This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fai	lure to report can re	esult in all interim	FORM APPROVE	D
payments made	since the beginning of the cost	reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938	-0050
					EXPIRES 05-3	1-2019
HOSPITAL AND H	IOSPITAL HEALTH CARE COMPLEX COS	T REPORT CERTIFICATION	Provider CCN: 15-1319		Worksheet S	
AND SETTLEMENT	SUMMARY			From 10/01/2016		
					Date/Time Pr	
					2/26/2018 1:	26 pm
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically filed co	st report		Date: 2/26/201	18 Time:	1:26 pm
use only	2. [] Manually submitted cost	report				
	3. [0] If this is an amended r	eport enter the number	of times the provide	r resubmitted this c	ost report	
	4. [F] Medicare Utilization. E	inter "F" for full or "L	" for low.		·	
Contractor	5. [1]Cost Report Status 6.	Date Received:	11	O. NPR Date:		
use only	(1) Ås Submitted 7.	Contractor No.	1	1. Contractor's Vendo	r Code:	4
,	(2) Settled without Audit 8.	[N] Initial Report fo	r this Provider CCN 1:	2. [0]If line 5, co	lumn 1 is 4:	Enter
	(3) Settled with Audit 9.	[N] Final Report for	this Provider CCN	number of tim		
	(4) Reopened				•	
	(5) Amended					
	(o) /illicitaca					

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GLBSON GENERAL HOSPITAL (15-1319) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl e	
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-329, 422	-50, 200	0	5, 230	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	33, 529	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	-295, 893	-50, 200	0	5, 230	200. 00

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

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1319 Peri od: Worksheet S-2 From 10/01/2016 Part I 09/30/2017 Date/Time Prepared: 2/26/2018 1:23 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1800 SHERMAN DRIVE 1.00 1.00 PO Box: State: IN Zi p Code: 47670-2.00 City: PRINCETON 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 Hospi tal GIBSON GENERAL HOSPITAL 151319 99915 12/16/2003 N 3.00 Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 GIBSON GENERAL SWING 15Z319 99915 12/16/2003 N 0 Ν 7.00 BFD Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospital -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA GIBSON HOME HEALTH 157445 99915 10/19/1995 Ν Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC GIBSON GENERAL FAMILY 158524 99915 09/11/2017 O 15.00 N 0 15.00 MEDI CI NE Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2016 09/30/2017 20.00 21.00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 22.00 Ν Ν share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 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) Is this a newly merged hospital that requires final uncompensated care payments to be Ν 22.02 22.02 Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 Ν 2 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

| In-State | In-State | Out-of | Out-of | Medicaid | Other

		in otato	· · · · · · · · · · · · · · · · · · ·	00.	041 0.	mour our u	0	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is ar	n IPPS hospital, enter the	0	0	0	0	0	0	24.00
in-state Medicaid paid	d days in column 1, in-state							
Medicaid eligible unpa	aid days in column 2,							
out-of-state Medicaid	paid days in column 3,							
out-of-state Medicaid	eligible unpaid days in column							
4, Medicaid HMO paid a	and eligible but unpaid days in							
column 5, and other Me	edicaid days in column 6.							
25.00 If this provider is ar	n IRF, enter the in-state	0	0	0	0	0		25.00
Medicaid paid days in	column 1, the in-state							
Medicaid eligible unpa	aid days in column 2,							
out-of-state Medicaid	days in column 3, out-of-state							
Medicaid eligible unpa	aid days in column 4, Medicaid							
HMO paid and eligible	but unpaid days in column 5.							

26.00 Enter your standard geographic classification (not wage) standard geographic reclassification (not wage) standard geographic classification (not wag	atus at the en for rural. If a in column 2. er of periods S	ginning of the d of the cost pplicable,	Urban/Rural	16 Part I 17 Date/ 2/26/2 S Date o	Time Pre 2018 1:2	pared: 3 pm 26.00
cost reporting period. Enter "1" for urban or "2" for rural. 27.00 Enter your standard geographic classification (not wage) streporting period. Enter in column 1, "1" for urban or "2" for enter the effective date of the geographic reclassification on the sis a sole community hospital (SCH), enter the number effect in the cost reporting period. 36.00 Enter applicable beginning and ending dates of SCH status. So of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH).	atus at the en for rural. If a in column 2. er of periods S	ginning of the d of the cost pplicable,	Urban/Rural 1.00	2/26/2 S Date o	2018 1:2 f Geogr	3 pm 26.00
cost reporting period. Enter "1" for urban or "2" for rural. 27.00 Enter your standard geographic classification (not wage) streporting period. Enter in column 1, "1" for urban or "2" for enter the effective date of the geographic reclassification on the sis a sole community hospital (SCH), enter the number effect in the cost reporting period. 36.00 Enter applicable beginning and ending dates of SCH status. So of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH).	atus at the en for rural. If a in column 2. er of periods S	d of the cost pplicable,	1.00	S Date o	f Geogr	26. 00
cost reporting period. Enter "1" for urban or "2" for rural. 27.00 Enter your standard geographic classification (not wage) streporting period. Enter in column 1, "1" for urban or "2" for enter the effective date of the geographic reclassification on the sis a sole community hospital (SCH), enter the number effect in the cost reporting period. 36.00 Enter applicable beginning and ending dates of SCH status. So of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH), enter the number of this sis a medicare dependent hospital (MDH).	atus at the en for rural. If a in column 2. er of periods S	d of the cost pplicable,		2 2	. 00	
27.00 Enter your standard geographic classification (not wage) stareporting period. Enter in column 1, "1" for urban or "2" for enter the effective date of the geographic reclassification as 35.00 If this is a sole community hospital (SCH), enter the number effect in the cost reporting period. 36.00 Enter applicable beginning and ending dates of SCH status. Sof periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number enter subsequent dates.	atus at the en for rural. If a i in column 2. er of periods S	ppl i cabl e,		2		07.00
enter the effective date of the geographic reclassification 35.00 If this is a sole community hospital (SCH), enter the number effect in the cost reporting period. 36.00 Enter applicable beginning and ending dates of SCH status. of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number	in column 2. er of periods S					27.00
36.00 Enter applicable beginning and ending dates of SCH status. Soft periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number of the subsequence.	Subscript line			0		35. 00
of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the no	Subscript line		Begi nni ng:	End	li ng:	
of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the no	Subscript line	0/ 6	1. 00		00	24.00
	umber of perio			0		36. 00 37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the MDH	transitional p	ayment in	N			37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" for yes (instructions) 38.00 If line 37 is 1, enter the beginning and ending dates of MDI		•				38. 00
greater than 1, subscript this line for the number of period enter subsequent dates.						30.00
			Y/N 1, 00	_	/N 00	
39.00 Does this facility qualify for the inpatient hospital payment hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii) for yes or "N" for no. Does the facility meet the mileage rewith 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y"	i)? Enter in c equirements in	olumn 1 "Y" accordance	N		N	39. 00
instructions) 40.00 Is this hospital subject to the HAC program reduction adjus "N" for no in column 1, for discharges prior to October 1.			N		N	40. 00
no in column 2, for discharges on or after October 1. (see				V XVII		
Prospective Payment System (PPS)-Capital			1.	00 2.00	3.00	
45. 00 Does this facility qualify and receive Capital payment for with 42 CFR Section §412. 320? (see instructions)	di sproporti ona	te share in ac	cordance	N N	N	45. 00
46.00 Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, P				N N	N	46.00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital´ 48.00 Is the facility electing full federal capital payment? Ento				N N	N N	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in approve	-			N I		56. 00
or "N" for no.	. 0					
57.00 If line 56 is yes, is this the first cost reporting period of GME programs trained at this facility? Enter "Y" for yes or is "Y" did residents start training in the first month of the for yes or "N" for no in column 2. If column 2 is "Y", com	or "N" for no i his cost repor plete Workshee	n column 1. If ting period?	column 1 Enter "Y"			57. 00
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if a 58.00 If line 56 is yes, did this facility elect cost reimbursemen	ent for physici	ans' services	as			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, comple 59.00 Are costs claimed on line 100 of Worksheet A? If yes, compl		. Pt. I.		N		59.00
		NAHE 413.85 Y/N	Worksheet / Line #	A Pass- Qualif Crit	Through i cati on eri on	
		1. 00	2. 00	_	ode 00	
60.00 Are you claiming nursing and allied health education (NAHE) any programs that meet the criteria under §413.85? (see in	costs for structions)	N				60.00
Y/N	IME	Direct GME	IME	Di red	ct GME	
1.00	2.00	3. 00	4. 00		00	(1.00
61.00 Did your hospital receive FTE slots under ACA N section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	0.00	0.00				61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of	0.00	0. 00				61. 02
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)	0.00	0. 00				61.03

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der CC		eriod: rom 10/01/2016 o 09/30/2017	Worksheet S-2 Part I Date/Time Pre 2/26/2018 1:2	pared:
	Y/N	IME	Direct GME	I ME	Direct GME	, , , , , ,
	1.00	2. 00	3. 00	4. 00	5. 00	
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00				61.0
.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line)	ne	0. 00	0.00			61.0
61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	<i>y</i>	0.00	0.00			61.0
care or general surgery. (See Thisti dectrons)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
1. 10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.1
.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0. 00	61.2
					1.00	
ACA Provisions Affecting the Health Resources and S	Servi ces	Administration	(HRSA)		1. 00	
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instr	al traine	d in this cost		iod for which	0. 00	62.0
2.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC proceeding the transfer of the trans	m a Teachi rogram. (s	ing Health Cen see instructio		your hospital	0.00	62.0
3.00 Has your facility trained residents in nonprovider	settings	during this c			N	63.0
"Y" for yes or "N" for no in column 1. If yes, comp	olete line	es 64 through	67. (see instr Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	1/ (col . 1 + col . 2))	
			Si te	·		
Section 5504 of the ACA Base Year FTE Residents in	Nonprovi	der Settings	1.00 This base year	2.00	7.00	
period that begins on or after July 1, 2009 and be	fore June	30, 2010.				
.00 Enter in column 1, if line 63 is yes, or your facilin the base year period, the number of unweighted resident FTEs attributable to rotations occurring is settings. Enter in column 2 the number of unweight resident FTEs that trained in your hospital. Enter of (column 1 divided by (column 1 + column 2)). (see	ity train non-priman n all non ted non-pr in column	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.0
Program Name		ogram Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTÉs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	

4. 00

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1319 Peri od: Worksheet S-2 From 10/01/2016 Part I 09/30/2017 Date/Time Prepared: 2/26/2018 1:23 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column

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

4)). (see instructions)

alth Financial Systems GIBSON GENERAL F				of For		
SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1319	Peri od: From 10/01/ To 09/30/	2016 2017	Workshe Part I Date/Ti 2/26/20	me Pre	epare
			1. 00	2. 00	3. 00	-
.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teach CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column indicate which program year began during this cost reporting process.	2004? Enter "Y" for yes ning program in accordan Column 3: If column 2 is	or "N" for ce with 42 Y,	1.00	2.00	0	76.
				1. C	00	
Long Term Care Hospital PPS .00 Is this a long term care hospital (LTCH)? Enter "Y" for yes at 1.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.		ng period? E	inter	N N		80. 81.
TEFRA Providers .00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) To Did this facility establish a new Other subprovider (excluded (a)(i)) (a) [a] [a] [b] [b] [b] [b] [b] [b] [c] [c] [c] [c] [c] [c] [c] [c] [c] [c			no.	N		85 86
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 1.00 Is this hospital a "subclause (II)" LTCH classified under sect for yes or "N" for no.	tion 1886(d)(1)(B)(iv)(I	·	/··	N		87
		1. 00		2. C		1
Title V and XIX Services	convices? Enter "V" for	N		Y		90
 .00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column. .00 Is this hospital reimbursed for title V and/or XIX through the 	e cost report either in	N N		Ϋ́Υ		90
full or in part? Enter "Y" for yes or "N" for no in the applic 00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable	certification)? (see			N		92
.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.	title V and XIX? Enter	N		N		93
OD Does title V or XIX reduce capital cost? Enter "Y" for yes, ar applicable column.		N		N		94
<pre>00 If line 94 is "Y", enter the reduction percentage in the appli 00 Does title V or XIX reduce operating cost? Enter "Y" for yes capplicable column.</pre>		0. 00 N		O. C N		95
00 If line 96 is "Y", enter the reduction percentage in the appli 00 Does title V or XIX follow Medicare (title XVIII) for the intestepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	erns and residents post	0. 00 Y		0. C Y		98
O1 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.				Υ		98
O2 Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.		Y		Υ		98
O3 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.	cal access hospital (CAH or "N" for no in column) N		N		98
O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reoutpatient services cost? Enter "Y" for yes or "N" for no in c in column 2 for title XIX.		d N		N		98
O5 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col				Υ		98
column 2 for title XIX. 06 Does title V or XIX follow Medicare (title XVIII) when cost re Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. Rural Providers		Y		Y		98
5.00 Does this hospital qualify as a CAH?		Y				105
5.00 If this facility qualifies as a CAH, has it elected the all-ir for outpatient services? (see instructions)	nclusive method of payme	nt N				106
7.00 f this facility qualifies as a CAH, is it eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1 yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2	I. (see instructions) If					107
reimbursed. If yes complete Wkst. D-2, Pt. II.	RNA fee schedule? See 4.					108

Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1319 Peri od: Worksheet S-2 From 10/01/2016 Part I Date/Time Prepared: 09/30/2017 2/26/2018 1:23 pm Speech Physi cal Occupati onal Respi ratory 1. 00 2. 00 3. 00 4. 00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν 109.00 therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes 110 00 N complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1.00 2.00 111.00|f this facility qualifies as a CAH, did it participate in the Frontier Community Ν 111.00 Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 Miscellaneous Cost Reporting Information 115.00|Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 Ν 0 115.00 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. Ν 116.00 117.00|s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Υ 117.00 no. 118.00|s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is 118.00 claim-made. Enter 2 if the policy is occurrence. Premi ums Losses Insurance 1. 00 2.00 3.00 0118.01 118.01 List amounts of mal practice premiums and paid losses: 45, 667 1. 00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119 00 120.00|s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Ν Ν 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or 'N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00|Did this facility incur and report costs for high cost implantable devices charged to 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Ν 122.00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If Ν 125.00 yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare certified kidney transplant center, enter the certification date 126.00 in column 1 and termination date, if applicable, in column 2. 127.00|If this is a Medicare certified heart transplant center, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00 of this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|If this is a Medicare certified lung transplant center, enter the certification date in 129, 00 column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 of this is an organ procurement organization (OPO), enter the OPO number in column 1 134 00 and termination date, if applicable, in column 2. All Providers

chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are citalized, enter in column 2. In Down of the chain number. "Column 2. In the column 2. In 1.00 and 2.00 and 1.00 and 2.00 and 2.	Health Financial Systems	GI BSON GENER					u of Form CMS-	
H80778 H	HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provi der CC	CN: 15-1319	From 10	0/01/2016	Part I Date/Time Pr	epared:
H80778 H						1.00	0.00	4
1.00	chapter 10? Enter "Y" for yes or	"N" for no in column 1. It	f yes, and home	office cos				140. 00
Additional part Additional	1.00	2. (00					
142.00 Street: 600 MARY STREET	office and enter the home office	contractor name and contra Contractor's Name: WI	actor number. ISCONSIN PHYSIC					141. 00
144.00 Are provider based physicians' costs included in Worksheet A? Y		PO Box:		Zi p Coc	le:	4771	0	142. 00 143. 00
144.00 Are provider based physicians' costs included in Worksheet A? Y	· · ·	·					1.00	
1.00 2.00	144 00 Are provider based physicians' co	sts included in Worksheet	A?					144.00
45. DOLIF costs for renal services are claimed on Wists. A, Line 74, are the costs for inpatient services only? Enter "" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "" for yes or "N" for no in column 1. 45. DOLIPas the cost allocation methodology changed from the previously filed cost report? (enter """ for yes or "N" for no in column 1. (See CMS Ppub. 15-2, chapter 40, \$4020) If ves, enter the approval date (mm/dd/yyyy) in column 2. 47. DOLIPas there a change in the statistical basis? Enter "Y" for yes or "N" for no. 48. DOLIPas there a change in the statistical basis? Enter "Y" for yes or "N" for no. 49. DOLIPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 49. DollPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 49. DollPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 49. DollPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 49. DollPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 49. DollPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 49. DollPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 49. DollPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 49. DollPas there a change in the statistical basis? Enter "Y" for yes or "N" for no. 40. DollPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 40. DollPas there a change in the statistical basis? Enter "Y" for yes or "N" for no. 40. DollPas there a change in the order of allocation? Enter "Y" for yes or "N" for no. 40. DollPas the post defined the post of the allocation? Enter "Y" for yes or "N" for no. 40. DollPas the cost in column 1. State in column 2. 40. DollPas the cost in column 3. CBSA in column 4. Enter "Y" for yes or "N" for no. 40. DollPas the cost incolumn 5 c								
inpatient services only? Enter "" for yes or "N" for no in column 1. If column 1 is no does the dial sys!s facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00Nas the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 149.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 149.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 149.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 140.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 140.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 140.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 140.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 140.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 140.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 140.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 150.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 150.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 150.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 150.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 150.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 150.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 150.00Was there a change in t	145 0016	Latinian and Milanta A. Lina 7	4 41	- 6		1. 00	2. 00	145. 00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N	inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i	" for yes or "N" for no in clude Medicare utilization for no in column 2. gy changed from the previo n column 1. (See CMS Pub.	n column 1. If n for this cost ously filed cos	column 1 is reporting t report?		N		146. 00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N							1.00	-
May 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. Now	47 00 Was there a change in the statist	ical basis? Enter "Y" for	ves or "N" for	no				147. 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) 55. 00Hospital 56. 00Subprovider - IPF 57. 00Subprovider - IRF 58. 00Subprovider - IRF 59. 00Subprovider - IRF 59. 00SNF 60. 00Subprovider - IRF 59. 00SNF 60. 00HoME HEALTH AGENCY 61. 00CMHC Multicampus 65. 00Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAS? Enter "Y" for yes or "N" for no. Multicampus 66. 00If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 67. 00Is this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under \$413.70(a) (6) (ii)? Enter "Y" for yes or "N" for no. (see instructions) Beginning Ending	48.00 Was there a change in the order of	f allocation? Enter "Y" fo	or yes or "N" f	or no.	or no.		N	148. 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. 00Hospital 156. 00Subprovider - IPF N								
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 Hospital N N N N N N N N N N N N N N N N N N N	Does this facility contain a prov	ider that qualifies for a						
S6. DO Subprovider - IPF	or charges? Enter "Y" for yes or						3. 13)	
S7. 00 Subprovider - IRF N								155. 0
60.00 HOME HEALTH AGENCY 61.00 CMHC N	57. 00 Subprovi der – I RF							156. 0 157. 0 158. 0
Multicampus 1.00 N								159. 0
Multicampus 65. 00 is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Name County State State County State State County State State County State Stat			N					160.0
Multicampus 65.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N	вт. оојсинс			I IN		IN		161. 0
Enter "Y" for yes or "N" for no. Name						204.0		4.5.0
Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 67.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. 68.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 68.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under \$413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 69.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) Beginning Ending		ampus hospital that has or	ne or more camp	uses in dif	ferent C	BSAs?	N	165. 00
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 67.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. 68.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 68.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under \$413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 69.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) Beginning Ending	<u>,</u>							
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Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 67.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 68.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 68.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 69.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) Beginning Ending	O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							1. 00	
68.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 68.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 69.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) Beginning Ending					nent Act			
68.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 69.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) Beginning Ending	68.00 If this provider is a CAH (line 1	05 is "Y") and is a meanim	ngful user (lin		"), ente	r the		167. 00 0168. 00
69.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) Beginning Ending	68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, doe ? Enter "Y" for yes or "N'	es this provide " for no. (see	instruction	s)			168. 0
Begi nni ng Endi ng	69.00 If this provider is a meaningful	user (line 167 is "Y") and				enter the	0.0	0169. 00
1 100 2 200	,					gi nni ng 1. 00	Endi ng 2. 00	
	170.00 Enter in columns 1 and 2 the EHR	beginning date and ending	date for the r	eporti ng				170.00

Health Financial Systems	GI BSON GENERAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA		Peri od: From 10/01/2016	Worksheet S-2 Part I)
				Date/Time Pre 2/26/2018 1:2	
				2, 20, 2010 112	, p
			1.00	2.00	
171.00 If line 167 is "Y", does this pro-	vider have any days for indi	viduals enrolled in	N	C	171.00
section 1876 Medicare cost plans	reported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in col	umn 1. If column 1 is yes, e	enter the number of section	on		
1876 Medicare days in column 2. (see instructions)				

leal th	Financial Systems GIBSON GENERA	L HOSPITAL		In Lie	u of Form CMS-	-2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 10/01/2016 To 09/30/2017	Date/Time Pr	epared:
				Y/N	2/26/2018 1: Date	23 pm
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ent	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation	h	The second	N.		1
	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c) N		1.00
		•	Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare P	rogram2 lf	1.00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in colum		IN.			2.00
	voluntary or "I" for involuntary.					
	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o		N			3.00
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe relationships? (see instructions)	rsimilar				
	(000 1100 1000 1000 1000 1000 1000 1000		Y/N	Type	Date	
le.	-:: al Data and Danasta		1.00	2. 00	3. 00	
	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Public	Y	A	01/24/2018	4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f	or Compiled,				
l'	or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	ilable in				
	Are the cost report total expenses and total revenues diffe	rent from	N			5.00
	those on the filed financial statements? If yes, submit rec					
				Y/N 1. 00	Legal Oper. 2.00	
A	Approved Educational Activities			1.00	2.00	
	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	ne provider i	s N		6.00
	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	structions.		N		7.00
	Were nursing school and/or allied health programs approved		d during the	N		8. 00
	cost reporting period? If yes, see instructions.	araduata madi	aal aduaatian	N		9.00
	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		car education	N		9.00
10.00	Was an approved Intern and Resident GME program initiated o		the current	N		10.00
	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& Rinan An	nroved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.	a K III ali Api	pi oveu	14		11.00
					Y/N	
F	Bad Debts				1. 00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes				Υ	12. 00
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	olicy change o	during this c	ost reporting	N	13.00
	lf line 12 is yes, were patient deductibles and/or co-payme	nts waived? I	fyes, see in	structions.	N	14.00
	Bed Complement	10.16		1 1	N.	15.00
15. 00	Did total beds available change from the prior cost reporti		yes, see ins	tructions. Par	N + R	15. 00
		Y/N	Date	Y/N	Date	
le le	OCAD Data	1. 00	2. 00	3. 00	4. 00	
	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	01/02/2018	Υ	01/02/2018	16.00
	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)					
	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
	Report data for corrections of other PS&R Report information? If yes, see instructions.					

	IERAL HOSPI TAL			u of Form C	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1319	Period: From 10/01/2016 To 09/30/2017	Worksheet Part II Date/Time 2/26/2018	Prepared:
	Descr	ipti on	Y/N	Y/N	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		0	1. 00	3. 00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
The part of action and action action and action action and action and action action and action action action action action action and action act	Y/N	Date	Y/N	Date	
	1.00	2. 00	3. 00	4. 00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				1. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (E	XCEPT CHILDRENS	HOSPLTALS)		1.00	
Capital Related Cost		,			
22.00 Have assets been relifed for Medicare purposes? If yes,	see instructions			N	22.00
23.00 Have changes occurred in the Medicare depreciation exper reporting period? If yes, see instructions.	nse due to apprai	sals made du	uring the cost	N	23.00
24.00 Were new leases and/or amendments to existing leases ent	ered into during	this cost r	reporting period?	N	24.00
25.00 Have there been new capitalized leases entered into duri instructions.	ng the cost repo	rting period	l? If yes, see	N	25. 00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during instructions.	g the cost report	ing period?	If yes, see	N	26.00
27.00 Has the provider's capitalization policy changed during copy.	the cost reporti	ng period? I	f yes, submit	N	27. 00
Interest Expense 28.00 Were new Loans, mortgage agreements or Letters of credit	entered into du	ring the cos	st reporting	N	28.00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/	or bond funds (D	ebt Service	Reserve Fund)	N	29.00
treated as a funded depreciation account? If yes, see in 30.00 Has existing debt been replaced prior to its scheduled m		debt? If ye	es, see	N	30.00
instructions. Has debt been recalled before scheduled maturity without instructions.	issuance of new	debt? If ye	es, see	N	31.00
Purchased Services 32.00 Have changes or new agreements occurred in patient care	corvi cos furni ch	od through o	contractual	N	32.00
arrangements with suppliers of services? If yes, see ins	structions.	_			33.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 no, see instructions. Provider-Based Physicians	аррітей регтатпі	ng to compet	it ive bidding? II	N N	33.00
34.00 Are services furnished at the provider facility under an	arrangement wit	h provider-b	pased physicians?	Υ	34.00
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended	Ü	•	. 3	N	35.00
physicians during the cost reporting period? If yes, see		THIS WITH THE	·		33.00
			Y/N 1.00	2. 00	
Home Office Costs					
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement beer	n prepared by the	home office	N 2? N		36. 00 37. 00
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home					38.00
the provider? If yes, enter in column 2 the fiscal year 39.00 If line 36 is yes, did the provider render services to c	end of the home	offi ce.			39.00
see instructions. 40.00 If line 36 is yes, did the provider render services to t	•	,			40.00
instructions.	Home office!	. i yes, see	114		40.00
	1.	00	2.	00	
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position	AUSTIN		FISHER		41.00
held by the cost report preparer in columns 1, 2, and 3, respectively.					
'			1		11 42 00
42.00 Enter the employer/company name of the cost report preparer.	BLUE & CO.				42.00

Health Financial Systems		GI BSON GENE	RAL HOSPIT	AL		In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH C	ARE REIMBURSEMENT	QUESTI ONNAI RE	Provi	der CCN: 15-131		eriod: rom 10/01/2016	Worksheet S-2 Part II	2	
					To		Date/Time Pro	epared:	
							2/26/2018 1:2	2 <mark>3 pm</mark>	
				3. 00					
Cost Report Preparer Con	tact Information								
41.00 Enter the first name, la			SENI OR A	CCOUNTANT				41.00	
held by the cost report	preparer in colum	ns 1, 2, and 3,							
respecti vel y.									
42.00 Enter the employer/compa	ny name of the co	st report						42.00	
preparer.									
43.00 Enter the telephone numb	er and email addr	ress of the cost						43.00	
report preparer in colum	ns 1 and 2, respe	ecti vel y.							

Heal th Fi nancialSystemsGIBSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 10/01/2016 | Part | To 09/30/2017 | Date/Time Prepared: Provi der CCN: 15-1319

						Го 09/30/2017	Date/Time Pre 2/26/2018 1:2	
							I/P Days /	БШ
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Ti tle V	
		Line Number 1.00		2. 00	Available 3.00	4.00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			2.00			5.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		20	7,300	20, 112.00		1.00
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO 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	26, 112. 00	0	7.00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		5	1, 82	2, 016. 00	0	1
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			25	0.10	20 120 00		13.00
14. 00 15. 00	Total (see instructions) CAH visits			25	9, 12!	28, 128. 00	0	1
16.00	SUBPROVIDER - IPF						U	16.00
17. 00	SUBPROVIDER - IPF							17.00
18. 00	SUBPROVI DER							18.00
19. 00	SKILLED NURSING FACILITY	44.00		0			0	1
20. 00	NURSING FACILITY	44.00	•	Ü	`			20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101.00					0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			25				27. 00
28.00	Observation Bed Days						0	
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0				32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
	LTCH non-covered days							33. 00 33. 01
33.01	LTCH site neutral days and discharges		I		I	1	I	33.01

Provider CCN: 15-1319

Peri od: Worksheet S-3 From 10/01/2016 Part I To 09/30/2017 Date/Time Prepared: 2/26/2018 1:23 pm

				•		2/26/2018 1:2	3 pm
	·	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
		,		'		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	779	11	1, 088			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)	184	36				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	O	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	678	0	678			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	248			6.00
7.00	Total Adults and Peds. (exclude observation	1, 457	11	2, 014			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	16	0	84			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, 473	11	2, 098	0.00	219. 12	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2, 310	0	3, 745	0.00	5. 20	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	0	0	34	0.00	0.05	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	224. 37	27.00
28.00	Observation Bed Days		0	527			28. 00
29.00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01

Provi der CCN: 15-1319

					0 77 307 2017	2/26/2018 1: 2	
		Full Time		Di sch	arges		
		Equi val ents			•		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	,	11. 00	12. 00	13. 00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	214	3	327	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)			39	9		2.00
3. 00	HMO IPF Subprovider				0		3.00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00						007	13.00
14.00	Total (see instructions)	0. 00	0	214	3	327	
15.00							15.00
16.00	SUBPROVIDER - I PF						16.00
17.00							17.00
18.00		0.00					18.00
19.00		0.00					19.00
20. 00 21. 00							20.00
21.00		0.00					21.00
23. 00		0.00					23.00
24. 00	, ,						24.00
24. 00							24. 00
25. 00							25. 00
26. 00		0.00					26.00
26. 25		0.00					26. 25
	Total (sum of lines 14-26)	0.00					27. 00
28. 00		0.00					28.00
29. 00	3						29.00
30.00							30.00
31. 00							31.00
32. 00							32.00
32. 00							32. 00
JZ. U1	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			О			33.00
	LTCH site neutral days and discharges			o o			33. 01
	1	1		,			

HOME HEALTH AGENCY STATISTICAL DATA HOME HEALTH AGENCY STATISTICAL DATA	ructions) OYEES trator(s)	Title V 1.00 0 0.00 Enter the numbe your normal	Title XVIII 2.00 84.00 er of hours in work week	Title XIX 3.00 O.C Number of Employees Staff 1.00	Peri od: From 10/01/2016 To 09/30/2017 Home Heal th Agency I 1. Other 4.00 0 0.00 Dl oyees (Full Ti Contract 2.00	Date/Time Pre 2/26/2018 1: 2 PPS 00 Total 5.00 0 0.00 me Equi val ent) Total 3.00	ppared: 23 pm 0.00
HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours Unduplicated Census Count (see inst HOME HEALTH AGENCY - NUMBER OF EMPL Administrator and Assistant Adminis Director(s) and Assistant Director(Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service	ructions) OYEES trator(s)	1.00 0 0.00 Enter the numbe your normal	2.00 0 84.00 er of hours in work week	3.00 O.C Number of Employments Staff 1.00	Agency I 1. Other 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	PPS 00 Total 5.00 0.00 me Equi val ent) Total 3.00	0.00
HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours Unduplicated Census Count (see inst HOME HEALTH AGENCY - NUMBER OF EMPLOY Administrator and Assistant Adminis Director(s) and Assistant Director(Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service	ructions) OYEES trator(s)	1.00 0 0.00 Enter the numbe your normal	2.00 0 84.00 er of hours in work week	3.00 O.C Number of Employments Staff 1.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total 5.00 0 0.00 me Equi val ent) Total 3.00	1.00
HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours Unduplicated Census Count (see inst HOME HEALTH AGENCY - NUMBER OF EMPLOY Administrator and Assistant Adminis Director(s) and Assistant Director(Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service	ructions) OYEES trator(s)	1.00 0 0.00 Enter the numbe your normal	2.00 0 84.00 er of hours in work week	3.00 O.C Number of Employments Staff 1.00	Other 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total 5.00 0 0.00 me Equi val ent) Total 3.00	1.00
HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours Unduplicated Census Count (see inst HOME HEALTH AGENCY - NUMBER OF EMPLOY Administrator and Assistant Adminis Director(s) and Assistant Director(Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service	ructions) OYEES trator(s)	1.00 0 0.00 Enter the numbe your normal	2.00 0 84.00 er of hours in work week	3.00 O.C Number of Employments Staff 1.00	4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 0.00 me Equi val ent) Total	1.00
HOME HEALTH AGENCY - NUMBER OF EMPLOY 3. 00 Administrator and Assistant Adminis Director(s) and Assistant Director(0 Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service	ructions) OYEES trator(s)	1.00 0 0.00 Enter the numbe your normal	2.00 0 84.00 er of hours in work week	3.00 O.C Number of Employments Staff 1.00	4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 0.00 me Equi val ent) Total	
HOME HEALTH AGENCY - NUMBER OF EMPLOY 3. 00 Administrator and Assistant Adminis Director(s) and Assistant Director(0 Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service	ructions) OYEES trator(s)	0.00 Enter the numbe your normal	84.00 er of hours in work week	O.C Number of Employments Staff	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0.00 me Equi val ent) Total 3.00	
2.00 Unduplicated Census Count (see inst HOME HEALTH AGENCY - NUMBER OF EMPLO 3.00 Administrator and Assistant Adminis 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	OYEES trator(s)	0.00 Enter the numbe your normal	84.00 er of hours in work week	O.C Number of Employments Staff	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0.00 me Equi val ent) Total 3.00	
3.00 Administrator and Assistant Adminis 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	trator(s)	your normal	work week	Staff 1.00	2.00 0 0.00	Total 3.00	
3.00 Administrator and Assistant Adminis 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	trator(s)	your normal	work week	1.00	2.00	3.00	
3.00 Administrator and Assistant Adminis 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	trator(s)	your normal	work week	1.00	2.00	3.00	
3.00 Administrator and Assistant Adminis 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	trator(s)	your normal	work week	1.00	2.00	3.00	
3.00 Administrator and Assistant Adminis 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	trator(s)	0		0.0	0.00		
3.00 Administrator and Assistant Adminis 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	trator(s)			0.0	0.00		
3.00 Administrator and Assistant Adminis 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	trator(s)			0.0	0.00		
3.00 Administrator and Assistant Adminis 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	trator(s)			0.0	0.00		
 4.00 Director(s) and Assistant Director(5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service 	. ,		40.00			0.00	Η.
5.00 Other Administrative Personnel 6.00 Direct Nursing Service 7.00 Nursing Supervisor 8.00 Physical Therapy Service	3)			1 0 0	0.00	0.00	
7.00 Nursing Supervisor 8.00 Physical Therapy Service				0.0		•	
8.00 Physical Therapy Service				2.6		•	
				0.0		l	
				0. 0		•	
10.00 Occupational Therapy Service				0.0	0.00	0. 09	10.00
11.00 Occupational Therapy Supervisor				0.0		1	
12.00 Speech Pathology Service 13.00 Speech Pathology Supervisor				0.0			
14.00 Medical Social Service				0.0	0. 00		
15.00 Medical Social Service Supervisor				0.0		l	
16.00 Home Health Aide 17.00 Home Health Aide Supervisor				0. 9		l	
18.00 Other (specify)				0. 0			
HOME HEALTH AGENCY CBSA CODES	· A			ı	1		10.00
19.00 Enter in column 1 the number of CBS you provided services during the co							19.00
reporting period.							
20.00 List those CBSA code(s) in column 1 during this cost reporting period (99915			20.00
contains the first code).	TITIE 20						
		Full Epi	<u>isodes</u> With Outliers	 	s PEP Only	Total (cols.	
		Outliers	with outfreis	LUPA EDISOGE	Epi sodes	1-4)	
DDC ACTIVITY DATA		1. 00	2. 00	3. 00	4. 00	5. 00	
PPS ACTIVITY DATA 21.00 Skilled Nursing Visits		1, 038	76		16	1, 170	21.00
22.00 Skilled Nursing Visit Charges		165, 651	12, 160				
23.00 Physical Therapy Visit Charges		694	13		9 9	725	1
24.00 Physical Therapy Visit Charges 25.00 Occupational Therapy Visits		138, 990 98	2, 665 3	1, 84	1, 845 0 0	145, 345 101	
26.00 Occupational Therapy Visit Charges		20, 090	615	1	0 0	20, 705	26.00
27.00 Speech Pathology Visits 28.00 Speech Pathology Visit Charges		27 5 525	0	1	0 0	27 5, 535	
28.00 Speech Pathology Visit Charges 29.00 Medical Social Service Visits		5, 535	0	1	0 0	0, 535	1
30.00 Medical Social Service Visit Charge	s s	O	0	1	0 0		30.00
31.00 Home Health Aide Visits 32.00 Home Health Aide Visit Charges		257 19, 275	22 1, 650		1 7 '5 525	287 21, 525	
33.00 Total visits (sum of lines 21, 23,	25, 27,	2, 114	1, 650		50 32		
29, and 31)	•		_				
34.00 Other Charges 35.00 Total Charges (sum of lines 22, 24,	26 28	0 349, 541	0 17, 090	l .	0 0 0	0 379, 881	
30, 32, and 34)	20, 20,	347, 341	17,070			3,7,001	55.00
36.00 Total Number of Episodes (standard/	non	112		1	7 1	130	36.00
outlier) 37.00 Total Number of Outlier Episodes			3		1	4	37.00
38.00 Total Non-Routi ne Medical Supply Ch	arges	10, 398	844	88	208		38. 00

Heal th	n Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-	-2552-1(
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1319	Peri od:	Worksheet S-8	8
			Component	CCN: 15-8524	From 10/01/2016 To 09/30/2017	Date/Time Pro 2/26/2018 1:2	
					RHC I	Cost	
					1.	00	-
	Clinic Address and Identification						
1. 00	Street		0:		7851 S. PROFES		1.00
				00	State 2.00	ZIP Code 3.00	
2. 00	City, State, ZIP Code, County		FORT BRANCH	00		47648	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for run	al or "II" for	urban		1.00	3.00
3.00	HOSPITAL-BASED FUNCS UNLT. Designation - Ent	er k for rur	ai 0i 0 10i		nt Award	Date	3.0
					1. 00	2.00	
	Source of Federal Funds						4
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A					1	4. 00 5. 00
6. 00	Health Services for the Homeless (Section 34					I	6.00
7. 00	Appal achi an Regi onal Commi ssi on	,				I	7.00
8.00	Look-Alikes					I	8.00
9. 00	OTHER (SPECIFY)						9.0
					1. 00	2. 00	
10.00	3 1					0	10.0
	yes or "N" for no in column 1. If yes, indic					I	
	2. (Enter in subscripts of line 11 the type o hours.)	or other operati	ion(s) and the	operating		l	
	Tiour 3.)	Sun	day	N	Monday	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11.0
	10.1111.0			100.00	171.00		1
	To the second se				1. 00	2. 00	
12. 00 13. 00					N N	0	12.00
13.00	30. 8? Enter "Y" for yes or "N" for no in col				IN	1	13.0
	number of providers included in this report.					I	
	numbers below.			T	:	CCN	
				Prov	ider name 1.00	CCN number 2.00	1
14. 00	RHC/FQHC name, CCN number					2.00	14.0
		Y/N	V	XVIII	XI X	Total Visits	
15 00	Hove you provided all an exhatratical and	1. 00	2. 00	3. 00	4. 00	5. 00	15.00
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in					I	15.00
	column 1. If yes, enter in columns 2, 3 and					I	
	4 the number of program visits performed by					I	
	Intern & Residents for titles V, XVIII, and					I	
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.					I	
	(see instructions)						
				inty			
2.00	City State 71D Code County			00			2.0
2. 00	City, State, ZIP Code, County	Tuesday	GI BSON Wedn	esday	Thur	sday	2.0
		to	from	to	from	to	
		6. 00	7.00	8. 00	9. 00	10.00	
44.05	Facility hours of operations (1)	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	GI BSON GENER	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	}
		Component		From 10/01/2016 To 09/30/2017		nared.
		общронент	0014. 10 0021	77 077 2017	2/26/2018 1: 2	23 pm
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 Clinic	08: 00	17: 00				11. 00

U5PI I	,	PI TAL ovi der	CCN: 15-1319	Pe	ri od:	w of Form CMS-2 Worksheet S-1	
	The street Electrical files of the street st	011 001	00.11 10 1017	Fr	om 10/01/2016		
				То	09/30/2017	Date/Time Pre 2/26/2018 1:2	
						1. 00	
	Uncompensated and indigent care cost computation						
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by	line 202 co	lumn 8	3)	0. 400457	1.
	Medicaid (see instructions for each line)					1 405 007	
00	Net revenue from Medicaid					1, 195, 037	2.
00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplementa	l navmo	nts from Mo	di cai d	42	N	3.
00	If line 4 is no, then enter DSH and/or supplemental payments from			ui cai c	<i>a</i> :	0	1
00	Medi cai d charges	iii wear e	ui u			9, 049, 683	
00	Medicaid cost (line 1 times line 6)					3, 624, 009	
00	Difference between net revenue and costs for Medicaid program (I	ine 7 m	inus sum of	lines	s 2 and 5; if	2, 428, 972	8.
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP) (see instructions for	each I	i ne)				
00	Net revenue from stand-alone CHIP					0	
0.00	Stand-alone CHIP charges					0	
2.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (I	ino 11	minus lino	o. if	< zoro thon	0	11.
2.00	enter zero)	THE T	illi ilus Title	7, 11	< Zero then		12.
	Other state or local government indigent care program (see instru	ucti ons	for each I	i ne)		I.	ĺ
3. 00	Net revenue from state or local indigent care program (Not inclu					0	13.
1. 00	Charges for patients covered under state or local indigent care	program	(Not inclu	ded i r	n lines 6 or	0	14.
	10)						
5. 00	State or local indigent care program cost (line 1 times line 14)				45 1 11	0	
5. 00	Difference between net revenue and costs for state or local indi- 13; if < zero then enter zero)	gent ca	re program	(Tine	15 minus line	0	16.
	Grants donations and total unreimbursed cost for Medicaid CHIP	and st	ate/Local i	ndi aer	nt care progra	ams (see	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and st	ate/local i	ndi ger	nt care progra	ams (see	
	instructions for each line) Private grants, donations, or endowment income restricted to fun-	idi ng ch	arity care	ndi ger	nt care progra	0	1
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to fun- Government grants, appropriations or transfers for support of ho	idi ng ch ispi tal	arity care operations			0	18.
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to fun-	idi ng ch ispi tal	arity care operations			0	18.
8. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fun- Government grants, appropriations or transfers for support of hor Total unreimbursed cost for Medicaid, CHIP and state and local</pre>	idi ng ch ispi tal	arity care operations	rams		0 0 2, 428, 972 Total (col. 1	18.
3. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fun- Government grants, appropriations or transfers for support of hor Total unreimbursed cost for Medicaid, CHIP and state and local</pre>	idi ng ch ispi tal	arity care operations t care prog Uninsure patient	rams ((sum of lines Insured patients	0 0 2, 428, 972 Total (col. 1 + col. 2)	18.
3. 00	instructions for each line) Private grants, donations, or endowment income restricted to fun- Government grants, appropriations or transfers for support of ho- Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	idi ng ch ispi tal	arity care operations t care prog	rams ((sum of lines	0 0 2, 428, 972 Total (col. 1	18.
3. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hor Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line)	ding ch spital indigen	arity care operations t care prog Uninsurpatient 1.00	rams ((sum of lines Insured patients 2.00	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to fun- Government grants, appropriations or transfers for support of ho- Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	ding ch spital indigen	arity care operations t care prog Uninsurpatient 1.00	rams ((sum of lines Insured patients	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00	18. 19.
8. 00 9. 00 0. 00	instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hor Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	ding ch spital indigen	arity care operations t care prog Uninsumpatient 1.00	rams ((sum of lines Insured patients 2.00	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00	18. 19.
8. 00 9. 00 0. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of homogeneous transfers for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discouninstructions)	ding ch spital indigen	arity care operations t care prog Uninsumpatient 1.00	rams (ed es	(sum of lines Insured patients 2.00	0 0 2, 428, 972 Total (col. 1 + col. 2) 3. 00	18. 19.
8. 00 9. 00 0. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of homogeneous transfers for medical formation for medical formation for each line) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or	ding ch spital indigen	arity care operations t care prog Uninsumpatient 1.00	rams (ed es	(sum of lines Insured patients 2.00	0 0 2, 428, 972 Total (col. 1 + col. 2) 3. 00	18. 19. 20. 21.
3. 00 9. 00 0. 00 1. 00 2. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of hor Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care	ding ch spital indigen	uni ty care operations t care prog Uni nsurpatient 1.00	rams (ed es ed es es ed es ed es ed es ed es es ed es	(sum of lines Insured patients 2.00 0	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566	18. 19. 20. 21.
3. 00 9. 00 0. 00 1. 00 2. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of hor Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care	ding ch spital indigen	uni ty care operations t care prog Uni nsurpatient 1.00	rams (ed :s	(sum of lines Insured patients 2.00	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566	18. 19. 20. 21.
3. 00 2. 00 3. 00 3. 00 4. 00 2. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hor Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care	ding ch spital indigen	uni ty care operations t care prog Uni nsurpatient 1.00	rams (ed es ed es es ed es ed es ed es ed es es ed es	(sum of lines Insured patients 2.00 0	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566 0 399, 566	18. 19. 20. 21.
0.00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of homogeneous transfers for Medicaid, CHIP and state and Local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22)	ding ch spital indigen lity ts (see	uni ty care operations to care proguent to care proguent to care proguent to care patient 1.00	rams (ed es s. 7, 774 o), 566 o), 566	(sum of lines Insured patients 2.00 0 0	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566	18. 19. 20. 21. 22. 23.
0.00	Instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hor Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care	ding ch spital indigen lity ts (see	uni ny care operations t care prog Uni nsurpatient 1.00 997 399	rams (ed es s. 7, 774 o), 566 o), 566	(sum of lines Insured patients 2.00 0 0	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566 0 399, 566	18. 19. 20. 21. 22. 23.
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of homogeneous total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written on charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care put line 24 is yes, enter the charges for patient days beyond the	ding ch spital indigen lity ts (see ff as	arity care operations t care prog Uninsurpatient 1.00 997 399 eyond a len	rams (ed es s 7, 774), 566 0 0, 566 gth of	Insured patients 2.00 0 0 f stay limit	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566 0 399, 566	20. 21. 22. 23.
33. 00 3. 00 3. 00 1. 00 2. 00 33. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of horotal unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit	ding chespital indigen	uni ty care operations t care prog Uni nsurpatient 1.00 997 399 eyond a len	rams (ed es s 7, 774), 566 0 0, 566 gth of	Insured patients 2.00 0 0 f stay limit	0 0 2, 428, 972 Total (col. 1 + col. 2) 3. 00 997, 774 399, 566 0 399, 566	20. 21. 22. 23.
33. 00 30. 00 31. 00 31. 00 32. 00 33. 00 44. 00 55. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of horotal unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care possessible line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst	lity lity days barogram? indige	uni ty care operations to care proguent	rams (ed es s 7, 774), 566 0 0, 566 gth of	Insured patients 2.00 0 0 f stay limit	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566 0 399, 566 1.00 N 0 3, 934, 980	20. 21. 22. 23. 24. 25.
33. 00 30. 00 31. 00 32. 00 44. 00 55. 00 66. 00 77. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of horotal unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care point line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex	ding ch spital indigen lity ts (see off as days b program? indige ruction (see in	uni ty care operations to care progratient 1.00 997 399 eyond a len nt care pross) structions)	rams (ed es s 7, 774), 566 0 0, 566 gth of	Insured patients 2.00 0 0 f stay limit	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566 0 399, 566 1.00 N 0 3, 934, 980 273, 951	20. 21. 22. 23. 24. 25. 26. 27.
33. 00 99. 00 11. 00 12. 00 14. 00 44. 00 65. 00 77. 00 77. 01	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of horotal unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex (see	ding ch spital indigen lity ts (see off as days b program? indige ruction (see in	uni ty care operations to care progratient 1.00 997 399 eyond a len nt care pross) structions)	rams (ed es s 7, 774), 566 0 0, 566 gth of	Insured patients 2.00 0 0 f stay limit	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566 0 399, 566 1.00 N 0 3, 934, 980 273, 951 421, 463	20. 21. 22. 23. 24. 25. 26. 27. 27.
0. 00 11. 00 22. 00 44. 00 55. 00 77. 00 77. 01 88. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of hototal unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care point line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (line 26 minus line 27.01)	ding chespital indigen lity ts (see of as a see of as a see of as a see of as a see of a se	arity care operations t care prog Uninsurpatient 1.00 997 399 eyond a len ont care pross) structions)	rams (ed :s	Insured patients 2.00 0 0 f stay limit	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566 0 399, 566 1.00 N 0 3, 934, 980 273, 951 421, 463 3, 513, 517	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundovernment grants, appropriations or transfers for support of horotal unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex (see	ding chespital indigen lity ts (see of as a see of as a see of as a see of as a see of a se	arity care operations t care prog Uninsurpatient 1.00 997 399 eyond a len ont care pross) structions)	rams (ed :s	Insured patients 2.00 0 0 f stay limit	0 0 2, 428, 972 Total (col. 1 + col. 2) 3.00 997, 774 399, 566 0 399, 566 1.00 N 0 3, 934, 980 273, 951 421, 463	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

Heal th	Financial Systems	GI BSON GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	CN: 15-1319 P	eri od:	Worksheet A	
				F	rom 10/01/2016		
				Te	o 09/30/2017	Date/Time Pre	
						2/26/2018 1: 2	3 pm
	Cost Center Description	Sal ari es	0ther	,	Recl assi fi cat	Reclassified	
				+ col. 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		1, 456, 660	1, 456, 660	292, 159	1, 748, 819	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		0	0	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	141, 992	16, 655	158, 647	601, 334	759, 981	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 486, 894	3, 462, 222	4, 949, 116	50, 165	4, 999, 281	5.00
7. 00	00700 OPERATION OF PLANT	115, 752	815, 107	930, 859	28, 904	959, 763	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE		45, 501		-2, 807	82, 960	8.00
		40, 266		· ·		·	
9.00	00900 HOUSEKEEPI NG	264, 694	146, 715		-13, 931	397, 478	9.00
10.00	01000 DI ETARY	389, 976	386, 667	776, 643	-385, 922	390, 721	10.00
11. 00	01100 CAFETERI A	0	0	_	371, 221	371, 221	11.00
13.00	01300 NURSING ADMINISTRATION	157, 488	15, 467	172, 955	0	172, 955	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	249, 799	146, 214	396, 013	-7, 128	388, 885	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 075, 706	522, 744	1, 598, 450	-82, 659	1, 515, 791	30.00
31.00	03100 INTENSIVE CARE UNIT	65, 053	69, 909	134, 962	-6, 795	128, 167	31.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
	ANCILLARY SERVICE COST CENTERS				-		
50.00	05000 OPERATING ROOM	643, 143	681, 562	1, 324, 705	-130, 908	1, 193, 797	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	613, 494	649, 248		-10, 633	1, 252, 109	54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	013, 474	122, 820		- 10, 033		54.00
	06000 LABORATORY	(41 022				122, 820	
60.00		641, 832	737, 501	1, 379, 333	-13, 060	1, 366, 273	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58, 837		0	58, 837	62.00
65.00	06500 RESPI RATORY THERAPY	398, 637	409, 515		-19, 410	788, 742	65.00
66. 00	06600 PHYSI CAL THERAPY	667, 062	281, 886	948, 948	-18, 442	930, 506	66.00
67.00	06700 OCCUPATI ONAL THERAPY	229, 967	51, 023	280, 990	-3, 381	277, 609	67.00
68.00	06800 SPEECH PATHOLOGY	118, 623	31, 547	150, 170	-2, 933	147, 237	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	182, 442	182, 442	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	ol	0		148, 130	148, 130	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	113, 271	1, 341, 195	-	-152	1, 454, 314	
73.00	OUTPATIENT SERVICE COST CENTERS	113, 271	1, 541, 175	1, 454, 400	102	1, 454, 514	75.00
88. 00	08800 RURAL HEALTH CLINIC	ol	0	0	12, 154	12, 154	88. 00
90.00	09000 CLINIC		0		12, 134	12, 134	90.00
		O O	-	_	U	-	
90. 01	09001 DI ABETES	0	6, 000	6, 000	0	6, 000	90. 01
90. 02	09002 OP PSYCH	0	0	0	0	0	90. 02
90. 03	09003 PAIN MANAGEMENT	134, 814	129, 635	· ·	-16, 799	247, 650	90. 03
91.00	09100 EMERGENCY	778, 171	744, 947	1, 523, 118	-21, 861	1, 501, 257	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	297, 885	141, 081	438, 966	-7, 728	431, 238	101.00
	SPECIAL PURPOSE COST CENTERS	· · ·	·	· · · · · · · · · · · · · · · · · · ·		•	
113. 00	11300 I NTEREST EXPENSE		295, 898	295, 898	-295, 898	Ω	113.00
118.00		8, 624, 519	12, 766, 556		646, 062	22, 037, 137	
	NONREI MBURSABLE COST CENTERS	5, 527, 517	12, 700, 550	21, 371, 073	040, 002	22,007,107	. 10.00
104 00	07950 MOB	3, 335, 442	2, 035, 168	5, 370, 610	-569, 942	4, 800, 668	104 00
	07950 MOB						
		51, 064	3, 973	· ·	0	55, 037	
	07952 ASC	0	0		0		194. 02
	07953 SNF - PERRY CO.	1, 283, 835	522, 982		-76, 120	1, 730, 697	
200.00	TOTAL (SUM OF LINES 118 through 199)	13, 294, 860	15, 328, 679	28, 623, 539	0	28, 623, 539	200. 00

 Health Financial
 Systems
 GIBSON GEN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 | Peri od: | Worksheet A | From 10/01/2016 | To 09/30/2017 | Date/Time Prepared: Provider CCN: 15-1319

				To	
	Cost Center Description	Adjustments	Net Expenses	2/20/2010 1.2	T piii
	occi contor boson per on	(See A-8)	For		
		(Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-14, 946	1, 733, 873		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	887, 197	1, 647, 178		4.00
5.00	00500 ADMINI STRATI VE & GENERAL	1, 879, 845	6, 879, 126		5.00
7.00	00700 OPERATION OF PLANT	94, 381	1, 054, 144		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	82, 960		8.00
9.00	00900 HOUSEKEEPI NG	0	397, 478		9.00
10.00	01000 DI ETARY	0	390, 721		10.00
11.00	01100 CAFETERI A	-137, 150	234, 071		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	60, 876	233, 831		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	40, 468	429, 353		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-53, 899	1, 461, 892		30.00
31.00	03100 INTENSIVE CARE UNIT	0	128, 167	•	31.00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44.00
	ANCILLARY SERVICE COST CENTERS	_			
50.00	05000 OPERATING ROOM	0	1, 193, 797		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-812	1, 251, 297		54.00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	122, 820		54. 03
60.00	06000 LABORATORY	0	1, 366, 273	•	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58, 837		62.00
65. 00	06500 RESPIRATORY THERAPY	-70, 637	718, 105		65.00
66. 00	06600 PHYSI CAL THERAPY	0	930, 506		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	277, 609	•	67.00
68. 00	06800 SPEECH PATHOLOGY	0	147, 237	•	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	•	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	182, 442		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	148, 130		72.00
	07300 DRUGS CHARGED TO PATIENTS	310, 329	1, 764, 643	•	73.00
	OUTPATIENT SERVICE COST CENTERS		.,,	1	
88. 00	08800 RURAL HEALTH CLINIC	0	12, 154		88. 00
90.00	09000 CLI NI C	0	0	1	90.00
	09001 DI ABETES	0	6, 000		90. 01
90. 02	09002 OP PSYCH	0	0		90.02
	09003 PAIN MANAGEMENT	-3, 981	243, 669		90.03
91. 00	09100 EMERGENCY	0,151	1, 501, 257	1	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	_	1, 22., 22.		92.00
	OTHER REIMBURSABLE COST CENTERS				
101 00	10100 HOME HEALTH AGENCY	0	431, 238		101.00
101100	SPECIAL PURPOSE COST CENTERS		1017200		1.000
113 00	11300 INTEREST EXPENSE	0	0		113.00
118.00		2, 991, 671	_	•	118.00
	NONREI MBURSABLE COST CENTERS	_, ,,,,,,,,,	,,	<u> </u>	1
194.00	07950 MOB	0	4, 800, 668		194. 00
	07951 FOUNDATI ON	0	55, 037	•	194. 01
	07952 ASC	0	0		194. 02
	07953 SNF - PERRY CO.	0	1, 730, 697	·	194. 03
200.00	1 1	2, 991, 671	31, 615, 210	•	200.00
	, , , , , , , , , , , , , , , , , , ,		, , 2	1	1

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 10/01/2016 | To 09/30/2017 | Date/Time Prepared: Provider CCN: 15-1319

					ite/lime Prepared: /26/2018 1:23 pm
		Increases		0.11	
	Cost Center 2.00	3.00	Sal ary 4. 00	0ther 5.00	
	C - CAFETERIA	3.00	4.00	5.00	
. 00	CAFETERI A	11. 00	186, 586	184, 635	1.00
. 00	0		186, 586	184, 635	1.00
	D - MED SUPPLY CHG PTS		,,	,	
. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	182, 442	1.00
	PATI ENT				
. 00	I MPL. DEV. CHARGED TO	72. 00	0	148, 130	2.00
00	PATI ENTS	0.00			0.00
. 00		0.00	0	0	3.00
. 00		0. 00 0. 00	0	0	4. 00 5. 00
. 00	1	0.00	O O	0	6.00
. 00		0.00	0	0	7.00
. 00		0.00	0	Ö	8.00
. 00		0. 00	o	Ö	9. 00
0. 00		0.00	o	Ö	10.00
1.00		0.00	O	0	11.00
2.00		0.00	o	0	12.00
3.00		0.00	0	0	13.00
	0		0	330, 572	
	F - BUSINESS HEALTH SER				
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	49, 964	42, 447	1.00
	0		49, 964	42, 447	
00	G - INTEREST CAP REL COSTS-BLDG & FIXT	1.00	0	292, 159	1 00
. 00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 739	1.00
. 00	0				2.00
	I - QUALITY SERVICES		<u> </u>	270,070	
. 00	ADMINISTRATIVE & GENERAL	5. 00	31, 405	16, 452	1.00
			31, 405	1 <u>6, 4</u> 52	
	J - HEALTH INSURANCE				
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	323, 287	1.00
. 00		0. 00	0	0	2.00
. 00		0. 00	0	0	3.00
. 00		0.00	0	0	4.00
. 00		0.00	0	0	5. 00
. 00		0. 00 0. 00	0	0	6.00
. 00	1	0.00	O O	0	7. 00 8. 00
. 00		0.00	o	0	9. 00
0. 00		0.00	o	0	10.00
1. 00		0. 00	o	Ö	11. 00
2. 00		0. 00	o	Ö	12. 00
3.00		0.00	O	0	13.00
4.00		0.00	o	0	14.00
5. 00		0. 00	0	0	15.00
6. 00		0. 00	0	0	16.00
7. 00		0. 00	0	0	17. 00
8. 00		0. 00	0	0	18. 00
9.00		0.00	0	0	19.00
0. 00				323, 287	20.00
	K - WELLNESS CENTER		<u> </u>	323, 207	
. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	136, 179	49, 457	1.00
			136, 179	49, 457	
	M - SNF OPERATION OF PLANT				
. 00	OPERATION OF PLANT	7. 00	35, 072	0	1.00
	0		35, 072	0	
	N - MALPRACTICE				
. 00	ADMINISTRATIVE & GENERAL	5. 00	0	45, 223	1.00
. 00		0.00	0	0	2.00
. 00		0.00	o	0	3.00
. 00		0.00	O	0	4.00
00		0.00	U	U	5.00
00		0.00		45, 223	6.00
	O - MOB COLLECTION EXPENSE		U	40, 223	
. 00	ADMINISTRATIVE & GENERAL	5. 00	0	4, 470	1.00
. 00	0			4, 470	1.00
	P - RHC RECLASS		9	., 170	
. 00	RURAL HEALTH CLINIC	88. 00	6, 718	5, 436	1.00
	TOTALS		6, 718	5, 436	
	Grand Total: Increases		445, 924	1, 297, 877	500.00

Provider CCN: 15-1319

					10	09/30/2017 Date/lime Pro 2/26/2018 1:3	
		Decreases				1 27 207 20 10	Ţ <u>, p</u>
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00 C - CAFETERI A	7. 00	8. 00	9. 00	10. 00		
1. 00	DI ETARY	10. 00	186, 586	184, 635	0		1.00
1.00	0		186, 586	184, 635			1.00
	D - MED SUPPLY CHG PTS						
1.00	ADULTS & PEDIATRICS	30.00	0	1, 657	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	11	0		2.00
3.00	OPERATING ROOM	50. 00	0	115, 790	0		3.00
4. 00	LABORATORY	60.00	0	1, 169	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	10, 252	0		5.00
6.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66.00	0	2, 398	0		6.00
7. 00 8. 00	DRUGS CHARGED TO PATIENTS	67. 00 73. 00	0	32 152	0		7.00
9. 00	PAIN MANAGEMENT	90. 03	0	12, 054	0		9.00
10.00	EMERGENCY	91.00	Ö	4, 620	0		10.00
11. 00	HOME HEALTH AGENCY	101. 00	o	308	Ö		11.00
12.00	MOB	194. 00	O	181, 811	0		12.00
13.00	SNF - PERRY CO.	194. 03	o_	318	0		13.00
	0		O	330, 572			
	F - BUSINESS HEALTH SER						4
1. 00	MOB	194. 00	49, 964	42, 447	0		1.00
	0		49, 964	42, 447			
1 00	G - INTEREST INTEREST EXPENSE	113. 00	ما	205 000	10		1 00
1. 00 2. 00	INTEREST EXPENSE	0.00	0	295, 898 0	0		1.00
2.00			— — —	0 295, 898			2.00
	I - QUALITY SERVICES		<u> </u>	275, 070			
1. 00	ADULTS & PEDIATRICS	30.00	31, 405	16, 452	0		1.00
			31, 405	16, 452	1		
	J - HEALTH INSURANCE						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	51, 124			1.00
2.00	OPERATION OF PLANT	7. 00	0	3, 568	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	2, 807	0		3.00
4. 00 5. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	13, 931 14, 701	0		4. 00 5. 00
6. 00	MEDICAL RECORDS & LIBRARY	16. 00	o	7, 128	0		6.00
7. 00	ADULTS & PEDIATRICS	30.00	o	32, 580	0		7.00
8. 00	INTENSIVE CARE UNIT	31. 00	o	6, 784	o		8.00
9.00	OPERATING ROOM	50.00	O	13, 809	0		9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	O	10, 633	0		10.00
11.00	LABORATORY	60.00	0	11, 891	0		11.00
12.00	RESPI RATORY THERAPY	65. 00	0	9, 158	0		12. 00
13. 00	PHYSI CAL THERAPY	66. 00	0	16, 044	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	3, 349	0		14.00
15. 00 16. 00	SPEECH PATHOLOGY	68. 00 90. 03	0	2, 933	0		15. 00 16. 00
17. 00	PAIN MANAGEMENT EMERGENCY	91. 00	0	4, 670 17, 241	0		17.00
18. 00	HOME HEALTH AGENCY	101.00	o	7, 420	0		18.00
	MOB	194. 00	0	55, 402			19.00
	SNF - PERRY_CO	194. 03	o	38, 114			20.00
	0			323, 287			
	K - WELLNESS CENTER						
1. 00	MOB	1 <u>94.</u> 00	13 <u>6, 1</u> 79	4 <u>9, 4</u> 57			1.00
	0		136, 179	49, 457			_
	M - SNF OPERATION OF PLANT	104 00	05 070				4
1. 00	SNF - PERRY CO.	1 <u>94.</u> 03	35, 072	0	0		1.00
	N - MALPRACTICE		35, 072	U			-
1. 00	OPERATION OF PLANT	7. 00	0	2, 600	0		1.00
2. 00	ADULTS & PEDIATRICS	30.00	0	565			2.00
3. 00	OPERATING ROOM	50. 00	o	1, 309			3.00
4.00	PAIN MANAGEMENT	90. 03	О	75	· · · · · · · · · · · · · · · · · · ·		4.00
5.00	MOB	194. 00	O	38, 058	O		5.00
6.00	SNF - PERRY CO.	1 <u>94.</u> 03	0_	<u>2, 6</u> 16			6. 00
	0		0	45, 223			_
1 00	O - MOB COLLECTION EXPENSE	404.60		4 470			4
1. 00	MOB	194.00					1.00
	P - RHC RECLASS		U	4, 470			-
1. 00	MOB	194. 00	6, 718	5, 436	0		1.00
50	TOTALS — — — —		6, 718	5, 436			1.00
500.00	Grand Total: Decreases		445, 924	1, 297, 877			500.00
		'			. '		•

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS GI BSON GENERAL HOSPI TAL

Provi der CCN: 15-1319

					То	09/30/2017	Date/Time Pre 2/26/2018 1:2	
				Acqui si ti ons	S		2/20/2010 1.2	o piii
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1. 00	2. 00	3. 00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	684, 802	0		0	0	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	19, 903, 822	0		0	0	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	14, 241, 503	236, 003		0	236, 003	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34, 830, 127	236, 003		0	236, 003	0	8. 00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	10.00 Total (line 8 minus line 9)		236, 003		0	236, 003	0	10.00
		Endi ng	Ful I y					
		Bal ance	Depreci ated					
			Assets					
		6. 00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	684, 802	0					1. 00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	19, 903, 822	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fi xed Equi pment	0	0					5.00
6.00	Movable Equipment	14, 477, 506	0					6.00
7.00	HIT designated Assets	0	0					7. 00
8.00	Subtotal (sum of lines 1-7)	35, 066, 130	0					8. 00
9. 00	Reconciling Items	0	0					9. 00
10.00	Total (line 8 minus line 9)	35, 066, 130	0					10.00

Heal th	Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lieu of Form CMS-2552-10			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1319	Peri od:	Worksheet A-7		
					From 10/01/2016 To 09/30/2017		narod.	
					077 307 2017	2/26/2018 1: 2	3 pm	
			SL	JMMARY OF CAP	I TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see	instructions)		
					instructions)			
		9. 00	10. 00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	· · · · · · · · · · · · · · · · · · ·	MN 2, LINES 1 a	and 2			4	
1.00	CAP REL COSTS-BLDG & FLXT	1, 269, 751	0		0 174, 989	11, 920	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00	
3.00	Total (sum of lines 1-2)	1, 269, 751	0		0 174, 989	11, 920	3.00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 456, 660			ļ	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
2 00	T-+-! (6 !: 1 2)		1 45/ //0	1			1 2 00	

0 0 0

1, 456, 660

2.00

3.00 Total (sum of lines 1-2)

Health Financial Systems	GI BSON GENERA	AL HOSPITAL		In Lieu of Form CMS-255			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 10/01/2016 To 09/30/2017			
	COMI	PUTATION OF RAT	ALLOCATION OF	OTHER CAPITAL	5 piii		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
		Leases	for Ratio	instructions)			
			(col. 1 -				
	1. 00	2.00	col. 2) 3.00	4.00	5. 00		
PART III - RECONCILIATION OF CAPITA		2.00	3.00	4.00	3.00		
1. 00 CAP REL COSTS-BLDG & FLXT	35, 066, 130	0	35, 066, 130	1.000000	0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	C	0. 000000	0	2.00	
3.00 Total (sum of lines 1-2)	35, 066, 130		35, 066, 130			3. 00	
	ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
		Capi tal -Rel at					
		ed Costs	through 7)				
PART III - RECONCILIATION OF CAPITA	6. 00	7. 00	8. 00	9. 00	10.00		
1.00 CAP REL COSTS-BLDG & FLXT	AL COSTS CENTERS			1, 269, 751	277, 213	1. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP				1, 207, 731	277, 213	2.00	
3.00 Total (sum of lines 1-2)		Ö		1, 269, 751	277, 213	3. 00	
		SL	JMMARY OF CAPI		,		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
		(see	instructions)				
		instructions)		ed Costs (see	9 through 14)		
	11.00	12.00	12.00	instructions)	15.00		
PART III - RECONCILIATION OF CAPITA	11.00	12. 00	13. 00	14. 00	15. 00		
1.00 CAP REL COSTS-BLDG & FIXT	0	174, 989	11, 920	0	1, 733, 873	1. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP			11, 720			2. 00	
3.00 Total (sum of lines 1-2)	0	174, 989	11, 920				
		•					

| Period: | Worksheet A-8 | From 10/01/2016 | To 09/30/2017 | Date/Time Prepared: Provi der CCN: 15-1319

COSTS-MVBLE EQUIP (chapter 2) Investment income - other (chapter 2)	
Cost Center Description Basis/Code Amount Cost Center Line # Wkst. A-7 Ref.	
C2	
1.00	
COSTS-BLDG & FIXT (chapter 2) 1 1 1 1 2 0 1 1 1 2 0 0 2 2 0 0 2 2 0 0	00
COSTS-MVBLE EQUIP (chapter 2) Investment i ncome - other (chapter 2)	
3.00 Investment income - other (chapter 2) 4.00 Trade, quantity, and time discounts (chapter 8) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 21) 8.00 Television and radio service (chapter 21) 9.00 Parking lot (chapter 21) 9.00 Parking lot (chapter 21) 11.00 Sale of scrap, waste, etc. (chapter 23) 10.00 O.00 O.	00
4.00 Trade, quantity, and time discounts (chapter 8) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 21) 8.00 Television and radio service A -215 OPERATION OF PLANT 7.00 OPERATIO	00
discounts (chapter 8)	00
expenses (chapter 8) 0 0 0 0 0 0 0 0 0	
6.00 Rental of provider space by suppliers (chapter 8) 7.00 Tel ephone services (pay stations excluded) (chapter 21) 8.00 Tel evision and radio service (chapter 21) 9.00 Parking lot (chapter 21) 10.00 Provider-based physician adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 0 0.00 0 0.00 0 0.00 0 9. 10.00 0.00 0.00 0 11.	00
7. 00 Tel ephone services (pay stations excluded) (chapter 21) 8. 00 Tel evision and radio service (chapter 21) 9. 00 Parking I ot (chapter 21) 10. 00 Provider-based physician adjustment 11. 00 Sale of scrap, waste, etc. (chapter 23) 7. 00 OPERATION OF PLANT 7. 00 O 8. -215 OPERATION OF PLANT 7. 00 O 8. -215 OPERATION OF PLANT 7. 00 O 9. 0. 00 O 0 10.	00
Stations excluded) (chapter 21)	00
8.00 Tel evision and radio service (chapter 21) 9.00 Provider-based physician adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) Tel evision and radio service A -215 OPERATION OF PLANT 7.00 0 8. 0.00 0 9. 127, 657 0 10.	00
9. 00 Provi der-based physician adj ustment 11. 00 Sale of scrap, waste, etc. Chapter 23 Chapter 24 Chapter 25 Chapter 26 Chapter 27 Chapter 27 Chapter 27 Chapter 28 Chapter 28	00
10.00 Provider-based physician A-8-2 -127,657 adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 0 10.	
adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 0 0 0 11.	
(chapter 23)	
	00
12. 00 Related organization A-8-1 4, 042, 028 0 12.	00
transactions (chapter 10) 13.00 Laundry and Linen service 0 0.00 0 13.	00
14.00 Cafeteria-employees and guests B -137,150 CAFETERIA 11.00 0 14.	
15.00 Rental of quarters to employee 0 0.00 0 15.	00
16. 00 Sal e of medical and surgical 0 0.00 0 16.	00
supplies to other than patients	
17.00 Sale of drugs to other than 0 0.00 0 17.	00
patients 18.00 Sale of medical records and B -9,589MEDICAL RECORDS & LIBRARY 16.00 0 18.	00
abstracts 19.00 Nursing and allied health 0 0.00 0 19.	00
19.00 Nursing and allied health 0 0.00 0 19. education (tuition, fees,	00
books, etc.) 20.00 Vendi ng machi nes 0 0.00 0.00 0.20.	00
20. 00 Vending machines	
interest, finance or penalty charges (chapter 21)	
22.00 Interest expense on Medicare 0 0.00 0.22.	00
overpayments and borrowings to repay Medicare overpayments	
23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.	00
therapy costs in excess of limitation (chapter 14)	
24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.	00
therapy costs in excess of limitation (chapter 14)	
25. 00 Utilization review - 0 *** Cost Center Deleted *** 114.00 25.	00
physicians' compensation (chapter 21)	
26.00 Depreciation - CAP REL 0 CAP REL COSTS-BLDG & FIXT 1.00 0 26.	00
COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 0 27.	00
COSTS-MVBLE EQUIP	
28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19. 00 28. 29. 00 Physicians' assistant 0 0 0 0 29.	
30.00 Adjustment for occupational A-8-3 OCCUPATIONAL THERAPY 67.00 30.	
therapy costs in excess of Iimitation (chapter 14)	
30. 99 Hospi ce (non-di sti nct) (see 0 ADULTS & PEDI ATRI CS 30. 00 30.	99
instructions)	

Heal th	Financial Systems		GIBSON GENERA	AL HOSPITAL	In Lieu of Form CMS-2552-10			
	MENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 10/01/2016 To 09/30/2017		pared:	
				Expense Classification or	Worksheet A			
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basis/Code	Amount	Cost Center	Line #	Wkst. A-7		
	cost center bescription	(2)	Allourt	cost center	LITTE #	Ref.		
		1. 00	2. 00	3. 00	4. 00	5. 00		
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00	
	pathology costs in excess of							
	limitation (chapter 14)							
32.00	CAH HIT Adjustment for		0		0.00	0	32.00	
	Depreciation and Interest							
	MISC INCOME	В	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33.00	
	PHYSICIAN RECRUITING	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02	
	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 03	
33. 04	ADVERTI SI NG	Α	· ·	PAIN MANAGEMENT	90. 03	0	33. 04	
	HAF FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	34.00	
		A		ADMINISTRATIVE & GENERAL	5. 00	0	35.00	
50.00			2, 991, 671				50.00	
	(Transfer to Worksheet A,							

column 6, line 200.)

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

				To 09/30/2017	Date/Time Pre 2/26/2018 1:2						
	Li ne No.	Cost Center	Expense Items	Amount of	Amount						
				Allowable Cost	Included in						
					Wks. A, column						
					5						
	1. 00	2. 00	3. 00	4. 00	5. 00						
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME										
	OFFICE COSTS:										
1. 00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	887, 197	0	1.00					
2.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2, 597, 547	0	2.00					
3.00	7. 00	OPERATION OF PLANT	HOME OFFICE	97, 642	0	3.00					
4.00	13. 00	NURSING ADMINISTRATION	HOME OFFICE	60, 876	0	4.00					
4. 01	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	310, 329	0	4.01					
4. 02	16. 00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	50, 057	0	4.02					
4.03	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	141, 408	0	4.03					
4.04	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	313, 859	416, 887	4.04					
5.00	TOTALS (sum of lines 1-4).			4, 458, 915	416, 887	5.00					
	Transfer column 6, line 5 to										
	Worksheet A-8, column 2,										
	line 12.										

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

			Related Organization(s) and	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	G		0.00	DEACONESS HOSP	0. 00	6. 00
7. 00			0.00		0.00	7. 00
8. 00			0. 00		0.00	8. 00
9. 00			0. 00		0. 00	9.00
10.00			0.00		0.00	10.00
100. 00 G.	Other (financial or	HOME OFFICE				100.00
non	n-financial) specify:					

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

Heal th	Financial Syst	ems			GLBSON	GENERAL	HOSPITAL			In	Li eu	ı of Form	CMS-2	2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED	ORGANI Z	ATIONS A	AND HOME	Provi der	CCN: 1	5-1319	Peri od:		Worksheet	A-8	-1
OFFICE	COSTS									From 10/01/2		İ		
										To 09/30/2	2017	Date/Time		
										L .		2/26/2018	3 1: 2	3 pm
	Net	Wkst. A-7 Ref.												
	Adjustments													
	(col. 4 minus													
	col. 5)*													
	6. 00	7. 00												
	A. COSTS INCUR	RED AND ADJUSTI	MENTS RE	QUI RED AS	S A RESU	JLT OF TR	ANSACTI ONS	WITH	RELATED	ORGANI ZATI ONS	OR	CLAIMED H	OME	
	OFFICE COSTS:													
1.00	887, 197	0												1.00
2.00	2, 597, 547	0												2.00
3.00	97, 642	0												3.00
4.00	60, 876	0												4.00
4. 01	310, 329	0												4.01
4. 02	50, 057	0	•											4.02
4. 03	141, 408	0												4.03
4 04	-103 028	1												4 04

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

5.00

1100 110	t boom pooted to normaneet m	der amin's 1 and 51 27 the amount allowable should be that eated the set amin't ell the parti	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	Type of business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOME OFFICE	6.00
7.00		7. 00
8. 00 9. 00 10. 00		8. 00
9.00		9. 00
10.00		10.00
100.00		100.00

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

4, 042, 028

5.00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-1319

					-	To 09/30/201	7 Date/Time Pro 2/26/2018 1::	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7.00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	721	721	1 C	C	0	1.00
2.00	30. 00	ADULTS & PEDIATRICS	53, 899	53, 899	9	C	0	2.00
3.00	54. 00	RADI OLOGY-DI AGNOSTI C	812	812		C	0	3.00
4.00	60.00	LABORATORY	40, 000	(40, 000	C	0	4.00
5.00	65. 00	RESPI RATORY THERAPY	70, 637	70, 637	7 C	C	0	5.00
6.00	90. 03	PAIN MANAGEMENT	1, 588	1, 588	3	C	0	6.00
7.00	91. 00	EMERGENCY	383, 083	(383, 083	C	0	7. 00
8.00	0.00		0	(0	C	0	8. 00
9.00	0.00		0	(0	C	0	9.00
10.00	0.00		0	(0	C	0	10.00
200.00			550, 740	127, 657	423, 083		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		ldentifier	Limit	Unadjusted RCE	Memberships &		of Malpractice	:
				Li mi t	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADMINISTRATIVE & GENERAL	0		-	1		
2. 00	30. 00 ADULTS & PEDIATRICS		0	1	-	C	ή	
3. 00		RADI OLOGY-DI AGNOSTI C	0	(0) C	0	
4. 00		LABORATORY	0	(0) C	0	
5.00		RESPI RATORY THERAPY	0	(0) C	0	
6. 00		PAIN MANAGEMENT	0	(0	0	0	0.00
7. 00		EMERGENCY	0	(0	0	0	
8. 00	0.00		0	(0) C	0	0.00
9. 00	0. 00		0	(0) C	0	
10. 00	0. 00		0	(0) C	0	
200.00			0	(0	C	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	+	
1. 00		ADMINI STRATI VE & GENERAL	15.00					1. 00
2.00		ADULTS & PEDIATRICS			-	53, 899	1	2.00
3. 00		RADI OLOGY-DI AGNOSTI C				812		3. 00
4. 00		LABORATORY				012	1	4.00
5. 00		RESPIRATORY THERAPY				70, 637	1	5.00
6. 00		PAIN MANAGEMENT				1, 588		6.00
7. 00		EMERGENCY				1, 300	1	7.00
8. 00	0.00	LINEIXOLINOT						8.00
9. 00	0.00							9.00
10.00	0.00							10.00
200.00	0.00					127, 657	,	200.00
200.00	1 1		1	1	٠, ١	127,037	I	200.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2016 | Part I | To 09/30/2017 | Date/Time Prepared: Provi der CCN: 15-1319

				Ť	o 09/30/2017	Date/Time Pre 2/26/2018 1:2	
			CAPI TAL REI	ATED COSTS		2/20/2010 1.2	3 pili
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)	1.00	0.00	4.00		
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	4. 00	4A	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	1, 733, 873	1, 733, 873				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	1, 733, 673	1, 733, 073	0			2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 647, 178	13, 737				4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	6, 879, 126	84, 561	Ö		7, 158, 167	5. 00
7. 00	00700 OPERATION OF PLANT	1, 054, 144	328, 293	Ö		1, 401, 756	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	82, 960				118, 960	8.00
9.00	00900 HOUSEKEEPI NG	397, 478	17, 408	0		448, 791	9.00
10.00	01000 DI ETARY	390, 721	41, 344	0	26, 052	458, 117	10.00
11.00	01100 CAFETERI A	234, 071	37, 862	0	23, 900	295, 833	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	233, 831	5, 222			259, 226	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	429, 353	25, 223	0	31, 997	486, 573	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			_			
30.00	03000 ADULTS & PEDI ATRI CS	1, 461, 892				1, 750, 476	1
31.00	03100 NTENSI VE CARE UNI T	128, 167	36, 632		·	173, 132	1
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	4 400 707	0/ 57/		00.004	4 070 754	F0 00
50. 00 54. 00	O5000 OPERATI NG ROOM O5400 RADI OLOGY-DI AGNOSTI C	1, 193, 797	96, 576			1, 372, 754	1
54.00	05400 RADI OLOGY - DI AGNOSTI C 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	1, 251, 297 122, 820	66, 150 7, 947			1, 396, 030 130, 767	1
60.00	06000 LABORATORY	1, 366, 273	28, 950			1, 477, 436	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	58, 837	20, 750		,	58, 837	
65. 00	06500 RESPIRATORY THERAPY	718, 105	30, 502		-	799, 669	1
66.00	06600 PHYSI CAL THERAPY	930, 506				1, 069, 140	1
67. 00	06700 OCCUPATI ONAL THERAPY	277, 609				322, 544	1
68. 00	06800 SPEECH PATHOLOGY	147, 237	1, 173			163, 605	1
69.00	06900 ELECTROCARDI OLOGY	0	0	1		0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	182, 442	67, 910	0	0	250, 352	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	148, 130	0	0	0	148, 130	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 764, 643	19, 149	0	14, 509	1, 798, 301	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	12, 154	0			13, 015	1
90.00	09000 CLINIC	0	0	1	-	0	90.00
90. 01	09001 DI ABETES	6, 000	26, 453		-	32, 453	
90. 02	09002 OP PSYCH	242 ((0	0	·	-	0	90.02
90. 03 91. 00	09003 PAIN MANAGEMENT 09100 EMERGENCY	243, 669		0		260, 937	90. 03 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 501, 257	167, 438	U	99, 677	1, 768, 372 0	1
92.00	OTHER REIMBURSABLE COST CENTERS					U	92.00
101 00	10100 HOME HEALTH AGENCY	431, 238	9, 555	0	38, 156	478, 949	101 00
101.00	SPECIAL PURPOSE COST CENTERS	101, 200	7,000		55, 155	170, 717	11011.00
113.00	11300 INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	25, 028, 808	1, 366, 412	0	1, 091, 890	24, 092, 322	118.00
	NONREI MBURSABLE COST CENTERS						
	07950 MOB	4, 800, 668	162, 254	0	402, 529	5, 365, 451	194. 00
	07951 FOUNDATI ON	55, 037	24, 769	0	6, 541	86, 347	
	07952 ASC	0	0	0	-		194. 02
	07953 SNF - PERRY CO.	1, 730, 697	180, 438	0	159, 955	2, 071, 090	
200.00	1 1						200.00
201.00	1 1 0	04 /45 040	0	1			201.00
202.00	TOTAL (sum lines 118 through 201)	31, 615, 210	1, 733, 873	0	1, 660, 915	31, 615, 210	J202. 00

Provider CCN: 15-1319

Peri od: Worksheet B From 10/01/2016 Part I To 09/30/2017 Date/Ti me Prepared: 2/26/2018 1: 23 pm

				''	077 007 2017	2/26/2018 1: 2	3 pm
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	7, 158, 167					5. 00
7. 00	00700 OPERATION OF PLANT	410, 270	1, 812, 026				7. 00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	34, 818	42, 751	196, 529			8. 00
9. 00	00900 HOUSEKEEPI NG	131, 353	24, 129		604, 273		9. 00
10.00	01000 DI ETARY	134, 083	57, 307	Ö	19, 843	669, 350	10.00
11. 00	01100 CAFETERI A	86, 585	52, 481	Ö	18, 172	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	75, 871	7, 239		2, 506	0	13. 00
16. 00		142, 412	34, 961	Ö	12, 106	0	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	112, 112	01, 701		12, 100	J	10.00
30. 00		512, 335	214, 593	21, 850	74, 305	74, 419	30.00
31.00		50, 673	50, 776		17, 582	3, 540	31. 00
44. 00	l i	0	0		17, 302	0, 340	44. 00
44.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		0	<u> </u>	0	44.00
50.00	05000 OPERATING ROOM	401, 782	133, 865	0	46, 352	0	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	408, 594	91, 691	0	31, 749	0	54.00
54. 03	05401 NUCLEAR MEDICINE-DI AGNOSTI C	38, 273	11, 016		3, 814	0	54.03
60.00		432, 420	40, 128		13, 895	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	17, 221	40, 128		13, 673	0	62.00
65.00		234, 050	42, 279	_	14, 639	0	65. 00
66.00		312, 919	73, 725		25, 528	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	94, 403	73, 723 21, 454		7, 429	0	67. 00
68.00	06800 SPEECH PATHOLOGY	1			7, 429 563	0	68. 00
		47, 884	1, 626		563	-	
69.00		72 274	04 120		9	0	69.00
71.00		73, 274	94, 130		32, 593	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	43, 355	0	-	0 100	0	72.00
73. 00		526, 332	26, 542	0	9, 190	0	73. 00
	OUTPATIENT SERVICE COST CENTERS				اء		
88.00	08800 RURAL HEALTH CLINIC	3, 809	0		0	0	88. 00
90.00	09000 CLI NI C	0	0	_	0	0	90.00
90. 01	09001 DI ABETES	9, 498	36, 666		12, 696	0	90. 01
90. 02	09002 OP PSYCH	0	0		0	0	90. 02
90. 03		76, 372	0	0	0	0	90. 03
91.00		517, 572	232, 086	0	80, 362	0	91.00
92. 00							92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	0 10100 HOME HEALTH AGENCY	140, 180	13, 245	0	4, 586	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	0 11300 I NTEREST EXPENSE						113. 00
118.00	- 122 2 2 (22 2 2 2 2 2 2 2 2 2 2 2 2 2 2	4, 956, 338	1, 302, 690	22, 889	427, 910	77, 959	118. 00
	NONREI MBURSABLE COST CENTERS						
	0 07950 MOB	1, 570, 384	224, 900		77, 874		194. 00
	1 07951 FOUNDATI ON	25, 272	34, 332		11, 888		194. 01
	2 07952 ASC	0	0	_	0		194. 02
	3 07953 SNF - PERRY CO.	606, 173	250, 104	173, 640	86, 601	591, 391	
200.00	1 1						200. 00
201.00		0	0	0	0		201. 00
202.00	0 TOTAL (sum lines 118 through 201)	7, 158, 167	1, 812, 026	196, 529	604, 273	669, 350	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2016 | Part I | To 09/30/2017 | Date/Time Prepared: Provi der CCN: 15-1319

				To	09/30/2017	Date/Time Pre 2/26/2018 1:2	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	<u>σ μ</u>
		11. 00	13. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 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	453, 071					11.00
13.00	01300 NURSING ADMINISTRATION	8, 582	353, 424				13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	13, 613	0	689, 665			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	56, 910			2, 823, 593	0	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 545	6, 906		307, 923	0	31.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00	05000 OPERATING ROOM	35, 049	22, 688	55, 692	2, 068, 182	0	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	33, 433	0		2, 083, 015	0	54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	ő		187, 578	0	54. 03
60.00	06000 LABORATORY	34, 977	О		2, 100, 800	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1, 297	77, 355	0	62.00
65.00	06500 RESPI RATORY THERAPY	21, 724	0	,	1, 145, 549	0	65.00
66.00	06600 PHYSI CAL THERAPY	36, 352	0	,	1, 576, 177	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	12, 532	0	,	478, 023	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 464	0	-,	228, 149 0	0	68. 00 69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	-	455, 566	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		196, 235	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 173	1		2, 421, 761	0	73.00
	OUTPATIENT SERVICE COST CENTERS			, ,	, , , ,		
88. 00	08800 RURAL HEALTH CLINIC	0	0	184	17, 008	0	88. 00
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 01	09001 DI ABETES	0	0		91, 643	0	90. 01
90. 02	09002 OP PSYCH	0	11 270	0 111	0	0	90. 02
90. 03 91. 00	09003 PAIN MANAGEMENT	6, 062 42, 407	11, 279 73, 292		363, 761 2, 802, 559	0	90. 03 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	42, 407	13, 292	00, 400	2, 602, 559	0	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	16, 234	19, 231	7, 029	679, 454	0	101. 00
	SPECIAL PURPOSE COST CENTERS		,	, -			
113.00	11300 INTEREST EXPENSE						113.00
118.00		334, 057	230, 785	595, 886	20, 104, 331	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	07950 MOB	48, 179	1	72, 951	7, 376, 810		194.00
	07951 FOUNDATI ON 07952 ASC	2, 783 0	0		160, 622		194. 01 194. 02
	07952 ASC 07953 SNF - PERRY CO.	68, 052		l ĭ	3, 973, 447		194. 02 194. 03
200.00		00,032	105, 500	20, 020	3, 973, 447		200. 00
201.00	1 1	0	0	0	ő		201.00
202.00		453, 071	353, 424	-	31, 615, 210		202.00
			. '	. '			

Health Financial Systems In Lieu of Form CMS-2552-10 GIBSON GENERAL HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1319 Peri od: Worksheet B From 10/01/2016

Part I

194.01

194.02

194. 03

200. 00

201.00

202.00

09/30/2017 Date/Time Prepared: 2/26/2018 1:23 pm Cost Center Description Total 26. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 823, 593 30.00 31.00 03100 INTENSIVE CARE UNIT 307, 923 31.00 04400 SKILLED NURSING FACILITY 44 00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 068, 182 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 083, 015 54.00 54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 187, 578 54 03 60.00 06000 LABORATORY 2, 100, 800 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 77, 355 62.00 06500 RESPIRATORY THERAPY 1, 145, 549 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 1, 576, 177 66.00 06700 OCCUPATI ONAL THERAPY 478, 023 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 228, 149 68.00 06900 ELECTROCARDI OLOGY 69 00 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 455, 566 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 196, 235 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 2, 421, 761 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 17,008 88.00 90.00 09000 CLI NI C 90.00 0 09001 DI ABETES 90.01 91, 643 90.01 09002 OP PSYCH 90.02 0 90.02 90.03 09003 PAIN MANAGEMENT 363, 761 90.03 91.00 09100 EMERGENCY 2, 802, 559 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 679, 454 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 20, 104, 331 118.00 NONREI MBURSABLE COST CENTERS 194, 00 07950 MOB 7, 376, 810 194.00

160, 622

3, 973, 447

31, 615, 210

0

0

194. 01 07951 FOUNDATI ON

194.03 07953 SNF - PERRY CO.

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

194. 02 07952 ASC

200.00

201.00

202.00

| Period: | Worksheet B | From 10/01/2016 | Part II | To 09/30/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1319

				Io	09/30/2017	Date/lime Pre 2/26/2018 1:2	
			CAPITAL RELATED COSTS			2/20/2010 1.2	J DIII
			CALLIAE RELATED COSTS				
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	13, 737	0	13, 737	13, 737	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	84, 561	0	84, 561	1, 608	5.00
7.00	00700 OPERATION OF PLANT	0	328, 293	0	328, 293	160	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	30, 842	0	30, 842	43	8. 00
9.00	00900 HOUSEKEEPI NG	0	17, 408	0	17, 408	280	9. 00
10.00	01000 DI ETARY	0	41, 344		41, 344	215	10.00
11. 00	01100 CAFETERI A	0	37, 862	0	37, 862	198	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	5, 222		5, 222	167	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	25, 223	0	25, 223	265	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0			154, 818	1, 106	30.00
31.00	03100 INTENSIVE CARE UNIT	0	36, 632		36, 632	69	31.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	96, 576		96, 576	681	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	66, 150		66, 150	650	54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	7, 947	0	7, 947	0	54.03
60.00	06000 LABORATORY	0	28, 950		28, 950	680	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	30, 502		30, 502	422	65.00
66.00	06600 PHYSI CAL THERAPY	0	53, 189	0	53, 189	706	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	15, 478		15, 478	244	67.00
68.00	06800 SPEECH PATHOLOGY	0	1, 173		1, 173	126	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	67, 910		67, 910	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	-	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	19, 149	0	19, 149	120	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS		0		ما		00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	7	88. 00
90. 00 90. 01	09000 CLI NI C 09001 DI ABETES	0	0	1	0	0	90. 00 90. 01
90.01	09001 DLABETES	0	26, 453		26, 453 0	0	90.01
90. 02	09002 OP PSYCH	0	0		0	143	90.02
90.03	09100 EMERGENCY	0	_		- ا	824	90.03
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	U	167, 438	۷	167, 438	824	91.00
92.00	OTHER REIMBURSABLE COST CENTERS				υĮ		92.00
101 00	10100 HOME HEALTH AGENCY	0	9, 555	0	9, 555	215	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	U	9, 555	U U	9, 555	315	101.00
112 00	11300 INTEREST EXPENSE						113. 00
118.00		0	1, 366, 412	0	1, 366, 412	0.020	118.00
110.00	NONREI MBURSABLE COST CENTERS	U	1, 300, 412	U U	1, 300, 412	7, 027	110.00
10/ 00	07950 MOB	0	162, 254	0	162, 254	3 333	194. 00
	07950 MOB 07951 FOUNDATI ON	0	24, 769		24, 769		194. 00
	207952 ASC		24, 709	0	24, 709		194. 01
	07952 ASC 307953 SNF - PERRY CO.		180, 438		180, 438		194. 02
200.00			100, 430		100, 430	1, 322	200.00
200.00	, ,		0	0	0	Λ	200.00
202.00		0	1, 733, 873		1, 733, 873	13, 737	
202.00	TOTAL (Sum TITIES TTO THEOUGH 201)	١	1, 133, 013	ı	1, 133, 013	13, 131	1202.00

Provider CCN: 15-1319

Peri od: Worksheet B From 10/01/2016 Part II To 09/30/2017 Date/Time Prepared:

				10	0 09/30/2017	2/26/2018 1: 2	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	'	E & GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	86, 169					5.00
7.00	00700 OPERATION OF PLANT	4, 938	333, 391				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	419	7, 866	39, 170			8.00
9.00	00900 HOUSEKEEPI NG	1, 581	4, 439	0	23, 708		9.00
10.00	01000 DI ETARY	1, 614	10, 544	0	779	54, 496	10.00
11.00	01100 CAFETERI A	1, 042	9, 656	0	713	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	913	1, 332	0	98		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 714	6, 432	0	475	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 167	39, 482				30.00
31.00	03100 INTENSIVE CARE UNIT	610	9, 342		690		31.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 836	24, 630		·	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 918	16, 870		., =	0	54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	461	2, 027				54.03
60.00	06000 LABORATORY	5, 205	7, 383			0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	207	0	_	0	_	62.00
65.00	06500 RESPI RATORY THERAPY	2, 817	7, 779		574	0	65.00
66.00	06600 PHYSI CAL THERAPY	3, 767	13, 565			0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 136	3, 947	0	291	0	67.00
68.00	06800 SPEECH PATHOLOGY	576	299	0	22	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	-	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	882	17, 319		•		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	522	0	0		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	6, 335	4, 883	0	361	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	46	0				88. 00
90.00	09000 CLI NI C	0	0			_	90.00
90. 01	09001 DI ABETES	114	6, 746			0	90. 01
90. 02	09002 OP PSYCH	0	0	_	0	0	90.02
90. 03	09003 PAIN MANAGEMENT	919	0			0	90. 03
91.00	09100 EMERGENCY	6, 230	42, 701	0	3, 153	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS			T			
101. 00	10100 HOME HEALTH AGENCY	1, 687	2, 437	0	180	0	101. 00
	SPECIAL PURPOSE COST CENTERS	T					
	11300 I NTEREST EXPENSE						113.00
118. 00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	59, 656	239, 679	4, 562	16, 790	6, 347	118. 00
404.00	NONREI MBURSABLE COST CENTERS	10.010	44.070		0.055		
	07950 MOB	18, 913	41, 379		·		194.00
	07951 FOUNDATI ON	304	6, 317				194. 01
	07952 ASC	0	0	_	0		194. 02
	07953 SNF - PERRY CO.	7, 296	46, 016	34, 608	3, 397		
200.00	,	_	_		_		200.00
201.00	1 0	0	0		0		201.00
202. 00	TOTAL (sum lines 118 through 201)	86, 169	333, 391	39, 170	23, 708	54, 496	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2016 | Part II | To 09/30/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1319

				أ	To 09/30/2017	Date/Time Pre 2/26/2018 1:2	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11. 00	13. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS		ı	Г	T		
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL						4. 00 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	49, 471					11.00
13.00	01300 NURSING ADMINISTRATION	937	8, 669				13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 486	0	35, 595	5		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 214	2, 314			0	30.00
31. 00 44. 00	03100 I NTENSI VE CARE UNI T	387 0	169			0	31.00 44.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0		0	U	44.00
50.00	05000 OPERATING ROOM	3, 827	556	2, 875	135, 800	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 650				0	54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	o o			0	54. 03
60.00	06000 LABORATORY	3, 819	0	5, 262		0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	67	274	0	62.00
65.00	06500 RESPI RATORY THERAPY	2, 372	0	.,,,,		0	65.00
66.00	06600 PHYSI CAL THERAPY	3, 969	0	-,		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 368	0	.,		0	67.00
68.00	06800 SPEECH PATHOLOGY	706 0	0			0	68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0			0	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	674	74			Ö	73.00
	OUTPATIENT SERVICE COST CENTERS		'				
88. 00	08800 RURAL HEALTH CLINIC	0	0	10	63	0	88. 00
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
90. 03 91. 00	09003 PAIN MANAGEMENT 09100 EMERGENCY	662 4, 630	277 1, 798			0	90. 03 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 030	1, 790	4, 300	231, 340	0	91.00
72.00	OTHER REIMBURSABLE COST CENTERS			l		0	72.00
101.00	10100 HOME HEALTH AGENCY	1, 772	472	363	16, 781	0	101. 00
	SPECIAL PURPOSE COST CENTERS	·		•			
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	36, 473	5, 660	30, 755	1, 130, 957	0	118. 00
194.00	07950 MOB	5, 260	419	3, 765	238, 377	0	194. 00
	07951 FOUNDATI ON	304	0				194. 01
	07952 ASC	_ 0	0	`	-		194. 02
	07953 SNF - PERRY CO.	7, 434	2, 590	1, 075			194. 03
200. 00 201. 00	3	^	0	(0		200. 00 201. 00
201.00		49, 471			1		201.00
202.00	1 1017/2 (Sum 111103 110 till bugil 201)	77,471	0,007	1 33, 370	, 1, 133, 013	ı	1202.00

Peri od: Worksheet B From 10/01/2016 Part II To 09/30/2017 Date/Time Prepared:

			2/26/2018 1:3	
	Cost Center Description	Total	1 = 1 = 0 = 0 = 0	
	, , , , , , , , , , , , , , , , , , ,	26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 00	00500 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
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			10.00
30.00	03000 ADULTS & PEDIATRICS	224, 687		30.00
31.00	03100 INTENSIVE CARE UNIT	48, 432		31.00
44. 00	04400 SKILLED NURSING FACILITY	40, 432		44.00
44.00		U		44.00
EO 00	ANCILLARY SERVICE COST CENTERS	125 000		F0 00
50.00	05000 OPERATING ROOM	135, 800		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	99, 754		54.00
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	10, 776		54.03
60.00	06000 LABORATORY	51, 844		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	274		62.00
65.00	06500 RESPI RATORY THERAPY	46, 179		65.00
66.00	06600 PHYSI CAL THERAPY	79, 218		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	23, 479		67.00
68. 00	06800 SPEECH PATHOLOGY	3, 315		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	87, 659		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	767		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	34, 290		73. 00
	OUTPATIENT SERVICE COST CENTERS			
88. 00	08800 RURAL HEALTH CLINIC	63		88. 00
90.00	09000 CLI NI C	0		90.00
90. 01	09001 DI ABETES	33, 828		90. 01
90. 02	09002 OP PSYCH	0		90. 02
90. 03	09003 PAIN MANAGEMENT	2, 471		90. 03
91.00	09100 EMERGENCY	231, 340		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY	16, 781		101. 00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 I NTEREST EXPENSE			113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 130, 957		118.00
	NONREI MBURSABLE COST CENTERS			
194.00	07950 MOB	238, 377		194. 00
	07951 FOUNDATI ON	32, 214		194. 01
	07952 ASC	0		194. 02
	07953 SNF - PERRY CO.	332, 325		194. 03
200.00		0		200.00
201.00	,	n		201.00
202.00		1, 733, 873		202.00
	1 1 1 1 2 (34 1 1 1 1 3 3 1 1 3 3 3 1 2 0 1)	., ,		1-02.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1319 Peri od: Worksheet B-1 From 10/01/2016 09/30/2017 Date/Time Prepared: 2/26/2018 1:23 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS F & GENERAL n (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 91, 634 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 91, 634 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 966, 725 4.00 726 726 4.00 00500 ADMINISTRATIVE & GENERAL 1, 518, 299 24, 457, 043 5.00 4.469 4, 469 -7, 158, 167 5.00 7.00 00700 OPERATION OF PLANT 17, 350 17, 350 150, 824 1, 401, 756 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1,630 1,630 40, 266 0 118, 960 8.00 00900 HOUSEKEEPI NG 920 0 448. 791 9.00 9 00 920 264 694 2, 185 0 10.00 01000 DI ETARY 2, 185 203, 390 458, 117 10.00 11.00 01100 CAFETERI A 2,001 2,001 186, 586 0 295, 833 11.00 13.00 01300 NURSING ADMINISTRATION 276 276 157, 488 0 259, 226 13.00 01600 MEDICAL RECORDS & LIBRARY 249, 799 333 1.333 486, 573 16 00 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 182 8, 182 1, 044, 301 0 1, 750, 476 30.00 03100 INTENSIVE CARE UNIT ol 31.00 31.00 1,936 1, 936 65,053 173, 132 04400 SKILLED NURSING FACILITY 44.00 44.00 C 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 5, 104 5, 104 643, 143 1, 372, 754 50.00 05400 RADI OLOGY-DI AGNOSTI C 3, 496 3, 496 0 54 00 613, 494 1, 396, 030 54 00 0 54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 420 420 0 130, 767 54.03 06000 LABORATORY 0 1, 477, 436 60.00 1.530 1,530 641, 832 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 58, 837 62.00 0 06500 RESPIRATORY THERAPY 398 637 799, 669 65.00 1 612 1 612 65 00 66.00 06600 PHYSI CAL THERAPY 2,811 2,811 667,062 1, 069, 140 66.00 06700 OCCUPATI ONAL THERAPY 818 229, 967 0 322, 544 67.00 818 67.00 0 06800 SPEECH PATHOLOGY 68.00 118, 623 163, 605 68.00 62 62 06900 ELECTROCARDI OLOGY 69.00 0 C 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3,589 3, 589 0 0 250, 352 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 148, 130 72.00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 73.00 1,012 1, 012 1<u>, 798, 301</u> 113, 271 73.00 88.00 08800 RURAL HEALTH CLINIC 6,718 0 13,015 88.00 o 90.00 09000 CLI NI C 0 0 0 90.00 09001 DI ABETES 1, 398 1, 398 0 90.01 90.01 0 32, 453 0 90.02 09002 OP PSYCH \cap 90.02 260, 937 90.03 09003 PAIN MANAGEMENT 134, 814 0 90.03 09100 EMERGENCY 8,849 8, 849 0 91.00 91.00 778, 171 1, 768, 372 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 505 505 297, 885 0 478, 949 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 72, 214 72, 214 8, 524, 317 -7, 158, 167 16, 934, 155 118. 00 NONREI MBURSABLE COST CENTERS 5, 365, 451 194. 00 194, 00 07950 MOB 3, 142, 581 8 575 8.575 194. 01 07951 FOUNDATI ON 1, 309 1, 309 51,064 0 86, 347 194. 01 194. 02 07952 ASC 0 194. 02 0 2, 071, 090 194. 03 194. 03 07953 SNF - PERRY CO. 9.536 9.536 1, 248, 763 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 733, 873 1,660,915 7, 158, 167 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 203 00 18. 921721 0.000000 0.128091 0. 292683 203. 00 204.00 Cost to be allocated (per Wkst. B, 86, 169 204. 00 13, 737 Part II) 0.003523 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.001059 11)

	ULOCATION CTATICTICAL DAGIC	OI DOON OLIVLIA		CN 15 1010 I		Wassissian D 1	
COST	ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-1319 1	Period: From 10/01/2016	Worksheet B-1	
					To 09/30/2017	Date/Time Pre	pared:
					.0 07,00,2017	2/26/2018 1: 2	23 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(PATI ENT	(GROSS	
		(SQUARE FEET)	(PATI ENT		DAYS)	SALARI ES)	
			DAYS)				
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	69, 089					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 630	15, 884				8.00
9.00	00900 HOUSEKEEPI NG	920	0		9		9.00
10.00	01000 DI ETARY	2, 185	0	1			10.00
11.00	01100 CAFETERI A	2, 001	0	1		8, 313, 873	11.00
13. 00	01300 NURSING ADMINISTRATION	276	0	1		157, 488	
	01600 MEDICAL RECORDS & LIBRARY	1, 333	0			249, 799	
	INPATIENT ROUTINE SERVICE COST CENTERS	,		,	-		
30.00	03000 ADULTS & PEDIATRICS	8, 182	1, 766	8, 182	1, 766	1, 044, 301	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 936	84	1		65, 053	
	04400 SKILLED NURSING FACILITY	o	0			0	
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		'	· _ · · · · · · · · · · · · · · · · · ·		
50.00	05000 OPERATI NG ROOM	5, 104	0	5, 104	1 0	643, 143	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 496	0	i .		613, 494	
54. 03	05401 NUCLEAR MEDICINE-DI AGNOSTI C	420	0			0.0, 171	1
60.00	06000 LABORATORY	1, 530	0	l .		641, 832	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			011,002	1
65. 00	06500 RESPIRATORY THERAPY	1, 612	0		1	398, 637	
66. 00	06600 PHYSI CAL THERAPY	2, 811	0	.,		667, 062	1
67. 00	06700 OCCUPATI ONAL THERAPY	818	0	818		229, 967	
68. 00	06800 SPEECH PATHOLOGY	62	0	1		118, 623	
69.00	06900 ELECTROCARDI OLOGY	0	0			0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 589	0		-	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	3,307	0			0	I
		1, 012	0	1		113, 271	1
70.00	OUTPATIENT SERVICE COST CENTERS	1,012		1,012		110, 271	70.00
88. 00	08800 RURAL HEALTH CLINIC	O	0	(0	0	88. 00
90. 00	09000 CLINIC		0	1		0	1
90. 01	09001 DI ABETES	1, 398	0	1, 398	-	0	1
90. 02	09002 OP PSYCH	0	0	., 5,		0	1
90. 03	09003 PAIN MANAGEMENT		0	•	0	111, 230	
91. 00	09100 EMERGENCY	8, 849	0	8, 849		778, 171	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART]	_			,	92.00
	OTHER REIMBURSABLE COST CENTERS	l.					1
101.00	10100 HOME HEALTH AGENCY	505	0	50!	5 0	297, 885	101.00
	SPECIAL PURPOSE COST CENTERS		-		-1	=,	1
113.00	11300 INTEREST EXPENSE						113.00
118.00	1 1	49, 669	1, 850	47, 119	1, 850	6, 129, 956	1
	NONREI MBURSABLE COST CENTERS	,	.,,		., ., ., .,	5, 121, 100	
194.00	07950 MOB	8, 575	0	8, 57	5 0	884, 090	194. 00
	07951 FOUNDATI ON	1, 309	0				194. 01
	07952 ASC	0	0	1			194. 02
	07953 SNF - PERRY CO.	9, 536	14, 034	9, 536	14, 034		
200.00			.,			,,	200.00
201.00	, ,						201.00
202.00		1, 812, 026	196, 529	604, 273	669, 350	453, 071	
	Part I)	1, 512, 523	,			,	
203.00		26. 227417	12. 372765	9. 081486	42. 139889	0. 054496	203.00
204.00		333, 391	39, 170				204.00
	Part II)		- ,				
205.00		4. 825529	2. 466004	0. 356302	3. 430874	0. 005950	205.00
		·			·		

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1319 Peri od: Worksheet B-1 From 10/01/2016 09/30/2017 Date/Time Prepared: 2/26/2018 1:23 pm Cost Center Description NURSI NG MEDI CAL ADMI NI STRATI O RECORDS & LI BRARY Ν (NURSE (GROSS SALARIES) PATI ENT REVENUE) 13. 00 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 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 3, 435, 616 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 57, 416, 461 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 917, 230 2,027,081 30.00 03100 INTENSIVE CARE UNIT 31.00 67, 136 60, 811 31.00 04400 SKILLED NURSING FACILITY 44.00 44 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 220, 547 4, 636, 383 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 10, 117, 980 54.00 0 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 54 03 308, 669 54 03 60.00 06000 LABORATORY 0 8, 486, 826 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 107, 981 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 0 0 2, 762, 903 65.00 06600 PHYSI CAL THERAPY 4, 871, 229 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 1, 636, 803 67.00 06800 SPEECH PATHOLOGY 0 68.00 666, 560 68.00 0 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 434, 340 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 395, 406 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 29, 479 4, 344, 839 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 15, 326 88.00 09000 CLI NI C 0 90.00 90.00 90.01 09001 DI ABETES 0 27, 482 90.01 09002 OP PSYCH 90.02 0 90.02 90.03 09003 PAIN MANAGEMENT 109, 639 758, 526 90.03 91.00 09100 EMERGENCY 712, 465 7, 365, 000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 186, 939 585, 171 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 2, 243, 435 49, 609, 316 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MOB 165, 945 194.00 6, 073, 192 194. 01 07951 FOUNDATI ON 194.01 194. 02 07952 ASC 194.02 194. 03 07953 SNF - PERRY CO. 194. 03 1,026,236 1, 733, 953 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 353, 424 689, 665 202.00

0.102871

0.002523

8,669

0.012012

0.000620

35, 595

203.00 204.00

205.00

Part I)

Part II)

II)

Unit cost multiplier (Wkst. B, Part I)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

203.00

204.00

205.00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1319	Peri od: Worksheet C From 10/01/2016 Part I To 09/30/2017 Date/Time Prepared:

					To 09/30/2017		
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	TENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	2, 823, 593		2, 823, 59		_	30.00
	INTENSIVE CARE UNIT	307, 923		307, 92			31.00
	SKILLED NURSING FACILITY	0			0	0	44.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	2, 068, 182		2, 068, 18		0	50.00
	RADI OLOGY-DI AGNOSTI C	2, 083, 015		2, 083, 01		0	54.00
	NUCLEAR MEDICINE-DIAGNOSTIC	187, 578		187, 57		0	54.03
	LABORATORY	2, 100, 800		2, 100, 80		0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	77, 355		77, 35	5 0	0	62.00
65.00 06500	RESPIRATORY THERAPY	1, 145, 549	0	1, 145, 54	9 0	0	65.00
66.00 06600	PHYSI CAL THERAPY	1, 576, 177	0	1, 576, 17	7 0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	478, 023	0	478, 02	3 0	0	67.00
68.00 06800	SPEECH PATHOLOGY	228, 149	0	228, 14	9 0	0	68. 00
69. 00 06900	ELECTROCARDI OLOGY	O			0	0	69. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	455, 566		455, 56	6 0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	196, 235		196, 23	5 0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2, 421, 761		2, 421, 76	1 0	0	73.00
OUTPA	TIENT SERVICE COST CENTERS						1
88. 00 08800	RURAL HEALTH CLINIC	17, 008		17, 00	8 0	0	88. 00
90.00 09000	CLINIC	0			0	0	90.00
90. 01 09001	DI ABETES	91, 643		91, 64	3 0	0	90. 01
90. 02 09002	OP PSYCH	0			0	0	90. 02
90. 03 09003	PAIN MANAGEMENT	363, 761		363, 76	1 0	0	90. 03
91.00 09100	EMERGENCY	2, 802, 559		2, 802, 55	9 0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	640, 110		640, 11	0	0	92.00
OTHER	R REIMBURSABLE COST CENTERS						1
101.00 10100	HOME HEALTH AGENCY	679, 454		679, 45	4	0	101.00
	AL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	20, 744, 441	0	20, 744, 44	1 0	0	200.00
201.00	Less Observation Beds	640, 110		640, 11		0	201.00
202.00	Total (see instructions)	20, 104, 331	0	1		0	202.00
•				•		-	•

Health Financial Systems	GI BSON GENERAL HOSPI TAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1319	Period: Worksheet C From 10/01/2016 Part I
		To 09/30/2017 Date/Time Prepared:

				To 09/30/2017	Date/Time Pre 2/26/2018 1:2	
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. (Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7.00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 815, 226		1, 815, 22	6		30.00
31.00 03100 INTENSIVE CARE UNIT	60, 812		60, 81	2		31.00
44.00 O4400 SKILLED NURSING FACILITY	0			0		44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	272, 780	4, 363, 603	4, 636, 38		0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	292, 578	9, 825, 402	10, 117, 98	0. 205873	0.000000	54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	18, 134	290, 535	308, 66	9 0. 607700	0.000000	54.03
60. 00 06000 LABORATORY	970, 131	7, 516, 695	8, 486, 82	6 0. 247537	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	24, 473	83, 508	107, 98	0. 716376	0.000000	62.00
65.00 06500 RESPIRATORY THERAPY	558, 320	2, 204, 583	2, 762, 90	0. 414618	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	834, 407	4, 036, 822	4, 871, 22	9 0. 323569	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	366, 863	1, 269, 940	1, 636, 80	0. 292047	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	45, 319	621, 241	666, 56	0. 342278	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	O	0		0. 000000	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	226, 279	208, 061	434, 34	0 1. 048870	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	51, 357	344, 049	395, 40	6 0. 496287	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	667, 770	3, 677, 069	4, 344, 83	9 0. 557388	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	15, 326	15, 32	6		88. 00
90. 00 09000 CLI NI C	o	0	1	0. 000000	0.000000	90.00
90. 01 09001 DI ABETES	o	27, 482	27, 48	2 3. 334655	0.000000	90. 01
90.02 09002 OP PSYCH	o	0	1	0. 000000	0.000000	90.02
90. 03 09003 PAI N MANAGEMENT	o	757, 014	757, 01	4 0. 480521	0.000000	90.03
91. 00 09100 EMERGENCY	122, 064	7, 242, 936	7, 365, 00	0. 380524	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 921	796, 621	807, 54	2 0. 792665	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS	,					1
101.00 10100 HOME HEALTH AGENCY	0	585, 171	585, 17	1		101.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	6, 337, 434	43, 866, 058	50, 203, 49	2		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	6, 337, 434	43, 866, 058	50, 203, 49	2		202.00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1319		Worksheet C Part I Date/Time Prepared: 2/26/2018 1:23 pm
	T1 11 30 (11)		

INPATIENT ROUTINE SERVICE COST CENTERS 11.00						2/26/2018 1::	23 pm
NPATI ENT ROUTI NE SERVI CE COST CENTERS 11.00				Title XVIII	Hospi tal	Cost	
NPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 31.00 31.00 03100 INTERNSI VE CARE UNIT 44.00 44.00 04400 SKI LLEAD MURSI NG FACILITY 44.00 4NCI LLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 50.000 54.00 05400 RADIOLOSY-DI AGNOSTI C 0.000000 54.00 65.00 05600 OPERATING ROOM 54.00 66.00 05600 DEPARTING PROMEDICINE - DI AGNOSTI C 0.000000 54.00 66.00 06600 LABORATORY 60.00 65.00 66.00 06600 CABORATORY 60.00 65.00 66.00 06600 RESPIRATORY THERAPY 0.000000 65.00 66.00 06600 RESPIRATORY THERAPY 0.000000 65.00 66.00 06600 OFERCE AND ADDRESS 0.000000 65.00 67.00 06700 CCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 67.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 67.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 67.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 73.00 73.00 07300 ORUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 07300 ORUGS CHARGED TO PATIENTS 0.000000 73.00 74.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 73.00 75.00 07000 MEDICAL SUPPLIES COST CENTERS 88.00 0800 0800 RURAL HEALTH CLINIC 0.000000 73.00 76.00 09000 0.0000 0.00000 0.00000 0.00000 77.00 0.00000 0.00000 0.00000 0.00000 78.00 09000 0.00000 0.00000 0.00000 79.00 0.00000 0.00000 0.00000 0.00000 79.00 0.00000 0.00000 0.00000 0.00000 79.00 0.000000 0.00000 0.000000 0.000000 79.00 0.000000 0.000000 0.000000 0.000000 79.00 0.000000 0.000000 0.000000 0.000000 79.00 0.000000 0.000000 0.000000 0.000000 79.00 0.000000 0.0000000 0.000000 0.000000 79.00 0.000000 0.000000 0.000000000 79.00 0.0000000 0.00000000 0.00000000	Cost Cen	ter Description	PPS Inpatient				
NPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 303000 ADULTS & PEDIATRICS 31.00 31.00 03100 INTENSI VE CARE UNIT 31.00 44.00 04400 SKI LLED NURSI NG FACI LITY 44.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 505000 OPERATI NG ROOM 0.000000 54.00 54.00 05400 RADIOLOGY-DI AGNOSTI C 0.000000 54.00 55.00 05401 NUCLEAR MEDI CINE-DI AGNOSTI C 0.000000 54.03 66.00 06400 RADIOLOGY-DI AGNOSTI C 0.000000 66.00 67.00 06500 RESPI RATORY THERAPY 0.000000 66.00 68.00 06600 PHYSI CAL THERAPY 0.000000 65.00 69.00 06600 PHYSI CAL THERAPY 0.000000 67.00 69.00 06600 PHYSI CAL THERAPY 0.000000 67.00 69.00 06600 SPECH PATHOLOGY 0.000000 67.00 69.00 066900 ELECTROCARDI OLOGY 0.000000 68.00 69.00 066900 ELECTROCARDI OLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 67.00 69.00 071.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 0700 MEDI CAL SUPPLIES CENTERS 74.000000 74.00 75.00 0700 MPLE THE SERVI CE COST CENTERS 74.000000 75.00 76.00 0700 0700 MEDI CAL SUPPLIES CENTERS 75.000000 75.00 76.00 0700 0			Ratio				
30. 00 03000 ADULTS & PEDIATRICS 30. 00 31. 00 031100 INTENSI VE CARE UNIT 31. 00 31. 00 03100 INTENSI VE CARE UNIT 44. 00 44.00 SKILLED NURSI NG FACILITY 44. 00 ADULTS NG FACILITY NG ROOM 50. 00 60. 00			11. 00				
31. 00 03100 INTENSIVE CARE UNIT							
44.00 04400 SKI LLED NURSI NG FACILITY	30. 00 03000 ADULTS &	PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS	31. 00 03100 I NTENSI VI	E CARE UNIT					31.00
50.00	44. 00 04400 SKILLED I	NURSING FACILITY					44.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0.000000 54.03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0.000000 66.00 06000 LABORATORY 0.000000 66.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 06600 PhySI CAL THERAPY 0.000000 66.00 06600 PhySI CAL THERAPY 0.000000 66.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 68.00 08900 SPECH PATHOLOGY 0.000000 08900 08900 ELECTROCARDI OLOGY 0.000000 08900 09900 08900 09900 09900 099000 099000 099000 09900 09900 099000 099000 099000 099000 099000 099000 099000 099000 099000 099000 099000 09							
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	50. 00 05000 OPERATI N	G ROOM	0. 000000				50.00
60. 00 06000 LABORATORY 0. 000000 62. 00 660. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 0000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 65. 00 06600 PHYSI CAL THERAPY 0. 000000 66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 06600 PHYSI CAL THERAPY 0. 000000 68. 00 06800 SPEECH PATHOLOGY 0. 000000 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 000000 71. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0. 000000 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 07300 DRUGS CHARGED TO PATIENTS 0. 000000 07300 DRUGS CHARGED TO PATIENTS 0. 000000 09000 CLI NI C 0. 000000 09000 CLI NI C 0. 000000 09000 CLI NI C 0. 000000 09000 0. 00000 09000 0. 000000 09000 0. 000000 09000 0. 000000 09000 0. 000000 09000 0. 000000 0. 000000 09000 0. 000000 0. 000000 09000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	54. 00 05400 RADI OLOG	Y-DI AGNOSTI C	0. 000000				54.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 06500 RESPIRATORY THERAPY 0.000000 06600 06700 06600 PATIS CAL THERAPY 0.000000 067. 00 06700 0CCUPATI ONAL THERAPY 0.000000 067. 00 06700 0CCUPATI ONAL THERAPY 0.000000 067. 00 06800 SPEECH PATHOLOGY 0.000000 069. 00 06900 ELECTROCARDI OLOGY 0.000000 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 073.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 073.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 073.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 07200 UNIVERSITY OF CONTROL OF CALLEY OF	54. 03 05401 NUCLEAR I	MEDICINE-DIAGNOSTIC	0. 000000				54.03
65. 00 06500 RESPI RATORY THERAPY 0. 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 0.000000 67. 00 06600 PHYSI CAL THERAPY 0. 0.000000 67. 00 06700 0CCUPATI ONAL THERAPY 0. 0.000000 68. 00 06800 SPEECH PATHOLOGY 0. 000000 68. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 000000 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 73. 00 00000 DRUGS CHARGED TO PATI ENTS 0. 000000 73. 00 00000 RURAL HEALTH CLINI C 88. 00 08800 RURAL HEALTH CLINI C 90. 000000 90. 01 09001 DI ABETES 0. 0.000000 90. 01 09001 DI ABETES 0. 0.000000 90. 01 09001 DI ABETES 0. 0.000000 90. 02 09 002 0P PSYCH 0. 0.000000 90. 03 941 N MANAGEMENT 0. 000000 90. 03 9003 PAI N MANAGEMENT 0. 0000000 90. 03 91. 00 09100 EMERGENCY 0. 000000 91. 00 09100 EMERGENCY 0. 000000 91. 00 09100 DI MERGENCY 0. 0000000 91. 00 09100 DI MERGENCY 0. 000000 91. 00 09100 DI MERGENCY 0. 000000 00000 00000 00000 00000 00000 0000	60. 00 06000 LABORATOI	RY.	0. 000000				60.00
66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0017PATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 90.00 90.01 09000 CLINIC 0.000000 90.00 90.01 09000 DI ABETES 0.000000 90.01 90.02 090002 OP PSYCH 0.000000 90.02 90.03 09003 PAIN MANAGEMENT 0.000000 90.03 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.000000 92.00 011 OTHER REI MBURSABLE COST CENTERS 101.00 101.00 10100 HOME HEALTH AGENCY 0.000000 92.00 103 003 OTHER REI MBURSABLE COST CENTERS 113.00 101.00 Less Observation Beds 200.00 201.00 Less Observation Beds 201.00	62.00 06200 WHOLE BLO	OOD & PACKED RED BLOOD CELLS	0. 000000				62.00
67. 00	65. 00 06500 RESPIRATO	DRY THERAPY	0. 000000				65.00
68. 00	66. 00 06600 PHYSI CAL	THERAPY	0. 000000				66.00
69. 00	67. 00 06700 OCCUPATION	ONAL THERAPY	0. 000000				67.00
71. 00	68. 00 06800 SPEECH PA	ATHOLOGY	0. 000000				68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 00TPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC 90. 01 09001 DIABETES 90. 02 09002 OP PSYCH 90. 03 09003 PAIN MANAGEMENT 90. 00 09100 EMERGENCY 90. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 90. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 101. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00 201. 00 Less Observation Beds 201. 00 201. 00 Less Observation Beds 200. 00 201. 00 Less Observation Beds 200. 00 201. 00 200. 000000 72. 00 000000 88. 00 0.000000 90. 01 0.000000 90. 01 0.000000 90. 02 0.000000 90. 02 0.000000 90. 03 0.000000 90. 04 0.000000 91. 00 0.000000 101. 00 0.000000 102. 00 0.000000 103. 00 0.000000 104. 0000000 105. 0000000 106. 0000000 107. 0000000 108. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 0000000 109. 000000 109.	69. 00 06900 ELECTROCA	ARDI OLOGY	0. 000000				69.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.0000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	71. 00 07100 MEDICAL S	SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
SB. 00	72. 00 07200 I MPL. DE	/. CHARGED TO PATLENTS	0. 000000				72.00
SB. 00	73. 00 07300 DRUGS CHA	ARGED TO PATIENTS	0. 000000				73.00
90. 00 09000 CLINIC 0.000000 90. 01 09001 DI ABETES 0.000000 90. 01 90. 02 09002 OP PSYCH 0.000000 90. 02 90. 03 09003 PAIN MANAGEMENT 0.000000 90. 03 91. 00 09100 EMERGENCY 0.000000 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 07000000 07000000 07000000 07000000 07000000 070000000 070000000 0700000000			<u>. </u>				
90. 01 09001 DI ABETES 0. 000000 90. 01 90. 02 90. 02 09002 OP PSYCH 0. 000000 90. 02 90. 03 09003 PAI N MANAGEMENT 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 000000 092. 00 ODD O	88. 00 08800 RURAL HEA	ALTH CLINIC					88. 00
90. 02 09002 0P PSYCH 0.000000 90.03 09003 PAI N MANAGEMENT 0.000000 90.03 09100 EMERGENCY 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 1300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	90. 00 09000 CLINIC		0. 000000				90.00
90. 03	90. 01 09001 DI ABETES		0. 000000				90. 01
91. 00	90. 02 09002 OP PSYCH		0. 000000				90.02
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.000000) OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 1300 INTEREST EXPENSE 113. 00 Subtotal (see instructions) 200. 00 Less Observation Beds 201. 00	90. 03 09003 PAIN MANA	AGEMENT	0. 000000				90. 03
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	91. 00 09100 EMERGENC	(0. 000000				91.00
101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	92. 00 09200 OBSERVAT	ON BEDS (NON-DISTINCT PART	0. 000000				92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	OTHER REI MBURS	ABLE COST CENTERS	<u>'</u>				
113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	101. 00 10100 HOME HEAI	_TH AGENCY					101.00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	SPECIAL PURPOS	E COST CENTERS	<u>'</u>				
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00							113.00
201.00 Less Observation Beds 201.00							

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1319	Peri od: From 10/01/2016 To 09/30/2017

					10 09/30/2017	Date/lime Pre 2/26/2018 1:2	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	TENT ROUTINE SERVICE COST CENTERS				-1		
	ADULTS & PEDIATRICS	2, 823, 593		2, 823, 59		2, 823, 593	
	INTENSIVE CARE UNIT	307, 923		307, 92			
	SKILLED NURSING FACILITY	0			0 0	0	44.00
	LARY SERVICE COST CENTERS				-1		
	OPERATING ROOM	2, 068, 182		2, 068, 18		, , .	
	RADI OLOGY-DI AGNOSTI C	2, 083, 015		2, 083, 01		2, 083, 015	
	NUCLEAR MEDICINE-DIAGNOSTIC	187, 578		187, 57		187, 578	
	LABORATORY	2, 100, 800		2, 100, 80		2, 100, 800	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	77, 355		77, 35		77, 355	
	RESPI RATORY THERAPY	1, 145, 549	0	1, 145, 54		1, 145, 549	
	PHYSI CAL THERAPY	1, 576, 177	0	1, 576, 17		1, 576, 177	
	OCCUPATI ONAL THERAPY	478, 023	0	478, 02	3 0	478, 023	
	SPEECH PATHOLOGY	228, 149	0	228, 14	9 0	228, 149	
	ELECTROCARDI OLOGY	0		1	0	0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	455, 566		455, 56		455, 566	
	IMPL. DEV. CHARGED TO PATIENTS	196, 235		196, 23		196, 235	
	DRUGS CHARGED TO PATIENTS	2, 421, 761		2, 421, 76	1 0	2, 421, 761	73.00
	TIENT SERVICE COST CENTERS				_		
	RURAL HEALTH CLINIC	17, 008		17, 00		17, 008	
	CLINIC	0			0	0	90.00
	DI ABETES	91, 643		91, 64	3 0	91, 643	
	OP PSYCH	0			0	0	90. 02
	PAIN MANAGEMENT	363, 761		363, 76		363, 761	
	EMERGENCY	2, 802, 559		2, 802, 55		2, 802, 559	1
	OBSERVATION BEDS (NON-DISTINCT PART	640, 110		640, 11	0	640, 110	92.00
	REIMBURSABLE COST CENTERS						
	HOME HEALTH AGENCY	679, 454		679, 45	4	679, 454	101. 00
	AL PURPOSE COST CENTERS	,					
	INTEREST EXPENSE					•	113.00
200. 00	Subtotal (see instructions)	20, 744, 441	0	, ,		/ /	
201. 00	Less Observation Beds	640, 110		640, 11		640, 110	
202. 00	Total (see instructions)	20, 104, 331	0	20, 104, 33	1 0	20, 104, 331	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: 15-1319	Period: Worksheet C From 10/01/2016 Part I To 09/30/2017 Date/Time Prepared:

				j	o 09/30/2017	Date/Time Pre 2/26/2018 1:2	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	T		T	T		
	03000 ADULTS & PEDI ATRI CS	1, 815, 226		1, 815, 226			30.00
31. 00	03100 I NTENSI VE CARE UNI T	60, 812		60, 812			31.00
44. 00	04400 SKILLED NURSING FACILITY	0		()		44.00
	ANCILLARY SERVICE COST CENTERS	11		1			
50.00	05000 OPERATING ROOM	272, 780	4, 363, 603			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	292, 578	9, 825, 402			0. 000000	
54. 03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	18, 134	290, 535			0. 000000	
60.00	06000 LABORATORY	970, 131	7, 516, 695			0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	24, 473	83, 508			0. 000000	
65.00	06500 RESPI RATORY THERAPY	558, 320	2, 204, 583			0. 000000	
66.00	06600 PHYSI CAL THERAPY	834, 407	4, 036, 822			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	366, 863	1, 269, 940			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	45, 319	621, 241	1		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0.00000	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	226, 279	208, 061			0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	51, 357	344, 049			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	667, 770	3, 677, 069	4, 344, 839	0. 557388	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS			1			
	08800 RURAL HEALTH CLINIC	0	15, 326	1		0. 000000	
90.00	09000 CLINIC	0	0	1		0. 000000	
90. 01	09001 DI ABETES	0	27, 482	27, 482		0. 000000	
	09002 OP PSYCH	0	0	(0. 000000	0. 000000	
90. 03	09003 PAIN MANAGEMENT	0	757, 014			0. 000000	
	09100 EMERGENCY	122, 064	7, 242, 936			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 921	796, 621	807, 542	0. 792665	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	1 .1		1	T		
101.00	10100 HOME HEALTH AGENCY	0	585, 171	585, 171			101.00
	SPECIAL PURPOSE COST CENTERS	1		1			
	11300 I NTEREST EXPENSE			50 000 :			113.00
200.00		6, 337, 434	43, 866, 058	50, 203, 492	<u>'</u>		200.00
201.00	1			50.000 :			201.00
202.00	Total (see instructions)	6, 337, 434	43, 866, 058	50, 203, 492	<u>'</u>		202. 00

Health Financial Systems	GIBSON GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1319	Peri od: From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Pre 2/26/2018 1:2	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient		-		

NPATIENT ROUTINE SERVICE COST CENTERS					2/26/2018 1:23 pm
NPATI ENT ROUTINE SERVICE COST CENTERS 11.00			Title XIX	Hospi tal	Cost
NPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 30.00 ADULTS & PEDI ATRICS 31.00 31.00 31.00 MULTESI VE CARE UNIT 44.00 440.00 440.00 50	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 30.00 ADULTS & PEDIATRICS 31.00 31.00 31.00 INTENSI VE CARE UNIT 31.00 31.00 INTENSI VE CARE UNIT 44.00 44.00 SKILLED NURSI NG FACILITY 44.00 AVAILLED NURSI NG FACILITY 44.00 ADULTARY SERVICE COST CENTERS 50.00		Ratio			
30. 00		11. 00			
31. 00	INPATIENT ROUTINE SERVICE COST CENTERS				
44. 00	30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS	31.00 03100 INTENSIVE CARE UNIT				31.00
50. 00 05000 05400 NATION 054000 NATION 05400 NATION 054000 NATION 054000 NATION 0	44.00 04400 SKILLED NURSING FACILITY				44.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0.54.00 0.54.00 0.54.01 NUCLEAR MEDI CI NE-DI AGNOSTI C 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	ANCILLARY SERVICE COST CENTERS				
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.000000 54.03 60.00 06000 LABORATORY 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCOPATI ONAL THERAPY 0.000000 67.00 68.00 08800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 90.01 09000 CLINIC 0.000000 90.01 90.02 09002 OP PSYCH 0.000000 90.01 90.01 09001 DIABETES 0.000000 90.01 90.02 09002 OP PSY	50. 00 05000 OPERATING ROOM	0. 000000			50.00
60. 00 06000 LABORATORY 0.000000 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 65. 00 06500 RESPI RATORY THERAPY 0.0000000 65. 00 06500 RESPI RATORY THERAPY 0.0000000 66. 00 06500 RESPI RATORY THERAPY 0.0000000 66. 00 067. 00 06700 0CUPATI ONAL THERAPY 0.0000000 67. 00 06800 SPECH PATHOLOGY 0.000000 68. 00 06800 SPECH PATHOLOGY 0.000000 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07200 SUBCS CHARGED TO PATI ENTS 0.000000 73. 00 07200 SPUGS CHARGED TO PATI ENTS 0.000000 73. 00 000000 000000 000000 0000000	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 065. 00 06500 RESPI RATORY THERAPY 0.000000 066. 00 06600 PHYSI CAL THERAPY 0.000000 067. 00 06700 0CCUPATI ONAL THERAPY 0.000000 067. 00 06700 0CCUPATI ONAL THERAPY 0.000000 067. 00 06800 SPEECH PATHOLOGY 0.000000 069. 00 06900 ELECTROCARDI OLOGY 0.000000 069. 00 06900 ELECTROCARDI OLOGY 0.000000 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 072. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000			54.03
65. 00 06500 RESPIRATORY THERAPY 0.000000 06500 06500 06600 PHYSI CAL THERAPY 0.000000 06600 06700 067000 06700 067000 067000 068000 0680000 069000 0680000 0680000 0680000 0680000 0680000 0680000 0680000 0680000 0680000 0680000 06800000 06800000 06800000 06800000 06800000 06800000 06800000 06800000 06800000 06800000 06800000 068000000 068000000 068000000 068000000 068000000 068000000 068000000 068000000 0680000000 0680000000 0680000000 0680000000 06800000000 06800000000 06800000000 068000000000 068000000000 0680000000000	60. 00 06000 LABORATORY	0. 000000			60.00
66. 00	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69	65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
68. 00 06800 SPEECH PATHOLOGY 0.000000 69. 00 6	66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 72.00 72.00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 000000 72.00 73.00 000000 73.00 000000 73.00 000000 73.00 000000 73.00 000000 000000 000000 000000 000000	68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 000000 000000 000000 000000 000000	69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
SERVICE COST CENTERS SERVICE COST CENTERS	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
88. 00	73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
90. 00 09000 CLINIC 0.000000 90. 00 90	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			
90. 01 09001 DI ABETES 0.000000 90. 01 90. 02 09002 OP PSYCH 0.000000 90. 02 90. 03 09003 PAI N MANAGEMENT 0.000000 90. 03 91. 00 09100 EMERGENCY 0.000000 91. 00 07HER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 9PECI AL PURPOSE COST CENTERS 113. 00 11300 1NTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00	88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
90. 02	90. 00 09000 CLI NI C	0. 000000			90.00
90. 03	90. 01 09001 DI ABETES	0. 000000			90. 01
91. 00 91. 00 92.	90. 02 09002 OP PSYCH	0. 000000			90. 02
92. 00	90. 03 09003 PAI N MANAGEMENT	0. 000000			90.03
92. 00	91. 00 09100 EMERGENCY	0. 000000			91.00
OTHER REI MBURSABLE COST CENTERS 101.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 113.00 113.00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					92.00
101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					101.00
113.00					
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					113.00
201.00 Less Observation Beds 201.00					
	,				

Health Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 10/01/2016 To 09/30/2017		pared: 3 pm
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	135, 800				2, 309	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	99, 754				1, 185	
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	10, 776		l .		324	
60. 00 06000 LABORATORY	51, 844				2, 277	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	274		l .		32	62.00
65. 00 06500 RESPI RATORY THERAPY	46, 179	2, 762, 903	0. 01671	4 194, 803	3, 256	65.00
66. 00 06600 PHYSI CAL THERAPY	79, 218	4, 871, 229	0. 01626	2 82, 400	1, 340	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	23, 479	1, 636, 803	0. 01434	4 24, 267	348	67.00
68.00 06800 SPEECH PATHOLOGY	3, 315	666, 560	0. 00497	3 13, 011	65	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	87, 659	434, 340	0. 20182	95, 842	19, 343	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	767	395, 406	0. 00194	0 29, 141	57	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	34, 290	4, 344, 839	0. 00789	2 188, 133	1, 485	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	63	15, 326	0. 00411	1 0	0	88. 00
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
90. 01 09001 DI ABETES	33, 828	27, 482	1. 23091	5 0	0	90. 01
90. 02 09002 OP PSYCH	0	0	0.00000	0 0	0	90. 02
90. 03 09003 PAIN MANAGEMENT	2, 471	757, 014	0. 00326	0	0	90. 03
91. 00 09100 EMERGENCY	231, 340	7, 365, 000	0. 03141	1 8, 450	265	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	50, 937	807, 542	0. 06307	7 0	0	92.00
200.00 Total (lines 50 through 199)	891, 994	47, 742, 283		1, 229, 663	32, 286	200. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1319	Period: Worksheet D

From 10/01/2016 Part IV To 09/30/2017 Date/Time Prepared: THROUGH COSTS 2/26/2018 1:23 pm Title XVIII Hospi tal Cost Nursi ng Cost Center Description Non Physician Nursi ng Allied Health Allied Health Anestheti st School School Post-Stepdown Post-Stepdown Adjustments Cost Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 0 0 54. 03 | 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 54.03 06000 LABORATORY 0 60.00 0 0 0 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0 62.00 06500 RESPIRATORY THERAPY 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 Ω 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0 72.00 0 0 72.00 0 0 0 73.00 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 0 0 0 0 0 0 Oı 0 09000 CLI NI C 0 0 0 0 0 90.00 0 90.00 90.01 09001 DI ABETES 0 0 90.01 90.02 09002 OP PSYCH 0 0 90.02 0 0 0 90. 03 09003 PAIN MANAGEMENT 0 90.03 0 01 91. 00 09100 EMERGENCY 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00

0 200.00

Total (lines 50 through 199)

200.00

Health Financial Systems	GI BSON GENERAL HOSPI TAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1319	
TUDOUGU COCTC		From 10/01/2016 Part IV

THROUGH COSTS To 09/30/2017 Date/Time Prepared: 2/26/2018 1:23 pm Title XVIII Hospi tal Cost Cost Center Description All Other Total Cost Total Charges Ratio of Cost Total Medi cal (sum of col 1 Outpati ent (from Wkst. to Charges Educati on C, Part I, (col. 5 ÷ through col Cost (sum of Cost 4) col . 2, 3 and col. 8) col. 7) 4. 00 5.00 6.00 7. 00 8. 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50 00 4, 636, 383 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 0 10, 117, 980 0.000000 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 308, 669 0.000000 54.03 54.03 06000 LABORATORY 0 8, 486, 826 0 0.000000 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 107, 981 0.000000 62.00 62.00 06500 RESPIRATORY THERAPY 2, 762, 903 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 4, 871, 229 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 0 0 1, 636, 803 67.00 06800 SPEECH PATHOLOGY 68.00 0 666, 560 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 434, 340 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 395, 406 C 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 344, 839 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 0. 000000 08800 RURAL HEALTH CLINIC 0 0 88.00 88.00 0 0 0 0 0 0 0 0 15, 326 90. 00 09000 CLINIC 0 0.000000 90.00 90. 01 09001 DI ABETES 0 0 27, 482 0.000000 90.01 90. 02 09002 OP PSYCH 0 0 0.000000 90.02 01 0 90. 03 09003 PAIN MANAGEMENT 757, 014 0.000000 90.03 91. 00 | 09100 | EMERGENCY 0 7, 365, 000 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 807, 542 92.00 0 0.000000 200.00 Total (lines 50 through 199) 47, 742, 283 200.00

Heal th Financial	Systems		GI B	SON GENER	L HOSPITA	L		In Lieu	of Form C	MS-2552-10
APPORTIONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE	OTHER PAS	S Provid	ler CCN	V: 15-1319	od: 10/01/2016 09/30/2017		Prepared:

					To 09/30/2017	Date/Time Pre 2/26/2018 1:2	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 000000	78, 817		0	0	50.00
	O RADI OLOGY-DI AGNOSTI C	0. 000000	120, 151		0	0	54.00
	1 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	9, 287		0	0	54.03
	O LABORATORY	0. 000000	372, 693		0	0	60.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	12, 668		0	0	62.00
	O RESPIRATORY THERAPY	0. 000000	194, 803		0	0	65.00
	O PHYSI CAL THERAPY	0. 000000	82, 400		0	0	66.00
	O OCCUPATI ONAL THERAPY	0. 000000	24, 267		0	0	67.00
	SPEECH PATHOLOGY	0. 000000	13, 011		0	0	68.00
	O ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	95, 842		0	0	71.00
	OIMPL. DEV. CHARGED TO PATIENTS	0. 000000	29, 141		0	0	72. 00
	ODRUGS CHARGED TO PATIENTS	0. 000000	188, 133		0 0	0	73.00
	ATLENT SERVICE COST CENTERS						
	ORURAL HEALTH CLINIC	0. 000000	0		0	0	88. 00
	O CLI NI C	0. 000000	0		0	0	90.00
	1 DI ABETES	0. 000000	0		0	0	90. 01
	2 OP PSYCH	0. 000000	0		0	0	90. 02
	3 PAIN MANAGEMENT	0. 000000	0		0	0	90. 03
	O EMERGENCY	0. 000000	8, 450		0	0	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200. 00	Total (lines 50 through 199)		1, 229, 663		0 0	0	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems GIBSON GENERAL HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1319 Peri od: Worksheet D From 10/01/2016 To 09/30/2017 Part V Date/Time Prepared: 2/26/2018 1:23 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 446077 1, 691, 359 05400 RADI OLOGY-DI AGNOSTI C 2, 754, 392 0 54.00 0.205873 0 0 54. 03 | 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.607700 0 108, 526 0 60.00 06000 LABORATORY 0. 247537 2, 678, 693 0 0 0 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.716376 38, 127 0 06500 RESPIRATORY THERAPY 795, 501 65.00 0.414618 0 06600 PHYSI CAL THERAPY 66.00 0. 323569 1, 439, 819 0 67.00 06700 OCCUPATI ONAL THERAPY 0. 292047 252, 739 o 0 33, 232 68.00 06800 SPEECH PATHOLOGY 0.342278 0 0 69.00 0 0

Health Financial Systems	GI BSON GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1319	Peri od: From 10/01/2016	Worksheet D Part V Date/Time Prepared:

				From 10/01/2016 To 09/30/2017	Part V Date/Time Pre 2/26/2018 1:2	
		Title	e XVIII	Hospi tal	Cost	
·	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	754, 476)			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	567, 055	0)			54.00
54. 03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	65, 951	0)			54.03
60. 00 06000 LABORATORY	663, 076	0)			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	27, 313)			62.00
65. 00 06500 RESPI RATORY THERAPY	329, 829	0)			65.00
66. 00 06600 PHYSI CAL THERAPY	465, 881	0)			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	73, 812	0)			67.00
68.00 06800 SPEECH PATHOLOGY	11, 375	0)			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0)			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78, 943	0)			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	69, 767	0)			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 139, 951	1, 177	1			73.00
OUTPATIENT SERVICE COST CENTERS	T					
88.00 08800 RURAL HEALTH CLINIC	0	0)			88. 00
90. 00 09000 CLI NI C	0	0)			90.00
90. 01 09001 DI ABETES	14, 659	0)			90. 01
90. 02 09002 0P PSYCH	0	0)			90. 02
90. 03 09003 PAI N MANAGEMENT	199, 640)			90. 03
91. 00 09100 EMERGENCY	627, 836	0)			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	280, 641	0)			92.00
200.00 Subtotal (see instructions)	5, 370, 205	1, 177				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	E 270 205	1 177	,			202.00
202.00 Net Charges (line 200 - line 201)	5, 370, 205	1, 177	1			202.00

			component	CCN: 15-Z319 1	0 09/30/2017	2/26/2018 1: 2	
			Title	XVIII S	wing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subj ect To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 446077	0	C	0	0	
	RADI OLOGY-DI AGNOSTI C	0. 205873	0	C	0	0	54.00
	NUCLEAR MEDICINE-DIAGNOSTIC	0. 607700	0	C	0	0	54.03
60.00 06000	LABORATORY	0. 247537	0	C	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 716376	0	C	0	0	62.00
65.00 06500	RESPI RATORY THERAPY	0. 414618	0	C	0	0	65.00
66.00 06600	PHYSI CAL THERAPY	0. 323569	0	C	0	0	66.00
67.00 06700	OCCUPATI ONAL THERAPY	0. 292047	0	C	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0. 342278	0	C	0	0	68. 00
69.00 06900	ELECTROCARDI OLOGY	0. 000000	0	C	0	0	69. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1. 048870	0	C	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 496287	0	l c	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 557388	0	l c	0	0	73.00
	TIENT SERVICE COST CENTERS						
88. 00 08800	RURAL HEALTH CLINIC	0.000000				0	88. 00
90.00 09000	CLINIC	0. 000000	0	C	0	0	90.00
	DI ABETES	3. 334655	0	C	0	0	90. 01
90. 02 09002	OP PSYCH	0. 000000	0	C	0	0	90. 02
90. 03 09003	PAIN MANAGEMENT	0. 480521	0	l c	0	0	90. 03
91.00 09100	EMERGENCY	0. 380524	0	l c	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0. 792665	0	l c	0	0	92.00
200. 00	Subtotal (see instructions)		0	l c	0	0	200. 00
201. 00	Less PBP Clinic Lab. Services-Program			C	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	(0	0	202.00

Health Financial Systems	GI BSON GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1319	Peri od: From 10/01/2016	Worksheet D
		Component CCN: 15-Z319		
		Title XVIII	Swing Beds - SNF	Cost

			Component	CCN: 15-Z319	10 09/30	:e/IIme Pre 26/2018 1:2	
			Title	XVIII	Swing Beds	Cost	
		Cos	sts				
Cost Center Descript	i on	Cost	Cost				
	R	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
	S	Subject To	Subject To				
	Dec	d. & Coins.	Ded. & Coins.				
	(:	see inst.)	(see inst.)				
		6. 00	7. 00				
ANCILLARY SERVICE COST CEN	ITERS						
50.00 05000 OPERATING ROOM		0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	0				54.00
54. 03 05401 NUCLEAR MEDICINE-DIA	GNOSTI C	0	0				54.03
60. 00 06000 LABORATORY		0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED	RED BLOOD CELLS	0	0				62.00
65. 00 06500 RESPIRATORY THERAPY		0	0				65.00
66.00 06600 PHYSI CAL THERAPY		0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY		o	0				67.00
68.00 06800 SPEECH PATHOLOGY		0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY		o	0				69.00
71.00 07100 MEDICAL SUPPLIES CHA	RGED TO PATIENT	o	0				71.00
72.00 07200 I MPL. DEV. CHARGED T	O PATIENTS	o	0				72.00
73.00 07300 DRUGS CHARGED TO PAT	I ENTS	o	0				73.00
OUTPATIENT SERVICE COST CE	NTERS						
88.00 08800 RURAL HEALTH CLINIC		0	0				88. 00
90. 00 09000 CLINIC		0	0				90.00
90. 01 09001 DI ABETES		o	0				90. 01
90. 02 09002 OP PSYCH		o	0				90. 02
90. 03 09003 PAIN MANAGEMENT		o	0				90.03
91. 00 09100 EMERGENCY		o	0				91.00
92.00 09200 OBSERVATION BEDS (NO	N-DISTINCT PART	o	0				92.00
200.00 Subtotal (see instru	ctions)	o	0				200.00
201.00 Less PBP Clinic Lab.	Servi ces-Program	ol					201.00
Only Charges							
202.00 Net Charges (line 20	0 - line 201)	o	0				202.00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1319	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 1:23 pm
	Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	2/26/2018 1: 2 Cost	3 pm
	Cost Center Description	I tile XVIII	110Spi tai	COST	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	excluding newborn)		2, 541	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			1, 615	2. 00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3.00
	do not complete this line.			4 000	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	1, 088	4. 00 5. 00
5.00	reporting period	on days) through becember	er 31 or the cost	U	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	678	6.00
	reporting period (if calendar year, enter 0 on this line)	-			
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	R1 of the cost	248	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	augs) area becomber a	or the cost	210	0.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	779	9. 00
40.00	newborn days)			0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom davs) after	678	11. 00
	December 31 of the cost reporting period (if calendar year, e	3 1			
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00
12 00	through December 31 of the cost reporting period	V anly (including privat	-a raam daya)	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			U	13. 00
14. 00	Medically necessary private room days applicable to the Progr			0	14. 00
15.00	Total nursery days (title V or XIX only)	, 3	,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
17 00	SWING BED ADJUSTMENT	and through Donomhor 21 o	£ +b2 222+		17 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 c	or the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	137. 32	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	155. 02	20. 00
20.00	reporting period	3 ditter becember 31 or	inc cost	133. 02	20.00
21.00	Total general inpatient routine service cost (see instruction			2, 823, 593	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	. 0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	ng poriod (line A	0	23. 00
23.00	x line 18)	31 of the cost reportin	ig perrou (Trile o	·	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	38, 445	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			861, 964	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 961, 629	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33.00
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 1, 961, 629	36. 00 37. 00
200	27 minus line 36)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		Т	4 04 4 4 5	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 214. 63 946, 197	
40.00	Medically necessary private room cost applicable to the Progr			946, 197	
	Total Program general inpatient routine service cost (line 39			946, 197	
			·	,	

	Financial Systems	GIBSON GENERA				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	Provider CCN: 15-1319 Period: From 10/01/2		Worksheet D-1	
				To C			pared:
				XVIII	Hospi tal	Cost	, p
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00	NUDCEDY (+:+Le V & VIV enly)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT	307, 923	84	3, 665. 7	5 16	58, 652	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	<u> </u>					1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			one)		508, 905	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 46) (see mstructi	urs)		1, 513, 754	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
51. 00	<pre> </pre>	atient ancillar	rv services (f	rom Wkst. D.	sum of Parts II	0	51.00
	and IV)		,	,		_	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated non-ph	vsician anest	hetist and	0	
33.00	medical education costs (line 49 minus line	9 1	ratea, non pri	ysi ci air ancst	noti st, and		33.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)	:		li F/i	1: 52)	0	
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (line 56 minus	Tine 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. ur	odated by the	market basket		0.00	60.00
	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of	the amount by	0	1
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	·				0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ner 31 of the	cost renortin	n neriod (See	823, 519	65.00
03.00	instructions)(title XVIII only)					023, 317	03.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	823, 519	66.00
67. 00	,	e costs through	December 31	of the cost r	eporting period	0	67.00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	a costs after [December 31 of	the cost ren	orting period	0	68. 00
00.00	(line 13 x line 20)	e costs arter t	December 31 of	the cost rep	or tring period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil)		70.00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	n (line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	•		,	D		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (Trom	worksneet B,	Part II, column		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitatio	n (line 78 mi	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (1)				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (ns)				83. 00 84. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					527	87.00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 214. 63	88.00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)	1			640, 110	I 84.00

Health Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2016 To 09/30/2017	Date/Time Pre 2/26/2018 1:2	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	224, 687	2, 823, 593	0. 07957	75 640, 110	50, 937	90.00
91.00 Nursing School cost	0	2, 823, 593	0.00000	00 640, 110	0	91.00
92.00 Allied health cost	0	2, 823, 593	0.00000	00 640, 110	0	92.00
93.00 All other Medical Education	0	2, 823, 593	0. 00000	640, 110	0	93. 00

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1319	Peri od: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 1:23 pm
	Title XIX	Hospi tal	Cost

		Title XIX	Hospi tal	2/26/2018 1: 2 Cost	3 pm
	Cost Center Description	II tie xix	nospi tai	Cost	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s. excludina newborn)		2, 541	1.00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		1, 615	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
4 00	do not complete this line.	ad daya)		1 000	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	1, 088 0	4. 00 5. 00
0.00	reporting period	om days) tri odgr becombe	n or or the cost	G	0.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	678	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	and a National Broads	24 . 6 . 1	0	7.00
7. 00	Total swing-bed NF type inpatient days (including private roc reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	248	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 .			
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	11	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	coom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		days)	O	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, e			0	40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	re room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room davs)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lir	ne)		
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15. 00 16. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost		17. 00
	reporting period	-			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	s through becomes or or	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20.00
21 00	reporting period	->		2 022 502	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	2, 823, 593 0	21. 00 22. 00
22.00	5 x line 17)	cr 31 or the cost report	ing perrou (ini	O	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00
0.4.00	x line 18)	24 - 6 11 1			04.00
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 or the cost reporti	ng period (iine	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)				
26. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		834, 889	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		1, 988, 704	27. 00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	
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 mi	nus line 33)(see instruc	ctions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x li			0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private rest "	fforontial (1)	1 000 704	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rremential (IIne	1, 988, 704	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see	•		1, 231. 40	
39.00	Program general inpatient routine service cost (line 9 x line	•		13, 545	
40. 00 41. 00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	,		0 13, 545	
	, 3 - 3 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		'	,	

Heal th	Financial Systems	GI BSON GENERA	I HOSPITAI		In lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	OF BOOK GENERA	Provi der C		eri od:	Worksheet D-1	
					rom 10/01/2016 o 09/30/2017	Date/Time Pre	pared:
			T: +1	o VIV		2/26/2018 1:2	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
		I npati ent	Inpatient	Diem (col. 1		(col. 3 x	
		Cost 1.00	<u>Days</u> 2. 00	÷ col. 2) 3.00	4. 00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	307, 923	84	3, 665. 75	0	0	43. 00 44. 00
	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk						48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)((see instructi	ons)		21, 951	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
						_	
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (fi	rom Wkst. D, s	um of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53.00	Total Program inpatient operating cost exclu		elated, non-phy	ysician anesth	etist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0. 00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and to	arget amount (THE OF III HOS	11116 00)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. um	odated by the i	market basket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0	61.00
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	i iisti ucti oiis)				0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doc	ombor 21 of the	o cost roporti	ng poriod (Soo	0	64. 00
04.00	instructions)(title XVIII only)	ts through bece	elliber 31 of the	e cost reporti	ig period (see	O	04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the o	cost reporting	peri od (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.00
	CAH (see instructions)	•	•		3.		
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31 (of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repo	rting period	0	68. 00
	(line 13 x line 20)		<u>.</u>		0 .	_	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	utine service (cost (line 37)			70. 00
71.00	Adjusted general inpatient routine service c	,	ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x li	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from \	Worksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider recor	de)			78. 00 79. 00
80.00	Total Program routine service costs for comp				us line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on			•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		,				84.00
85.00	Utilization review - physician compensation	(see instruction					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		irougn 85)				86. 00
87. 00	Total observation bed days (see instructions					527	87. 00
88.00	Adjusted general inpatient routine cost per					1, 231. 40	
07.00	Observation bed cost (line 87 x line 88) (se	e instructions)	,			648, 948	09.00

Health Financial Systems	GIBSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2016 To 09/30/2017	Date/Time Prep 2/26/2018 1:23	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	224, 687	2, 823, 593	0. 07957	75 648, 948	51, 640	90.00
91.00 Nursing School cost	0	2, 823, 593	0. 00000	00 648, 948	0	91.00
92.00 Allied health cost	0	2, 823, 593	0. 00000	00 648, 948	ol	92.00
93.00 All other Medical Education	0	2, 823, 593	0. 00000	648, 948	ا	93. 00

Health Financial System			ON 45 4040		u of Form CMS-2	
INPATIENT ANCILLARY SE	RVICE COST APPORTIONMENT	Provi der C		Peri od: From 10/01/2016	Worksheet D-3	i
				To 09/30/2017		
		Title	XVIII	Hospi tal	Cost	
Cost Cente	r Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	IE SERVI CE COST CENTERS					1
30.00 03000 ADULTS & P				667, 057		30.00
31. 00 03100 I NTENSI VE				29, 365		31.00
ANCI LLARY SERVI C						
50. 00 05000 OPERATING			0. 44607			
54. 00 05400 RADI OLOGY-			0. 20587		24, 736	
	DI CI NE-DI AGNOSTI C		0. 60770			
60. 00 06000 LABORATORY			0. 24753			
	D & PACKED RED BLOOD CELLS		0. 71637			
65. 00 06500 RESPIRATOR			0. 41461			
66. 00 06600 PHYSI CAL T			0. 32356			
67. 00 06700 OCCUPATION			0. 29204			
68. 00 06800 SPEECH PAT			0. 34227		4, 453	
69. 00 06900 ELECTROCAR			0.00000		100 53/	69.00
	PPLIES CHARGED TO PATIENT		1. 04887			
73. 00 07300 DRUGS CHAR	CHARGED TO PATIENTS		0. 49628 0. 55738		14, 462 104, 863	
OUTPATIENT SERVI			0. 55736	0 100, 133	104, 603	/3.00
88. 00 08800 RURAL HEAL			0.00000		0	88.00
90. 00 09000 CLINIC	TH CLINIC		0.00000		0	
90. 01 09001 DI ABETES			3. 33465		0	
90. 02 09002 OP PSYCH			0.00000		0	1
90. 03 09003 PAIN MANAG	EMENT		0. 48052		0	90.02
91. 00 09100 EMERGENCY	LIVILINI		0. 48052			
	N BEDS (NON-DISTINCT PART		0. 38032		3, 213	1
	of lines 50 through 94 and 96 through 98)		0.79200	1, 229, 663	508, 905	
	Linic Laboratory Services-Program only cha			1, 227, 003		201 00

201. 00 202. 00

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

201.00 202.00

Health Financial Systems GIBSON GENER				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der 0		Peri od: From 10/01/2016	Worksheet D-3	3
	Component	CCN: 15-Z319	To 09/30/2017		
	Title	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0	l .	30.00
31. 00 03100 INTENSIVE CARE UNIT			0		31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 44607		7, 950	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20587			
54. 03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 60770			
60. 00 06000 LABORATORY		0. 24753	1		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 71637	1	4, 277	
65. 00 06500 RESPI RATORY THERAPY		0. 41461			
66. 00 06600 PHYSI CAL THERAPY		0. 32356	1		
67. 00 06700 OCCUPATI ONAL THERAPY		0. 29204			
68. 00 06800 SPEECH PATHOLOGY		0. 34227	1		
69. 00 06900 ELECTROCARDI OLOGY		0.00000		٠ -	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 04887	1	l '	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49628		0	1 /2:00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 55738	125, 214	69, 793	73.00
OUTPATIENT SERVICE COST CENTERS		1	[_	
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	00.00
90. 00 09000 CLINIC		0.00000		Ĭ	, , , , , ,
90. 01 09001 DI ABETES		3. 33465		0	70.0.
90. 02 09002 OP PSYCH		0.00000		0	70.02
90. 03 09003 PAI N MANAGEMENT		0. 48052		0	90.03
91. 00 09100 EMERGENCY		0. 38052		0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 79266		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1	816 114	328. 557	1200, 00

201. 00 202. 00

328, 557 200. 00

816, 114

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)

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

Heal th Financial Systems GIBSON GENERA		ON 45 4046		u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 10/01/2016	Worksheet D-3	
			To 09/30/2017		pared:
				2/26/2018 1: 2	
	Ti ti	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	The state of the s	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
LANDATI FAIT DOUTLAS OFFINAS OFFITEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		ı	
30. 00 03000 ADULTS & PEDI ATRI CS			7, 953		30.00
31. 00 03100 I NTENSI VE CARE UNI T			1, 007		31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 44607			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20587			
54. 03 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 60770			
60. 00 06000 LABORATORY		0. 24753	1		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 71637			62.00
65. 00 06500 RESPI RATORY THERAPY		0. 41461			
66. 00 06600 PHYSI CAL THERAPY		0. 32356		92	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 29204		0	
68. 00 06800 SPEECH PATHOLOGY		0. 34227		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 04887		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49628	87 0	0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 55738	88 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		1. 10974	18 0	0	88. 00
90. 00 09000 CLI NI C		0.00000	00	0	90.00
90. 01 09001 DI ABETES		3. 33465	55 0	0	90. 01
90. 02 09002 OP PSYCH		0.00000	0 0	0	90. 02
90. 03 09003 PAI N MANAGEMENT		0. 48052	21 0	0	90. 03
91. 00 09100 EMERGENCY		0. 38052	3, 678	1, 400	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 79266	5 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			26, 121	8. 406	200 00

201. 00 202. 00

8, 406 200. 00

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)

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

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1319	From 10/01/2016	Worksheet E Part B Date/Time Prepared: 2/26/2018 1:23 pm

ABET B - WEDLIAL AND OTHER HEATTH SERVICES 1.00				077 007 2017	2/26/2018 1: 2	3 pm
Name			Title XVIII	Hospi tal		
Name						
					1.00	
Medical and other services relibransed under OPPS (see instructions) 0 2.00		PART B - MEDICAL AND OTHER HEALTH SERVICES				
3.00 OPS payments	1.00	Medical and other services (see instructions)			5, 371, 382	1.00
0.01 in Payment (See Instructions)	2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		0	2.00
0.00 0.000 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00 0.00	3.00	OPPS payments			0	3.00
0.00 0.00	4.00	Outlier payment (see instructions)			0	4.00
Line 2 Times Ine 5	4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
Line 2 Tieses Iline 5	5.00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0.000	5.00
Transitional corridor payment (see instructions) 0 8 00 90 00 00 00 00	6.00	Line 2 times line 5			0	6.00
Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
10.00	8.00	Transitional corridor payment (see instructions)			0	8. 00
10.00	9.00	Ancillary service other pass through costs from Wkst. D. Pt.	IV, col. 13, line 200		0	9.00
COMPUTATION OF LESSER OF COST OR CHARGES					0	10.00
COMPUTATION OF LESSER OF COST OR CHARGES	11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 371, 382	11. 00
Reasonable charges						
12.00 Ancil Hary service charges 0 12.00 13.00 13.00 107an acquisit fron charges (fron West. D-4, Pt. III, col. 4, line 69) 0 13.00 13.00 107an acquisit fron charges (sum of lines 12 and 13) 0 14.00 0 14.00 0 15.00 16.						
13.00 Organ acquisition charges (From Wist. D-4, Pt. III., col. 4, line 69) 0 13.00 0 14.00 Color reasonable charges (sum of lines 12 and 13) 0 14.00 Color reasonable charges (sum of lines 12 and 13) 0 14.00 0 15.00 Organization (sum of lines 12 and 12 15.00 Organization (sum of lines 13 15.00 Organization (sum of lines 12 15.00 Organization (sum of lines 13 15.00	12.00				0	12.00
14.00 Total reasonable chargés (sum of lines 12 and 13) 14.00 14.00 15.00			ine 69)		0	13.00
Countries Coun	14.00		,		0	14.00
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00						
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 National Control National National Control National C	15.00		payment for services on	a charge basis	0	15. 00
had such payment been made in accordance with 42 CFR \$413.13(e)					0	
17.00				3	1	
18. 00 Total customary charges (see instructions) 0 18. 00 18. 00 19. 00 10. 00	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		,				
instructions			lvifline 18 exceeds li	ne 11) (see	0	
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00			,	, (1	
instructions	20.00	1	ly if line 11 exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents \(\tilde{\scriptsize} \) instructions 0 22.00 23.00 2		instructions)		, ,		
22.00 Interns and residents (see instructions) 0 22.00 23.00 23.00 Cots of physic ian's services in a teaching hospital (see instructions) 0 24.00 23.00 Cots of physic ian's services in a teaching hospital (see instructions) 0 24.00 Cots of physic ian's services in a teaching hospital (see instructions) 0 24.00 Cots of physic ian's services in a teaching hospital (see instructions) 0 24.00 Cots of physic ian's services in a teaching hospital (see instructions) 0 24.00 Cots of physic ian's services in a teaching hospital (see instructions) 2.341,145 26.00 27.00 Eductible sand Coinsurance (for CAH, see instructions) 2.341,146 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 2.341,146 26.00 27.00 ESRD direct medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00	21.00	Lesser of cost or charges (line 11 minus line 20) (see instru	ictions)		5, 425, 096	21.00
Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	22.00	Interns and residents (see instructions)			0	22.00
COMPUTATION OF REINBURSEMENT SETTLEMENT	23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
25 00 Deductible and coin surance (for CAH, see instructions) 2, 341,146 26 00	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
2. 341, 146 26. 00 2. 341, 146 26. 00 27. 00		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 50) 0 29.00 29.00	25.00	Deductibles and coinsurance (for CAH, see instructions)			46, 753	25.00
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 0 29.00 29.00	26.00	Deductibles and Coinsurance relating to amount on line 24 (fo	r CAH, see instructions))	2, 341, 146	26.00
28. 00	27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	3, 037, 197	27.00
29.00 ESRD difrect medical education costs (from Wkst. E-4, line 36) 3, 29, 00 30.00 Subtotal (sum of lines 27 through 29) 3, 037, 197 30, 00 31.00 Primary payer payments 476 31, 00 32.00 Autotal (line 30 minus line 31) 3, 036, 721 32, 00 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 386, 119 34, 00 34.00 Allowable bad debts (see instructions) 250, 977 35, 00 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 372, 837 36, 00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 372, 837 36, 00 37.00 Subtotal (see instructions) 32, 287, 698 37, 00 38.00 MSP-LCC reconciliation amount from PS&R 0 39, 00 39.01 ThERA ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39, 00 39.07 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39, 97 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 3, 287, 698 40		instructions)				
30.00 Subtotal (sum of lines 27 through 29) 3.037, 197 30.00 31.00 31.00 31.00 32.00	28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
31.00	29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 3.00 33.00 Allowable bad debts (see instructions) 386, 119 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 372, 873 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 372, 873 36.00 37.00 Subtotal (see instructions) 372, 873 36.00 38.00 MSP-LCC reconciliation amount from PS&R 38.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.90 Pioneer ACO demonstration payment adjustment for replaced devices (see instructions) 39.97 99.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 99.97 RECOVERY OF ACCELERATED DEPRECIATION 39.98 99.97 RECOVERY OF ACCELERATED DEPRECIATION 39.99 99.97 Professed amounts (see instructions) 39.97 99.	30.00	Subtotal (sum of lines 27 through 29)			3, 037, 197	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 386, 119 34.00 34.00 Allowable bad debts (see instructions) 250, 977 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 36.00 372, 837 372, 837 38.00 372, 837 38.00 372, 837 38.00 372, 837 38.00 38.00 39.00 39.50 39.	31.00	Primary payer payments			476	31.00
33.00 Composite rate ESRD (from Wkst. i-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 386, 119 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 250, 977 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 372, 837 36.00 37.00 Subtotal (see instructions) 3, 287, 698 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.99 RECOVERY OF ACCELERATED DEPRECIATION 3, 287, 698 40.00 40.01 Sequestration adjustment (see instructions) 3, 287, 698 40.00 40.01 Sequestration adjustment (see instructions) 3, 287, 698 40.00 40.01 Sequestration adjustment for the sequestration 40.02 Interim payments 3, 272, 144 41.00 42.00 Tentative settlement (for contractors use only) 42.00 Tentative settlement (for contractors use only) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	32.00				3, 036, 721	32.00
34.00 Allowable bad debts (see instructions) 386, 119 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 250, 977 37.50 37.00			CES)			
35.00 Adjusted reimbursable bad debts (see instructions) 250,977 35.00 30.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 372,837 36.00 37.00 Subtotal (see instructions) 37.00 Subtotal (see instructions) 37.00 39.50 39.00 MSP-LCC reconciliation amount from PS&R 0.38.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0.39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0.39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.99 Partial or full credits received from manufacturers for replaced devices (see instructions		1 '			-	
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 372,837 36.00 37.00 Subtotal (see instructions) 3,287,698 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.01 Sequestration adjustment (see instructions) 3,287,698 40.00 40.01 Sequestration adjustment (see instructions) 65,754 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 3,272,144 41.00 42.00 Tentative settlement (for contractors use only) -50,200 43.00 43.00 Balance due provider/program (see instructions) -50,200 43.00 41.00 <td< td=""><td></td><td>,</td><td></td><td></td><td></td><td></td></td<>		,				
37.00 Subtotal (see instructions) 3, 287, 698 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 3, 287, 698 40.00 40.01 Sequestration adjustment (see instructions) 3, 287, 698 40.00 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.02 40.02 40.02 40.02 40.03 40.03 40.04 40.04 40.05 40.0		,				
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.50 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.01 Subtotal (see instructions) 3, 287,698 40.00 40.02 Demonstration payment adjustment amount after sequestration 65,754 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 3, 272, 144 41.00 42.00 Interim payments 3, 272, 144 41.00 43.00 Balance due provider/program (see instructions) -50, 200 43.00 44.00 Forested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 <td></td> <td>,</td> <td>ructions)</td> <td></td> <td></td> <td></td>		,	ructions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50 Pomonstration payment adjustment amount before sequestration 39.71 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 39.99 Sequestration adjustment (see instructions) 39.99 (5.754 do. 0.00 Demonstration payment adjustment amount after sequestration 40.01 Interim payments 40.02 Interim payments 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{5115.2}{5115.2}\$ TO BE COMPLETED BY CONTRACTOR 90.00 Tiginal 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) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 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)					3, 287, 698	
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39. 97 39. 98 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 Subtotal (see instructions) 39. 99 40. 01 Sequestration adjustment (see instructions) 39. 99 40. 01 Interim payment adjustment amount after sequestration 40. 02 Interim payments 41. 00 Interim payments 42. 00 Interim payments 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, 50 \$\frac{10}{2}\$ BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 79. 00 Outlier reconciliation adjustment amount (see instructions) 79. 00 The rate used to calculate the Time Value of Money 79. 00 Time Value of Money (see instructions)		1 ' ' ' '				
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98		1 3 3 1	is)			
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99					-	
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 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, \$\frac{1}{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) 93.00 Time Value of Money (see instructions) 94.00 Og 40.00 95.00 Time Value of Money (see instructions) 97.00 Og 93.00		·	ced devices (see instruc	ctions)	01	
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40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 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, provided amounts (nonallowable cost report items) 45.15.2 Provided amounts (nonallowable cost report items) 46.00 Original outlier amount (see instructions) 47.00 Outlier reconciliation adjustment amount (see instructions) 48.00 Outlier reconciliation adjustment amount (see instructions) 49.00 The rate used to calculate the Time Value of Money 40.02 40.02 40.00 40.0	40. 00	1				
41.00 Interim payments 1.00 Interim payments 2.00 Tentative settlement (for contractors use only) 3.272, 144 41.00 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, 5.115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 0.00 Outlier reconciliation adjustment amount (see instructions) 79.00 The rate used to calculate the Time Value of Money 79.00 Time Value of Money (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 Outlier reconciliation adjustment amount (see instructions) 3.272, 144 41.00 42.00 42.00 43.00 44.00 44.00 44.00 45.10 44.00 46.00 44.00 47.00 44.00 48.00 44.00 49.00 00 00 00 00 00 00 00 00 00					65, 754	
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 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) 0 42.00 43.00 44.00 45.00 45.00 46.00 47.00 49.00 49.00 40.00 40.00 41.00 42.00 43.00 44.00 44.00 45.00 4					-	
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 43.00 44.00 44.00 45.00 45.00 46.00 45.00 47.00 90.00 90.00 90.00 91.00 92.00 92.00 70.00 93.00		1 . 3				
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		1			-	
\$115.2 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) 93.00 Time Value of Money (see instructions)						
70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00	44.00	,	nce with CMS Pub. 15-2,	chapter 1,	01	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) 90.00 91.00 92.00 93.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0 93.00						
93.00 Time Value of Money (see instructions) 0 93.00		• · · · · · · · · · · · · · · · · · · ·				
94.00 Total (sum of lines 91 and 93) 0 94.00		, , , , , , , , , , , , , , , , , , ,				
	94.00	Tiorai (2000 of fines 41 and 43)			0	94.00

Health Financial Systems GIBS ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-1319

1.00 Total interim payments paid to provider		tle XVIII tient Part A	Hospi tal	2/26/2018 1: 2: Cost	-
1.00 Total interim navments paid to provider		tient Part A	Dai		
1 00 Total interim payments paid to provider	mm/dd/yy		Fai	rt B	
1 00 Total interim navments paid to provider		/v Amount	mm/dd/yyyy	Amount	
1 00 Total interim navments paid to provider	1.00	2.00	3. 00	4. 00	
		1, 599, 1	00	2, 854, 144	1.00
2.00 Interim payments payable on individual bills, eith	ner		0	0	2.00
submitted or to be submitted to the contractor for	r				
services rendered in the cost reporting period. I	f none,				
write "NONE" or enter a zero					
3.00 List separately each retroactive lump sum adjustme					3.00
amount based on subsequent revision of the interin					
for the cost reporting period. Also show date of a payment. If none, write "NONE" or enter a zero.					
Program to Provider	1)				l
3. 01 ADJUSTMENTS TO PROVI DER			0 03/10/2017	43, 500	3.01
3. 02			0 04/26/2017	88, 000	3.02
3. 03	05/10/20	17 42, 1	00 05/10/2017	286, 500	3. 03
3. 04			0	0	3.04
3. 05			0	0	3.05
Provider to Program					
3.50 ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51			0	0	3. 51
3. 52			0	0	3. 52
3. 53			0	0	3.53
3.54		42.1	0	0	3.54
3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of line 3. 50-3. 98)		42, 1		418, 000	3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.9		1, 641, 2	00	3, 272, 144	4.00
(transfer to Wkst. E or Wkst. E-3, line and column	n as				
appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00 List separately each tentative settlement payment	after				5.00
desk review. Also show date of each payment. If no					3.00
write "NONE" or enter a zero. (1)	5110,				
Program to Provider	<u> </u>	<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
Provi der to Program					
5. 50 TENTATI VE TO PROGRAM			0	0	5.50
5. 51 5. 52			0	0	5. 51 5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of line	26		0		5. 99
5. 50-5. 98)				١	
6.00 Determined net settlement amount (balance due) bas the cost report. (1)	sed on				6. 00
6. 01 SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02 SETTLEMENT TO PROGRAM		329, 4	22	50, 200	6. 02
7.00 Total Medicare program liability (see instructions	s)	1, 311, 7	78	3, 221, 944	7. 00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1. 00	2.00	
8.00 Name of Contractor					8.00

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

		Component	CCN. 13-2319	10 09/30/2017	2/26/2018 1: 2:	
		Title	XVIII S	wing Beds - SNF		
		Inpatien	t Part A	Par	t B	
		/- - /	A	/- - /	A	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1. 00	Total interim payments paid to provider	1.00	1, 084, 099		4.00	1. 00
2. 00	Interim payments payable on individual bills, either		1,004,099		0	2. 00
2.00	submitted or to be submitted to the contractor for				Ĭ	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER				0	3. 01
3. 02	ABSOSTMENTS TO TROVIDER				0	3. 02
3. 03					ol	3. 03
3.04					o	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
3. 53 3. 54						3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
0. 77	3. 50-3. 98)				Ĭ	0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 084, 099		o	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR	I	I	T		F 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)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02					0	5. 02
5. 03			(0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	5. 52 5. 99
5. 99	5. 50-5. 98)			ή	ا	3. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
3. 00	the cost report. (1)					5. 50
6. 01	SETTLEMENT TO PROVIDER		33, 529		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		()	0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 117, 628		0	7. 00
				Contractor	NPR Date	
		,)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	manie or contractor	ļ		1	ı	0.00

Heal th	Financial Systems GIBSON GENERAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUI	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1319 Period: From 10/01/2016				1
	To 09/30/2017				
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6. 00
7. 00	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I				7. 00
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00	Sequestration adjustment amount (see instructions)				9.00
10.00					10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00					31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

GIBSON GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
SWING BEDS	Provider CCN: 15-1319		Worksheet E-2
		From 10/01/2016	
	Component CCN: 15-Z319	To 09/30/2017	Date/Time Prepared:
	•		2/26/2018 1:23 pm
	GIBSON GENERAL SWING BEDS		

		Component Con. 13-2319	10 07/30/2017	2/26/2018 1: 2	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		021 754	0	1 00
1.00	Inpatient routine services - swing bed-SNF (see instructions)		831, 754	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)	+ A and our of Wise+ D	221 042	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part Part Part Part Part Part Part Par		331, 843	0	3.00
4. 00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in: Per diem cost for interns and residents not in approved teach			0. 00	4.00
4.00	instructions)	ing program (see		0.00	4.00
5. 00	Program days		678	0	5. 00
6. 00	Interns and residents not in approved teaching program (see i	nstructions)	0.0	0	
7. 00	Utilization review - physician compensation - SNF optional me		0	_	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 163, 597	0	
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1, 163, 597	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applied	cable to physician	0	0	11.00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		1, 163, 597	0	12. 00
13.00	Coinsurance billed to program patients (from provider records)) (exclude coinsurance	23, 160	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	1, 140, 437	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instructions		0	0	
16. 55	Rural community hospital demonstration project (§410A Demonstration project (§410A Demonstrations)	ration) payment	U		16. 55
16. 99	Demonstration payment adjustment amount before sequestration			0	16. 99
	Allowable bad debts (see instructions)			0	1
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	1
	Total (see instructions)	r de trons)	1, 140, 437	0	
19. 01	Sequestration adjustment (see instructions)		22, 809	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
	Interim payments		1, 084, 099	0	1
	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)	33, 529	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from N	Wkst D 1 Dt II line			201. 00
201.00	66 (title XVIII hospital))	wkst. D-1, Pt. 11, Tille			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst D-3 col 3 lin	e		202. 00
202.00	200 (title XVIII swing-bed SNF))		~		202.00
203.00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons		
	peri od)				
205.00	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see inst	•			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines	1		208. 00
202 22	and 3)	-+!>			200 20
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	CLIONS)			209.00
∠10.00	Reserved for future use Comparision of PPS versus Cost Reimbursement				210.00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line :	200 plus lino 210) (200			215. 00
210.00	instructions)	207 piùs i i ile 210) (See			210.00
	1.1.02. 402. 5110)		1		1

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1319	From 10/01/2016	Worksheet E-3 Part V Date/Time Pre 2/26/2018 1:2	pared:
	Title XVIII	Hospi tal	Cost	
			1 00	

				2/20/2018 1:2	3 piii
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpatient services			1, 513, 754	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3.00				0	3.00
4. 00	Subtotal (sum of lines 1 through 3)			1, 513, 754	
5. 00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 528, 892	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 320, 072	0.00
7 00	Reasonable charges			0	7 00
7.00	Routine service charges			0	
8. 00	Ancillary service charges			0	8.00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for			0	11.00
12.00	Amounts that would have been realized from patients liable for	r payment for services o	on a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e	2)			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete or	ly if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)				
16.00	Excess of reasonable cost over customary charges (complete or	ly if line 6 exceeds lir	ne 14) (see	0	16.00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	,		1, 528, 892	19.00
20.00	Deductibles (exclude professional component)			213, 317	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 315, 575	
23. 00	Coi nsurance			0	23. 00
24. 00	Subtotal (line 22 minus line 23)			1, 315, 575	
25. 00	Allowable bad debts (exclude bad debts for professional servi	cas) (saa instructions)		35, 344	
26. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see mistructions)		22, 974	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		32, 956	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 338, 549	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 338, 549	
30. 01	Sequestration adjustment (see instructions)			26, 771	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
31.00	Interim payments			1, 641, 200	31.00
32.00	Tentative settlement (for contractor use only)			0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0	2, 31, and 32)		-329, 422	33.00
34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2.	chapter 1,	0	
	§115. 2		•		

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1319		Worksheet E-3 Part VII Date/Time Prepared: 2/26/2018 1:23 pm

			10 09/30/2017	2/26/2018 1: 2	epareu: 23 pm
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	CES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		21, 951		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		21, 951	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)		21, 951	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		8, 960		8.00
9.00	Ancillary service charges		26, 121	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)		35, 081	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
	basi s				
14. 00	Amounts that would have been realized from patients liable for p	9	ן ו	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)		35, 081	0	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	13, 130	0	17.00
10.00	line 4) (see instructions)	. 6 1		0	10.00
18. 00	Excess of reasonable cost over customary charges (complete only	IT line 4 exceeds line	9	0	18. 00
19. 00	16) (see instructions)			0	19.00
20.00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	ti one)		0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	ti ons)	21, 951	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	mploted for DDS provide		0	21.00
22 00	Other than outlier payments	ipreted for 113 provid	0	0	22. 00
	Outlier payments			0	
	Program capital payments		0	O	24.00
	Capital exception payments (see instructions)				25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		21, 951	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		21, 951	0	31.00
	Deducti bl es		0	0	
33.00	Coinsurance		o	0	
34.00	Allowable bad debts (see instructions)		o	0	34.00
35.00	Utilization review		o		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	21, 951	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
	Subtotal (line 36 ± line 37)		21, 951	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		21, 951	0	40.00
41.00	Interim payments		16, 721	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		5, 230	0	42.00
42 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43.00
43.00					

Health Financial Systems

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

Provider CCN: 15-1319

Peri od: Worksheet G From 10/01/2016 To 09/30/2017 Date/Time Prepared:

onl y)			10	09/30/2017	2/26/2018 1: 2	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1. 00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3, 867, 933		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0	0	0	0	2. 00 3. 00
4. 00	Accounts receivable	5, 902, 512		0	0	4.00
5. 00	Other recei vabl e	47, 108		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2, 007, 488	0	0	0	6.00
7. 00	Inventory	783, 371		0	0	7.00
8. 00 9. 00	Prepai d expenses	248, 364	0	0	0 0	8. 00 9. 00
10.00	Other current assets Due from other funds	0		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	8, 841, 800	1	Ö	-	11.00
	FIXED ASSETS					
12.00	Land	421, 244		0	0	12.00
13.00	Land improvements	263, 558		0	_	13.00
14. 00 15. 00	Accumulated depreciation Buildings	-177, 588 20, 009, 769	1	0	0	14. 00 15. 00
16. 00	Accumulated depreciation	-11, 790, 238		0	Ö	16.00
17. 00	Leasehold improvements	0	0	0	0	17.00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19. 00	Fixed equipment	3, 951, 644		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-3, 344, 569		0	0	20.00
22. 00	Accumulated depreciation	0		0	0	22.00
23. 00	Major movable equipment	9, 735, 971	Ö	0	0	23.00
24.00	Accumul ated depreciation	-8, 909, 610	0	0	0	24.00
25. 00	Minor equipment depreciable	683, 944		0	0	25. 00
26. 00	Accumulated depreciation	-555, 477	1	0	0	26.00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0		0	0 0	27. 00 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)	10, 288, 648		0	0	30.00
	OTHER ASSETS					
31.00	Investments	3, 163, 902	1	0	0	31.00
32. 00 33. 00	Deposits on leases Due from owners/officers	0		0	0	32. 00 33. 00
34. 00	Other assets	Ö		0	Ö	34.00
35.00	Total other assets (sum of lines 31-34)	3, 163, 902	2 0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22, 294, 350	0	0	0	36.00
27 00	CURRENT LIABILITIES	412 017	'l ol	0	0	27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	612, 017 1, 636, 650	1	0	0	37. 00 38. 00
39. 00	Payrol I taxes payable	0		0	ő	39.00
40.00	Notes and Loans payable (short term)	124, 283	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0		0	,	42.00
43. 00 44. 00	Due to other funds Other current liabilities	757, 746		0	0	43. 00 44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	3, 130, 696		0		
	LONG TERM LIABILITIES	., .,,				
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	7, 822, 014		0		47.00
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	0		0	0	48. 00 49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7, 822, 014		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	10, 952, 710		0		51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	11, 341, 640	1			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0 00	replacement, and expansion	11 241 440	1	0	_	50.00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	11, 341, 640 22, 294, 350		0	0	59. 00 60. 00
55. 55	59)			J	ĺ	55.00
			,	'		

Provider CCN: 15-1319

				To	09/30/2017	Date/Time Pre 2/26/2018 1:2	pared:
		General	Fund	Special Pu	rpose Fund	Endowment Fund	
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 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)	0 0	9, 628, 432 1, 713, 208 11, 341, 640	0 0 0	0	0 0 0	5. 00 6. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0	0 11, 341, 640	0 0 0	0	0 0 0	8. 00 9. 00 10. 00 11. 00 12. 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17)	0 0 0 0	0 11, 341, 640	0 0 0 0	0	0 0 0 0	15. 00 16. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7.00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 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)	0	0 0 0 0	0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0	0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

| Peri od: | Worksheet G-2 | From 10/01/2016 | Parts | & II | To 09/30/2017 | Date/Time Prepared:

Cost Center Description				To 09/30/2017	Date/Time Pre 2/26/2018 1:2	
PART I - PATIENT REVENUES 1.00 2.00 3.00		Cost Center Description	Inpatient	Outpati ent		J
PART 1 - PATENT REVENUES						
Secretal Inpatient Routine Services 1,815,226 1,815,226 2,00 2,00 3		PART I - PATIENT REVENUES				
1.00						
2.00 SUBPROVIDER - IPF	1.00		1, 815, 22	26	1, 815, 226	1.00
4.00 SUBPROVIDER	2.00	SUBPROVI DER - I PF				2.00
4.00 SUBPROVIDER						1
5.00						1
6.00 Swing bed - NF 0 0 0 0 0 0 0 0 0	5. 00	Swing bed - SNF		o	0	1
7. 00 SKILLED NURSING FACILITY 0 0 0 7. 00 9. 00 9. 00 9. 00 9. 00 0 9. 00 0 9. 00 0 9. 00 0 0 9. 00 0 0 0 9. 00 0 0 0 0 0 0 0 0 0				0		1
8. 00 NURSING FACILITY	7. 00	, 9		0	0	7.00
9.00 OTHER LONG TERM CARE 9.00 1,815,226 1,815						1
10.00 Total general inpatient care services (sum of lines 1-9) 1,815,226 1,815,226 10.00	9. 00					9.00
Intensive Care Type Inpatient Hospital Services	10.00		1, 815, 22	26	1, 815, 226	10.00
11.00 INTENSIVE CARE UNIT				<u>'</u>		
12.00 CORONARY CARE UNIT	11.00		60, 8	2	60, 812	11.00
14. 00 SURGICAL INTENSIVE CARE UNIT 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 OTHER SPECIAL CARE (SPECIFY) 16.00 Total intensive care type inpatient hospital services (sum of lines 60, 812 60, 812 16.00 17.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 876, 038 1, 876, 038 17.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 876, 038 4, 328, 411 34, 441, 508 38, 769, 919 18.00 15, 326 16, 326 16,	12.00	CORONARY CARE UNIT				12.00
15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 16. 00 16. 00 17. 11. 15 17. 00 Total intensive care type inpatient hospital services (sum of lines 18. 00 18.	13.00	BURN INTENSIVE CARE UNIT				13.00
16.00 Total intensive care type inpatient hospital services (sum of lines 10 and 16)	14.00	SURGICAL INTENSIVE CARE UNIT				14.00
16. 00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 11.876.038 1.876.038	15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
11-15	16.00		ies 60, 8°	2	60, 812	16.00
18. 00 Ancillary services 4, 328, 411 34, 441, 508 38, 769, 919 18. 00 20. 00 2					·	
19.00 Outpatient services	17.00	Total inpatient routine care services (sum of lines 10 and 16)	1, 876, 03	38	1, 876, 038	17. 00
20. 00 RURÂL HEALTH CLINIC 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 22. 00 HOME HEALTH AGENCY 23. 00 HOME HEALTH AGENCY 24. 00 CMHC 25. 00 AMBULANCE SERVICES 26. 00 HOSPICE 27. 00 MOB 27. 00 MOB 27. 00 MOB 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 8, 071, 387 51, 461, 140 59, 532, 527 59, 532, 527 59) 29. 00 Qaperating expenses (per Wkst. A, column 3, line 200) 31. 00 32. 00 33. 00	18.00	Ancillary services	4, 328, 4	1 34, 441, 508	38, 769, 919	18.00
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 585, 171 585, 171 22. 00 22. 00 HOME HEALTH AGENCY 585, 171 585, 171 22. 00 23. 00 AMBULANCE SERVICES CMHC 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 40. 00 HOSPICE MOB 70. 01 SIN PERRY CO 71. 02 PRO FEES Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 8, 071, 387 51, 461, 140 59, 532, 527 527 59, 532, 527 51, 101 1) PART II - OPERATING EXPENSES 90. 01 SPECIFY) 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 39. 00 40	19.00	Outpati ent servi ces	132, 98	8, 824, 053	8, 957, 038	19.00
22. 00 HOME HEALTH AGENCY 585, 171 585, 171 22. 00 23. 00 AMBULANCE SERVICES 24. 00 CMHC 24. 00 25. 00 26. 00 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 25. 00 26. 00 27. 00 MOB 0 6, 073, 192 6, 073, 192 27. 00 27. 01 27. 02 27. 01 27. 02 27. 01 27. 02 27. 02 27. 02 27. 03 27. 01 27. 02 27. 03 27. 01 27. 02 27. 03 27. 01 27. 02 27. 03 27. 01 27. 02 27. 03 27	20.00	RURAL HEALTH CLINIC		0 15, 326	15, 326	20.00
23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20	21.00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21.00
24. 00 25. 00 26. 00 26. 00 27. 00 MOB	22.00	HOME HEALTH AGENCY		585, 171	585, 171	22.00
24. 00 25. 00 26. 00 26. 00 27. 00 MOB	23.00	AMBULANCE SERVICES				23. 00
26. 00 HOSPICE	24.00	CMHC				24.00
26. 00 HOSPICE	25.00	AMBULATORY SURGI CAL CENTER (D. P.)				25. 00
27. 01 SNF PERRY CO						
27. 01 SNF PERRY CO				0 6, 073, 192	6, 073, 192	
27. 02 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) Ogradian and the stream of lines 30-35) Total additions (sum of lines 30-35) DEDUCT (SPECIFY) Ogradian and the stream of lines 30-35) DEDUCT (SPECIFY) Ogradian and the stream of lines 30-35) DEDUCT (SPECIFY) Ogradian and the stream of lines 30-35) DEDUCT (SPECIFY) Ogradian and the stream of lines 30-35) DEDUCT (SPECIFY) Ogradian and the stream of lines 30-35) Ogradian and		SNF PERRY CO	1, 733, 95			
G-3, line 1) PART II - OPERATING EXPENSES 29.00 30.00 31.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 28, 623, 539 29.00 30.00 31.00 31.00 31.00 32.00 33.00 34.00 35.00 0 36.00 37.00 38.00 39.00 40.00	27. 02	PRO FEES				27. 02
G-3, line 1) PART II - OPERATING EXPENSES 29.00 30.00 31.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 28, 623, 539 29.00 30.00 31.00 31.00 31.00 32.00 33.00 34.00 35.00 0 36.00 37.00 38.00 39.00 40.00	28. 00	Total patient revenues (sum of lines 17-27) (transfer column 3 to	Wkst. 8,071,38	51, 461, 140	59, 532, 527	28. 00
29. 00 Operating expenses (per Wkst. A, column 3, line 200) 28,623,539 29.00 30.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 40.00 40.00						
30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) 0 37.00 38.00 39.00 40.00 0 0 40.00		PART II - OPERATING EXPENSES	•	<u> </u>		
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) Total of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00	29.00	Operating expenses (per Wkst. A, column 3, line 200)		28, 623, 539		29. 00
32.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00	30.00	ADD (SPECIFY)		0		30.00
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) DEDUCT (SPECIFY) DEDUCT (SPECIFY) O 37.00 38.00 39.00 40.00 33.00 0 0 34.00 35.00 0 0 37.00 37.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00			0		31.00
34.00 35.00 36.00 37.00 38.00 39.00 40.00 34.00 0 35.00 0 0 37.00 37.00 38.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00			0		32.00
34.00 35.00 36.00 37.00 38.00 39.00 40.00 34.00 0 35.00 0 0 37.00 37.00 38.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00			0		33.00
36.00 Total additions (sum of lines 30-35) 0 36.00 37.00 38.00 39.00 40.00 0 0 0 40.00 0 0 0 0 0 0 0 0				0		34.00
37. 00 DEDUCT (SPECIFY)	35.00			0		35.00
38. 00 39. 00 40. 00	36.00	Total additions (sum of lines 30-35)		0		36.00
39. 00 40. 00 39. 00 40. 00	37.00	DEDUCT (SPECIFY)		0		37.00
40.00	38.00			0		38.00
	39.00			0		39. 00
44.00	40.00			0		40.00
41.00	41.00			0		41.00
42.00 Total deductions (sum of lines 37-41) 0 42.00	42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 28,623,539 43.00	43.00		ransfer	28, 623, 539		43.00
to Wkst. G-3, line 4)		to Wkst. G-3, line 4)	[

	Financial Systems GIBSON GENERAL			u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1319	Peri od: From 10/01/2016	Worksheet G-3	
			To 09/30/2017	Date/Time Pre	pared:
				2/26/2018 1:2	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii			59, 532, 527	1.00
2. 00	Less contractual allowances and discounts on patients' accou	ints		29, 575, 145	2.00
3. 00	Net patient revenues (line 1 minus line 2)			29, 957, 382	3.00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		28, 623, 539	4.00
5. 00	Net income from service to patients (line 3 minus line 4)			1, 333, 843	5.00
	OTHER I NCOME		1		
6.00	Contributions, donations, bequests, etc			223, 700	ł
7. 00	Income from investments			14, 946	1
8.00	Revenues from telephone and other miscellaneous communicatio	n services		0	
9.00	Revenue from television and radio service			0	,
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			0	1
12.00	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			137, 150	1
	Revenue from rental of living quarters				15.00
	Revenue from sale of medical and surgical supplies to other	than patients			16.00
	Revenue from sale of drugs to other than patients				17.00
	Revenue from sale of medical records and abstracts			-	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			59, 192	
23. 00	Governmental appropriations			0	23. 00
	MI SCELLANEOUS I NCOME			64, 484	1
	Total other income (sum of lines 6-24)			499, 472	1
	Total (line 5 plus line 25)			1, 833, 315	1
	OTHER EXPENSE			120, 107	ı
78 (1(1	Total other expenses (sum of line 27 and subscripts)			120 107	1 72 (1(1)

120, 107 28. 00 1, 713, 208 29. 00

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

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

-7.727

431, 238

431, 238

24.00

24.00 Total (sum of lines 1-23)

Provider CEX 19-1379 Period Of 17777011 Port Of 17777011 Port Of Of 17777011 Port Of	Heal th	Financial Systems		GIBSON GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Net Expenses Rings A			COST		Provi der C		Peri od: From 10/01/2016	Worksheet H-1 Part I Date/Time Pre	pared:
Capital Related - Rings September Capital Related - Rings Capital Rings Capital Related Capital Related Rings Capital Rings									<u>3 piii </u>
Col.				Capital Rela	ited Costs		Agency I		
CENTRAL SERVICE COST CENTERS			for Cost Allocation (from Wkst.			Operation 8	k n		
Capital Related - Bidg. & 0 0 0 0 0 0 0 0 0		CENEDAL SEDVICE COST CENTEDS		1. 00	2. 00	3.00	4. 00	4A. 00	
2.00 Capital Related - Movable 0 0 0 0 2.00	1. 00	Capital Related - Bldg. &	0	0				0	1.00
1.00 Plant Operation & Main Internance 0 0 0 0 0 0 0 0 0	2. 00		o		0			О	2. 00
4.00 Transportation 0 0 0 0 4 4.00	3 00		0	0	0		0	0	3 00
HAN RETIMBURSABLE SERVICES 0 0 0 0 0 0 0 0 0	4.00	Transportati on	O	Ö		1	0 0		4.00
7.00 Physical Therapy 35,075 0 0 0 35,075 7.00 7.618 8.00 00.00	5.00		145, 487	0	0		0 0	145, 487	5.00
0.00 0.00				I		1			
10.00 Medical Social Services 0 0 0 0 0 0 3,762 11.00 10.00 Medical Social Services 33,762 0 0 0 0 0 33,762 11.00 12.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 12.00	8.00	Occupational Therapy	7, 618	O				7, 618	8. 00
11.00				-1	0		٥	1	1
13.00 Drugs	11. 00	Home Health Aide	33, 762	O	0		0 0	33, 762	11.00
HAA NONREI MBURSABLE SERVICES				-1	0		٥	1	•
15.00 Home Dial ysis Aide Services 0 0 0 0 0 0 15.00	14. 00		0	o	0		0 0	0	14.00
17.00 Pri vate Duty Nursing 0 0 0 0 0 0 17.00 18.00 Clinic 0 0 0 0 0 0 0 18.00 19.00 Heal th Promotion Activities 0 0 0 0 0 0 0 19.00 19.00 Loga Care Program 0 0 0 0 0 0 0 20.00 19.00 Home Deli vered Meal s Program 0 0 0 0 0 0 0 0 19.00 Home Deli vered Meal s Program 0 0 0 0 0 0 0 19.00 Home Deli vered Meal s Program 0 0 0 0 0 0 0 19.00 Home Deli vered Meal s Program 0 0 0 0 0 0 20.00 Loga Care Program 0 0 0 0 0 0 21.00 Loga Care Program 0 0 0 0 0 0 23.00 All Others (specify) 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 23.50 Telemedic ine 0 0 0 0 0 0 0 24.00 Transportation Maintenance 0 0 0 0 25.00 Transportation 0 0 0 0 0 26.00 Transportation 0 0 0 0 0 0 27.00 Transportation 0 0 0 0 0 0 28.00 Transportation 0 0 0 0 0 0 0 29.00 Speech Pathology 0 0 0 0 0 0 0 29.00 Speech Pathology 0 0 0 0 0 0 0 0 29.00 Speech Pathology 0 0 0 0 0 0 0 0 29.00 Transportation 0 0 0 0 0 0 0 0 0 29.00 Transportation 0 0 0 0 0 0 0 0 0		Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
18. 00 Cit in c				- 1		1	-	0	•
20.00 Day Care Program	18.00	Clinic	Ö	Ö	Ö		0 0	ő	18. 00
21.00 Home Deli Vered Meals Program 0 0 0 0 0 0 0 0 0			0	0	0		0 0		•
23.00 All Others (specify) 0 0 0 0 0 0 0 0 0	21.00	Home Delivered Meals Program	0	O	0		0 0	0	21. 00
23.50 Telemedic ine 0 0 0 0 0 0 23.50 24.00 Total (Sum of lines 1-23)			0	0	0		0 0	0	•
Administrative & General de A		Tel emedi ci ne	1	0		1		· ·	1
Seneral Service Cost Centers	24.00	Total (sum of lines 1-23)			0		0 0	431, 238	24.00
CENERAL SERVICE COST CENTERS									
Fixtures	1 00		0.00	0.00					1.00
Equi pment		Fixtures							1.00
3.00	2. 00								2.00
Administrative and General 145, 487 HIAR REIMBURSABLE SERVICES		Plant Operation & Maintenance							•
HHA REIMBURSABLE SERVICES		•	145, 487						1
7. 00 Physical Therapy 17,858 52,933 7.00 8. 00 Occupational Therapy 3,879 11,497 8.00 9. 00 Speech Pathology 953 2,825 9.00 10. 00 Medical Social Services 0 0 10.00 11. 00 Home Health Aide 17,190 50,952 11.00 12. 00 Supplies (see instructions) 0 0 12.00 13. 00 Drugs 0 0 13.00 14. 00 DME 0 0 14.00 HHA NONREI MBURSABLE SERVI CES 14.00 15.00 16.00 16. 00 Respiratory Therapy 0 0 15.00 17. 00 Pri vate Duty Nursing 0 0 17.00 18. 00 Cli nic 0 0 18.00 19. 00 Day Care Program 0 0 19.00 20. 00 Day Care Program 0 0 21.00 10. Home Deli vered Meals Program 0 0 22.00 23. 00 All Others (specify) 0 <td< td=""><td>4 00</td><td></td><td></td><td>212 021</td><td></td><td></td><td></td><td></td><td>4 00</td></td<>	4 00			212 021					4 00
9.00 Speech Pathology 953 2,825 9.00 10.00 Medical Social Services 0 0 11.00 Home Heal th Aide 17,190 50,952 11.00 12.00 Supplies (see instructions) 0 0 13.00 Drugs 0 0 14.00 DME 0 0 HHA NONREIMBURSABLE SERVICES 0 16.00 Respiratory Therapy 0 0 17.00 Private Duty Nursing 0 0 18.00 Clinic 0 0 19.00 Heal th Promotion Activities 0 0 19.00 Day Care Program 0 0 20.00 Day Care Program 0 0 21.00 Home Delivered Meals Program 0 0 22.00 Homemaker Service 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedicine 0 0 10.00 10.00 11.00 10.00 12.00 10.00 13.00 10.00 14.00 15.00 15.00 15.00 16.00 17.00 17.00 17.00 18.00 19.00 19.00 19.00 20.00 20.00 21.00 22.00 22.00 23.00 23.50 Tel emedicine 0 0 23.50 Tel emedicine 0 25.00 25.50 25.50 25.00 25.50 25.50 25.00 25.50 25.50 25.00 25.50 25.50 25.00 25.50 25.50 25.00 25.50 25.50 25.00 25.50 25.50 25.00 25.50 25.00 25.50 25.50 25.00 25.50 25.00 25.50 25.00 25.50 25.00 25.50 25.00 25.50 25.00 25.50 26.00 26.00 27.00 27.00 28.00 27.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00	7.00	Physi cal Therapy	17, 858	52, 933					7. 00
10.00 Medical Social Services 0 0 10.00 11.00 Home Health Aide 17,190 50,952 11.00 12.00 Supplies (see instructions) 0 0 12.00 13.00 Drugs 0 0 0 13.00 14.00 DME 0 0 0 14.00 HHA NONREI MBURSABLE SERVI CES 15.00 Home Dialysis Aide Services 0 0 0 15.00 16.00 Respiratory Therapy 0 0 0 15.00 17.00 Private Duty Nursing 0 0 17.00 18.00 Clinic 0 0 0 18.00 19.00 Health Promotion Activities 0 0 0 19.00 20.00 Day Care Program 0 0 0 19.00 21.00 Home Delivered Meals Program 0 0 0 22.00 22.00 Home Delivered Meals Program 0 0 0 22.00 23.00 All Others (specify) 0 0 0 23.50 Tel emedicine 0 0 0 0 23.50									1
12.00 Supplies (see instructions) 0 0 0 13.00 13.00 14.00 DME 0 0 0 14.00 14.00 DME 15.00 Home Dialysis Aide Services 0 0 0 15.00 16.00 Private Duty Nursing 0 0 0 17.00 18.00 Clinic 0 0 0 18.00 19.00	10.00	Medical Social Services	0	0					10.00
13.00 Drugs									1
HHA NONREIMBURSABLE SERVICES 15.00 Home Dialysis Aide Services 0 0 0 15.00	13.00	Drugs							13.00
16.00 Respiratory Therapy 0 0 17.00 Private Duty Nursing 0 0 18.00 Clinic 0 0 19.00 Health Promotion Activities 0 0 20.00 Day Care Program 0 0 21.00 Home Delivered Meals Program 0 0 22.00 Homemaker Service 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedicine 0 0	14.00		0	U ₁					14.00
17.00 Private Duty Nursing 0 0 18.00 Clinic 0 0 19.00 Health Promotion Activities 0 0 20.00 Day Care Program 0 0 21.00 Home Delivered Meals Program 0 0 22.00 Homemaker Service 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedicine 0 0		1							•
19.00 Heal th Promotion Activities 0 0 20.00 Day Care Program 0 0 21.00 Home Delivered Meals Program 0 0 22.00 Homemaker Service 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedicine 0 0	17. 00	Private Duty Nursing	0	О					17. 00
20.00 Day Care Program 0 0 21.00 Home Delivered Meals Program 0 0 22.00 Homemaker Service 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedicine 0 0									
22. 00 Homemaker Service 0 0 23. 00 All Others (specify) 0 0 23. 50 Tel emedicine 0 0	20.00	Day Care Program							20. 00
23. 50 Tel emedi ci ne 0 0 23. 50		,	· ·						1
			· ·						1
									•

lealth Financial Systems		GI BSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	<u> 2552-1</u>
COST ALLOCATION - HHA STATISTICAL B	ASIS		Provi der C	CN: 15-1319	Peri od:	Worksheet H-1	
			HHA CCN:		From 10/01/2016 To 09/30/2017	Part II Date/Time Pre 2/26/2018 1:2	pared: 3 pm
					Home Health	PPS	•
					Agency I		
	Capital Rel	ated Costs	·				
	Bl dgs &	Movabl e	Plant	Transportation	Reconciliatio	Admi ni strati v	
	Fixtures	Equi pment	Operation &	n (MI LEAGE)		e & General	
	(SQUARE FEET)	(DOLLAR	Mai ntenance	(22/102)		(ACCUM. COST)	
		VALUE)	(SQUARE FEET)				
	1. 00	2. 00	3.00	4.00	5A. 00	5. 00	
GENERAL SERVICE COST CENTERS				•	•		
							1

Worksheet H-2 Part I Date/Time Prepared: 2/26/2018 1:23 pm From 10/01/2016 To 09/30/2017 HHA CCN: 15-7445 Home Health PPS

						Agency I	PPS	
			CAPI TAL REL	ATED COSTS		, igene,		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
		0	1. 00	2. 00	4. 00	4A	5. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 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) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to	0 313, 031 52, 933 11, 497 2, 825 0 50, 952 0 0 0 0 0 0 0 0 0 0 0	9, 555 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0	47, 711 313, 031 52, 933 11, 497 2, 825 0 50, 952 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 478, 949 0. 0000000	13, 964 91, 618 15, 493 3, 365 827 0 14, 913 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00
	6 decimal places. Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	
		7. 00	8. 00	9. 00	10.00	11. 00	13. 00	
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 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) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	13, 245 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	4, 586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	16, 234 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19, 231 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16. 00 17. 00 18. 00 19. 00 19. 50

⁽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.

Provider CCN: 15-1319 HHA CCN: 15-7445

						Home Health	PPS	
						Agency I		
	Cost Center Description	MEDI CAL	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
		RECORDS &		Resi dents		A&G (see Part	Costs	
		LI BRARY		Cost & Post		11)		
				Stepdown				
				Adjustments				
		16. 00	24. 00	25. 00	26. 00	27. 00	28. 00	
1.00	Administrative and General	7, 029	122, 000	0	122, 000			1.00
2.00	Skilled Nursing Care	0	404, 649	0	404, 649	· ·	493, 207	
3.00	Physi cal Therapy	0	68, 426	0	68, 426		83, 401	3.00
4.00	Occupational Therapy	0	14, 862	0	14, 862	3, 253	18, 115	4.00
5.00	Speech Pathology	0	3, 652	0	3, 652	799	4, 451	5.00
6.00	Medical Social Services	0	0	0	C	0	0	6.00
7.00	Home Health Aide	0	65, 865	0	65, 865	14, 415	80, 280	7. 00
8.00	Supplies (see instructions)	0	0	0	C	0	0	8.00
9.00	Drugs	0	0	0	C	0	0	9.00
10.00	DME	0	0	0	C	0	0	10.00
11.00	Home Dialysis Aide Services	o	0	0	l c	o	0	11.00
12.00	Respiratory Therapy	o	0	0	l c	o	0	12.00
13.00	Private Duty Nursing	O	0	0		o	0	13.00
14.00	Clinic	O	0	0		o	0	14.00
15.00	Health Promotion Activities	0	0	0	l c	o	0	15.00
16.00	Day Care Program	0	0	0		o	0	16.00
17.00	Home Delivered Meals Program	0	0	0		o	0	17.00
18.00	Homemaker Service	o	0	0	l c	ol	0	18.00
19.00	All Others (specify)	0	0	0		ol	0	19.00
19. 50	Tel emedi ci ne	0	0	0		ol	0	19.50
20.00	Total (sum of lines 1-19) (2)	7, 029	679, 454	0	679, 454	122, 000	679, 454	20.00
21. 00	Unit Cost Multiplier: column	,	,			0. 218852	,	21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	,	'	'	'	ı	1		'

⁽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	GI BSON GENERAL HOSPI TAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS		Peri od: Worksheet H-2
BASIS		From 10/01/2016 Part II To 09/30/2017 Date/Time Prepared:
	1	2/26/2018 1: 23 pm

-							2/20/2016 1. 2	3 PIII
						Home Health	PPS	
		CAPITAL REL	ATED COSTS			Agency I		
		CALLIAL KLL	AILD COSTS					
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
	cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFI TS	n	E & GENERAL	PLANT	
		(SQUARE TELT)	(SQUARE LELT)	DEPARTMENT	''	(ACCUM. COST)	(SQUARE FEET)	
				(GROSS		(ACCOM. COST)	(SQUARE FEET)	
				SALARI ES)				
		1. 00	2. 00	4. 00	5A	5. 00	7. 00	
1. 00	Administrative and General	505	505	297, 885	C		505	1. 00
2.00	Skilled Nursing Care	0	o	0			0	2.00
3. 00	Physi cal Therapy	0	ol	0			0	3. 00
4.00	Occupational Therapy	0	ol	0			o	4.00
5.00	Speech Pathology	0	0	0			0	5.00
6.00	Medi cal Soci al Servi ces	0	ol	0			o	6.00
7. 00	Home Heal th Ai de	0	ol	0		50, 952	0	7. 00
8. 00	Supplies (see instructions)	0	ol	0			0	8. 00
9. 00	Drugs	0	ol	0		0	0	9. 00
10.00	DME	0	ol	0			0	10.00
11.00	Home Dialysis Aide Services	0	o	0		0	0	11.00
12. 00	Respiratory Therapy	0	ol	0			0	12.00
13. 00	Private Duty Nursing	0	ol	0			0	13. 00
14.00	Clinic	0	ol	0		0	o	14.00
15.00	Health Promotion Activities	0	ol	0		0	o	15.00
16.00	Day Care Program	0	ol	0		0	o	16.00
17. 00	Home Delivered Meals Program	0	ol	0		0	o	17.00
18. 00		0	ol	0		0	o	18. 00
19.00	All Others (specify)	0	o	0		0	0	19.00
	Tel emedi ci ne	0	ol	0		0	o	19.50
20.00	Total (sum of lines 1-19)	505	505	297, 885		478, 949	505	20.00
21.00	Total cost to be allocated	9, 555	o	38, 156		140, 180	13, 245	21.00
22.00	Unit cost multiplier	18. 920792	0. 000000	0. 128090		0. 292683	26. 227723	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	MEDI CAL	
		LINEN SERVICE	(SQUARE FEET)	(PATI ENT	(GROSS	ADMI NI STRATI O	RECORDS &	
		(PATI ENT		DAYS)	SALARI ES)	N	LI BRARY	
		DAYS)				(NURSE	(GROSS	
						SALARI ES)	PATI ENT	
							REVENUE)	
		8. 00	9. 00	10. 00	11. 00	13. 00	16. 00	
1. 00	Administrative and General	0	505	0			585, 171	1. 00
2.00	Skilled Nursing Care	0	0	0	0	_	0	2.00
3. 00	Physi cal 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	5. 00
6. 00	Medical Social Services	0	0	0	0		0	6. 00
7. 00	Home Heal th Ai de	0	0	0	0		0	7. 00
8. 00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9. 00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0		0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0		0	11. 00
12. 00		0	0	0	1	_	0	12.00
13. 00	Private Duty Nursing	0	0	0			0	
14. 00	Clinic	0	0	0		_	0	14.00
15. 00	· •	0	0	0	0	0	0	15. 00
16. 00		0	0	0	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18. 00	1	0	0	0	0	0	0	18. 00
19. 00		0	0	0	0	0	0	19. 00
19. 50		0	0	0	0	0	0	19. 50
20.00		0	505	0	297, 885		585, 171	20.00
21. 00	Total cost to be allocated	0	4, 586	0	16, 234		7, 029	
22. 00	Unit cost multiplier	0. 000000	9. 081188	0. 000000	0. 054498	0. 102873	0. 012012	22.00

Hool +b	Financial Systems		GI BSON GENERA	AL HOSDITAL		In Lio	u of Form CMS-2	DEE2 10
	TIONMENT OF PATIENT SERVICE COST	TS.	GI BOON GENERA	Provi der C	CN: 15-1319	Peri od:	Worksheet H-3	
711 0101	TOTAL OF TAXIFER SERVICE GOST			HHA CCN:	15-7445	From 10/01/2016 To 09/30/2017		pared:
				Title	· XVIII	Home Health Agency I	PPS	<u>3 piii </u>
	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	Total HHA Costs (cols 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷	
		0	Part I)	Part II)	2.00	4.00	col . 4)	
	PART I - COMPUTATION OF LESSER	0	1. 00	2.00	3.00	4. 00	5. 00	
	COST LIMITATION	OF AGGREGATE	PRUGRAM CUSI, /	AGGREGATE OF T	HE PRUGRAW LI	MITATION COST, C	JR BENEFICIARY	
1 00	Cost Per Visit Computation	2.00	402.207	I	100.00	1 020	255 55	1 00
1.00	Skilled Nursing Care	2.00		l e	493, 20	· ·		1.00
2. 00	Physi cal Therapy	3. 00	· ·	0	,		75. 48	
3. 00	Occupational Therapy	4.00		l	, .		75. 48	
4. 00	Speech Pathology	5. 00		0	4, 4!		75. 44	
5.00	Medical Social Services	6. 00	0			0 15	0. 00	
6.00	Home Health Aide	7. 00	80, 280		80, 28	396	202. 73	6.00
7.00	Total (sum of lines 1-6)		679, 454	0	679, 4	54 3, 745		7.00
					Program Visi	ts		
					P	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
	oost center bescription	0031 21 1111 13	000/11/0. (1)	l lare A	to	Deducti bl es		
					Deducti bl es			
					Coi nsurance			
		0	1. 00	2. 00	3.00	4. 00	5. 00	
	Limitation Cost Computation					_		
8.00	Skilled Nursing Care		99915	0	1, 1	70		8.00
9.00	Physical Therapy		99915	l	1	25		9.00
10.00	Occupational Therapy		99915	0	l .	01		10.00
11. 00	Speech Pathology		99915		l .	27		11.00
12. 00	Medical Social Services		99915		•	0		12.00
13. 00	Home Heal th Ai de		99915			87		13.00
14. 00	1		77713		1			14.00
14.00	Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	14.00
	odst denter bescription	H-2 Part I, col. 28, line	Costs (from Wkst. H-2, Part I)	Ancillary Costs (from Part II)	Costs (cols		÷ col . 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput	ati ons			•			
15.00	Cost of Medical Supplies	8. 00	0	0		0 0	0. 000000	15. 00
16. 00	Cost of Drugs	9. 00				0 0	0. 000000	16.00
			Program Visits		Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	·		to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1, 170			0 298, 994		1.00
2. 00	Physi cal Therapy	l o	725	ł		0 54, 723		2.00
3. 00	Occupational Therapy	l	101		1	0 7, 623		3.00
4. 00	Speech Pathology	ا م	27			0 2,037		4.00
5. 00	Medical Social Services	١	0	ł		0 2,037		5.00
6. 00	Home Heal th Aide		287	l .		0 58, 184		6.00
7. 00	Total (sum of lines 1-6)	0				0 421, 561		7.00
, . 50	1.5ta/ (5am 61 111165 1 6)	١ ٠	2,310	I	I	721, 301	ı	, , , , , ,

Heal th	Financial Systems		GI BSON GENER.	AL HOSDITAL		In Lie	u of Form CMS-2	2552_10
	TIONMENT OF PATIENT SERVICE COST	ΓS	OI DOON GENER	Provi der Co	CN: 15-1319	Peri od:	Worksheet H-3	
				HHA CCN:	15-7445	From 10/01/2016 To 09/30/2017	Part I Date/Time Pre 2/26/2018 1:2	pared:
				Title	XVIII	Home Health	PPS	<u> Брііі</u>
	Cost Contor Doscription					Agency I		
	Cost Center Description	6, 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation	0.00	7.00	0.00	7.00	10.00	11.00	
8.00	Skilled Nursing Care							8. 00
9.00	Physi cal Therapy							9. 00
10. 00 11. 00	Occupational Therapy Speech Pathology							10.00 11.00
12.00	Medical Social Services							12.00
13. 00	Home Heal th Ai de							13.00
14.00	Total (sum of lines 8-13)							14.00
		Progi	ram Covered Cha	arges	Cost of			
					Servi ces			
			Par	rt B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
		6. 00	Coi nsurance 7.00	8.00	9. 00	Coi nsurance 10.00	11. 00	
	Supplies and Drugs Cost Comput		7.00	0.00	7.00	10.00	11.00	
	Cost of Medical Supplies	0				0 0		
16. 00	Cost of Drugs	T	0	0		0	0	16. 00
	Cost Center Description	Total Program Cost (sum of						
		col s. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST,	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, O	R BENEFICIARY	
	COST LIMITATION Cost Per Visit Computation							1
1.00	Skilled Nursing Care	298, 994						1.00
2.00	Physi cal Therapy	54, 723						2.00
3.00	Occupational Therapy	7, 623						3.00
4.00	Speech Pathology	2, 037						4.00
5. 00 6. 00	Medical Social Services Home Health Aide	0 58, 184						5. 00 6. 00
7. 00	Total (sum of lines 1-6)	421, 561						7.00
7.00	Cost Center Description	1217001						7.00
		12. 00						
	Limitation Cost Computation	T	Г					
8. 00 9. 00	Skilled Nursing Care Physical Therapy							8. 00 9. 00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Heal th Ai de							13.00
14. 00	Total (sum of lines 8-13)	l						14.00

Heal th	Financial Systems	GI BSON GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
APP0R1	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7445	From 10/01/2016 To 09/30/2017		
				Title	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED I	BY SHARED HOSP	TAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 323569	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 292047	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 342278	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	1. 048870	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 557388	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems GIBSON GENE ATION OF HHA REIMBURSEMENT SETTLEMENT	RAL HOSPITAL Provider C	^N· 15_1210	Peri od:	u of Form CMS-2 Worksheet H-4	
ALCUL	ATTOM OF HIM RETWINDUNGEWEINT SEFFEEWEINT	HHA CCN:	15-7445	From 10/01/2016 To 09/30/2017	Part I-II Date/Time Pre	pare
		Title	XVIII	Home Health	2/26/2018 1: 2 PPS	3 pm
				Agency I Par	t B	
			Part A	Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	
			1.00	Coi nsurance 2.00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR	CUSTOMARY CHARGI		2.00	3.00	
	Reasonable Cost of Part A & Part B Services					1
00	Reasonable cost of services (see instructions)			0 0	0	1.
00	Total charges Customary Charges			0 0	0	2.
00	Amount actually collected from patients liable for paymen	nt for services		0 0	0	3.
	on a charge basis (from your records)					
. 00	Amount that would have been realized from patients liable for services on a charge basis had such payment been made with 42 CFR §413.13(b)			0 0	0	4.
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000			5.
00	Total customary charges (see instructions) Excess of total customary charges over total reasonable c	cost (complete		0 0	0	7.
. 00	only if line 6 exceeds line 1)	ost (comprete			U	'
00	Excess of reasonable cost over customary charges (complet 1 exceeds line 6)	e only if line		0 0	0	8.
00	Primary payer amounts			0 0	0	9
				Part A Services 1.00	Part B Servi ces 2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
. 00	Total reasonable cost (see instructions)			0	0	
2. 00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			0	281, 850 6, 467	1
3. 00	Total PPS Reimbursement - LUPA Episodes			0	7, 240	
. 00	Total PPS Reimbursement - PEP Episodes			0	2, 029	
. 00	Total PPS Outlier Reimbursement - Full Episodes with Outl	i ers		0	2, 070	
. 00	Total PPS Outlier Reimbursement - PEP Episodes			0	953	
. 00	Total Other Payments DME Payments			0	0	17 18
. 00	Oxygen Payments			0	0	19
. 00	Prosthetic and Orthotic Payments			0	0	20
. 00	Part B deductibles billed to Medicare patients (exclude c	coi nsurance)			0	21
. 00	,			0	300, 609	
. 00	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	0 300, 609	
. 00	Coinsurance billed to program patients (from your records	;)			875	1
. 00	Net cost (line 24 minus line 25)	• •		0	299, 734	
. 00	Reimbursable bad debts (from your records)					27
3. 00	Reimbursable bad debts for dual eligible beneficiaries (s)	_		28
). 00). 00	Total costs - current cost reporting period (line 26 plus OTHER ADJUSTMENT	s line 2/)		0	299, 734 0	30
. 50	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	0	1
. 99	Demonstration payment adjustment amount before sequestrat	,		0	0	30
. 00	Subtotal (see instructions)			0	299, 734	31
1. 01	Sequestration adjustment (see instructions)			0	5, 995	
1. 02	Demonstration payment adjustment amount after sequestrati	on		0	202 720	31
2.00	Interim payments (see instructions) Tentative settlement (for contractor use only)			0	293, 739 0	32
	promise ve settrement (for contractor use only)			_		
3. 00 4. 00	Balance due provider/program (line 31 minus lines 31.01,	32. and 33)		0	0	34

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

Peri od: From 10/01/2016 To 09/30/2017 Date/Time Prepared: 2/26/2018 1:23 pm PPS HHA CCN: 15-7445

				Home Health Agency I	PPS	
		Inpatien	t Part A		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			0	293, 739 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				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0 0	3. 03 3. 04
3. 04				0		3. 04
3. 03	Provider to Program			<u> </u>	0	3. 03
3.50				0	0	3.50
3. 51				0	0	3.51
3. 52				0	0	3.52
3. 53				0	0	3. 53
3. 54	Cubtatal (aug af lines 2 01 2 40 minus aug af lines			0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	293, 739	4.00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
F 04	Program to Provider					E 04
5. 01 5. 02				0	0 0	5. 01 5. 02
5. 02				0		5. 02
0.00	Provider to Program			<u> </u>		0.00
5. 50				0	0	5.50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	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	o	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6.02
7. 00	Total Medicare program liability (see instructions)			0	293, 739	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	GIBSON GENERA		CN: 15-1319	Peri od:	wof Form CMS-2 Worksheet M-1	
			Component	CCN: 15-8524	From 10/01/2016 To 09/30/2017		
					RHC I	Cost	о ріп
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
				,		(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	C	1	0 -2, 621	-2, 621	1.00
2.00	Physician Assistant	0	C	1	0	0	2.00
3.00	Nurse Practitioner	0	C	1	0 4, 911	4, 911	3.00
4.00	Visiting Nurse	0	C		0 0	0	
5.00	Other Nurse	0	C		0 2, 370		
6. 00	Clinical Psychologist	0	C		0 0	0	
7. 00	Clinical Social Worker	0	C		0 0	0	
8. 00	Laboratory Techni ci an	0	C	1	0 0	0	
9. 00	Other Facility Health Care Staff Costs	0	C		0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	0	C		0 4, 660		
11.00	Physician Services Under Agreement	0	C		0	0	11.00
12.00	Physician Supervision Under Agreement	0	C		0	0	
13.00	Other Costs Under Agreement	0	C		0 0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	C	1	0	0	
15.00	Medical Supplies	0	C	1	0 0	0	
16.00	Transportation (Health Care Staff)	0	C		0 0	0	
17. 00 18. 00	Depreciation-Medical Equipment	0	C			0	17. 00 18. 00
	Professional Liability Insurance Other Health Care Costs	0				0	
20.00	Allowable GME Costs	٩	C		0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	C		0	0	
22. 00	Total Cost of Health Care Services (sum of	0	0		0 4,660	_	
22.00	lines 10, 14, and 21)	o o	C	1	4,000	4,000	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00		0	C		0 0	0	23.00
24. 00	Dental	o	C	1	0 0	0	
25.00	Optometry	O	C)	0 0	0	25.00
25. 01	Tel eheal th	0	C)	0 0	0	25. 01
25.02	Chronic Care Management	0	C	1	0 0	0	25. 02
26.00	All other nonreimbursable costs	0	C)	0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	C	1	0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	C		0 356		29. 00
30.00	Administrative Costs	0	C	1	0 7, 138		
31. 00	Total Facility Overhead (sum of lines 29 and	0	C	1	0 7, 494	7, 494	31.00
	30)						
22 00	Total facility costs (sum of lines 22 28	Λl	(d .	0 12 154	12 154	

0

12, 154

12, 154

32.00

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

Health Financial Systems	GIBSON GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 10/01/2016	Worksheet M-1
	Component CCN: 15-8524	To 09/30/2017	Date/Time Prepared: 2/26/2018 1:23 pm
		RHC I	Cost

					2/26/2018 1: 2	23 pm
				RHC I	Cost	
		Adjustments	Net Expenses			
		•	for			
			Allocation			
			(col. 5 +			
			col. 6)			
		6. 00	7.00			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00			
1. 00	Physi ci an	0	-2, 621			1.00
2. 00	Physician Assistant	0	-2, 021			2.00
		0	4, 911			1
3.00	Nurse Practitioner	0	·			3.00
4. 00	Visiting Nurse	0	0			4.00
5.00	Other Nurse	0	2, 370			5.00
6.00	Clinical Psychologist	0	0			6.00
7.00	Clinical Social Worker	0	0			7.00
8.00	Laboratory Techni ci an	0	O			8. 00
9.00	Other Facility Health Care Staff Costs	0	ol			9.00
10.00	Subtotal (sum of lines 1 through 9)	0	4, 660			10.00
11. 00		0	0			11.00
12. 00		0	o o			12.00
	Other Costs Under Agreement	0	0			13.00
14. 00	· ·	0	0			14.00
	,	0	- 1			
15.00	Medical Supplies	0	0			15.00
16. 00		0	0			16.00
17. 00	The second secon	0	0			17. 00
	Professional Liability Insurance	0	0			18. 00
19. 00	Other Health Care Costs	0	0			19. 00
20.00	Allowable GME Costs					20.00
21.00	Subtotal (sum of lines 15 through 20)	0	O			21.00
22.00	Total Cost of Health Care Services (sum of	0	4, 660			22.00
	lines 10, 14, and 21)		· ·			
	COSTS OTHER THAN RHC/FQHC SERVICES		<u> </u>			1
23.00		0	0			23.00
24. 00	Dental	0	ol			24.00
25. 00	Optometry	0	0			25. 00
25. 01	Tel eheal th	0	0			25. 01
25. 01	Chronic Care Management	0	0			25. 02
26. 00	All other nonreimbursable costs	0	0			26.00
		U	٩			27.00
27. 00	Nonallowable GME costs					
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0			28. 00
	through 27)					
	FACILITY OVERHEAD					
29. 00	1	0	356			29. 00
30.00	Administrative Costs	0	7, 138			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	7, 494			31.00
	30)					
32.00	Total facility costs (sum of lines 22, 28	0	12, 154			32.00
	and 31)					
	·		*			

	Financial Systems	GIBSON GENERA				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2016 To 09/30/2017	Date/Time Pre	pared.
						2/26/2018 1:2	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
		1.00	0.00	0.00	1 x col . 3)	col . 4	
	VICITE AND PRODUCTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY Positions						
1. 00	Physi ci an	0.00		4, 20	0 0		1.00
2.00	Physician Assistant	0.00		1			2.00
3. 00	Nurse Practitioner	0.00					3.00
4. 00	Subtotal (sum of lines 1 through 3)	0.05			105	105	4.00
5. 00	Visiting Nurse	0.00			100	0	5.00
6. 00	Clinical Psychologist	0.00		1		0	6.00
7. 00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	0.05	34	ļ.		105	8.00
	through 7)						
9. 00	Physician Services Under Agreements		()		0	9.00
						1.00	
	DETERMINATION OF ALLOWARIE COST APPLICABLE 3	O HOCDITAL DAG	ED DUO (EQUIO CE	D) // OFC		1. 00	
10. 00	DETERMINATION OF ALLOWABLE COST APPLICABLE 1 Total costs of health care services (from Wi			RVICES		4, 660	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	·				4, 660	11.00
12.00	Cost of all services (excluding overhead) (s					4, 660	
13. 00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fi			ine 31)		7, 494	
15. 00	Parent provider overhead allocated to facili			1110 01)		4, 854	
16. 00	Total overhead (sum of lines 14 and 15)	ty (555 11.5t. u	01.01.0)			12, 348	
17. 00	Allowable GME overhead (see instructions)					0	•
18. 00	Enter the amount from line 16					12, 348	18.00
19. 00	Overhead applicable to hospital-based RHC/FG	QHC services (I	ine 13 x line	18)		12, 348	19.00
	Total allowable cost of hospital-based RHC/	-0110 (E I! 1	0 1 10)		47.000	20.00

	Financial Systems GIBSON GENERAL			u of Form CMS-2	
SERVI (LATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1319	Peri od: From 10/01/2016	Worksheet M-3	
SERVI	<i>7</i> .23	Component CCN: 15-8524	To 09/30/2017	Date/Time Pre 2/26/2018 1:2	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			17, 008	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li Total allowable cost excluding vaccine (line 1 minus line 2)	ne 15)		0 17, 008	2. 00 3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			105	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			105	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	161.98 of limit (1)	7.00
			our our attron	01 21 111 (1)	
			Prior to Jan.	On or After	
			1 (Rate Period 1)	Jan. 1 (Rate Period 2)	
			1.00	2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0. 00	8. 00
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		161. 98	161. 98	9. 00
10.00	Program covered visits excluding mental health services (from	contractor records)	0	0	10.00
11. 00	Program cost excluding costs for mental health services (line		0	0	11.00
12.00	Program covered visits for mental health services (from contr	actor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x li	•	0	0	13.00
14. 00 15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction	•	0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	0	16.00
16. 01	Total program charges (see instructions)(from contractor's re			0	16. 01
16. 02	Total program preventive charges (see instructions)(from prov			0	16. 02
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0	•		0	16. 03 16. 04
10.04	(Titles V and XIX see instructions.)	3 and 16) trilles . 60)		U	10.04
16.05	Total program cost (see instructions)		0	0	16.05
17.00	Primary payer amounts			0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		0	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		0	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			0	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	21.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			0	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	23. 01 24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	25.00
25. 50	1 ' ' ' ' '	s)		0	25. 50
	Demonstration payment adjustment amount before sequestration			0	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			0	26. 00 26. 01
26. 01	1 '			0	26.01
	Interim payments			0	27.00
28. 00	1			0	28. 00
	Balance due component/program (line 26 minus lines 26.01, 26.			0	29.00
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-11	'	0	30.00