Health Financi	ial Systems	s	GIBSON GENERAL	HATTARANH		Tn Lio	u of some su	c 3553 10
			ig; 42 CFR 413.20(b)). Fa	illure to report can	racul	t in all intorim	u of Form CM	2-5225-10
payments made	since the	beginning of the co	st reporting period being	ig deemed overbavmen	ts (42	USC 1395a).	OMB NO. 093	
HOSPITAL AND I	HOSPITAL H T SUMMARY	EALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provider CCN: 15		Period: From 10/01/2013	Worksheet S	repared:
Provider							******	
use only	2.[]M	Rectronically filed anually submitted co	ost report			Date: 2/19/20		8:49 am
	3.[0]I 4.[F]M	f this is an amended edicare Utilization.	l report enter the numbe Enter "F" for full or '	of times the provi 'L" for low.	der re	submitted this c	ost report	
Contractor use only	5. [1]C (1) As (2) Se	ost Report Status Submitted ttled without Audit ttled with Audit opened		or this Provider CC	11. Co	PR Date: ontractor's Vendo 0]If line 5, co number of tim	olumn 1 is 4:	
PART II - CERT	IFICATION							 1
PROVIDED OR PR	ACTION, F OCURED THE	INE AND/OR IMPRISON	NFORMATION CONTAINED IN MENT UNDER FEDERAL LAW. RECTLY OR INDIRECTLY OF	FURTHERMORE, IF SEI	RVTCFS	TOENTTETED IN TH	ITS REPORT WE	OC

TRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY 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 (151319) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 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.

Encryption Information

ECR: Date: 2/19/2015 Time: 8:49 am Lk25VU0GYsENyxRHLPAAQzIVDJ9z00 QkrhIOqKRJfSLsNMOPVUSAV.nUD4HC HOGcO8GChMOSsr8h

Date: 2/19/2015 Time: 8:49 am 66.NOHxogoF4T4KTzHSWifG1xZ2sC0 tRnGx0rFv3w2fLxZhSfJ.oXZn9Fzvo H6CsOujDog05jf.0

(Signed)

		Title >	(VIII		
	Title V	Part A	Part B	HIT	Title XIX
,	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
.00 Hospital	0	262.873	-385,562	0	1,480,423 1.
.00 Subprovider - IPF	o	0	0	ŭ	0 2.
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.00 SKILLED NURSING FACILITY	امّ	0	0		0 6.
.00 HOME HEALTH AGENCY I	ŏ	٠٥	1	Ĭ	0 7.
00.00 Total	ام	279,016	-385,563	0	0 9.
he above amounts represent "due to" or "due fr	om" the applicable	program for the	element of the	above comple	1,480,423 200.

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 Provi der CCN: 151319 Peri od: Worksheet S-2 From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: 2/19/2015 8:48 am 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 Zip Code: 47670-County: GIBSON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) 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 GIBSON GENERAL HOSPITAL 151319 21780 12/16/2003 Ν 0 3.00 Hospi tal 1 Subprovider - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF 7 00 GIBSON GENERAL SWING 15Z319 21780 12/16/2003 N 0 N 7.00 BFD 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF GIBSON GENERAL SNF 155093 21780 06/14/1969 Ρ 0 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA GIBSON HOME HEALTH 157445 21780 10/19/1995 Ν Р Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2013 09/30/2014 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N 22.00 N 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 §412.06(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 cost reporting 22.01 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) 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 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 ves or "N" for no In-State In-State Out-of Out-of Medicai d Other Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 6.00 1.00 2. 00 3. 00 4.00 5.00 24.00 If this provider is an IPPS hospital, enter the 24 00 in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state 0 0 0 0 0 25.00 Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00

Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,

If this is a sole community hospital (SCH), enter the number of periods SCH status in

enter the effective date of the geographic reclassification in column 2.

2

27.00

35.00

effect in the cost reporting period.

27.00

35.00

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151319 Peri od: Worksheet S-2 From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: 2/19/2015 8:48 am Begi nni ng: Endi ng: 1. 00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 in effect in the cost reporting period. Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number 38.00 of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39. 00 hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) XVIII V XI X 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through 47.00 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no 48.00 N N Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes 56.00 56.00 or "N" for no. If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 57 00 57 00 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.
Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I. 59.00 59.00 Ν 60.00 Are you claiming nursing school and/or allied health costs for a program that meets the N 60.00 provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) IME Direct GME Direct GME 1.00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0 00 0.00 61.00 N 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 0.00 o. od 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 0.00 o. od 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 0.00 0.00 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 0.00 o. od 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 0.00 61.05 0.00 and/or general surgery FTEs and the current year 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 0.00 o. od 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151319 Peri od: Worksheet S-2 From 10/01/2013 Part I Date/Time Prepared: 09/30/2014 2/19/2015 8:48 am Program Code Unweighted IME Program Name Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 0.00 61.20 61.20 Of the FTEs in line 61.05, specify each expanded 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 and enter in column 4 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) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Non-Provider Settings 63.00 Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) N 63.00 Unwei ghted Unwei ghted Ratio (col. 1/ FTEs in FTES (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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. 3/ FTEs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 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 66.00 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 non-provider 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)

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151319 Peri od: Worksheet S-2 From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: 2/19/2015 8:48 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 67.00 67.00 Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Ν Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. O 71.00 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (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. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no N 80.00 TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 N 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. ٧/ XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for N 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 cost report either in Ν 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92 00 N 92 00 Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 93.00 Ν Ν Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν 94.00 applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. 95 00 0 00 95 00 0 00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00

105.00

106.00

Ν

Rural Providers

105.00 Does this hospital qualify as a Critical Access Hospital (CAH)?

for outpatient services? (see instructions)

106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment

Health Financial Systems GIBSON GENERA				n Li e	u of For		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 151319	Period: From 10/01 To 09/30		Workshe Part I Date/Ti 2/19/20	me Pre	epared:
			1. 00	`	XIX		
107.00 Column 1: If this facility qualifies as a CAH, is it eligil for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on Whigh 25 and the program would be cost reimbursed. If yes completed Column 2: If this facility is a CAH, do I&Rs in an approved train in the CAH's excluded IPF and/or IRF unit? Enter "Y' column 2. (see instructions)	o in column 1. orksheet B, Pa e Worksheet D-2 d medical educa	(see rt I, column 2, Part II. ation program	N)	2. C		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				a h	Docni r	atory	108. 00
	Physi cal 1.00	Occupationa 2.00	al Speed		Respirate 4. C		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		109. 00
				1.0	0 2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of enter the method used (A, B, or E only) in column 2. If columneither "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital providers 15-1, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry mal practice insurance.	umn 2 is "E", e for long term s) based on the for yes or "N'	enter in colu care (include definition 'for no.	ımn [°] 3 Hes in CMS	N N N		0	115. 00 116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence pol		,		0			118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losse	es	Insura	ance	
		1.00	0.00				
118.01 List amounts of malpractice premiums and paid losses:		1. 00	0 2.00)	3. 0		0 118. 01
			1. 00	`	2.0	10	_
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 119.00 DO NOT USE THIS LINE			N N)	2.0		118. 02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no.	n column 1 "Y" ualifies for tl	for yes or ne Outpatient			N		120. 00
121.00 Did this facility incur and report costs for high cost imple patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y				121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N				 125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en	nter the certi						126. 00
in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, enin column 1 and termination date, if applicable, in column 1	ter the certifi	cation date					127. 00
128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 1	2.		_				128. 00
129.00 If this is a Medicare certified lung transplant center, enterolumn 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center,			П				129. 00 130. 00
date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center	lumn 2. r, enter the co						131. 00
date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, en in column 1 and termination date, if applicable, in column 3	ter the certifi	cation date					132. 00
133.00 f this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column 2	ter the certifi	cation date					133. 00
134.00 If this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2.		n column 1					134. 00
All Providers							

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151319 Peri od: Worksheet S-2 From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: To 2/19/2015 8:48 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 145. 00 145.00 of costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient Ν services only? Enter "Y" for yes or "N" for no. 1. 00 2.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146. 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 Ν 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. Ν 148. 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for Ν 149.00 no. Title XIX Part A Title V Part B 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155. 00 Ν Ν 156.00 Subprovi der - IPF N N Ν N 156 00 157.00 Subprovi der - IRF Ν Ν Ν Ν 157.00 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY 160.00 N N Ν N 161.00 CMHC N Ν 161.00 Ν 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. County Zip Code CBSA FTE/Campus Name State 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no. 167.00 168.00|If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 169.00|If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting

period respectively (mm/dd/yyyy)

1.00

10/01/2013

2.00

09/30/2014

170.00

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	GIBSON GENERAL HOSPITAL STIONNAIRE Provider		eriod: rom 10/01/2013	eu of Form CMS- Worksheet S-2 Part II	
				o 09/30/2014	Date/Time Pre	
				Y/N	2/19/2015 8: 4 Date	18 am
	General Instruction: Enter Y for all YES resp	poncos Entor N for all NO ro	coopeas Entar	1. 00	2.00	
	mm/dd/yyyy format.	Johnses. Effet in for all no re	sponses. Litter	all dates III	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
. 00	Has the provider changed ownership immediatel	y prior to the beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of	the change in column 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in yes, enter in column 2 the date of termination		N			2.00
00	voluntary or "I" for involuntary.					2 0
. 00	Is the provider involved in business transact contracts, with individuals or entities (e.g.	tions, including management , chain home offices, drug	N			3.00
	or medical supply companies) that are related officers, medical staff, management personnel	d to the provider or its				
	of directors through ownership, control, or 1					
	relationships? (see instructions)		Y/N	Typo	Date	
			1.00	Type 2. 00	3. 00	
	Financial Data and Reports Column 1: Were the financial statements pre	pared by a Cortified Dublic	У	С	03/01/2011	4.00
. 00	Accountant? Column 2: If yes, enter "A" for		T T		03/01/2011	4.00
	or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instru					
. 00	Are the cost report total expenses and total		N			5. 00
	those on the filed financial statements? If y	yes, submit reconciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool 2 Column 2: If was is th	o providor is	N		6.00
. 00	the legal operator of the program?	oor? Corumin 2. Tr yes, is th	le provider is	IN		0.00
. 00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health programs'		l during the	N N		7. 00
	cost reporting period? If yes, see instruction	ons.	Ü	IN		0.00
. 00	Are costs claimed for Intern-Resident program yes, see instructions.	ms claimed on the current cos	t report? If	N		9.00
0. 00	Was an Intern-Resident program been initiated	d or renewed in the current c	ost reporting	N		10.00
1. 00	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & R in an App	roved	N		11.00
	Teaching Program on Worksheet A? If yes, see)/ /N	
					Y/N 1.00	
	Bad Debts	d debte2 If yes ose instruct	iono		l v	12.00
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del			t reporting	Y N	12. 00
4 00	period? If yes, submit copy.		: voo ooo laat	rusti one	N	14.00
	<u>If line 12 is yes, were patient deductibles a</u> Bed Complement	and/or co-payments warved? II	yes, see mst	ructions.	l N	14.00
5. 00	Did total beds available change from the price	or cost reporting period? If	r e		N Part B	15. 00
		Description	Y/N	t A Date	Y/N	
	PS&R Data	0	1.00	2. 00	3. 00	
	Was the cost report prepared using the PS&R		Υ	01/02/2015	Y	16. 00
	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					
7. 00	instructions) Was the cost report prepared using the PS&R		N		N	17. 00
. 00	Report for totals and the provider's records		l N		IV.	17.00
	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns					
	2 and 4. (see instructions)					
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		N		N	18.00
	claims that have been billed but are not					
	included on the PS&R Report used to file this cost report? If yes, see instructions.					
	If line 16 or 17 is yes, were adjustments		N		N	19. 00
7. 00	made to PS&R Report data for corrections of					
9. 00						
	other PS&R Report information? If yes, see instructions.					
	other PS&R Report information? If yes, see		N		N	20. 00

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151319 Peri od: Worksheet S-2 From 10/01/2013 Part II 09/30/2014 Date/Time Prepared: 2/19/2015 8:48 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21 00 21.00 Was the cost report prepared only using the Ν N provider's records? If yes, see . instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 23.00 Ν reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 Ν instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions.

If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provider-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs costs claimed on the cost report? 2/ 00

36.00	Were home office costs claimed on the cost report?		IN IN		36.00
37.00	If line 36 is yes, has a home office cost statement been pr	repared by the home office?	N		37. 00
	If yes, see instructions.				
38.00	If line 36 is yes, was the fiscal year end of the home off	fice different from that of	N		38. 00
	the provider? If yes, enter in column 2 the fiscal year end	d of the home office.			
39.00	If line 36 is yes, did the provider render services to other	er chain components? If yes,	N		39. 00
	see instructions.				
40.00	If line 36 is yes, did the provider render services to the	home office? If yes, see	N		40. 00
	instructions.				
		1.00	2.	00	
	Cost Report Preparer Contact Information				
41 OO					
41.00	Enter the first name, last name and the title/position	RI CH	FERRI ELL		41. 00
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RI CH	FERRI ELL		41. 00
41.00		RI CH	FERRI ELL		41. 00
42. 00	held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH ALLIANT MANAGEMENT SERVICES	FERRI ELL		41. 00 42. 00
	held by the cost report preparer in columns 1, 2, and 3, respectively.		FERRI ELL		
42. 00	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES	FERRI ELL RFERRI ELL@ALLI	ANTMANAGEMENT.	
42. 00	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		ANTMANAGEMENT.	42. 00

Health Financial Systems	GIBSON GENERA	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	ESTI ONNAI RE	Provider CCN: 151319		Worksheet S-2 Part II Date/Time Pre 2/19/2015 8:4	epared:
	Part B				
	Date				
	4. 00				
PS&R Data					
16.00 Was the cost report prepared using the PS&R	01/02/2015				16. 00

		Part B		271772013 0.4	U UIII
			-		
		Date			
		4. 00			
	PS&R Data				_
16.00	Was the cost report prepared using the PS&R	01/02/2015			16. 00
	Report only? If either column 1 or 3 is yes,				
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 (see				
	instructions)				
17.00	Was the cost report prepared using the PS&R				17.00
	Report for totals and the provider's records				
	for allocation? If either column 1 or 3 is				
	yes, enter the paid-through date in columns				
	2 and 4. (see instructions)				
18. 00	,				18.00
10.00	made to PS&R Report data for additional				10.00
	claims that have been billed but are not				
	included on the PS&R Report used to file				
	this cost report? If yes, see instructions.				
19. 00					19.00
19.00	made to PS&R Report data for corrections of				19.00
	other PS&R Report information? If yes, see				
	instructions.				
20. 00					20.00
20.00	made to PS&R Report data for Other? Describe				20.00
	the other adjustments:				
21 00	Was the cost report prepared only using the				21. 00
21.00	provider's records? If yes, see				21.00
	instructions.				
	THISTI UCTI OHS.				
			3.00		
	Cost Report Preparer Contact Information		3.00		
41. 00		/nosition	REIMBURSEMENT MANAGER		41.00
41.00	held by the cost report preparer in columns		INET WIDONSEWENT WINWAGEN		11.00
	respectively.	i, 2, and 5,			
42 00	Enter the employer/company name of the cost i	renort			42.00
12.00	preparer.	opor t			12.00
43 00	Enter the telephone number and email address	of the cost			43.00
4 3.00	report preparer in columns 1 and 2, respective				1 -3.00
	proport proparer in corumns rand z, respectiv	, C. y.	1	I	1

Heal th Fi nancial SystemsGIBSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

						10 09/30/2014	2/19/2015 8: 4	
							I/P Days / 0/P	<u> </u>
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	· · · · ·	Line Number			Avai I abl e			
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		20	7, 300	38, 424. 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	38, 424. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		5	1, 82	5, 208. 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, 12!	43, 632. 00	0	14. 00
15. 00	CAH visits					10,000	0	15. 00
16. 00	SUBPROVIDER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44.00		45	16, 42!	5	o	19. 00
20. 00	NURSING FACILITY	00			10, 12			20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					o	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00						23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00				70				27. 00
28. 00	Observation Bed Days			70			0	28. 00
29. 00							U	29. 00
30.00	Employee discount days (see instruction)							29. 00 30. 00
31. 00								31. 00
				0]			
32. 00	Labor & delivery days (see instructions)			Ü	1			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions)							33. 00
33.00	LTCH non-covered days	l l			I	T	1	33.00

Provider CCN: 151319

				'	0 09/30/2014	2/19/2015 8: 4	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6, 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 009	7.00	1, 601	7. 00	10.00	1, 00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1,007	74	1, 001			1.00
2.00	HMO and other (see instructions)	12	o				2. 00
3.00	HMO IPF Subprovider	l ol	o				3. 00
4.00	HMO IRF Subprovider	ol	o				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	561	o	561			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		99	99			6. 00
7. 00	Total Adults and Peds. (exclude observation	1, 570	193	2, 261			7. 00
	beds) (see instructions)	, , ,		, -			
8.00	INTENSIVE CARE UNIT	151	o	217			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)	1, 721	193	2, 478	0.00	269. 88	1
15. 00	CAH visits	0	0	_,			15. 00
16. 00	SUBPROVIDER - I PF		آ				16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	793	8, 856	14, 654	0.00	20. 94	1
20. 00	NURSING FACILITY		.,	.,			20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	724	151	4, 536	0.00	5. 60	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)			.,			23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	ol	o	0			24. 10
25. 00	CMHC - CMHC	٩	Ĭ	· ·			25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	296. 42	
28. 00	Observation Bed Days		0	426		270. 12	28. 00
29. 00	Ambul ance Tri ps	ام	Ĭ	120			29. 00
30. 00	Employee discount days (see instruction)	٩		0			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	٥	0	0			32. 00
32. 00	Total ancillary labor & delivery room		٩	0			32. 00
JZ. U1	outpatient days (see instructions)			Ü			32.01
33. 00	LTCH non-covered days	O					33. 00

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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

				To	09/30/2014	Date/Time Pre 2/19/2015 8:4	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			313	28	490	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			2	0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	0.00		0 313	28	490	14. 00 15. 00 16. 00 17. 00 18. 00
19. 00 20. 00 21. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0. 00					19. 00 20. 00 21. 00
22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 29. 00 30. 00 31. 00 32. 00 33. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0. 00					22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 151319	Period: Worksheet S-3 From 10/01/2013 Part IV To 09/30/2014 Date/Time Prepared:

PART IV - WAGE RELATED COSTS 1.00		To 09/30/2014		
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00 d01K Employer Contributions 0 1.00 2.00 Tax Sheltered Annulty (TSA) Employer Contribution 0 2.00 2.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 0 0 0 0 0 0 0 0 0		Part A - Core List		
2. 00 Tax Shelt tered Annuity (TSA) Employer Contribution 0 2. 00 Nonqualified Defined Benefit Plan Cost (see Instructions) 0 3. 00 0.		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 235, 430 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 235, 430 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 401K/TSA Plan Administration fees 0 5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 9.00 9.	1.00		0	1.00
A. 0. Oual I fied Defined Benefit Plan Cost (see instructions) EAN ADMINISTRATIVE COSTS (Paid to External Organization) S. 00 Cost A01K/TSA Plan Administration fees A01K/TSA Plan Administration	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration Fees 0 5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
5.00 401K/TSA Pl an Administration fees 0 6.00 1	4.00	Qualified Defined Benefit Plan Cost (see instructions)	235, 430	4. 00
Legal / Accounting / Management Fees - Pension Plan 0 6.00				
The color of the				
HEALTH AND INSURANCE COST 8. 00 Heal th Insurance (Purchased or Self Funded) 2, 312, 341 8. 00 9. 00 10. 0	6.00		0	6. 00
Heal th Insurance (Purchased or Self Funded) 2, 312, 341 8. 00 9. 00 10. 0	7.00		0	7. 00
9.00 Prescription Drug Plan				
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 234,286 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion 16.00 Non cumulative portion 1,035,392 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 9,115 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 10.00 Long Related cost (Sum of Lines 1 -23) 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 20.00 Contact Cont			2, 312, 341	
11.00 Life Insurance (If employee is owner or beneficiary) 0 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 234, 286 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 17.00 TAXES	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	0	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuit ion Rei mbursement 24.00 First B - Other than Core Related Cost	11. 00		0	
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only Redicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see Instructions)) 22. 00 Day Care Cost and Allowances Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 'Workers' Compensation Insurance	13.00		0	
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20.00 State or Federal Unemployment Taxes THER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00		_	
Non cumulative portion) TAXES 17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 19. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuit ion Reimbursement 24. 00 Part B - Other than Core Related Cost			234, 286	
TAXES	16.00		0	16. 00
17.00 Fi CA-Employers Portion Only 1,035,392 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 9,115 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 3,826,564 Part B - Other than Core Related Cost				1
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 9, 115 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 3,826,564 24.00 Part B - Other than Core Related Cost				
19.00 Unemployment Insurance 9, 115 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 3, 826, 564 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 0 DTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 3,826,564 Part B - Other than Core Related Cost				
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 24.00				
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20. 00		0	20.00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 3,826,564 24.00		·		
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 0 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 3, 826, 564 Part B - Other than Core Related Cost	21. 00		0	21. 00
23.00 Tui tion Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 3,826,564 Part B - Other than Core Related Cost				
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 3,826,564 24.00				
Part B - Other than Core Related Cost				
	24. 00		3, 826, 564	24. 00
25.00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25.00				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Heal th	Financial Systems	GI BSON GENERA	AL HOSPLTAL		In lie	eu of Form CMS-:	2552-10
	IEALTH AGENCY STATISTICAL DATA	or book officers			Peri od:	Worksheet S-4	
			Component		From 10/01/2013 To 09/30/2014	Date/Time Pre	
					Home Health	2/19/2015 8: 4 PPS	<u>8 am</u>
					Agency I		_
					1.	00	
0. 00	County				GI BSON		0. 00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00			0 0 106.00		1. 00 2. 00
2.00	Tondapiroated census count (see Thati detrons)	0.00	01.00		oloyees (Full Ti		2.00
		Enter the numb	er of hours in work week	Staff	Contract	Total	
		your norman	WOLK WOOK				
	hour uru ar	()	1.00	2. 00	3.00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		3. 00	0.0	0. 00	0.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			0.0		l .	1
7. 00	Nursi ng Supervi sor			0.0			7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			0.0		l e	8. 00 9. 00
10.00	Occupational Therapy Service			0.0			1
11.00	Occupational Therapy Supervisor			0.0			
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.0			
14.00	Medical Social Service			0.0	0.00	0.00	14. 00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0.0			1
17. 00	Home Heal th Aide Supervisor			0.0			
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where				1		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			21780			20. 00
	during this cost reporting period (line 20						
	contains the first code).	Full Ep	oi sodes				
		Without	With Outliers	LUPA Epi sodes		Total (cols.	
		0utliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5. 00	
21 00	PPS ACTIVITY DATA	0/2	20		24	027	21.00
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	863 100, 772		•		l .	21. 00 22. 00
23. 00	Physical Therapy Visits	678	0		2 7	687	1
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	88, 779 180		1	3 922 2 4	89, 964 186	1
26.00	Occupational Therapy Visit Charges	23, 446	0	26	3 527	24, 236	26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	1 132		•	0 0 0	•	27. 00 28. 00
29. 00	Medical Social Service Visits	2	O		0	2	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	351 322	0 17	•	0 0 2		30. 00 31. 00
32. 00	Home Health Aide Visit Charges	23, 017	1, 230		0 145		1
33. 00	Total visits (sum of lines 21, 23, 25, 27,	2, 046	45	2	6 37	2, 154	33. 00
34. 00	29, and 31) Other Charges	0	C		0 0	_	34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	236, 497	4, 723	2, 33	7 4, 311	247, 868	35. 00
36. 00	30, 32, and 34) Total Number of Epi sodes (standard/non	94			8 3	105	36. 00
27 00	outlier)		1			1	27.00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	827] 1] 2	1	0 2		37. 00 38. 00
		•		•	•		•

Health Financial Systems	GIBSON GENERAL HO	SPI TAI			Inlie	u of Form CMS-2	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		_	CCN: 151319	Pe	ri od:	Worksheet S-7	
THOSE ESTIVE THIMENT FOR SIM STATESTICALE BATTA					om 10/01/2013	nor noricot o 7	
				То	09/30/2014	Date/Time Pre	
				L,		2/19/2015 8: 4	8 am
		Group	SNF Days	- 1		Total (sum of	
					Days	col. 2 + 3)	
10.00		1.00	2. 00		3. 00	4. 00	
69. 00		PE2		0	0	0	
70. 00		PE1		0	0	0	
71. 00		PD2		0	0	0	71.00
72. 00		PD1		/	0	7	72. 00
73. 00		PC2		0	0	0	73. 00
74. 00		PC1		7	0	7	74. 00
75. 00		PB2		0	0	0	75. 00
76. 00		PB1		0	0	0	76. 00
77. 00		PA2		0	0	0	77. 00
78. 00		PA1		0	0	0	78. 00
199. 00		AAA		1	0	1	199. 00
200. 00 TOTAL			7'	93	0		200. 00
					CBSA at	CBSA on/after	
					Beginning of	October 1 of	
				C	Cost Reporting		
					Peri od	Reporting	
						Period (if	
				-	1. 00	appl i cabl e) 2. 00	
SNF SERVICES					1.00	2.00	
201.00 Enter in column 1 the SNF CBSA code or 5 chara	ector pop CBSA coo	o if a rur	al facility		21780	21780	201. 00
in effect at the beginning of the cost reporti				ľ	1760	21700	201.00
in effect on or after October 1 of the cost report							
The creek on or arter october 1 or the cost re	portring perrou (i	т арргтсар	Expenses		Percentage	Associ ated	
			ZAPONOGO		. o. ooago	with Direct	
						Patient Care	
						and Related	
						Expenses?	
			1.00		2. 00	3. 00	
A notice published in the Federal Register Vol	ume 68, No. 149 A	ugust 4, 2	003 provided	fo	r an increase	in the RUG	
payments beginning 10/01/2003. Congress expect	ed this increase	to be used	for direct	oat	ient care and	rel ated	
expenses. For lines 202 through 207: Enter in							
column 2 the percentage of total expenses for							
line 7, column 3. In column 3, enter "Y" for y				ts	increases asso	oci ated	
with direct patient care and related expenses	for each category	. (see ins	tructions)				
202. 00 Staffi ng				0	0. 00		202. 00
203.00 Recrui tment				0	0. 00		203. 00
204.00 Retention of employees				0	0. 00		204. 00
205. 00 Trai ni ng				0	0. 00		205. 00
206. 00 OTHER (SPECIFY)				0	0. 00		206. 00
207.00 Total SNF revenue (Worksheet G-2, Part I, line	e 7, column 3)		1, 598, 0	71			207. 00

Heal th	Financial Systems GIBSON GENERAL HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151319	Peri od:	Worksheet S-10	0
				From 10/01/2013 To 09/30/2014	Date/Time Prep 2/19/2015 8:48	
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided caid (see instructions for each line)	ded by li	ne 202 column	1 8)	0. 421212	1. 00
2.00	Net revenue from Medicaid				1, 884, 230	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	,	from Medicaio	l?		4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from I	Medi cai d			0	5. 00
6.00	Medi cai d charges				6, 738, 123	6. 00
7.00	Medicaid cost (line 1 times line 6)		6.11		2, 838, 178	7. 00
8. 00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lir	nes 2 and 5; if	953, 948	8. 00
	<pre>< zero then enter zero) State Children's Health Insurance Program (SCHIP) (see instruction</pre>	ons for e	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	9. 00
10.00	Stand-alone SCHIP charges				0	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	
12. 00	Difference between net revenue and costs for stand-alone SCHIP (enter zero)	line 11 m	inus line 9;	if < zero then	0	12. 00
	Other state or local government indigent care program (see instru					
13. 00	Net revenue from state or local indigent care program (Not inclu					13. 00
14. 00	Charges for patients covered under state or local indigent care 10)	orogram (Not included	in lines 6 or	0	14. 00
15.00	State or local indigent care program cost (line 1 times line 14)				0	15. 00
16. 00	Difference between net revenue and costs for state or local indigital; if < zero then enter zero)	gent care	program (lir	ne 15 minus line	0	16. 00
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fun					17. 00
18. 00	Government grants, appropriations or transfers for support of hos				0	18. 00
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	i ndi gent	care program	ns (sum of lines	953, 948	19. 00
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
			1. 00	2. 00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (charges excluding non-reimbursable cost centers) for the entire		269, 3			20. 00
21. 00	Cost of initial obligation of patients approved for charity care times line 20)		113, 43	662, 654	776, 091	21. 00
22. 00	· · · · · · · · · · · · · · · · · · ·		39, 3	19, 592	58, 922	22. 00
23. 00			74, 10		717, 169	
	•				1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient	davs bevo	nd a Length o	of stav limit	N N	24. 00
	imposed on patients covered by Medicaid or other indigent care p			J		
25. 00	If line 24 is "yes," charges for patient days beyond an indigen	t care pr	ogram's Lengt	h of stay limit	0	25. 00
26. 00		,			3, 651, 059	
27. 00					100, 360	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line				3, 550, 699	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (line	1 times line	28)	1, 495, 597	
30.00		20)			2, 212, 766	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line)	e 30)			3, 166, 714	31.00

Health Financial Systems	GIBSON GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 151319	Peri od:	Worksheet A	
				From 10/01/2013		
				Γο 09/30/2014	Date/Time Pre	pared:
					2/19/2015 8: 4	8 am
Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT		1, 431, 400	1, 431, 40	-538, 539	892, 861	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0		1, 276, 910	1, 276, 910	2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	149, 115	385, 511	534, 62		697, 078	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	1, 824, 703	4, 085, 049	5, 909, 75		5, 921, 167	5. 00
7. 00 00700 OPERATION OF PLANT	331, 083		1, 287, 15		1, 275, 520	7. 00
		956, 073				
8. 00 00800 LAUNDRY & LINEN SERVICE	45, 200	64, 024			108, 523	8. 00
9. 00 00900 HOUSEKEEPI NG	304, 786	180, 272			481, 251	9. 00
10. 00 01000 DI ETARY	416, 959	401, 738			402, 210	10. 00
11. 00 01100 CAFETERI A	0	0		412, 405	412, 405	11. 00
13.00 O1300 NURSING ADMINISTRATION	148, 212	29, 026	177, 23	3 0	177, 238	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	232, 073	138, 984	371, 05	7 -1, 317	369, 740	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 102, 860	525, 882	1, 628, 74	2 -80, 801	1, 547, 941	30. 00
31. 00 03100 INTENSIVE CARE UNIT	177, 589	47, 717			219, 232	31. 00
44. 00 04400 SKILLED NURSING FACILITY	835, 070	309, 869			1, 134, 769	44. 00
ANCI LLARY SERVICE COST CENTERS	000,010	007,007	1, 111, 70	7 10, 170	1, 101, 707	11.00
50. 00 05000 OPERATI NG ROOM	700, 855	1, 410, 531	2, 111, 38	-428, 209	1, 683, 177	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		728, 139			1, 362, 556	54.00
	694, 023					
54. 03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	120, 824		I	120, 824	54. 03
60. 00 06000 LABORATORY	687, 365	948, 133			1, 604, 870	60. 00
65. 00 06500 RESPI RATORY THERAPY	357, 512	340, 469			657, 405	65. 00
66. 00 06600 PHYSI CAL THERAPY	626, 993	255, 979	882, 97	2 -64, 341	818, 631	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	237, 356	52, 740	290, 09	5 -852	289, 244	67. 00
68. 00 06800 SPEECH PATHOLOGY	126, 798	54, 103	180, 90	1 -1, 295	179, 606	68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0		ol ol	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	ol	-6, 912	-6, 91	77, 024	70, 112	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	,	370, 099	370, 099	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	163, 342	1, 157, 807	1, 321, 14		1, 274, 881	73. 00
OUTPATIENT SERVICE COST CENTERS	1007012	.,,	., 02.,	, 10, 200	1/2/1/001	70.00
90. 00 09000 CLINI C	100, 211	108, 754	208, 96	-6, 950	202, 015	90.00
90. 01 09001 DI ABETES	36, 763	20, 446			57, 082	90. 01
					· ·	
90. 02 09002 OP PSYCH	62, 338	96, 646			158, 534	90. 02
91. 00 09100 EMERGENCY	722, 137	614, 812	1, 336, 94	9 -22, 271	1, 314, 678	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00 04040 CARDI AC REHAB	0	0		0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	285, 272	137, 184	422, 45	-2, 856	419, 600	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE		266, 949	266, 94	-266, 949	0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	10, 368, 615	14, 862, 149	25, 230, 76	269, 395	25, 500, 159	118. 00
NONREI MBURSABLE COST CENTERS	.,,					
194. 00 07950 MOB	4, 197, 679	2, 765, 441	6, 963, 12	-269, 394	6, 693, 726	194 00
194. 01 07951 FOUNDATI ON	42, 082	4, 595	46, 67		46, 676	
194. 02 07952 ASC	42,002	7, J7J				194. 02
194. 03 07953 SNF - PERRY CO.	430, 565	1/1 01/		-	572, 379	
		141, 814		I		
200.00 TOTAL (SUM OF LINES 118-199)	15, 038, 941	17, 773, 999	32, 812, 94	이	32, 812, 940	∠UU. UU

Heal th FinancialSystemsGIBSON GERECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 151319

				2/19/2015	8: 48 am
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-17, 867	874, 994	·	1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-172, 964	1, 103, 946	l .	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	102, 062	799, 140		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 211, 383	4, 709, 784		5. 00
7.00	00700 OPERATION OF PLANT	-9, 686	1, 265, 834		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	108, 523		8. 00
9.00	00900 HOUSEKEEPI NG	0	481, 251	l .	9. 00
10. 00	01000 DI ETARY	0	402, 210		10. 00
11. 00	01100 CAFETERI A	-169, 110	243, 295		11. 00
13.00	01300 NURSING ADMINISTRATION	0	177, 238		13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-9, 875	359, 865		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-40, 774	1, 507, 167		30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	219, 232		31. 00
44.00	04400 SKILLED NURSING FACILITY	0	1, 134, 769		44. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	-325, 000	1, 358, 177		50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 362, 556		54. 00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	120, 824		54. 03
60.00	06000 LABORATORY	-30, 983	1, 573, 887		60.00
65. 00	06500 RESPI RATORY THERAPY	-25, 637	631, 768		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	818, 631		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	289, 244		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	179, 606		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70, 112		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	370, 099		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 274, 881		73. 00
	OUTPATIENT SERVICE COST CENTERS				
90. 00	09000 CLI NI C	0	202, 015		90. 00
90. 01	09001 DI ABETES	0	57, 082		90. 01
90. 02	09002 OP PSYCH	-74, 338	84, 196		90. 02
91. 00	09100 EMERGENCY	0	1, 314, 678		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
93. 00	04040 CARDI AC REHAB	0	0		93. 00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	419, 600		101. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE	0	0	l .	113. 00
118.00		-1, 985, 555	23, 514, 604		118. 00
40.5	NONREI MBURSABLE COST CENTERS		, ,,,, ==:1		46: 65
	07950 MOB	0	6, 693, 726		194. 00
	07951 FOUNDATI ON	0	46, 676		194. 01
	07952 ASC	0	0	l .	194. 02
	07953 SNF - PERRY CO.	0	572, 379	·	194. 03
200.00	TOTAL (SUM OF LINES 118-199)	-1, 985, 555	30, 827, 385		200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 151319

					To 09/30/2014 Date/Time Prepared 2/19/2015 8:48 am
		Increases			271772318 3. 18 diii
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
	A - INSURANCE	3.00	4.00	3.00	
	NEW CAP REL COSTS-MVBLE	2. 00	0	25, 333	1. C
	EQUI P	+			
	B - DEPRECIATION		UJ	25, 333	
	NEW CAP REL COSTS-MVBLE	2.00	0	496, 993	1.0
	EQUI P				
	TOTALS D - CAFETERIA		0	496, 993	
	CAFETERI A	11. 00	210, 036	202, 369	1.0
	TOTALS		210, 036	202, 369	1. 0
	E - MED SUPPLY CHG PTS				
	MEDICAL SUPPLIES CHARGED TO	71. 00	0	77, 024	1.0
	PATIENTS IMPL. DEV. CHARGED TO	72. 00	0	370, 099	2.0
	PATIENTS	72.00	٩	370,099	2. 0
3. 00		0.00	o	0	3.0
4. 00		0.00	0	0	4. 0
5.00		0.00	0	0	5. 0
5. 00 7. 00		0. 00 0. 00	0	0	6. C 7. C
3. 00		0.00	ő	ő	8.0
10. 00		0. 00	О	Ō	10.0
11.00		0.00	0	0	11. 0
12.00		0.00	0	0	12. 0
13. 00 14. 00		0. 00 0. 00	0	0	13. 0
15. 00		0.00	Ö	0	15. 0
16. 00		0.00	o	0	16. 0
	TOTALS		0	447, 123	
	F - RENTAL EXPENSE	2 00	ما	474 4/0	1.0
	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	474, 468	1.0
2. 00	Legit	0.00	o	0	2.0
3. 00		0.00	O	0	3.0
9. 00		0.00	0	0	9. 0
10. 00 12. 00		0. 00 0. 00	0	0	10. 0
13. 00		0.00	Ö	0	13.0
15. 00		0.00	ō	0	15. 0
16. 00		0.00	О	0	16.0
17. 00		0.00	0	0	17. 0
21. 00 22. 00		0. 00 0. 00	0	0	21. (
24. 00		0.00	o	0	24. 0
27. 00		0.00	Ö	Ö	27. 0
	TOTALS		0	474, 468	
	H - BUSINESS HEALTH SER	4 00	20, 020	27 500	1.0
. 00	EMPLOYEE BENEFITS DEPARTMENT TOTALS	4.00	3 <u>8, 0</u> 30 38, 030	2 <u>7, 5</u> 98 27, 598	1.0
	I - INTEREST		30, 030	27, 370	
1.00		0.00	0	0	1.0
	NEW CAP REL COSTS-MVBLE	2. 00	0	263, 903	2.0
	EQUI P	F 00		2 044	2.0
	ADMINISTRATIVE & GENERAL TOTALS			<u>3, 046</u> 266, 949	3.0
	J - PROPERTY TAX		O O	200, 777	
1. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	16, 213	1.0
	EQUI P	+			
	TOTALS K - QUALITY SERVICES		0	16, 213	
	ADMINISTRATIVE & GENERAL	5. 00	32, 823	23, 319	1.0
	TOTALS		32, 823	23, 319	
	L - HEALTH INSURANCE				
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	96, 824	1. 0
. 00 . 00		0. 00 0. 00	0	0	2. (
. 00		0.00	0	0	3. (
. 00		0.00	o	o o	5. (
. 00		0. 00	O	0	8.0
. 00		0.00	0	0	9. (
0.00		0.00	0	0	10.0
11. 00 12. 00		0. 00 0. 00	0	0	11. 0

Health Financial Systems RECLASSIFICATIONS GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 151319 | Period: | Worksheet A-6 | From 10/01/2013 | To 09/30/2014 | Date/Time Prepared: 2/19/2015 8:48 am

					2/19/2015 8:48 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
13.00		0. 00	0	0	13.00
15. 00		0.00	0	0	15. 00
16. 00		0.00	0	0	16.00
17. 00		0.00	0	0	17. 00
18. 00		0.00	0	0	18.00
19. 00		0.00	0	0	19.00
22. 00		0.00	0	0	22. 00
23. 00		0.00	0	0	23.00
24. 00		0.00	0	0	24. 00
25. 00		0.00	0	0	25. 00
26. 00		0.00	0	0	26. 00
28. 00		0.00	0	0	28. 00
29. 00		0.00	0	0	29. 00
30. 00		0.00	0	0	30.00
Į.	TOTALS			96, 824	
500.00	Grand Total: Increases		280, 889	2, 077, 189	500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 10/01/2013 | To 09/30/2014 | Date/Time Prepared: Provider CCN: 151319

					To	09/30/2014 Date/Time 2/19/2015	
		Decreases				1 27 177 2010	0. 10 diii
	Cost Center	Li ne #	Sal ary	0ther 9.00	Wkst. A-7 Ref.		
	6. 00 A - I NSURANCE	7. 00	8. 00	9.00	10. 00		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	25, 333	9		1. 00
	FIXT		↓				
	TOTALS		0	25, 333			
1. 00	B - DEPRECIATION NEW CAP REL COSTS-BLDG &	1.00	0	496, 993	9		1.00
1.00	FIXT	1.00	٥	490, 993	9		1.00
	TOTALS	$=$ $=$ \pm		496, 993			
	D - CAFETERIA						
1. 00	DI ETARY	10. 00	<u>210, 036</u>	20 <u>2, 3</u> 69			1. 00
	TOTALS E - MED SUPPLY CHG PTS		210, 036	202, 369			
1.00	E - WED SUFFET CHG F13	0.00	O	0	0		1.00
2.00		0.00	o	0	1		2. 00
3.00	ADMINISTRATIVE & GENERAL	5.00	O	32	. o		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	3, 644	1		4. 00
5. 00	INTENSIVE CARE UNIT	31.00	0	321			5. 00
6. 00 7. 00	SKILLED NURSING FACILITY OPERATING ROOM	44. 00 50. 00	0	722 322, 954			6. 00 7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	935			8. 00
10.00	LABORATORY	60.00	О	1, 658	o		10. 00
11. 00	RESPI RATORY THERAPY	65. 00	0	17, 315			11. 00
12.00	PHYSICAL THERAPY	66.00	0	3, 721			12.00
13. 00 14. 00	DRUGS CHARGED TO PATIENTS EMERGENCY	73. 00 91. 00	0	66 5, 479	1		13. 00 14. 00
15. 00	HOME HEALTH AGENCY	101.00	0	484	1		15. 00
16. 00	MOB	194.00	Ö	89, 792	1		16. 00
	TOTALS			447, 123			
4 00	F - RENTAL EXPENSE	9 99	- I				
1. 00 2. 00	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	0 31, 843	1		1. 00 2. 00
3. 00	OPERATION OF PLANT	7. 00	0	8, 647			3.00
9. 00	ADULTS & PEDIATRICS	30.00	o	12, 392			9. 00
10.00	INTENSIVE CARE UNIT	31.00	o	5, 217	1		10.00
12.00	OPERATING ROOM	50.00	0	101, 649	1		12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	53, 424			13.00
15. 00 16. 00	LABORATORY RESPI RATORY THERAPY	60. 00 65. 00	0	25, 258 21, 924			15. 00 16. 00
17. 00	PHYSI CAL THERAPY	66.00	0	57, 678			17. 00
21. 00	DRUGS CHARGED TO PATIENTS	73. 00	ō	45, 408			21. 00
22. 00	CLINIC	90.00	0	5, 434	1		22. 00
24. 00	EMERGENCY	91.00	0	10, 435			24. 00
27. 00	MOB	194.00	0	9 <u>5, 1</u> 59 474, 468			27. 00
	H - BUSINESS HEALTH SER		<u> </u>	474, 400	'		
1.00	MOB	194.00	38, 030	27, 598	0		1.00
	TOTALS		38, 030	27, 598			
4 00	I - INTEREST	442.00		0// 0/0			4 00
1. 00 2. 00	I NTEREST EXPENSE	113. 00 0. 00	0	266, 949 0			1. 00 2. 00
3. 00		0.00	0	0	0		3. 00
0.00	TOTALS			266, 949	<u> </u>		0.00
	J - PROPERTY TAX						
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	16, 213	9		1. 00
	FI XT	+		1 6, 2 13	 		
	K - QUALITY SERVICES		<u> </u>	10, 213			
1.00	ADULTS & PEDIATRICS	30.00	32, 823	23, 319			1.00
	TOTALS		32, 823	23, 319			
1 00	L - HEALTH INSURANCE	F 00	ما	15 000			1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	0	15, 898 2, 989			1. 00 2. 00
3. 00	LAUNDRY & LINEN SERVICE	8.00	o	701			3. 00
4. 00	HOUSEKEEPI NG	9. 00	Ö	3, 807			4. 00
5.00	DI ETARY	10. 00	0	4, 082	. 0		5. 00
8.00	MEDI CAL RECORDS & LI BRARY	16.00	0	1, 317	1		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	8, 623			9.00
10. 00 11. 00	INTENSIVE CARE UNIT SKILLED NURSING FACILITY	31. 00 44. 00	0	536 9, 448			10. 00 11. 00
12. 00	OPERATING ROOM	50.00	0	3, 606			12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	5, 247			13. 00
15.00	LABORATORY	60.00	О	3, 712	. o		15. 00
16.00	RESPIRATORY THERAPY	65.00	0	1, 337	1		16.00
17. 00	PHYSI CAL THERAPY	66. 00	0	2, 942	0		17. 00

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 151319 Period: Worksheet A-6

Peri od: Worksheet A-6
From 10/01/2013
To 09/30/2014 Date/Time Prepared:

						2/19/2015 8: 48	3 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
18.00	OCCUPATI ONAL THERAPY	67.00	0	852	0		18. 00
19.00	SPEECH PATHOLOGY	68. 00	0	1, 295	0		19.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	794	0		22.00
23.00	CLI NI C	90.00	0	1, 516	0		23.00
24.00	DI ABETES	90. 01	0	127	0		24.00
25.00	OP PSYCH	90. 02	0	450	0		25.00
26.00	EMERGENCY	91.00	0	6, 357	0		26.00
28. 00	HOME HEALTH AGENCY	101.00	0	2, 372	2		28.00
29.00	FOUNDATI ON	194. 01	0	1	0		29.00
30.00	MOB	194. 00	0	1 <u>8, 8</u> 15	0		30.00
	TOTALS		0	96, 824			
500.00	Grand Total: Decreases		280, 889	2, 077, 189			500.00

In Lieu of Form CMS-2552-10 RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 151319 Peri od: Worksheet A-7 From 10/01/2013 Part I Date/Time Prepared: 09/30/2014 2/19/2015 8:48 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 660, 012 19, 500 19, 500 0 1.00 0 2.00 Land Improvements 0 2.00 0 3. 00 3.00 Buildings and Fixtures 19, 083, 961 248, 089 248, 089 0 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 12, 688, 012 885, 298 885, 298 0 6.00 0 7.00 HIT designated Assets 7.00 0 8.00 Subtotal (sum of lines 1-7) 32, 431, 985 1, 152, 887 1, 152, 887 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) <u>1, 152, 88</u>7 32, 431, 985 1, 152, 887 10.00 10.00 0 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 679, 512 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 19, 332, 050 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 13, 573, 310 6.00

33, 584, 872

33, 584, 872

0

0

0

7.00

8.00

9.00

10.00

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

Heal th	Financial Systems	GIBSON GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151319	Peri od: From 10/01/2013	Worksheet A-7 Part II		
					To 09/30/2014	Date/Time Pre		
						2/19/2015 8: 4	8 am	
SUMMARY OF CAPITAL								
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
					instructions)	instructions)		
		9.00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 431, 400	0		0 0	0	1. 00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	1, 431, 400	0		0 0	0	3. 00	
	· · · · · · · · · · · · · · · · · · ·	SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 431, 400				1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2. 00	
3.00	Total (sum of lines 1-2)	0	1, 431, 400				3. 00	

Health Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 10/01/2013 To 09/30/2014	Worksheet A-7 Part III Date/Time Pre 2/19/2015 8:4	pared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col	instructions)		
	1.00	2.00	2)	4.00	F 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	1.00	2.00	3.00	4. 00	5. 00	
1. 00 NEW CAP REL COSTS-BLDG & FLXT	1, 245, 381	0	1, 245, 38	1 1. 000000	0	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	Ō		0. 000000		2. 00
3.00 Total (sum of lines 1-2)	1, 245, 381	0	1, 245, 38	1 1. 000000	0	3. 00
	ALLOCA'	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	6. 00	d Costs 7.00	through 7) 8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		7.00	0.00	7.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 874, 994	0	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 276, 910	-172, 964	2. 00
3.00 Total (sum of lines 1-2)	0	0		0 2, 151, 904	-172, 964	3. 00
		Sl	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE					.0.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0		0 0	874, 994	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	1		0 0	1, 103, 946	2. 00
3.00 Total (sum of lines 1-2)	0	0		0 0	1, 978, 940	3. 00

	Financial Systems		GIBSON GENERAL			u of Form CMS-2	
ADJUST	TMENTS TO EXPENSES			Provi der CCN: 151319	Peri od: From 10/01/2013	Worksheet A-8	
					To 09/30/2014		
				Expense Classification (n Worksheet A	2/19/2015 8:4	8 am
			Т	o/From Which the Amount i			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1.00	2.00	3.00 EW CAP REL COSTS-BLDG &	4. 00	5. 00 0	1. 00
1.00	REL COSTS-BLDG & FIXT (chapter			IXT	1.00		1.00
0.00	2)		170 0/41	EW OAR REL COCTO MURI E	0.00	40	0.00
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter	В .		EW CAP REL COSTS-MVBLE QUIP	2. 00	10	2. 00
	2)		-	2011			
3.00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
	di scounts (chapter 8)						
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by		o		0.00	0	6. 00
	suppliers (chapter 8)						
7. 00	Telephone services (pay stations excluded) (chapter	A	-9, 6860	PERATION OF PLANT	7. 00	0	7. 00
	21)						
8. 00	Tel evi si on and radio servi ce		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10.00	Provi der-based physician	A-8-2	-496, 732		0.00	Ö	
44.00	adjustment				0.00		44 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	o			0	12.00
12.00	transactions (chapter 10)				0.00		12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-169, 110 C	AFFTERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		0		0.00	0	1
16. 00	and others Sale of medical and surgical				0.00	0	16. 00
16.00	supplies to other than		٩		0.00	0	16.00
	patients						
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and	В	-9, 875M	EDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts					_	
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00	Vendi ng machi nes		o		0.00	0	20.00
21. 00	Income from imposition of		0		0.00	0	21.00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		О		0.00	0	22. 00
	overpayments and borrowings to	'					
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	OR	ESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	OP	HYSICAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of	A-0-3	O F1	IIISI CAL IIIERAFI	00.00		24.00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0 *	** Cost Center Deleted **	* 114.00		25. 00
	(chapter 21)						
26. 00	Depreciation - NEW CAP REL			EW CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL			IXT EW CAP REL COSTS-MVBLE	2. 00	0	27. 00
27.00	COSTS-MVBLE EQUIP		E	QUI P			
28. 00	Non-physician Anesthetist		0 *	** Cost Center Deleted **			28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	00	CCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of				1		
20.00	limitation (chapter 14)			DILLTO & DEDIATRICO	20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		UA	DULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech	A-8-3	0 s	PEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for	А	-17, 867N	EW CAP REL COSTS-BLDG &	1. 00	9	32.00
	Depreciation and Interest	<u> </u>		I XT		<u> </u>	<u> </u>

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES	Provi der CCN: 151319	Peri od: From 10/01/2013	Worksheet A-8	
			Date/Time Prep 2/19/2015 8:48	
	Expense Classification of To/From Which the Amount i			

				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
33. 00	MISC INCOME	В	-27, 175	ADMINISTRATIVE & GENERAL	5. 00		
33. 01			0		0. 00		33. 01
33. 02			0		0.00		33. 02
33. 03	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00		33. 03
34.00	EMPLOYEE DI SCOUNT	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00		34. 00
35.00	HAF FEE	A	-928, 414	ADMINISTRATIVE & GENERAL	5. 00	0	35. 00
36.00			0		0.00	0	36. 00
37.00			0		0.00	ol	37. 00
38.00			0		0.00	ol	38. 00
39.00			0		0.00	ol	39. 00
40.00			0		0.00	ol	40.00
41.00			0		0.00	o	41.00
42.00			0		0.00	o	42.00
43.00			0		0.00	j ol	43.00
44.00			0		0.00	l o	44. 00
45.00			0		0.00	l o	45. 00
50.00	TOTAL (sum of lines 1 thru 49)		-1, 985, 555				50.00
	(Transfer to Worksheet A,						1
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

					-	To 09/30/2014	Date/Time Pre 2/19/2015 8:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
					•		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	40, 774		C	0	0	
2.00	50.00	OPERATING ROOM	325, 000	325, 000	C	0	0	2. 00
3.00	65. 00	RESPI RATORY THERAPY	73, 962	25, 637	48, 325	0	0	3. 00
4.00	60.00	LABORATORY	30, 983	30, 983	C	0	0	4. 00
5.00	90. 02	OP PSYCH	74, 338	74, 338	C	0	0	5. 00
6.00	91. 00	EMERGENCY	249, 371	0	249, 371	0	0	6. 00
7.00	90. 01	DI ABETES	6, 000	0	6,000	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			800, 428	496, 732	303, 696	,	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	0	_	1	_	
2.00		OPERATING ROOM	0	0	_	0	0	2. 00
3.00		RESPI RATORY THERAPY	0	0	C	1	_	3. 00
4.00		LABORATORY	0	0	C	0	0	4. 00
5.00		OP PSYCH	0	0	C	0	0	5. 00
6.00		EMERGENCY	0	0	C	0	0	6. 00
7.00	90. 01	DI ABETES	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	0	200. 00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	1/ 00	47.00	10.00		
1 00	1.00	2. 00	15. 00	16. 00	17. 00	18.00		1 00
1. 00 2. 00		ADULTS & PEDIATRICS OPERATING ROOM	0	-	_	1	•	1. 00 2. 00
			0	0			•	
3.00		RESPI RATORY THERAPY		0	_	,		3. 00
4.00		LABORATORY		0	_	,		4. 00
5.00		OP PSYCH			C	, ,, 000		5. 00
6.00		EMERGENCY		0	C	0		6. 00
7.00		DI ABETES		0				7. 00
8.00	0.00		0	0	C	0		8. 00
9.00	0.00		0	0		1 0		9. 00
10.00	0. 00		0	0	_	0		10.00
200.00			1 0	0	C	496, 732		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151319 Peri od: Worksheet B From 10/01/2013 Part I Date/Time Prepared: 09/30/2014 2/19/2015 8:48 am CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE **EMPLOYEE** Subtotal for Cost FIXT **FOULP BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 874, 994 874 994 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 1, 103, 946 1, 103, 946 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 799, 140 5, 386 6, 795 811, 321 4.00 00500 ADMINISTRATIVE & GENERAL 53. 840 4, 907, 771 5 00 4 709 784 42, 674 101 473 5 00 7.00 00700 OPERATION OF PLANT 1, 265, 834 150, 278 189, 600 18,086 1, 623, 798 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 108, 523 15, 565 19, 637 2, 469 146, 194 8.00 9.00 00900 HOUSEKEEPI NG 481, 251 8, 785 11,084 16,650 517, 770 9.00 01000 DI ETARY 10 00 402, 210 50, 418 11, 304 503, 894 10 00 39, 962 11.00 01100 CAFETERI A 243, 295 C 11, 474 254, 769 11.00 01300 NURSING ADMINISTRATION 177, 238 3, 325 8,097 191, 295 13.00 2,635 13.00 01600 MEDICAL RECORDS & LIBRARY 359, 865 401, 331 16, 00 12, 729 <u>16</u>, 059 12.678 16, 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 507, 167 78, 128 98, 571 58, 454 1, 742, 320 30.00 03100 INTENSIVE CARE UNIT 219, 232 9, 701 270, 743 31.00 18, 486 23, 324 31.00 04400 SKILLED NURSING FACILITY 60, 702 76, 585 1, 317, 674 44.00 1, 134, 769 45, 618 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 358, 177 48, 737 61, 490 38, 286 1, 506, 690 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 362, 556 33, 383 42, 118 37, 913 1, 475, 970 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54.03 120.824 4.010 5.060 129, 894 54.03 60.00 06000 LABORATORY 1, 573, 887 14,610 18, 432 37.549 1, 644, 478 60.00 15, 393 06500 RESPIRATORY THERAPY 631, 768 19, 420 19,530 686, 111 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 818, 631 26, 842 33, 865 34, 251 913, 589 66.00 06700 OCCUPATIONAL THERAPY 7, 811 12, 966 67.00 289, 244 9, 855 319, 876 67.00 68.00 06800 SPEECH PATHOLOGY 179, 606 592 747 6, 927 187, 872 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 70, 112 34, 271 43, 238 0 147, 621 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 370,099 370, 099 72 00 1, 305, 659 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 274, 881 9,663 12.192 8,923 73.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 202.015 19, 432 5. 474 242, 323 90.00 15.402 90.01 09001 DI ABETES 57,082 13, 349 16, 842 2,008 89, 281 90.01 09002 OP PSYCH 1, 919 91, 942 90.02 84, 196 2, 422 3, 405 90.02 09100 EMERGENCY 39, 449 91.00 91.00 1, 314, 678 84.497 106, 607 1, 545, 231 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 Λ 93.00 04040 CARDI AC REHAB 0 93.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 4, 822 446, 090 101, 00 419,600 6,084 15 584 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113. 00 118.00 SUBTOTALS (SUM OF LINES 1-117) 23, 514, 604 750, 631 947, 042 558, 269 22, 980, 285 118. 00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MOB 6, 693, 726 81,508 102.836 227, 232 7, 105, 302 194. 00 194. 01 07951 FOUNDATI ON 12, 499 15, 770 2, 299 77, 244 194. 01 46, 676 194. 02 07952 ASC 0 194. 02 664, 554 194. 03 194.03 07953 SNF - PERRY CO. 572.379 30, 356 38, 298 23.521 200.00 Cross Foot Adjustments 0 200.00 Negative Cost Centers 201.00 0 201.00 202.00 TOTAL (sum lines 118-201) 874, 994 1, 103, 946 811, 321 30, 827, 385 202. 00 30, 827, 385

| Peri od: | Worksheet B | From 10/01/2013 | Part I | To 09/30/2014 | Date/Time Prepared: Provider CCN: 151319

				10	09/30/2014	Date/IIme Pre 2/19/2015 8:4	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	o aiii
	2001 2011101 20001 1 pt 1 011	& GENERAL	PLANT	LINEN SERVICE	HOUSENEEL THO	512.7	
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 907, 771					5. 00
7.00	00700 OPERATION OF PLANT	307, 460	1, 931, 258				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	27, 681	44, 423	218, 298			8. 00
9.00	00900 HOUSEKEEPI NG	98, 038	25, 073	9, 578	650, 459		9. 00
10.00	01000 DI ETARY	95, 410	114, 055	3, 189	39, 849	756, 397	10.00
11. 00	01100 CAFETERI A	48, 239	0	0	0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	36, 221	7, 522	0	2, 628	0	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	75, 990	36, 329	0	12, 692	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	329, 901	222, 987	65, 688	77, 907	210, 186	30. 00
31.00	03100 INTENSIVE CARE UNIT	51, 264	52, 763	1, 800	18, 434	0	31.00
44.00	04400 SKILLED NURSING FACILITY	249, 496	173, 250	53, 962	60, 530	368, 520	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	285, 286	139, 101	9, 302	48, 599	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	279, 469	95, 278	9, 452	33, 288	0	54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	24, 595	11, 446	0	3, 999	0	54. 03
60.00	06000 LABORATORY	311, 375	41, 698	0	14, 568	0	60.00
65.00	06500 RESPI RATORY THERAPY	129, 912	43, 932	5, 072	15, 349	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	172, 984	76, 609	13, 555	26, 766	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	60, 567	22, 293	0	7, 789	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	35, 573	1, 690	0	590	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 951	97, 812	0	34, 174	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	70, 077	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	247, 221	27, 580	0	9, 636	0	73. 00
	OUTPATIENT SERVICE COST CENTERS			I			
90.00	09000 CLI NI C	45, 883	43, 960	0	15, 359	0	90. 00
90. 01	09001 DI ABETES	16, 905	38, 100		13, 311	0	90. 01
90. 02	09002 OP PSYCH	17, 409	5, 478		1, 914	0	90. 02
91. 00	09100 EMERGENCY	292, 583	241, 167	19, 719	84, 257	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00	04040 CARDI AC REHAB	0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS		10.7/0				
101.00	10100 HOME HEALTH AGENCY	84, 465	13, 763	0	4, 808	0	101. 00
440.04	SPECIAL PURPOSE COST CENTERS						440.00
	11300 INTEREST EXPENSE	0 404 055	4 57/ 000	404 047	FO (447	F70 70/	113.00
118. 00		3, 421, 955	1, 576, 309	191, 317	526, 447	578, 706	1118.00
104.00	NONREI MBURSABLE COST CENTERS	1 245 250	222 (25		01 270	0	194. 00
	07950 MOB	1, 345, 359	232, 635	0	81, 278		194. 00
	07951 FOUNDATI ON 07952 ASC	14, 626	35, 675	0	12, 464		194. 01
	307953 SNF - PERRY CO.	125, 831	86, 639	26, 981	30, 270	177, 691	
200.00	l l	120, 031	00, 039	20, 981	30, 270	177,091	200. 00
200.00	,		^	0		Ō	201. 00
201.00	1 3	4, 907, 771	1, 931, 258	218, 298	650, 459	756, 397	
202.00		4, 707, 771	1, 751, 250	210, 270	030, 439	130, 371	1202.00

Provider CCN: 151319 | Period: | Worksheet B | From 10/01/2013 | Part I | To 09/30/2014 | Part / I me Proposed | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	09/30/2014		
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	o alli
	5551 551151 25551 Pt. 511	07.11 2 7 2 1 1 1 1 1	ADMI NI STRATI ON	RECORDS &	oub to tu.	Residents Cost	
				LI BRARY		& Post	
						Stepdown	
						Adjustments	
		11.00	13.00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS	T.	T T	ı			
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY	•					10.00
	01100 CAFETERI A	303, 008					11. 00
	01300 NURSING ADMINISTRATION	2, 079					13. 00
	01600 MEDI CAL RECORDS & LI BRARY	15, 311	0	541, 653			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	48, 785	78, 478	161, 210	2, 937, 462	0	30. 00
	03100 INTENSIVE CARE UNIT	6, 470		2, 657	414, 540	0	31. 00
44.00	04400 SKILLED NURSING FACILITY	43, 522	70, 012	3, 543	2, 340, 509	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	16, 815		57, 133	2, 062, 926	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	26, 687	0	48, 718	1, 968, 862	0	54.00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	000000	0	0	169, 934	0	54. 03
	06000 LABORATORY	30, 866	l 1	40, 746	2, 083, 731	0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	12, 147	0	16, 830	909, 353	0	65. 00 66. 00
67. 00	06700 OCCUPATIONAL THERAPY	24, 248 7, 370		73, 077 0	1, 300, 828 417, 895	0	67. 00
	06800 SPEECH PATHOLOGY	3, 515		0	229, 240	0	68. 00
	06900 ELECTROCARDI OLOGY	3,313		0	227, 240 N	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 930	1 "	Ö	309, 488	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	1 0	o	0	440, 176	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	4, 507	o	0	1, 594, 603	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	4, 389		443	352, 357	0	90. 00
	09001 DI ABETES	2, 076	3, 339	0	163, 012	0	90. 01
	09002 OP PSYCH	2, 427	0	0	119, 170	0	90. 02
	09100 EMERGENCY	26, 421	42, 501	136, 853	2, 388, 732	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	_	_		_	0	92. 00
	04040 CARDI AC REHAB OTHER REI MBURSABLE COST CENTERS	0	0	0	0	0	93. 00
	10100 HOME HEALTH AGENCY	1 0	ol	0	549, 126	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS		<u> </u>	U _I	547, 120	U	101.00
113. 00	11300 I NTEREST EXPENSE						113. 00
118.00		279, 565	204, 739	541, 210	20, 751, 944	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	07950 MOB	0		443	8, 765, 017		194. 00
	07951 FOUNDATI ON	1, 682	0	0	141, 691		194. 01
	07952 ASC	0	0	0	0		194. 02
	07953 SNF - PERRY CO.	21, 761	35, 006	0	1, 168, 733		194. 03
200.00	Cross Foot Adjustments				0		200. 00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118-201)	303, 008	0 239, 745	0 541 652	0 30, 827, 385		201. 00 202. 00
202.00	TOTAL (SUII TITIES TIB-201)	303,008	239, 145	541, 653	JU, 8∠1, 385	0	1202. UU

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

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151319
 Period: From 10/01/2013 | Part I To 09/30/2014 | Date/Time Prepared: Date/Tim

	Cost Center Description	Total	27 177 23 10 31	10 0
	· ·	26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	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 NURSING ADMINISTRATION			13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T		
30. 00	03000 ADULTS & PEDI ATRI CS	2, 937, 462		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	414, 540		31.00
44. 00	04400 SKILLED NURSING FACILITY	2, 340, 509		44. 00
	ANCILLARY SERVICE COST CENTERS	1 1		
50. 00	05000 OPERATING ROOM	2, 062, 926		50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 968, 862		54. 00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	169, 934		54. 03
60.00	06000 LABORATORY	2, 083, 731		60.00
65. 00	06500 RESPI RATORY THERAPY	909, 353		65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 300, 828		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	417, 895		67. 00
68. 00	06800 SPEECH PATHOLOGY	229, 240		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	309, 488		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	440, 176		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 594, 603		73. 00
	OUTPATIENT SERVICE COST CENTERS	250 257		
	09000 CLINIC	352, 357		90.00
90. 01	09001 DI ABETES	163, 012		90. 01
	09002 OP PSYCH	119, 170		90. 02
91.00	09100 EMERGENCY	2, 388, 732		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040 CARDI AC REHAB OTHER REI MBURSABLE COST CENTERS	0		93. 00
101 00		F40 10/		101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	549, 126		101. 00
112 00	11300 INTEREST EXPENSE	I		113. 00
118.00		20, 751, 944		118.00
110.00	NONREI MBURSABLE COST CENTERS	20, 731, 944		1118.00
104 00	07950 MOB	8, 765, 017		194. 00
	07951 FOUNDATION	141, 691		194. 00
	207951 FOUNDATTON 207952 ASC	141,091		194. 01
	07952 ASC 8 07953 SNF - PERRY CO.	1, 168, 733		194. 02
200.00		1, 100, 733		200. 00
200.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			200.00
201.00		30, 827, 385		201.00
202.00	TOTAL (Suil TITIES TTO-201)	30, 027, 303		1202.00

| Peri od: | Worksheet B | From 10/01/2013 | Part | I | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151319

				То	09/30/2014	Date/Time Pre 2/19/2015 8:4	
			CAPI TAL REI	ATED COSTS		27 177 2013 0.4	o aiii
	Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FIXT	EQUI P		BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 386		12, 181	12, 181	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	42, 674		96, 514	1, 523	5. 00
7.00	00700 OPERATION OF PLANT	0	150, 278		339, 878	271	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	15, 565		35, 202	37	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	8, 785 39, 962		19, 869 90, 380	250 170	9. 00 10. 00
11. 00	01100 CAFETERI A	0	39, 902		90, 360	170	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	2, 635		5, 960	122	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	Ö	12, 729		28, 788	190	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-	.=, .=.				
30.00	03000 ADULTS & PEDIATRICS	0	78, 128	98, 571	176, 699	877	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	18, 486		41, 810	146	31. 00
44. 00	04400 SKILLED NURSING FACILITY	0	60, 702	76, 585	137, 287	685	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	48, 737		110, 227	575	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	33, 383		75, 501	569	54.00
54. 03 60. 00	05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 06000 LABORATORY	0	4, 010 14, 610		9, 070 33, 042	0 564	54. 03 60. 00
65. 00	06500 RESPIRATORY THERAPY	0	15, 393		34, 813	293	65.00
66. 00	06600 PHYSI CAL THERAPY	Ö	26, 842		60, 707	514	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o	7, 811	9, 855	17, 666	195	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	592	747	1, 339	104	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	o	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34, 271	43, 238	77, 509	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	9, 663	12, 192	21, 855	134	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS		15 400	10 422	24 024	0.2	00.00
90. 00 90. 01	09000 CLI NI C 09001 DI ABETES	0	15, 402 13, 349		34, 834 30, 191	82 30	90. 00 90. 01
90. 01	09001 DI ABETES	0	13, 349		4, 341	30 51	90.01
91. 00	09100 EMERGENCY	0	84, 497		191, 104	592	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		04, 477	100,007	171, 104	372	92.00
93. 00	04040 CARDI AC REHAB	0	0	О	o	0	1
	OTHER REIMBURSABLE COST CENTERS	-"		'			
101.00	10100 HOME HEALTH AGENCY	0	4, 822	6, 084	10, 906	234	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
118.00		0	750, 631	947, 042	1, 697, 673	8, 380	118. 00
404.00	NONREI MBURSABLE COST CENTERS		04 500	100.00/	404 044	0.440	104.00
	07950 MOB	0	81, 508		184, 344		194. 00
	07951 FOUNDATI ON 07952 ASC		12, 499 0	15, 770	28, 269 0		194. 01 194. 02
	307953 SNF - PERRY CO.		30, 356	1 4	68, 654		194. 02
200.00			30, 330	30, 270	00, 054 N	333	200. 00
201.00	1 1		0	0	o	0	201. 00
202.00		o	874, 994	1, 103, 946	1, 978, 940	12, 181	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2013 | Part II | To 09/30/2014 | Date/Time Prepared: |

				''	0 09/30/2014	2/19/2015 8: 4	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	<u> </u>
	, , , , , , , , , , , , , , , , , , ,	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	98, 037					5. 00
7.00	00700 OPERATION OF PLANT	6, 141	346, 290				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	553	7, 965	43, 757			8. 00
9.00	00900 HOUSEKEEPI NG	1, 958	4, 496	1, 920	28, 493		9. 00
10.00	01000 DI ETARY	1, 906	20, 451	639	1, 746	115, 292	10.00
11. 00	01100 CAFETERI A	964	0	0	0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	723	1, 349	0	115	0	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 518	6, 514	0	556	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 589	39, 983	13, 167	3, 413	32, 037	30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 024	9, 461	361	807	0	31. 00
44.00	04400 SKILLED NURSING FACILITY	4, 983	31, 065	10, 816	2, 651	56, 171	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 698	24, 942	1, 864	2, 129	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 582	17, 084	1, 895	1, 458	0	54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	491	2, 052	0	175	0	54. 03
60.00	06000 LABORATORY	6, 219	7, 477	0	638	0	60.00
65. 00	06500 RESPI RATORY THERAPY	2, 595	7, 877	1, 017	672	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 455		2, 717	1, 172	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 210	3, 997	0	341	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	711	303	0	26	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	558	17, 539	0	1, 497	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 400	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 938	4, 945	0	422	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	916				0	90. 00
90. 01	09001 DI ABETES	338	6, 832	0	583	0	90. 01
90. 02	09002 OP PSYCH	348	982		0.1	0	90. 02
91. 00	09100 EMERGENCY	5, 844	43, 244	3, 953	3, 692	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
93. 00		0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
101. 0	D 10100 HOME HEALTH AGENCY	1, 687	2, 468	0	211	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	D 11300 INTEREST EXPENSE						113. 00
118. 0		68, 349	282, 645	38, 349	23, 061	88, 208	118. 00
	NONREI MBURSABLE COST CENTERS						
	0/07950 MOB	26, 883		0	3, 560		194. 00
	1 07951 FOUNDATI ON	292	6, 397	0	546		194. 01
	2 07952 ASC	0	0	0	0		194. 02
	3 07953 SNF - PERRY CO.	2, 513	15, 535	5, 408	1, 326	27, 084	
200.0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						200. 00
201. 0	1 1 9	0	0	0	0		201. 00
202. 0	TOTAL (sum lines 118-201)	98, 037	346, 290	43, 757	28, 493	115, 292	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2013 | Part II | To 09/30/2014 | Date/Time Prepared: | 2/19/2015 8: 48 am | Cultivate | Cultiva Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS GIBSON GENERAL HOSPITAL Provi der CCN: 151319

						2/19/2015 8: 4	<u>8 am</u>
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	
	·		ADMI NI STRATI ON	RECORDS &		Residents Cost	
				LI BRARY		& Post	
						Stepdown	
						Adjustments	
		11.00	13.00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	10.00	24.00	23.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMI NI STRATI VE & 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	1, 136					11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	8	8, 277				13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	57	0	37, 623			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	183	2, 710	11, 197	286, 855	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	24	359	185	54, 177	0	31.00
44.00	04400 SKILLED NURSING FACILITY	163	2, 417	246	246, 484	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	63	0	3, 968	149, 466	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	100	0	3, 384	105, 573	0	54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		11, 788	0	54. 03
60. 00	06000 LABORATORY	116	l o		50, 886	0	60.00
65. 00	06500 RESPI RATORY THERAPY	46	0		48, 482	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	91	0	.,	87, 469	Ö	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	28			23, 437	Ö	67. 00
68. 00	06800 SPEECH PATHOLOGY	13	0	-	2, 496		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		2, 470	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1 7	0		97, 110		71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	/	0			0	71.00
		17			1, 400	_	
73. 00	07300 DRUGS CHARGED TO PATIENTS	17	0	0	32, 311	0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1/		24	44 424	0	90. 00
90.00	09000 CLI NI C	16			44, 434	_	
90. 01	09001 DI ABETES	8			38, 097	0	90. 01
90. 02	09002 OP PSYCH	9	0	0	5, 815		90. 02
91. 00	09100 EMERGENCY	99	1, 467	9, 506	259, 501	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
93. 00	04040 CARDI AC REHAB	0	0	0	0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	15, 506	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
118.00	1002:01:120 (00:11:01:01:01:01:01:01)	1, 048	7, 068	37, 592	1, 561, 287	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	07950 MOB	0	0	31	259, 944		194. 00
194. 01	07951 FOUNDATI ON	6	0	0	35, 545		194. 01
194. 02	07952 ASC	0	0	0	0	0	194. 02
194.03	07953 SNF - PERRY CO.	82	1, 209	0	122, 164	0	194. 03
200.00		1			. 0	0	200. 00
201.00	1 1	0	o	О	0		201. 00
202.00	1 1 3	1, 136	8, 277	37, 623	1, 978, 940		202. 00
	1 . (.,	-, -, ,	1 2., 020	.,, ,	ı	

| Peri od: | Worksheet B | From 10/01/2013 | Part | I | To 09/30/2014 | Date/Time Prepared: Provider CCN: 151319

	Cost Center Description	Total	27 177 2010 0	
	· ·	26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 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 ADMINI STRATI ON			13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	TI		4
30. 00	03000 ADULTS & PEDI ATRI CS	286, 855		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	54, 177		31. 00
44. 00	04400 SKILLED NURSING FACILITY	246, 484		44. 00
	ANCILLARY SERVICE COST CENTERS	1		
50.00	05000 OPERATING ROOM	149, 466		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	105, 573		54. 00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	11, 788		54. 03
60.00	06000 LABORATORY	50, 886		60.00
65. 00	06500 RESPI RATORY THERAPY	48, 482		65. 00
66. 00	06600 PHYSI CAL THERAPY	87, 469		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	23, 437		67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 496		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0 07 110		69. 00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	97, 110		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 400		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	32, 311		73. 00
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	44 424		1 00 00
90. 00 90. 01	09000 CET NT C 09001 DI ABETES	44, 434 38, 097		90. 00 90. 01
90.01				
90. 02	09002 OP PSYCH 09100 EMERGENCY	5, 815 259, 501		90. 02 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	239, 301		91.00
	04040 CARDI AC REHAB	o		93. 00
73.00	OTHER REIMBURSABLE COST CENTERS	l o		33.00
101 00	10100 HOME HEALTH AGENCY	15, 506		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	15, 300		11011.00
113 00	11300 I NTEREST EXPENSE			113. 00
118.00	i i	1, 561, 287		118. 00
110.00	NONREI MBURSABLE COST CENTERS	1,001,207		1110.00
194.00	07950 MOB	259, 944		194. 00
	07951 FOUNDATION	35, 545		194. 01
	207952 ASC	00,040		194. 02
	07953 SNF - PERRY CO.	122, 164		194. 03
200.00		0		200.00
201.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			201. 00
202.00	1 1 9	1, 978, 940		202. 00
50	1 - 3 - 1 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2			

Heal th	Financial Systems	GIBSON GENERA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
					rom 10/01/2013		
					o 09/30/2014	Date/Time Pre	
						2/19/2015 8: 4	8 am
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	·	FLXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
				SALARI ES)			
	T	1.00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						1
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	91, 634					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		91, 634				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	564	564				4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	4, 469	4, 469			25, 919, 614	
		1					1
7. 00	00700 OPERATION OF PLANT	15, 738	15, 738			1, 623, 798	
8.00	00800 LAUNDRY & LINEN SERVICE	1, 630	1, 630	45, 200	0	146, 194	8. 00
9.00	00900 HOUSEKEEPI NG	920	920	304, 786	0	517, 770	9. 00
10.00	01000 DI ETARY	4, 185	4, 185	206, 923	0	503, 894	10.00
11. 00	01100 CAFETERI A	1,	0			254, 769	
		27/					
13. 00	01300 NURSING ADMINISTRATION	276	276	•		191, 295	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 333	1, 333	232, 073	0	401, 331	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 182	8, 182	1, 070, 037	0	1, 742, 320	30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 936	1, 936			270, 743	
44. 00	04400 SKILLED NURSING FACILITY	6, 357				1, 317, 674	
44.00		0, 357	6, 357	835,070) U	1, 317, 674	44.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	5, 104	5, 104	700, 855	0	1, 506, 690	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 496	3, 496	694, 023	0	1, 475, 970	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	420	420		0	129, 894	
60.00	06000 LABORATORY	1, 530	1, 530		_	1, 644, 478	
	l l	1					
65. 00	06500 RESPI RATORY THERAPY	1, 612	1, 612			686, 111	
66. 00	06600 PHYSI CAL THERAPY	2, 811	2, 811	626, 993	0	913, 589	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	818	818	237, 356	0	319, 876	67.00
68.00	06800 SPEECH PATHOLOGY	62	62			187, 872	
69. 00	06900 ELECTROCARDI OLOGY		0			0	1
		2 500	-		_		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 589	3, 589		0	147, 621	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	370, 099	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 012	1, 012	163, 342	0	1, 305, 659	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	1, 613	1, 613	100, 211	0	242, 323	90.00
90. 01	09001 DI ABETES	1, 398	1, 398			89, 281	
	1 1						1
90. 02	09002 OP PSYCH	201	201			91, 942	
91. 00	09100 EMERGENCY	8, 849	8, 849	722, 137	0	1, 545, 231	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 CARDI AC REHAB	l ol	0		o	0	93. 00
	OTHER REIMBURSABLE COST CENTERS	- 1			-		
101 00	10100 HOME HEALTH AGENCY	505	505	285, 272	2 0	446, 090	101 00
101.00	SPECIAL PURPOSE COST CENTERS	303	303	200, 272		440,070	101.00
440.00				I			140.00
	11300 INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	78, 610	78, 610	10, 219, 500	-4, 907, 771	18, 072, 514	J118. 00
	NONREI MBURSABLE COST CENTERS						
194.00	07950 MOB	8, 536	8, 536	4, 159, 649	0	7, 105, 302	1194. 00
	07951 FOUNDATI ON	1, 309	1, 309				194. 01
	1 1	1,307			0		
	07952 ASC	0	0		1		194. 02
	07953 SNF - PERRY CO.	3, 179	3, 179	430, 565	0	664, 554	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	1 1 0	874, 994	1, 103, 946	811, 321		4, 907, 771	1
202.00	Part I)	074, 774	1, 103, 740	011, 321		4, 707, 771	202.00
202 22		0.540700	10 047011	0.054400		0.4000	202 22
203.00		9. 548792	12. 047341			0. 189346	
204.00	Cost to be allocated (per Wkst. B,			12, 181		98, 037	204. 00
	Part II)						
205.00	1 1 *			0. 000820		0. 003782	205.00
	1 1:17	1 I		ı	1	ı	1

Heal th	Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-:	<u> 2552-10</u>
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
					rom 10/01/2013	D-+- /T: D	
				T	o 09/30/2014	Date/Time Pre 2/19/2015 8:4	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	O alli
	cost center bescription	PLANT	LI NEN SERVI CE	(SQUARE	(MEALS	(FTE'S)	
		(SQUARE	(POUNDS OF	FEET)	SERVED)	(112 3)	
		FEET)	LAUNDRY)	1 - 1 - 1 - 1	JERVED)		
		7.00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT	70, 863					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 630					8. 00
9. 00	00900 HOUSEKEEPING	920					9. 00
10. 00	01000 DI ETARY	4, 185			63, 384		10.00
11. 00	01100 CAFETERI A	1 0	,, 237		05, 304	303, 172	
13. 00	01300 NURSING ADMINISTRATION	276			ő	2, 080	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 333			ő	15, 319	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 333		1, 333	<u> </u>	10, 017	10.00
30. 00	03000 ADULTS & PEDIATRICS	8, 182	190, 283	8, 182	17, 613	48, 812	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 936			17,019	6, 474	1
44. 00	04400 SKILLED NURSING FACILITY	6, 357	156, 319		30, 881	43, 546	
44.00	ANCI LLARY SERVI CE COST CENTERS	0, 337	130, 317	0, 337	30, 00 1	43, 340	1 44.00
50. 00	05000 OPERATING ROOM	5, 104	26, 945	5, 104	0	16, 824	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 496				26, 701	1
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	420			0	20, 701	1
60. 00	06000 LABORATORY	1, 530			0	30, 883	1
65. 00	06500 RESPIRATORY THERAPY	1, 612	14, 692	,	0	12, 154	
66. 00	06600 PHYSI CAL THERAPY	1	39, 267		0	-	1
67. 00	06700 OCCUPATIONAL THERAPY	2, 811 818			0	24, 261	1
68. 00	06800 SPEECH PATHOLOGY	1		62	0	7, 374 3, 517	68. 00
		62	l ~		0	-	1
69.00	06900 ELECTROCARDI OLOGY		0	_	0	1 021	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 589	0		0	1, 931	1
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 012			0	0 4, 509	
73.00	OUTPATIENT SERVICE COST CENTERS	1,012		1, 012	l ol	4, 309	73.00
90. 00	09000 CLINIC	1 (12	0	1 (12	ol	4 201	90.00
90. 00	09001 DI ABETES	1, 613 1, 398			0	4, 391 2, 077	1
90. 01	09002 OP PSYCH	201			0	2, 428	
91. 00	1 1	1	1	•	0		1
	09100 EMERGENCY	8, 849	57, 123	8, 849	ا ا	26, 435	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			o	0	92. 00 93. 00
93. 00	O4O4O CARDI AC REHAB OTHER REI MBURSABLE COST CENTERS	0	0	0	U U	U	93.00
101 00	10100 HOME HEALTH AGENCY	505	0	505	O	^	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	303		303	l ol	0	101.00
112 00	11300 INTEREST EXPENSE						113. 00
118.00		E7 020	EE4 200	55, 289	48, 494	270 714	1
110.00	NONREI MBURSABLE COST CENTERS	57, 839	554, 209	33, 209	40, 494	279, 716	1110.00
104 00	07950 MOB	8, 536		8, 536	O		194. 00
	07951 FOUNDATI ON	1, 309	0		0		194. 01 194. 02
	07952 ASC	2 170	1		14 000		
	07953 SNF - PERRY CO.	3, 179	78, 159	3, 179	14, 890	21, 773	194. 03
200.00	1 1						200. 00
201.00		4 004 050	040 000	/50 450	75/ 007	202 202	201. 00
202.00		1, 931, 258	218, 298	650, 459	756, 397	303, 008	202.00
202.00	Part I)	27 252424	0.045007	0 501745	11 000574	0.000450	202 00
203.00		27. 253404				0. 999459	
204.00	Cost to be allocated (per Wkst. B, Part II)	346, 290	43, 757	28, 493	115, 292	1, 136	204. 00
205.00		4. 886753	0.040105	0.417005	1 010045	0 002747	205 00
200.00	II)	4. 000/53	0. 069195	0. 417095	1. 818945	0. 003747	200.00
	1 1117	I	I	I	ı		I

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151319 Peri od: Worksheet B-1 From 10/01/2013 To 09/30/2014 Date/Time Prepared: 2/19/2015 8:48 am Cost Center Description NURSI NG MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY (NRSE FTE'S) (TIME SPENT) 13.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 149, 117 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 223 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 48, 812 30 00 364 31.00 03100 INTENSIVE CARE UNIT 6, 474 31.00 04400 SKILLED NURSING FACILITY 43, 546 44.00 8 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 129 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 110 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54.03 00000000 54.03 0 06000 LABORATORY 92 60 00 60 00 06500 RESPIRATORY THERAPY 65.00 38 65.00 06600 PHYSI CAL THERAPY 165 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 06800 SPEECH PATHOLOGY 68 00 68 00 0 06900 ELECTROCARDI OLOGY 69.00 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 0 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 90 00 90.01 09001 DI ABETES 2,077 0 90.01 09002 OP PSYCH 90 02 Λ 90 02 91.00 09100 EMERGENCY 309 91.00 26, 435 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 CARDI AC REHAB 93.00 0 93.00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101. 00 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1-117) 127, 344 1, 222 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MOB 194.00 0 194. 01 07951 FOUNDATI ON 0 0 194. 01 194. 02 07952 ASC 0 194. 02 194.03 07953 SNF - PERRY CO. 21, 773 0 194. 03 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 239, 745 202. 00 Cost to be allocated (per Wkst. B, 541, 653 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 1.607764 442. 888798 203.00 204.00 Cost to be allocated (per Wkst. B, 8, 277 37, 623 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.055507 205.00 30.762878 II)

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151319	Period: Worksheet C From 10/01/2013 Part I		

					Fo 09/30/2014	Date/Time Pre 2/19/2015 8:4	pared: 8 am
			Ti tl	e XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_1		
30. 00	03000 ADULTS & PEDI ATRI CS	2, 937, 462		2, 937, 46		2, 937, 462	
	03100 INTENSIVE CARE UNIT	414, 540		414, 540			
44. 00	04400 SKILLED NURSING FACILITY	2, 340, 509		2, 340, 50	9 0	2, 340, 509	44. 00
	ANCILLARY SERVICE COST CENTERS	T			.1 _		l
50. 00	05000 OPERATING ROOM	2, 062, 926		2, 062, 92		2, 062, 926	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 968, 862		1, 968, 86		1, 968, 862	
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	169, 934		169, 93		169, 934	
60.00	06000 LABORATORY	2, 083, 731	_	2, 083, 73		2, 083, 731	
65. 00	06500 RESPI RATORY THERAPY	909, 353	0	1,		909, 353	
66. 00	06600 PHYSI CAL THERAPY	1, 300, 828	0	1, 300, 82		1, 300, 828	
67. 00	06700 OCCUPATI ONAL THERAPY	417, 895	0	417, 89		417, 895	
68. 00	06800 SPEECH PATHOLOGY	229, 240	0	229, 240	0	229, 240	
69. 00	06900 ELECTROCARDI OLOGY	0			0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	309, 488		309, 48		309, 488	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	440, 176		440, 17			
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 594, 603		1, 594, 60	3 0	1, 594, 603	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	352, 357		352, 35		002,007	
90. 01	09001 DI ABETES	163, 012		163, 01:		163, 012	1
	09002 OP PSYCH	119, 170		119, 170		119, 170	
	09100 EMERGENCY	2, 388, 732		2, 388, 73		2, 388, 732	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	480, 571		480, 57		480, 571	
93. 00	04040 CARDI AC REHAB	0			0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS				1		
101.00	10100 HOME HEALTH AGENCY	549, 126		549, 12	6	549, 126	101. 00
	SPECIAL PURPOSE COST CENTERS	1			1		
	11300 INTEREST EXPENSE						113. 00
200.00		21, 232, 515	O				
201.00		480, 571		480, 57		480, 571	
202.00	Total (see instructions)	20, 751, 944	0	20, 751, 94	4 0	20, 751, 944	202. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu o	f Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151319	Peri od: Wo From 10/01/2013 Pa	orksheet C art I

09/30/2014 Date/Time Prepared: To 2/19/2015 8:48 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpatient Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 834, 872 1, 834, 872 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 309, 636 309, 636 31.00 04400 SKILLED NURSING FACILITY 1, 597, 862 1, 597, 862 44.00 44.00 ANCILLARY SERVICE COST CENTERS 5, 228, 308 0.000000 50.00 4, 617, 768 0.394569 50.00 05000 OPERATING ROOM 610, 540 54.00 05400 RADI OLOGY-DI AGNOSTI C 293, 978 9, 557, 727 9, 851, 705 0.199850 0.000000 54.00 54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 14, 130 322, 289 336, 419 0.505126 0.000000 54.03 7, 207, 349 8, 187, 755 0. 254494 06000 LABORATORY 980, 406 0.000000 60.00 60.00 06500 RESPIRATORY THERAPY 392, 906 2, 210, 788 0.000000 65.00 1, 817, 882 0.411325 65 00 66.00 06600 PHYSI CAL THERAPY 819, 115 3, 204, 942 4, 024, 057 0.323263 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 325, 897 1, 262, 370 1, 588, 267 0.263114 0.000000 67.00 691, 223 06800 SPEECH PATHOLOGY 62, 645 0.304085 0.000000 68.00 753, 868 68.00 69.00 06900 ELECTROCARDI OLOGY 0 C 0.000000 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 698, 026 476, 591 1, 174, 617 0. 263480 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 458, 255 170, 338 628, 593 0.700256 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 872, 560 2, 980, 797 0.534959 73.00 2, 108, 237 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 09000 CLI NI C 38, 578 38, 578 9. 133625 90.00 09001 DI ABETES 0 35, 790 35, 790 90.01 4.554680 0.000000 90.01 09002 OP PSYCH 90.02 0 189, 206 189, 206 0.629843 0.000000 90.02 91.00 09100 EMERGENCY 192, 130 7, 196, 642 7, 388, 772 0.323292 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 18,094 329, 908 348,002 1.380943 0.000000 92.00 04040 CARDI AC REHAB 93 00 0.000000 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 559, 331 559, 331 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 9, 481, 052 39, 786, 171 49, 267, 223 200.00 201. 00 201.00 Less Observation Beds 202 00 Total (see instructions) 9, 481, 052 39, 786, 171 49, 267, 223 202 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151319	Peri od: From 10/01/2013 Part I To 09/30/2014 Date/Time Prepared: 2/19/2015 8 48 am		

			10 07/30/2014	2/19/2015 8:48 am
		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 O4400 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
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 PATIENTS	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
OUTPATIENT SERVICE COST CENTERS				
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
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
93. 00 04040 CARDI AC REHAB	0. 000000			93. 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				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151319	Peri od: Worksheet C From 10/01/2013 Part I To 09/30/2014 Date/Time Prepared:		

				-	Го 09/30/2014	Date/Time Pre 2/19/2015 8:4	
			Ti t	le XIX	Hospi tal	PPS	<u> </u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	2, 937, 462		2, 937, 462	0	2, 937, 462	30.00
	03100 INTENSIVE CARE UNIT	414, 540		414, 540	0	414, 540	31.00
	04400 SKILLED NURSING FACILITY	2, 340, 509		2, 340, 50	9 0	2, 340, 509	44. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 062, 926		2, 062, 920		2, 062, 926	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 968, 862		1, 968, 862	2 0	1, 968, 862	54.00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	169, 934		169, 93	1 0	169, 934	
60.00	06000 LABORATORY	2, 083, 731		2, 083, 73	1 0	2, 083, 731	60.00
65. 00	06500 RESPI RATORY THERAPY	909, 353	0	909, 353	3 0	909, 353	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 300, 828	0	1, 300, 828	3 0	1, 300, 828	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	417, 895	0	417, 89	5 0	417, 895	67. 00
68. 00	06800 SPEECH PATHOLOGY	229, 240	0	229, 240	0	229, 240	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		(0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	309, 488		309, 488	3 0	309, 488	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	440, 176		440, 176	6 0	440, 176	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 594, 603		1, 594, 603	3 0	1, 594, 603	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	352, 357		352, 35	7 0	352, 357	90. 00
	09001 DI ABETES	163, 012		163, 012	2 0	163, 012	90. 01
90. 02	09002 OP PSYCH	119, 170		119, 170	0	119, 170	90. 02
91. 00	09100 EMERGENCY	2, 388, 732		2, 388, 732	2 0	2, 388, 732	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	480, 571		480, 57°	1	480, 571	92.00
93. 00	04040 CARDI AC REHAB	0		(0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	549, 126		549, 120	6	549, 126	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
200.00		21, 232, 515	0			,,	
201.00		480, 571		480, 57°		480, 571	
202.00	Total (see instructions)	20, 751, 944	0	20, 751, 94	4 0	20, 751, 944	202. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151319	Period: Worksheet C From 10/01/2013 Part I
		To 09/30/2014 Date/Time Prepared:

				j	o 09/30/2014	Date/Time Pre 2/19/2015 8:4	pared: 8 am
			Ti t	le XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 834, 872		1, 834, 872	2		30.00
31.00	03100 INTENSIVE CARE UNIT	309, 636		309, 636			31.00
44.00	04400 SKILLED NURSING FACILITY	1, 597, 862		1, 597, 862	2		44. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	610, 540	4, 617, 768	5, 228, 308	0. 394569	0.000000	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	293, 978	9, 557, 727	9, 851, 705	0. 199850	0.000000	54. 00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	14, 130	322, 289		0. 505126	0.000000	54. 03
60.00	06000 LABORATORY	980, 406	7, 207, 349	8, 187, 755	0. 254494	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	392, 906	1, 817, 882	2, 210, 788	0. 411325	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	819, 115	3, 204, 942	4, 024, 057	0. 323263	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	325, 897	1, 262, 370	1, 588, 267	0. 263114	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	62, 645	691, 223	753, 868	0. 304085	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	o	0		0. 000000	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	698, 026	476, 591	1, 174, 617	0. 263480	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	458, 255	170, 338	628, 593	0. 700256	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	872, 560	2, 108, 237	2, 980, 797	0. 534959	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS	,					1
90.00	09000 CLI NI C	0	38, 578	38, 578	9. 133625	0.000000	90.00
90. 01	09001 DI ABETES	0	35, 790	35, 790	4. 554680	0.000000	90. 01
90.02	09002 OP PSYCH	0	189, 206	189, 206	0. 629843	0.000000	90. 02
91.00	09100 EMERGENCY	192, 130	7, 196, 642	7, 388, 772	0. 323292	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	18, 094	329, 908	348, 002	1. 380943	0.000000	92.00
93.00	04040 CARDI AC REHAB	0	0	(0. 000000	0.000000	93. 00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	559, 331	559, 331			101. 00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	9, 481, 052	39, 786, 171	49, 267, 223	3		200. 00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	9, 481, 052	39, 786, 171	49, 267, 223	3		202. 00
		·			·		

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151319	Peri od: Worksheet C From 10/01/2013 Part I To 09/30/2014 Date/Time Prepared:

				2/19/2015 8:48 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Rati o			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
44.00 O4400 SKILLED NURSING FACILITY				44. 00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 394569			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 199850			54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 505126			54. 03
60. 00 06000 LABORATORY	0. 254494			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 411325			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 323263			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 263114			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 304085			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 263480			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 700256			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 534959			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	9. 133625			90. 00
90. 01 09001 DI ABETES	4. 554680			90. 01
90. 02 09002 OP PSYCH	0. 629843			90. 02
91. 00 09100 EMERGENCY	0. 323292			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 380943			92.00
93. 00 04040 CARDI AC REHAB	0. 000000			93. 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				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	GIBSON GENERAL HO	OSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE	COST TO CHARGE RATIOS NET OF	Provi der CCN: 151319		Worksheet C
DEDUCTIONS FOR MEDICALD ONLY			From 10/01/2013	Part II

REDUCTIONS FOR MEDICALD ONLY To 09/30/2014 Date/Time Prepared: 2/19/2015 8:48 am Title XIX Hospi tal PPS Total Cost Capital Cost Operating Cost Operating Cost Cost Center Description Capi tal (Wkst. B, Part (Wkst. B, Part Net of Capital Reducti on Reducti on I, col. 26) II col. 26) Cost (col. 1 Amount col. 2) 5. 00 1.00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 149, 466 1, 913, 460 50.00 05000 OPERATING ROOM 2, 062, 926 50.00 0 0 0 0 0 0 0 0 0 0 0 105, 573 1, 863, 289 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 1, 968, 862 0 54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 169, 934 11, 788 158, 146 54.03 06000 LABORATORY 2, 083, 731 2, 032, 845 60.00 50, 886 0 60.00 06500 RESPIRATORY THERAPY 909.353 48, 482 860, 871 65.00 0 65.00 06600 PHYSI CAL THERAPY 66.00 1, 300, 828 87, 469 1, 213, 359 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 417, 895 23, 437 394, 458 0 67.00 68.00 06800 SPEECH PATHOLOGY 229, 240 2, 496 226, 744 68.00 06900 ELECTROCARDI OLOGY 69.00 Ω Λ Ω 69.00 97, 110 212, 378 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 309, 488 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 440, 176 1, 400 438, 776 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 594, 603 32, 311 1, 562, 292 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 352, 357 44, 434 307, 923 0 0 09001 DI ABETES 163, 012 38, 097 124, 915 90. 01 90.01 0 0 09002 OP PSYCH 90.02 119, 170 113, 355 90.02 5, 815 0 91.00 09100 EMERGENCY 2, 388, 732 259, 501 2, 129, 231 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 480, 571 60, 286 420, 285 0 0 92.00 04040 CARDI AC REHAB 93.00 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 549, 126 15, 506 533, 620 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 Subtotal (sum of lines 50 thru 199) 15, 540, 004 1,034,057 14, 505, 947 0 0 200. 00 200.00 201.00 Less Observation Beds 480, 571 60, 286 420, 285 0 0 201.00 0 202.00 ol 202.00 Total (line 200 minus line 201) 15, 059, 433 973, 771 14, 085, 662

Health Financial Systems	GIBSON GENERAL HOSPITAL In Lieu of I			
CALCULATION OF OUTPATIENT SERVICE COST TO REDUCTIONS FOR MEDICAID ONLY	CHARGE RATIOS NET OF	Provider CCN: 151319	Peri od: From 10/01/2013 To 09/30/2014	Worksheet C Part II Date/Time Prepared:

			'	0 07/30/2014	2/19/2015 8: 48 am
		Ti t	le XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges			
	Capital and		Cost to Charge		
	Operating Cost				
	Reduction	8)	/ col. 7)		
	6. 00	7. 00	8. 00		
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	2, 062, 926		•		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 968, 862				54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	169, 934		•		54. 03
60. 00 06000 LABORATORY	2, 083, 731		•		60.00
65. 00 06500 RESPIRATORY THERAPY	909, 353				65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 300, 828		•		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	417, 895	1, 588, 267	0. 263114		67. 00
68. 00 06800 SPEECH PATHOLOGY	229, 240	753, 868	0. 304085		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.000000		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	309, 488	1, 174, 617	0. 263480		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	440, 176	628, 593	0. 700256	,	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 594, 603	2, 980, 797	0. 534959		73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	352, 357	38, 578	9. 133625		90.00
90. 01 09001 DI ABETES	163, 012	35, 790	4. 554680		90. 01
90. 02 09002 OP PSYCH	119, 170	189, 206	0. 629843		90. 02
91. 00 09100 EMERGENCY	2, 388, 732	7, 388, 772	0. 323292		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	480, 571	348, 002	1. 380943		92. 00
93. 00 04040 CARDI AC REHAB	0	0	0.000000		93. 00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY	549, 126	559, 331	0. 981755	i	101. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113. 00
200.00 Subtotal (sum of lines 50 thru 199)	15, 540, 004	45, 524, 853			200. 00
201.00 Less Observation Beds	480, 571	0			201. 00
202.00 Total (line 200 minus line 201)	15, 059, 433	45, 524, 853			202. 00

Heal th	Fi nanci al	Systems		GIBSON GENERA	AL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	FIONMENT OF	INPATIENT ANCILLARY SERVICE	CAPI TAL	COSTS		Provi der	CCN: 151319	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part II Date/Time Pre 2/19/2015 8:4	
						Ti tl	e XVIII	Hospi tal	Cost	
	Cost	: Center Description		Capital Related Cost from Wkst. B, Part II, col. 26)	(from Part	Wkst. C, I, col. 8)	2)	Program 1. Charges	Capital Costs (column 3 x column 4)	
				1. 00		2.00	3.00	4. 00	5. 00	
	ANCI LLARY	SERVI CE COST CENTERS								
50.00	05000 OPER	RATING ROOM		149, 466		5, 228, 308	0. 0285	362, 578	10, 365	50.00
F 4 00	105 400 5454	OLOGY BLACKGOTIC	1	405 570	ı	0 054 305	0 0407	4.		

	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 + col.	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	149, 466	5, 228, 308	0. 028588	362, 578	10, 365	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	105, 573	9, 851, 705	0. 010716	157, 162	1, 684	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	11, 788	336, 419	0. 035040	8, 469	297	54. 03
60.00	06000 LABORATORY	50, 886	8, 187, 755	0. 006215	504, 511	3, 136	60.00
65.00	06500 RESPI RATORY THERAPY	48, 482	2, 210, 788	0. 021930	244, 103	5, 353	65.00
66.00	06600 PHYSI CAL THERAPY	87, 469	4, 024, 057	0. 021737	166, 995	3, 630	66.00
67.00	06700 OCCUPATI ONAL THERAPY	23, 437	1, 588, 267	0. 014756	52, 049	768	67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 496	753, 868	0. 003311	26, 062	86	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0.000000	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	97, 110	1, 174, 617	0. 082674	235, 995	19, 511	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 400	628, 593	0. 002227	458, 255	1, 021	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	32, 311	2, 980, 797	0. 010840	351, 117	3, 806	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	44, 434	38, 578	1. 151796	0	0	90. 00
90. 01	09001 DI ABETES	38, 097	35, 790	1. 064459	0	0	90. 01
90. 02	09002 OP PSYCH	5, 815	189, 206	0. 030734	0	0	90. 02
91.00	09100 EMERGENCY	259, 501	7, 388, 772	0. 035121	3, 029	106	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	60, 286	348, 002	0. 173235	678	117	92. 00
93.00	04040 CARDI AC REHAB	0	0	0. 000000	0	0	93. 00
200.00	Total (lines 50-199)	1, 018, 551	44, 965, 522		2, 571, 003	49, 880	200. 00
				'	•		

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS			CCN: 151319	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part IV	pared:	
		Ti tl	e XVIII	Hospi tal	Cost		
Cost Center Description	Anesthetist Cost	Nursing School		Medical Education Cost	4)		
	1.00	2.00	3. 00	4. 00	5. 00		
ANCILLARY SERVICE COST CENTERS]	
50.00 05000 OPERATING ROOM	0	C		0	0	00.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0	0		
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	C)	0	0		
60. 00 06000 LABORATORY	0	C)	0	0		
65. 00 06500 RESPI RATORY THERAPY	0	(C)	0	0	65. 00	
66. 00 06600 PHYSI CAL THERAPY	0	C)	0	0	00.00	
67. 00 06700 OCCUPATI ONAL THERAPY	0	C)	0	0		
68. 00 06800 SPEECH PATHOLOGY	0	[C)	0	0	00.00	
69. 00 06900 ELECTROCARDI OLOGY	0	[C)	0	0	07.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(C)	0	0	, 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0	0		
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	C)	0 0	0	73. 00	
OUTPATIENT SERVICE COST CENTERS						1	
90. 00 09000 CLI NI C	0	C)	0	0		
90. 01 09001 DI ABETES	0	C)	0	0		
90. 02 09002 OP PSYCH	0	C)	0	0		
91. 00 09100 EMERGENCY	0	C)	0	0	,	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C)	0	0	72.00	
93. 00 04040 CARDI AC REHAB	0	[C)	0	0	70.00	
200.00 Total (lines 50-199)	0	C)	0 0	0	200. 00	

Heal th	Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10							
APPOR	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PAS:	S			Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Pre 2/19/2015 8:4	
					e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and	(from Part	Wkst. C,	Ratio of Cos to Charges (col. 5 ÷ col 7)	Ratio of Cost	Inpatient Program Charges	
		4)		0)	''	7)		
		6, 00		7. 00	8. 00	9, 00	10.00	
	ANCILLARY SERVICE COST CENTERS		1					
50.00	05000 OPERATI NG ROOM	0		5, 228, 308	0.00000	0. 000000	362, 578	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		9, 851, 705	0.00000	0. 000000	157, 162	54. 00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0		336, 419	0.00000	0. 000000	8, 469	54. 03
60.00	06000 LABORATORY	0		8, 187, 755	l .			
65.00	06500 RESPI RATORY THERAPY	0	1	2, 210, 788	•		244, 103	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		4, 024, 057				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		1, 588, 267				
68. 00	06800 SPEECH PATHOLOGY	0)	753, 868				
69. 00	06900 ELECTROCARDI OLOGY	0	9	0				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9	1, 174, 617				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0)	628, 593			458, 255	
73. 00	07300 DRUGS CHARGED TO PATIENTS] 0	9	2, 980, 797	0.00000	0. 000000	351, 117	73. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC			38. 578	0.00000	0. 000000	0	90.00
90.00	109000 CET NT C 109001 DI ABETES	0	()	38, 578 35, 790				90.00
90.01	09001 DI ABETES	0	()	35, 790 189, 206			0	90.01
90. 02	09100 EMERGENCY		()	7, 388, 772			ľ	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		()	348, 002				
93. 00	04040 CARDI AC REHAB		(340, 002				
200.00	1 1	0	4	4, 965, 522		0.00000	2, 571, 003	

Health Financial Systems	GIBSON GENERAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151319	Period: From 10/01/2013	Worksheet D Part IV Date/Time Prepared:

						10	09/ 30/ 2014	2/19/2015 8:	
				Ti tl	e XVIII		Hospi tal	Cost	
	Cost Center Description	I npati ent	Out	patient	Outpati ent				
		Program	Р	rogram	Program				
		Pass-Through	C	harges	Pass-Through				
		Costs (col. 8			Costs (col.	9			
		x col. 10)			x col. 12)				
		11.00		12. 00	13. 00				
	ANCILLARY SERVICE COST CENTERS								
	05000 OPERATING ROOM	0		0		0			50. 00
	05400 RADI OLOGY-DI AGNOSTI C	0		0		0			54. 00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0		0		0			54. 03
	06000 LABORATORY	0		0		0			60. 00
	06500 RESPI RATORY THERAPY	0		0		0			65. 00
	06600 PHYSI CAL THERAPY	0		0		0			66. 00
	06700 OCCUPATI ONAL THERAPY	0		0		0			67. 00
	06800 SPEECH PATHOLOGY	0		0		0			68. 00
	06900 ELECTROCARDI OLOGY	0		0		0			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0		0			73. 00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLI NI C	0		0		0			90.00
90. 01	09001 DI ABETES	0		0		0			90. 01
90. 02	09002 OP PSYCH	0		0		0			90. 02
91.00	09100 EMERGENCY	0		0		0			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0			92. 00
93.00	04040 CARDI AC REHAB	0		0		0			93. 00
200.00	Total (lines 50-199)	0		0		0			200. 00

Heal th	Financial Systems	GIBSON GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST		!	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Pre 2/19/2015 8:4	
			Titl	e XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		4.00	0.00	(see inst.)	(see inst.)	F 00	
	ANGLILARY CERVICE COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0. 394569		1 5/5 00	7 0	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 394569		1, 565, 99 [°] 2, 679, 89 [°]		0	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 199630		121, 51		0	1
	06000 LABORATORY	0. 303120		2, 902, 440		0	1
	06500 RESPIRATORY THERAPY	0. 234474		469, 20		0	65.00
	06600 PHYSI CAL THERAPY	0. 323263	l .	1, 094, 63		0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 323203		228, 220		0	67.00
	06800 SPEECH PATHOLOGY	0. 304085		42, 44		0	68. 00
	06900 ELECTROCARDI OLOGY	0. 000000		42, 44	0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 263480		89, 39		0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 700256		141, 34		0	
	07300 DRUGS CHARGED TO PATIENTS	0. 534959				0	
70.00	OUTPATIENT SERVICE COST CENTERS	0.001707		0,0,00	, ., ., .,		70.00
90.00	09000 CLI NI C	9. 133625	0	32, 64	1 0	0	90.00
90. 01	09001 DI ABETES	4. 554680	0	9, 84	2 0	0	90. 01
90. 02	09002 OP PSYCH	0. 629843	0		0	0	90. 02
91.00	09100 EMERGENCY	0. 323292	0	1, 585, 86	4 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 380943	0	133, 83	2 0	0	92.00
93.00	04040 CARDI AC REHAB	0. 000000	0		0	0	93.00
200.00	Subtotal (see instructions)		0	11, 972, 32 ⁻	7 1, 808	0	200. 00
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	11, 972, 32	7 1, 808	0	202. 00

 Heal th Financial
 Systems
 GIBSON GENER

 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

				То	09/30/2014	Date/Time Pro 2/19/2015 8:4	
		Ti tl	e XVIII		Hospi tal	Cost	
	Cos						
Cost Center Description	Cost	Cost					
	Rei mbursed	Rei mbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins.					
	(see inst.)	(see inst.)	_				
	6. 00	7. 00					
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	617, 894)				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	535, 577	l .	2				54. 00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	61, 380	l .	2				54. 03
60. 00 06000 LABORATORY	738, 654		2				60. 00
65. 00 06500 RESPI RATORY THERAPY	192, 996	l e	2				65. 00
66. 00 06600 PHYSI CAL THERAPY	353, 856	l e)				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	60, 049	l e)				67. 00
68. 00 06800 SPEECH PATHOLOGY	12, 906		2				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C	2				69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	23, 552		2				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	98, 975		2				72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	468, 121	967	1				73. 00
OUTPATIENT SERVICE COST CENTERS	200 101						
90. 00 09000 CLI NI C	298, 131	C	2				90.00
90. 01 09001 DI ABETES	44, 827		2				90. 01
90. 02 09002 OP PSYCH	540 (07		2				90. 02
91. 00 09100 EMERGENCY	512, 697	l	?				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	184, 814		?				92. 00
93. 00 04040 CARDI AC REHAB	4 004 400		2				93. 00
200.00 Subtotal (see instructions)	4, 204, 429	967					200. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges							201. 00
202.00 Net Charges (line 200 +/- line 201)	4, 204, 429	967	,				202. 00
202.00	4, 204, 429	1 907	I				J202. 00

 Heal th Financial
 Systems
 GIBSON GENERAL
 HOSPITAL

 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE
 COST
 Providence

		ooporrorr		0 077 007 2011	2/19/2015 8: 4	8 am
		Ti tl	e XVIII S	wing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS		1	1 -	_		
50. 00 05000 OPERATI NG ROOM	0. 394569			0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 199850	l .	C	0	0	54. 00
54. 03 05401 NUCLEAR MEDICINE-DI AGNOSTI C	0. 505126	l .	C	0	0	
60. 00 06000 LABORATORY	0. 254494	l .	C	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 411325		l c	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 323263		0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 263114		0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 304085		0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	l .	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 263480	l .	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 700256		0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 534959	0	C	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	9. 133625		0	0	0	, , , , , ,
90. 01 09001 DI ABETES	4. 554680		0	0	0	90. 01
90. 02 09002 0P PSYCH	0. 629843	l .	0	0	0	90. 02
91. 00 09100 EMERGENCY	0. 323292	l .) C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 380943	0	C	0	0	92. 00
93. 00 04040 CARDI AC REHAB	0. 000000	0	C	0	0	, , , , , ,
200.00 Subtotal (see instructions)		0	0	0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program			0	0		201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0)	0	0	202. 00

Health Financial Systems

GIBSON GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151319

Period: Worksheet D

From 10/01/2013 | Part V

From 10/01/2013 To 09/30/2014 Component CCN: 15Z319 Date/Time Prepared: 2/19/2015 8:48 am Title XVIII Swing Beds - SNF Cost Costs 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 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 54.00 54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 54. 03 06000 LABORATORY 0 60.00 60.00 65. 00 06500 RESPIRATORY THERAPY 65.00 66. 00 |06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 0 0 0 0 0 0 90.01 09001 DI ABETES 0 90.01 90. 02 09002 OP PSYCH 0 90.02 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 93. 00 | 04040 | CARDI AC REHAB 0 93.00 200.00 Subtotal (see instructions) 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

0

202. 00

202.00

Net Charges (line 200 +/- line 201)

Uool +h	Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10								
	FITMATICIAL_SYSTEMS TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CCN: 151319	Peri od:	Worksheet D	2552-10		
	H COSTS	WOL STILL THE			From 10/01/2013	Part IV			
			Component	t CCN: 155093	To 09/30/2014 Date/Time Pre 2/19/2015 8:4				
			Ti tl	e XVIII	Skilled Nursing	PPS			
		I		I	Facility				
	Cost Center Description		Nursing School	Allied Healt		Total Cost			
		Anesthetist			Medi cal	(sum of col 1			
		Cost			Education Cost				
		1.00	2.00	3.00	4. 00	4) 5. 00			
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00			
50. 00	05000 OPERATING ROOM	1	0	d .	0 0	0	50.00		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0				0	54. 00		
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 0		54. 03		
60. 00	06000 LABORATORY	0	0		0 0	0	60.00		
65. 00	06500 RESPIRATORY THERAPY	0	0	,	0 0	0	65. 00		
66. 00	06600 PHYSI CAL THERAPY	0	0	,	0 0	0	66. 00		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0)	0 0	0	67. 00		
68. 00	06800 SPEECH PATHOLOGY	0	0	,	0 0	O	68. 00		
69. 00	06900 ELECTROCARDI OLOGY	0	0)	0 0	0	69. 00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 0	0	71. 00		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 0	0	72. 00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00		
	OUTPATIENT SERVICE COST CENTERS								
	09000 CLI NI C	0	0	1	0	0			
90. 01	09001 DI ABETES	0	0		0	0	90. 01		
90. 02	09002 OP PSYCH	0	0	1	0	0	90. 02		
91. 00	09100 EMERGENCY	0	0	1	0	0	91. 00		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	0 0	0	92. 00		
	04040 CARDI AC REHAB	0	0	1	0	0	93. 00		
200.00	Total (lines 50-199)	1 0	ıl O	11	0 0	0	200. 00		

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10								
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI			CCN: 151319	Period:	Worksheet D	2552-10		
THROUGH COSTS	WICE UINER PAS	3 Provider	CCN. 131319	From 10/01/2013	Part IV			
TIROUGH COSTS		Componen	t CCN: 155093	To 09/30/2014	Date/Time Pre			
					2/19/2015 8: 4	8 am		
		litl	e XVIII	Skilled Nursing	PPS			
Cost Center Description	Total	Total Charges	Datio of Cos	Facility t Outpatient	Inpati ent			
Cost Center Description	Outpati ent	(from Wkst. C,		Ratio of Cost	Program			
	Cost (sum of		(col . 5 ÷ col		Charges			
	col . 2, 3 and	•	7)	(col. 6 ÷ col.	Chai ges			
	4)		')	7)				
	6.00	7. 00	8.00	9. 00	10.00			
ANCILLARY SERVICE COST CENTERS								
50. 00 05000 OPERATING ROOM	0	5, 228, 308	0.00000	0. 000000	0	50. 00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 851, 705	0. 00000	0. 000000	6, 608	54.00		
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	336, 419	0.00000	0. 000000	0	54. 03		
60. 00 06000 LABORATORY	0	8, 187, 755	0. 00000	0. 000000	83, 886	60.00		
65. 00 06500 RESPIRATORY THERAPY	0	2, 210, 788	0. 00000	0. 000000	41, 456	65. 00		
66. 00 06600 PHYSI CAL THERAPY	0	4, 024, 057	0.00000	0.00000	228, 228	66. 00		
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 588, 267	0.00000	0.00000	125, 381	67.00		
68.00 06800 SPEECH PATHOLOGY	0	753, 868	0.00000	0. 000000	17, 645	68. 00		
69. 00 06900 ELECTROCARDI OLOGY	0) (0.00000	0. 000000	0	69. 00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 174, 617			10, 573	71. 00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	628, 593			0			
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 980, 797	0.00000	0.000000	82, 299	73. 00		
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000 CLI NI C	0	38, 578			0			
90. 01 09001 DI ABETES	0	35, 790			0	90. 01		
90. 02 09002 0P PSYCH	0	189, 206			0			
91. 00 09100 EMERGENCY	0	7, 388, 772	1		0			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	348, 002			0			
93. 00 04040 CARDI AC REHAB	0	(1 0.0000	0. 000000	0			
200.00 Total (lines 50-199)	0	44, 965, 522	2		596, 076	200. 00		

Health Financial Systems GIBSON GENERAL HO				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS			CCN: 151319	Peri od: From 10/01/2013	Worksheet D	
THROUGH COSTS			CCN: 155093	To 09/30/2014		
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			

					Facility	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent		
		Program	Program	Program		
		Pass-Through	Charges	Pass-Through		
		Costs (col. 8		Costs (col. 9		
		x col. 10)		x col. 12)		
		11. 00	12. 00	13. 00		
	ANCILLARY SERVICE COST CENTERS					
50. 00	05000 OPERATI NG ROOM	0	C) (50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C) (54. 00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	C) (54. 03
60.00	06000 LABORATORY	0	C) (60.00
65. 00	06500 RESPI RATORY THERAPY	0	C) (65. 00
66.00	06600 PHYSI CAL THERAPY	0	C) (66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	C) (67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C) (68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C) (69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C) (71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C) (72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C) (D	73. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0	C) (D	90.00
90. 01	09001 DI ABETES	0	C) (90. 01
90. 02	09002 OP PSYCH	0	C) (90. 02
91.00	09100 EMERGENCY	0	C) (91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C) (92. 00
93.00	04040 CARDI AC REHAB	o	C) (93.00
200.00	Total (lines 50-199)	0	C) (200. 00
				•		•

Heal th	Financial Systems	GIBSON GENERA	AL HOSPITAL	IOSPITAL In Lieu			2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
					From 10/01/2013		narad.
					To 09/30/2014	Date/Time Pre 2/19/2015 8:4	
			Ti t	tle XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
		Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
		(from Wkst. B,		Related Cost	The state of the s		
		Part II, col.		(col. 1 - col			
		26)		2)			
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	286, 855	63, 554	223, 30	1 2, 027	110. 16	30. 00
31.00	INTENSIVE CARE UNIT	54, 177		54, 17	7 217	249. 66	31.00
44.00	SKILLED NURSING FACILITY	246, 484		246, 48	4 14, 654	16. 82	44. 00
200.00	Total (lines 30-199)	587, 516		523, 96	2 16, 898		200. 00
	Cost Center Description	I npati ent	Inpati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDI ATRI CS	94	10, 355	5			30. 00
31.00	INTENSIVE CARE UNIT	0	(31.00
44.00	SKILLED NURSING FACILITY	8, 856	148, 958	3			44. 00
200.00	Total (lines 30-199)	8, 950					200. 00

Hea	Ith Financial Systems	GIBSON GENERA	AL HOS	SPI TAL		In Lie	eu of Form CMS-2	2552-10
APF	PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		Provi der		Peri od:	Worksheet D	
						From 10/01/2013		
						To 09/30/2014	Date/Time Prep 2/19/2015 8:48	
				Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total	l Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from	n Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part	I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
		1.00		2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.	00 05000 OPERATI NG ROOM	149, 466		5, 228, 308	0. 02858	150, 940	4, 315	50.00
54.	00 05400 RADI OLOGY-DI AGNOSTI C	105, 573		9, 851, 705	0. 01071	6 4, 849	52	54.00
54.	03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	11, 788		336, 419	0. 03504	0 0	0	54.03
60.	00 06000 LABORATORY	50, 886		8, 187, 755	0. 00621	5 44, 264	275	60.00
65.	00 06500 RESPIRATORY THERAPY	48, 482		2, 210, 788	0. 02193	34, 231	751	65.00
//	00 07400 DUVCLCAL THEDADY	07 4/0	l	4 024 057	0 00170	0 5/7	10/	44 00

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D		
				From 10/01/2013			
				To 09/30/2014			
					2/19/2015 8: 4	8 am	
			le XIX	Hospi tal	PPS		
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs		
		Cost	Medi cal	Adjustment	(sum of cols.		
			Education Cos	t Amount (see	1 through 3,		
				instructions)	minus col. 4)		
	1.00	2.00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30. 00	
31.00 03100 INTENSIVE CARE UNIT	0	ol o)	0	0	31.00	
44.00 04400 SKILLED NURSING FACILITY	0		,		0	44. 00	
200.00 Total (lines 30-199)	0				0	200. 00	
Cost Center Description	Total Patient	Per Diem (col.	Inpatient	Inpati ent	_		
	Days	5 ÷ col . 6)	Program Days				
	,-		· · · · · · · · · · · · · · · · · · ·	Pass-Through			
				Cost (col. 7 x			
				col . 8)			
	6, 00	7.00	8.00	9. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00			
30. 00 03000 ADULTS & PEDIATRICS	2, 027	0.00	9	4 0		30. 00	
31. 00 03100 NTENSI VE CARE UNI T	217		1			31.00	
44. 00 04400 SKI LLED NURSING FACILITY	14, 654		l .	6		44. 00	
200.00 Total (lines 30-199)	16, 898		8, 95			200.00	
200.00 10tal (11165 30-199)	10, 898	'I	1 6, 95	0	I	1200.00	

Health Financial Systems	GIBSON GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETHEOUGH COSTS				Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV	pared:
	_	Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Healt	h All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	C) c)	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C) c)	0	0	54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	() C)	0	0	
60. 00 06000 LABORATORY	C) C)	0	0	
65. 00 06500 RESPI RATORY THERAPY	C) C)	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	C) C)	0	0	00.00
67. 00 06700 OCCUPATI ONAL THERAPY	C) C)	0	0	
68. 00 06800 SPEECH PATHOLOGY	C) C)	0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	C) C)	0	0	1 0 / 1 0 0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C) C)	0	0	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	C) C)	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS) <u> </u>)	0 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C))	0	0	
90. 01 09001 DI ABETES)	0	0	
90. 02 09002 0P PSYCH)	0	0	
91. 00 09100 EMERGENCY)	0	0	1 , 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			2	0	0	1 ,2.00
93. 00 04040 CARDI AC REHAB			(0	0	1 ,0.00
200.00 Total (lines 50-199)	1	را د	וי	U _I 0	1 0	200. 00

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10								
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CCN: 151319	Peri od:	Worksheet D	10		
THROUGH COSTS				From 10/01/2013	Part IV			
				To 09/30/2014	Date/Time Pre 2/19/2015 8:4	pared:		
		Ti t	I e XIX	Hospi tal	PPS	o ani		
Cost Center Description	Total	Total Charges			Inpati ent			
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program			
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges			
	col . 2, 3 and	8)	7)	(col . 6 ÷ col .				
	4)			7)				
	6. 00	7. 00	8. 00	9. 00	10.00			
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0	5, 228, 308						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 851, 705	•					
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	336, 419						
60. 00 06000 LABORATORY	0	8, 187, 755				60.00		
65. 00 06500 RESPIRATORY THERAPY	0	2, 210, 788				65. 00		
66. 00 06600 PHYSI CAL THERAPY	0	4, 024, 057				66. 00		
67. 00 06700 0CCUPATI ONAL THERAPY	0	1, 588, 267				67. 00		
68.00 06800 SPEECH PATHOLOGY	0	753, 868	0.00000	0. 000000	549	68. 00		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0. 000000	0	69. 00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 174, 617			0	71. 00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	628, 593	0.00000	0. 000000	0	72. 00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 980, 797	0.00000	0. 000000	39, 607	73. 00		
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000 CLI NI C	0	38, 578	0.00000			90. 00		
90. 01 09001 DI ABETES	0	35, 790	0.00000	0. 000000	0	90. 01		
90. 02 09002 OP PSYCH	0	189, 206	0.00000	0. 000000	0	90. 02		
91. 00 09100 EMERGENCY	0	7, 388, 772	0.00000	0. 000000	29, 095	91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	348, 002	0.00000	0. 000000	0	92. 00		
93. 00 04040 CARDI AC REHAB	0	0	0.00000	0. 000000	0	93. 00		
200.00 Total (lines 50-199)	0	44, 965, 522			315, 931	200. 00		

Health Financial Systems	GIBSON GENERAL HO	In Lieu of Form CMS-2552-			
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151319	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared:	

						10	09/ 30/ 2014	2/19/2015 8:	
	Title XIX		le XIX		Hospi tal	PPS			
	Cost Center Description	I npati ent	Out	patient	Outpati ent				
		Program	Р	rogram	Program				
		Pass-Through	C	harges	Pass-Through				
		Costs (col. 8			Costs (col.	9			
		x col. 10)			x col. 12)				
		11. 00		12. 00	13. 00				
	ANCILLARY SERVICE COST CENTERS								
	05000 OPERATING ROOM	0		0		0			50. 00
	05400 RADI OLOGY-DI AGNOSTI C	0		0		0			54. 00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0		0		0			54. 03
	06000 LABORATORY	0		0		0			60. 00
	06500 RESPI RATORY THERAPY	0		0		0			65. 00
	06600 PHYSI CAL THERAPY	0		0		0			66. 00
	06700 OCCUPATI ONAL THERAPY	0		0		0			67. 00
	06800 SPEECH PATHOLOGY	0		0		0			68. 00
	06900 ELECTROCARDI OLOGY	0		0		0			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0		0			73. 00
	OUTPAȚI ENT SERVI CE COST CENTERS								
	09000 CLI NI C	0		0		0			90. 00
	09001 DI ABETES	0		0		0			90. 01
	09002 OP PSYCH	0		0		0			90. 02
	09100 EMERGENCY	0		0		0			91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0			92. 00
	04040 CARDI AC REHAB	0		0		0			93. 00
200.00	Total (lines 50-199)	0		0		0			200. 00

Heal th	Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		O VACCINE COST Provi der CCN: 151319		CCN: 151319	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Pre 2/19/2015 8:4	
-			Ti t	le XIX	Hospi tal	PPS	
	·			Charges	<u> </u>	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 394569			0 492, 529		00.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 199850			0 1, 136, 753	0	54. 00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 505126			0 20, 807	0	54. 03
60.00	06000 LABORATORY	0. 254494			0 893, 666	0	60. 00
65.00	06500 RESPI RATORY THERAPY	0. 411325			0 192, 446	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 323263			0 181, 997	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 263114	0		0 121, 202	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 304085	0		0 173, 951	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 263480	0		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 700256	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 534959	0		0 147, 996	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	9. 133625	0		0	0	
90. 01	09001 DI ABETES	4. 554680			0 3, 636	0	90. 01
90. 02	09002 OP PSYCH	0. 629843	0		0	0	90. 02
91.00	09100 EMERGENCY	0. 323292	0		0 1, 554, 177	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 380943	0		0 0	0	92. 00
93.00	04040 CARDI AC REHAB	0. 000000	0		0 0	0	93. 00
200.00	Subtotal (see instructions)		0		0 4, 919, 160	0	200. 00
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	1	0 4, 919, 160	0	202. 00

Health Financial Systems GIBSON GENERAL HOSPI		SPI TAL		In Lieu of Form CMS-2552-10	
APPORTLONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151319	Peri od:	Worksheet D	

From 10/01/2013
To 09/30/2014 Part V
Date/Time Prepared: 2/19/2015 8: 48 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 194, 337 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 227, 180 54.00 54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 10, 510 54. 03 06000 LABORATORY 60.00 227, 433 60.00 65. 00 06500 RESPIRATORY THERAPY 79, 158 65.00 06600 PHYSI CAL THERAPY 66.00 58, 833 66.00 06700 OCCUPATI ONAL THERAPY 67.00 31, 890 67.00 68.00 06800 SPEECH PATHOLOGY 52, 896 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 79, 172 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 0 0 0 0 0 90.01 09001 DI ABETES 16, 561 90.01 90.02 09002 OP PSYCH 90.02 91.00 09100 EMERGENCY 502, 453 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 93. 00 | 04040 | CARDI AC REHAB 93.00 200.00 Subtotal (see instructions) 1, 480, 423 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 202. 00 1, 480, 423

Health Financial Systems	GIBSON GENERAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT C	PERATING COST	Provi der CCN: 151319	From 10/01/2013	Worksheet D-1 Date/Time Prepared: 2/19/2015 8:48 am
		Title XVIII	Hospi tal	Cost

			10 077 007 2011	2/19/2015 8: 4	8 am			
	Cost Center Description	Title XVIII	Hospi tal	Cost				
	Cost Center Description			1. 00				
	PART I - ALL PROVIDER COMPONENTS			1.00				
	INPATIENT DAYS							
1.00	Inpatient days (including private room days and swing-bed days,			2, 687 2, 027	1.00			
2. 00					2. 00			
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00			
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days		1, 601	4. 00			
5.00	Total swing-bed SNF type inpatient days (including private room	561	5. 00					
3.00	reporting period	days) thi ough beceine	1 31 01 the cost	301	3.00			
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	o	6. 00			
	reporting period (if calendar year, enter 0 on this line)			- 1				
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	99	7. 00			
	reporting period							
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00			
0.00	reporting period (if calendar year, enter 0 on this line)	+b - D (ldi	and an include	1 000	0.00			
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	1, 009	9. 00			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	oom days)	561	10.00			
	through December 31 of the cost reporting period (see instructi		oom dayo,	1	10.00			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00			
	December 31 of the cost reporting period (if calendar year, ent							
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12. 00			
40.00	through December 31 of the cost reporting period				40.00			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13. 00			
14. 00	Medically necessary private room days applicable to the Program			o	14. 00			
15. 00	Total nursery days (title V or XIX only)	(excluding swing-bed	uays)	0	15. 00			
16. 00	Nursery days (title V or XIX only)			0	16.00			
	SWI NG BED ADJUSTMENT							
17. 00					17. 00			
	reporting period							
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00			
19. 00	reporting period On Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00			
19.00	reporting period	till odgir becelliber 31 of	the cost	181. 25	19.00			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	181. 25	20. 00			
	reporting period							
21. 00	Total general inpatient routine service cost (see instructions)			2, 937, 462	21. 00			
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00			
22.00	5 x line 17)	1 of the cost reportin	a ported (line (22.00			
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	or the cost reportin	g period (line 6	0	23. 00			
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	17, 944	24. 00			
200	7 x line 19)		ing pointed (initial	1.,,,,,	2 11 00			
25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00			
	x line 20)							
26. 00	Total swing-bed cost (see instructions)			650, 808	26. 00			
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		2, 286, 654	27. 00			
28. 00	General inpatient routine service charges (excluding swing-bed	and observation had ch	arnos)	0	28. 00			
29. 00	Private room charges (excluding swing-bed charges)	and observation bed en	ar gcs)	Ö	29. 00			
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			Ö	30.00			
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00			
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32. 00			
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00			
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	34. 00			
35. 00	Average per diem private room cost differential (line 34 x line	31)		0. 00 0	35. 00			
36. 00					36. 00 37. 00			
37. 00								
	27 minus line 36)							
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS						
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 128. 10	38. 00			
39. 00	Program general inpatient routine service cost (line 9 x line 3	-		1, 138, 253	39. 00			
40. 00	Medically necessary private room cost applicable to the Program	-		0	40. 00			
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 138, 253	41. 00			

Heal th	Financial Systems	GI BSON GENERA	AL HOSPITAL			In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			der CCN: 1		eri od:	Worksheet D-1	
						rom 10/01/2013 o 09/30/2014	Date/Time Pre	pared:
				itle XVII		Hospi tal	2/19/2015 8: 48 Cost	3 am
	Cost Center Description	Total	Total	_	age Per	Program Days	Program Cost	
	'	Inpatient Cost	Inpatient D	aysDiem ((col. 1 ÷		(col. 3 x col.	
		1.00	2. 00		1 . 2) 3 . 00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00		3. 00	4.00	3.00	42. 00
	Intensive Care Type Inpatient Hospital Units						200 450	
43. 00 44. 00	INTENSIVE CARE UNIT	414, 540		217	1, 910. 32	151	288, 458	43. 00 44. 00
45.00								45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1. 00	
48. 00	Program inpatient ancillary service cost (Wk						1, 055, 977	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instruc	tions)			2, 482, 688	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (f	rom Wkst.	D. sum	of Parts I and	0	50. 00
			•					
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services	(from Wks	st. D, su	m of Parts II	0	51. 00
52. 00	Total Program excludable cost (sum of lines	50 and 51)					o	52. 00
53.00	Total Program inpatient operating cost exclu		elated, non-	physi ci an	anesthe	tist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54. 00	Program discharges						0	54. 00
55.00							0.00	
56. 00	Target amount (line 54 x line 55)			(1: 5/		: 52)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount	(Tine 56	minus i	ine 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996	, updated	and com	pounded by the	0.00	
	market basket						0.00	
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					he amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than							01.00
	amount (line 56), otherwise enter zero (see instructions)						o	
62.00	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)							62. 00 63. 00
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(300 1113114	101137				0	00.00
64. 00		ts through Dece	ember 31 of	the cost	reporti n	g period (See	632, 864	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of th	e cost re	eporti na	period (See	o	65. 00
	instructions) (title XVIII only)							
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus lin	e 65)(tit	Te XVIII	only). For	632, 864	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 3	1 of the	cost rep	orting period	0	67. 00
40.00	(line 12 x line 19)	t£t D		-6 41		*:		
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after b	recember 31	or the co	st repor	ting period	U	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		•		no 27)			70. 00
71. 00	Adjusted general inpatient routine service c	-			116 37)			71. 00
72. 00	Program routine service cost (line 9 x line	71)		ŕ				72.00
73.00	Medically necessary private room cost applic							73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			et B. Pa	rt II. column		74. 00 75. 00
	26, line 45)		(-, -,	,		
76.00	Per diem capital related costs (line 75 ÷ li	,						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	· · · · · · · · · · · · · · · · · · ·						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der rec	ords)				79. 00
80.00	Total Program routine service costs for comp		ost limitat	ion (line	78 minu	s line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)					81. 00 82. 00
83. 00								83. 00
84. 00	Program inpatient ancillary services (see in	structions)						84.00
85.00	Utilization review - physician compensation							85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ıı ougri 85)					86. 00
87. 00	Total observation bed days (see instructions)					426	
88. 00		•					1, 128. 10 480, 571	
U7. UU	Observation bed cost (line 87 x line 88) (se	c manuchons)					I 400, 371	U 7. UU

Health Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2013 To 09/30/2014		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	286, 855	2, 286, 654	0. 12544	7 480, 571	60, 286	90.00
91.00 Nursing School cost	0	2, 286, 654	0. 00000	0 480, 571	0	91.00
92.00 Allied health cost	0	2, 286, 654	0. 00000	0 480, 571	0	92.00
93.00 All other Medical Education	0	2, 286, 654	0. 00000	0 480, 571	0	93.00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151319	Peri od: From 10/01/2013	Worksheet D-1
	Component CCN: 155093		Date/Time Prepared: 2/19/2015 8:48 am
	Title XVIII	Skilled Nursing	PPS

		litle XVIII	Facility	PPS		
	Cost Center Description					
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days,			14, 654	1. 00	
2.00	Inpatient days (including private room days, excluding swing-bed			14, 654	2. 00	
3. 00	Private room days (excluding swing-bed and observation bed days)). If you have only pr	ivate room days,	0	3. 00	
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		14, 654	4. 00	
5. 00					5. 00	
	reporting period					
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00	
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room of	tave) through December	31 of the cost	0	7. 00	
7.00	reporting period	days) through becomber	or the cost	O	7.00	
8.00	Total swing-bed NF type inpatient days (including private room of	days) after December 3	1 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)			700		
9. 00	Total inpatient days including private room days applicable to inewborn days)	the Program (excluding	swing-bed and	793	9. 00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	/ (including private r	oom days)	0	10. 00	
	through December 31 of the cost reporting period (see instruction	ons)	,			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00	
12 00	December 31 of the cost reporting period (if calendar year, enters Swing-bed NF type inpatient days applicable to titles V or XIX of		o room days)	0	12. 00	
12. 00	through December 31 of the cost reporting period	only (including privat	e room days)	U	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including privat	e room days)	0	13. 00	
	after December 31 of the cost reporting period (if calendar year					
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14.00	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00	
10.00	SWING BED ADJUSTMENT			0	10.00	
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00	
	reporting period					
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00	
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services to	through December 31 of	the cost	181. 25	19. 00	
17.00	reporting period	in ough becomber of or	the cost	101. 20	17.00	
20.00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of t	he cost	181. 25	20. 00	
21 00	reporting period			2 240 500	21 00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	2, 340, 509 0	21. 00 22. 00	
22.00	5 x line 17)	or or the cost report	ing period (inic	G	22.00	
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reportin	g period (line 6	0	23. 00	
24.00	x line 18)	14 -£ +L++!	(1:	0	24.00	
24. 00	Swing-bed cost applicable to NF type services through December (7×1) (ine 19)	or the cost reporti	ng period (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00	
	x line 20)					
	Total swing-bed cost (see instructions)	21! ! 2/)		0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost (li PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus i i ne 26)		2, 340, 509	27.00	
28. 00	General inpatient routine service charges (excluding swing-bed a	and observation bed ch	arges)	0	28. 00	
29. 00			J ,	0	29. 00	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ l	ine 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	32. 00 33. 00	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruc	tions)	0. 00		
35.00	Average per diem private room cost differential (line 34 x line	, ,		0. 00	35. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00	
37. 00					37. 00	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see in	nstructions)			38. 00	
39.00	Program general inpatient routine service cost (line 9 x line 38				39. 00	
40.00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +				40. 00 41. 00	
41.00	Trotal Trogram general Tripatrent routine service cost (Tille 39 +	11116 40 <i>)</i>	ı		41.00	

//PUT	ATION OF INPATIENT OPERATING COST			CCN: 151319	Peri od: From 10/01/2013	Worksheet D-1	
				t CCN: 155093	To 09/30/2014	2/19/2015 8: 4	
			Ti ti	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42.
00	Intensive Care Type Inpatient Hospital Units	5					J 42.
	INTENSIVE CARE UNIT						43.
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 45.
	SURGI CAL INTENSIVE CARE UNIT						46.
00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (W						48.
00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructi	ons)			49.
00	Pass through costs applicable to Program in	patient routine s	services (fro	m Wkst. D, sur	n of Parts I and		50.
	111)		•				
00	Pass through costs applicable to Program in and IV)	patient ancillary	/ services (fi	rom Wkst. D, s	sum of Parts II	 	51
00	Total Program excludable cost (sum of lines	50 and 51)					52
00	Total Program inpatient operating cost excl		ated, non-phy	ysician anesth	netist, and		53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
00	Program di scharges						54
	Target amount per discharge						55
	Target amount (line 54 x line 55) Difference between adjusted inpatient opera	ting cost and tar	caet amount (ine 56 minus	line 53)		56 57
	Bonus payment (see instructions)	tring cost and tai	get amount (The 50 millios	11116 33)		58
00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	endi ng 1996, i	updated and co	ompounded by the		59
00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	tated by the i	markat haskat			60
	If line 53/54 is less than the lower of line				the amount by		61
	which operating costs (line 53) are less the		s (lines 54 x	60), or 1% of	f the target		
00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)					62
	Allowable Inpatient cost plus incentive pay	ment (see instrud	ctions)				63
	PROGRAM INPATIENT ROUTINE SWING BED COST						ļ
00	Medicare swing-bed SNF inpatient routine con instructions)(title XVIII only)	sts through Decem	mber 31 of the	e cost reporti	ng period (See		64
00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	er 31 of the (cost reportino	g period (See		65
00	instructions)(title XVIII only)			(E) (11 11 10 11 1			١,,
00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line 6	54 prus rine (55)(TITIE XVII	i only). For		66
00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost re	eporting period		67
00	(line 12 x line 19)	as soots often Do	oombon 21 of	the east ron	neting ported		/ .
00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs arter be	ecember 31 01	the cost repo	orting period		68
00	Total title V or XIX swing-bed NF inpatient						69
00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci					2, 340, 509	70
	Adjusted general inpatient routine service					159. 72	1
	Program routine service cost (line 9 x line					126, 658	
00	Medically necessary private room cost appliational Program general inpatient routine ser					0 126, 658	
00	Capital -related cost allocated to inpatient	•			Part II, column	120, 038	1
00	26, line 45)					0.00	_,
00	Per diem capital-related costs (line 75 ÷ 1 Program capital-related costs (line 9 x line					0.00	1
00	Inpatient routine service cost (line 74 min	us line 77)				Ö	
	Aggregate charges to beneficiaries for exce					0	
	Total Program routine service costs for com Inpatient routine service cost per diem lim		ost iimitatio	n (IINe 78 mir	nus iine 79)	0.00	
00	Inpatient routine service cost limitation ()			0.00	82
	Reasonable inpatient routine service costs	(see instructions				126, 658	1
	Program inpatient ancillary services (see in Utilization review - physician compensation		ne)			198, 667 0	1
00	Total Program inpatient operating costs (su					325, 325	1
	PART IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST					
						Δ'	87
00	Total observation bed days (see instruction: Adjusted general inpatient routine cost per		line 2)			0. 00	

Health Financial Systems	GIBSON GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	COMPUTATION OF INPATIENT OPERATING COST			Peri od:	Worksheet D-1	
		Componen		From 10/01/2013 To 09/30/2014		
		Ti tl	e XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
					(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	() (0.00000	00	0	90.00
91.00 Nursing School cost			0.00000	0 0	0	91.00
92.00 Allied health cost		ol c	0.00000	0 0	0	92.00
93.00 All other Medical Education) c	0.00000	00	0	93. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 1	151319 Period: From 10/01/2013	Worksheet D-1
			Date/Time Prepared: 2/19/2015 8:48 am
	Title XI)	X Hospi tal	PPS

			10 077 007 2011	2/19/2015 8: 48	8 am
		Title XIX	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			2, 687	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			2, 027	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.			ا م م م	
4.00	Semi-private room days (excluding swing-bed and observation bed			1, 601	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	561	5. 00
	reporting period			ا	,
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)		21 -6	00	7 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through becember	31 of the cost	99	7. 00
0 00	reporting period	daya) aftar Dagambar 2	1 of the cost	o	0 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	uays) arter becember s	i oi the cost	١	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (eveluding	swing had and	94	9. 00
9.00	newborn days)	the Frogram (excluding	Swifig-bed and	74	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	nom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructi		Join days)	١	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		Join days) arter	Ĭ	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	99	12. 00
12.00	through December 31 of the cost reporting period	om y (mer daring pri vat	o room days)	, ´´!	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00
.0.00	after December 31 of the cost reporting period (if calendar yea			ĭ	10.00
14.00	Medically necessary private room days applicable to the Program			ol	14. 00
15. 00	Total nursery days (title V or XIX only)	(0	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 services	through December 31 o	f the cost		17. 00
	reporting period				
18.00	ledicare rate for swing-bed SNF services applicable to services after December 31 of the cost				18. 00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	181. 25	19. 00
	reporting period				
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	181. 25	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)			2, 937, 462	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	17, 944	24. 00
	7 x line 19)			ا	
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
27 00	x line 20)			/F0 000	2/ 00
26. 00	Total swing-bed cost (see instructions)	i 21i 1 i 2/)		650, 808	•
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 minus Tine 26)		2, 286, 654	27. 00
20.00		and abasement on had ab	25222)	0	20 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cir	ai yes)	0	
29. 00	Pri vate room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 20)			
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	111le 26)		0. 000000 0. 00	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00		
34. 00	Average per diem private room charge differential (line 32 minu	0.00			
35. 00	Average per diem private room cost differential (line 34 x line	0.00			
36. 00					36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fforontial (line	0 2, 286, 654	
37.00	27 minus line 36)	d private room cost di	ilerentiai (ilile	2, 200, 034	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 128. 10	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1	,		106, 041	•
40. 00	Medically necessary private room cost applicable to the Program	,		0	•
	Total Program general inpatient routine service cost (line 39 +	•		106, 041	
	1	·- ·-,	ı	.55,511	

	alth Financial Systems GIBSON GENERAL H MPUTATION OF INPATIENT OPERATING COST				CCN: 151319	Period:	In Lieu of Form CMS- od: Worksheet D-1	
JUNIPUTA	ATTON OF INPATTENT OPERATING COST			ri ovi der	CON: 151319	From 10/01/2013 To 09/30/2014		pared:
					le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Inpati		Average Pe Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
40.00	NUDCEDY (+: +1 - V 0 VIV1)	1.00	2	. 00	3. 00	4. 00	5. 00	12.0
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units							42.0
	INTENSIVE CARE UNIT	414, 540		217	1, 910.	32 0	0	43.0
	CORONARY CARE UNIT							44.0
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45. 0 46. 0
	OTHER SPECIAL CARE (SPECIFY)		ŀ					47.0
	Cost Center Description	1			'			
10.00	December 1 and 1 a	-+ D 21 2		200)			1.00	40.0
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				ons)		120, 407 226, 448	1
	PASS THROUGH COST ADJUSTMENTS	· · · · · · · · · · · · · · · · · · ·					2237 110]
50. 00	Pass through costs applicable to Program inp	atient routine	servi d	es (from	n Wkst. D, su	m of Parts I and	10, 355	50.0
51. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	v serv	rices (fr	om Wkst D	sum of Parts II	7, 089	51.0
55	and IV)	G.JOTTI GI	, 551 (- 55 (11		2	,,,,,,,	5
	Total Program excludable cost (sum of lines						17, 444	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	erated,	non-phy	ısıcıan anest	netist, and	209, 004	53. 0
	TARGET AMOUNT AND LIMIT COMPUTATION							
	Program di scharges						0	
	Target amount per discharge Target amount (line 54 x line 55)						0.00	55. C
	Difference between adjusted inpatient operat	ing cost and ta	arget a	mount (I	ine 56 minus	line 53)	Ö	57.0
	Bonus payment (see instructions)						0	
9. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi no	j 1996, ι	updated and c	ompounded by the	0.00	59. (
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	odated	by the m	narket basket		0.00	60. C
1. 00	If line 53/54 is less than the lower of line						0	61.0
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lir	ies 54 x	60), or 1% o	f the target		
52. 00	Relief payment (see instructions)	riisti ucti olis)					0	62.0
	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons	5)			0	63. C
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mhar 3	11 of the	cost report	ing period (See	0	64. C
74.00	instructions)(title XVIII only)	tis till odgir beec	JIIIDCI C	or the	cost report	riig perrou (see	l	04.0
55. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31	of the d	cost reportin	g period (See	0	65.0
56. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plu	ıs line 6	55)(title XVI	II only). For	0	66. 0
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CAH (see instructions)		0. p. c		,0) (1. 1. 0 /1.			00.0
57. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n Decen	ber 31 d	of the cost r	eporting period	17, 944	67.0
58. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecembe	er 31 of	the cost rep	orting period	0	68. 0
	(line 13 x line 20)				·	3 1		
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						17, 944	69.0
	Skilled nursing facility/other nursing facil							70.0
1	Adjusted general inpatient routine service c		ine 70	÷line	2)			71.0
1	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line	11 v Li	ne 35)			72.0
4. 00	Total Program general inpatient routine serv							74. 0
5. 00	Capital-related cost allocated to inpatient	routine service	costs	(from V	Vorksheet B,	Part II, column		75.0
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)						76. (
- 1	Program capital-related costs (line 9 x line	•						77.0
	Inpatient routine service cost (line 74 minu							78.0
1	Aggregate charges to beneficiaries for exces					nue lino 70)		79. (80. (
	Total Program routine service costs for comp Inpatient routine service cost per diem limi		JUST II	ııı tatı Ol	, (11116 /0 IIII	nus IIIIc /9)		81. (
2. 00	Inpatient routine service cost limitation (I	ine 9 x line 81						82.0
1	Reasonable inpatient routine service costs (ns)					83.0
1	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)					84.0
1	Total Program inpatient operating costs (sum			85)				86.0
ĺ	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST						
37. 00	Total observation bed days (see instructions			٥)				87.0
	Adjusted general inpatient routine cost per	diem (line)/ ÷	- IIne	71			1, 128. 10	

Health Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lieu of Form CMS-2		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2013 To 09/30/2014		
					2/19/2015 8: 4	3 am
			le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	286, 855	2, 286, 654	0. 12544	7 480, 571	60, 286	90.00
91.00 Nursing School cost	0	2, 286, 654	0.00000	0 480, 571	0	91.00
92.00 Allied health cost	0	2, 286, 654	0.00000	0 480, 571	0	92.00
93.00 All other Medical Education	0	2, 286, 654	0. 00000	0 480, 571	0	93. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2			
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151319	Peri od: From 10/01/2013	Worksheet D-1		
	Component CCN: 155093		Date/Time Prepared: 2/19/2015 8:48 am		
	Title XIX	Skilled Nursing	Cost		

		Facility	Cost	
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days,		14, 654	
2.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)		14, 654	
3. 00	do not complete this line.	o. If you have only private room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)	14, 654	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) after becember 31 of the cost	U	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December 31 of the cost	0	7. 00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private room or reporting period (if calendar year, enter 0 on this line)	days) after December 31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding swing-bed and	8, 856	9. 00
	newborn days)			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		0	11. 00
	December 31 of the cost reporting period (if calendar year, entity	er O on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year		O	13.00
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed days)	0	
15. 00	Total nursery days (title V or XIX only)		0	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of the cost		17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of the cost		18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	through December 31 of the cost	181. 25	19. 00
	reporting period			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of the cost	181. 25	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)		2, 340, 509	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporting period (line	0	22. 00
	5 x line 17)			
23. 00	Swing-bed cost applicable to SNF type services after December 3' x line 18)	of the cost reporting period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reporting period (line	0	24. 00
	7 x line 19)			
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (1)	ne 21 minus line 26)	2, 340, 509	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed a Private room charges (excluding swing-bed charges)	and observation bed charges)	0	28. 00 29. 00
30. 00	Semi -private room charges (excluding swing-bed charges)		0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	i ne 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus	s line 33)(see instructions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	, · · · · · · · · · · · · · · · · · · ·	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	,	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost differential (line	2, 340, 509	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see i	nstructi ons)		38. 00
39.00	Program general inpatient routine service cost (line 9 x line 3)			39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	,		40. 00 41. 00
	1	/		

	Financial Systems ATION OF INPATIENT OPERATING COST	GIBSON GENERA			CCN: 151319	Peri od:	worksheet D-1	
				Component	CCN: 155093	From 10/01/2013 To 09/30/2014	Date/Time Pre	
				Ti t	le XIX	Skilled Nursing Facility	2/19/2015 8: 4 Cost	18 ai
	Cost Center Description	Total Inpatient Cost		otal ient Days	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		·	ļ ·		col . 2)		4)	
. 00	NURSERY (title V & XIX only)	1.00		2. 00	3.00	4. 00	5. 00	42
	Intensive Care Type Inpatient Hospital Units	T			ı		Ī	
. 00 . 00	INTENSIVE CARE UNIT CORONARY CARE UNIT							43
	BURN INTENSIVE CARE UNIT							45
	SURGICAL INTENSIVE CARE UNIT		•					46
. 00	OTHER SPECIAL CARE (SPECIFY)							47
	Cost Center Description						1. 00	
00	Program inpatient ancillary service cost (Wk:	st. D-3. col. 3	3. lin	e 200)			1.00	48
	Total Program inpatient costs (sum of lines				ns)			40
	PASS THROUGH COST ADJUSTMENTS							
. 00	Pass through costs applicable to Program inpa	atient routine	servi	ces (from	Wkst. D, sun	of Parts I and		50
00	Pass through costs applicable to Program inp	atient ancillar	rv ser	vices (fr	om Wkst. D. s	um of Parts II		5
	and IV)		,		-, -,			
. 00	Total Program excludable cost (sum of lines		_1					52
. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ei ated	, non-phy	sician anesth	etist, and		5
	TARGET AMOUNT AND LIMIT COMPUTATION	32)						
. 00	Program di scharges] 5·
. 00	Target amount per discharge							5!
. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget	amount (1	ine 56 minus	line 53)		5
00	Bonus payment (see instructions)	ing cost and ta	ai ge t	amount (i	THE 50 III HUS	111le 53)		5
. 00							5	
	market basket							
. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines					the amount by		60
. 00	which operating costs (line 53) are less than					,		6
	amount (line 56), otherwise enter zero (see		(00), 0. 1.0 0.	the target		
. 00	Relief payment (see instructions)							62
. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ucti on	s)				63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember	31 of the	cost reporti	na period (See		6.
	instructions)(title XVIII only)	Ü			·			
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31	of the c	ost reportino	period (See		6
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nl	us line 6	5) (title XVII	Lonly) For		6
. 00	CAH (see instructions)	ne costs (1111e	оч рі	us iiiic c	o) (ti ti e xvii	1 Om y). 101		0
. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	h Dece	mber 31 d	f the cost re	porting period		6
00	(line 12 x line 19)	o occto often [Daaamb	or 21 of	+ba aaa+ mana	unting paried		
. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs arter t	Deceilib	er 31 01	the cost repo	irting period		6
. 00	Total title V or XIX swing-bed NF inpatient	routine costs ((line	67 + line	68)			6
	PART III - SKILLED NURSING FACILITY, OTHER NU							4_
. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of						2, 340, 509 159. 72	
. 00	Program routine service cost (line 9 x line		/	o . iiile	<i>-)</i>		1, 414, 480	
. 00	Medically necessary private room cost applications	,	m (lin	e 14 x li	ne 35)		0	
. 00	Total Program general inpatient routine serv	•					1, 414, 480	
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e cost	s (from W	orksheet B, F	art II, column	246, 484	7!
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					16. 82	7
. 00	Program capital-related costs (line 9 x line						148, 958	
	Inpatient routine service cost (line 74 minus				->		1, 265, 522	
. 00	Aggregate charges to beneficiaries for excess					us line 70)	1 265 522	1
. 00	Total Program routine service costs for companient routine service cost per diem limi		cust I	ımı tatlON	11111 8/ SILL)	ius IIIIE /7)	1, 265, 522 0. 00	
. 00	Inpatient routine service cost limitation (1)				0.00	
. 00	Reasonable inpatient routine service costs (ns)				148, 958	
. 00	Program inpatient ancillary services (see in:		one)				0	
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum			85)			0 148, 958	1 .
. 50	PART IV - COMPUTATION OF OBSERVATION BED PASS		Jugii	30)			170, 730] "
. 00	Total observation bed days (see instructions)					0	87
. 00	Adjusted general inpatient routine cost per						0.00) 88

Health Financial Systems	GIBSON GENER	AL HOSPITAL		In Lie	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	COMPUTATION OF INPATIENT OPERATING COST			Peri od:	Worksheet D-1	
				From 10/01/2013		
			CCN: 155093	To 09/30/2014	Date/Time Prep 2/19/2015 8:48	
		Ti t	le XIX	Skilled Nursing		
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	0	0	0.00000	00	0	90. 00
91.00 Nursing School cost	0	0	0.00000	0 0	0	91.00
92.00 Allied health cost	0	0	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0.00000	0 0	0	93. 00

Health Financial Systems GIBSON GENERAL HOSPITAL		In Lie	eu of Form CMS-	2552 10
	CCN: 151319	Peri od:	Worksheet D-3	
		From 10/01/2013 To 09/30/2014		pared: 8 am
Ti t	le XVIII	Hospi tal	Cost	
Cost Center Description	Ratio of Cos	t Inpatient	Inpati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		795, 137		30. 00
31. 00 03100 INTENSIVE CARE UNIT		199, 131		31. 00
ANCILLARY SERVICE COST CENTERS			1	
50.00 05000 OPERATING ROOM	0. 3945		· ·	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1998!			
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 50512	· ·	· ·	
60. 00 06000 LABORATORY	0. 2544	· ·	128, 395	
65. 00 06500 RESPI RATORY THERAPY	0. 4113		· ·	
66. 00 06600 PHYSI CAL THERAPY	0. 3232	· ·	· ·	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 2631		· ·	
68. 00 O6800 SPEECH PATHOLOGY	0. 30408			
69. 00 06900 ELECTROCARDI OLOGY	0. 00000		l ~	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 26348		· ·	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 7002			
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 5349	351, 117	187, 833	73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	9. 1336		0	70.00
90. 01 09001 DI ABETES	4. 55468		0	, , , , , ,
90. 02 09002 OP PSYCH	0. 6298		0	1 ,0.02
91. 00 09100 EMERGENCY	0. 3232		l .	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 3809		l	
93. 00 04040 CARDI AC REHAB	0. 00000		0	93. 00
200.00 Total (sum of lines 50-94 and 96-98)		2, 571, 003	1, 055, 977	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)	I	2, 571, 003		202. 00

Heal th Financial Systems GIBSON GENERA		2011 454040		eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Period: From 10/01/2013	Worksheet D-3	
	Component		To 09/30/2014		oared:
				2/19/2015 8: 48	
	Ti tl		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
LANDATI FAIT DOUTLAND OFFICE OFFICE		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1		
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31. 00
ANCILLARY SERVICE COST CENTERS		0.0045/	0 7.754	2.000	F0 00
50. 00 05000 OPERATI NG ROOM		0. 39456			50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 19985			
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 50512		07.054	54. 03
60. 00 06000 LABORATORY		0. 25449			60.00
65. 00 06500 RESPI RATORY THERAPY		0. 41132			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 32326			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26311			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 30408		1, 784	
69.00 06900 ELECTROCARDIOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	69. 00
		0. 26348			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 70025 0. 53495		0	72. 00 73. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0.53495	9 100, 364	53, 691	/3.00
90. 00 09000 CLINIC		9. 13362	E 0	0	90. 00
90. 01 09000 CL1 N1 C 90. 01 09001 DI ABETES		4. 55468		0	90.00
90. 02 09002 OP PSYCH		0. 62984			90.01
90. 02 09002 0P PSYCH		0. 02984		0	90.02

0. 323292

1.380943

0.000000

587, 454

587, 454

91.00 0

92.00

201. 00 202. 00

1, 066

0 93.00

201, 200 200. 00

91. 00 09100 EMERGENCY

200.00

201.00 202.00

93. 00 | 04040 | CARDI AC REHAB

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

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

Health Financial Systems	GIBSON GENERAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151319	Peri od:	Worksheet D-3	
	Component	t CCN: 155093	From 10/01/2013 To 09/30/2014	Date/Time Pre 2/19/2015 8:4	
	Ti tl	e XVIII	Skilled Nursing Facility		
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3.00	
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT			0		30. 00 31. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 3945	69 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3945			54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 5051			54. 03
60. 00 06000 LABORATORY		0. 2544			
65. 00 06500 RESPIRATORY THERAPY		0. 4113			
66. 00 06600 PHYSI CAL THERAPY		0. 3232	63 228, 228	73, 778	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2631	14 125, 381	32, 989	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 3040	85 17, 645	5, 366	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.0000	00 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2634		2, 786	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7002		0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 5349	59 82, 299	44, 027	73. 00
OUTPATIENT SERVICE COST CENTERS		0.4007	٥٥		00.00
90. 00 09000 CLI NI C		9. 1336		-	90.00
90. 01 09001 DI ABETES		4. 5546		0	90. 01
90. 02 09002 0P PSYCH 91. 00 09100 EMERGENCY		0. 6298 0. 3232		0	90. 02 91. 00
		1. 3809		0	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 93. 00 04040 CARDI AC REHAB		0.0000		0	
200.00 Total (sum of lines 50-94 and 96-98)		0.0000	596, 076		
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges (line 61)		370, 070		201.00
202.00 Net Charges (line 200 minus line 201)	ogram om y charges (Title of)		596, 076	l	202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	IERAL HOSPI TAL	CCN: 151319	Peri od:	eu of Form CMS-: Worksheet D-3	
INPATTENT ANCILLARY SERVICE COST APPORTIONMENT	Provider	CCN: 151319	From 10/01/2013)
			To 09/30/2014	Date/Time Pre	
				2/19/2015 8: 4	8 am
	Tit	le XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			106, 481		30.00
31. 00 03100 NTENSI VE CARE UNI T			17, 365	1	31.00
ANCILLARY SERVICE COST CENTERS		1		1	1
50. 00 05000 OPERATI NG ROOM		0. 3945	69 150, 940	59, 556	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1998	50 4, 849	969	54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 50512	26 0	0	54. 03
60. 00 06000 LABORATORY		0. 2544			
65. 00 06500 RESPIRATORY THERAPY		0. 4113			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 32320			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2631		•	
68. 00 06800 SPEECH PATHOLOGY		0. 3040		167	
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26348		0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 7002		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 5349	59 39, 607	21, 188	73. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC		0.1227	٥٦		00.00
90. 00 09000 CLI NI C 90. 01 09001 DI ABETES		9. 1336		_	
90. 01 09001 DEABETES 90. 02 09002 OP PSYCH		4. 55468 0. 6298		0	
91. 00 09100 EMERGENCY		0. 3232			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		1. 3809		9, 400	1
93. 00 04040 CARDI AC REHAB		0.0000		0	
200.00 Total (sum of lines 50-94 and 96-98)		0.0000	315, 931	1	
201.00 Less PBP Clinic Laboratory Services-Program only cl	narges (line 61)		313, 731	120, 407	201.00
202.00 Net Charges (line 200 minus line 201)	iai gcs (Title 01)	1	315, 931	1	202.00

Heal th Fi	nancial Systems	GIBSON GENERAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT		CCN: 151319 CCN: 155093	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Pre 2/19/2015 8:4	pared:
		Ti t	le XIX	Skilled Nursing Facility	Cost	
	Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2) 3.00	
I NE	PATIENT ROUTINE SERVICE COST CENTERS			<u>'</u>		
31. 00 03 ⁻	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT			0	l .	30. 00 31. 00
	CILLARY SERVICE COST CENTERS					
	OOO OPERATING ROOM		0. 3945		l	
	400 RADI OLOGY-DI AGNOSTI C		0. 1998		0	
	401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 5051		0	
	000 LABORATORY 500 RESPI RATORY THERAPY		0. 2544 0. 4113		0	
	600 PHYSI CAL THERAPY		0.4113		0	
	700 OCCUPATIONAL THERAPY		0. 3232		0	
	800 SPEECH PATHOLOGY		0. 2031		0	
	900 ELECTROCARDI OLOGY		0. 3040			
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2634		0	
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 7002		0	
	300 DRUGS CHARGED TO PATIENTS		0. 5349			
	TPATIENT SERVICE COST CENTERS		0.00.7	5,1 5		70.00
	000 CLI NI C		9. 1336	25 0	0	90.00
90. 01 090	001 DI ABETES		4. 5546		0	90. 01
90. 02 090	002 OP PSYCH		0. 6298	43 0	0	90. 02
91.00 09	100 EMERGENCY		0. 3232		0	91.00
92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 3809	43 0	0	92.00
93. 00 040	040 CARDI AC REHAB		0.0000	00 0	0	93.00
200. 00	Total (sum of lines 50-94 and 96-98)			0	0	200. 00
201.00	Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)			0		202. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151319	From 10/01/2013	Worksheet E Part B Date/Time Prepared: 2/19/2015 8:48 am
	T1 11 \ \0.00 11		

Name Second All Office				10 09/30/2014	2/19/2015 8:48	
			Title XVIII	Hospi tal		o ani
Next B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Modical and other services (see instructions) 4, 205, 396 1.00 0.0			THE XVIII	1103pi tui	0031	
Medical and other services (see instructions)					1. 00	
Word call and other services roll abursed under OPPS (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES				
Description	1.00				4, 205, 396	1. 00
0.00 0.00		,	ons)		-	•
Enter the fixespital specific payment to cost ratio (see instructions) 0.000 5.00		1 ' 3			-	•
Line 2 times line 5		, , ,			-	•
7.00 Sam of Time 3 plus line 4 divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 0 0.00 9.00 Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200 0 0.00 11.00 Organ acquisitions 4,205,396 11.00 12.00 Total cost (sum of lines 1 and 10) (see instructions) 4,205,396 11.00 12.00 Modifiary Service charges 0 12.00 12.00 12.00 14.00 Intell pass acquisition charges (from Worksheet D-4, Part III, line 69, col. 4) 0 12.00 13.00 13.00 13.00 13.00 13.00 14.00			ions)			•
Transitional corridor payment (see instructions) 8. 00 9. 00 Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200 0. 00					-	
9.00 Ancil lary service other pass through costs from Worksheet D, Part IV, column 13, line 200 0 0.00 0.10 0 0.00 <td></td> <td>1</td> <td></td> <td></td> <td></td> <td>1</td>		1				1
10.00 Organ acquisitions 4, 205, 396 COUNTITATION OF LESSER OF COST OR CHARGES 4, 205, 396 COUNTITATION OF LESSER OF COST OR CHARGES 5		, , ,	rt IV column 13 line 1	200	-	•
1.00 Total cost (sum of lines 1 and 10) (see instructions) 4, 205, 396 11, 00			TETV, COLUMN 19, TITLE 2	200	-	
Computation of LESSER of COST OR CHARGES Reasonable charges Reasonable charges 0 12.00 Ancil lary service charges (from Worksheet D-4, Part III, line 69, col. 4) 0 13.00 13.00 Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4) 0 13.00 13.00 Organ acquisition charges (sum of lines 12 and 13) 0 14.00 Cost Computation 0 14.00 Cost Cost Cost Cost Cost Cost Cost Cost					-	•
2.00 Ancil lary service charges 0 12.00 13.00 101 10						
13.00 Organ acquisition charges (from Worksheet D-4, Part III, Iline 69, col. 4)		Reasonable charges				
14, 00 Total reasonable charges (sum of lines 12 and 13)	12.00	Ancillary service charges			0	12. 00
Customary_charges			9, col. 4)		-	
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00	14. 00				0	14. 00
16. 00 Amounts that would have been realized from patients liable for payment for services on a chargebasis Nad such payment been made in accordance with 42 CFR 413.13(e) 0.000000 17. 00 17. 00 18.10 of line 15 to line 16 (not to exceed 1.000000) 0.000000 17. 00 18.	45.00					1 4 - 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) 17.00 18.00 18.00 19.00 Excess of customary charges (see instructions) 0 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00 1	16.00	,	payment for services on	a chargebasis	U	16.00
18.00 Total customary charges (see instructions)	17 00				0.000000	17 00
9, 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19, 00 19, 00 10 10 10 10 10 10 10						•
Instructions			if line 18 exceeds line	e 11) (see	-	•
Instructions		, , ,			- 1	
21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 4, 247, 450 21.00	20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds line	e 18) (see	0	20. 00
22.00 Interns and residents (see instructions)						
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT		, , ,	instructions)			1
Act Dotal prospective payment (sum of lines 3, 4, 8 and 9) 24.00		1				•
COMPUTATION OF RELIMBURSEMENT SETTLEMENT 25.00 Deductibles and coinsurance (for CAH, see instructions) 34,939 25.00 26.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 1,827,108 26.00 27.00 Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, 2,385,403 27.00 Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, 2,385,403 27.00 Subtotal (sum of lines 27 through 29) 0 28.00 29.00 ESRD direct medical education costs (from Worksheet E-4, line 36) 0 29.00			CTI ons)		-	
25.00 Deductibles and coinsurance (for CAH, see instructions) 34,939 25.00	24.00				U	24.00
26. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 1,827,108 26. 00 27. 00 Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 2,385,403 27. 00 28. 00 Direct graduate medical education payments (from Worksheet E-4, line 50) 0 28. 00 30. 00 Subtotal (sum of lines 27 through 29) 2,385,403 30. 00 31. 00 Primary payer payments 5,57 31. 00 32. 00 Subtotal (line 30 minus line 31) 2,384,846 32. 00 34. 00 AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 33. 00 34. 00 Allowable bad debts (see instructions) 122,946 34. 00 35. 00 Allowable bad debts (see instructions) 93,439 35. 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 101,716 36. 00 37. 00 Subtotal (see instructions) 2,478, 285 37. 00 38. 00 MP-LCC reconciliation amount from PS&R 0 38. 00 39. 09 Primar manufactures for replaced devices (se	25 00				34 939	25 00
27.00 Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 28.00 September 28.00 ESRD direct medical education payments (from Worksheet E-4, line 50) 0 28.00 29.00			CAH, see instructions)			1
See instructions				23} (for CAH,		1
29.00 ESRD diffect medical education costs (from Worksheet E-4, line 36) 29.00 30.00						
30.00 Subtotal (sum of lines 27 through 29) 2,385,403 30.00 557 31.00 7 rimary payer payments 557 31.00 2,384,846 32.00					-	
31.00 Subtotal (line 30 mlnus line 31) 2,384,846 32.00 Subtotal (line 30 mlnus line 31) 2,384,846 32.00 Subtotal (line 30 mlnus line 31) 2,384,846 32.00 Subtotal (line 30 mlnus line 31) 32.00 33.00 34.00 Allowable BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 34.00 34.00 Allowable bad debts (see instructions) 122,946 34.00 35.00 Allowable bad debts (see instructions) 93.439 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 101,716 36.00 37.00 38.00 MSP-LCC reconciliation amount from PS&R 2,478,285 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 2,478,285 40.00 40.01 40.00 40.01 40.00 40.01 40.00		•	6)		-	
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Worksheet I-5, line 11) 0 33.00 34.00 34.00 34.00 35.00 Allowable bad debts (see instructions) 122,946 34.00 35.00 Allowable bad debts (see instructions) 101,716 35.00 37.00 Subtotal (see instructions) 2,478,285 37.00 37.00 Subtotal (see instructions) 2,478,285 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2,478,285 40.00 40.01 Sequestration adjustment (see instructions) 2,478,285 40.00 40.01 Sequestration adjustment (see instructions) 2,814,281 41.00 42.00 43.00 Bal ance due provider/program (see instructions) 2,814,281 41.00 42.00 43.00 80.00 40.		,				1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 Composite rate ESRD (from Worksheet I-5, line 11) 0 33. 00 33. 00 33. 00 All owable bad debts (see instructions) 122,946 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 93, 439 35. 00 36. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 101,716 36. 00 37. 00 Subtotal (see instructions) 2,478, 285 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 90 99. Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 99. Partial or full credits received from manufacturers for replaced devices (see instructions) 2,478, 285 40. 00 40. 00 Subtotal (see instructions) 2,478, 285 40. 00 40. 01 41. 00 Interim payments 2,478, 285 40. 00 42. 00 43. 00 Bal ance due provider/program (see instructions) -385,562 43. 00 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 0 90. 00 91. 00 00 00 00 00 00 00 00						ı
33.00 Composite rate ESRD (from Worksheet I-5, line 11) 33.00 34.00 34.00 Allowable bad debts (see instructions) 122,946 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 93,439 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 101,716 36.00 37.00 Subtotal (see instructions) 2,478,285 37.00 39.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 39.00 39.90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.90 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.99 Advanced to the provided of the payments 2,478,285 40.00 40.01 41.00 1nterim payments 2,478,285 40.00 42.00 43.00 Bal ance due provider/program (see instructions) 2,814,281 41.00 41.00 Bal ance due provider/program (see instructions) -385,562 43.00 44.00 Advanced to the provider payment 44.00 44.0	32.00		6)		2, 384, 846	32.00
34.00 Allowable bad debts (see instructions) 122, 946 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 93, 439 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 101, 716 36.00 37.00 Subtotal (see instructions) 2, 478, 285 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.90 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.90 40.00 Subtotal (see instructions) 2, 478, 285 40.00 40.01 Interim payments 2, 814, 281 41.00 42.00 Tentative settlement (for contractors use only) 44.00 Ealance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 1515.2 TO BE COMPLETED BY CONTRACTOR 0 90.00 91.00 Ottolier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 93.00 0 93.00	33 00		3)		0	33 00
35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 (a) Subtotal (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 (a) Sequestration adjustment (see instructions) 39.99 (a) Sequestration adjustment (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 (a) Sequestration adjustment (see instructions) 39.99 (a) Sequestration (see instructions) 39.90 (a) Seque		1			-	•
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Tiginal outlier amount (see instructions) 70.00 Outlier reconciliation adjustment amount (see instructions) 70.00 The rate used to calculate the Time Value of Money 70.00 Time Value of Money (see instructions) 70.00 Outlier reconciliation adjustment amount (see instructions)						1
37.00 Subtotal (see instructions) 2, 478, 285 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2, 478, 285 40.00 40.01 Interim payments 2, 814, 281 41.00 42.00 43.00 Balance due provider/program (see instructions) 2, 814, 281 41.00 42.00 43.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 515.2 TO BE COMPLETED BY CONTRACTOR 0 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 93.00 Time Value of Money (see instructions) 0 93.00 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 93.00 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00		, , , , , , , , , , , , , , , , , , , ,	ctions)			•
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Og 93. 00	37.00		ŕ		2, 478, 285	37. 00
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50. 39. 99 40. 00 Subtotal (see instructions) 60. 00 Sequestration adjustment (see instructions) 61. 00 Interim payments 62. 01 Tentative settlement (for contractors use only) 63. 00 Balance due provider/program (see instructions) 63. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, only 115. 2 63. 00 Original outlier amount (see instructions) 70. 00 Outlier reconciliation adjustment amount (see instructions) 70. 00 Outlier reconciliation adjustment amount (see instructions) 70. 00 The rate used to calculate the Time Value of Money 70. 00 Time Value of Money (see instructions) 70. 00 Outlier of Money (see instructions)	38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 2, 478, 285 40. 00 40. 01 41. 00 49. 566 40. 01 41. 00 42. 00 42. 00 42. 00 43. 00 8al ance due provider/program (see instructions) 2,814, 281 41. 00 42. 00 44. 00 44. 00 44. 00 45						1
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.01 Interim payments 42.00 Interim payments 42.00 Bal ance due provider/program (see instructions) 43.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		·	d devices (see instructi	ions)	-	
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{515.2}{10 \text{ BE COMPLETED BY CONTRACTOR}}{\text{Original outlier amount (see instructions)}} 90.00 Outlier reconciliation adjustment amount (see instructions) 10 90.00 The rate used to calculate the Time Value of Money 11 me Value of Money (see instructions) 12						ł
41.00 Interim payments 2,814,281 41.00 42.00 43.00 Balance due provider/program (see instructions) -385,562 43.00 44.00 Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 0 0 0 0 0 0 0 0 0						1
Tentative settlement (for contractors use only) 42.00 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, over 15 to BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 000 Outlier reconciliation adjustment amount (see instructions) 10 90.00 10 000 10 000 11 ime Value of Money (see instructions) 10 90.00 92.00 93.00						1
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions)		. ,				•
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{91} \] TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 10 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{91} \] 90.00 Original outlier amount (see instructions) 10 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{91} \] 90.00 Original outlier amount (see instructions) 10 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{91} \] 90.00 Original outlier amount (see instructions) 10 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{92} \] 90.00 Original outlier amount (see instructions) 91.00 Original outlier amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 11 Image Value of Money (see instructions) 12 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{91} \] 93.00 The rate used to calculate the Time Value of Money 12 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{91} \] 94.00 Original outlier amount (see instructions) 95.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions)		` <i>3'</i>				•
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 p1.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 1 Time Value of Money (see instructions) 0 p3.00		, , , , , , , , , , , , , , , , , , , ,	e with CMS Pub 15-2 ch	hapter 1		1
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00			o t oo . a.z o	apro,		
91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 91. 00 92. 00 93. 00 93. 00		-]
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00		, ,				1
93.00 Time Value of Money (see instructions) 0 93.00					-	•
		1				1
94. 00 Total (Suiii of Tines 91 and 93)		1				•
	74. UU	Tiotai (Suil OI TITIES 71 and 73)			U	74.00

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

					2/19/2015 8: 4	8 am
			Title XVIII	Hospi tal	Cost	
		I npa	tient Part A	Par	rt B	
		mm/dd/yy	/y Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 795, 03	3	2, 723, 181	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services reporting period. If none,			0	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) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	09/15/20	14 132, 100	04/17/2014	91, 100	3. 01
3. 01	ADDUSTMENTS TO FROVIDER	09/13/20		0 04/1//2014	91, 100	3. 01
3. 02						3. 02
3. 03						3. 04
3. 05						3. 05
3.03	Provider to Program	l	<u> </u>	٧١		3.03
3.50	ADJUSTMENTS TO PROGRAM			D	0	3. 50
3. 51				D	0	3. 51
3.52				o	0	3. 52
3.53				o	0	3. 53
3.54				O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		132, 100	D	91, 100	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		1, 927, 13	3	2, 814, 281	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
5. 01	TENTATI VE TO PROVIDER			D	0	5. 01
5.02				D	0	5. 02
5.03			(D	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		<u> </u>	D)	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		262, 87	3	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			O	385, 562	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 190, 01		2, 428, 719	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

		Ti +I	e XVIII Sv	wing Beds - SNF	2/19/2015 8: 4 Cost	o alli
			nt Part A		rt B	
		i iipati ei	. C T GIT C A	7 41		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		725, 150		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1	·	1	
3. 01	ADJUSTMENTS TO PROVIDER	09/15/2014	81, 300		0	
3. 02			0		0	
3.03			0		0	
3.04			0		0	
3.05			0		0	3. 05
	Provider to Program		1	ı	1	
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	0.0.
3. 52			0		0	0.02
3.53			0		0	
3.54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		81, 300		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		806, 450		0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		600, 430		0	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	1	l			
5.00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			<u>'</u>	•	
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	0.00
5. 51			0		0	5. 51
5.52			0		0	0.02
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		4,			
6. 01	SETTLEMENT TO PROVIDER		16, 143		0	
6. 02	SETTLEMENT TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		822, 593		0	7. 00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
3.00	Indine of contractor	1		l	I	0.00

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

		Titl	e XVIII	Skilled Nursing Facility	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		209, 027		0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		()	0	3. 01
3.02			(0	3. 02
3.03			(0	3. 03
3.04			(0	3. 04
3.05			(0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51			(0	3. 51
3. 52			(0	3. 52
3.53			(0	3. 53
3.54			(0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		(0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		209, 027	7	0	4. 00
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)					
F 01	Program to Provider TENTATIVE TO PROVIDER			J	0	E 01
5. 01 5. 02	TENTATIVE TO PROVIDER		(0	5. 01 5. 02
5. 02					0	5. 02
5.05	Provider to Program			7	0	5.05
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51	TEITH TE TO THOUSE IN				0	5. 51
5. 52					Ö	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(D	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		(0	6. 01
6.02	SETTLEMENT TO PROGRAM		(0	6. 02
7.00	Total Medicare program liability (see instructions)		209, 027	7	0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Heal th	Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu				
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 151319 Period: Workshee From 10/01/2013 Part II To 09/30/2014 Date/Tir 2/19/20				
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S	-3, Part I column 15 li	ne 14	490	1. 00
2.00	2.00 Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12				
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			12	3. 00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1,	8-12		1, 818	4. 00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			49, 267, 223	5. 00
6.00	Total hospital charity care charges from Wkst S-10, column 3 l	ine 20		1, 842, 518	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of ce	rtified HIT technology	Worksheet S-2,	0	7. 00
	Part I line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	.00 Sequestration adjustment amount (see instructions) 0				
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				
	I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)			0	30. 00
31.00	Other Adjustment (specify)			0	31. 00
32 00	00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

0 30.00 0 31.00 0 32.00

Health Financial Systems	GIBSON GENERAL HO	SPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN	N: 151319	Peri od:	Worksheet E-2
				From 10/01/2013	
		Component CO	CN: 15Z319	To 09/30/2014	Date/Time Prepared:

	C	omponent CCN: 15Z319	To 09/30/2014	Date/Time Pre 2/19/2015 8:4	
		Title XVIII	Swing 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)		639, 193	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A,	, and sum of Wkst. D,	203, 212	0	3. 00
	Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instru				
4.00	Per diem cost for interns and residents not in approved teaching p	program (see		0.00	4. 00
	instructions)				
5.00	Program days		561	0	5. 00
6.00	Interns and residents not in approved teaching program (see instru			0	6. 00
7.00	Utilization review - physician compensation - SNF optional method	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		842, 405	0	
9.00	Primary payer payments (see instructions)		0	0	,
10.00	Subtotal (line 8 minus line 9)		842, 405	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	e to physician	0	0	11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		842, 405	0	1
13. 00	Coinsurance billed to program patients (from provider records) (ex	xcl ude coi nsurance	3, 024	0	13. 00
	for physician professional services)			_	
	80% of Part B costs (line 12 x 80%)			0	1
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		839, 381	0	15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
	RURAL DEMONSTRATION PROJECT		0	0	16. 50
	Allowable bad debts (see instructions)		0	0	1
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
	Allowable bad debts for dual eligible beneficiaries (see instructi	ions)	0	0	18. 00
19. 00	Total (see instructions)		839, 381	0	19. 00
19. 01	Sequestration adjustment (see instructions)		16, 788	0	19. 01
20. 00	Interim payments		806, 450	0	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
22. 00	Balance due provider/program line 19 minus lines 19.01, 20 and 21		16, 143	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance v	with CMS Pub. 15-2,	0	0	23. 00
	section 115.2				l

Health Financial Systems	GIBSON GENERAL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151319	From 10/01/2013	Worksheet E-3 Part V Date/Time Prepared: 2/19/2015 8:48 am
		Title XVIII	Hosni tal	Cost

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				10 09/30/2014	2/19/2015 8: 4	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT			Title XVIII	Hospi tal		
PART V - CALCULATION OF RETUBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RETUBURSEMENT		· · · · · · · · · · · · · · · · · · ·				
1.00 Inpatient services 2, 482, 688 2, 402, 688 3, 00 0 0 0 0 0 0 0 0 0					1. 00	
2.00		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE P	ART A SERVICES - COST	REIMBURSEMENT		
0	1.00	Inpatient services			2, 482, 688	1.00
A.00 Subtotal (sum of lines 1 thru 3) 2, 482, 688 6.00	2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2. 00
Final Pry payer payments	3.00	Organ acqui si ti on			0	3. 00
Total cost (line 4 less line 5). For CAH (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Routine service on a charge basis Routine services on a charge service services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a	4.00	Subtotal (sum of lines 1 thru 3)			2, 482, 688	4.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Routine service charges Routine services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge services on a charge basis Routine services on a charge s	5.00	Primary payer payments			0	5.00
Reasonable charges Routine service charges Routine services Routine services Routine services Routine services Routine services on a charge basis Routine services on a	6.00				2, 507, 515	6. 00
7.00 Routine service charges 0 8.00 Ancillary service charges 0 9.00 Organ acquisition charges, net of revenue 0 10.00 Total reasonable charges 0 0 Customary charges 0 11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 1 13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 15.00 Excess of customary charges (see instructions) 0 16.00 Excess of reasonable cost over customary charges (complete only if line 14 exceeds line 6) (see instructions) 0 17.00 Cost of physicians' services in a teaching hospital (see instructions) 0 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 19.00 Cost of covered services (sum of lines 6, 17 and 18) 2, 507, 515 0 19.00 Cost of covered services (sum of lines 6) (7 and 18) 2, 229, 000 1, 216 0 22.00 Subtotal (line 19 minus line 20 and 21) 2, 229, 000 1, 216 0 23.00 Cionsurance 1, 216 0 24.00 Subtotal (line 22 minus line 23) 2, 227, 784 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 9, 106 0 24.00 Subtotal (sum of lines 24 and 25, or line 26) 0 25.00 Ratio and the service of the s		COMPUTATION OF LESSER OF COST OR CHARGES				
8.00 Ancillary service charges 0 0 0 0 0 0 0 0 0						
9.00 Organ acquisition charges, net of revenue Total reasonable charges 11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 15.00 Excess of customary charges (see instructions) 16.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.07 Allowable bad debts (exclude bad debts for professional services) (see instructions) 27.00 Allowable bad debts (exclude bad debts (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 Titler ADJUSTMENTS (SEE INSTRUCTIONS) 29.00 Subtotal (line 28, plus or minus lines 29) 20.01 Sequestration adjustment (see instructions) 20.01 Sequestration adjustment (see instructions) 20.02 Sequestration adjustment (see instructions) 20.03 Sequestration adjustment (see instructions)		· · · · · · · · · · · · · · · · · · ·				
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21.00 Excess reasonable cost (from line 16) 0 22.00 Subtotal (line 19 minus line 20 and 21) 2, 229, 000 23.00 Coinsurance 1, 216 24.00 Subtotal (line 22 minus line 23) 2, 227, 784 25.00 All lowable bad debts (exclude bad debts for professional services) (see instructions) 9, 106 26.00 Adjusted reimbursable bad debts (see instructions) 6, 921 27.00 All owable bad debts for dual eligible beneficiaries (see instructions) 6, 921 28.00 Subtotal (sum of lines 24 and 25, or line 26) 2, 234, 705 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.99 Recovery of Accelerated Depreciation 0 30.00 Subtotal (line 28, plus or minus lines 29) 2, 234, 705 30.01 Sequestration adjustment (see instructions) 44, 694						
22. 00 Subtotal (line 19 minus line 20 and 21) 2, 229,000 23. 00 Coinsurance 1, 216 24. 00 Subtotal (line 22 minus line 23) 2, 227, 784 25. 00 All lowable bad debts (exclude bad debts for professional services) (see instructions) 9, 106 26. 00 Adjusted reimbursable bad debts (see instructions) 6, 921 27. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 6, 764 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 2, 234, 705 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 99 Recovery of Accelerated Depreciation 0 30. 00 Subtotal (line 28, plus or minus lines 29) 2, 234, 705 30. 01 Sequestration adjustment (see instructions) 44, 694						
23. 00 Coinsurance 24. 00 Subtotal (line 22 minus line 23) 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 99 Recovery of Accelerated Depreciation 30. 00 Subtotal (line 28, plus or minus lines 29) 30. 01 Sequestration adjustment (see instructions) 1, 216 2, 227, 784						
24.00 Subtotal (line 22 minus line 23) 2, 227, 784 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 3, 100 Adjusted reimbursable bad debts (see instructions) 4, 110 wable bad debts for dual eligible beneficiaries (see instructions) 5, 764 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 7, 29.99 Recovery of Accelerated Depreciation 7, 200 Subtotal (line 28, plus or minus lines 29) 7, 234, 705 7, 784 2, 227, 227 2, 227, 227 2, 227, 227 2, 227, 227		1 '				l
25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 30.01 Sequestration adjustment (see instructions) 9, 106 6, 921 2, 234, 705 0 2, 234, 705 2, 234, 705						
26.00 Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (sum of lines 24 and 25, or line 26) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Provided by the subtotal (line 28, plus or minus lines 29) Subtotal (line 28, plus or minus lines 29) Sequestration adjustment (see instructions) 26, 921 27.00 29.47,705 29.50 20.20			s) (see instructions)			
27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 30.01 Sequestration adjustment (see instructions) 6,764 2,234,705 0 2,234,705			, (, , , , , , , , , , , , , , , , , ,			
28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 30.01 Sequestration adjustment (see instructions) 2, 234, 705 2, 234, 705 3, 201 3,			ctions)			
29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (line 28, plus or minus lines 29) 30.01 Sequestration adjustment (see instructions) 0 2, 234, 705 44, 694		,	,			
29. 99 Recovery of Accelerated Depreciation 30. 00 Subtotal (line 28, plus or minus lines 29) 30. 01 Sequestration adjustment (see instructions) 0 2, 234, 705 44, 694	29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
30.00 Subtotal (line 28, plus or minus lines 29) 30.01 Sequestration adjustment (see instructions) 2, 234, 705 44, 694	29. 99	, , , , ,			0	29. 99
30.01 Sequestration adjustment (see instructions) 44,694					2, 234, 705	
31.00 Interim payments 1,927,138		, ,				
			32		262, 873	33.00
	34.00			chapter 1,		
§115. 2		§115. 2		•		

Financial Systems GIBSON GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
	Provider CCN: 151319 Component CCN: 155093	Peri od:	Worksheet E-3 Part VI Date/Time Pre	pared:	
	Title XVIII	Skilled Nursing Facility		<u> </u>	
			1. 00		
SERVI CES	IER HEALTH SERVICES FOR T	ITLE XVIII PART A	PPS SNF		
,			27/ 072	1. 00	
			0	2. 00 3. 00	
			274. 873		
			=: :, =:=		
	costs are included in lin	e 1 of W/S E,		5. 00	
Deducti bl e			0	6. 00	
Coi nsurance			61, 580	7. 00	
8.00 Allowable bad debts (see instructions)					
Reimbursable bad debts for dual eligible beneficiaries (see i	nstructions)		0	9. 00	
Adjusted reimbursable bad debts (see instructions)			0	10. 00	
			0	11. 00	
Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see	Instructions)		213, 293	12. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHSERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS) Resource Utilization Group Payment (RUGS) Routine service other pass through costs Ancillary service other pass through costs Subtotal (sum of lines 1 through 3) COMPUTATION OF NET COST OF COVERED SERVICES Medical and other services (Do not use this line as vaccine of Part B. This line is now shaded.) Deductible Coinsurance Allowable bad debts (see instructions) Reimbursable bad debts for dual eligible beneficiaries (see in Adjusted reimbursable bad debts (see instructions) Utilization review	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR T SERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS) Resource Utilization Group Payment (RUGS) Routine service other pass through costs Ancillary service other pass through costs Subtotal (sum of lines 1 through 3) COMPUTATION OF NET COST OF COVERED SERVICES Medical and other services (Do not use this line as vaccine costs are included in lin Part B. This line is now shaded.) Deductible Coinsurance Allowable bad debts (see instructions) Reimbursable bad debts for dual eligible beneficiaries (see instructions) Adjusted reimbursable bad debts (see instructions)	Provider CCN: 151319 Component CCN: 151319 Component CCN: 155093 Title XVIII PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART ASERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS) Resource Utilization Group Payment (RUGS) Routine service other pass through costs Ancillary service other pass through costs Subtotal (sum of lines 1 through 3) COMPUTATION OF NET COST OF COVERED SERVICES Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.) Deductible Coinsurance Allowable bad debts (see instructions) Reimbursable bad debts (see instructions) Reimbursable bad debts (see instructions) Utilization review	LATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 151319 Component CCN: 155093 Title XVIII Skilled Nursing Facility PPS SRF SERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS) Resource Utilization Group Payment (RUGS) Ancillary service other pass through costs Ancillary service other pass through costs Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.) Deductible Coinsurance Allowable bad debts (see instructions) Reimbursable bad debts (see instructions) Reimbursable bad debts (see instructions) O Utilization review Provider CCN: 151319 Component CCN: 151319 From 10/01/2013 Part VI From 10/01/2013 Part VI Pa	

Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,

0 13.00

0

0

0 18.00

0 19.00

213, 293

209, 027

4, 266

14.00

14. 99 0

15.00

15.01

16.00

17.00

Inpatient primary payer payments
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

Tentative settlement (for contractor use only)

18.00 Balance due provider/program line 15 minus 15.01, 16 and 17

Recovery of Accelerated Depreciation
Subtotal (line 12 minus 13 ± lines 14

15.01 | Sequestration adjustment (see instructions)

Interim payments

§115. 2

14.00

14. 99

15.00

16.00

17.00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151319	Peri od: Worksheet E-3
		From 10/01/2013 Part VII
		To 00/20/2014 Doto/Time Dropored.

			To 09/30/2014		
		Title XIX	Hospi tal	PPS	
	·		Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	ICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			1, 480, 423	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	.,,	4. 00
5. 00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments		_	0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	1, 480, 423	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges				0.00
8. 00 9. 00	Routine service charges Ancillary service charges		315, 931	4, 919, 160	8. 00 9. 00
10. 00	Organ acquisition charges, net of revenue		313, 931	4, 919, 100 ₁	10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		315, 931	4, 919, 160	
12.00	CUSTOMARY CHARGES		313, 731	4, 717, 100	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000		
16. 00	Total customary charges (see instructions)		315, 931	4, 919, 160	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	315, 931	3, 438, 737	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	_	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		0		
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	,		1, 400, 423	21.00
22. 00	Other than outlier payments	Simple tea 101 113 provide	0	0	22. 00
23. 00	Outlier payments		0	_	23. 00
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	1, 480, 423	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	_	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	.,,	
32. 00	Deducti bl es		0	_	32.00
	Coinsurance		0	_	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Utilization review		0	_	34. 00 35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	22)	0		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	0	1, 460, 423	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	1, 480, 423	
	Direct graduate medical education payments (from Wkst. E-4)		0	1, 400, 423	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	1, 480, 423	
41. 00	Interim payments		0	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		0		
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2	-			

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Worksheet E-3
		From 10/01/2013	
	Component CCN: 155093	To 09/30/2014	
	·		2/19/2015 8:48 am
	Title XIX	Skilled Nursing	Cost
		Facility	

		THE XIX	Facility	0001	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		148, 958		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		148, 958	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		148, 958	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges				1
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13. 00
	basis				
14.00	Amounts that would have been realized from patients liable for p	ayment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)		0	0	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	148, 958	0	18. 00
	16) (see instructions)		_	_	
19.00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instruc		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
00.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	mpleted for PPS provide			
22. 00	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		١	0	1
27. 00 28. 00	, ,		0 0	0	1
	Customary charges (title V or XIX PPS covered services only)		0		1
29. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		l d	0	29. 00
30. 00	Excess of reasonable cost (from line 18)		148, 958	0	30.00
			146, 936	0	
32.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles			0	
33. 00	Coi nsurance			0	
34. 00	Allowable bad debts (see instructions)			0	
35. 00	Utilization review			U	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	2)		0	1
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	3)		0	
	Subtotal (line 36 ± line 37)			0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)			U	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)			0	
41. 00	Interim payments			0	
41.00	Balance due provider/program (line 40 minus line 41)			0	
42.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15_2		0	
- 3.00	chapter 1, §115.2	w. til omo rub 13-2,	١	U	75.00
	0.10p to 1 3110.2		1		I

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

Provi der CCN: 151319 | Peri od: | From 10/01/201

| Period: | Worksheet G | From 10/01/2013 | To 09/30/2014 | Date/Time Prepared: 2/19/2015 8:48 am

					2/19/2015 8: 4	8 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1.00	Cash on hand in banks	997, 121		0	0	1.00
2. 00	Temporary investments	777,121			Ö	2. 00
3.00	Notes receivable	0			Ō	3. 00
4.00	Accounts receivable	8, 128, 252	2	0	0	4. 00
5.00	Other recei vable	306, 293		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-4, 685, 432	2	0	0	6. 00
7.00	Inventory	667, 976		0	0	7. 00
8.00	Prepai d expenses	132, 126		0	0	
9. 00	Other current assets	0)	1	0	9. 00
10.00	Due from other funds	0) (0	10.00
11. 00	Total current assets (sum of lines 1-10)	5, 546, 336) (0	0	11. 00
12.00	FIXED ASSETS			0	0	10.00
12. 00 13. 00	Land	0			0	
14. 00	Land improvements Accumulated depreciation		1			14.00
15. 00	Buildings	33, 584, 872			0	15. 00
16. 00	Accumulated depreciation	-21, 041, 792	1	-	0	16.00
17. 00	Leasehold improvements	21,041,772		-	0	17. 00
18. 00	Accumulated depreciation				Ö	18. 00
19. 00	Fixed equipment	0		0	0	19. 00
20. 00	Accumulated depreciation	0		0	Ō	20.00
21. 00	Automobiles and trucks	0		0	Ō	21. 00
22. 00	Accumulated depreciation	0		0	Ō	22. 00
23. 00	Major movable equipment	0		0	0	23. 00
24. 00	Accumulated depreciation	0		0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0		0	0	25. 00
26.00	Accumulated depreciation	0) (0	0	26. 00
27.00	HIT designated Assets	0) (0	0	27. 00
28.00	Accumulated depreciation	0) (0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0) (0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	12, 543, 080)	0	0	30. 00
	OTHER ASSETS			_		
31. 00	Investments	0) (0	-	31.00
32. 00	Deposits on Leases	0)	1	0	32. 00
33. 00	Due from owners/officers	0)	1	0	33. 00
34. 00	Other assets	4, 853, 899	•	1	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	4, 853, 899		٥ -	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	22, 943, 315	5 (0	0	36. 00
07.00	CURRENT LI ABI LI TI ES	F0/ 000				07.00
37. 00	Accounts payable	536, 999				37. 00
38. 00	Salaries, wages, and fees payable	1, 526, 826	1	-	0	38.00
39. 00	Payroll taxes payable (chart tarm)	3, 468			0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	901, 132			0	40. 00 41. 00
41.00	Accelerated payments				U	42.00
43. 00	Due to other funds			0	0	1
44. 00	Other current liabilities					
45. 00	Total current liabilities (sum of lines 37 thru 44)	2, 968, 425	1	o o		
.5. 55	LONG TERM LIABILITIES	2,700, 120		-		1
46. 00	Mortgage payable	0) (0	0	46. 00
47. 00	Notes payable	8, 792, 456	,	o o		
48. 00	Unsecured Loans	0		0	0	48. 00
49.00	Other long term liabilities	0		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49	8, 792, 456		0	0	50. 00
51.00	Total liabilites (sum of lines 45 and 50)	11, 760, 881		0	0	51.00
	CAPI TAL ACCOUNTS]
52.00	General fund balance	11, 182, 434				52. 00
53.00	Specific purpose fund		(53. 00
54.00	Donor created - endowment fund balance - restricted		1	0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted		1	0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant		1		0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
F0	repl acement, and expansi on	44.45				F.C. 5-
59. 00	Total fund balances (sum of lines 52 thru 58)	11, 182, 434		و 0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	22, 943, 315	'	0	0	60.00
	[59]	I	1	1	I	I

			To	09/30/2014	Date/Time Prep 2/19/2015 8:48	
	General	Fund	Special Pu	rpose Fund	Endowment Fund	
	1.00	2 00	3 00	4.00	5.00	
Fund balances at beginning of period	1.00		3.00			1.00
				_		2.00
				C)	3. 00
` ,	0	,,	0	_	0	4. 00
(), (o		0			
	o		0			
	0		0			
	0		0		0	
	0		0		0	
Total additions (sum of line 4-9)		0	_	C)	10.00
		11 182 434		Ċ		11.00
	0	,,	0		0	
beddetrone (dobrt day detimorre) (epeerty)			0			
			0			
			0			
			0			
			0		0	
Total deductions (sum of lines 12-17)		0	Ü	C		18. 00
		11 182 434		Ċ		19.00
		,,				. ,
	Endowment Fund	PI ant	Fund			
	6.00	7 00	8 00			
Fund balances at beginning of period	0.00	7.00	0.00			1.00
						2. 00
	0		0			3. 00
		0	_			4. 00
(cp		o				5. 00
		ol				6.00
		ol				7. 00
		ol				8.00
		ol				9.00
Total additions (sum of line 4-9)	0	1	0			10.00
			0			11. 00
, ,		o	_			12. 00
, , , , , , , , , , , , , , , , , , ,		0				13.00
		0				14. 00
		ol				15. 00
		ol				16. 00
	1	ol				17. 00
Total deductions (sum of lines 12-17)	o	Ĭ	0			18.00
	. "					
Fund balance at end of period per balance	o		0			19.00
	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) O Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) O Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) O Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) O Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 4-9) Subtotal (line 3 plus line 10) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	Total additions (sum of line 4-9) Subtotal (line 11 minus line 18) Endowment Fund Plant Fund	Fund balances at beginning of period 1.00 2.00 3.00 4.00	Total additions (sum of line 4-9) Subtotal (line 11 minus line 18) Endowment Fund Plant Fund

Heal th Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151319 | Period: From 10/01/2013 To 09/30/2014 | Parts | & II Date/Time Prepared: 2/19/2015 8: 48 am

| Cost Center Description | Inpatient | Outpatient | Total |
| 1.00 | 2.00 | 3.00 |
| PART I - PATIENT REVENUES | General Inpatient Routine Services

	Cost Center Description	I npati ent	Outpati ent	Total	
		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	2, 153, 914		2, 153, 914	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	1, 598, 071		1, 598, 071	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)	3, 751, 985		3, 751, 985	
10.00	Intensive Care Type Inpatient Hospital Services	3, 731, 703		3, 731, 703	10.00
11. 00	INTENSIVE CARE UNIT	343, 493		343, 493	11. 00
12. 00	CORONARY CARE UNIT	343, 473		343, 473	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
	SURGICAL INTENSIVE CARE UNIT				14. 00
14.00					
15.00	OTHER SPECIAL CARE (SPECIFY)	0.40, 400		0.40, 400	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	343, 493		343, 493	16. 00
47.00	11-15)			4 005 470	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	4, 095, 478		4, 095, 478	
18. 00	Ancillary services	5, 678, 333	38, 665, 896	44, 344, 229	
19. 00	Outpati ent servi ces	0	263, 573	263, 573	
20.00	RURAL HEALTH CLINIC	0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		559, 331	559, 331	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 AND SNF	838, 297	966, 761	1, 805, 058	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	10, 612, 108	40, 455, 561	51, 067, 669	28. 00
	G-3, line 1)	.,.,	,,	, ,	
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		32, 812, 940		29. 00
30. 00	ADD (SPECIFY)	0	,		30. 00
31. 00	(6. 25.1.1)	Ö			31. 00
32. 00		0			32. 00
33. 00		ĺ			33. 00
34. 00		ĺ			34. 00
35. 00		0			35. 00
	Total additions (sum of lines 20 25)	٥	0		36. 00
36.00	Total additions (sum of lines 30-35)	2 114 540	U		
37. 00	NON OPERATING EXPENSE	3, 114, 540			37. 00
38. 00	I NDUSTRI AL MEDI CI NE EXPENSE	3, 816, 502			38. 00
39. 00	DR BAD DEBT	322			39. 00
40. 00		0			40. 00
41. 00		0			41. 00
42. 00	Total deductions (sum of lines 37-41)		6, 931, 364		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		25, 881, 576		43.00
	to Wkst. G-3, line 4)				

	El	OCDI TAI		C. F ONC. (2550 40
	Financial Systems GIBSON GENERAL HO ENT OF REVENUES AND EXPENSES	Provider CCN: 151319	Period:	u of Form CMS-2 Worksheet G-3	2552-10
SIAIL	ENT OF REVENUES AND EXTENSES	Trovider con. 191917	From 10/01/2013		
			To 09/30/2014		
				2/19/2015 8: 48	s am
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		51, 067, 669	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			24, 881, 013	2. 00
3.00	Net patient revenues (line 1 minus line 2)			26, 186, 656	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		25, 881, 576	4. 00
5.00	Net income from service to patients (line 3 minus line 4)	•		305, 080	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	
9. 00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	
	Parking Lot receipts			0	
13. 00	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other that	in patients		0	
	Revenue from sale of drugs to other than patients			0	
18.00	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
	Rental of vending machines			0	
22. 00	Rental of hospital space			-	
23. 00 24. 00	Governmental appropriations OTHER OPERATING REVENUE			0 473, 761	
24. 00	NET INDUSTRIAL MEDICINE			209, 361	
24. 01	NON OPERATING INCOME			571, 185	
25. 00	Total other income (sum of lines 6-24)			1, 254, 307	
26. 00	Total (line 5 plus line 25)			1, 559, 387	
27. 00	NET NON OPERATING REVENUE			2, 059, 594	
27. 00	INCI NON OF ENATING REVENUE			2, 037, 374	
27. 01				0	
	Total other expenses (sum of line 27 and subscripts)			2, 059, 594	
	Net income (or loss) for the period (line 26 minus line 28)			-500, 207	
27. 30	[ļ	000, 207	00

24.00	lotal (sum of lines 1-23)	285, 272	81, 842	30, 118	0	25, 224	422, 456	24.00
		Recl assi fi cati	Recl assi fi ed	Adjustments	Net Expenses			
		on	Trial Balance		for Allocation			
			(col. 6 +		(col. 8 + col.			
			col . 7)		9)			
		7. 00	8.00	9. 00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0	0	0	0			1.00
	Fi xtures							
2.00	Capital Related - Movable	0	0	0	0			2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0	0			3. 00
4.00	Transportation	0	0	0	0			4. 00
5.00	Administrative and General	-2, 856	147, 327	0	147, 327			5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	212, 996	0	212, 996			6. 00
7.00	Physi cal Therapy	0	0	0	0			7. 00
8.00	Occupational Therapy	0	0	0	0			8. 00
9.00	Speech Pathology	0	0	0	0			9. 00
	Medical Social Services	0	0	0	0			10.00
	Home Health Aide	0	58, 793	0	58, 793			11. 00
	Supplies (see instructions)	0	484	0	484			12.00
	Drugs	0	0	0	0			13.00
14. 00		0	0	0	0			14. 00
	HHA NONREIMBURSABLE SERVICES							
	Home Dialysis Aide Services	0	0	0	0			15. 00
	Respi ratory Therapy	0	0	0	0			16. 00
	Private Duty Nursing	0	0	0	0			17. 00
	Clinic	0	0	0	0			18. 00
	Health Promotion Activities	0	0	0	0			19. 00
	Day Care Program	0	0	0	0			20. 00
21. 00	Home Delivered Meals Program	0	0	0	0			21. 00
22.00	Homemaker Service	0	0	0	0			22. 00
23.00	All Others (specify)	0	0	0	0			23. 00
24.00	Total (sum of lines 1-23)	-2, 856	419, 600	0	419, 600			24. 00
								-

3.00 4.00	Transportation & Maintenance	0	0	0	0	0	Ü	4. 00
5. 00	Administrative and General	147, 327	ő	Ö	Ö	o	147, 327	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	212, 996	0	0	0	0	212, 996	1
7. 00	Physi cal Therapy	0	0	0	0	0	0	7. 00
8. 00	Occupational Therapy	0	0	0	0	0	0	8. 00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services Home Health Aide	58, 793	0	0	0	0	58, 793	10. 00 11. 00
11. 00 12. 00	Supplies (see instructions)	484	0	0	0	0	36, 793 484	•
13. 00	Drugs	0	o	0	0	o o	0	13. 00
14. 00	DME		Ö	0	0	0	0	14. 00
00	HHA NONREIMBURSABLE SERVICES	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>		
15. 00	Home Dialysis Aide Services	0	0	0	0	0	0	15. 00
16.00	Respiratory Therapy	O	0	0	0	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	0	0	0	17. 00
18. 00	Clinic	0	0	0	0	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0	0	0	0	19. 00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	O O	0	U	0	0	21. 00 22. 00
	All Others (specify)	0	o o	0	0	0	0	23. 00
	Total (sum of lines 1-23)	419, 600	0	0	0	0	419, 600	1
2 11 00	Tretar (sam er rriise i 20)	Admi ni strati ve	Total (cols.	<u> </u>	<u> </u>	Ü	1177 000	211 00
		& General	4A + 5)					
		5. 00	6. 00		<u> </u>			
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. &							1. 00
2 00	Fixtures Capital Balated Mayable							2.00
2. 00	Capital Related - Movable Equipment							2. 00
3.00	Plant Operation & Maintenance							3. 00
4. 00	Transportation							4. 00
5.00	Administrative and General	147, 327						5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	115, 252	328, 248					6. 00
7. 00	Physi cal Therapy	0	0					7. 00
8.00	Occupational Therapy	0	0					8. 00
9.00	Speech Pathology	0	0					9.00
10. 00 11. 00	Medical Social Services Home Health Aide	31, 813	90, 606					10. 00 11. 00
12. 00	Supplies (see instructions)	262	746					12.00
13. 00	Drugs	0	0					13. 00
14. 00	DME	Ö	Ö					14. 00
	HHA NONREIMBURSABLE SERVICES		'					
15.00	Home Dialysis Aide Services	0	0					15. 00
16. 00	Respi ratory Therapy	0	0					16. 00
17. 00	Private Duty Nursing	0	0					17. 00
18. 00	Clinic	0	0					18. 00
19. 00	Health Promotion Activities	0	0					19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0					20.00
	Homemaker Service	0	o					21. 00 22. 00
23. 00	All Others (specify)		o					23. 00
	Total (sum of lines 1-23)		419, 600					24. 00
	1 (22)		, ===0					

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HHA STATISTICAL BASIS		Peri od: From 10/01/2013	Worksheet H-1
	HHA CCN: 157445		Date/Time Prepared: 2/19/2015 8:48 am
		Home Health	PPS
		Agency I	

						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		DI I O		DI I				
		Bldgs & Fixtures	Movable			n Reconciliation	& General	
			Equipment (DOLLAR VALUE)	Operation &	(MI LEAGE)			
		(SQUARE FEET)	(DULLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	JA. 00	3.00	
1.00	Capi tal Related - Bldg. &	0				0		1. 00
1.00	Fixtures	Ĭ						1.00
2.00	Capital Related - Movable		0			0		2. 00
	Equipment							
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		-147, 327	272, 273	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0		0 0	212, 996	6. 00
7.00	Physi cal Therapy	0	0	0		0 0	0	7. 00
8.00	Occupational Therapy	0	0	0		0 0	0	8. 00
9.00	Speech Pathology	0	0	0		0 0	0	9. 00
10.00	Medical Social Services	0	0	0		0 0	0	10. 00
11. 00	Home Health Aide	0	0	0		0 (0	58, 793	
12.00	Supplies (see instructions)	0	0	0		0 (0	484	12.00
13.00	Drugs	0	0	0		0	0	13.00
14. 00		0	0	0		0	0	14. 00
	HHA NONREIMBURSABLE SERVICES					_		
15. 00	Home Dialysis Aide Services	0	0	0		0		15. 00
16. 00	Respi ratory Therapy	0	0	0		0	0	16. 00
17. 00	Private Duty Nursing	0	0	0		0	0	17. 00
18. 00	Clinic	0	0	0		0	0	18. 00
19. 00	Health Promotion Activities	0	0	0		0	0	19. 00
20.00	Day Care Program	0	0	0		0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	0		0	0	21. 00
22. 00	Homemaker Servi ce	0	0	0		0	0	22. 00
23. 00		0	0	0		0	0	23. 00
24. 00		0	0	0		-147, 327		
25. 00	Cost To Be Allocated (per	0	0	0		ט	147, 327	25. 00
04.65	Worksheet H-1, Part I)	0.000000	0.000000	0.000000	0.00000		0.546100	0, 00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.00000	J	0. 541100	26.00

Peri od: Worksheet H-2
From 10/01/2013 Part I
To 09/30/2014 Date/Ti me Prepared: 2/19/2015 8:48 am Provi der CCN: 151319 Peri od: HHA CCN: 157445 Home Health PPS

						Agency I	FF3	
			CAPITAL REL	ATED COSTS		, geney :		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & 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 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	90, 606 746 0 0 90, 606 746 0 0 0	4, 822 0 0 0 0 0 0 0 0 0 0 0	6, 084 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 584 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26, 490 328, 248 0 0 0 0 90, 606 746 0 0 0 0	5, 016 62, 152 0 0 0 0 17, 156 141 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00 20. 00 21. 00	Homemaker Service All Others (specify) 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 6 decimal places.	0 0 419, 600	0 0 4, 822 LAUNDRY &	0 0 6, 084 HOUSEKEEPI NG	0 0 15, 584 DI ETARY	0 446, 090 0. 000000		18. 00 19. 00 20. 00 21. 00
	Cost Center Description	PLANT	LINEN SERVICE				ADMI NI STRATI ON	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME 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) 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 6 decimal places.	7. 00 13, 763 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 13, 763	8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 4, 808 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 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	3. 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.

Health Financial Systems GIE ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: Worksheet H-2
From 10/01/2013 Part I
To 09/30/2014 Date/Time Prepared: 2/19/2015 8: 48 am

Home Heal th PPS Provi der CCN: 151319 Peri od: HHA CCN: 157445

						Home Health	PPS	
						Agency I		
	Cost Center Description	MEDI CAL	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
		RECORDS &		Residents Cost		A&G (see Part	Costs	
		LI BRARY		& Post		11)		
				Stepdown				
				Adjustments				
	T	16. 00	24. 00	25. 00	26. 00	27. 00	28. 00	
1.00	Administrative and General	0	50, 077		50, 077			1. 00
2.00	Skilled Nursing Care	0	390, 400	0	390, 400	39, 175	429, 575	
3.00	Physical Therapy	0	0	0	0	0	0	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
5.00	Speech Pathology	0	0	0	0	0	0	5. 00
6.00	Medical Social Services	0	0	0	0	0	0	6. 00
7.00	Home Health Aide	0	107, 762	0	107, 762	10, 813	118, 575	7. 00
8.00	Supplies (see instructions)	0	887	0	887	89	976	8. 00
9.00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	o	0	0	0	0	0	15. 00
16.00	Day Care Program	o	0	0	0	0	0	16. 00
17.00	Home Delivered Meals Program	o	0	0	0	0	0	17. 00
18.00	Homemaker Service	o	0	0	0	0	0	18. 00
19.00	All Others (specify)	o	0	0	0	0	0	19. 00
20.00	Total (sum of lines 1-19) (2)	o	549, 126	0	549, 126	50, 077	549, 126	20. 00
21.00	Unit Cost Multiplier: column					0. 100345		21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	•	. '		•	•	. '	'	•

⁽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.

Worksheet H-2 Part II Date/Time Prepared: 2/19/2015 8:48 am From 10/01/2013 To 09/30/2014 BASIS HHA CCN: 157445 Home Health PPS

						Agency I		
		CAPITAL REL	ATED COSTS	,				
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4. 00	5A	5. 00	7. 00	
2. 00 Ski 3. 00 Phy 4. 00 Occ 5. 00 Spe 6. 00 Mco 7. 00 Hon 8. 00 Sup 9. 00 Dru 10. 00 DME 11. 00 Hon 12. 00 Res 13. 00 Pri 14. 00 Cli 15. 00 Hon 16. 00 Day 17. 00 Hon 18. 00 Hon 19. 00 Al I 20. 00 Tot 21. 00 Tot		505 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 505 0 0 0 0 0 0 0 0 0 0 0	4.00 285, 272 0 0 0 0 0 0 0 0 0 0 0 0 0		26, 490 328, 248 0 0 0 0 90, 606 746 0 0 0	7. 00 505 0 0 0 0 0 0 0 0 0 0 0	
		LAUNDRY)				(NRSE FTE'S)	(TIME SPENT)	
		8. 00	9. 00	10. 00	11. 00	13. 00	16. 00	
2. 00 Ski 3. 00 Phy 4. 00 Occ 5. 00 Spe 6. 00 Mco 7. 00 Hon 8. 00 Sup 9. 00 Dru 10. 00 DME 11. 00 Hon 12. 00 Res 13. 00 Pri 14. 00 Cli 15. 00 Hon 16. 00 Day 17. 00 Hon 19. 00 All 20. 00 Tot 21. 00 Tot		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	505 0 0 0 0 0 0 0 0 0 0 0 0 0 0 4,808 9,520792	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00

	n Financial Systems		GIBSON GENERA				eu of Form CMS-2	
APPORT	TIONMENT OF PATIENT SERVICE COST	-S		Provi der HHA CCN:		Period: From 10/01/2013 To 09/30/2014	Date/Time Pre	pared:
				Ti tI	e XVIII	Home Health Agency I	2/19/2015 8: 48 PPS	8 am
	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from	Total HHA Costs (cols. + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col.	
				Part II)	,	1.00	4)	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	1.00 PROGRAM COST, A	2.00 GGREGATE OF TH	3.00 IE PROGRAM LIM	4.00 ITATION COST, OF	5. 00 R	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							<u> </u>
1.00	Skilled Nursing Care	2. 00			429, 57			
2.00	Physical Therapy Occupational Therapy	3. 00 4. 00			•	0 1, 429 0 399		
4. 00	Speech Pathology	5. 00			•	0 399		1
5.00	Medical Social Services	6. 00		_		0 4	0.00	1
6.00	Home Heal th Ai de	7. 00		ł	118, 57			ł
7. 00	Total (sum of lines 1-6)		548, 150	C	548,15 Program Visit			7. 00
						rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t Deductibles Coinsurance			
		0	1.00	2.00	3. 00	4. 00	5. 00	
0.00	Limitation Cost Computation		04700					0.00
8. 00 9. 00	Skilled Nursing Care Physical Therapy	l .	21780 21780	59 66	•			8. 00 9. 00
10.00			21780	22	•			10.00
11. 00		l .	21780	0	•	1		11. 00
12.00		l .	21780	0 34		2		12.00
13. 00 14. 00	Home Health Aide Total (sum of lines 8-13)		21780	181				13. 00 14. 00
		From Wkst. H-2	Facility Costs	Shared	Total HHA	Total Charges	Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from Part II)	Costs (cols. + 2)	1 (from HHA Record)	÷ col. 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	ations 8.00	976		97	4 7/5	0.204027	15.00
16. 00		9. 00		l .		6 4, 765 0 0		1
10.00	Josef of Brage		Program Visits		Cost of Services		0. 000000	10.00
				t B		Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7. 00	8.00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIM	ITATION COST, OF	\$	
1 00	Cost Per Visit Computation	5.5	070		40 =	2 100 (22		1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	59 66			12, 74	3 189, 630 0 0		1. 00 2. 00
3. 00	Occupational Therapy	22			1	0 0		3.00
4.00	Speech Pathology	0				0 0		4. 00
5.00	Medical Social Services	0	2			0 0		5.00
/ 00	Home Heal th Ai de	34 181	307 1, 973	l e	5, 91 18, 65			6. 00 7. 00
6. 00 7. 00	Total (sum of lines 1-6)	101	1,770					7.00
	Total (sum of lines 1-6) Cost Center Description	/ 22	7.00					
6. 00 7. 00	Cost Center Description	6. 00	7.00	8. 00	9. 00	10. 00	11. 00	
7. 00 8. 00	Cost Center Description Limitation Cost Computation Skilled Nursing Care	6. 00	7.00	8.00	9.00	10.00	11.00	8. 00
7. 00 8. 00 9. 00	Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy	6.00	7.00	8.00	9.00	10.00	11.00	9. 00
7. 00 8. 00 9. 00 10. 00	Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	6. 00	7.00	8.00	9.00	10.00	11.00	9. 00 10. 00
7. 00 8. 00 9. 00 10. 00 11. 00	Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	6.00	7.00	8.00	9.00	10.00	11.00	
7.00 8.00 9.00 10.00 11.00 12.00 13.00	Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	6. 00	7.00	8.00	9.00	10.00	11.00	9. 00 10. 00 11. 00

	Financial Systems		GIBSON GENER				u of Form CMS-2	
APP0R1	IONMENT OF PATIENT SERVICE COST	ΓS		Provi der HHA CCN:	CCN: 151319 157445	Peri od: From 10/01/2013 To 09/30/2014		pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	o alli
		Prog	ram Covered Cha	arges	Cost of Services	Agency 1		
	Cost Center Description	Part A	Not Subject to Deductibles &	Deductibles &	Part A	Part B Not Subject to Deductibles &	Deductibles &	
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	9. 00	Coi nsurance 10.00	Coi nsurance 11.00	
	Supplies and Drugs Cost Comput		7.00	0.00	7.00	10.00	11.00	
	Cost of Medical Supplies Cost of Drugs		0	C		0	0	15. 00 16. 00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	AGGREGATE OF TH	IE PROGRAM LII	MITATION COST, OF	?	
00	Cost Per Visit Computation	202 272						1 1 0
. 00	Skilled Nursing Care Physical Therapy	202, 373						1.00
3. 00	Occupati onal Therapy							3.00
. 00	Speech Pathology	0						4.00
. 00	Medical Social Services	0	ı					5. 0
. 00	Home Health Aide	59, 286	,					6.0
. 00	Total (sum of lines 1-6)	261, 659						7.0
	Cost Center Description		_					
		12. 00						
	Limitation Cost Computation							8.0
. 00	Skilled Nursing Care Physical Therapy							9.0
0.00	Occupati onal Therapy							10.0
1. 00	Speech Pathology							11. 0
2. 00	Medical Social Services							12. 0
		1	1					13.00
13. 00	Home Health Aide							13.00

Health Financial Systems		GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVI	APPORTIONMENT OF PATIENT SERVICE COSTS				Peri od:	Worksheet H-3	
			LILLA CON.	157445	From 10/01/2013 To 09/30/2014	Part II	nanad.
			HHA CCN:	13/443	10 09/30/2014	Date/Time Prep 2/19/2015 8:48	
			Ti tl	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Descri		Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	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	F COST OF HHA SERVI	CES FURNI SHED E	BY SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66. 0	0. 323263	(0 col. 2, line 2	. 00	1. 00
2.00 Occupational Therapy	67. 0	0. 263114	(0 col. 2, line 3	. 00	2. 00
3.00 Speech Pathology	68. 0	0. 304085	C		0 col. 2, line 4	. 00	3. 00
4.00 Cost of Medical Supplies	71. 0	0. 263480	()	0 col. 2, line 1	5. 00	4. 00
5.00 Cost of Drugs	73. 0	0. 534959	()	0 col. 2, line 1	5. 00	5. 00

CULATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 151319	Peri od:	Worksheet H-4	
	HHA CCN:	157445	From 10/01/2013 To 09/30/2014		
	Ti tl	e XVIII	Home Health Agency I	PPS	
				t B	
		Part A		Deductibles &	
		1 00	Coi nsurance	Coi nsurance	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	MARY CHARGE	1. 00 S	2. 00	3. 00	
Reasonable Cost of Part A & Part B Services		-			
Reasonable cost of services (see instructions)			0 0		
Total charges			0 0	0) 2
Customary Charges Amount actually collected from patients liable for payment for	convices		0 0	0	3
on a charge basis (from your records) O Amount that would have been realized from patients liable for particular to the particular to the particular to the particular to the particular to payment for p			0 0	0	
for services on a charge basis had such payment been made in a			0	0	ή ΄
wi th 42 CFR 413.13(b)					
0 Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	l	
Total customary charges (see instructions)			0	0	
Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)	complete		0	0) 7
0 Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	yifline		0 0	0) 8
O Primary payer amounts			0 0	0) 9
			Part A	Part B	
			Servi ces	Servi ces	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1. 00	2. 00	+
00 Total reasonable cost (see instructions)			0	0	10
00 Total PPS Reimbursement - Full Episodes without Outliers			21, 896	240, 468	11
00 Total PPS Reimbursement - Full Episodes with Outliers			0	1, 831	
00 Total PPS Reimbursement - LUPA Episodes			0	2, 451	
00 Total PPS Reimbursement - PEP Episodes			0	2, 121	
					8 15
00 Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	568	
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes			0	0	16
00 Total PPS Outlier Reimbursement - Full Episodes with Outliers 00 Total PPS Outlier Reimbursement - PEP Episodes 00 Total Other Payments			0	0	16
OU Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments			0 0 0	0	16 17 18
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments			0 0 0 0	0 0 0	16 17 18 19
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Outlier Reimbursement - PEP Episodes DME Payments Outlier Reimbursement - PEP Episodes DME Payments Outlier Per Episodes With Outliers	rance)		0 0 0 0	0 0 0 0 0	16 17 18 19 19 20 21
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Ouygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsum Subtotal (sum of lines 10 thru 20 minus line 21)	rance)		0 0 0 0 0 0 21, 896	0 0 0 0 0 0 247, 439	16 17 18 19 19 20 21 22 22
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsul Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	rance)		0	0 0 0 0 0 0 247, 439	16 17 18 19 19 20 21 22 23
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsul Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)	rance)		0 0 0 0 0 21, 896 0 21, 896	0 0 0 0 0 0 247, 439 0 247, 439	16 17 18 19 19 20 21 22 22 24
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsul Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)	rance)		0 21, 896	0 0 0 0 0 0 247, 439 0 247, 439	16 17 18 19 20 21 22 22 23 24 25 25 26 27 27 28 28 28 28 28 28 28 28 28 28 28 28 28
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsum Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)	rance)		0	0 0 0 0 0 0 247, 439 0 247, 439	16 17 18 19 20 21 22 22 23 24 25 25 26 27 27 28 28 28 28 28 28 28 28 28 28 28 28 28
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see insertice)	structions)		0 21, 896	0 0 0 0 0 247, 439 0 247, 439 0 247, 439	160 160 170 180 180 180 180 180 180 180 180 180 18
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line	structions)		0 21, 896	0 0 0 0 0 0 247, 439 0 247, 439	160 160 170 180 180 180 180 180 180 180 180 180 18
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsul Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see insum total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	structions)		21, 896 21, 896 21, 896 0	0 0 0 0 0 247, 439 0 247, 439 247, 439	16 16 17 18 19 19 19 19 19 19 19 19 19 19 19 19 19
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsul Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see insum total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 29 plus/minus line 30)	structions)		21, 896 21, 896 21, 896 21, 896	0 0 0 0 0 247, 439 0 247, 439 247, 439	16 16 17 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsum Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instoal costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 29 plus/minus line 30) Sequestration adjustment (see instructions)	structions)		21, 896 21, 896 21, 896 21, 896 0 21, 896 438	0 0 0 0 0 247, 439 0 247, 439 247, 439 247, 439 4, 949	16 16 17 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsured Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 29 plus/minus line 30) Sequestration adjustment (see instructions)	structions)		21, 896 21, 896 21, 896 21, 896	0 0 0 0 0 247, 439 0 247, 439 247, 439 247, 439 4, 949 242, 491	16 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18
Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instout Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 29 plus/minus line 30) Sequestration adjustment (see instructions)	structions) 27)		21, 896 21, 896 21, 896 21, 896 0 21, 896 438	0 0 0 0 0 247, 439 0 247, 439 247, 439 247, 439 4, 949	16 16 17 17 17 17 17 17 17 17 17 17 17 17 17

 Heal th Financial
 Systems
 GIBSON GENERAL
 HOSPITAL

 ANALYSIS OF PAYMENTS
 TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO
 Providence
 In Lieu of Form CMS-2552-10 Provi der CCN: 151319

PROGRAM BENEFICIARIES

157445 HHA CCN:

				Home Health	PPS	
		Innetion	+ Don+ A	Agency I	t B	
			t Part A			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		21, 458		242, 491	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)					
0.04	Program to Provider	Γ		I		0.01
3. 01			0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05			0		0	3. 05
3. 50	Provider to Program	T T	0		0	3. 50
3. 50						3. 50
3. 51			0			3. 52
3. 52						3. 52
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 99
J. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		21, 458		242, 491	4. 00
00	(transfer to Wkst. H-4, Part II, column as appropriate,		2.7.100		2 12, 17.	00
	line 32)					
	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		_	ı	_	
5. 01			0		0	5. 01
5. 02			0		0	5. 02
5. 03	Provider to Program		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		0		o o	5. 99
0. , ,	5. 50-5. 98)		Ĭ			0. ,,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		0		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		1	6. 02
7. 00	Total Medicare program liability (see instructions)		21, 458		242, 490	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00		()	1. 00	2. 00	0.00
8. 00	Name of Contractor	l			l l	8. 00