OO3 PAIN MANAGEMENT	687, 785		687, 78	5 0	0	90. 03
91.00 09	100 EMERGENCY	4, 066, 666		4, 066, 66	6 0	0	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	837, 408		837, 40	3	0	92.00
	HER REIMBURSABLE COST CENTERS						
	100 HOME HEALTH AGENCY	982, 667		982, 66	7	0	101. 00
	ECIAL PURPOSE COST CENTERS						
	300 INTEREST EXPENSE						113.00
200. 00	Subtotal (see instructions)	26, 168, 943	0	,, .			200. 00
201. 00	Less Observation Beds	837, 408		837, 40			201. 00
202. 00	Total (see instructions)	25, 331, 535	0	25, 331, 53	5 0	0	202. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1319	Peri od:	Worksheet C
		From 10/01/2018	
		To 00 /20 /2010	Doto/Time Dropored.

				-	Fo 09/30/2019	Part I Date/Time Pre 2/25/2020 4:2	
			Title	: XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		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						
	03000 ADULTS & PEDI ATRI CS	2, 480, 793		2, 480, 793		1	30.00
	03100 INTENSIVE CARE UNIT	101, 660		101, 660		1	31.00
44.00	04400 SKILLED NURSING FACILITY	0		(44.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	150, 064	4, 079, 057			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	210, 930	10, 267, 984		0. 231490	0. 000000	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	7, 853	369, 758	377, 61		0.000000	
60.00	06000 LABORATORY	789, 721	6, 115, 168			0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	19, 909	58, 086	77, 99		0.000000	
65.00	06500 RESPI RATORY THERAPY	580, 099	2, 388, 062	2, 968, 16	0. 420868	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	990, 080	4, 349, 812	5, 339, 892	0. 308485	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	463, 767	1, 436, 553	1, 900, 320	0. 271654	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	46, 789	592, 742	639, 53	0. 256818	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	(0.000000	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	307, 242	115, 512	422, 754	1. 152401	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	40, 299	827, 009	867, 308	0. 966855	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	938, 388	4, 317, 865	5, 256, 253	0. 512168	0.000000	73.00
76.00	03480 I NFUSI ON THERAPY	200	262, 229	262, 429	1. 022124	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	268, 843	268, 843	3	·	88. 00
90.00	09000 CLI NI C	0	0	(0.000000	0.000000	90.00
	09001 DI ABETES	0	7, 128	7, 128	0. 359568	0. 000000	90. 01
90.02	09002 OP PSYCH	0	0	(0. 000000	0. 000000	90. 02
90.03	09003 PAIN MANAGEMENT	0	2, 193, 513	2, 193, 513	0. 313554	0.000000	90.03
91.00	09100 EMERGENCY	207, 399	6, 740, 076	6, 947, 475	0. 585344	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	31, 703	741, 899	773, 602	1. 082479	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	766, 887	766, 887	7		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	7, 366, 896	45, 898, 183	53, 265, 079	9		200. 00
201.00							201.00
202.00	Total (see instructions)	7, 366, 896	45, 898, 183	53, 265, 079	9		202. 00

Health Financial Systems	GI BSON GENERAL HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1319	Period: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Prepared: 2/25/2020 4:21 pm

				2/25/2020 4: 21 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000			54. 03
60. 00 06000 LABORATORY	0. 000000			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76.00 03480 INFUSION THERAPY	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 DI ABETES	0. 000000			90. 01
90. 02 09002 OP PSYCH	0. 000000			90. 02
90. 03 09003 PAI N MANAGEMENT	0. 000000			90. 03
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
				•

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1319	Peri od: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Prepared: 2/25/2020 4:21 pm

					o 09/30/2019	Date/Time Pre 2/25/2020 4:2	pared: 1 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	3, 970, 811		3, 970, 811	0	3, 970, 811	30.00
	100 INTENSIVE CARE UNIT	162, 983		162, 983	0	162, 983	31.00
44.00 04	400 SKILLED NURSING FACILITY	0		C	0	0	44. 00
	CILLARY SERVICE COST CENTERS						
50.00 050	OOO OPERATING ROOM	1, 780, 011		1, 780, 011	0	1, 780, 011	50.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	2, 425, 764		2, 425, 764	0	2, 425, 764	54.00
54. 03 05	401 NUCLEAR MEDICINE-DIAGNOSTIC	241, 800		241, 800	0	241, 800	54. 03
60.00 06	DOO LABORATORY	2, 672, 666		2, 672, 666	0	2, 672, 666	60.00
62. 00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	68, 869		68, 869	0	68, 869	62.00
65.00 06	500 RESPI RATORY THERAPY	1, 249, 204	0	1, 249, 204	. 0	1, 249, 204	65.00
66. 00 06	600 PHYSI CAL THERAPY	1, 647, 276	0	1, 647, 276	o	1, 647, 276	66.00
67. 00 06	700 OCCUPATI ONAL THERAPY	516, 229	0	516, 229	o	516, 229	67.00
68. 00 06	800 SPEECH PATHOLOGY	164, 243	0	164, 243	o	164, 243	68.00
69. 00 06	900 ELECTROCARDI OLOGY	0		l c	o	0	69.00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	487, 182		487, 182	. 0	487, 182	71.00
72. 00 07:	200 IMPL. DEV. CHARGED TO PATIENTS	838, 561		838, 561	0	838, 561	72.00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	2, 692, 084		2, 692, 084	. 0	2, 692, 084	73.00
76. 00 03·	480 INFUSION THERAPY	268, 235		268, 235	0	268, 235	76.00
OU ⁻	TPATIENT SERVICE COST CENTERS						
88. 00 08	800 RURAL HEALTH CLINIC	405, 936		405, 936	0	405, 936	88. 00
90.00 09	DOO CLI NI C	0		C	0	0	90.00
90. 01 090	001 DI ABETES	2, 563		2, 563	o	2, 563	90. 01
90. 02 090	002 OP PSYCH	0		[C	o	0	90.02
90. 03 090	DO3 PAIN MANAGEMENT	687, 785		687, 785	0	687, 785	90.03
91.00 09	100 EMERGENCY	4, 066, 666		4, 066, 666	o	4, 066, 666	91.00
92. 00 09:	200 OBSERVATION BEDS (NON-DISTINCT PART	837, 408		837, 408		837, 408	92.00
OTI	HER REIMBURSABLE COST CENTERS						
101.00 10	100 HOME HEALTH AGENCY	982, 667		982, 667		982, 667	101.00
SPI	ECLAL PURPOSE COST CENTERS						
113. 00 11:	300 INTEREST EXPENSE						113.00
200. 00	Subtotal (see instructions)	26, 168, 943	0	26, 168, 943	o	26, 168, 943	200.00
201. 00	Less Observation Beds	837, 408		837, 408		837, 408	201.00
202. 00	Total (see instructions)	25, 331, 535	0	25, 331, 535	o	25, 331, 535	202.00
		•	•	•			•

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1319	Peri od:	Worksheet C
		From 10/01/2018	
		To 00 /20 /2010	Doto/Time Dropored.

					To 09/30/2019	Date/Time Pre 2/25/2020 4:2	
			Ti tl	e XIX	Hospi tal	Cost	. г ріп
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	·	+ col. 7)	Ratio	I npati ent	
				·		Rati o	
		6. 00	7.00	8. 00	9. 00	10.00	
	FLENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	2, 480, 793		2, 480, 793			30.00
	INTENSIVE CARE UNIT	101, 660		101, 660			31.00
	SKILLED NURSING FACILITY	0		(44.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	150, 064	4, 079, 057			0. 000000	
	RADI OLOGY-DI AGNOSTI C	210, 930	10, 267, 984			0.000000	
	1 NUCLEAR MEDICINE-DIAGNOSTIC	7, 853	369, 758			0. 000000	
	LABORATORY	789, 721	6, 115, 168			0. 000000	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	19, 909	58, 086			0. 000000	
	RESPI RATORY THERAPY	580, 099	2, 388, 062			0. 000000	1
	PHYSI CAL THERAPY	990, 080	4, 349, 812	5, 339, 892		0. 000000	1
	OCCUPATI ONAL THERAPY	463, 767	1, 436, 553			0.000000	
	SPEECH PATHOLOGY	46, 789	592, 742	639, 531		0.000000	
	ELECTROCARDI OLOGY	0	0	١ `		0.000000	
	MEDICAL SUPPLIES CHARGED TO PATIENT	307, 242	115, 512			0.000000	
	IMPL. DEV. CHARGED TO PATIENTS	40, 299	827, 009			0. 000000	
	DRUGS CHARGED TO PATIENTS	938, 388	4, 317, 865			0.000000	
	INFUSION THERAPY	200	262, 229	262, 429	1. 022124	0.000000	76.00
	ATIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0	268, 843	268, 843		0. 000000	
	CLI NI C	0	0			0.000000	
	1 DI ABETES	0	7, 128	7, 128		0.000000	
	2 OP PSYCH	0	0	(0. 000000	0.000000	
	3 PAIN MANAGEMENT	0	2, 193, 513			0.000000	
	EMERGENCY	207, 399	6, 740, 076			0.000000	
	OBSERVATION BEDS (NON-DISTINCT PART	31, 703	741, 899	773, 602	1. 082479	0.000000	92.00
	R REIMBURSABLE COST CENTERS						1
	HOME HEALTH AGENCY	0	766, 887	766, 887	7		101.00
	AL PURPOSE COST CENTERS						
	INTEREST EXPENSE						113.00
200. 00	Subtotal (see instructions)	7, 366, 896	45, 898, 183	53, 265, 079	7		200.00
201. 00	Less Observation Beds						201.00
202. 00	Total (see instructions)	7, 366, 896	45, 898, 183	53, 265, 079	9		202. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1319	From 10/01/2018	Worksheet C Part I Date/Time Prepared: 2/25/2020 4:21 pm

				2/25/2020 4: 21 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
44.00 O4400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000			54. 03
60. 00 06000 LABORATORY	0. 000000			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03480 INFUSION THERAPY	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 DI ABETES	0. 000000			90.01
90. 02 09002 0P PSYCH	0. 000000			90.02
90. 03 09003 PAI N MANAGEMENT	0. 000000			90.03
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				
202.00 Total (see instructions)				201. 00 202. 00

Health Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2018 To 09/30/2019	Part II Date/Time Pre	narod:
				10 09/30/2019	2/25/2020 4: 2	
		Title	: XVIII	Hospi tal	Cost	<u>. p</u>
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_	,				
50.00 05000 OPERATING ROOM	114, 410				1, 141	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	84, 638				706	54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	9, 251	377, 611			123	54.03
60. 00 06000 LABORATORY	43, 785	6, 904, 889	0. 00634	220, 964	1, 401	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	179	77, 995	0. 00229	8, 334	19	62.00
65. 00 06500 RESPIRATORY THERAPY	39, 025	2, 968, 161	0. 01314	163, 437	2, 149	65.00
66. 00 06600 PHYSI CAL THERAPY	66, 497	5, 339, 892	0. 01245	50, 173	625	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	19, 865	1, 900, 320	0. 01045	22, 384	234	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 341	639, 531	0. 00366	7, 824	29	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	74, 538	422, 754	0. 17631	5 92, 098	16, 238	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 138	867, 308	0.00246	5 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	29, 350	5, 256, 253	0. 00558	191, 717	1, 071	73.00
76. 00 03480 I NFUSI ON THERAPY	23, 056	262, 429	0. 08785	6 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	1, 106	268, 843	0. 00411	4 0	0	88. 00
90. 00 09000 CLI NI C	0	0	0. 00000	0 0	0	90.00
90. 01 09001 DI ABETES	9	7, 128	0. 00126	0	0	90. 01
90. 02 09002 OP PSYCH	0	0	0. 00000	0 0	0	90. 02
90. 03 09003 PAIN MANAGEMENT	35, 580	2, 193, 513	0. 01622	21 0	0	90. 03
91. 00 09100 EMERGENCY	197, 910	6, 947, 475	0. 02848	2, 824	80	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	43, 479	773, 602	0. 05620	1, 580	89	92.00
200.00 Total (lines 50 through 199)	787, 157	49, 915, 739	1	895, 926		200.00
	•	•	•	*	•	

Health Financial Systems	GI BSON GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1319	Peri od:	Worksheet D
TURQUOU COCTO			Erom 10/01/2010	Dart IV

From 10/01/2018 | Part IV | Date/Time | Prepared: 2/25/2020 | 4:21 pm THROUGH COSTS Title XVIII Hospi tal Cost Nursi ng Cost Center Description Non Physician Nursi ng Allied Health Allied Health Anestheti st School School Post-Stepdown Post-Stepdown Adjustments Cost Adjustments 1. 00 3A 2.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 0 0 54. 03 | 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 54.03 06000 LABORATORY 0 60.00 0 0 0 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 0 06500 RESPIRATORY THERAPY 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 Ω 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 72.00 0 0 72.00 0 73.00 73.00 0 76.00 03480 INFUSION THERAPY 0 76.00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 0 0 0 0 0 0 90.00 09000 CLI NI C 0 0 90.00 90. 01 09001 DI ABETES 0 0 0 90.01 0 0 90. 02 09002 OP PSYCH 0 90.02 0 0 0 0 90. 03 09003 PAIN MANAGEMENT 90. 03 0 0 0 91.00 91. 00 | 09100 | EMERGENCY 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 Total (lines 50 through 199) 0 200.00 200.00 0 0

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1319	Peri od: Worksheet D
THROUGH COSTS		From 10/01/2018 Part IV

				Т	o 09/30/2019	Date/Time Pre 2/25/2020 4:2	
			Title	XVIII	Hospi tal	Cost	ı pııı
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS		,		_		
	05000 OPERATING ROOM	0	0	C	4, 229, 121	0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(10, 478, 914	l	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	(377, 611		
60.00	06000 LABORATORY	0	0	(6, 904, 889	•	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(77, 995	•	1
65.00	06500 RESPI RATORY THERAPY	0	0	(2, 968, 161	0.000000	
66. 00	06600 PHYSI CAL THERAPY	0	0	(5, 339, 892	•	
	06700 OCCUPATI ONAL THERAPY	0	0	(1, 900, 320	•	1
	06800 SPEECH PATHOLOGY	0	0	(639, 531	0.000000	
	06900 ELECTROCARDI OLOGY	0	0	(0	0.000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(422, 754	l	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(867, 308	l	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	(5, 256, 253	0.000000	73.00
76.00	03480 I NFUSI ON THERAPY	0	0	C	262, 429	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	(268, 843	0.000000	88. 00
	09000 CLI NI C	0	0	(0	0.000000	90.00
	09001 DI ABETES	0	0	(7, 128	0.000000	90. 01
90. 02	09002 OP PSYCH	0	0	(0	0.000000	90. 02
90. 03	09003 PAIN MANAGEMENT	0	0	(2, 193, 513	0.000000	90. 03
91.00	09100 EMERGENCY	0	0	(6, 947, 475	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(773, 602	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	ıl c	49, 915, 739		200. 00

Health Financial Systems	GIBSON GENERAL HOSP	PI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Pro		Peri od: From 10/01/2018	Worksheet D
INKUUGH CUSIS				Data/Tima Dranarad

THROUG	GH COSTS				o 09/30/2019	Date/Time Pre	
			T: 41 -	WILL	11: 4-1	2/25/2020 4: 2	ı pm
	Cook Cooker Doorsinking	0		XVIII	Hospi tal	Cost	
	Cost Center Description	Outpatient Ratio of Cost	Inpati ent	Inpatient Program	Outpatient Program	Outpati ent	
		to Charges	Program	Pass-Through	9	Program Pass-Through	
		(col. 6 ÷	Charges	Costs (col. 8	Charges	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9.00	10. 00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0. 000000	42, 167		0	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	87, 412	•	o o	0	54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	5, 012	•	0	0	54. 03
60.00	06000 LABORATORY	0. 000000	220, 964		o o	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	8, 334		0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	163, 437		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	50, 173		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	22, 384		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	7, 824		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	l c	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	92, 098		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	191, 717	l c	0	0	73.00
76.00	03480 I NFUSI ON THERAPY	0. 000000	0	l c	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0	C	0	0	88. 00
90.00	09000 CLI NI C	0. 000000	0	C	0	0	90.00
90. 01	09001 DI ABETES	0. 000000	0	C	0	0	90. 01
90. 02	09002 OP PSYCH	0. 000000	0	C	0	0	90. 02
90. 03	09003 PAIN MANAGEMENT	0. 000000	0	C	0	0	90. 03
91.00	09100 EMERGENCY	0. 000000	2, 824	[C	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 580	•	0	0	, 2. 00
200.00	Total (lines 50 through 199)		895, 926	[c	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1319 Peri od: Worksheet D From 10/01/2018 To 09/30/2019 Part V Date/Time Prepared: 2/25/2020 4:21 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 420894 1, 663, 141 05400 RADI OLOGY-DI AGNOSTI C 2, 428, 536 0 0.231490 54.00 54.00 0 0 54. 03 | 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.640342 0 146, 546 0 54.03 60.00 06000 LABORATORY 0.387069 1, 846, 127 0 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.882992 12, 964 0 62.00 65.00 06500 RESPIRATORY THERAPY 0.420868 792, 559 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.308485 1, 597, 568 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 271654 355, 180 0 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0. 256818 37,874 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1. 152401 0 110, 311 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 0.966855 418, 651 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 709, 900 0 73 00 0.512168 6.782 0 73 00 03480 INFUSION THERAPY 76.00 1. 022124 0 97, 955 0 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0.000000 0 88.00 09000 CLI NI C 0.000000 0 0 Ω 90 00 90 00 0 09001 DI ABETES 90.01 0.359568 0 2, 160 0 0 90.01 90.02 09002 OP PSYCH 0.000000 0 90.02 90.03 09003 PAIN MANAGEMENT 0.313554 0 686, 021 0 0 90.03 91.00 91. 00 09100 EMERGENCY 0.585344 0 1, 665, 285 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.082479 0 291, 867 95 0 92.00 200.00 Subtotal (see instructions) 13, 862, 645 6,877 0 200.00 Less PBP Clinic Lab. Services-Program

13, 862, 645

6, 877

201.00

0 202.00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems	GI BSON GENERA	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1319	From 10/01/2018	Worksheet D Part V Date/Time Prepared:

				To 09/30/2019		
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS		_	1			
50. 00 05000 OPERATING ROOM	700, 006		ł			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	562, 182	0				54.00
54. 03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	93, 840	0				54. 03
60. 00 06000 LABORATORY	714, 579	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	11, 447	0				62.00
65. 00 06500 RESPI RATORY THERAPY	333, 563	0				65.00
66. 00 06600 PHYSI CAL THERAPY	492, 826	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	96, 486	0				67.00
68. 00 06800 SPEECH PATHOLOGY	9, 727	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	127, 123	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	404, 775					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	875, 756					73.00
76.00 03480 INFUSION THERAPY	100, 122	0				76. 00
OUTPATIENT SERVICE COST CENTERS			T			
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
90. 00 09000 CLI NI C	0	0				90.00
90. 01 09001 DI ABETES	777	0				90. 01
90. 02 09002 0P PSYCH	0	0				90. 02
90. 03 09003 PAI N MANAGEMENT	215, 105	0				90. 03
91. 00 09100 EMERGENCY	974, 765	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	315, 940					92.00
200.00 Subtotal (see instructions)	6, 029, 019	3, 577				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	/ 000 010	0 577				000 00
202.00 Net Charges (line 200 - line 201)	6, 029, 019	3, 577				202. 00

Health Financial Systems	GI BSON GENERAL I	HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1319	Peri od:	Worksheet D

From 10/01/2018 | Part V | Date/Time Prepared: Component CCN: 15-Z319 2/25/2020 4: 21 pm Title XVIII Swing Beds - SNF Cost Costs Charges PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 420894 50.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.231490 0 0 0 0 0 0 0 0 0 0 0 0 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 54.03 0.640342 0 54.03 60.00 0 06000 LABORATORY 0.387069 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.882992 0 0 62.00 01 0 65.00 06500 RESPIRATORY THERAPY 0.420868 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.308485 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 271654 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0. 256818 0 68.00 0 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1. 152401 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 0.966855 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0. 512168 0 73.00 73 00 0 0 03480 INFUSION THERAPY 76.00 1. 022124 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0.000000 0 88.00 09000 CLI NI C 0 90 00 0.000000 0 0 0 0 0 0 0 0 0 Ω 90 00 0 09001 DI ABETES 90.01 0.359568 0 0 90.01 90.02 09002 OP PSYCH 0.000000 0 90.02 0 90.03 09003 PAIN MANAGEMENT 0.313554 0 0 90.03 0 91.00 91. 00 09100 EMERGENCY 0.585344 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.082479 0 0 92.00 0 200.00 Subtotal (see instructions) 0 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00

0

0 202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems		GIBSON GENERAL	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST	Provi der (CCN: 15-1319	Peri od: From 10/01/2018	Worksheet D	
			Component	CCN: 15-Z319	To 09/30/2019		
			Ti tl	e XVIII	Swing Beds - SNF	Cost	
		Costs	3				

						2/25/2020 4::	21 pm
			Title	XVIII	Swing Beds - S	SNF Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0				50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	1			54.03
	06000 LABORATORY	0	0	1			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1			62.00
	06500 RESPI RATORY THERAPY	0	0	1			65.00
	06600 PHYSI CAL THERAPY	0	0	1			66.00
	06700 OCCUPATI ONAL THERAPY	0	0	1			67.00
	06800 SPEECH PATHOLOGY	0	0	1			68.00
	06900 ELECTROCARDI OLOGY	0	0	1			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76.00	03480 I NFUSI ON THERAPY	0	0				76. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0)			88. 00
	09000 CLI NI C	0	0)			90.00
	09001 DI ABETES	0	0	1			90. 01
90. 02	09002 OP PSYCH	0	0				90. 02
	09003 PAIN MANAGEMENT	0	0				90. 03
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1			92.00
200.00		0	0	1			200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10)
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-131	From 10/01/2018	Worksheet D-1 Date/Time Prepared: 2/25/2020 4:21 pm	
	Title XVIII	Hospi tal	Cost	-

		Title XVIII	Hospi tal	2/25/2020 4: 2 Cost	1 pm
	Cost Center Description	THE AVIII	1103pi tui	0031	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	s excluding newborn)		3, 663	1.00
2. 00	Inpatient days (including private room days, excluding swing-			1, 513	
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3. 00
4 00	do not complete this line.			000	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	880 0	4. 00 5. 00
3.00	reporting period	om days) trii ough beecimbe	or or the cost	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	1, 417	6.00
7 00	reporting period (if calendar year, enter 0 on this line)		24 . 6 . 1		7 00
7. 00	Total swing-bed NF type inpatient days (including private rool reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	733	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	513	9. 00
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	room days)	0	10.00
	through December 31 of the cost reporting period (see instruc		oom dayo,	· ·	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	1, 417	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		o room dove)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (frictualing privat	.e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y			_	
14. 00 15. 00	Medically necessary private room days applicable to the Prograte Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period		the cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	129. 14	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	129. 14	20. 00
20.00	reporting period	3 di tel becember 31 di t	.110 0031	127. 17	20.00
21. 00	Total general inpatient routine service cost (see instruction			3, 970, 811	•
22. 00	Swing-bed cost applicable to SNF type services through Decemb 5×1 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	31 of the cost reportir	na period (line d	0	23. 00
	x line 18)	·			
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	94, 660	25 00
20.00	x line 20)		, por ou (11110 0	7.1, 000	20.00
26.00	Total swing-bed cost (see instructions)	(1)		1, 969, 238	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		2, 001, 573	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	Semi -pri vate room charges (excluding swing-bed charges)	11		0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 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 mi	nus line 33)(see instruc	tions)	0.00	•
35. 00	Average per diem private room cost differential (line 34 x li		, (1 0113)	0.00	•
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	-	
	27 minus line 36)	<u> </u>	·		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LISTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 322. 92	38. 00
39.00	Program general inpatient routine service cost per diem (see			678, 658	
40. 00	Medically necessary private room cost applicable to the Progr	,		0,0,000	
41.00	Total Program general inpatient routine service cost (line 39	•		678, 658	41.00

0.00 CORDMANY CARE UNIT		Financial Systems	GI BSON GENERA				u of Form CMS-2	
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-1319			
Cost Center Description							Date/Time Pre	pared:
Inpatient Inpatient Inpatient Diem (Col. 1 Col. 4)							Cost	, p
Cost Days -col 2 col 40		Cost Center Description						
A				•				
Interestive Care Page Inpartient Hospital Units 162,983 88 1,862.06 23 42,598 44.00 CORRINARY CARE UNIT 162,983 88 1,862.06 23 42,598 43.00 INTERIST CARE CARE UNIT 45.00 808 INTERIST CARE CARE UNIT 45.00 808 INTERIST CARE CARE UNIT 47.00 808 INTERIST CARE CARE UNIT 47.00 47.00 INTERIST CARE CARE UNIT 47.00 INTERIST CARE UNIT 47.0	42.00	NUDCEDY (+:+1 - V 0 VIV1.)	1. 00	2. 00	3.00	4. 00	5. 00	42.00
1.875.08 1.875.08 23 42.598 44.00 2008/AMP CARE UNIT 45.00 88R 1.852.08 23 42.598 44.00 2008/AMP CARE UNIT 45.00 88R 1.875.08 23 42.598 44.00 2008/AMP CARE UNIT 45.00 88R 1.875.08 23 42.598 44.00 2008 47.00 2001 2008 200	42.00				1			42.00
45.00 SURKI INTENSIVE CARE UNIT 47.00		INTENSIVE CARE UNIT	162, 983	88	1, 852. 0	08 23	42, 598	
3.00 Program inpatient and Intervention 3.00 1.00								44. 00 45. 00
Cost Center Description 48.00 Program inpatient ancillary service cost (##st. D-3, col. 3, line 200) 49.00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 59.00 Poss through costs applicable to Program inpatient routine services (from Wist. D., sum of Parts I and Description of the St. D	46.00							46.00
1.00	47. 00							47.00
49.00 Total Program inpati ent costs (sum of lines 41 through 48) (see instructions) 40.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts I and D. 10.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts II 0.51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II 0.51.00 Pass through costs (sum of lines 50 and 51) 0.52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 0.52.00 Pass through costs (sum of lines 50 and 51) 0.52.00 Pass through costs (sum of lines 50 and 51) 0.52.00 Pass trained in the service of services (sum of lines 50 and 51) 0.52.00 0.52.		<u> </u>						
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program inpatient routine services (from West. D., sum of Parts I and 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D., sum of Parts III 52.00 Total Program incutudable cost (sum of lines 50 and 51) 53.00 Total Program incutudable cost (sum of lines 50 and 51) 53.00 Total Program incutudable cost (sum of lines 50 and 51) 53.00 Total Program incutudable cost (sum of lines 50 and 51) 54.00 Program discharges 60.00 Total Program discharges 70.00 Total IIII (SUMPLIAN) 70.00 Total College and Sumplian (sumplian) 70.00 Total Program discharges 70.00 Total College and Sumplian (sumplian) 70.00 Medicare swing-bed SMF (inpatient routine costs through December 31 of the cost reporting period (see Instructions) 70.00 Medicare swing-bed SMF (inpatient routine costs through December 31 of the cost reporting period (see Instructions) 70.00 Medicare swing-bed SMF (inpatient routine costs (line 64 plus line 65) (title XVIII only). For College and SMF (inpatient routine costs (line 64 plus line 65) (title XVIII only). For College and SMF (inpatient routine costs (line 67 plus III) (see Instructions). SMF (inpatient routine costs (line 67 plus III) (see I					ons)			1
III) Sas through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 0 51. and IV) St. 00 Total Program excludable cost (sum of lines 50 and 51) 0 52. 00 Total Program inpatient operating cost excluding capital related. non-physician anesthetist, and 0 53. needical education costs (line 49 minus line 52)	49.00		41 (111 Ough 46) (see mstructi	ulis)		1, 155, 576	49.00
51.00 Pass through costs applicable to Program Inpatient ancillary services (from West. D. sum of Parts II and IIV) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) ### ACCOUNT CONTROL OF THE PROGRAM AND ADDRESS (line 49 minus line 52) ### ACCOUNT CONTROL OF THE PROGRAM AND ADDRESS (line 49 minus line 52) ### ACCOUNT CONTROL OF THE PROGRAM AND ADDRESS (line 50 minus line 53) ### ACCOUNT CONTROL OF THE PROGRAM AND ADDRESS (line 50 minus line 53) ### ACCOUNT CONTROL OF THE PROGRAM AND ADDRESS (line 50 minus line 53) ### ACCOUNT CONTROL OF THE PROGRAM AND ADDRESS (line 53 minus line 53) ### ACCOUNT CONTROL OF THE PROGRAM AND ADDRESS (line 53 minus line 53) ### ACCOUNT CONTROL OF THE PROGRAM AND ADDRESS (line 53 minus line 53) ### ACCOUNT CONTROL OF THE PROGRAM AND ADDRESS (line 53 minus line 63 min	50. 00	1	atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	0	50.00
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(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost (see instructions) 83.84.00 Program inpatient accillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) 85.00 Drotal Program inpatient operating costs (sum of lines 83 through 85) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 87.00 Total observation bed days (see instructions) 88.00 Total observation bed days (see instructions)	69 00		o costs after D	ocombor 21 of	the cost ron	orting poriod	_	69 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 9 x line 76) 77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 70. 01 Inpatient routine service cost per diem limitation 10 Inpatient routine service cost limitation (line 78 minus line 79) 80. 01 Reasonable inpatient routine service costs (see instructions) 81. 00 Reasonable inpatient ancillary services (see instructions) 82. 00 Utilization review - physician compensation (see instructions) 82. 00 Program inpatient ancillary services (see instructions) 83. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions)	00.00		e costs after b	ecember 31 or	the cost rep	or tring perrou		08.00
70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 + line 2) 77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions) 87. 00 Total observation bed days (see instructions) 88. 87. 00 Total observation bed days (see instructions)	69. 00						0	69. 00
Program routine service cost (line 9 x line 71) 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 18.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine services (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Total observation bed days (see instructions) 88.00 Total observation bed days (see instructions)	70. 00)		70.00
73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 ÷ line 2) 77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 01 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine service costs (see instructions) 83. 00 Reasonable inpatient ancillary services (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions) 87. 00 Total observation bed days (see instructions)				ine 70 ÷ line	2)			71.00
Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 + line 2) 77. 00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 70. 10 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine services (see instructions) 83. 00 Program inpatient ancillary services (see instructions) 84. 00 Utilization review - physician compensation (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions) 88.		,	,	(line 14 x l	ine 35)			72. 00 73. 00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.		Total Program general inpatient routine serv	ice costs (line	72 + line 73)			74.00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.	75. 00		routine service	costs (from	Worksheet B,	Part II, column		75.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.01 Inpatient routine service cost limitation (line 9 x line 81) 82.02 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 87.00 Total observation bed days (see instructions) 88.00 Total observation bed days (see instructions) 89.00 Total observation bed days (see instructions) 89.00 Total observation bed days (see instructions) 89.00 Total observation bed days (see instructions)		Per diem capital-related costs (line 75 ÷ li	,					76.00
79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions) 88. 87.								77. 00 78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.		,		rovi der recor	ds)			79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.				ost limitatio	n (line 78 mi	nus line 79)		80. 00 81. 00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 83. 84. 85. 86. 85. 86. 86. 87. 88. 88. 88. 88. 88. 88. 88. 88. 88)				82.00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88. 88. 88. 88. 88. 88. 88. 88. 88. 88	83.00	Reasonable inpatient routine service costs (see instruction	* .				83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 86. 87.00 Total observation bed days (see instructions)				ns)				84. 00 85. 00
87.00 Total observation bed days (see instructions) 633 87.		Total Program inpatient operating costs (sum	of lines 83 th					86.00
	87 ∩∩						633	87.00
	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 322. 92	88. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 837,408 89.	89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				837, 408	89.00

Health Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2018 To 09/30/2019		pared: 1 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	206, 167	3, 970, 811	0. 05192	837, 408	43, 479	90.00
91.00 Nursing School cost	0	3, 970, 811	0.00000	00 837, 408	0	91.00
92.00 Allied health cost	0	3, 970, 811	0.00000	00 837, 408	0	92.00
93.00 All other Medical Education	0	3, 970, 811	0. 00000	837, 408	0	93.00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1319	Peri od: From 10/01/2018		
		To 09/30/2019	Date/Time Prep 2/25/2020 4:2	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

		Ti tle XIX	Hospi tal	2/25/2020 4: 2 Cost	1 pm
	Cost Center Description	THE AIR	поэрт саг		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 663	•
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed days)	<i>y</i> ,	sivata room dave	1, 513 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pr	i vate i oom days,		3.00
4.00	Semi-private room days (excluding swing-bed and observation b			880	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	1, 417	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 ,		,	
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	733	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	dayo, area boombor e		, 55	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	15	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private m	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		com days)		10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
12.00	through December 31 of the cost reporting period	A only (Therduring privat	te room days)		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 y Medically necessary private room days applicable to the Progr			0	14.00
15. 00		all (excluding swing-bed	uays)	0	1
	Nursery days (title V or XIX only)			0	
47.00	SWING BED ADJUSTMENT	I be a selection of	C 11.		1 4 7 00
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 d	or the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of 1	the cost	0.00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	3, 970, 811 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost report	ing period (inte		22.00
23. 00		31 of the cost reportin	ng period (line 6	0	23. 00
24 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 21 of the cost reporti	ng poriod (line	0	24.00
24.00	7 x line 19)	1 31 01 the cost reporti	ng perrou (Trie		24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			1 020 241	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 920, 361 2, 050, 450	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(=		_,,	
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	1
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0 0	
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	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nus lino 22) (soo instru	stions)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		. (1 0115)	0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	·/		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 050, 450	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 355. 23	
39.00	Program general inpatient routine service cost (line 9 x line	•		20, 328	
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 20, 328	40. 00 41. 00
	, 5 5 , 1 , 2 , 2 , 2 , 2 , 2 , 2 , 2 , 2 , 2	,			

	Financial Systems	GIBSON GENERA				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-1319	Peri od: From 10/01/2018		
			T	VI V	To 09/30/2019	2/25/2020 4: 2	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT	162, 983	88	1, 852. 0	0 8	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	<u> </u>		2 11 200			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		20, 055 40, 383	1
FO 00	PASS THROUGH COST ADJUSTMENTS	-+!++!		WI+ D	£ Danta I		FO 00
50. 00	Pass through costs applicable to Program inp	attent routine	services (Tro	m wkst. D, Su	m or Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	ysician anest	hetist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	J2)					
	Program discharges Target amount per discharge					0 00	54. 00 55. 00
56.00	Target amount (line 54 x line 55)					0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (line 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	· ·	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. ur	odated by the	market basket		0.00	60.00
	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of	the amount by	0	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)						0	
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	o costs through	Docombor 21	of the cost r	operting period	0	67. 00
07.00	(line 12 x line 19)	e costs through	i becember 31	or the cost i	eporting perrod		07.00
68. 00							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		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x l	ine 35)			72. 00 73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Dort II column		74. 00 75. 00
75.00	26, line 45)	routine service	e costs (110m	worksneet b,	Part II, Corumni		75.00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on		(70			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					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	: line 2)			633 1, 355. 22	1
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions))			857, 854	89. 00

Health Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2018 To 09/30/2019		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	206, 167	3, 970, 811	0. 05192	1 857, 854	44, 541	90.00
91.00 Nursing School cost	0	3, 970, 811	0.00000	0 857, 854	0	91.00
92.00 Allied health cost	0	3, 970, 811	0.00000	0 857, 854	0	92.00
93.00 All other Medical Education	0	3, 970, 811	0. 00000	0 857, 854	0	93. 00

Health Financial S	ystems GIBSON GENERA	I HUSDI TVI		In Lie	u of Form CMS-2	2552 10
	RY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1319	Peri od: From 10/01/2018 To 09/30/2019	Worksheet D-3	
					2/25/2020 4: 2	
		Title	XVIII	Hospi tal	Cost	
Cost (Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1 00	0.00	col . 2)	
I NDATI ENT. D	OUTLINE CERVICE COCT CENTERS		1. 00	2. 00	3. 00	
	OUTINE SERVICE COST CENTERS		ı	4/4 000		00.00
	S & PEDIATRICS			461, 880 44, 965		30.00
31. 00 03100 I NTENS	ERVICE COST CENTERS			44, 900		31.00
50. 00 05000 OPERAT			0. 42089	94 42, 167	17, 748	50.00
	LOGY-DI AGNOSTI C		0. 2314	· ·		
	AR MEDICINE-DIAGNOSTIC		0. 64034	· ·		
60. 00 06000 LABORA			0. 3870			
	BLOOD & PACKED RED BLOOD CELLS		0. 88299			
	RATORY THERAPY		0. 42086			
66. 00 06600 PHYSI (CAL THERAPY		0. 30848			66.00
67. 00 06700 OCCUPA	ATI ONAL THERAPY		0. 2716	54 22, 384	6, 081	67.00
68. 00 06800 SPEECH	I PATHOLOGY		0. 2568	18 7, 824	2, 009	68. 00
69. 00 06900 ELECTF			0.00000			69. 00
	AL SUPPLIES CHARGED TO PATIENT		1. 15240		106, 134	71.00
	DEV. CHARGED TO PATIENTS		0. 96685		0	72.00
	CHARGED TO PATIENTS		0. 5121		98, 191	73.00
76. 00 03480 I NFUSI			1. 02212	24 0	0	76.00
	SERVI CE COST CENTERS		0.0000	20		00.00
88. 00 08800 RURAL 90. 00 09000 CLI NI (HEALTH CLINIC		0.00000		0	88.00
90. 00 09000 CLI NI C			0. 00000 0. 35956		0	90. 00 90. 01
90. 01 09001 DI ABE			0. 35950		0	90.01
90. 03 09002 OF P31			0. 3135		0	90.02
91. 00 09100 EMERGE			0. 58534			
	/ATION BEDS (NON-DISTINCT PART		1. 0824			
	(sum of lines 50 through 94 and 96 through 98)		1.0024	895, 926		
	PBP Clinic Laboratory Services-Program only charg	ges (line 61)		075, 720		201.00
	narges (line 200 minus line 201)	3 (51)		895, 926	l .	202.00
, ,				•	<u>-</u>	•

Health Financial Systems GI	BSON GENERAL HOSPITAL		In Lie	u of Form CMS-2	2552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CO	CN: 15-1319	Peri od:	Worksheet D-3	
	C		From 10/01/2018		
	Component	CCN: 15-Z319	To 09/30/2019	Date/Time Pre 2/25/2020 4:2	
	Title	XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2, 00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 NTENSI VE CARE UNI T			0	1	31.00
ANCILLARY SERVICE COST CENTERS			<u>'</u>		1
50. 00 05000 OPERATING ROOM		0. 42089			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23149			
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 64034			
60. 00 06000 LABORATORY		0. 38706			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	•	0. 88299			
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 42086 0. 30848			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 30848			
68. 00 06800 SPEECH PATHOLOGY		0. 27103			
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0,000	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 15240			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 96685	5 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 51216		139, 573	
76.00 03480 INFUSION THERAPY		1. 02212	4 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			_1		
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
90. 00 09000 CLI NI C 90. 01 09001 DI ABETES	•	0. 00000 0. 35956		0	
90. 01 09001 DEABETES 90. 02 09002 OP PSYCH		0. 00000		0	
90. 03 09003 PALN MANAGEMENT		0. 31355		0	
91. 00 09100 EMERGENCY		0. 51533		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 08247		Ō	
200.00 Total (sum of lines 50 through 94 and 96 th	hrough 98)		1, 489, 108	634, 683	
201.00 Less PBP Clinic Laboratory Services-Program	m only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			1, 489, 108		202.00

Health Financial Systems	GIBSON GENERAL HOSPITAL		In Lio	u of Form CMS-:	2552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Ci		Period: From 10/01/2018 To 09/30/2019	Worksheet D-3	pared:
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			15.000		
30. 00 03000 ADULTS & PEDI ATRI CS			15, 068		30.00
31. 00 03100 I NTENSI VE CARE UNIT ANCI LLARY SERVI CE COST CENTERS			1, 908		31.00
50. 00 05000 OPERATING ROOM		0. 42089	4 6, 583	2, 771	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23149		1, 883	
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 64034		398	
60. 00 06000 LABORATORY		0. 38706	9 18, 197	7, 043	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 88299	2 347	306	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 42086		3, 409	
66. 00 06600 PHYSI CAL THERAPY		0. 30848		166	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 27165		0	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 25681		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 15240		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 96685 0. 51216		0	72. 00 73. 00
76. 00 03480 NFUSION THERAPY		1. 02212		0	76.00
OUTPATIENT SERVICE COST CENTERS		1.02212	4 0	U	70.00
88. 00 08800 RURAL HEALTH CLINIC		1, 50993	7 0	0	88.00
90. 00 09000 CLINIC		0.00000		Ö	90.00
90. 01 09001 DI ABETES		0. 35956	8 0	0	90. 01
90. 02 09002 OP PSYCH		0.00000	0 0	0	90. 02
90. 03 09003 PAI N MANAGEMENT		0. 31355	4 0	0	90. 03
91. 00 09100 EMERGENCY		0. 58534	4 6, 968	4, 079	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 08247	9 0	0	92.00
200.00 Total (sum of lines 50 through 94 and			49, 490	20, 055	
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		l	49, 490		202. 00

Health Financial Systems	GI BSON GENERAL HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1319		Worksheet E Part B Date/Time Prepared: 2/25/2020 4:21 pm

			10 09/30/2019	2/25/2020 4: 2	
		Title XVIII	Hospi tal	Cost	
				1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			, 000 F0/	1 00
1.00	Medical and other services (see instructions)	+i ono)		6, 032, 596	1
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	tions)		0	
4. 00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	5.00
6. 00	Line 2 times line 5			0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7.00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10. 00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 032, 596	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12. 00	Reasonable charges Ancillary service charges			0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	The 07)		0	
00	Customary charges				1 00
15. 00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable fo	r payment for services o	on a chargebasis	0	16. 00
	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)			0. 000000	
18.00	Total customary charges (see instructions)	l ! & l! 10	11) (0	
19. 00	Excess of customary charges over reasonable cost (complete on instructions)	ry ir fine 18 exceeds fi	ne II) (see	0	19.00
20. 00	Excess of reasonable cost over customary charges (complete on	lv if line 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)	ry in time in exceeds in	110 10) (300		20.00
21. 00	Lesser of cost or charges (see instructions)			6, 092, 922	21.00
22. 00	Interns and residents (see instructions)			0	1
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instruction	•		45, 808	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on lin	•		2, 358, 877	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of fittes 22	z anu zsj (see	3, 688, 237	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			3, 688, 237	30.00
31. 00	Primary payer payments			5, 518	31.00
32. 00	Subtotal (line 30 minus line 31)			3, 682, 719	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0 339, 957	33.00
35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			220, 972	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		320, 230	
	Subtotal (see instructions)	r de trons,		3, 903, 691	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instrud	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			3, 903, 691	1
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			78, 074 0	1
41. 00	Interim payments			3, 879, 732	
42. 00	Tentative settlement (for contractors use only)			0,077,702	42.00
43. 00	Balance due provider/program (see instructions)			-54, 115	
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2]
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	1
93. 00 94. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
, 1. 00	10ta. (3am 01 111100 /1 and 70)		ļ	0	, , , , , , ,

Health Financial Systems GIBS ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 10/01/2018 | Part | To 09/30/2019 | Date/Time Prepared: Provi der CCN: 15-1319

				0 09/30/2019	2/25/2020 4:2	
		Title	XVIII	Hospi tal	Cost	. p
			t Part A		t B	
		/- - /	A	/- - /	A	
		mm/dd/yyyy	Amount 2.00	mm/dd/yyyy 3.00	Amount	
1. 00	Total interim payments paid to provider	1. 00	1, 105, 891		4. 00 3, 812, 432	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		(0	2. 00
3. 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)					3. 00
	Program to Provider					
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVIDER)))	67, 300 0 0 0	3. 01 3. 02 3. 03 3. 04 3. 05
	Provider to Program					
3. 50 3. 51 3. 52 3. 53	ADJUSTMENTS TO PROGRAM		())	0 0 0	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)		(0 67, 300	3. 54 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, 105, 891		3, 879, 732	4.00
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
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
F 04	Program to Provider TENTATIVE TO PROVIDER			J		F 04
5. 01 5. 02 5. 03	TENTATIVE TO PROVIDER		(0 0 0	5. 01 5. 02 5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	5. 52 5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER				ol	6. 01
6. 02	SETTLEMENT TO PROGRAM		129, 652	1	54, 115	6. 02
7. 00	Total Medicare program liability (see instructions)	•	976, 239		3, 825, 617	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
	In the second second	()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financial Systems GIBS ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Title XVIII Swing Beds - SNF Cost	pm
mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.02 3.03 3.04	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 3.03 3.04	1.00
submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 3.02 3.03 3.04	2.00
services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 0 3.02 3.03 0 0 0 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) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 0 3.02 3.03 3.04	
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 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 0 3.02 3.03 0 0 0 0 0	
for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 ADJUSTMENTS TO PROVIDER 0 0 0 3. 02 3. 03 3. 04 0 0 0 0	3.00
payment. If none, write "NONE" or enter a zero. (1)	
Program to Provider	
3. 01 ADJUSTMENTS TO PROVI DER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
3. 02 3. 03 3. 04	
3. 03 3. 04	3. 01
3.04	3. 02
	3.03
	3.04
	3. 05
Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0	3. 50
3.51 ADJOSTMENTS TO TROOKAW	3. 51
3.52	3. 52
3.53	3. 53
3.54	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0	3. 99
3. 50-3. 98)	
4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,767,314 0	4.00
(transfer to Wkst. E or Wkst. E-3, line and column as	
appropri ate)	
TO BE COMPLETED BY CONTRACTOR	г оо
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none,	5.00
write "NONE" or enter a zero. (1)	
Program to Provi der	
- · · · · · · · · · · · · · · · · · · ·	5. 01
5. 02	5. 02
5.03	5.03
Provider to Program	
	5.50
5.51	5. 51
5.52	5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0	5. 99
5. 50-5. 98)	, 00
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
	7. 00
Contractor NPR Date	
Number (Mo/Day/Yr)	
0 1.00 2.00	
8.00 Name of Contractor	8. 00

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu					2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1319 Period: Workshop From 10/01/2018 Part					
	To 09/30/2019 Date/Time Prej					
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N			1	
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	S-3, Pt. I col. 15 lin	e 14		1.00	
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
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	line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00	

Health Financial Systems	GI BSON GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-1319		Worksheet E-2
			From 10/01/2018	
		Component CCN: 15-Z319	To 09/30/2019	Date/Time Prepared:
		•		2/25/2020 4: 21 pm
		Title XVIII	Swing Reds - SNE	Cost

				2/25/2020 4: 2	1 pm
		Title XVIII S	wing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		1, 893, 324	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		/ 44 000	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A		641, 030	0	3. 00
4. 00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instr	•		0. 00	4. 00
4.00	Per diem cost for interns and residents not in approved teaching instructions)	program (see		0.00	4.00
5. 00	Program days		1, 417	0	5. 00
6. 00	Interns and residents not in approved teaching program (see inst	ructions)	1, 417	0	6.00
7. 00	Utilization review - physician compensation - SNF optional metho		0	O	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	a 5 y	2, 534, 354	0	8.00
9. 00	Primary payer payments (see instructions)		2, 001, 001	0	9. 00
10. 00	Subtotal (line 8 minus line 9)		2, 534, 354	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicab	Le to physician	2, 00 1, 00 1	0	11.00
11.00	professional services)	re to physician	١	O	11.00
12. 00	Subtotal (line 10 minus line 11)		2, 534, 354	0	12.00
	Coinsurance billed to program patients (from provider records) (excl ude coi nsurance	15, 318	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)		2, 519, 036	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 Demonstrat	ion) payment	0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	0	0	18. 00
	Total (see instructions)		2, 519, 036	0	19. 00
	Sequestration adjustment (see instructions)		50, 381	0	19. 01
	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
	Interim payments		2, 767, 314	0	20.00
	Tentative settlement (for contractor use only)		0	0	21. 00
	Balance due provider/program (line 19 minus lines 19.01, 20, and		-298, 659	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
000 00	Rural Community Hospital Demonstration Project (§410A Demonstrat				000 00
200.00	Is this the first year of the current 5-year demonstration perio	a under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from Wks	+ D 1 D+ II lino			201 00
201.00	66 (title XVIII hospital))	t. D-1, Pt. 11, Tine			201. 00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from W	kst D_3 col 3 line			202. 00
202.00	200 (title XVIII swing-bed SNF))	K31. D-3, COI. 3, ITHE			202.00
203 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
201.00	Computation of Demonstration Target Amount Limitation (N/A in fi	rst year of the curren	t 5-vear demons		
	peri od)	or your or the our ran	t o your domono		
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time	s line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem		'		
207.00	Program reimbursement under the §410A Demonstration (see instruc				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	•			208. 00
	and 3)				
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209. 00
	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see		·	215. 00
	instructions)				

Health Financial Systems	GIBSON GENERAL H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1319	Peri od: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Pre 2/25/2020 4:2	pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
PART V - CALCULATION OF REIMBURSEMENT SE	TTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT		

-		Title XVIII	Hospi tal	Cost	Грііі		
			110001 141	0001			
				1. 00			
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT	11.00			
1. 00	Inpatient services			1, 155, 376	1.00		
2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	•		
3. 00	Organ acquisition	,		Ō			
4. 00	Subtotal (sum of lines 1 through 3)			1, 155, 376			
5. 00	Primary payer payments			0	5.00		
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 166, 930			
	COMPUTATION OF LESSER OF COST OR CHARGES						
	Reasonable charges						
7.00	Routi ne servi ce charges			0	7.00		
8.00	Ancillary service charges			0	8.00		
9.00	Organ acquisition charges, net of revenue			0	9.00		
10.00	Total reasonable charges		0	10.00			
	Customary charges						
11.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	11.00		
12.00	Amounts that would have been realized from patients liable for	r payment for services o	n a charge basis	0	12.00		
	had such payment been made in accordance with 42 CFR 413.13(e	2)					
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00				
14.00	Total customary charges (see instructions)		0	14.00			
15.00							
	instructions)						
16. 00							
	instructions)						
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00		
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				40.00		
18.00	Direct graduate medical education payments (from Worksheet E-	4, IIne 49)		0			
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 166, 930			
20.00	Deductibles (exclude professional component)			180, 058	•		
21. 00	Excess reasonable cost (from line 16)			0 00 072			
22. 00	Subtotal (line 19 minus line 20 and 21) Coinsurance			986, 872 0			
23. 00 24. 00				986, 872			
25.00	Subtotal (line 22 minus line 23) Allowable bad debts (exclude bad debts for professional servi	cos) (cos instructions)		14, 293			
26. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see Histi uctions)		9, 290			
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		12, 061			
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	ructions)		996, 162			
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			990, 102			
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	ie)					
29. 99	Demonstration payment adjustment amount before sequestration	13)		0	29. 99		
30.00	Subtotal (see instructions)			996, 162			
30. 01	Sequestration adjustment (see instructions)			19, 923			
30. 02	Demonstration payment adjustment amount after sequestration			0	•		
31. 00	Interim payments			1, 105, 891			
32. 00	Tentative settlement (for contractor use only)			1, 103, 071			
33. 00	,						
34. 00							
2 30	§115. 2		1		34.00		
	•			•	•		

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1319	From 10/01/2018	Worksheet E-3 Part VII Date/Time Prepared: 2/25/2020 4:21 pm		

		٦	o 09/30/2019	Date/Time Pre 2/25/2020 4:2	
		Title XIX	Hospi tal	Cost	ı pııı
			Inpatient	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES	· · · · · · · · · · · · · · · · · · ·			
1.00	Inpatient hospital/SNF/NF services		40, 383		1.00
2. 00	Medical and other services		12,000	0	2.00
3. 00	Organ acquisition (certified transplant centers only)		0	Ü	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		40, 383	0	4.00
5. 00	Inpatient primary payer payments		0	Ü	5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		40, 383	0	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		107 000		,,,,,
	Reasonable Charges				
8. 00	Routine service charges		16, 976		8.00
9. 00	Ancillary service charges		49, 490	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		66, 466	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	0	0	13.00	
	basis				
14.00	Amounts that would have been realized from patients liable for	0	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	
	Total customary charges (see instructions)		66, 466	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	26, 083	0	17. 00	
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds line	0	0	18. 00
40.00	16) (see instructions)				40.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	•	40, 202	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 10		40, 383	0	21. 00
22. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of Other than outlier payments	compreted for PPS provid	0	0	22.00
23. 00	Outlier payments		0	0	23. 00
24. 00			0	U	24.00
	Program capital payments 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)		o	0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)		40, 383	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		40, 303		27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		40, 383	0	31.00
	Deductibles		0	0	32.00
33. 00	Coinsurance		0	0	33.00
34. 00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review	0		35.00	
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	40, 383	0	36.00	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00	
	Subtotal (line 36 ± line 37)	40, 383	0	38. 00	
	Direct graduate medical education payments (from Wkst. E-4)	0		39. 00	
	Total amount payable to the provider (sum of lines 38 and 39)	40, 383	0	40.00	
41.00	Interim payments	19, 808	0	41.00	
42.00	Balance due provider/program (line 40 minus line 41)	20, 575	0	42.00	
43.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

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

Provi der CCN: 15-1319

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	, p
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5, 582, 823	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	5, 337, 816	0	0	0	3. 00 4. 00
5. 00	Other recei vable	396, 345		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	l .	-	0	_	6.00
7.00	Inventory	689, 106		0	0	7.00
8.00	Prepai d expenses	703, 024		0	0	8. 00
9. 00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	10, 640, 201	0	0	0	11.00
12. 00	Land	421, 244	0	0	0	12.00
13. 00	Land improvements	258, 790		0		ł
14.00	Accumulated depreciation	-186, 255	0	0	0	14.00
15.00	Bui I di ngs	19, 828, 965		0	0	15.00
16. 00	· ·	-12, 664, 921	0	0	0	16.00
17.00	•	0	0	0	0	17.00
	Accumulated depreciation Fixed equipment	5, 676, 469	0	0	0	18. 00 19. 00
20.00	Accumulated depreciation	-3, 412, 250		0	0	20.00
21. 00		0, 412, 230	Ö	0	_	21.00
22. 00		0	Ö	0	0	22.00
23.00	Maj or movable equipment	10, 612, 304	0	0	0	23.00
24.00		-8, 312, 826		0	0	24.00
25. 00		951, 216		0	0	25.00
26.00	Accumulated depreciation	-629, 543	0	0	0	26.00
28.00	HIT designated Assets Accumulated depreciation	0	0	0	0	27. 00 28. 00
	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.00
30.00		12, 543, 193		0	-	•
	OTHER ASSETS	12/2/2/	-1			
31.00	Investments	1, 618, 629	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00		0	0	0	0	33.00
34.00	Other assets	1 (10 (20	0	0	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	1, 618, 629 24, 802, 023	0	0	-	ł
30.00	CURRENT LIABILITIES	24,002,023	9			30.00
37.00		1, 252, 578	0	0	0	37.00
38.00		1, 650, 336	0	0	0	38. 00
	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	176, 874		0	0	40.00
	Deferred income	0	0	0	0	
42. 00 43. 00	Accel erated payments Due to other funds	0	0	0	0	42. 00 43. 00
	Other current liabilities	2, 338, 963		0		
	Total current liabilities (sum of lines 37 thru 44)	5, 418, 751		0		ı
	LONG TERM LIABILITIES		·			
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	9, 100, 267	0	0	0	
48. 00	Unsecured Loans	0	0	0	0	
	Other long term liabilities	0 100 277	0	0	0	
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	9, 100, 267 14, 519, 018		0		
31.00	CAPITAL ACCOUNTS	14, 317, 016	<u> </u>		0	31.00
52.00		10, 283, 005				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00				0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
58. 00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	10, 283, 005	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	24, 802, 023		0	0	60.00
	59)					

Provider CCN: 15-1319

| Peri od: | Worksheet G-1 | From 10/01/2018 | To 09/30/2019 | Date/Time Prepared:

					10	09/30/2019	2/25/2020 4:2	
		General	Fund	Speci al	Pui	rpose Fund	Endowment	
				·		•	Fund	
		1. 00	2. 00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period		10, 248, 421			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		34, 584					2.00
3.00	Total (sum of line 1 and line 2)		10, 283, 005			0		3. 00
4. 00	Additions (credit adjustments) (specify)	0			0		0	4.00
5.00		0			0		0	
6.00		0			0		0	
7. 00 8. 00		0			0		0	
9. 00		0			0		0	
10.00	Total additions (sum of line 4-9)	U	0		٥	0	U	10.00
11. 00	Subtotal (line 3 plus line 10)		10, 283, 005			0		11.00
12. 00	Deductions (debit adjustments) (specify)	0	10, 200, 000		0	Ĭ	0	
13. 00	bedaetrens (assi t day astmorres) (speer ry)	0			0		0	
14. 00		0			0		0	
15. 00		0			0		0	15.00
16.00		0			0		0	16.00
17.00		0			0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		10, 283, 005			0		19. 00
	sheet (line 11 minus line 18)							
		Endowment	PI ant	Fund				
		Fund						
		6. 00	7. 00	8.00				
1. 00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00			0					5. 00
6.00			0					6. 00
7.00			0					7.00
8.00			0					8.00
9.00	T-1-1 - 11111 (6 11 4 0)		0					9.00
10.00	Total additions (sum of line 4-9)	0			0			10. 00 11. 00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	U	0		U			12.00
13.00	beductions (debit adjustments) (specify)		0					13.00
14. 00			0					14.00
15. 00			0					15.00
16. 00			0					16.00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)	О	_		0			18.00
19.00	Fund balance at end of period per balance	О			0			19. 00
	sheet (line 11 minus line 18)							

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1319

			То	09/30/2019	Date/Time Prep 2/25/2020 4:2	
	Cost Center Description	I npati en	+	Outpati ent	Total	ı pili
	oust defited beschiption	1.00		2.00	3. 00	
	PART I - PATIENT REVENUES	100		2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	2, 480,	793		2, 480, 793	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					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		0		0	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)	2, 480,	793		2, 480, 793	10.00
44 00	Intensive Care Type Inpatient Hospital Services	101			101 ((0	44 00
11.00	INTENSIVE CARE UNIT	101,	660		101, 660	11.00
12.00	CORONARY CARE UNIT					12.00
13. 00 14. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT					13. 00 14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16.00	Total intensive care type inpatient hospital services (sum of li	nes 101,	660		101, 660	16. 00
10.00	11-15)	nes lot,	000		101,000	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2, 582,	453		2, 582, 453	17. 00
18. 00	Ancillary services	4, 545,		35, 179, 837	39, 725, 178	18. 00
19.00	Outpatient services	239,		9, 682, 616	9, 921, 718	19.00
20.00	RURAL HEALTH CLINIC		0	268, 843	268, 843	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	O	0	21.00
22.00	HOME HEALTH AGENCY			766, 887	766, 887	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26. 00	HOSPI CE					26.00
27. 00	MOB		406	6, 286, 542	6, 285, 136	27. 00
27. 01	SNF PERRY CO	988,		0	988, 353	27. 01
27. 02	PRO FEES		0	927, 093	927, 093	27. 02
27. 03	PROFESSI ONAL		465	545, 906	547, 371	27. 03
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to G-3, line 1)	Wkst. 8,355,	308	53, 657, 724	62, 013, 032	28. 00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			33, 115, 101		29. 00
30.00	ADD (SPECIFY)		0	00, 110, 101		30.00
31. 00	(6. 26.1.1)		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)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38.00
39. 00			0			39.00
40.00			0			40.00
41.00	Total daductions (com of lines 07 44)		0			41.00
42.00	Total deductions (sum of lines 37-41)	(transfor		22 115 101		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42) to Wkst. G-3, line 4)	(ri alisi ei		33, 115, 101		43.00
	10 mcst. 0-0, 1116 4)	I	1	ı	ı	

	n Financial Systems GIBSON GENERAL			u of Form CMS-2				
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1319	Peri od:	Worksheet G-3				
			From 10/01/2018 To 09/30/2019	Date/Time Pre	narod:			
			10 07/30/2017	2/25/2020 4: 2				
				1. 00				
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		62, 013, 032	1.00			
2.00	Less contractual allowances and discounts on patients' accou	unts		29, 589, 666	2.00			
3.00	Net patient revenues (line 1 minus line 2)			32, 423, 366	3.00			
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		33, 115, 101	4.00			
5.00	Net income from service to patients (line 3 minus line 4)			-691, 735	5.00			
	OTHER I NCOME							
6.00	Contributions, donations, bequests, etc			392, 083 115, 553	1			
7.00								
	8.00 Revenues from telephone and other miscellaneous communication services							
	9.00 Revenue from television and radio service							
10.00	Purchase di scounts			0				
11. 00	Rebates and refunds of expenses			0				
12.00				0				
13. 00	,			0				
14. 00	1			145, 585				
15. 00	3 1				15.00			
16. 00	3	than patients		0				
17. 00	9			0				
18. 00				0				
19. 00	, , , , , , , , , , , , , , , , , , , ,			0				
20. 00	3			0	20.00			
21. 00	9			0	21. 00			
22. 00				69, 933				
23. 00				0	23. 00			
	MI SC I NCOME			·	24. 00			
	Total other income (sum of lines 6-24)		726, 319	1				
	Total (line 5 plus line 25)			34, 584	1			
	OTHER EXPENSES (SPECIFY)			0				
28 00	Intal other evenence (sum of line 27 and subscripts)			Λ	28 00			

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

28.00 0 34, 584 29. 00

0

18, 880

0

639, 561

0

0

639, 561

23.50

24.00

Tel emedi ci ne

24.00 Total (sum of lines 1-23)

23.50

Heal th	Financial Systems		GIBSON GENERAL	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provider C	CN: 15-1319 15-7445	Peri od: From 10/01/2018 To 09/30/2019	Worksheet H-1 Part I	pared:
						Home Health Agency I	PPS	т рііі
			Capital Rela	ited Costs		Agency		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation 8 Maintenance		Subtotal (cols. 0-4)	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3.00	4. 00	4A. 00	
1. 00	Capital Related - Bldg. &	0	0				0	1.00
2. 00	Fixtures Capital Related - Movable	O		0			0	2.00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3. 00
4.00	Transportati on	o o	O	Ö		0 0	_	4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	247, 424	0	0		0 0	247, 424	5.00
6. 00 7. 00	Skilled Nursing Care	284, 901	0	0	1	0 0	284, 901	1
8. 00	Physical Therapy Occupational Therapy	56, 081 11, 008	0	0	1	0 0	56, 081 11, 008	
9. 00 10. 00	Speech Pathology Medical Social Services	2, 761 0	0	0	1	0 0	2, 761 0	ı
11. 00	Home Health Aide	37, 386	O	0		0 0	37, 386	11. 00
12. 00 13. 00	Supplies (see instructions) Drugs	0	0	0		0 0	0	
14.00	DME	0	0	0	1	0 0	0	ı
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0	l .	0 0	0	
18. 00	Clinic	0	0	0		0 0	0	18. 00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
21. 00	Home Delivered Meals Program	Ö	Ö	0		0 0	0	21. 00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	
23. 50	Tel emedi ci ne	0	0	0	1	0 0	0	23. 50
24.00	Total (sum of lines 1-23)	639, 561 Admi ni strati v	Total (cols.	0		0 0	639, 561	24.00
		e & General 5.00	4A + 5) 6.00					
1 00	GENERAL SERVICE COST CENTERS	1	0.00					1.00
1. 00	Capital Related - Bldg. & Fixtures							1.00
2. 00	Capital Related - Movable Equipment							2.00
3. 00	Plant Operation & Maintenance							3. 00
4. 00 5. 00	Transportation Administrative and General	247, 424						4. 00 5. 00
	HHA REIMBURSABLE SERVICES Skilled Nursing Care		141 442					
6. 00 7. 00	Physi cal Therapy	179, 762 35, 385	464, 663 91, 466					6. 00 7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	6, 946 1, 742	17, 954 4, 503					8. 00 9. 00
10.00	Medical Social Services	0	0					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	23, 589	60, 975 0					11. 00 12. 00
13.00	Drugs	0	О					13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 00 16. 00
17. 00	Private Duty Nursing	0	0					17. 00
18. 00 19. 00	Clinic Health Promotion Activities	0	0					18. 00 19. 00
20.00	Day Care Program	0	0					20.00
21. 00 22. 00	,	0	0					21. 00 22. 00
23.00	All Others (specify) Telemedicine	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		639, 561					24. 00

lealth Financial Systems		GIBSON GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
OST ALLOCATION - HHA STATISTICAL BASIS			Provider C		Period: From 10/01/2018 To 09/30/2019	Worksheet H-1 Part II	pared:
					Home Health Agency I	PPS	
	Capi tal Rel	ated Costs					
	BI dgs & Fi xtures (SQUARE FEET)	Movabl e Equi pment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
	1. 00	2. 00	3, 00	4.00	5A. 00	5. 00	

		Capi tal Rel	ated Costs					
		BI dgs &	Movabl e	Plant	Transportatio	Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance	II (IIII EE/IOE)		(ACCUM. COST)	
		(**************************************	VALUE)	(SQUARE FEET)			(**************************************	
		1. 00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0)	0		3.00
4.00	Transportation (see	0	0	0	0			4.00
	instructions)							
5.00	Administrative and General	0	0	0	0	-247, 424	392, 137	5. 00
	HHA REIMBURSABLE SERVICES					_		
6.00	Skilled Nursing Care	0	0	0	1		284, 901	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	56, 081	7. 00
8.00	Occupational Therapy	0	0	0	0	0	11, 008	
9.00	Speech Pathology	0	0	0	0	0	2, 761	
	Medical Social Services	0	0	0	0	0	0	
	Home Health Aide	0	0	0	0	0	37, 386	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	O	12.00
13.00	Drugs	0	0	0)	0	ol	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREI MBURSABLE SERVI CES							
15. 00	Home Dialysis Aide Services	0	0	0	0	0	0	15. 00
	Respiratory Therapy	0	0	0	0	0	O	16.00
17.00	Private Duty Nursing	0	0	0	0	0	O	17.00
18.00	Clinic	0	0	0	0	0	O	18. 00
19.00	Health Promotion Activities	0	0	0	0	0	ol	19. 00
	Day Care Program	0	0	0	0	0	ol	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	ol	21.00
22.00	Homemaker Service	0	0	0	0	0	ol	22.00
23.00	All Others (specify)	0	0	0	0	0	ol	23.00
23. 50	Tel emedi ci ne	o	0	0	0	0	o	23. 50
24.00	Total (sum of lines 1-23)	o	0	0) o	-247, 424	392, 137	24.00
25.00	Cost To Be Allocated (per	o	0	0	0		247, 424	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.000000		0. 630963	26. 00

Peri od: Worksheet H-2
From 10/01/2018 Part I
To 09/30/2019 Date/Time Prepared: 2/25/2020 4:21 pm

Home Heal th PPS HHA CCN: 15-7445

						Home Health Agency I	PPS	
			CAPI TAL REI	ATED COSTS		Agency		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
		0	1. 00	2. 00	4. 00	4A	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 464, 663 91, 466 17, 954 4, 503 0 60, 975 0 0 0 0 0 0 0 0 0 0 0	7, 884 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	55, 987 55, 987 0 0 0 0 0 0 0 0 0 0 0 0 0	63, 871 464, 663 91, 466 17, 954 4, 503 0 60, 975 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16, 754 121, 886 23, 992 4, 710 1, 181	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00
	column 26, line 1, rounded to 6 decimal places. Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	
		7. 00	8. 00	9. 00	10. 00	11. 00	N 13. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	20, 123 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 519 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25, 867 25, 867	30, 073 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

0

0

982, 667

19.00

19.50

20 00

21.00

0

0

175, 343

0.217190

19.00

19.50

20 00

21.00

All Others (specify)

6 decimal places.

Total (sum of lines 1-19) (2)

Unit Cost Multiplier: column

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

Tel emedi ci ne

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS BASIS	TO HHA COST CENTERS STATISTICAL Provider CCN: 15-131 HHA CCN: 15-74	From 10/01/2018 Part II
		2,20,2020 1121 5

						2/23/2020 4.2	ı μιι
					Home Health Agency I	PPS	
	CAPITAL R	ELATED COSTS			Agency		
Cost Center Descri	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			SALARI ES)				
	1. 00	2. 00	4. 00	5A	5. 00	7. 00	
1.00 Administrative and Gene 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instruction 9.00 Drugs 10.00 DME	ons)	5 505 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	413, 774 0 0 0 0 0 0 0 0		464, 663 91, 466 17, 954 4, 503 0 60, 975 0 0	505 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
11. 00 Home Dialysis Aide Serv 12. 00 Respiratory Therapy 13. 00 Private Duty Nursing 14. 00 Clinic 15. 00 Health Promotion Activi 16. 00 Day Care Program 17. 00 Home Delivered Meals Pri 18. 00 Homemaker Service 19. 00 All Others (specify) 19. 50 Telemedicine 20. 00 Total (sum of lines 1-1)	ies ogram V) 50		0 0 0 0 0 0 0 0 0 0 0 413, 774		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	
21.00 Total cost to be alloca			55, 987		184, 517 0, 262310	20, 123	
22.00 Unit cost multiplier Cost Center Descri		HOUSEKEEPING (SQUARE FEET)	O. 135308 DI ETARY (PATI ENT DAYS)	CAFETERI A (GROSS SALARI ES)	NURSI NG ADMI NI STRATI O N (NURSE SALARI ES)	CENTRAL SERVI CE & SUPPLY (COSTED REQUI S.)	22.00
	8. 00	9. 00	10. 00	11. 00	13. 00	14. 00	
1.00 Administrative and Gene 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instruction 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Serv 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activi 16.00 Day Care Program 17.00 Home Delivered Meals Profile 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-1) 21.00 Total cost to be alloca	ces i es egram	0 505 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	413, 774	248, 682 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 810 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00

Health Financial Systems		GIBSON GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF GENERAL SERVICE COSTS T BASIS	O HHA COST CEN	TERS STATISTICAL	Provider HHA CCN:	CCN: 15-1319 15-7445	Peri od: From 10/01/2018 To 09/30/2019	Worksheet H-2 Part II Date/Time Pre 2/25/2020 4:2	pared:
					Home Health Agency I	PPS	
Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS PATI ENT REVENUE)					
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	15. 00 0 0 0 0 0 0 0 0 0 0 0 0	16. 00 766, 887 0 0 0 0 0 0 0 0 0 0 0 0 0					1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00 22. 00

Hoal th	Financial Systems		GI BSON GENERA	N HUSDITAI		In Lie	u of Form CMS 3	0552 10
	<u>Financial Systems</u> TONMENT OF PATLENT SERVICE COST	rs .	GI DOUN GENERA	Provider C	CN: 15_1310	Peri od:	u of Form CMS-2 Worksheet H-3	2332-10
711 1 0101	TONNENT OF TATTENT SERVICE 6031	. 3		HHA CCN:	15-7445	From 10/01/2018 To 09/30/2019	Part I Date/Time Pre	
				Title	e XVIII	Home Health Agency I	2/25/2020 4: 2° PPS	т рііі
	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	Total HHA Costs (cols 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷	
			Part I)	Part II)		4 00	col . 4)	
	DART I COMPUTATION OF LECCED	0	1.00	2.00	3.00	4.00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TI	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	Cost Per Visit Computation							
1. 00	Skilled Nursing Care	2.00			713, 9			1.00
2.00	Physi cal Therapy	3.00					89. 86	2.00
3.00	Occupational Therapy	4.00	· ·		,		89. 86	3.00
4. 00	Speech Pathology	5.00		0	6, 9		89. 86	4.00
5.00	Medical Social Services	6.00	0			0	0. 00	5.00
6.00	Home Health Aide	7. 00	93, 686		93, 68	304	308. 18	6.00
7. 00	Total (sum of lines 1-6)		982, 667	0	,02,0			7.00
					Program Visi	ts		
					P.	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to	Deducti bl es		
					Deducti bl es	&		
					Coi nsurance	;		
		0	1. 00	2. 00	3.00	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	1, 4	75		8.00
9.00	Physi cal Therapy		99915	0	9.	46		9.00
10.00	Occupational Therapy		99915	0	18	30		10.00
11.00	Speech Pathology		99915	0		23		11.00
12.00	Medical Social Services		99915	0		0		12.00
13.00	Home Health Aide		99915	0	24	40		13.00
14.00	Total (sum of lines 8-13)			0	2, 8	64		14.00
	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	Total HHA Costs (cols 1 + 2)		Ratio (col. 3 ÷ col. 4)	
		0	Part I) 1.00	Part II) 2.00	3.00	4.00	5. 00	
	Supplies and Drugs Cost Comput		1.00	2.00	3.00	4.00	5.00	
15 00	Cost of Medical Supplies	8.00	0	0		0 0	0. 000000	15 00
	Cost of Drugs	9. 00	0	0		0 0		
			Program Visits		Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	·		to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8. 00	9. 00	10. 00	11.00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TI	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	Cost Per Visit Computation							
		0	1, 475		1	0 393, 810		1.00
1. 00	Skilled Nursing Care	1				0 0 000		2.00
2.00	Physical Therapy	0	946			0 85, 008		
2. 00 3. 00		0	180			0 16, 175		3. 00
2.00	Physical Therapy Occupational Therapy Speech Pathology	0 0	180 23					
2. 00 3. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 0	180 23 0			0 16, 175 0 2, 067 0 0		3.00
2. 00 3. 00 4. 00 5. 00 6. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0 0 0	180 23 0 240			0 16, 175 0 2, 067 0 0 0 73, 963		3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	000000000000000000000000000000000000000	180 23 0 240			0 16, 175 0 2, 067 0 0		3. 00 4. 00 5. 00

Heal th	Financial Systems		GIBSON GENER	AL HOSPLTAL		In lie	u of Form CMS-:	2552-10
	TIONMENT OF PATIENT SERVICE COST	ΓS		Provider Co	CN: 15-1319 15-7445	Peri od: From 10/01/2018 To 09/30/2019	Worksheet H-3 Part I Date/Time Pre	epared:
							2/25/2020 4: 2	21 pm
				litle	XVIII	Home Health Agency I	PPS	
	Cost Center Description					Agency		
	5551 5511ton 25551 Pt. 511	6. 00	7. 00	8.00	9. 00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8. 00
9. 00	Physi cal Therapy							9. 00
10. 00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services Home Health Aide							12.00
13.00	Total (sum of lines 8-13)			•				13. 00 14. 00
14.00	Total (Suil of Titles 6-13)	Progr	ram Covered Ch	l arnes	Cost of			14.00
		11091	alli covered chi	ai ges	Servi ces			
					00. 1. 000			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance	44.00	
	Cumpling and Dauga Coat Comput	6.00	7. 00	8. 00	9. 00	10.00	11. 00	
15 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 0	29, 862	. 0	Γ	0 0	0	15.00
	Cost of Drugs	0	29, 802	l .		0		
10.00	Cost Center Description	Total Program		, 0		0	0	10.00
	2001 3011to: 20001 Pt. 011	Cost (sum of						
		col s. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST,	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, C	R BENEFICIARY	
	COST LIMITATION							_
	Cost Per Visit Computation	200 010						1 00
1.00	Skilled Nursing Care	393, 810 85, 008						1.00 2.00
2. 00 3. 00	Physical Therapy Occupational Therapy	16, 175						3.00
4. 00	Speech Pathology	2, 067						4.00
5. 00	Medical Social Services	2,007						5.00
6. 00	Home Heal th Aide	73, 963						6.00
7. 00	Total (sum of lines 1-6)	571, 023						7. 00
	Cost Center Description							
	·	12. 00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8. 00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology Medical Social Services							11. 00 12. 00
12. 00 13. 00	Home Health Aide							13.00
	Total (sum of lines 8-13)							14.00
1 1. 00	1.00a. (Sum of 111103 0 10)	ı	I					1 11.00

Heal th	Financial Systems	GI BSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
APP0R1	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C	CN: 15-1319	Peri od:	Worksheet H-3	
				HHA CCN:	15-7445	From 10/01/2018 To 09/30/2019		
				Title	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED I	BY SHARED HOSP	TAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 308485	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 271654	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68. 00	0. 256818	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	1. 152401	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 512168	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems GIBSON GENERA ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-1319	Peri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7445	From 10/01/2018 To 09/30/2019		
		Title	· XVIII	Home Health Agency I	PPS	. г рш
				Par	t B	
			Part A	Not Subject to	Subject to Deductibles &	
				Deductibles & Coinsurance	Coi nsurance	
	DADT I COMMITATION OF THE LESSED OF DEASONABLE COST OD CL	ISTOMARY CHARC	1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CU Reasonable Cost of Part A & Part B Services	JSTUWARY CHARG	<u> </u>			1
00	Reasonable cost of services (see instructions)			0 0	0	1
00	Total charges			0 0	0	2
	Customary Charges		1			
00	Amount actually collected from patients liable for payment on a charge basis (from your records)			0 0	-	
00	Amount that would have been realized from patients liable to for services on a charge basis had such payment been made in with 42 CFR §413.13(b)			0 0	0	4
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000			
00 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cos	st (complete		0 0	0	
00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete	only if line		0 0	0	8
00	1 exceeds line 6) Primary payer amounts			0 0	0	9
<i>J</i> O	Fifilially payer allouitts		l	Part A	Part B	7
				Servi ces 1. 00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)			0	0	
00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			0	384, 497 8, 690	
.00	Total PPS Reimbursement - LUPA Episodes			0	7, 639	
00	Total PPS Reimbursement - PEP Episodes			o o	1, 358	
00	Total PPS Outlier Reimbursement - Full Episodes with Outlie	ers		Ō	3, 282	
00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	1
00	Total Other Payments			0	0	17
00	DME Payments			0	0	18
00	Oxygen Payments			0	0	
00	Prosthetic and Orthotic Payments			0	0	
00	Part B deductibles billed to Medicare patients (exclude coi	nsurance)		_	405 444	
00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			0	405, 466 0	1
00	Subtotal (line 22 minus line 23)			0	405, 466	
00	Coinsurance billed to program patients (from your records)				103, 400	1
	Net cost (line 24 minus line 25)			0	405, 466	
	Reimbursable bad debts (from your records)				1007 100	27
00	•	e instructions)			28
00	Total costs - current cost reporting period (line 26 plus I	line 27)		0	405, 466	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	
50	Pioneer ACO demonstration payment adjustment (see instructi			0	0	
99	Demonstration payment adjustment amount before sequestration	on		0	0	
.00	Subtotal (see instructions)			0	405, 466	
. 01	Sequestration adjustment (see instructions)	_		0	8, 109	
. 02	Demonstration payment adjustment amount after sequestration	n		0	207 254	
	, , , , , , , , , , , , , , , , , , , ,					1
	,	2 and 33)				
			S Pub. 15-2			
32. 00 33. 00 34. 00 35. 00	Interim payments (see instructions) Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32	2, and 33)	S Pub. 15-2,		0 0 0	0 397, 356 0 0 0 1

Health Financial Systems GIBSON GENERAL ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 GIBSON GENERAL HOSPITAL Provider CCN: 15-1319

Peri od: From 10/01/2018 To 09/30/2019 Date/Time Prepared: 2/25/2020 4:21 pm PPS TO PROGRAM BENEFICIARIES HHA CCN: 15-7445

				Home Health Agency I	PPS	ı piii
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider			0	397, 356	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					
3. 01				0	0	3. 01
3. 02 3. 03				0	0 0	3. 02 3. 03
3. 04				0		3. 04
3. 05				0	0	3.05
0.50	Provider to Program		<u> </u>			0.50
3. 50 3. 51				0	0 0	3. 50 3. 51
3. 52				0		3. 52
3. 53				0	0	3.53
3. 54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0	397, 356	4.00
	(transfer to Wkst. H-4, Part II, column as 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	Program to Provider			0	0	5. 01
5. 02				Ö	0	5. 02
5. 03				0	0	5.03
5. 50	Provider to Program			0	0	5. 50
5. 51				0		5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER			0	1	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)			0	0 397, 357	6. 02 7. 00
7.00	Total medicale program frability (see instructions)			Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8.00
0.00	Inallie of Contractor			I	I I	0.00

	Financial Systems	GIBSON GENERA				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Period: From 10/01/2018	Worksheet M-1	
			Component		To 09/30/2019	Date/Time Pre	nared.
			00p00c	00.11 10 0021	0,, 00, 20.,	2/25/2020 4: 2	1 pm
					RHC I	Cost	
		Compensation	Other Costs	Total (col. 1	Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
	EAGLELTY HEALTH OADS OTASS COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0		0	0	
2.00	Physician Assistant	0	0		0	0	
3. 00	Nurse Practitioner	122, 513	0	122, 51		122, 513	
4.00	Visiting Nurse	0	0	45.04	0	0	
5.00	Other Nurse	15, 848	0	15, 84		15, 848	1
6. 00	Clinical Psychologist	0	0		0	0	
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	0	0		0	0	
10.00	Subtotal (sum of lines 1 through 9)	138, 361	0	138, 36	1 0	138, 361	1
11.00	Physician Services Under Agreement	0	0		0	0	
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00		0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	The second section is a second	0	0		0	0	
16.00	Transportation (Heal th Care Staff)	0	0		0	0	16.00
17.00		0	0		0	0	17.00
18.00		0	0		0 0	0	18.00
19. 00 20. 00	Other Health Care Costs Allowable GME Costs	U	0		U U	0	19.00 20.00
21. 00		0	_		0	0	
22. 00		138, 361	0	138, 36	٥	138, 361	
22.00	lines 10, 14, and 21)	130, 301	٥	130, 30		130, 301	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00		0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25. 00	Optometry	0	0		0 0	0	
25. 01	Tel eheal th	0	0		0 0	, o	25. 01
25. 02		0	0		0 0	o o	25. 02
26. 00	All other nonreimbursable costs	0	١		0 0	0	26.00
27. 00	Nonallowable GME costs	0			٦		27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	
_0.00	through 27)	Ü			-		20.00
	FACILITY OVERHEAD				•		1
29. 00	Facility Costs	0	5, 686	5, 68	6 0	5, 686	29.00
	Administrative Costs	53 049					

53, 049

53, 049

191, 410

5, 686 97, 354 103, 040

103, 040

5, 686 150, 403

156, 089

294, 450

5, 686 148, 652

154, 338

292, 699

-1, 751

-1, 751

-1, 751

30.00

31.00

32.00

30.00 Administrative Costs

31.00

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1319	Peri od: From 10/01/2018	Worksheet M-1
	Component CCN: 15-8524	To 09/30/2019	Date/Time Prepared: 2/25/2020 4:21 pm
		DUC I	Coot

			Component	CCN. 15-0524	10 09/30/2019	2/25/2020 4: 21	
					RHC I	Cost	<u></u>
		Adjustments	Net Expenses		•		
		, l	for				
			Allocation				
			(col. 5 +				
			col . 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0				1.00
2.00	Physician Assistant	o	0				2.00
3.00	Nurse Practitioner	o	122, 513				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	15, 848				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	0				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	138, 361			1	10.00
11.00	Physician Services Under Agreement	0	0			1	11. 00
12.00	Physician Supervision Under Agreement	0	0			1	12.00
13.00	Other Costs Under Agreement	O	0			1	13.00
14.00	Subtotal (sum of lines 11 through 13)	o	0			1	14.00
15.00	Medical Supplies	o	0			1	15. 00
16.00	Transportation (Health Care Staff)	o	0			1	16.00
17.00	Depreciation-Medical Equipment	o	0			1	17. 00
18.00	Professional Liability Insurance	o	0			1	18.00
19.00	Other Health Care Costs	o	0			1	19. 00
20.00	Allowable GME Costs					2	20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	0			2	21. 00
22.00	Total Cost of Health Care Services (sum of	o	138, 361			2	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0			2	23. 00
24.00	Dental	0	0			2	24. 00
25.00	Optometry	0	0			2	25. 00
25. 01	Tel eheal th	0	0			2	25. 01
25. 02	Chronic Care Management	0	0			I	25. 02
26.00	All other nonreimbursable costs	0	0			I	26. 00
27.00	Nonallowable GME costs					•	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0			2	28. 00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	5, 686			•	29. 00
30.00	Administrative Costs	0	148, 652	1			30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	154, 338			3	31. 00
	30)						
32.00	, ,	0	292, 699			3	32. 00
	and 31)	l		l			

	Financial Systems	GI BSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2018 To 09/30/2019	Date/Time Pre	narad:
			Component	CCN. 13-6324	10 09/30/2019	2/25/2020 4: 2	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions		T		-1		
1.00	Physi ci an	0.00					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 86	l			1 00/	3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 86		•	1, 806	1, 806	4.00
5.00	Visiting Nurse	0.00)		0	5.00
6.00	Clinical Psychologist	0.00		2		0	6.00
7.00	Clinical Social Worker	0.00	l			0	7.00
7. 01 7. 02	Medical Nutrition Therapist (FQHC only) Diabetes Self Management Training (FQHC	0. 00 0. 00	l .	(0	7. 01 7. 02
7. 02	only)	0.00		'		Ü	7.02
8. 00	Total FTEs and Visits (sum of lines 4	0. 86	537	,		1, 806	8.00
0.00	through 7)	0.00	337			1,000	0.00
9. 00	Physician Services Under Agreements		(0	9.00
7. 00	The oral controls and right sometics						71.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			138, 361	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			138, 361	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.	M-1, col. 7, I	ine 31)		154, 338	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			113, 237	15. 00
16.00	Total overhead (sum of lines 14 and 15)					267, 575	
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					267, 575	
	Overhead applicable to hospital-based RHC/FC					267, 575	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		405, 936	20.00

	Financial Systems GIBSON GENERAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Period:	u of Form CMS-2 Worksheet M-3	
SERVI (Component CCN: 15-8524	From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:2	pared:
		Title XVIII	RHC I	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 (fro	· · · · · · · · · · · · · · · · · · ·		405, 936	
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		20, 855	
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			385, 081 1, 806	3. 00 4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		1, 000	5.00
6.00	Total adjusted visits (line 4 plus line 5)	,		1, 806	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			213. 22	7.00
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		213. 22	213. 22	9.00
10.00	CALCULATION OF SETTLEMENT			1/7	10.00
10. 00 11. 00	OD Program covered visits excluding mental health services (from contractor records)		0	167 35, 608	
12. 00	Program covered visits for mental health services (from contr	•	0	0	1
13.00	Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions	•	0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	35, 608	15. 00 16. 00
16. 00	Total program charges (see instructions)(from contractor's re		U	37, 253	
16. 02	Total program preventive charges (see instructions) (from prov	•		2, 080	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			1, 988	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		25, 154	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	27, 142	16. 05
17. 00	Pri mary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		2, 177	18. 00
19. 00	records)	nc) (from contractor		6, 599	19.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	iis) (II oiii coiiti actoi		0, 599	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			27, 142	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		1, 342	
22. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			28, 484 0	1
23. 00	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25. 00
	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 28, 484	
26. 01	Sequestration adjustment (see instructions)			570	
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27.00	0 Interim payments		22, 073	1	
28. 00 29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		0 5, 841	28. 00 29. 00
30.00	Protested amounts (nonallowable cost report items) in accorda		,	0, 641	30.00
	chapter I, §115.2				1

Health Financial Systems	GIBSON GENERAL HOS	SPI TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC PM	NEUMOCOCCAL AND INFLUENZA Pr		Peri od: From 10/01/2018	Worksheet M-4
VACCINE COST	Co	omponent CCN: 15-8524		Date/Time Prepared: 2/25/2020 4:21 pm
		Title XVIII	RHC I	Cost

				27 207 2020 1. 2	ı pııı
		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)		138, 361	138, 361	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0. 000468	0. 013109	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	65	1, 814	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	741	4, 488	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	806	6, 302	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	138, 361	138, 361	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		267, 575	267, 575	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 005825	0. 045548	8.00
	divided by line 6)				ł
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	1, 559	12, 188	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	2, 365	18, 490	10.00
	lines 5 and 9)				1
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	5	140	11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1		473.00	132. 07	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	2	3	13.00
	benefi ci ari es				1
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	946	396	14.00
	(line 12 x line 13)				1
15.00				20, 855	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3				1
16. 00	Total Program cost of pneumococcal and influenza vaccine and			1, 342	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			1
	line 21)				l

Health Financial Systems	GI BSON GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA	RLFS	Provider CCN: 15-1319 Component CCN: 15-8524	From 10/01/2018	
			DUIG I	<u> </u>

		Component Con. 13-8324	10 097 307 2019	2/25/2020 4: 2	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2, 00	
00	Total interim payments paid to hospital-based RHC/FQHC			22, 073	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		o	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	3
)2				0	3
)3				0	3
04				0	3
)5				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.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line	:	22, 073	4
	27)				
	TO BE COMPLETED BY CONTRACTOR			I	5
00					
	each payment. If none, write "NONE" or enter a zero. (1)				
)1	Program to Provider			0	
)2				0	5
)3					5
	Provider to Program			U	-
0	Frovider to Frogram			0	5
51				0	5
52					5
19	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)				è
1	SETTLEMENT TO PROVIDER			5, 841	1
)2	SETTLEMENT TO PROGRAM			0,041	1
00	Total Medicare program liability (see instructions)			27, 914	7
	Total mod. od. o program readility (300 restractions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	
	Name of Contractor	-			