This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1319 Worksheet S Peri od: From 10/01/2019 Parts I-III AND SETTLEMENT SUMMARY 09/30/2020 Date/Time Prepared: 4/28/2021 8:15 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 4/28/2021 8: 15 am Manually prepared cost report use only ]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. Contractor 10. NPR Date: ]Cost Report Status As Submitted
7. Contractor No.

Settled without Audit
8. [ N ] Initial Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter 5. Settled with Audit 9. [ N ] Final Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter 12. [ 0 ] If line 5, column 1 is 4: Enter 13. Settled with Audit 14. Settled with Audit 15. Settled with Audit 16. Settled with Audit 17. Settled with Audit 18. [ N ] Final Report for this Provider CCN 18. Settled with Audit 19. Set 11. Contractor's Vendor Code: (1) As Submitted use only (2) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GLBSON GENERAL HOSPITAL (15-1319) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 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.

[ X ]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) RI CK HARNI NG
Officer or Administrator of Provider(s)

CF0 Title

(Dated when report is electronically signed.)
Date

Title XVIII Cost Center Description Title V Part A Part B HI T Title XIX 1.00 5.00 2.00 4.00 PART III - SETTLEMENT SUMMARY 1 00 Hospi tal 0 508. 322 165, 180 26, 581 1 00 Subprovider - IPF 2.00 0 2.00 0 0 Subprovider - IRF 3.00 0 0 0 0 0 3.00 Swing Bed - SNF Swing Bed - NF 5.00 1, 107, 582 0 0 5.00 6.00 0 6.00 SKILLED NURSING FACILITY 7.00 0 0 7.00 C HOME HEALTH AGENCY I 0 9.00 0 0 9.00 0 10 00 FORT BRANCH RHC I 16 400 0 10 00 CLARK & WELLS RHC II 0 10.01 48.805 Λ 10.01 1, 615, 904 230, 385 26, 581 200. 00 200, 00 Total 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 10/01/2019 Part I 09/30/2020 Date/Time Prepared: 4/28/2021 8:15 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1800 SHERMAN DRIVE 1.00 PO Box: 1.00 State: IN 2.00 City: PRINCETON Zi p Code: 47670-County: GIBSON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 GIBSON GENERAL HOSPITAL 151319 99915 12/16/2003 Ν 0 0 3.00 Hospi tal Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF GIBSON GENERAL SWING 15Z319 99915 12/16/2003 N 0 N 7.00 BFD 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA GIBSON HOME HEALTH 157445 99915 10/19/1995 N Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC GIBSON GENERAL FAMILY 158524 99915 O 15.00 09/11/2017 N 0 15.00 MEDICINE FORT Hospital-Based Health Clinic - RHC GIBSON GENERAL FAMILY 158553 99915 15.01 05/29/2019 0 15.01 MEDICINE- 510 16 00 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 To: From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2019 09/30/2020 20.00 21.00 Type of Control (see instructions) 2 21.00 3. 00 1.00 2. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for 22 00 Ν N disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22 01 22 01 Ν Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas N Ν 22.03 N

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)

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 10/01/2019 Part I 09/30/2020 Date/Time Prepared: 4/28/2021 8:15 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d Medi cai d State State HMO days paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 0 24.00  $\cap$ Λ in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 2.00 1.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26, 00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 |If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν N Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA 56.00 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

58.00

59.00

N

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

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

|  |                              | L HOSPITAL             | ON. 4E 4040        |  | u of Form CMS-2   |                  |
|--|------------------------------|------------------------|--------------------|--|---|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA  | ATA                          | Provi der Co           |                    | Peri od:<br>From 10/01/2019<br>To 09/30/2020 | Worksheet S-2<br>Part I<br>Date/Time Pre<br>4/28/2021 8:1 | pared:           |
|  |                              |                        | NAHE 413.85<br>Y/N | Worksheet A<br>Line #                        | Pass-Through<br>Qualification<br>Criterion<br>Code        |                  |
|  |                              |                        | 1.00               | 2. 00  | 3. 00   |                  |
| 60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent (adjustement? Enter "Y" for yes or "N" for no in colu   | 85? (s<br>umn 1.<br>CR) NAHE | see<br>If column 1     | N                  |  |   | 60.00            |
|  | Y/N                          | IME                    | Direct GME         | I ME   | Direct GME  |                  |
|  | 1.00                         | 2. 00                  | 3. 00              | 4. 00  | 5. 00   |                  |
| 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)  Enter the average number of unweighted primary care   | N                            |                        |                    | 0.00   | 0.00  | 61. 00           |
| FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,   |                              |                        |                    |  |   | 61. 02           |
| and primary care FTEs added under section 5503 of 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   |                              |                        |                    |  |   | 61. 03           |
| instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the   |                              |                        |                    |  |   | 61. 04           |
| current cost reporting period. (see instructions).  61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line  |                              |                        |                    |  |   | 61. 05           |
| 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  |                              |                        |                    |  |   | 61.06            |
|  | Pro                          | gram Name              | Program Cod        | e Unweighted<br>IME FTE Count                | Unweighted Direct GME FTE Count                           |                  |
|  |                              | 1. 00                  | 2. 00              | 3.00   | 4. 00   |                  |
| 61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents 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. 10           |
| 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. 20           |
| the direct ome ric diwerghted count.   |                              |                        |                    |  | 1.00  |                  |
| ACA Provisions Affecting the Health Resources and Ser  |                              |                        |                    |  |   |                  |
| 62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructed). Enter the number of FTE residents that rotated from a  | ctions)                      |                        |                    |  |   | 62. 00<br>62. 01 |
| during in this cost reporting period of HRSA THC prog<br>Teaching Hospitals that Claim Residents in Nonprovide   | gram. (s<br>er Setti         | see instructio<br>ings | ons)               |  | 3.00  | 02.01            |
| 63.00 Has your facility trained residents in nonprovider se<br>"Y" for yes or "N" for no in column 1. If yes, comple   | ettings                      | during this o          |                    |  | N   | 63. 00           |

| Health Financial Systems   | GI BSON  | GENERAL HOSPITAL  |  | In lie                            | ı of Form CMS-2                          | 2552-10 |
|--|--|---|--|-----------------------------------|--|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPI  |  |   |  | eriod:<br>com 10/01/2019          | Worksheet S-2<br>Part I<br>Date/Time Pre | pared:  |
|  |  |   | Unweighted                                   | Unwei ghted                       | 4/28/2021 8: 1<br>Ratio (col.            | 5 am    |
|  |  |   | FTEs<br>Nonprovi der<br>Si te                | FTEs in<br>Hospital               | 1/ (col. 1 + col. 2))                    |         |
|  |  |   | 1.00   | 2. 00                             | 3. 00                                    |         |
| Section 5504 of the ACA Base Year  |  |   | This base year                               | is your cost                      | reporti ng                               |         |
| period that begins on or after J 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo   | yes, or your facili-<br>ber of unweighted nor<br>tations occurring in<br>number of unweighted    | ty trained residents<br>n-primary care<br>all nonprovider<br>d non-primary care | 0.00   | 0.00                              | 0. 000000                                | 64.00   |
| of (column 1 divided by (column  |  |   | Upwai abtad                                  | Hawai ahtad                       | Datio (oal                               |         |
|  | Program Name   | Program Code  | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te | Unweighted<br>FTEs in<br>Hospital | Ratio (col.<br>3/ (col. 3 +<br>col. 4))  |         |
|  | 1. 00  | 2. 00   | 3. 00  | 4. 00                             | 5. 00                                    |         |
| 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) |  |   | 0.00   | 0.00                              | 0. 000000                                | 65.00   |
|  |  |   | FTEs<br>Nonprovi der<br>Si te                | FTEs in<br>Hospital               | 1/ (col . 1 + col . 2))                  |         |
|  |  |   | 1. 00  | 2. 00                             | 3. 00                                    |         |
| Section 5504 of the ACA Current beginning on or after July 1, 20   |  | n Nonprovider Setting   | gsEffective f                                | or cost report                    | ing periods                              |         |
| 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +  | unweighted non-priman<br>ccurring in all nonpo<br>unweighted non-priman<br>al. Enter in column 3 | rovider settings.<br>ry care resident<br>3 the ratio of                         | 0.00   | 0. 00                             |  | 66.00   |
|  | Program Name   | Program Code  | Unwei ghted<br>FTEs                          | Unweighted<br>FTEs in             | Ratio (col. 3 +                          |         |
|  |  |   | Nonprovi der                                 | Hospi tal                         | col . 4))                                |         |
|  | 1 00   | 2 00  | Si te  | 4 00                              | 5 00                                     |         |
| 67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)   | 1.00   | 2. 00   | 3.00   | 4. 00<br>0. 00                    | 5. 00<br>0. 000000                       | 67.00   |

|  | 1. 00 | 2.00 |        |
|--|-------|------|--------|
| Title V and XIX Services   |       |      |        |
| 0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for   | N     | Υ    | 90.00  |
| yes or "N" for no in the applicable column.  |       |      |        |
| I.00  s this hospital reimbursed for title V and/or XIX through the cost report either in  | N     | Υ    | 91.00  |
| full or in part? Enter "Y" for yes or "N" for no in the applicable column.   |       |      |        |
| 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see   |       | N    | 92.00  |
| instructions) Enter "Y" for yes or "N" for no in the applicable column.  |       |      |        |
| 3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter   | N     | N    | 93.00  |
| "Y" for yes or "N" for no in the applicable column.  |       |      |        |
| 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the   | N     | N    | 94.00  |
| applicable column.   | 0.00  | 0.00 | 05.00  |
| 5.00 If line 94 is "Y", enter the reduction percentage in the applicable column.   | 0.00  | 0.00 | 95.00  |
| 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the   | N     | N    | 96.00  |
| applicable column  | 0.00  | 0.00 | 07.00  |
| 7.00   If line 96 is "Y", enter the reduction percentage in the applicable column.   | 0.00  | 0.00 | 97.00  |
| 8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post  | Y     | Y    | 98. 00 |
| stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in  |       |      |        |
| column 1 for title V, and in column 2 for title XIX.  B.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. | Υ     | Υ    | 98. 01 |
| C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for   | ı     | ı    | 90.01  |
| title XIX.   |       |      |        |
| 8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation  | Y     | Y    | 98. 02 |
| bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1   | '     |      | 70.02  |
| for title V, and in column 2 for title XIX.  |       |      |        |
| 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)  | l N   | l N  | 98. 03 |
| reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1  |       |      |        |
| for title V, and in column 2 for title XIX.  |       |      |        |
| 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of  | N     | N    | 98. 04 |
| outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and   |       |      |        |
| in column 2 for title XIX.   |       |      |        |
| 8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on  | Υ     | Y    | 98. 05 |
| Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in  | n     |      |        |
| column 2 for title XIX.  |       |      |        |
| 8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,   | Υ     | Υ    | 98.06  |
| Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in   |       |      |        |
| column 2 for title XIX.  |       |      |        |
| Rural Providers  | T     | 1    |        |
| 05.00 Does this hospital qualify as a CAH?   | Y     |      | 105.00 |
| 06.00 $\parallel$ lf this facility qualifies as a CAH, has it elected the all-inclusive method of payment  | . N   |      | 106.00 |
| for outpatient services? (see instructions)  |       |      | 407.0  |
| 07.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R   | N     |      | 107.00 |
| training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)   |       |      |        |
| Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train 1&Rs in an  |       |      |        |
| approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?   |       |      |        |
| Enter "Y" for yes or "N" for no in column 2. (see instructions)  | 1     | I    | ı      |

| Health Financial Systems GIBSON GENERAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA   | _   | CN: 15-1319 Pe                            | In Lie        | Worksheet S-               |                |
|---|---|---|---------------|----------------------------|----------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA   | Provider C                                      | Fr  | om 10/01/2019 | Part I                     |                |
|   |   | To  |               | Date/Time Pro 4/28/2021 8: |                |
|   |   |   | 1. 00         | 2. 00                      | -              |
| 108.00 is this a rural hospital qualifying for an exception to the  | CRNA fee sche                                   | edul e? See 42                            | N N           | 2.00                       | 108.00         |
| CFR Section §412.113(c). Enter "Y" for yes or "N" for no.   | Physi cal                                       | Occupati onal                             | Speech        | Respi ratory               |                |
|   | 1. 00   | 2. 00                                     | 3. 00         | 4. 00                      | _              |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.   | N   | N   | N             | N                          | 109.00         |
|   |   |   | 101           | 1.00                       | 110.00         |
| 110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.   | Y" for yes or                                   | r "N" for no. I                           | f yes,        | N                          | 110.00         |
|   |   |   | 1.00          | 2. 00                      |                |
| 111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this compared by the second of the FCHIP demonstration properties and the second of the FCHIP demonstration properties and the second of the FCHIP demonstration properties and the second of the FCHIP demonstration of the second of | ost reporting<br>Dlumn 1 is Y,<br>Ticipating in | period? Enter<br>enter the<br>n column 2. | N             |                            | 111. 00        |
|   |   | 1.00                                      | 2. 00         | 3.00                       | -              |
| 112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceal participation in the demonstration, if applicable.   | peri od?<br>s "Y", enter<br>ne                  | N   |               |                            | 112.00         |
| Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or   | "N" for no                                      | N   |               |                            | _ <br>0115. 00 |
| in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.  | 3, or E only)<br>93" percent<br>(includes       |   |               |                            |                |
| 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.  | for yes or                                      | N   |               |                            | 116. 00        |
| 117.00 s this facility legally-required to carry malpractice insur  | ance? Enter                                     | Y   |               |                            | 117. 00        |
| "Y" for yes or "N" for no.  118.00 Is the mal practice insurance a claims-made or occurrence pol  | icv? Enter 1                                    | 1   |               |                            | 118. 00        |
| if the policy is claim-made. Enter 2 if the policy is occurr  |   |   |               |                            |                |
|   |   | Premi ums                                 | Losses        | Insurance                  |                |
| 440.00  |   | 1.00                                      | 2. 00         | 3.00                       | 0110 01        |
| 118.01 List amounts of malpractice premiums and paid losses:  |   | 51, 445                                   | (             | 0                          | 0 118. 01      |
|   |   |   | 1.00          | 2.00                       | 110.00         |
| 118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.   |   |   | Y             |                            | 118. 02        |
| 119.00D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.   | n column 1, "'<br>ualifies for '                | Y" for yes or<br>the Outpatient           | N             | N                          | 120.00         |
| 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.  | ntable device                                   | es charged to                             | Υ             |                            | 121. 00        |
| 122.00 Does the cost report contain healthcare related taxes as def<br>Act?Enter "Y" for yes or "N" for no in column 1. If column 1<br>the Worksheet A line number where these taxes are included.<br>Transplant Center Information   |   |   | N             |                            | 122. 00        |
| 125.00 Does this facility operate a transplant center? Enter "Y" fo   | or yes and "N                                   | for no. If                                | N             |                            | 125. 00        |
| yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, en   |   | fication 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, end  | er the certi                                    | fication date                             |               |                            | 127. 00        |
| in column 1 and termination date, if applicable, in column 2  |   | C' 11 1-1-                                |               |                            | 128. 00        |
| 128.00 If this is a Medicare certified liver transplant center, ent   | er the certi                                    | rication date 🗆                           |               |                            |                |

| Health Financial Systems  | GI BSON GENE   | RAL HOSPITAL                       |                       | In Li                      | eu of Form CMS               | S-2552-10          |  |
|---|--|------------------------------------|-----------------------|----------------------------|------------------------------|--------------------|--|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE  | X IDENTIFICATION DATA  | Provi der Co                       | CN: 15-1319           | Peri od:<br>From 10/01/201 |                              |                    |  |
|   |  |                                    |                       | To 09/30/202               | O Date/Time P<br>4/28/2021 8 |                    |  |
|   |  | <u> </u>                           |                       | 1.00                       |                              |                    |  |
| 130.00 If this is a Medicare certified pa   | ancreas transplant cente   | r, enter the cer                   | ti fi cati on         | 1. 00                      | 2.00                         | 130.00             |  |
| date in column 1 and termination of 131.00 If this is a Medicare certified in   | date, if applicable, in o  | column 2.                          |                       |                            |                              | 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                                  |  |                                    |                       |                            |                              |                    |  |
| in column 1 and termination date, 133.00 Removed and reserved   | if applicable, in column   | n 2.                               |                       |                            |                              | 133. 00            |  |
| 134.00 If this is an organ procurement or<br>and termination date, if applicable  |  | the OPO number                     | in column 1           |                            |                              | 134. 00            |  |
| All Providers  140.00 Are there any related organization chapter 10? Enter "Y" for yes or '   |  |                                    |                       | Y                          | HB0778                       | 140. 00            |  |
| are claimed, enter in column 2 the  | e home office chain numbe  |                                    |                       | 3.00                       |                              |                    |  |
| If this facility is part of a chain office and enter the home office of   | n organization, enter o<br>contractor name and cont  | n lines 141 thro<br>ractor number. |                       | name and addres            |                              |                    |  |
| 141.00 Name: DEACONESS HEALTH SYSTEM  | Contractor's Name: N   | WISCONSIN PHYSIC<br>SERVICES       | I ANS Contract        | or's Number: 08            | 101                          | 141. 00            |  |
| 142.00 Street: 600 MARY STREET  | PO Box:  |                                    |                       |                            |                              | 142. 00            |  |
| 143. 00 Ci ty: EVANSVI LLE  | State:   | I N                                | Zi p Code             | : 47                       | 710                          | 143. 00            |  |
| 114 000   | and the second s |                                    |                       |                            | 1. 00                        | 144.00             |  |
| 144.00 Are provider based physicians' cos   | sts included in worksnee   | τ Α?                               |                       |                            | Y                            | 144. 00            |  |
| 145.00 If costs for renal services are cl   | aimed on Wkst A line   | 74 are the cost                    | rs for                | 1. 00                      | 2. 00                        | 145. 00            |  |
| inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"  | ' for yes or "N" for no i<br>clude Medicare utilizatio   | in column 1. If                    | column 1 is           |                            |                              | 145.00             |  |
| 146.00 Has the cost allocation methodolog<br>Enter "Y" for yes or "N" for no in<br>yes, enter the approval date (mm/o   | gy changed from the previ<br>n column 1. (See CMS Pub  |                                    |                       | f N                        |                              | 146. 00            |  |
|   |  |                                    |                       |                            | 1. 00                        |                    |  |
| 147.00 Was there a change in the statisti   |  |                                    |                       |                            | N N                          | 147. 00            |  |
| 148.00 Was there a change in the order of 149.00 Was there a change to the simplifi   |  |                                    |                       | r no                       | N<br>N                       | 148. 00<br>149. 00 |  |
|   |  | Part A                             | Part B                | Title V                    | Title XIX                    |                    |  |
| Does this facility contain a provi  | der that qualifies for   | 1.00                               | 2.00<br>om the applic | 3.00                       | 4.00<br>ower of costs        |                    |  |
| or charges? Enter "Y" for yes or '  |  | onent for Part A                   | and Part B.           | (See 42 CFR §4             | 113. 13)                     | 455.00             |  |
| 155.00 Hospi tal<br>156.00 Subprovi der - IPF   |  | N<br>N                             | N<br>N                | N<br>N                     | N<br>N                       | 155. 00<br>156. 00 |  |
| 157.00 Subprovi der - IRF   |  | N                                  | N                     | N                          | N                            | 157. 00            |  |
| 158. 00 SUBPROVI DER<br>159. 00 SNF   |  | N                                  | l<br>N                | N                          | N                            | 158. 00<br>159. 00 |  |
| 160.00HOME HEALTH AGENCY  |  | N<br>N                             | N N                   | N N                        | N N                          | 160.00             |  |
| 161. 00 CMHC  |  |                                    | l N                   | N                          | N                            | 161. 00            |  |
| Mari del companyo   |  |                                    |                       |                            | 1.00                         |                    |  |
| Multicampus  165.00 Is this hospital part of a Multica  | ampus hospital that has  | one or more camp                   | uses in diff          | erent CBSAs?               | N                            | 165. 00            |  |
| Enter "Y" for yes or "N" for no.  | Name   | County                             | State Zi              | p Code CBSA                | FTE/Campus                   |                    |  |
| 1// 0016 11-2 1/5 12  | 0  | 1. 00                              | 2. 00                 | 3.00 4.00                  | 5. 00                        | 001// 02           |  |
| 166.00  f   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) |  |                                    |                       |                            | 0.                           | 00 166. 00         |  |
|   |  |                                    |                       |                            | 1.00                         | +                  |  |
| Health Information Technology (HI   | Γ) incentive in the Amer   | i can Recovery ar                  | nd Reinvestme         | ent Act                    |                              | 4/                 |  |
| 167.00 Is this provider a meaningful user<br>168.00 If this provider is a CAH (line 10  | 05 is "Y") and is a mean   | ingful user (lir                   |                       | ), enter the               | Y                            | 167. 00<br>168. 00 |  |
| reasonable cost incurred for the H<br>168.01 If this provider is a CAH and is r   |  |                                    | er qualify fo         | r a hardship               |                              | 168. 01            |  |
| exception under §413.70(a)(6)(ii)?  | ? Enter "Y" for yes or "I  | N" for no. (see                    | instructions          | )                          |                              |                    |  |
| 169.00 If this provider is a meaningful utransition factor. (see instruction  |  | nu is not a CAH                    | (TINE TOO IS          | ν, enter tr                | 9.                           | 99169. 00          |  |

| Health Financial Systems   | GIBSON GENERAL I | HOSPI TAL | In Lie                           | u of Form CMS-2 | 2552-10 |
|--|------------------|-----------|----------------------------------|-----------------|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT  |                  |           |                                  | Worksheet S-2   |         |
|  |                  |           | From 10/01/2019<br>To 09/30/2020 |                 |         |
|  |                  |           | Begi nni ng                      | Endi ng         |         |
|  |                  |           | 1. 00                            | 2. 00           |         |
| 170.00 Enter in columns 1 and 2 the EHR beginnir period respectively (mm/dd/yyyy)  |                  |           | 170. 00                          |                 |         |
|  |                  |           |                                  |                 |         |
|  |                  |           | 1. 00                            | 2. 00           |         |
| 171.00 ffline 167 is "Y", does this provider has section 1876 Medicare cost plans reported "Y" for yes and "N" for no in column 1. I 1876 Medicare days in column 2. (see inst | on N             | 0         | 171.00                           |                 |         |

|                | Financial Systems GIBSON GENERA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   | Provi der C                                 | CN: 15-1319    | Peri od:        | worksheet S-2              |                |
|----------------|---|---|----------------|-----------------|----------------------------|----------------|
|                |   |   | [ ]            | From 10/01/2019 | Part II                    |                |
|                |   |   |                | To 09/30/2020   | Date/Time Pre 4/28/2021 8: |                |
|                |   | <u> </u>                                    | <u>'</u>       | Y/N             | Date                       |                |
|                |   |   |                | 1. 00           | 2. 00                      |                |
|                | General Instruction: Enter Y for all YES responses. Enter N   | for all NO re                               | esponses. Ente | er all dates in | the                        |                |
|                | mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS   |   |                |                 |                            |                |
|                | Provider Organization and Operation   |   |                |                 |                            |                |
| 00             | Has the provider changed ownership immediately prior to the   | heainnina of                                | the cost       | N               |                            | 1.0            |
| . 00           | reporting period? If yes, enter the date of the change in c   |   |                |                 |                            | '. \           |
|                |   | `   | Y/N            | Date            | V/I                        |                |
|                |   |   | 1.00           | 2.00            | 3. 00                      |                |
| . 00           | Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.   |   | N              |                 |                            | 2.0            |
| 00             | Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe relationships? (see instructions) | offices, drug<br>ler or its<br>of the board | N              |                 |                            | 3.0            |
|                | relationships: (see matractions)  |   | Y/N            | Type            | Date                       |                |
|                |   |   | 1.00           | 2. 00           | 3. 00                      |                |
|                | Financial Data and Reports  |   |                |                 |                            |                |
| . 00           | Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe  | or Compiled,<br>ailable in                  | Y              | A               |                            | 4. 0<br>5. 0   |
| 00             | those on the filed financial statements? If yes, submit rec   |   | IN IN          |                 |                            | 3.0            |
|                | This of the fire a financial statements. It yes, submit to  |   |                | Y/N             | Legal Oper.                |                |
|                |   |   |                | 1. 00           | 2.00                       |                |
|                | Approved Educational Activities   |   |                |                 |                            |                |
| . 00           | Column 1: Are costs claimed for nursing school? Column 2:   | If yes, is t                                | he provider is | s N             |                            | 6.0            |
| 00             | the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in   | etructi one                                 |                | N               |                            | 7.0            |
| 00             | Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.   |   | d during the   | N               |                            | 8.0            |
| 00             | Are costs claimed for Interns and Residents in an approved  |   | cal education  | N               |                            | 9.0            |
| . 00           | program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.  |   | the current    | N               |                            | 10.0           |
| . 00           | Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  | & R in an App                               | proved         | N               |                            | 11. (          |
|                |   |   |                |                 | Y/N                        |                |
|                | Bad Debts   |   |                |                 | 1. 00                      |                |
| 2. 00<br>3. 00 | Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p   |   |                | ost reporting   | Y<br>N                     | 12. 0<br>13. 0 |
| 4. 00          | period? If yes, submit copy.<br>If line 12 is yes, were patient deductibles and/or co-payme   | ents waived? I                              | fyes, see ins  | structions.     | N                          | 14.0           |
| 5. 00          | Bed Complement Did total beds available change from the prior cost reporti  | ng period? If                               | yes, see inst  |                 | N                          | 15. 0          |
|                |   |   | t A            |                 | rt B                       |                |
|                |   | Y/N<br>1,00                                 | Date           | Y/N             | Date                       |                |
|                | PS&R Data   | 1. 00                                       | 2.00           | 3. 00           | 4. 00                      |                |
| 5. 00          | Was the cost report prepared using the PS&R Report only?  If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)  | Υ   | 02/19/2021     | Y               | 02/19/2021                 | 16.0           |
| . 00           | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)   | N   |                | N               |                            | 17. C          |
| . 00           | If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for additional claims that have been billed<br>but are not included on the PS&R Report used to file this  | N   |                | N               |                            | 18.0           |
| . 00           | cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.   | N   |                | N               |                            | 19.0           |

|         | Financial Systems GIBSON GENERAL   |                  | 20N 45 4040     |  | u of Form CM   |          |
|---------|--|------------------|-----------------|--|--|----------|
| HUSPI I | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provi der (      | CCN: 15-1319    | Peri od:<br>From 10/01/2019<br>To 09/30/2020 | Worksheet S<br>Part II<br>Date/Time F<br>4/28/2021 8 | repared: |
|         |  | Desci            | iption          | Y/N  | Y/N  |          |
|         |  |                  | 0               | 1. 00  | 3. 00  |          |
| 20. 00  | If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for Other? Describe the other adjustments:   |                  | _               | N  | N  | 20.00    |
|         |  | 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 (EXCE  | EPT CHILDRENS    | HOSPI TALS)     |  | 1.00   |          |
|         | Capital Related Cost   |                  |                 |  |  |          |
| 22.00   | Have assets been relifed for Medicare purposes? If yes, see  | e instructions   | 3               |  | N  | 22. 00   |
| 23. 00  | Have changes occurred in the Medicare depreciation expense   | due to apprai    | sals made du    | ring the cost                                | N  | 23. 00   |
|         | reporting period? If yes, see instructions.  |                  |                 |  |  |          |
| 24. 00  | Were new leases and/or amendments to existing leases entere  | ed into durin    | g this cost r   | eporting period?                             | N  | 24.00    |
| 25. 00  | If yes, see instructions Have there been new capitalized leases entered into during  | the cost ren     | orting period   | ? If ves see                                 | N  | 25. 00   |
| 20.00   | instructions.  | c 5551 1 6pt     | s. tring period | 1 900, 300                                   | 14   | 25.00    |
| 26. 00  | Were assets subject to Sec. 2314 of DEFRA acquired during the  | If yes, see      | N               | 26. 00                                       |  |          |
|         | instructions.  |                  |                 | -  |  |          |
| 27. 00  |  | f yes, submit    | N               | 27. 00                                       |  |          |
|         | copy. Interest Expense   |                  |                 |  |  |          |
| 28 00   | Were new Loans, mortgage agreements or Letters of credit er  | N                | 28.00           |  |  |          |
|         | period? If yes, see instructions.  |                  |                 |  |  |          |
| 29.00   | Did the provider have a funded depreciation account and/or   | N                | 29. 00          |  |  |          |
|         | treated as a funded depreciation account? If yes, see instr  |                  |                 |  |  |          |
| 30.00   | Has existing debt been replaced prior to its scheduled matu  | N                | 30.00           |  |  |          |
| 21 00   | instructions.  |                  | N               | 21 00  |  |          |
| 31. 00  | Has debt been recalled before scheduled maturity without is instructions.  | ssuance or ne    | w debt? IT ye   | s, see                                       | N  | 31.00    |
|         | Purchased Services   |                  |                 |  |  |          |
| 32.00   | Have changes or new agreements occurred in patient care ser  | rvi ces furni sl | ned through c   | ontractual                                   | N  | 32.00    |
|         | arrangements with suppliers of services? If yes, see instru  |                  |                 |  |  |          |
| 33.00   | If line 32 is yes, were the requirements of Sec. 2135.2 app  | olied pertaini   | ng to compet    | itive bidding? If                            | N  | 33. 00   |
|         | no, see instructions.  |                  |                 |  |  |          |
|         | Provi der-Based Physi ci ans   |                  |                 |  |  |          |
| 34.00   | Are services furnished at the provider facility under an ar  | rrangement wi    | th provider-b   | ased physicians?                             | Υ  | 34. 00   |
| 35 00   | If yes, see instructions. If line 34 is yes, were there new agreements or amended exi  | sting agreem     | ants with the   | nrovi der-hased                              | N  | 35.00    |
| 33.00   | physicians during the cost reporting period? If yes, see in  | 5 5              | ents with the   | pi ovi dei -based                            | IV   | 33.00    |
|         | iprojection and the control of the c |                  |                 | Y/N  | Date   |          |
|         |  |                  |                 | 1.00   | 2. 00  |          |
| 0,      | Home Office Costs  |                  |                 |  |  |          |
|         | Were home office costs claimed on the cost report?   | conordal II      | - hom:CC        | N N  |  | 36.00    |
| 37.00   | If line 36 is yes, has a home office cost statement been pr  | repared by the   | e nome office   | ? N  |  | 37.00    |
| 38. 00  | If yes, see instructions.<br> If line 36 is yes , was the fiscal year end of the home off  | fice differen    | t from that o   | f N  |  | 38.00    |
| 30.00   | the provider? If yes, enter in column 2 the fiscal year end  |                  |                 | . IN   |  | 30.00    |
| 39.00   | If line 36 is yes, did the provider render services to other   |                  |                 | s, N   |  | 39.00    |
|         | see instructions.  |                  | <b>3</b> ·      |  |  |          |
| 40.00   | , , , , , , , , , , , , , , , , , , ,  | home office?     | If yes, see     | N  |  | 40. 00   |
|         | i nstructi ons.  |                  |                 |  |  |          |
|         |  | 1                | . 00            | 2.   | nn   |          |
|         | Cost Report Preparer Contact Information   |                  |                 |  |  |          |
| 41.00   |  | AUSTI N          |                 | FISHER                                       |  | 41.00    |
|         | held by the cost report preparer in columns 1, 2, and 3,   |                  |                 |  |  |          |
|         | respecti vel y.  | D. 115           |                 |  |  |          |
| 42. 00  | ' ' ' ' '  | BLUE & CO.       |                 |  |  | 42.00    |
|         | preparer. Enter the telephone number and email address of the cost   | 317-275-7438     |                 | AFI SHER@BLUEAN                              | OCO COM  | 43.00    |
| 13 UU   | THE THE LEFENDOR NUMBER AND EMAIL ADDRESS OF THE COST  | 01/-2/0-/400     |                 | ALL SHEKEDLUEAN                              | JOU. CON   | H 43.00  |
| 43. 00  | report preparer in columns 1 and 2, respectively.  |                  |                 |  |  |          |

| Health Financial Systems                | GI BSON GENER           | RAL HOSPITAL |      | In Lie                     | u of Form CMS-2                | 2552-10        |
|---|-------------------------|--------------|------|----------------------------|--------------------------------|----------------|
| HOSPITAL AND HOSPITAL HEALTH CARE REIME | BURSEMENT QUESTIONNAIRE | Provi der (  |      | Period:<br>From 10/01/2019 |                                |                |
|   |                         |              |      | Го 09/30/2020              | Date/Time Pre<br>4/28/2021 8:1 | pared:<br>5 am |
|   |                         |              |      |                            |                                |                |
|   |                         | 3            | . 00 |                            |                                |                |
| Cost Report Preparer Contact Inf        | ormati on               |              |      |                            |                                |                |
| 41.00 Enter the first name, last name   |                         | MANAGER      |      |                            |                                | 41.00          |
| held by the cost report preparer        | in columns 1, 2, and 3, |              |      |                            |                                |                |
| respecti vel y.                         |                         |              |      |                            |                                |                |
| 42.00 Enter the employer/company name   | of the cost report      |              |      |                            |                                | 42.00          |
| preparer.                               |                         |              |      |                            |                                |                |
| 43.00 Enter the telephone number and e  |                         |              |      |                            |                                | 43.00          |
| report preparer in columns 1 and        | l 2, respectively.      |              |      |                            |                                | [              |

Health Financial SystemsGIBSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Period: | Worksheet S-3 | From 10/01/2019 | Part | To 09/30/2020 | Date/Time Prepared: Provi der CCN: 15-1319

|                  |  |                 |    |            |           | То | 09/30/2020           | Date/Time F<br>4/28/2021 8 |     |                  |
|------------------|--|-----------------|----|------------|-----------|----|----------------------|----------------------------|-----|------------------|
|                  |  |                 |    |            |           |    |                      | I/P Days /                 |     | Zili             |
|                  |  |                 |    |            |           |    |                      | 0/P Visits                 | /   |                  |
|                  |  |                 |    |            |           |    |                      | Tri ps                     |     |                  |
|                  | Component  | Worksheet A     | No | o. of Beds | Bed Days  |    | CAH Hours            | Title V                    |     |                  |
|                  |  | Line Number     |    | 2.00       | Available |    | 4.00                 | F 00                       |     |                  |
| 1. 00            | Hospital Adults & Peds. (columns 5, 6, 7 and                             | 1. 00<br>30. 00 |    | 2.00       | 3.00      | 20 | 4. 00<br>17, 496. 00 | 5. 00                      | 0   | 1. 00            |
| 1.00             | 8 exclude Swing Bed, Observation Bed and                                 | 30.00           |    | 20         | 7,32      | 20 | 17, 490.00           |                            | ۷   | 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                                    |                 |    |            |           |    |                      |                            | ol  | 5.00             |
| 6.00             | Hospital Adults & Peds. Swing Bed NF                                     |                 |    |            |           |    |                      |                            | ol  | 6.00             |
| 7.00             | Total Adults and Peds. (exclude observation                              |                 | İ  | 20         | 7, 32     | 20 | 17, 496. 00          |                            | o   | 7.00             |
|                  | beds) (see instructions)   |                 |    |            |           |    |                      |                            |     |                  |
| 8.00             | INTENSIVE CARE UNIT  | 31.00           | İ  | 5          | 1, 83     | 30 | 1, 848. 00           |                            | o   | 8.00             |
| 9.00             | CORONARY CARE UNIT   |                 |    |            |           |    |                      |                            |     | 9.00             |
| 10.00            | BURN INTENSIVE CARE UNIT   |                 |    |            |           |    |                      |                            | I   | 10.00            |
| 11.00            | SURGICAL INTENSIVE CARE UNIT   |                 |    |            |           |    |                      |                            | I   | 11.00            |
| 12.00            | OTHER SPECIAL CARE (SPECIFY)   |                 |    |            |           |    |                      |                            | I   | 12.00            |
| 13.00            | NURSERY  |                 |    |            |           |    |                      |                            | I   | 13.00            |
| 14.00            | Total (see instructions)   |                 |    | 25         | 9, 15     | 50 | 19, 344. 00          |                            | 0   | 14.00            |
| 15.00            | CAH visits   |                 |    |            |           |    |                      |                            | 0   | 15.00            |
| 16.00            | SUBPROVI DER - I PF  |                 |    |            |           |    |                      |                            |     | 16.00            |
| 17.00            | SUBPROVI DER - I RF  |                 |    |            |           |    |                      |                            |     | 17.00            |
| 18.00            | SUBPROVI DER   |                 |    |            |           |    |                      |                            |     | 18.00            |
| 19. 00           | SKILLED NURSING FACILITY   | 44. 00          |    | 0          |           | 0  |                      |                            | 0   | 19.00            |
| 20.00            | NURSING FACILITY   |                 |    |            |           |    |                      |                            |     | 20.00            |
| 21. 00           | OTHER LONG TERM CARE   |                 |    |            |           |    |                      |                            |     | 21.00            |
| 22. 00           | HOME HEALTH AGENCY   | 101. 00         |    |            |           |    |                      |                            | 0   | 22.00            |
| 23. 00           | AMBULATORY SURGICAL CENTER (D. P. )                                      |                 |    |            |           |    |                      |                            |     | 23.00            |
| 24. 00           | HOSPI CE   |                 |    |            |           |    |                      |                            |     | 24.00            |
| 24. 10           | HOSPICE (non-distinct part)  | 30. 00          |    |            |           |    |                      |                            |     | 24. 10           |
| 25.00            | CMHC - CMHC  |                 |    |            |           |    |                      |                            |     | 25.00            |
| 26.00            | FORT BRANCH RHC  | 88. 00          |    |            |           |    |                      |                            | 0   | 26.00            |
| 26. 01           | CLARK & WELLS RHC  | 88. 01          |    |            |           |    |                      |                            | 0   | 26. 01           |
| 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   | 28. 00           |
| 29. 00           | Ambulance Trips  |                 |    |            |           |    |                      |                            |     | 29.00            |
| 30.00            | Employee discount days (see instruction)                                 |                 |    |            |           |    |                      |                            |     | 30.00            |
| 31. 00<br>32. 00 | Employee discount days - IRF<br>Labor & delivery days (see instructions) |                 |    | 0          |           | 0  |                      |                            |     | 31. 00<br>32. 00 |
| 32. 00<br>32. 01 | Total ancillary labor & delivery room                                    |                 |    | 0          |           | U  |                      |                            |     | 32. 00<br>32. 01 |
| 32.01            | outpatient days (see instructions)                                       |                 |    |            |           |    |                      |                            |     | 32.01            |
| 33 NO            | LTCH non-covered days  |                 |    |            |           |    | ŀ                    |                            |     | 33. 00           |
|                  | LTCH site neutral days and discharges                                    |                 |    |            |           |    |                      |                            |     | 33. 00           |
| 00.01            | 12. s s. ts .louti ai days and ai sonai ges                              | 1               | ı  |            | ı         | Į. | ı                    |                            | - 1 | 55.01            |

Heal th Fi nancial SystemsGIBSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Period: Worksheet S-3 From 10/01/2019 Part I Provi der CCN: 15-1319

| 1/P Days / 0/P VIsits / Trips  |        |   |             |                   |         | rom 10/01/2019<br>o 09/30/2020 |               | nared. |
|--|--------|---|-------------|-------------------|---------|--------------------------------|---------------|--------|
| Title XVIII  |        |   |             |                   |         |                                |               |        |
| Negatian    |        |   | I/P Days    | / O/P Visits      | / Trips | Full Time I                    | Equi val ents |        |
| Negatian    |        |   |             |                   |         |                                |               |        |
| Negatian    |        |   | T           | <b>-</b> 1.11 VIV |         |                                |               |        |
| 1.00   |        | Component                                 | litle XVIII | litle XIX         |         |                                |               |        |
| 1.00   Hospit al Adults & Peds. (col umns 5, 6, 7 and 8  |        |   | 4 00        | 7 00              |         |                                |               |        |
| 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   2  | 1 00   | Hospital Adults & Peds (columns 5 6 7 and |             |                   |         |                                | 10.00         | 1 00   |
| Hospice days) (see instructions for col. 2   7   | 1.00   |   | 373         | 10                | 727     |                                |               | 1.00   |
| For the portion of LDP room avail able beds)   0   |        |   |             |                   |         |                                |               |        |
| 3.00   HMO IPF Subprovider   |        |   |             |                   |         |                                |               |        |
| 3.00   HMO IPF Subprovider   | 2.00   | HMO and other (see instructions)          | 0           | 44                |         |                                |               | 2.00   |
| 5.00   | 3.00   |   | 0           | 0                 |         |                                |               | 3.00   |
| 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 beds) (see instructions) 1,428 18 2,410   | 4.00   | HMO IRF Subprovider                       | 0           | 0                 |         |                                |               | 4.00   |
| 7. 00   Total Adul ts and Peds. (exclude observation beds) (see instructions)   1, 428   18   2, 410   | 5.00   | Hospital Adults & Peds. Swing Bed SNF     | 1, 055      | 0                 | 1, 055  |                                |               | 5.00   |
| Beds) (see instructions)   NTENSIVE CARE UNIT   22   0   77   8.00   | 6.00   | Hospital Adults & Peds. Swing Bed NF      |             | 0                 | 626     | ,                              |               | 6.00   |
| 8. 00   INTENSI VE CARE UNIT   22   0   77   8. 00   | 7.00   |   | 1, 428      | 18                | 2, 410  |                                |               | 7.00   |
| 9.00   CORONARY CARE UNIT   9.00   BURN INTENSIVE CARE UNIT   10.00   10.00   BURN INTENSIVE CARE UNIT   11.00   11.00   11.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   13.00 |        |   |             |                   |         |                                |               |        |
| 10.00   BURN INTENSIVE CARE UNIT   10.00   11.00   1   |        | 1   | 22          | 0                 | 77      |                                |               |        |
| 11.00   SURGICAL INTENSIVE CARE UNIT   11.00   12.00   OTHER SPECIAL CARE (SPECIFY)   12.00   12.00   12.00   OTHER SPECIAL CARE (SPECIFY)   12.00     |        | i i                                       |             |                   |         |                                |               |        |
| 12.00   OTHER SPECIAL CARE (SPECIFY)   13.00   NURSERY   14.00   Total (see instructions)   1,450   18   2,487   0.00   209.77   14.00   15.00   CAH visits   0   0   0   0   0   0   15.00   15.00   CAH visits   0   0   0   0   0   0   15.00   1   |        | i i                                       |             |                   |         |                                |               | 1      |
| 13.00   NURSERY  |        | · ·                                       |             |                   |         |                                |               |        |
| 14. 00 Total (see instructions) 15. 00 CAH visits 0 CAH visits 0 CAH visits 0 COAH visits 0 CAH visits 0 COAH visits 0 CAH visits 0 COAH visit |        |   |             |                   |         |                                |               |        |
| 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 00 ONLWSING FACILITY 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 FORT BRANCH RHC 26. 00 FORT BRANCH RHC 27. 00 CARK & WELLS RHC 28. 00 UCLARK & WELLS RHC 29. 00 ODSERVALIFED HEALTH CENTER 29. 00 ODSERVALIF DEBALTH C |        | · ·                                       |             |                   |         |                                |               |        |
| 16. 00   SUBPROVI DER - I PF   17. 00   SUBPROVI DER - I RF   18. 00   SUBPROVI DER   18   |        |   | 1, 450      | 18                | 2, 487  | 0.00                           | 209. 77       |        |
| 17. 00   SUBPROVIDER - IRF   |        | · ·                                       | O           | 0                 | Ü       |                                |               |        |
| 18.00   SUBPROVI DER   18.00   19.00   SVI LLED NURSI NG FACILITY   0   0   0   0   0   0   0   0   0  |        |   |             |                   |         |                                |               |        |
| 19. 00   SKILLED NURSING FACILITY   0   0   0   0   0   0   0   0   0  |        | l e                                       |             |                   |         |                                |               |        |
| 20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   OTHER LONG TERM CARE   22.00   HOME HEALTH AGENCY   3,476   173   5,498   0.00   7.30   22.00   22.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   24.00   HOSPICE   24.10   HOSPICE (non-distinct part)   24.10   25.00   CMHC - CMHC   25.00   CMHC - CMHC   25.00   26.01   CLARK & WELLS RHC   234   355   1,762   0.00   3.06   26.00   26.25   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0.00   26.25   27.00   Total (sum of lines 14-26)   27.00   28.00   Observation Bed Days   0   0   0   0   0   0   0   0   0  |        |   |             | 0                 | 0       | 0.00                           | 0.00          |        |
| 21.00  |        |   | U           | U                 | U       | 0.00                           | 0.00          |        |
| 22.00   HOME HEALTH AGENCY   3,476   173   5,498   0.00   7.30   22.00   |        | l e                                       |             |                   |         |                                |               |        |
| 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 FORT BRANCH RHC 26.01 CLARK & WELLS RHC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 LTCH non-covered days 32.00 LTCH non-covered days  |        |   | 3 176       | 173               | 5 409   | 0.00                           | 7 30          |        |
| 24. 00   |        |   | 3, 470      | 173               | 3, 470  | 0.00                           | 7.30          | 1      |
| 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 FORT BRANCH RHC 26. 01 CLARK & WELLS RHC 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 29. 00 Employee discount days (see instructions) 31. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  24. 10 25. 00 25. 00 24. 10 25. 00 25. 00 26. 00 27. 00 28. 00 0 0 0 0. 00  |        | , ,                                       |             |                   |         |                                |               |        |
| 25. 00 CMHC - CMHC 26. 00 FORT BRANCH RHC 26. 01 CLARK & WELLS RHC 27. 00 FEDERALLY QUALIFIED HEALTH CENTER 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 LTCH non-covered days 30. 00 LTCH non-covered days 30. 00 ENGRED RANCH RHC 234 355 1,762 0.00 0.00 2.48 26.00 416 291 1,832 0.00 0.00 2.48 26.01 0 0 0 0 0 0.00 0.00 2.48 26.01 0 0 0 0 0 0.00 0.00 222.61 27.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |        |   |             |                   | 0       |                                |               |        |
| 26. 00 FORT BRANCH RHC 234 355 1,762 0. 00 3. 06 26. 00 26. 01 CLARK & WELLS RHC 416 291 1,832 0. 00 2. 48 26. 01 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0. 00 0. 00 222. 61 27. 00 28. 00 0bservation Bed Days 0 0 705 28. 00 29. 00 Ambul ance Trips 0 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 0 1. 25 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0 0 1. CTCH non-covered days 0 0 1. CTCH non-covered days 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |        |   |             |                   |         |                                |               |        |
| 26. 01 CLARK & WELLS RHC 416 291 1,832 0.00 2.48 26.01 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 222.61 27.00 28.00 Observation Bed Days 0 705 28.00 Ambul ance Trips 0 Employee discount days (see instruction) 31.00 Employee discount days - IRF 0 1.832 0.00 29.00 20.00 222.61 27.00 28.00 29. |        | · ·                                       | 234         | 355               | 1, 762  | 0.00                           | 3. 06         |        |
| 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 222. 61 27. 00 28. 00 Observation Bed Days 0 705 28. 00 Ambul ance Trips 0 Employee discount days (see instruction) 0 51. 00 Employee discount days - IRF 0 0 31. 00 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 0 33. 00 UTCH non-covered days 0 0 0 0 33. 00 33. 00   |        |   |             |                   | · ·     |                                |               | 1      |
| 28.00   Observation Bed Days   0   705   28.00   29.00   30.00   Employee discount days (see instruction)   0   30.00   29.00   31.00   29.00   32.00   32.00   32.01   33.00   LTCH non-covered days   0   33.00   33.00   33.00   CTCH non-covered days   0   33.00  |        |   |             | 0                 |         |                                |               |        |
| 29.00 Ambulance Trips 0 29.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 0 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 32.01 33.00 LTCH non-covered days 0 0 33.00  | 27.00  | Total (sum of lines 14-26)                |             |                   |         | 0.00                           | 222. 61       | 27.00  |
| 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  30.00 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   | 28. 00 |   |             | 0                 | 705     |                                |               | 28.00  |
| 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  31.00 0 0 0 0 32.00 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | 29.00  | Ambul ance Trips                          | 0           |                   |         |                                |               | 29.00  |
| 32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 33.00 LTCH non-covered days 0 33.00  | 30.00  | Employee discount days (see instruction)  |             |                   | 0       | 1                              |               | 30.00  |
| 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  0 33.00   | 31.00  | Employee discount days - IRF              |             |                   | 0       |                                |               | 31.00  |
| outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00   | 32.00  |   | 0           | 0                 | 0       |                                |               | 32.00  |
| 33. 00 LTCH non-covered days 0 33. 00  | 32. 01 |   |             |                   | O       |                                |               | 32. 01 |
|  |        |   |             |                   |         |                                |               |        |
| 33.01  LICH site neutral days and discharges   0        33.01  |        | 1   | -1          |                   |         |                                |               | 1      |
|  | 33. 01 | LICH site neutral days and discharges     | 0           |                   |         | 1                              |               | 33. 01 |

Heal th Fi nancialSystemsGIBSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-1319

|                  |  |               |         | To          | 09/30/2020 | Date/Time Pre<br>4/28/2021 8:1 |                  |
|------------------|--|---------------|---------|-------------|------------|--------------------------------|------------------|
|                  |  | Full Time     |         | Di sch      | arges      | 4/20/2021 0.1                  | J alli           |
|                  |  | Equi val ents |         |             | 9          |                                |                  |
|                  | 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         |               | C       | 123         | 4          | 227                            | 1. 00            |
|                  | 8 exclude Swing Bed, Observation Bed and             |               |         |             |            |                                |                  |
|                  | Hospice days) (see instructions for col. 2           |               |         |             |            |                                |                  |
| 2 00             | for the portion of LDP room available beds)          |               |         |             | 17         |                                | 2.00             |
| 2.00             | HMO and other (see instructions) HMO IPF Subprovider |               |         | 0           | 17<br>0    |                                | 2. 00<br>3. 00   |
| 3. 00<br>4. 00   | HMO IRF Subprovider                                  |               |         |             | 0          |                                | 4.00             |
| 5. 00            | Hospital Adults & Peds. Swing Bed SNF                |               |         |             | ٩          |                                | 5.00             |
| 6. 00            | Hospital Adults & Peds. Swing Bed NF                 |               |         |             |            |                                | 6.00             |
| 7. 00            | Total Adults and Peds. (exclude observation          |               |         |             |            |                                | 7. 00            |
| 7.00             | beds) (see instructions)                             |               |         |             |            |                                | 7.00             |
| 8. 00            | INTENSIVE CARE UNIT                                  |               |         |             |            |                                | 8. 00            |
| 9. 00            | CORONARY CARE UNIT                                   |               |         |             |            |                                | 9. 00            |
| 10.00            | BURN INTENSIVE CARE UNIT                             |               |         |             |            |                                | 10.00            |
| 11.00            | SURGICAL INTENSIVE CARE UNIT                         |               |         |             |            |                                | 11.00            |
| 12.00            | OTHER SPECIAL CARE (SPECIFY)                         |               |         |             |            |                                | 12.00            |
| 13.00            | NURSERY  |               |         |             |            |                                | 13.00            |
| 14.00            | Total (see instructions)                             | 0.00          | C       | 123         | 4          | 227                            | 14.00            |
| 15.00            | CAH visits   |               |         |             |            |                                | 15.00            |
| 16.00            | SUBPROVI DER - I PF                                  |               |         |             |            |                                | 16.00            |
| 17. 00           | SUBPROVI DER - I RF                                  |               |         |             |            |                                | 17. 00           |
| 18. 00           | SUBPROVI DER   |               |         |             |            |                                | 18. 00           |
| 19. 00           | SKILLED NURSING FACILITY                             | 0. 00         |         |             |            |                                | 19. 00           |
| 20.00            | NURSING FACILITY                                     |               |         |             |            |                                | 20.00            |
| 21. 00           | OTHER LONG TERM CARE                                 | 0.00          |         |             |            |                                | 21.00            |
| 22. 00           | HOME HEALTH AGENCY                                   | 0. 00         |         |             |            |                                | 22.00            |
| 23.00            | AMBULATORY SURGICAL CENTER (D. P. )                  |               |         |             |            |                                | 23.00            |
| 24. 00<br>24. 10 | HOSPICE HOSPICE (non-distinct part)                  |               |         |             |            |                                | 24. 00<br>24. 10 |
| 25. 00           | CMHC - CMHC  |               |         |             |            |                                | 25. 00           |
| 26. 00           | FORT BRANCH RHC                                      | 0.00          |         |             |            |                                | 26.00            |
| 26. 01           | CLARK & WELLS RHC                                    | 0.00          |         |             |            |                                | 26. 01           |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER                    | 0.00          |         |             |            |                                | 26. 25           |
| 27. 00           | Total (sum of lines 14-26)                           | 0.00          |         |             |            |                                | 27. 00           |
| 28. 00           | Observation Bed Days                                 | 3.33          |         |             |            |                                | 28. 00           |
| 29.00            | Ambul ance Trips                                     |               |         |             |            |                                | 29. 00           |
| 30.00            | Employee discount days (see instruction)             |               |         |             |            |                                | 30.00            |
| 31.00            | Employee discount days - IRF                         |               |         |             |            |                                | 31.00            |
| 32.00            | Labor & delivery days (see instructions)             |               |         |             |            |                                | 32.00            |
| 32. 01           | Total ancillary labor & delivery room                |               |         |             |            |                                | 32. 01           |
|                  | outpatient days (see instructions)                   |               |         |             |            |                                |                  |
| 33. 00           | LTCH non-covered days                                |               |         | 0           |            |                                | 33. 00           |
| 33. 01           | LTCH site neutral days and discharges                |               |         | 0           |            |                                | 33. 01           |

| Heal th          | Financial Systems   | GIBSON GENERAL            | HOSPI TAL      |                             | In Lie                                       | u of Form CMS-:      | 2552-10          |
|------------------|---|---------------------------|----------------|-----------------------------|--|----------------------|------------------|
|                  | EALTH AGENCY STATISTICAL DATA   |                           | Provi der C    | CN: 15-1319<br>CCN: 15-7445 | Peri od:<br>From 10/01/2019<br>To 09/30/2020 | Worksheet S-4        | pared:           |
|                  |   |                           |                |                             | Home Health                                  | PPS                  |                  |
|                  |   |                           |                |                             | Agency I                                     |                      |                  |
| 0.00             | County  |                           |                |                             | 1.   | 00                   | 0.00             |
|                  |   |                           | Title XVIII    | Title XIX                   | Other  | Total                |                  |
|                  | HOME HEALTH AGENCY STATISTICAL DATA   | 1. 00                     | 2.00           | 3.00                        | 4. 00  | 5. 00                |                  |
| 1. 00            | Home Health Aide Hours  | 0                         | C              |                             | 0 0  | 0                    | 1.00             |
| 2. 00            | Unduplicated Census Count (see instructions)  | 0.00                      | 140.00         |                             |  |                      | 2.00             |
|                  |   |                           |                | Number of Em                | ployees (Full Ti                             | me Equivalent)       |                  |
|                  |   | Enter the number          | of hours in    | Staff                       | Contract                                     | Total                |                  |
|                  |   | your normal               |                | Starr                       | Contract                                     | Total                |                  |
|                  |   |                           |                |                             |  |                      |                  |
|                  |   | 0                         |                | 1.00                        | 2. 00  | 3. 00                |                  |
| 3. 00            | HOME HEALTH AGENCY - NUMBER OF EMPLOYEES  Administrator and Assistant Administrator(s)                            |                           | 40.00          | 0. (                        | 0.00   | 0.00                 | 3.00             |
| 4. 00            | Director(s) and Assistant Director(s)   |                           | 10. 00         | 1. (                        |  | •                    |                  |
| 5.00             | Other Administrative Personnel  |                           |                | 0.0                         |  |                      |                  |
| 6. 00<br>7. 00   | Direct Nursing Service<br>Nursing Supervisor  |                           |                | 3. 0.                       |  | •                    |                  |
| 8.00             | Physical Therapy Service  |                           |                | 0.                          |  | •                    |                  |
| 9. 00<br>10. 00  | Physical Therapy Supervisor<br>Occupational Therapy Service   |                           |                | 0. 0                        |  | •                    | 1                |
| 11. 00           | Occupational Therapy Supervisor   |                           |                | 0.                          |  | l                    |                  |
| 12.00            | Speech Pathology Service  |                           |                | 0.                          |  |                      | 1                |
| 13. 00<br>14. 00 | Speech Pathology Supervisor<br>Medical Social Service   |                           |                | 0. (                        |  | l .                  |                  |
| 15. 00           | Medical Social Service Supervisor   |                           |                | 0. (                        |  | 1                    | 1                |
| 16.00            | Home Heal th Ai de  |                           |                | 1. (                        |  | l                    | 1                |
| 17. 00<br>18. 00 | Home Health Aide Supervisor<br>Other (specify)  |                           |                | 0. (                        |  |                      | 1                |
|                  | HOME HEALTH AGENCY CBSA CODES   |                           |                |                             |  |                      |                  |
| 19. 00           | Enter in column 1 the number of CBSAs where you provided services during the cost                                 |                           |                |                             | 1  |                      | 19.00            |
|                  | reporting period.   |                           |                |                             |  |                      |                  |
| 20. 00           | List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code). |                           |                | 99915                       |  |                      | 20.00            |
|                  |   | Full Epi:                 |                | LUDA Establis               | DED OU                                       | Talal (asla          |                  |
|                  |   | Without   W<br>  Outliers | ith Outliers   | LUPA Epi sode               | PEP Only<br>Epi sodes                        | Total (cols.<br>1-4) |                  |
|                  | DDC ACTIVITY DATA   | 1. 00                     | 2. 00          | 3. 00                       | 4. 00  | 5. 00                |                  |
| 21. 00           | PPS ACTIVITY DATA Skilled Nursing Visits  | 1, 394                    | 166            |                             | 42 1   | 1, 603               | 21.00            |
| 22. 00           | Skilled Nursing Visit Charges   | 223, 040                  | 26, 560        | 6, 7                        | 20 160                                       | 256, 480             | 22.00            |
| 23. 00<br>24. 00 | Physical Therapy Visits Physical Therapy Visit Charges  | 974<br>199, 670           | 131<br>26, 855 | 1                           | 8 4<br>40 820                                | 1, 117<br>228, 985   |                  |
| 25. 00           | Occupational Therapy Visits   | 268                       | 105            |                             | 1 2  | 376                  | 1                |
| 26.00            | Occupational Therapy Visit Charges  | 54, 985                   | 21, 525        |                             | 05 410                                       |                      |                  |
| 27. 00<br>28. 00 | Speech Pathology Visits Speech Pathology Visit Charges  | 90<br>18, 450             | 56<br>11, 480  |                             | 0 4 820                                      | 150<br>30, 750       | 1                |
| 29. 00           | Medical Social Service Visits   | 0                         | C              |                             | 0 0  | 0                    | 29.00            |
| 30. 00<br>31. 00 | Medical Social Service Visit Charges<br>Home Health Aide Visits   | 0<br>192                  | 35             | l .                         | 0 0 3  | 0<br>230             | 1                |
| 32.00            | Home Health Aide Visit Charges  | 14, 400                   | 2, 625         |                             | 0 225  | l e                  |                  |
| 33. 00           | Total visits (sum of lines 21, 23, 25, 27, 20, and 31)  | 2, 918                    | 493            | !                           | 51 14  | 3, 476               | 33.00            |
| 34. 00           | 29, and 31)<br>Other Charges  | o                         | C              |                             | 0 0  | 0                    |                  |
| 35. 00           | Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)   | 510, 545                  | 89, 045        | 8, 5                        | 65 2, 435                                    | 610, 590             | 35. 00           |
| 36. 00           | 1   | 243                       |                |                             | 25 0   | 268                  | 36. 00           |
|                  | Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges   | 0                         | 22<br>0        |                             | 0 1 0  | 23<br>0              | 37. 00<br>38. 00 |
|                  |   | 1                         |                | •                           |  |                      |                  |

| Heal th        | n Financial Systems  | GIBSON GENER                     | AL HOSPITAL                     |                          | In Lie                           | u of Form CMS-                 | 2552-10 |
|----------------|--|----------------------------------|---------------------------------|--------------------------|----------------------------------|--------------------------------|---------|
| HOSPI          | TAL-BASED RHC/FQHC STATISTICAL DATA  |                                  | Provi der C                     | CN: 15-1319              | Peri od:                         | Worksheet S-8                  | 3       |
|                |  |                                  | Component                       | CCN: 15-8524             | From 10/01/2019<br>To 09/30/2020 | Date/Time Pre<br>4/28/2021 8:1 |         |
|                |  |                                  |                                 |                          | RHC I                            | Cost                           |         |
|                |  |                                  |                                 |                          | 1                                | 00                             | -       |
|                | Clinic Address and Identification  |                                  |                                 |                          |                                  |                                |         |
| 1. 00          | Street   |                                  | l c:                            |                          | 7851 S. PROFES                   |                                | 1.00    |
|                |  |                                  |                                 | 00                       | 2. 00                            | ZIP Code<br>3.00               |         |
| 2. 00          | City, State, ZIP Code, County  |                                  | FORT BRANCH                     | 00                       |                                  | 47648                          | 2.00    |
|                |  |                                  |                                 |                          |                                  | 1.00                           |         |
| 3. 00          | HOSPITAL-BASED FOHCs ONLY: Designation - Ent   | er "R" for rur                   | al or "U" for                   | urban                    |                                  | 1.00                           | 3.00    |
| 0.00           | THOSE THE BROCK PEROS ONET. BOST GRACTION EN   | er K Tor Tur                     | <u> </u>                        |                          | nt Award                         | Date                           | 0.00    |
|                |  |                                  |                                 |                          | 1. 00                            | 2. 00                          |         |
| 4. 00          | Source of Federal Funds Community Health Center (Section 330(d), PHS   | : Act)                           |                                 | T                        |                                  |                                | 4.00    |
| 5.00           | Migrant Health Center (Section 339(d), PHS A   |                                  |                                 |                          |                                  |                                | 5.00    |
| 6.00           | Health Services for the Homeless (Section 34   | O(d), PHS Act)                   |                                 |                          |                                  |                                | 6.00    |
| 7. 00<br>8. 00 | Appalachian Regional Commission Look-Alikes  |                                  |                                 |                          |                                  |                                | 7.00    |
| 9.00           | OTHER (SPECIFY)  |                                  |                                 |                          |                                  |                                | 9.00    |
|                |  |                                  |                                 | ·                        |                                  |                                |         |
| 10.00          | Describe Control   |                                  | DUO - FOLIOO F                  | 11. 11. 11. 11. 11.      | 1.00                             | 2. 00                          | 10.00   |
| 10. 00         | Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type of hours.)  | ate number of                    | other operatio                  | ns in column             |                                  | 0                              | 10.00   |
|                | modi 3. )  | Sur                              | ıday                            | N                        | Monday                           | Tuesday                        |         |
|                |  | from                             | to                              | from                     | to                               | from                           |         |
|                | Facility hours of operations (1)   | 1. 00                            | 2. 00                           | 3. 00                    | 4.00                             | 5. 00                          | -       |
| 11. 00         | CLINIC   |                                  |                                 | 08: 00                   | 17: 00                           | 08: 00                         | 11.00   |
|                |  |                                  |                                 | '                        |                                  |                                |         |
| 12. 00         | Have you received an approval for an excepti   | on to the prod                   | uctivity stand                  | and?                     | 1. 00<br>Y                       | 2. 00                          | 12.00   |
| 13. 00         |  | ed in CMS Pub.<br>umn 1. If yes, | 100-04, chapte<br>enter in colu | r 9, section<br>mn 2 the |                                  | 0                              |         |
|                |  |                                  |                                 | Prov                     | ider name                        | CCN number                     |         |
| 14.00          | DUC/FOLIC CON  |                                  |                                 |                          | 1. 00                            | 2. 00                          | 14.00   |
| 14.00          | RHC/FQHC name, CCN number  | Y/N                              | V                               | XVIII                    | XIX                              | Total Visits                   | 14.00   |
|                |  | 1. 00                            | 2.00                            | 3. 00                    | 4.00                             | 5. 00                          |         |
| 15. 00         | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) |                                  |                                 |                          |                                  |                                | 15. 00  |
|                |  |                                  |                                 | inty                     |                                  |                                |         |
| 2. 00          | City, State, ZIP Code, County  |                                  | GI BSON                         | 00                       |                                  |                                | 2.00    |
| 2.00           | Jointy, State, Zir Code, County  | Tuesday                          |                                 | esday                    | Thur                             | sday                           | 2.00    |
|                |  | to                               | from                            | to                       | from                             | to                             |         |
|                |  | 6. 00                            | 7. 00                           | 8. 00                    | 9. 00                            | 10. 00                         |         |
| 11 00          | Facility hours of operations (1)   | 17: 00                           | 08: 00                          | 17: 00                   | 08: 00                           | 17: 00                         | 11.00   |
| 11.00          | OLI NI C   | 117.00                           | JOO. UU                         | J17.00                   | <sub>[</sub> 00. 00              | 117.00                         | 1 11.00 |

| Health Financial Systems                 | GIBSON GENERAL HOSPITAL |             |       | In Lieu of Form CMS-2552-10      |               |        |  |
|--|-------------------------|-------------|-------|----------------------------------|---------------|--------|--|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |                         | Provi der C |       | Peri od:                         | Worksheet S-8 | 3      |  |
|  |                         | Component   |       | From 10/01/2019<br>To 09/30/2020 |               |        |  |
|  |                         |             |       | RHC I                            | Cost          |        |  |
|  | Fri                     | day         | ıy Sa |                                  |               |        |  |
|  | from                    | to          | from  | to                               |               |        |  |
|  | 11. 00                  | 12. 00      | 13.00 | 14. 00                           |               |        |  |
| Facility hours of operations (1)         |                         |             |       |                                  |               |        |  |
| 11. 00 CLINIC                            | 08: 00                  | 17: 00      |       |                                  |               | 11. 00 |  |

| Heal th        | n Financial Systems   | GIBSON GENER    | AL HOSPITAL    |              | In Lie                           | eu of Form CMS- | 2552-10        |
|----------------|---|-----------------|----------------|--------------|----------------------------------|-----------------|----------------|
| HOSPI 7        | TAL-BASED RHC/FQHC STATISTICAL DATA   |                 | Provi der C    | CN: 15-1319  | Peri od:                         | Worksheet S-8   | 8              |
|                |   |                 | Component      | CCN: 15-8553 | From 10/01/2019<br>To 09/30/2020 |                 |                |
|                |   |                 |                |              | RHC II                           | Cost            |                |
|                |   |                 |                |              | 1.                               | 00              | _              |
|                | Clinic Address and Identification   |                 |                |              |                                  |                 |                |
| 1. 00          | Street  |                 |                |              | 510 N MAIN ST.                   | 1               | 1.00           |
|                |   |                 |                | ty           | State                            | ZIP Code        |                |
| 2. 00          | City, State, ZIP Code, County   |                 | PRI NCETON     | 00           | 2.00                             | 3. 00<br>47670  | 2.00           |
| 2.00           | orty, State, 211 code, county   |                 | I KI NOL TON   |              | 110                              | 47070           | 2.00           |
|                |   |                 |                |              |                                  | 1. 00           |                |
| 3. 00          | HOSPITAL-BASED FQHCs ONLY: Designation - Ent  | er "R" for rur  | C              | 3.00         |                                  |                 |                |
|                |   |                 |                |              | nt Award<br>1.00                 | Date<br>2.00    |                |
|                | Source of Federal Funds   |                 |                |              | 1.00                             | 2.00            |                |
| 4. 00          | Community Health Center (Section 330(d), PHS  | S Act)          |                |              |                                  |                 | 4.00           |
| 5.00           | Migrant Health Center (Section 329(d), PHS A  |                 |                |              |                                  |                 | 5.00           |
| 6.00           | Health Services for the Homeless (Section 34  | O(d), PHS Act)  |                |              |                                  |                 | 6.00           |
| 7. 00          | Appalachian Regional Commission   |                 |                |              |                                  |                 | 7.00           |
| 8. 00<br>9. 00 | Look-Alikes<br>OTHER (SPECIFY)  |                 |                |              |                                  |                 | 8. 00<br>9. 00 |
| 7. 00          | OTHER (SECONTY)   |                 |                | 1            |                                  |                 | 7.00           |
|                |   |                 |                |              | 1. 00                            | 2. 00           |                |
| 10.00          | j 1   |                 |                |              |                                  | C               | 10.00          |
|                | yes or "N" for no in column 1. If yes, indic  |                 |                |              |                                  |                 |                |
|                | 2. (Enter in subscripts of line 11 the type of hours.)                                  | of other operat | ion(s) and the | operating    |                                  |                 |                |
|                | Tiours. )   | Sur             | nday           | 1 1          | Monday                           | Tuesday         |                |
|                |   | from            | to             | from         | to                               | from            |                |
|                |   | 1. 00           | 2.00           | 3. 00        | 4. 00                            | 5. 00           |                |
| 44.00          | Facility hours of operations (1)  |                 | 1              | loo oo       | 47.00                            | loo oo          |                |
| 11.00          | CLINIC  |                 |                | 08: 00       | 17: 00                           | 08: 00          | 11.00          |
|                |   |                 |                |              | 1. 00                            | 2.00            |                |
| 12. 00         | Have you received an approval for an excepti  | on to the prod  | uctivity stand | ard?         | N                                | 2100            | 12.00          |
| 13.00          |   |                 |                |              | N                                | C               | 13.00          |
|                | 30.8? Enter "Y" for yes or "N" for no in col  |                 |                |              |                                  |                 |                |
|                | number of providers included in this report. numbers below.                             | List the name   | s of all provi | ders and     |                                  |                 |                |
|                | Trumber's berow.  |                 |                | Prov         | ider name                        | CCN number      |                |
|                |   |                 |                |              | 1. 00                            | 2.00            |                |
| 14.00          | RHC/FQHC name, CCN number   |                 |                |              |                                  |                 | 14.00          |
|                |   | Y/N             | V              | XVIII        | XIX                              | Total Visits    |                |
| 15 00          | Have you provided all or substantially all  | 1. 00           | 2. 00          | 3. 00        | 4. 00                            | 5. 00           | 15.00          |
| 15. 00         | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in |                 |                |              |                                  |                 | 15.00          |
|                | column 1. If yes, enter in columns 2, 3 and   |                 |                |              |                                  |                 |                |
|                | 4 the number of program visits performed by   |                 |                |              |                                  |                 |                |
|                | Intern & Residents for titles V, XVIII, and   |                 |                |              |                                  |                 |                |
|                | XIX, as applicable. Enter in column 5 the number of total visits for this provider.     |                 |                |              |                                  |                 |                |
|                | (see instructions)  |                 |                |              |                                  |                 |                |
|                |   |                 | Cou            | inty         |                                  |                 |                |
|                |   |                 | 4.             | 00           |                                  |                 |                |
| 2. 00          | City, State, ZIP Code, County   |                 | GI BSON        |              |                                  |                 | 2.00           |
|                |   | Tuesday         |                | esday<br>T   |                                  | rsday<br>T      |                |
|                |   | to              | from           | to<br>e oo   | 9.00                             | to<br>10.00     |                |
|                | Facility hours of operations (1)  | 6. 00           | 7. 00          | 8. 00        | 9.00                             | 10.00           |                |
| 11. 00         | CLINIC  | 17: 00          | 08: 00         | 17: 00       | 08: 00                           | 17: 00          | 11.00          |
|                | 1   | 1               |                |              |                                  |                 |                |

| 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                  | 3       |
|  |               | Component   | CCN: 15-8553 | From 10/01/2019<br>To 09/30/2020 | Date/Time Pre<br>4/28/2021 8:1 |         |
|  |               |             |              | RHC II                           | Cost                           |         |
|  | Fri           | day         | iy Sa        |                                  |                                |         |
|  | 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  |

| IUSPI I  |   | SPITAL   | . 15 1210   |   | u of Form CMS-2   |   |  |  |
|--|---|--|---|---|---|---|--|--|
|  | TAL UNCOMPENSATED AND INDIGENT CARE DATA  | rovider CCN  | : 15-1319   | Peri od:<br>From 10/01/2019             | Worksheet S-1   | U   |  |  |
|  |   |  |   | To 09/30/2020                           | Date/Time Pre<br>4/28/2021 8:1  | pared<br>5 am   |  |  |
|  |   |  |   |   | 1. 00   |   |  |  |
|  | Uncompensated and indigent care cost computation  |  |   |   | 11.00   |   |  |  |
| . 00   | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi  | ided by lin  | e 202 colum   | n 8)                                    | 0. 532386   | 1.0   |  |  |
|  | Medicaid (see instructions for each line)   | -  |   |   |   |   |  |  |
| . 00   | Net revenue from Medicaid   |  |   |   | 2, 630, 335   |   |  |  |
| . 00   | Did you receive DSH or supplemental payments from Medicaid?   |  |   |   | Y   | 3.0   |  |  |
| . 00   | If line 3 is yes, does line 2 include all DSH and/or supplementa  |  |   | ai d'?                                  | Υ   | 4.0   |  |  |
| . 00<br>. 00   | If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges  | om wedicald  |   |   | 0<br>8, 101, 401  |   |  |  |
| . 00   | Medicaid charges  Medicaid cost (line 1 times line 6)   |  |   |   | 4, 313, 072   | 1   |  |  |
| . 00   | Difference between net revenue and costs for Medicaid program (I  | line 7 minu  | s sum of li   | nes 2 and 5 if                          | 1, 682, 737   | 1   |  |  |
| . 00   | <pre>&lt; zero then enter zero)</pre>   | 7 11110  | 3 3 <b>u</b> m 01 11                                      | nes z una e, i i                        | 1,002,707   | 0.0   |  |  |
|  | Children's Health Insurance Program (CHIP) (see instructions for  | each line  | )   |   |   | Ī   |  |  |
| . 00   | Net revenue from stand-alone CHIP   |  |   |   | 0   | 9. (  |  |  |
|  | Stand-alone CHIP charges  |  |   |   | 0   | 1   |  |  |
| 1.00   | Stand-alone CHIP cost (line 1 times line 10)  |  | 0   | 1                                       |   |   |  |  |
| 2. 00  | Difference between net revenue and costs for stand-alone CHIP (I  | if < zero then   | 0   | 12.0                                    |   |   |  |  |
|  | <pre>enter zero) Other state or local government indigent care program (see instr</pre>   | suctions fo  | r oach Lino   | ١                                       |   | ł   |  |  |
| 3. 00  | Net revenue from state or local indigent care program (Not inclu  |  |   |   | 0   | 13. (   |  |  |
|  | Charges for patients covered under state or local indigent care program (Not included in lines 6 or   |  |   |   |   |   |  |  |
| 00   | 10)   | p. 09. a (   |   |   | 0   | 14.   |  |  |
| 5. 00  | State or local indigent care program cost (line 1 times line 14)  |  | 0   | 15.                                     |   |   |  |  |
| 6. 00  | Difference between net revenue and costs for state or local indi  | ne 15 minus line   | 0   | 16.                                     |   |   |  |  |
|  | 13; if < zero then enter zero)  |  |   |   |   |   |  |  |
|  | Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  | and state  | /local indi   | gent care progra                        | ıms (see  |   |  |  |
| 7. 00  | Private grants, donations, or endowment income restricted to fur  | nding chari  | ty care   |   | 0   | 17. (   |  |  |
| 8.00   | Government grants, appropriations or transfers for support of ho  | ospital ope  | rati ons  |   | 0   | 18.0  |  |  |
| 9. 00  | Total unreimbursed cost for Medicaid , CHIP and state and local   | indigent c   | are program   | s (sum of lines                         | 1, 682, 737   | 19. (   |  |  |
|  | 8, 12 and 16)   |  | 11.1  | 1                                       | T. I. I. (I. 4  |   |  |  |
|  |   |  | Uni nsured pati ents                                      | Insured patients                        | Total (col. 1<br>+ col. 2)  |   |  |  |
|  |   |  | 1.00  | 2.00                                    | 3. 00   |   |  |  |
|  | Uncompensated Care (see instructions for each line)   |  |   | 2.00                                    | 0.00  |   |  |  |
|  |   | ility  | 215, 84   | 12 0                                    | 215, 842  |   |  |  |
| 0. 00  | (see instructions)  |  |   |   |   | 20. (   |  |  |
|  | 1.  | atc (coo   | 114 01  | 1                                       | 114 011   |   |  |  |
|  | Cost of patients approved for charity care and uninsured discour  | nts (see   | 114, 91   | 1 0                                     | 114, 911  |   |  |  |
| 1. 00  | Cost of patients approved for charity care and uninsured discourinstructions)   | ,  | 114, 91   |   |   | 21. (   |  |  |
| 1. 00  | Cost of patients approved for charity care and uninsured discour  | ,  | 114, 91   | 0 0                                     |   | 21. (   |  |  |
| 1. 00<br>2. 00   | Cost of patients approved for charity care and uninsured discour<br>instructions)<br>Payments received from patients for amounts previously written of  | ,  | 114, 91<br>114, 91  | 0 0                                     | 0   | 21. (   |  |  |
| 1. 00<br>2. 00   | Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care   | ,  |   | 0 0                                     | 0 114, 911  | 21. (   |  |  |
| 1. 00<br>2. 00<br>3. 00  | Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)  | off as   | 114, 91   | 0 0 1 0                                 | 114, 911  | 21. (<br>22. (<br>23. (   |  |  |
| 1. 00<br>2. 00<br>3. 00  | Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient  | off as   | 114, 91   | 0 0 1 0                                 | 0 114, 911  | 21. (<br>22. (<br>23. (   |  |  |
| 1. 00<br>2. 00<br>3. 00<br>4. 00                                     | Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written 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 patients.   | off as  t days beyo  | 114, 91<br>nd a Length                                    | 0 0 1 0 O of stay limit                 | 0<br>114, 911<br>1. 00<br>N   | 21. (   |  |  |
| 1. 00<br>2. 00<br>3. 00<br>4. 00                                     | Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient  | off as  t days beyo  | 114, 91<br>nd a Length                                    | 0 0 1 0 O of stay limit                 | 114, 911  | 21. (   |  |  |
| 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00                            | Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written 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 plf line 24 is yes, enter the charges for patient days beyond the   | t days beyo<br>program?<br>e indigent                                | 114, 91<br>nd a Length                                    | 0 0 1 0 O of stay limit                 | 0<br>114, 911<br>1. 00<br>N   | 21. (<br>22. (<br>23. (<br>24. (<br>25. (                                     |  |  |
| 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00          | Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written 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 plf 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   | t days beyo<br>program?<br>e indigent<br>tructions)<br>(see instr    | 114,91<br>nd a length<br>care progra<br>uctions)          | 0 0 1 0 O of stay limit                 | 114, 911<br>1.00<br>N<br>0<br>2, 665, 099<br>186, 330                                 | 21. (<br>22. (<br>23. (<br>24. (<br>25. (<br>26. (<br>27. (                   |  |  |
| 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>7. 01 | Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written 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 plf 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  | t days beyo<br>program?<br>e indigent<br>tructions)<br>(see instr    | 114,91<br>nd a length<br>care progra<br>uctions)          | 0 0 1 0 O of stay limit                 | 0<br>114, 911<br>1.00<br>N<br>0<br>2, 665, 099<br>186, 330<br>286, 661                | 21.<br>22.<br>23.<br>24.<br>25.<br>26.<br>27.<br>27.                          |  |  |
| 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>7. 00<br>7. 01<br>8. 00 | Cost of patients approved for charity care and uninsured discourinstructions)  Payments received from patients for amounts previously written 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 plf 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 allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) | t days beyo<br>program?<br>e indigent<br>tructions)<br>(see instruct | 114,91<br>nd a length<br>care progra<br>uctions)<br>ions) | 0 0 0 1 0 0 of stay limit m's length of | 0<br>114, 911<br>1.00<br>N<br>0<br>2, 665, 099<br>186, 330<br>286, 661<br>2, 378, 438 | 21. (<br>22. (<br>23. (<br>24. (<br>25. (<br>27. (<br>27. (<br>27. (<br>28. ( |  |  |
| 22. 00<br>23. 00<br>24. 00<br>25. 00<br>27. 00<br>28. 00<br>29. 00   | Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written 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 plf 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  | t days beyo<br>program?<br>e indigent<br>tructions)<br>(see instruct | 114,91<br>nd a length<br>care progra<br>uctions)<br>ions) | 0 0 0 1 0 0 of stay limit m's length of | 0<br>114, 911<br>1.00<br>N<br>0<br>2, 665, 099<br>186, 330<br>286, 661                | 21. (<br>22. (<br>23. (<br>24. (<br>25. (<br>27. (<br>27. (<br>28. (<br>29. ( |  |  |

|                  | ealth Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Form CMS-2552-10 |                     |                      |                         |                            |                            |                               |                  |
|------------------|---|---------------------|----------------------|-------------------------|----------------------------|----------------------------|-------------------------------|------------------|
| RECLAS           | SSIFICATION AND ADJUSTMENTS OF TRIA   | AL BALANCE OF EXPEN | ISES                 | Provi der Co            |                            | Period:<br>From 10/01/2019 | Worksheet A                   |                  |
|                  |   |                     |                      |                         |                            | To 09/30/2020              | 4/28/2021 8: 1                | pared:<br>5 am   |
|                  | Cost Center Description   | Sal a               | ri es                | Other                   | Total (col. 1<br>+ col. 2) | Reclassificat<br>ions (See | Reclassified<br>Trial Balance |                  |
|                  |   |                     |                      |                         | + COI. 2)                  | A-6)                       | (col. 3 +-                    |                  |
|                  |   |                     |                      |                         |                            | ,                          | col . 4)                      |                  |
|                  | LOSAUSDAL OSDALOS COOT OSAUSDO  | 1.                  | 00                   | 2. 00                   | 3. 00                      | 4. 00                      | 5. 00                         |                  |
| 1. 00            | GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT               |                     |                      | 2, 336, 832             | 2, 336, 83                 | 2 231, 651                 | 2, 568, 483                   | 1.00             |
| 2. 00            | 00200 CAP REL COSTS-MVBLE EQUIP   |                     |                      | 2, 330, 032             |                            | 0 231,031                  | 2, 300, 403                   | 2.00             |
| 4. 00            | 00400 EMPLOYEE BENEFITS DEPARTMEN   | Т                   | 85, 318              | 1, 504, 458             |                            | -                          | 921, 384                      | 4.00             |
| 5.00             | 00500 ADMINISTRATIVE & GENERAL  | 1,                  | 541, 521             | 5, 745, 586             | 7, 287, 10                 |                            | 6, 502, 013                   | 5.00             |
| 7. 00            | 00700 OPERATION OF PLANT  |                     | 180, 864             | 790, 642                |                            |                            |                               | 1                |
| 8.00             | 00800 LAUNDRY & LI NEN SERVI CE   |                     | 45, 367              | 30, 177                 |                            |                            | 81, 195                       | 1                |
| 9. 00<br>10. 00  | 00900 HOUSEKEEPI NG<br>01000 DI ETARY                                       |                     | 262, 579<br>347, 253 | 125, 088<br>323, 199    |                            |                            | 413, 658<br>186, 049          | 1                |
| 11. 00           | 1 1   |                     | 0                    | 323, 199<br>0           |                            | 527, 961                   | 527, 961                      | 1                |
| 13. 00           | 1 1   |                     | o                    | 6, 362                  |                            |                            | l                             | 1                |
| 14.00            | 1 1   |                     | 182, 914             | 87, 533                 |                            |                            | l                             | 1                |
| 15.00            |   |                     | 146, 600             | 593, 667                | 740, 26                    | 7 820                      | 741, 087                      | 15.00            |
| 16.00            |   |                     | 237, 784             | 76, 334                 | 314, 11                    | 8 13, 804                  | 327, 922                      | 16.00            |
| 20.00            | INPATIENT ROUTINE SERVICE COST CE   |                     | (21 (72              | 050 252                 | 2 500 02                   | 12 (25                     | 2 (02 5(0                     | 20.00            |
| 30. 00<br>31. 00 |   | 1,                  | 631, 672<br>0        | 958, 253<br>712         |                            |                            | 2, 602, 560<br>625            | •                |
| 44. 00           | 1 1   |                     | 0                    | 0                       |                            | 0 0                        | •                             | 44.00            |
|                  | ANCILLARY SERVICE COST CENTERS  |                     |                      |                         |                            | -                          |                               |                  |
| 50.00            | 1 1   |                     | 059, 352             | 730, 705                |                            |                            |                               |                  |
| 54.00            |   |                     | 683, 689             | 708, 943                |                            | ·                          | 1, 103, 305                   | 1                |
| 54. 03           |   |                     | 0                    | 164, 703                |                            |                            | 140, 226                      |                  |
| 60. 00<br>62. 00 | 1 1   |                     | 680, 119             | 1, 694, 884<br>59, 616  |                            |                            | 2, 383, 608<br>59, 616        | 1                |
| 65.00            | 1   |                     | 385, 539             | 494, 228                |                            |                            | 880, 215                      | ł                |
| 66. 00           |   |                     | 602, 110             | 271, 343                |                            |                            | l .                           | •                |
| 67.00            | 1 1   |                     | 197, 318             | 45, 658                 |                            |                            | 247, 833                      | •                |
| 68.00            |   |                     | 77, 535              | 17, 845                 | 95, 38                     | 1, 577                     | 96, 957                       | 68. 00           |
| 69. 00           |   |                     | 0                    | 0                       |                            | 0                          | 0                             |                  |
| 71.00            |   |                     | 0                    | 371                     | 37                         | ·                          |                               |                  |
| 72. 00<br>73. 00 |   | NIS                 | 0                    | 0<br>1, 829, 952        |                            | 0 423, 720<br>2 0          | 423, 720<br>1, 829, 952       | 1                |
| 76.00            | 1 1   |                     | 90, 896              | 56, 819                 |                            |                            |                               | 1                |
| , 0, 00          | OUTPATIENT SERVICE COST CENTERS   | <u> </u>            | 70,070               | 00,017                  |                            | ., 000                     | 1.107.701                     | 70.00            |
| 88.00            |   |                     | 206, 538             | 142, 588                | 349, 12                    | 6 -13, 779                 | 335, 347                      | 88. 00           |
| 88. 01           | 08801 CLARK & WELLS RHC   |                     | 621, 830             | 280, 176                |                            |                            | l                             | 1                |
| 90.00            | 09000 CLI NI C<br>09001 DI ABETES   |                     | 8, 019               | 4, 486                  |                            |                            |                               | 1                |
| 90. 01<br>90. 02 |   |                     | 0                    | 1, 057<br>0             |                            | 7 -871<br>0 0              | 186<br>0                      | 90. 01<br>90. 02 |
| 90. 02           | 1 1   |                     | 151, 263             | 391, 093                |                            | -                          |                               | 90.02            |
| 91.00            | 1 1   |                     | 902, 611             | 1, 573, 812             |                            |                            | 2, 497, 250                   |                  |
| 92.00            |   |                     |                      |                         | ,                          |                            | , , , ,                       | 92.00            |
|                  | OTHER REIMBURSABLE COST CENTERS   |                     |                      |                         |                            |                            |                               |                  |
| 101.00           | 0 10100 HOME HEALTH AGENCY  |                     | 459, 861             | 218, 858                | 678, 71                    | 9 29, 437                  | 708, 156                      | 101. 00          |
| 112 00           | SPECIAL PURPOSE COST CENTERS 0 11300   NTEREST EXPENSE                      |                     |                      | 231, 938                | 231, 93                    | -231, 938                  |                               | ]<br>113. 00     |
| 118.00           |   | hrough 117) 10      | 788, 552             | 231, 936                | 32, 286, 47                |                            | •                             |                  |
| 110.00           | NONREI MBURSABLE COST CENTERS   | in ough 117)   10,  | 700,002              | 21, 177, 710            | 02,200,17                  | 2,7,117                    | 01,707,001                    | 1110.00          |
|                  | 0 07950 MOB   | 2,                  | 334, 482             | 1, 543, 271             | 3, 877, 75                 | 3 297, 572                 |                               |                  |
|                  | 1 07951 FOUNDATI ON   |                     | 46, 825              | 7, 351                  |                            |                            |                               |                  |
|                  | 2 07952  ASC  |                     | 0                    | 10.010                  |                            | 0                          |                               | 194. 02          |
|                  | 3 07953 SNF - PERRY CO.   |                     | 0                    | -19, 818                |                            |                            | -19, 818                      | •                |
| 200.00           | 4 07954 TELE BEHAVIORAL<br>0  TOTAL (SUM OF LINES 118 thr                   | nuah 199)   13      | 4, 666<br>174, 525   | 42, 856<br>23, 071, 578 |                            |                            | 47, 522<br>36, 246, 103       |                  |
| 200.00           | - 1.5 (55 61 E11125 110 till  |                     | , 520                | 23, 37 1, 370           | 1 33,210,10                | -1                         | 1 55,215,105                  | ,=00.00          |

 
 Health Financial
 Systems
 GIBSON GEN

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

|  |             |              | 4/28/2021 8: |                  |
|--|-------------|--------------|--------------|------------------|
| Cost Center Description  | Adjustments | Net Expenses | 172072021 0. | TO GIII          |
|  | (See A-8)   | For          |              |                  |
|  | , ,         | Allocation   |              |                  |
|  | 6. 00       | 7. 00        |              |                  |
| GENERAL SERVICE COST CENTERS   |             |              |              |                  |
| 1.00 O0100 CAP REL COSTS-BLDG & FLXT   | -52, 326    | 2, 516, 157  |              | 1.00             |
| 2.00 O0200 CAP REL COSTS-MVBLE EQUIP   | 0           | 0            |              | 2.00             |
| 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT  | 1, 360, 566 | 2, 281, 950  |              | 4. 00            |
| 5. 00   00500   ADMINI STRATI VE & GENERAL   | 2, 344, 202 |              |              | 5. 00            |
| 7.00 00700 OPERATION OF PLANT  | -249, 103   |              |              | 7. 00            |
| 8.00   00800   LAUNDRY & LINEN SERVICE   | 0           | 81, 195      |              | 8. 00            |
| 9. 00   00900   HOUSEKEEPI NG  | 210, 589    |              |              | 9. 00            |
| 10. 00 01000 DI ETARY  | 80, 720     |              |              | 10.00            |
| 11. 00   01100   CAFETERI A  | -112, 360   |              |              | 11.00            |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON  | 295, 404    |              |              | 13.00            |
| 14. 00 01400 CENTRAL SERVICE & SUPPLY  | 0           | 200/ 100     |              | 14.00            |
| 15. 00   01500   PHARMACY  | 330, 999    |              |              | 15.00            |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY   | 41, 605     | 369, 527     |              | 16. 00           |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS     | -346, 832   | 2, 255, 728  |              | 30.00            |
| 31. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT          | 1           |              |              | 31.00            |
| 44.00 O4400 SKILLED NURSING FACILITY   | 0           |              |              | 44.00            |
| ANCI LLARY SERVICE COST CENTERS  |             | <u> </u>     |              | 44.00            |
| 50. 00 05000 OPERATING ROOM  | -767, 429   | 776, 129     |              | 50.00            |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 0,427       | 1, 103, 305  |              | 54.00            |
| 54. 03   05401   NUCLEAR   MEDICINE-DI AGNOSTI C                                   | 0           |              |              | 54. 03           |
| 60. 00   06000   LABORATORY  | 0           | 2, 383, 608  |              | 60.00            |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                                  | 0           | 59, 616      |              | 62.00            |
| 65. 00 06500 RESPI RATORY THERAPY  | -60, 659    | 819, 556     |              | 65.00            |
| 66. 00   06600 PHYSI CAL THERAPY   | 0           | 896, 510     |              | 66.00            |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 0           | 247, 833     |              | 67.00            |
| 68.00 06800 SPEECH PATHOLOGY   | 0           | 96, 957      |              | 68. 00           |
| 69. 00 06900 ELECTROCARDI OLOGY  | 0           | ol           |              | 69.00            |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                    | 0           | 269, 450     |              | 71.00            |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS   | 0           | 423, 720     |              | 72. 00           |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  | -59, 522    |              |              | 73. 00           |
| 76. 00 03480 I NFUSI ON THERAPY  | -25, 000    | 123, 781     |              | 76. 00           |
| OUTPATIENT SERVICE COST CENTERS  | _           |              |              | 4                |
| 88. 00 08800 FORT BRANCH RHC   | 0           | 335, 347     |              | 88. 00           |
| 88. 01 08801 CLARK & WELLS RHC   | 0           | /            |              | 88. 01           |
| 90. 00   09000   CLI NI C  | 0           | 12, 914      |              | 90.00            |
| 90. 01   09001   DI ABETES   | 0           | 186          |              | 90. 01           |
| 90. 02   09002   0P   PSYCH  | 0           | 0            |              | 90. 02           |
| 90. 03   09003   PALN MANAGEMENT   | 0           | 359, 201     |              | 90.03            |
| 91.00   09100   EMERGENCY<br>92.00   09200   OBSERVATION   BEDS (NON-DISTINCT PART | 0           | 2, 497, 250  |              | 91. 00<br>92. 00 |
| 92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS   |             |              |              | 92.00            |
| 101.00 10100 HOME HEALTH AGENCY  | 0           | 708, 156     |              | 101.00           |
| SPECIAL PURPOSE COST CENTERS   |             | 706, 136     |              | 101.00           |
| 113. 00 11300 I NTEREST EXPENSE  | 0           | O            |              | 113.00           |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                                      | 2, 990, 854 |              |              | 118.00           |
| NONREI MBURSABLE COST CENTERS  | 2,770,004   | 34, 777, 703 |              | 1110.00          |
| 194. 00 07950 MOB  | 0           | 4, 175, 325  |              | 194.00           |
| 194. 01 07951 FOUNDATI ON  | 0           | 54, 023      |              | 194. 01          |
| 194. 02 07952 ASC  | l o         | 0            |              | 194. 02          |
| 194. 03 07953 SNF - PERRY CO.  | 0           | -19, 818     |              | 194. 03          |
| 194. 04 07954 TELE BEHAVI ORAL   | 0           | 47, 522      |              | 194. 04          |
| 200.00 TOTAL (SUM OF LINES 118 through 199)  | 2, 990, 854 |              |              | 200.00           |
|  | •           |              |              | •                |

Provider CCN: 15-1319

Peri od: From 10/01/2019 To 09/30/2020 Date/Ti me Prepared: 4/28/2021 8:15 am

|         |                              |                                |                    |          | 4/28/2021 8: 15 | <u>am</u> |
|---------|------------------------------|--------------------------------|--------------------|----------|-----------------|-----------|
|         |                              | Increases                      |                    |          |                 |           |
|         | Cost Center                  | Li ne #                        | Sal ary            | 0ther    |                 |           |
|         | 2. 00                        | 3. 00                          | 4. 00              | 5. 00    |                 |           |
|         | A - CAFETERIA                |                                |                    |          |                 |           |
| 1.00    | CAFETERI A                   | 11. 00                         | 274, 816           | 253, 145 |                 | 1.00      |
|         | 0                            |                                | 274, 816           | 253, 145 |                 |           |
|         | B - MED SUPPLY CHG PTS       |                                |                    |          |                 |           |
| 1.00    | MEDICAL SUPPLIES CHARGED TO  | 71. 00                         | 0                  | 269, 079 |                 | 1.00      |
|         | PATI ENT                     |                                |                    |          |                 |           |
| 2.00    | IMPL. DEV. CHARGED TO        | 72. 00                         | o                  | 423, 720 |                 | 2.00      |
| 2.00    | PATI ENTS                    | 72.00                          | J                  | 120, 720 |                 | 2.00      |
| 3. 00   | TATTENTO                     | 0.00                           | o                  | 0        |                 | 3.00      |
| 4. 00   |                              | 0.00                           | ő                  | 0        |                 | 4. 00     |
|         | +                            |                                | o                  | 0        | +               |           |
| 5. 00   |                              | 0.00                           |                    | 9        |                 | 5.00      |
| 6. 00   |                              | 0. 00                          | 0                  | 0        |                 | 6. 00     |
| 7. 00   |                              | 0. 00                          | 0                  | 0        |                 | 7. 00     |
| 8. 00   |                              | 0. 00                          | 0                  | 0        |                 | 8.00      |
| 9.00    |                              | 0. 00                          | 0                  | 0        |                 | 9.00      |
| 10.00   |                              | 0.00                           | 0                  | 0        | 1               | 10.00     |
| 11.00   |                              | 0. 00                          | 0                  | 0        | 1               | 11.00     |
| 12.00   |                              | 0.00                           | 0                  | 0        | ] 1             | 12.00     |
| 13.00   |                              | 0.00                           | O                  | 0        | 1               | 13.00     |
| 14.00   |                              | 0.00                           | o                  | 0        |                 | 14.00     |
| 15. 00  |                              | 0.00                           | o                  | 0        |                 | 15. 00    |
| . 5. 55 |                              |                                | <del> </del>       | 692, 799 |                 |           |
|         | C - BUSINESS HEALTH SER      |                                | U <sub>I</sub>     | 072, 177 |                 |           |
| 1. 00   | EMPLOYEE BENEFITS DEPARTMENT | 4.00                           | 54, 546            | 17, 830  |                 | 1. 00     |
| 1.00    | DEPARTMENT                   |                                |                    |          |                 | 1.00      |
|         | U LNTEDECT                   |                                | 54, 546            | 17, 830  |                 |           |
| 4 00    | D - INTEREST                 |                                |                    | 001 (5:1 |                 | 4 00      |
| 1. 00   | CAP REL COSTS-BLDG & FIXT    | 1. 00                          | 0                  | 231, 651 |                 | 1.00      |
| 2.00    | ADMI NI STRATI VE & GENERAL  | 5. 00                          |                    |          |                 | 2.00      |
|         | 0                            |                                |                    | 231, 938 |                 |           |
|         | E - QUALITY SERVICES         |                                |                    |          |                 |           |
| 1.00    | ADMINISTRATIVE & GENERAL     | 5. 00                          | 67, 430            | 26, 708  |                 | 1.00      |
|         | 0 — — — — — —                | - $  +$                        | 67, 430            | 26, 708  |                 |           |
|         | F - HEALTH INSURANCE         |                                |                    |          |                 |           |
| 1.00    | ADMINISTRATIVE & GENERAL     | 5. 00                          | 0                  | 104, 673 |                 | 1.00      |
| 2. 00   | OPERATION OF PLANT           | 7. 00                          | Ö                  | 10, 311  |                 | 2. 00     |
| 3. 00   | LAUNDRY & LINEN SERVICE      | 8. 00                          | ő                  | 7, 534   |                 | 3.00      |
| 4. 00   | HOUSEKEEPI NG                | 9. 00                          | Ö                  | 26, 609  |                 | 4. 00     |
|         |                              |                                |                    |          |                 |           |
| 5. 00   | DI ETARY                     | 10.00                          | 0                  | 46, 887  |                 | 5.00      |
| 6. 00   | CENTRAL SERVICE & SUPPLY     | 14. 00                         | 0                  | 18, 123  |                 | 6.00      |
| 7. 00   | PHARMACY                     | 15. 00                         | 0                  | 7, 459   |                 | 7. 00     |
| 8.00    | MEDICAL RECORDS & LIBRARY    | 16. 00                         | 0                  | 13, 804  |                 | 8.00      |
| 9. 00   | ADULTS & PEDIATRICS          | 30. 00                         | 0                  | 110, 128 |                 | 9.00      |
| 10.00   | OPERATING ROOM               | 50.00                          | 0                  | 48, 606  | 1               | 10.00     |
| 11.00   | RADI OLOGY-DI AGNOSTI C      | 54.00                          | 0                  | 22, 011  | 1               | 11.00     |
| 12.00   | LABORATORY                   | 60.00                          | 0                  | 21, 443  | ] 1             | 12.00     |
| 13.00   | RESPI RATORY THERAPY         | 65. 00                         | o                  | 22, 988  | 1               | 13.00     |
| 14.00   | PHYSI CAL THERAPY            | 66. 00                         | o                  | 39, 209  |                 | 14.00     |
| 15. 00  | OCCUPATIONAL THERAPY         | 67. 00                         | O                  | 6, 524   |                 | 15.00     |
| 16. 00  | SPEECH PATHOLOGY             | 68. 00                         | Ö                  | 1, 577   |                 | 16. 00    |
| 17. 00  | INFUSION THERAPY             | 76. 00                         | Ö                  | 3, 466   |                 | 17. 00    |
|         |                              |                                |                    |          |                 |           |
| 18.00   | FORT BRANCH RHC              | 88.00                          | 0                  | 11, 074  |                 | 18.00     |
| 19.00   | CLINIC                       | 90.00                          | 0                  | 438      |                 | 19.00     |
| 20.00   | PAIN MANAGEMENT              | 90. 03                         | 0                  | 7, 460   |                 | 20.00     |
| 21. 00  | EMERGENCY                    | 91. 00                         | O                  | 27, 605  |                 | 21.00     |
| 22.00   | HOME HEALTH AGENCY           | 101. 00                        | 0                  | 29, 744  |                 | 22. 00    |
| 23.00   | MOB                          | 194. 00                        | 0                  | 143, 994 |                 | 23. 00    |
| 24.00   | CLARK & WELLS RHC            | <u>88.</u> 01                  | 0                  | 9, 624   |                 | 24.00     |
|         | 0                            |                                |                    | 741, 291 |                 |           |
|         | G - WELLNESS CENTER          |                                |                    |          |                 |           |
| 1.00    | EMPLOYEE BENEFITS DEPARTMENT | 4. 00                          | 0                  | 523      |                 | 1.00      |
|         | 0                            | — — <del></del> ° <del>†</del> | — — — <del>ў</del> |          |                 | . 55      |
|         | I - MALPRACTICE              |                                | ٥                  | 020      |                 |           |
| 1. 00   | ADMINISTRATIVE & GENERAL     | 5. 00                          | ol                 | 69, 473  |                 | 1.00      |
|         | ADMINISTRATIVE & GENERAL     | 0.00                           | •                  |          |                 |           |
| 2.00    |                              |                                | 0                  | 0        |                 | 2.00      |
| 3.00    |                              | 0.00                           | 0                  | 0        |                 | 3.00      |
| 4.00    | 1                            | 0. 00                          | 0                  | 0        |                 | 4.00      |
| 5. 00   |                              | 0. 00                          | 0                  | 0        |                 | 5.00      |
| 6. 00   | <u></u>                      | 0.00                           | 0                  | 0        |                 | 6.00      |
|         | 0                            |                                | 0                  | 69, 473  |                 |           |
|         | J - MOB COLLECTION EXPENSE   |                                |                    |          |                 |           |
| 1.00    | OPERATI NG ROOM              | 50.00                          | 0                  | 636      |                 | 1.00      |
| 2. 00   | FORT BRANCH RHC              | 88. 00                         | Ö                  | 36       |                 | 2.00      |
| 3. 00   | MOB                          | 194. 00                        | ٥                  | 1, 610   |                 | 3.00      |
| 5.00    | 0 — — — — —                  |                                | — — — #            | 2, 282   |                 | 5.00      |
|         | I~                           |                                | <u> </u>           | ۷, ۷۵۷   |                 |           |
|         |                              |                                |                    |          |                 |           |

Health Financial Systems RECLASSIFICATIONS GI BSON GENERAL HOSPI TAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1319

| Peri od: | Worksheet A-6 | From 10/01/2019 | To 09/30/2020 | Date/Time Prepared:

|                |                               |                                 |                  |             | 4/28/2021 8 |                |
|----------------|-------------------------------|---------------------------------|------------------|-------------|-------------|----------------|
|                |                               | Increases                       |                  |             |             |                |
|                | Cost Center                   | Li ne #                         | Sal ary          | 0ther       |             |                |
|                | 2. 00                         | 3. 00                           | 4. 00            | 5. 00       |             |                |
|                | K - UTILITIES RECLASS         |                                 |                  |             |             |                |
| 1.00           | OPERATION OF PLANT            | 7. 00                           | 0                | 190, 952    |             | 1.00           |
| 2.00           |                               | 0. 00                           | 0                | 0           |             | 2. 00          |
| 3.00           |                               | 0. 00                           | 0                | 0           |             | 3. 00          |
| 4.00           |                               | 0. 00                           | 0                | 0           |             | 4. 00          |
| 5. 00          |                               | 0. 00                           | 0                | 0           |             | 5. 00          |
| 6.00           |                               | 0. 00                           | 0                | 0           |             | 6. 00          |
| 7. 00          |                               | 0. 00                           | 0                | 0           |             | 7. 00          |
| 8. 00          |                               | <u>0.</u> 00                    |                  | 0           |             | 8. 00          |
|                | 0                             |                                 | 0                | 190, 952    |             |                |
|                | L - HRS RECLASS               |                                 |                  |             |             |                |
| 1.00           | ADMINISTRATIVE & GENERAL      | 5. 00                           | 0                | 24, 719     |             | 1.00           |
| 2.00           |                               | 0.00                            | 0                | 0           |             | 2.00           |
| 3.00           |                               | 0.00                            | 0                | 0           |             | 3.00           |
| 4.00           |                               | 0.00                            | 0                | 0           |             | 4.00           |
| 5. 00          |                               | 0.00                            |                  | 0           |             | 5. 00          |
|                | U PUO PEOLACC                 |                                 | 0                | 24, 719     |             | _              |
| 1 00           | M - RHC RECLASS               | 104.00                          | 440, 440         | 122 (04     |             | 1 100          |
| 1. 00          | MOB                           | 194.00                          | 440, 462         | 133, 604    |             | 1.00           |
|                | TOTALS                        |                                 | 440, 462         | 133, 604    |             | _              |
| 1 00           | N - MAINTENANCE RECLASS       | 7 00                            | ما               | 1 454 075   |             | 1 100          |
| 1.00           | OPERATION OF PLANT            | 7. 00<br>0. 00                  | 0                | 1, 454, 865 |             | 1.00           |
| 2. 00<br>3. 00 |                               | 0.00                            | 0                | 0           |             | 2. 00<br>3. 00 |
| 4. 00          |                               | 0.00                            | 0                | 0           |             | 4.00           |
| 5. 00          |                               | 0.00                            | 0                | 0           |             | 5.00           |
| 6. 00          |                               | 0.00                            | 0                | 0           |             | 6.00           |
| 7. 00          |                               | 0.00                            | 0                | 0           |             | 7.00           |
| 8. 00          |                               | 0.00                            | 0                | 0           |             | 8.00           |
| 9. 00          |                               | 0.00                            | 0                | 0           |             | 9.00           |
| 10. 00         |                               | 0.00                            | o                | 0           |             | 10.00          |
| 11. 00         |                               | 0.00                            | Ö                | 0           |             | 11.00          |
| 12. 00         |                               | 0.00                            | o                | 0           |             | 12.00          |
| 13. 00         |                               | 0.00                            | o                | 0           |             | 13. 00         |
| 14. 00         |                               | 0.00                            | 0                | 0           |             | 14. 00         |
| 15. 00         |                               | 0.00                            | o                | 0           |             | 15. 00         |
| 16. 00         |                               | 0.00                            | 0                | 0           |             | 16. 00         |
| 17. 00         |                               | 0.00                            | 0                | 0           |             | 17. 00         |
| 18. 00         |                               | 0.00                            | 0                | 0           |             | 18. 00         |
| 19. 00         |                               | 0.00                            | Ö                | 0           |             | 19. 00         |
| 20. 00         |                               | 0.00                            | o                | 0           |             | 20. 00         |
| 00             | TOTALS — — — —                | — — <del></del> <del></del>     | — — <del> </del> | 1, 454, 865 |             |                |
|                | O - FORT BRANCH PHYS RECLASS  |                                 | 3                | .,,         |             |                |
| 1. 00          | FORT BRANCH RHC               | 88. 00                          | 0                | 18, 304     |             | 1.00           |
|                | TOTALS                        | — — <del></del> -* <del>+</del> | <del> </del>     | 18, 304     |             |                |
|                | P - FORT BRANCH SIMPSON RECLA | iss                             |                  | .,          |             |                |
| 1. 00          | CLARK & WELLS RHC             | 88. 01                          | 18, 224          | O           |             | 1.00           |
|                | TOTALS                        | — — <del>— "</del> †            | 18, 224          | <u>0</u>    |             |                |
| 500.00         | Grand Total: Increases        |                                 | 855, 478         | 3, 858, 433 |             | 500.00         |
|                |                               | '                               |                  |             |             |                |

Provi der CCN: 15-1319

Peri od: From 10/01/2019 To 09/30/2020 Date/Time Prepared: 4/28/2021 8: 15 am

|        |                              |                 |                   |                  |                | 4/28/2021 8 | : 15 am |
|--------|------------------------------|-----------------|-------------------|------------------|----------------|-------------|---------|
|        |                              | Decreases       |                   |                  |                |             |         |
|        | Cost Center                  | Li ne #         | Sal ary           |                  | Wkst. A-7 Ref. |             |         |
|        | 6. 00                        | 7. 00           | 8. 00             | 9. 00            | 10.00          |             |         |
|        | A - CAFETERIA                |                 |                   |                  |                |             |         |
| 1. 00  | DI ETARY                     | 1000            | 27 <u>4, 8</u> 16 | <u>253, 1</u> 45 |                |             | 1. 00   |
|        | 0                            |                 | 274, 816          | 253, 145         |                |             |         |
|        | B - MED SUPPLY CHG PTS       |                 |                   |                  |                |             |         |
| 1. 00  | PHARMACY                     | 15. 00          | 0                 | 2                | 0              |             | 1. 00   |
| 2.00   | ADULTS & PEDIATRICS          | 30. 00          | 0                 | 2, 943           |                |             | 2. 00   |
| 3.00   | OPERATING ROOM               | 50. 00          | 0                 | 161, 351         | 0              |             | 3. 00   |
| 4.00   | RADI OLOGY-DI AGNOSTI C      | 54.00           | 0                 | 2, 112           | 0              |             | 4. 00   |
| 5. 00  | NUCLEAR MEDICINE-DIAGNOSTIC  | 54. 03          | 0                 | 24, 477          | 0              |             | 5. 00   |
| 6. 00  | RESPI RATORY THERAPY         | 65. 00          | 0                 | 11, 649          | 0              |             | 6. 00   |
| 7.00   | PHYSI CAL THERAPY            | 66. 00          | 0                 | 2, 192           | 0              |             | 7. 00   |
| 8.00   | INFUSION THERAPY             | 76. 00          | 0                 | 2, 313           | 0              |             | 8. 00   |
| 9.00   | FORT BRANCH RHC              | 88. 00          | 0                 | 22, 845          | 0              |             | 9. 00   |
| 10. 00 | CLI NI C                     | 90. 00          | 0                 | 29               | 0              |             | 10.00   |
| 11. 00 | PAIN MANAGEMENT              | 90. 03          | 0                 | 187, 801         | 0              |             | 11. 00  |
| 12.00  | EMERGENCY                    | 91. 00          | 0                 | 5, 054           | 0              |             | 12.00   |
| 13.00  | HOME HEALTH AGENCY           | 101. 00         | 0                 | 205              | 0              |             | 13. 00  |
| 14.00  | MOB                          | 194. 00         | 0                 | 202, 604         | 0              |             | 14. 00  |
| 15. 00 | CLARK & WELLS RHC            | 8801            | 0_                | 6 <u>7, 2</u> 22 | 0              |             | 15. 00  |
|        | 0                            |                 | 0                 | 692, 799         |                |             |         |
|        | C - BUSINESS HEALTH SER      |                 |                   |                  |                |             |         |
| 1. 00  | MOB                          | 1 <u>94.</u> 00 | 5 <u>4, 5</u> 46  | 1 <u>7, 8</u> 30 |                |             | 1.00    |
|        | 0                            |                 | 54, 546           | 17, 830          |                |             |         |
|        | D - INTEREST                 |                 |                   |                  |                |             |         |
| 1. 00  | INTEREST EXPENSE             | 113. 00         | 0                 | 231, 938         | 10             |             | 1. 00   |
| 2.00   |                              |                 | •                 | 0                | 0              |             | 2. 00   |
|        | 0                            |                 | 0                 | 231, 938         |                |             |         |
|        | E - QUALITY SERVICES         |                 |                   |                  |                |             |         |
| 1. 00  | ADULTS & PEDI ATRI CS        | 30. 00          | 67, 430           | 2 <u>6, 7</u> 08 | 0              |             | 1.00    |
|        | 0                            |                 | 67, 430           | 26, 708          |                |             |         |
|        | F - HEALTH INSURANCE         |                 |                   |                  |                |             |         |
| 1. 00  | EMPLOYEE BENEFITS DEPARTMENT | 4. 00           | 0                 | 741, 291         | 0              |             | 1. 00   |
| 2.00   |                              | 0. 00           | 0                 | 0                | 0              |             | 2. 00   |
| 3.00   |                              | 0. 00           | 0                 | 0                | l .            |             | 3. 00   |
| 4. 00  |                              | 0. 00           | 0                 | 0                |                |             | 4. 00   |
| 5.00   |                              | 0. 00           | 0                 | 0                | 0              |             | 5. 00   |
| 6.00   |                              | 0. 00           | 0                 | 0                | 0              |             | 6. 00   |
| 7. 00  |                              | 0. 00           | 0                 | 0                | 0              |             | 7. 00   |
| 8. 00  |                              | 0. 00           | 0                 | 0                | 0              |             | 8. 00   |
| 9.00   |                              | 0. 00           | 0                 | 0                |                |             | 9. 00   |
| 10.00  |                              | 0. 00           | 0                 | 0                | 0              |             | 10. 00  |
| 11. 00 |                              | 0. 00           | 0                 | 0                |                |             | 11. 00  |
| 12.00  |                              | 0. 00           | 0                 | 0                | 0              |             | 12. 00  |
| 13.00  |                              | 0. 00           | 0                 | 0                | 0              |             | 13. 00  |
| 14.00  |                              | 0. 00           | 0                 | 0                | 0              |             | 14. 00  |
| 15. 00 |                              | 0. 00           | 0                 | 0                | 0              |             | 15. 00  |
| 16.00  |                              | 0. 00           | 0                 | 0                | 0              |             | 16. 00  |
| 17. 00 |                              | 0. 00           | 0                 | 0                | 0              |             | 17. 00  |
| 18. 00 |                              | 0. 00           | 0                 | 0                | 0              |             | 18. 00  |
| 19. 00 |                              | 0. 00           | 0                 | 0                | 0              |             | 19. 00  |
| 20.00  |                              | 0. 00           | 0                 | 0                |                |             | 20.00   |
| 21.00  |                              | 0. 00           | 0                 | 0                | 0              |             | 21.00   |
| 22. 00 |                              | 0. 00           | 0                 | 0                | 0              |             | 22. 00  |
| 23.00  |                              | 0. 00           | 0                 | 0                | 0              |             | 23. 00  |
| 24.00  |                              | 000             | 0                 | 0                | 0              |             | 24. 00  |
|        | 0                            |                 | 0                 | 741, 291         |                |             |         |
|        | G - WELLNESS CENTER          |                 |                   |                  |                |             |         |
| 1. 00  | MOB                          | 194. 00         | 0_                | <u>523</u>       |                |             | 1.00    |
|        | 0                            |                 | 0                 | 523              |                |             |         |
|        | I - MALPRACTICE              |                 |                   |                  |                |             |         |
| 1. 00  | OPERATING ROOM               | 50. 00          | 0                 | 19, 968          | 0              |             | 1.00    |
| 2.00   | RESPI RATORY THERAPY         | 65. 00          | 0                 | 614              | 0              |             | 2. 00   |
| 3.00   | FORT BRANCH RHC              | 88. 00          | 0                 | 1, 224           | 0              |             | 3. 00   |
| 4. 00  | PAIN MANAGEMENT              | 90. 03          | 0                 | 184              | 0              |             | 4. 00   |
| 5. 00  | MOB                          | 194. 00         | 0                 | 36, 967          | 0              |             | 5. 00   |
| 6. 00  | CLARK & WELLS RHC            | 8801            | 이                 | 1 <u>0, 5</u> 16 | 0              |             | 6. 00   |
|        | 0                            |                 | 0                 | 69, 473          |                |             | _       |
|        | J - MOB COLLECTION EXPENSE   |                 |                   |                  |                |             |         |
| 1.00   | ADMINISTRATIVE & GENERAL     | 5. 00           | 0                 | 1, 953           | 0              |             | 1. 00   |
| 2.00   | CLARK & WELLS RHC            | 88. 01          | 0                 | 329              | 0              |             | 2. 00   |
| 3. 00  |                              | 0.00            | •                 | 0                | 0              |             | 3. 00   |
|        | 0                            |                 | 0                 | 2, 282           |                |             | Į.      |
|        |                              |                 |                   |                  |                |             |         |

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 10/01/2019 | To 09/30/2020 | Date/Time Prepared: Provi der CCN: 15-1319

|        |                               |                 |                  |                  |                | 4/28/2021                               |        |
|--------|-------------------------------|-----------------|------------------|------------------|----------------|---|--------|
|        |                               | Decreases       |                  | <u> </u>         |                | , |        |
|        | Cost Center                   | Li ne #         | Sal ary          | 0ther            | Wkst. A-7 Ref. | <u> </u>                                |        |
|        | 6. 00                         | 7. 00           | 8. 00            | 9. 00            | 10.00          |   |        |
|        | K - UTILITIES RECLASS         |                 |                  |                  |                |   |        |
| 1.00   | ADMINISTRATIVE & GENERAL      | 5. 00           | 0                | 50, 428          | C              |   | 1.00   |
| 2.00   | NURSING ADMINISTRATION        | 13. 00          | 0                | 1, 708           | C              |   | 2.00   |
| 3.00   | OPERATING ROOM                | 50.00           | O                | 60, 395          | C              |   | 3.00   |
| 4.00   | PHYSI CAL THERAPY             | 66.00           | 0                | 9, 742           | C              |   | 4.00   |
| 5.00   | DI ABETES                     | 90. 01          | O                | 871              | C              |   | 5.00   |
| 6.00   | HOME HEALTH AGENCY            | 101.00          | o                | 102              |                |   | 6. 00  |
| 7. 00  | МОВ                           | 194. 00         | o                | 56, 445          |                |   | 7.00   |
| 8. 00  | CLARK & WELLS RHC             | 88. 01          | o                | 11, 261          |                | 1                                       | 8.00   |
|        | 0                             |                 |                  | 190, 952         |                | 1                                       |        |
|        | L - HRS RECLASS               | 1               |                  | ,                |                |   |        |
| 1. 00  | OPERATI NG ROOM               | 50.00           | 0                | 1, 725           | C              |   | 1.00   |
| 2. 00  | FORT BRANCH RHC               | 88. 00          | O                | 900              |                |   | 2.00   |
| 3. 00  | CLARK & WELLS RHC             | 88. 01          | 0                | 5, 590           |                | 1                                       | 3.00   |
| 4. 00  | PAIN MANAGEMENT               | 90. 03          | o                | 5, 5, 5          |                | 1                                       | 4.00   |
| 5. 00  | MOB                           | 194. 00         | 0                | 16, 499          |                | 1                                       | 5.00   |
| 3.00   |                               | 174.00          |                  |                  |                |   | 3.00   |
|        | M - RHC RECLASS               |                 | <u> </u>         | 24, 717          |                | 1                                       |        |
| 1. 00  | CLARK & WELLS RHC             | 88. 01          | 440, 462         | 133, 604         | C              |   | 1.00   |
| 1.00   | TOTALS                        |                 | 440, 462         | 133, 604         |                |   | 1.00   |
|        | N - MAINTENANCE RECLASS       |                 | 440, 402         | 133,004          |                |   |        |
| 1. 00  | ADMINISTRATIVE & GENERAL      | 5. 00           |                  | 1, 026, 003      | C              |   | 1.00   |
| 2.00   | LAUNDRY & LINEN SERVICE       | 8. 00           |                  | 1, 020, 003      |                |   | 2.00   |
| 3. 00  | HOUSEKEEPI NG                 | 9. 00           |                  | 618              |                |   | 3.00   |
| 4. 00  | DI ETARY                      | 10. 00          |                  | 3, 329           |                | 1                                       | 4.00   |
| 5.00   | CENTRAL SERVICE & SUPPLY      | 14. 00          |                  | 3, 329<br>170    |                | •                                       | 5.00   |
| 6. 00  | PHARMACY                      | 15. 00          |                  | 6, 637           |                | 1                                       | 6.00   |
| 7. 00  | ADULTS & PEDIATRICS           | 30. 00          |                  | 412              |                | 1                                       | 7.00   |
| 8. 00  | INTENSIVE CARE UNIT           | 31. 00          |                  | 87               |                | 1                                       | 8.00   |
| 9. 00  | OPERATING ROOM                |                 |                  |                  | _              |   |        |
|        |                               | 50.00           |                  | 52, 302          |                |   | 9.00   |
| 10.00  | RADI OLOGY-DI AGNOSTI C       | 54.00           |                  | 309, 226         |                | 1                                       | 10.00  |
| 11.00  | LABORATORY                    | 60.00           |                  | 12, 838          |                | 1                                       | 11.00  |
| 12.00  | RESPIRATORY THERAPY           | 65. 00          |                  | 10, 277          | C              | 1                                       | 12.00  |
| 13.00  | PHYSI CAL THERAPY             | 66.00           |                  | 4, 218           |                | 1                                       | 13.00  |
| 14.00  | OCCUPATIONAL THERAPY          | 67. 00          |                  | 1, 667           | C              | 1                                       | 14.00  |
| 15. 00 | I NFUSI ON THERAPY            | 76. 00          |                  | 87               | C              |   | 15.00  |
| 16. 00 | CLARK & WELLS RHC             | 88. 01          |                  | 2, 229           |                | 1                                       | 16.00  |
| 17.00  | PAIN MANAGEMENT               | 90. 03          |                  | 2, 625           |                |   | 17.00  |
| 18. 00 | EMERGENCY                     | 91. 00          |                  | 1, 724           | C              |   | 18. 00 |
| 19. 00 | MOB                           | 194. 00         |                  | 18, 380          |                | 1                                       | 19.00  |
| 20.00  | FOUNDATI ON                   | 1 <u>94.</u> 01 |                  | <u>1</u> 53      |                | 0                                       | 20. 00 |
|        | TOTALS                        |                 | 0                | 1, 454, 865      |                | <u> </u>                                | _      |
|        | O - FORT BRANCH PHYS RECLASS  |                 |                  |                  |                |   |        |
| 1. 00  | MOB                           | 1 <u>94.</u> 00 |                  | 1 <u>8, 3</u> 04 |                | <u>D</u>                                | 1.00   |
|        | TOTALS                        |                 | 0                | 18, 304          |                |   |        |
|        | P - FORT BRANCH SIMPSON RECLA |                 |                  |                  |                |   |        |
| 1.00   | FORT BRANCH RHC               |                 | 1 <u>8, 2</u> 24 | 0                |                |   | 1.00   |
|        | TOTALS                        |                 | 18, 224          |                  |                | 1                                       |        |
| 500.00 | Grand Total: Decreases        |                 | 855, 478         | 3, 858, 433      |                | 1                                       | 500.00 |

|  |              |                | T               | o 09/30/2020 | Date/Time Pre 4/28/2021 8:1 |       |
|--|--------------|----------------|-----------------|--------------|-----------------------------|-------|
|  |              |                | Acqui si ti ons |              | 17 207 2021 0. 1            |       |
|  | Begi nni ng  | Purchases      | Donati on       | Total        | Disposals and               |       |
|  | Bal ances    |                |                 |              | Retirements                 |       |
|  | 1. 00        | 2.00           | 3. 00           | 4. 00        | 5. 00                       |       |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE |              |                |                 |              |                             |       |
| 1. 00 Land                                   | 680, 034     | 0              | 0               | 0            | 0                           | 1.00  |
| 2.00 Land Improvements                       | 0            | 0              | 0               | 0            | 0                           | 2.00  |
| 3.00 Buildings and Fixtures                  | 19, 707, 979 | 788, 127       | 0               | 788, 127     | 0                           | 3.00  |
| 4.00 Building Improvements                   | 0            | 0              | 0               | 0            | 0                           | 4. 00 |
| 5.00 Fixed Equipment                         | 17, 360, 975 | 4, 990, 072    | 0               | 4, 990, 072  |                             | 5.00  |
| 6.00 Movable Equipment                       | 0            | 0              | 0               | 0            | 0                           | 6. 00 |
| 7.00 HIT designated Assets                   | 0            | 0              | 0               | 0            | 0                           | 7.00  |
| 8.00 Subtotal (sum of lines 1-7)             | 37, 748, 988 | 5, 778, 199    | 0               | 5, 778, 199  |                             |       |
| 9.00 Reconciling Items                       | 0            | 0              | 0               | 0            | 0                           | 9.00  |
| 10.00   Total (line 8 minus line 9)          | 37, 748, 988 |                | 0               | 5, 778, 199  | 120, 986                    | 10.00 |
|  | Endi ng      | Fully          |                 |              |                             |       |
|  | Bal ance     | Depreciated    |                 |              |                             |       |
|  | 6, 00        | Assets<br>7.00 |                 |              |                             |       |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE |              | 7.00           |                 |              |                             |       |
| 1.00 Land                                    | 680, 034     | 0              |                 |              |                             | 1.00  |
| 2.00 Land Improvements                       | 000,034      | 0              |                 |              | ļ                           | 2.00  |
| 3.00 Buildings and Fixtures                  | 20, 496, 106 | 0              |                 |              |                             | 3.00  |
| 4.00 Building Improvements                   | 20, 470, 100 | 0              |                 |              | ļ                           | 4.00  |
| 5. 00 Fi xed Equipment                       | 22, 230, 061 | 0              |                 |              | ļ                           | 5.00  |
| 6.00 Movable Equipment                       | 0            | o              |                 |              | ļ                           | 6.00  |
| 7.00 HIT designated Assets                   | ol           | ol             |                 |              | ļ                           | 7.00  |
| 8.00 Subtotal (sum of lines 1-7)             | 43, 406, 201 | o              |                 |              | l                           | 8.00  |
| 9.00 Reconciling Items                       | 0            | o              |                 |              |                             | 9. 00 |
| 10.00 Total (line 8 minus line 9)            | 43, 406, 201 | o              |                 |              | ļ                           | 10.00 |
|  |              | . '            |                 |              |                             | •     |

| Heal th | n Financial Systems                          | GIBSON GENERA    | AL HOSPITAL        |             | In Lieu of Form CMS-2552-10                  |                          |        |  |
|---------|--|------------------|--------------------|-------------|--|--------------------------|--------|--|
| RECON   | CILIATION OF CAPITAL COSTS CENTERS           |                  | Provi der C        | CN: 15-1319 | Peri od:<br>From 10/01/2019<br>To 09/30/2020 |                          | pared: |  |
|         |  |                  | SUMMARY OF CAPITAL |             |  |                          |        |  |
|         | Cost Center Description                      | Depreciation     | Lease              | Interest    | Insurance<br>(see<br>instructions)           | Taxes (see instructions) |        |  |
|         |  | 9. 00            | 10. 00             | 11. 00      | 12.00  | 13.00                    |        |  |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUN  | MN 2, LINES 1      | and 2       |  |                          |        |  |
| 1.00    | CAP REL COSTS-BLDG & FIXT                    | 2, 068, 894      | 0                  |             | 0 259, 062                                   | 8, 876                   | 1.00   |  |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                    | 0                | 0                  |             | 0 0  | 0                        | 2.00   |  |
| 3.00    | Total (sum of lines 1-2)                     | 2, 068, 894      | 0                  |             | 0 259, 062                                   | 8, 876                   | 3.00   |  |
|         |  | SUMMARY O        | F CAPITAL          |             |  |                          |        |  |
|         | Cost Center Description                      | Other            | Total (1)          |             |  |                          |        |  |
|         |  | Capi tal -Rel at | (sum of cols.      |             |  |                          |        |  |
|         |  | ed Costs (see    | 9 through 14)      |             |  |                          |        |  |
|         |  | instructions)    |                    |             |  |                          |        |  |
|         |  | 14. 00           | 15. 00             |             |  |                          |        |  |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLU   | MN 2, LINES 1      | and 2       |  |                          |        |  |
| 1.00    | CAP REL COSTS-BLDG & FLXT                    | 0                | 2, 336, 832        |             |  |                          | 1.00   |  |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                    | 0                | 0                  |             |  |                          | 2.00   |  |
| 3. 00   | Total (sum of lines 1-2)                     | 0                | 2, 336, 832        |             |  |                          | 3.00   |  |

| Health Financial S | Systems                            | GIBSON GENERA                                  | AL HOSPITAL      |                     | In Lieu of Form CMS-2552-10                 |               |                |  |
|--------------------|------------------------------------|--|------------------|---------------------|---|---------------|----------------|--|
| RECONCILIATION OF  | CAPITAL COSTS CENTERS              |  | Provi der C      |                     | Period:<br>From 10/01/2019<br>To 09/30/2020 |               | pared:         |  |
|                    |                                    | COMF   | PUTATION OF RAT  | TI OS               | ALLOCATION OF                               | OTHER CAPITAL | o am           |  |
| 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)<br>3.00    | 4.00  | 5. 00         |                |  |
| DADT III _         | RECONCILIATION OF CAPITAL COSTS C  |  | 2.00             | 3.00                | 4.00  | 5.00          |                |  |
|                    | STS-BLDG & FLXT                    | 43, 406, 201                                   | 0                | 43, 406, 20         | 1. 000000                                   | 0             | 1. 00          |  |
|                    | STS-MVBLE EQUIP                    | 0  | 0                |                     | 0. 000000                                   | -             | 2. 00          |  |
|                    | of lines 1-2)                      | 43, 406, 201                                   | 0                | 43, 406, 20         |   |               | 3.00           |  |
|                    |                                    | ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL |                  |                     |   |               |                |  |
| Cost               | Center Description                 | Taxes  | Other            | Total (sum of       | Depreciation                                | Lease         |                |  |
|                    | ·                                  |  | Capi tal -Rel at | cols. 5             | ·   |               |                |  |
|                    |                                    |  | ed Costs         | through 7)          |   |               |                |  |
|                    |                                    | 6. 00  | 7. 00            | 8. 00               | 9. 00                                       | 10.00         |                |  |
|                    | RECONCILIATION OF CAPITAL COSTS C  | ENTERS   | 0                |                     | 0 2 0/0 004                                 | 170 225       | 1 00           |  |
|                    | STS-BLDG & FIXT<br>STS-MVBLE EQUIP | 0  | 0                |                     | 0 2, 068, 894                               | 179, 325<br>0 | 1. 00<br>2. 00 |  |
|                    | of lines 1-2)                      | 0  | 0                |                     | 0 2, 068, 894                               | 179, 325      | 3. 00          |  |
| 3.00 Total (Suiii  | 01 1111e3 1-2)                     | 0  | SI               | I<br>JMMARY OF CAPI |   | 177, 323      | 3.00           |  |
|                    |                                    |  |                  |                     |   |               |                |  |
| Cost               | Center Description                 | Interest                                       | Insurance        | Taxes (see          | 0ther                                       | Total (2)     |                |  |
|                    |                                    |  | (see             | instructions)       |   |               |                |  |
|                    |                                    |  | instructions)    |                     | ed Costs (see                               | 9 through 14) |                |  |
|                    |                                    | 11 00  | 10.00            | 10.00               | instructions)                               | 45.00         |                |  |
| DADT III           | RECONCILIATION OF CAPITAL COSTS C  | 11.00  | 12. 00           | 13.00               | 14. 00                                      | 15. 00        |                |  |
|                    | STS-BLDG & FLXT                    | LIVIERS  | 259, 062         | 8, 87               | 6 0   | 2, 516, 157   | 1. 00          |  |
|                    | STS-MVBLE EQUIP                    |  | 237,002          |                     | 0 0   | 2, 310, 137   | 2. 00          |  |
|                    | of lines 1-2)                      | 0  | 259, 062         |                     | -   | -             | 3. 00          |  |
| ,                  | •                                  |  |                  | •                   | •   |               |                |  |

|                  | E.N.O TO EAR ENGLO  |              |                  |   | from 10/01/2019<br>to 09/30/2020 |                | pared:           |
|------------------|---|--------------|------------------|---|----------------------------------|----------------|------------------|
|                  |   |              | Т                | Expense Classification on Fo/From Which the Amount is |                                  | 4/28/2021 8: 1 | 5 am             |
|                  |   |              |                  |   |                                  |                |                  |
|                  | Cost Center Description   | Basi s/Code  | Amount           | Cost Center   | Li ne #                          | Wkst. A-7      |                  |
|                  |   | (2)<br>1. 00 | 2. 00            | 3. 00   | 4. 00                            | Ref.<br>5. 00  |                  |
| 1. 00            | Investment income - CAP REL   | В            | -52, 3260        | CAP REL COSTS-BLDG & FLXT                             | 1. 00                            | 10             | 1.00             |
| 2. 00            | COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2) |              | olo              | CAP REL COSTS-MVBLE EQUIP                             | 2.00                             | 0              | 2.00             |
| 3. 00            | Investment income - other (chapter 2)   |              | 0                |   | 0. 00                            | 0              | 3.00             |
| 4. 00            | Trade, quantity, and time discounts (chapter 8)   |              | 0                |   | 0.00                             | 0              | 4. 00            |
| 5. 00            | Refunds and rebates of expenses (chapter 8)   | А            | -277 A           | ADMINISTRATIVE & GENERAL                              | 5. 00                            | 0              | 5. 00            |
| 6. 00            | Rental of provider space by suppliers (chapter 8)                                       |              | 0                |   | 0.00                             | 0              | 6. 00            |
| 7. 00            | Telephone services (pay<br>stations excluded) (chapter<br>21)                           | А            | -6, 107          | OPERATION OF PLANT                                    | 7. 00                            | 0              | 7. 00            |
| 8. 00            | Television and radio service (chapter 21)   | А            | -117 C           | PERATION OF PLANT                                     | 7. 00                            | 0              | 8. 00            |
| 9. 00<br>10. 00  | Parking Lot (chapter 21)<br>Provider-based physician                                    | A-8-2        | 0<br>-899, 040   |   | 0.00                             | 0              |                  |
| 11. 00           | adjustment Sale of scrap, waste, etc.   |              | 0                |   | 0.00                             | 0              | 11.00            |
| 12. 00           | (chapter 23) Related organization transactions (chapter 10)                             | A-8-1        | 5, 876, 174      |   |                                  | 0              | 12. 00           |
| 13. 00<br>14. 00 | Laundry and linen service Cafeteria-employees and quests                                | В            | 0<br>-112, 360 0 | CAFFTERI A  | 0. 00<br>11. 00                  | 0              |                  |
| 15. 00           | Rental of quarters to employee and others   |              | 0                | ,   | 0.00                             | 0              | 1                |
| 16. 00           | Sale of medical and surgical supplies to other than patients                            |              | 0                |   | 0. 00                            | 0              | 16. 00           |
| 17. 00           | Sale of drugs to other than patients  |              | 0                |   | 0.00                             | 0              | 17. 00           |
| 18. 00           | Sale of medical records and abstracts   | В            | -3, 123 N        | MEDICAL RECORDS & LIBRARY                             | 16. 00                           | 0              | 18. 00           |
| 19. 00           | Nursing and allied health education (tuition, fees, books, etc.)                        |              | 0                |   | 0. 00                            | 0              | 19. 00           |
| 20. 00<br>21. 00 | Vending machines Income from imposition of interest, finance or penalty                 |              | 0                |   | 0. 00<br>0. 00                   | 0              | 20. 00<br>21. 00 |
| 22. 00           | charges (chapter 21)  |              | 0                |   | 0. 00                            | 0              | 22. 00           |
| 23. 00           | repay Medicare overpayments   | A-8-3        | OF               | RESPI RATORY THERAPY                                  | 65. 00                           |                | 23. 00           |
| 24. 00           | limitation (chapter 14)   | A-8-3        | OF               | PHYSICAL THERAPY                                      | 66. 00                           |                | 24. 00           |
| 25. 00           | limitation (chapter 14) Utilization review - physicians' compensation                   |              | 0 *              | *** Cost Center Deleted ***                           | 114. 00                          |                | 25. 00           |
| 26. 00           | (chapter 21)<br>Depreciation - CAP REL  |              | 0                | CAP REL COSTS-BLDG & FLXT                             | 1.00                             | 0              | 26. 00           |
| 27. 00           | COSTS-BLDG & FIXT Depreciation - CAP REL  |              | olo              | CAP REL COSTS-MVBLE EQUIP                             | 2. 00                            | 0              | 27. 00           |
| 28. 00           | COSTS-MVBLE EQUIP Non-physician Anesthetist   |              | 0 *              | *** Cost Center Deleted ***                           | 19. 00                           | 0              | 28.00            |
| 29. 00<br>30. 00 | Physicians' assistant Adjustment for occupational therapy costs in excess of            | A-8-3        | 000              | OCCUPATI ONAL THERAPY                                 | 0. 00<br>67. 00                  | 0              | 29. 00<br>30. 00 |
| 30. 99           | limitation (chapter 14) Hospice (non-distinct) (see instructions)                       |              | O                | ADULTS & PEDIATRICS                                   | 30. 00                           |                | 30. 99           |

| Heal th | Financial Systems                              |            | GI BSON GENERA | AL HOSPITAL                 | In Lie                           | u of Form CMS-2 | 2552-10 |
|---------|--|------------|----------------|-----------------------------|----------------------------------|-----------------|---------|
| ADJUST  | MENTS TO EXPENSES                              |            |                |                             | Peri od:                         | Worksheet A-8   |         |
|         |  |            |                |                             | From 10/01/2019<br>To 09/30/2020 | Date/Time Pre   | narod:  |
|         |  |            |                |                             | 10 09/30/2020                    | 4/28/2021 8: 1  | 5 am    |
|         |  |            |                | Expense Classification or   | Worksheet A                      |                 |         |
|         |  |            |                |                             |                                  |                 |         |
|         |  |            |                |                             |                                  |                 |         |
|         |  |            |                |                             |                                  |                 |         |
|         |  |            |                |                             |                                  |                 |         |
|         |  |            |                |                             |                                  |                 |         |
|         |  |            |                |                             |                                  |                 |         |
|         | Cost Center Description                        | Basis/Code | Amount         | Cost Center                 | Li ne #                          | Wkst. A-7       |         |
|         | ·  | (2)        |                |                             |                                  | Ref.            |         |
|         |  | 1. 00      | 2. 00          | 3. 00                       | 4. 00                            | 5. 00           |         |
| 31. 00  | 1 2  | A-8-3      | 0              | SPEECH PATHOLOGY            | 68. 00                           |                 | 31.00   |
|         | pathology costs in excess of                   |            |                |                             |                                  |                 |         |
| 32. 00  | limitation (chapter 14) CAH HIT Adjustment for |            | 0              |                             | 0.00                             | 0               | 32.00   |
| 32.00   | Depreciation and Interest                      |            | 0              |                             | 0.00                             | Ü               | 32.00   |
| 33 00   | MISC INCOME                                    | В          | -9 512         | ADMINISTRATIVE & GENERAL    | 5. 00                            | 0               | 33.00   |
|         | MISC INCOME                                    | В          |                | ADMINISTRATIVE & GENERAL    | 5. 00                            | 0               | 33. 01  |
| 33. 02  | PHYSI CI AN RECRUI TI NG                       | A          |                | EMPLOYEE BENEFITS DEPARTMEN |                                  | 0               | 33. 02  |
| 33. 03  | ADVERTI SI NG                                  | Α          | -123, 799      | ADMINISTRATIVE & GENERAL    | 5. 00                            | 0               | 33. 03  |
| 33.04   | HAF FEE  | Α          | -1, 294, 759   | ADMINISTRATIVE & GENERAL    | 5. 00                            | 0               | 33. 04  |
| 34.00   | LOBBYI NG                                      | Α          | -880           | ADMINISTRATIVE & GENERAL    | 5. 00                            | 0               | 34.00   |
| 34. 01  | 340B   | Α          | •              | DRUGS CHARGED TO PATIENTS   | 73. 00                           | 0               | 34. 01  |
| 35. 00  | CRNA   | Α          | 1              | OPERATING ROOM              | 50. 00                           | 0               | 35.00   |
| 50.00   | TOTAL (sum of lines 1 thru 49)                 |            | 2, 990, 854    |                             |                                  |                 | 50.00   |
|         | (Transfer to Worksheet A,                      |            |                |                             |                                  |                 |         |
|         | column 6, line 200.)                           |            |                |                             |                                  |                 |         |

<sup>(1)</sup> 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.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 15-1319

Worksheet A-8-1

Peri od: From 10/01/2019 | To 09/30/2020 | Date/Time Prepared:

|       |                              |                               |                             | 10 09/30/2020   | 4/28/2021 8: 1 |       |
|-------|------------------------------|-------------------------------|-----------------------------|-----------------|----------------|-------|
|       | 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 ADJUST | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED O | RGANIZATIONS OR | CLAIMED HOME   |       |
|       | OFFICE COSTS:                |                               |                             |                 |                |       |
| 1. 00 | 1                            | EMPLOYEE BENEFITS DEPARTMENT  |                             | 1, 369, 163     | 1              | 1. 00 |
| 2.00  | 1                            |                               | HOME OFFICE                 | 2, 320, 228     | 0              | 2.00  |
| 3.00  | 7.00                         | OPERATION OF PLANT            | HOME OFFICE                 | 474, 267        | 717, 146       | 3.00  |
| 3. 01 | 9.00                         | HOUSEKEEPI NG                 | HOME OFFICE                 | 210, 589        | 0              | 3. 01 |
| 3.02  | 10.00                        | DI ETARY                      | HOME OFFICE                 | 80, 720         | 0              | 3.02  |
| 4.00  | 13.00                        | NURSING ADMINISTRATION        | HOME OFFICE                 | 86, 809         | 0              | 4.00  |
| 4.01  | 15. 00                       | PHARMACY                      | HOME OFFICE                 | 330, 999        | 0              | 4. 01 |
| 4.02  | 16.00                        | MEDICAL RECORDS & LIBRARY     | HOME OFFICE                 | 44, 728         | 0              | 4.02  |
| 4.03  | 5. 00                        | ADMINISTRATIVE & GENERAL      | HOME OFFICE                 | 194, 460        | 0              | 4.03  |
| 4.04  | 5. 00                        | ADMINISTRATIVE & GENERAL      | HOME OFFICE                 | 1, 172, 833     | 88, 497        | 4.04  |
| 4.05  | 13. 00                       | NURSING ADMINISTRATION        | HOME OFFICE                 | 208, 595        | 0              | 4.05  |
| 4.06  | 5. 00                        | ADMINISTRATIVE & GENERAL      | HOME OFFICE                 | 657, 907        | 469, 481       | 4.06  |
| 5.00  | TOTALS (sum of lines 1-4).   |                               |                             | 7, 151, 298     | 1, 275, 124    | 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.

| <br>a net been peeted to normanie i and a 27 the amount arrenable should be rise and a 27 the parti- |       |               |                              |                |  |  |  |  |  |
|--|-------|---------------|------------------------------|----------------|--|--|--|--|--|
|  |       |               | Related Organization(s) and/ | or Home Office |  |  |  |  |  |
|  |       |               | 3 ( )                        |                |  |  |  |  |  |
|  |       |               |                              |                |  |  |  |  |  |
|  |       |               |                              |                |  |  |  |  |  |
|  |       |               |                              |                |  |  |  |  |  |
| Symbol (1)   | Name  | Percentage of | Name                         | Percentage of  |  |  |  |  |  |
|  |       | Ownershi p    |                              | Ownershi p     |  |  |  |  |  |
| 1. 00  | 2. 00 | 3. 00         | 4. 00                        | 5. 00          |  |  |  |  |  |
| B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:                                  |       |               |                              |                |  |  |  |  |  |

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

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

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

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

| Heal th           | Financial Syste | ems             |               | GI BSON       | GENERAL    | HOSPI TAL   |        |         | In Li                      | eu of Form   | CMS-2552-1               | 10 |
|-------------------|-----------------|-----------------|---------------|---------------|------------|-------------|--------|---------|----------------------------|--------------|--------------------------|----|
| STATEME<br>OFFICE | ENT OF COSTS OF | SERVICES FROM   | RELATED ORGA  | NI ZATI ONS A | ND HOME    | Provi der   | CCN: 1 | 5-1319  | Peri od:<br>From 10/01/201 | Workshee     | t A-8-1                  | _  |
| UFFICE            | 00313           |                 |               |               |            |             |        |         | To 09/30/202               | 20 Date/Time | e Prepared:<br>1 8:15 am | :  |
|                   | Net             | Wkst. A-7 Ref.  |               |               |            |             |        |         | '                          |              |                          |    |
|                   | Adjustments     |                 |               |               |            |             |        |         |                            |              |                          |    |
|                   | (col. 4 minus   |                 |               |               |            |             |        |         |                            |              |                          |    |
|                   | col. 5)*        |                 |               |               |            |             |        |         |                            |              |                          |    |
|                   | 6. 00           | 7. 00           |               |               |            |             |        |         |                            |              |                          |    |
|                   | A. COSTS INCUR  | RED AND ADJUSTI | MENTS REQUIRE | D AS A RESU   | JLT OF TRA | ANSACTI ONS | WITH   | RELATED | ORGANI ZATI ONS (          | OR CLAIMED F | HOME                     |    |
|                   | OFFICE COSTS:   |                 |               |               |            |             |        |         |                            |              |                          |    |
| 1.00              | 1, 369, 163     | 0               |               |               |            |             |        |         |                            |              | 1.0                      | Ю  |
| 2.00              | 2, 320, 228     | 0               |               |               |            |             |        |         |                            |              | 2.0                      | Ю  |
| 3.00              | -242, 879       | 0               |               |               |            |             |        |         |                            |              | 3.0                      | Ю  |
| 3. 01             | 210, 589        | 0               |               |               |            |             |        |         |                            |              | 3.0                      | 11 |
| 3. 02             | 80, 720         | 0               |               |               |            |             |        |         |                            |              | 3.0                      | )2 |
| 4.00              | 86, 809         | 0               |               |               |            |             |        |         |                            |              | 4.0                      | Ю  |
| 4.01              | 330, 999        | 0               |               |               |            |             |        |         |                            |              | 4.0                      | )1 |
| 4.02              | 44, 728         | 0               |               |               |            |             |        |         |                            |              | 4.0                      | )2 |
| 4.03              | 194, 460        | 0               |               |               |            |             |        |         |                            |              | 4.0                      | )3 |
| 4.04              | 1, 084, 336     | 0               |               |               |            |             |        |         |                            |              | 4.0                      | )4 |
| 4.05              | 208, 595        | 0               |               |               |            |             |        |         |                            |              | 4.0                      | )5 |
| 4.06              | 188, 426        | 0               |               |               |            |             |        |         |                            |              | 4.0                      | 16 |
| 5.00              | 5, 876, 174     |                 |               |               |            |             |        |         |                            |              | 5. 0                     | Ю  |

\* 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.

| 1100 1101 | boon postou to normande m      | oct amino i ana, ci 2, the amount arrowable choara so mai datea in coramin i ci the parti |  |
|-----------|--------------------------------|---|--|
|           | Related Organization(s)        |   |  |
|           | and/or Home Office             |   |  |
|           |                                |   |  |
|           |                                |   |  |
|           | Type of Business               |   |  |
|           |                                |   |  |
|           | 6, 00                          |   |  |
|           | 1 11                           |   |  |
|           | B. INTERRELATIONSHIP TO RELATE | TED ORGANIZATION(S) AND/OR HOME OFFICE:   |  |
|           |                                |   |  |

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

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

|                   | of mode Schiotic direct Aviii. |        |  |  |  |  |  |  |  |  |
|-------------------|--------------------------------|--------|--|--|--|--|--|--|--|--|
|                   | HOME OFFICE                    | 6.00   |  |  |  |  |  |  |  |  |
| 7.00              | PFS                            | 7.00   |  |  |  |  |  |  |  |  |
| 8. 00<br>9. 00    |                                | 8.00   |  |  |  |  |  |  |  |  |
| 9.00              |                                | 9.00   |  |  |  |  |  |  |  |  |
| 10. 00<br>100. 00 |                                | 10.00  |  |  |  |  |  |  |  |  |
| 100.00            |                                | 100.00 |  |  |  |  |  |  |  |  |

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

| Period: | Worksheet A-8-2 | From 10/01/2019 | To 09/30/2020 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-1319

|        |                |                       |                |                | -               | To 09/30/2020 | Date/Time Pre<br>4/28/2021 8:1 |              |
|--------|----------------|-----------------------|----------------|----------------|-----------------|---------------|--------------------------------|--------------|
|        | Wkst. A Line # | Cost Center/Physician | Total          | Professi onal  | Provi der       | RCE Amount    | Physi ci an/Prov               | <del>U</del> |
|        |                | I denti fi er         | Remuneration   | Component      | Component       |               | ider Component                 |              |
|        |                |                       |                | '              | · ·             |               | Hours                          |              |
|        | 1.00           | 2. 00                 | 3. 00          | 4.00           | 5. 00           | 6. 00         | 7. 00                          |              |
| 1.00   | 30.00          | ADULTS & PEDIATRICS   | 346, 832       | 346, 832       | 0               | 0             | 0                              | 1.00         |
| 2.00   | 50.00          | OPERATING ROOM        | 466, 549       | 466, 549       | 0               | 0             | 0                              | 2.00         |
| 3.00   | 60.00          | LABORATORY            | 40, 000        | 0              | 40, 000         | 0             | 0                              | 3.00         |
| 4.00   | 65. 00         | RESPI RATORY THERAPY  | 60, 659        | 60, 659        | 0               | 0             | 0                              | 4.00         |
| 5.00   | 76. 00         | INFUSION THERAPY      | 25, 000        | 25, 000        | 0               | 0             | 0                              | 5.00         |
| 6.00   | 91.00          | EMERGENCY             | 1, 258, 137    | 0              | 1, 258, 137     | 0             | 0                              | 6.00         |
| 7.00   | 0.00           |                       | 0              | 0              | 0               | 0             | 0                              | 7. 00        |
| 8.00   | 0.00           |                       | 0              | 0              | 0               | 0             | 0                              | 8.00         |
| 9.00   | 0.00           |                       | 0              | 0              | 0               | 0             | 0                              | 9.00         |
| 10.00  | 0.00           |                       | 0              | 0              | 0               | 0             | 0                              | 10.00        |
| 200.00 |                |                       | 2, 197, 177    |                | 1, 298, 137     |               | 0                              | 200.00       |
|        | Wkst. A Line # | l 3                   | Unadjusted RCE |                | Cost of         |               | Physician Cost                 |              |
|        |                | I denti fi er         | Limit          | Unadjusted RCE | •               | Component     | of Malpractice                 |              |
|        |                |                       |                | Limit          | Conti nui ng    | Share of col. | Insurance                      |              |
|        |                |                       |                |                | Educati on      | 12            |                                |              |
|        | 1.00           | 2.00                  | 8. 00          | 9. 00          | 12.00           | 13. 00        | 14. 00                         |              |
| 1.00   |                | ADULTS & PEDIATRICS   | 0              | 0              | _               | 1             | 0                              | 1.00         |
| 2.00   |                | OPERATI NG ROOM       | 0              | 0              |                 |               | 0                              | 2.00         |
| 3.00   |                | LABORATORY            | 0              | 0              | _               |               | 0                              | 3.00         |
| 4.00   |                | RESPIRATORY THERAPY   | 0              | 0              | 0               | 1             | 0                              | 4.00         |
| 5.00   |                | I NFUSI ON THERAPY    | 0              | 0              | 0               | 0             | 0                              | 5.00         |
| 6. 00  |                | EMERGENCY             | 0              | 0              | 0               | 0             | 0                              | 6. 00        |
| 7.00   | 0.00           |                       | 0              | 0              | 0               | 0             | 0                              | 7.00         |
| 8. 00  | 0.00           |                       | 0              | 0              | 0               | 0             | 0                              | 8. 00        |
| 9.00   | 0.00           | 1                     | 0              | 0              | 0               | 0             | 0                              | 9.00         |
| 10.00  | 0.00           |                       | 0              | 0              | _               | 1             | 0                              | 10.00        |
| 200.00 | Wkst. A Line # | Cost Center/Physician | Provi der      | Adjusted RCE   | RCE             |               | 0                              | 200.00       |
|        | WKSt. A Line # | I denti fi er         | Component      | Limit          | Di sal I owance | Adjustment    |                                |              |
|        |                | ruentiffei            | Share of col.  | LIIIII         | Disarrowance    |               |                                |              |
|        |                |                       | 14             |                |                 |               |                                |              |
|        | 1. 00          | 2.00                  | 15. 00         | 16. 00         | 17. 00          | 18. 00        |                                |              |
| 1. 00  | 30.00          | ADULTS & PEDIATRICS   | 0              | 0              | 0               | 346, 832      |                                | 1. 00        |
| 2.00   | 50.00          | OPERATING ROOM        | 0              | 0              | 0               | 466, 549      |                                | 2.00         |
| 3.00   | 60.00          | LABORATORY            | 0              | 0              | 0               | 0             |                                | 3.00         |
| 4.00   | 65. 00         | RESPIRATORY THERAPY   | 0              | 0              | 0               | 60, 659       |                                | 4.00         |
| 5.00   | 76. 00         | INFUSION THERAPY      | 0              | 0              | 0               | 25, 000       |                                | 5.00         |
| 6.00   |                | EMERGENCY             | 0              | 0              | 0               | 0             |                                | 6.00         |
| 7.00   | 0.00           |                       | 0              | 0              | 0               | 0             |                                | 7.00         |
| 8. 00  | 0.00           |                       | 0              | 0              | 0               | 0             |                                | 8.00         |
| 9.00   | 0.00           |                       | 0              | 0              | 0               | 0             |                                | 9.00         |
| 10.00  | 0.00           |                       | 0              | 0              | 0               | 0             |                                | 10.00        |
| 200.00 |                |                       | 0              | 0              | 0               | 899, 040      |                                | 200.00       |
|        | •              | •                     | •              | •              | •               |               |                                |              |

| Period: | Worksheet B | From 10/01/2019 | Part | To 09/30/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1319

|                               |   |  |                       | <del> </del> | To 09/30/2020                |                         | pared:             |
|-------------------------------|---|--|-----------------------|--------------|------------------------------|-------------------------|--------------------|
|                               |   |  | CAPITAL RELATED COSTS |              |                              | 4/28/2021 8: 1          | 5 am               |
| Cost Center Description       |   | Net Expenses<br>for Cost<br>Allocation | BLDG & FIXT           | MVBLE EQUIP  | EMPLOYEE BENEFITS DEPARTMENT | Subtotal                |                    |
|                               |   | (from Wkst A                           |                       |              |                              |                         |                    |
|                               |   | col. 7)<br>0                           | 1. 00                 | 2.00         | 4. 00                        | 4A                      |                    |
|                               | GENERAL SERVICE COST CENTERS  |  |                       |              |                              |                         |                    |
|                               | 00100 CAP REL COSTS-BLDG & FLXT                                       | 2, 516, 157                            | 2, 516, 157           |              |                              |                         | 1.00               |
|                               | 00200 CAP REL COSTS-MVBLE EQUIP<br>00400 EMPLOYEE BENEFITS DEPARTMENT | 0<br>2, 281, 950                       | 19, 212               | •            | 2, 301, 162                  |                         | 2. 00<br>4. 00     |
| 5.00                          | 00500 ADMINISTRATIVE & GENERAL  | 8, 846, 215                            | 136, 868              | •            |                              | 9, 267, 130             | 1                  |
|                               | 00700 OPERATION OF PLANT  | 2, 378, 531                            | 686, 476              |              | 31, 930                      |                         |                    |
|                               | 00800 LAUNDRY & LINEN SERVICE<br>00900 HOUSEKEEPING                   | 81, 195                                | 44, 672               |              | -,                           |                         | 1                  |
|                               | 01000 DI ETARY  | 624, 247<br>266, 769                   | 25, 214<br>90, 770    |              |                              |                         | 1                  |
|                               | 01100 CAFETERI A  | 415, 601                               | 23, 926               |              |                              |                         | 1                  |
|                               | 01300 NURSING ADMINISTRATION  | 300, 058                               | 7, 564                |              | 0                            | ,                       |                    |
|                               | 01400 CENTRAL SERVICE & SUPPLY<br>01500 PHARMACY                      | 288, 400                               | 0                     |              |                              |                         |                    |
|                               | 01600 MEDICAL RECORDS & LIBRARY                                       | 1, 072, 086<br>369, 527                | 36, 533               |              | 25, 881<br>41, 979           |                         | 1                  |
|                               | INPATIENT ROUTINE SERVICE COST CENTERS                                | 0077027                                | 00,000                |              | ,, ,,,                       | 1,0,007                 | 10.00              |
|                               | 03000 ADULTS & PEDIATRICS   | 2, 255, 728                            | 251, 153              |              |                              |                         | 1                  |
|                               | 03100 INTENSIVE CARE UNIT<br>04400 SKILLED NURSING FACILITY           | 625<br>0                               | 53, 059<br>0          |              |                              |                         | 1                  |
| 44.00                         | ANCILLARY SERVICE COST CENTERS  | <u> </u>                               | 0                     |              | )                            | 0                       | 44.00              |
|                               | 05000 OPERATING ROOM  | 776, 129                               | 139, 882              | (            | 187, 020                     | 1, 103, 031             | 50.00              |
|                               | 05400 RADI OLOGY-DI AGNOSTI C   | 1, 103, 305                            | 95, 813               |              | 120, 700                     |                         | 1                  |
|                               | 05401 NUCLEAR MEDICINE-DIAGNOSTIC<br>06000 LABORATORY                 | 140, 226<br>2, 383, 608                | 11, 511<br>41, 932    |              |                              | 151, 737<br>2, 545, 610 |                    |
|                               | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                            | 59, 616                                | 41, 732               |              | 0                            | 59, 616                 | 1                  |
| 65.00                         | 06500 RESPIRATORY THERAPY   | 819, 556                               | 44, 179               |              | 68, 064                      | 931, 799                | 1                  |
|                               | 06600 PHYSI CAL THERAPY   | 896, 510                               | 77, 039               |              |                              |                         | 1                  |
| 67. 00<br>68. 00              | 06700 OCCUPATIONAL THERAPY<br>06800 SPEECH PATHOLOGY                  | 247, 833<br>96, 957                    | 22, 418<br>1, 699     |              |                              |                         |                    |
|                               | 06900 ELECTROCARDI OLOGY  | 0, 737                                 | 0                     | 1            |                              | 0                       | 1                  |
|                               | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                             | 269, 450                               | 98, 362               |              | -                            | 367, 812                |                    |
|                               | 07200 IMPL. DEV. CHARGED TO PATIENTS                                  | 423, 720                               | 0                     |              | 0                            | 423, 720                | 1                  |
|                               | 07300 DRUGS CHARGED TO PATIENTS<br>03480 INFUSION THERAPY             | 1, 770, 430<br>123, 781                | 36, 779<br>29, 243    |              | 0<br>16, 047                 | 1, 807, 209<br>169, 071 | 1                  |
|                               | OUTPATIENT SERVICE COST CENTERS                                       | 120/701                                | 27/210                |              | ,                            | 1077 071                | 70.00              |
|                               | 08800 FORT BRANCH RHC   | 335, 347                               | 0                     | •            |                              |                         | 1                  |
|                               | 08801 CLARK & WELLS RHC<br>09000 CLINIC                               | 258, 641<br>12, 914                    | 11, 511<br>0          |              |                              |                         | 1                  |
|                               | 09001 DI ABETES   | 12, 914                                | 0                     |              | 1, 11,                       | 14, 330                 | 1                  |
|                               | 09002 OP PSYCH  | 0                                      | 0                     |              | 0                            | 0                       | 90. 02             |
|                               | 09003 PAIN MANAGEMENT   | 359, 201                               | 43, 165               |              |                              |                         | 1                  |
|                               | 09100 EMERGENCY<br>09200 OBSERVATION BEDS (NON-DISTINCT PART          | 2, 497, 250                            | 213, 277              | (            | 159, 349                     | 2, 869, 876<br>0        | 1                  |
|                               | OTHER REIMBURSABLE COST CENTERS                                       |  |                       |              |                              | 0                       | 72.00              |
| 101.00                        | 10100 HOME HEALTH AGENCY  | 708, 156                               | 13, 840               | (            | 81, 185                      | 803, 181                | 101.00             |
|                               | SPECIAL PURPOSE COST CENTERS  |  |                       |              |                              |                         | 110 00             |
| 113.00                        | 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)         | 34, 979, 905                           | 2, 256, 097           |              | 1, 811, 810                  | 34, 230, 493            | 113.00             |
| NONREI MBURSABLE COST CENTERS |   |  |                       |              | 34, 230, 473                 | 1110.00                 |                    |
|                               | 07950 MOB   | 4, 175, 325                            | 224, 185              |              |                              |                         | 1                  |
|                               | 07951 FOUNDATI ON<br>07952 ASC  | 54, 023                                | 35, 875               |              |                              |                         | 194. 01            |
|                               | 07952 ASC<br>07953 SNF - PERRY CO.                                    | -19, 818                               | 0                     | 1            | 0                            |                         | 194. 02<br>194. 03 |
|                               | 07954 TELE BEHAVI ORAL  | 47, 522                                | 0                     | 1            | 824                          |                         | 194. 04            |
| 200.00                        | Cross Foot Adjustments  |  |                       |              |                              | 0                       | 200.00             |
| 201.00                        |   | 20 224 057                             | 0                     |              |                              |                         | 201.00             |
| 202. 00                       | TOTAL (sum lines 118 through 201)                                     | 39, 236, 957                           | 2, 516, 157           | (            | 2, 301, 162                  | 37, 230, 957            | 1202.00            |

Provider CCN: 15-1319

Peri od: Worksheet B From 10/01/2019 Part I To 09/30/2020 Date/Ti me Prepared:

|  |                  |              |               | 0 07/30/2020  | 4/28/2021 8: 1 |         |
|--|------------------|--------------|---------------|---------------|----------------|---------|
| 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             | 9, 267, 130      |              |               |               |                | 5.00    |
| 7.00 00700 OPERATION OF PLANT                    | 956, 988         | 4, 053, 925  |               |               |                | 7.00    |
| 8.00   00800 LAUNDRY & LINEN SERVICE             | 41, 369          | 108, 209     | 283, 454      |               |                | 8.00    |
| 9. 00 00900 HOUSEKEEPI NG                        | 215, 015         | 61, 075      | 0             | 971, 907      |                | 9.00    |
| 10. 00 01000 DI ETARY                            | 114, 435         | 219, 870     | l o           | 55, 010       | 759, 642       | 10.00   |
| 11. 00   01100   CAFETERI A                      | 150, 811         | 57, 955      |               | 14, 500       | 0              | 11.00   |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON          | 95, 059          | 18, 323      |               |               | 0              | 13.00   |
| 14. 00 01400 CENTRAL SERVICE & SUPPLY            | 99, 097          | 0            | 0             | 0             | 0              | 14.00   |
| 15. 00 01500 PHARMACY                            | 339, 284         | 0            | Ö             | 0             | Ö              | 15.00   |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY         | 138, 449         | 88, 492      | 0             | 22, 140       | 0              | 16.00   |
| INPATIENT ROUTINE SERVICE COST CENTERS           | 100, 117         | 00, 172      |               | 22, 110       | <u> </u>       | 10.00   |
| 30. 00 03000 ADULTS & PEDIATRICS                 | 859, 988         | 608, 361     | 271, 726      | 152, 204      | 728, 211       | 30.00   |
| 31. 00   03100   NTENSI VE CARE UNI T            | 16, 589          | 128, 523     |               |               | 31, 431        | 31.00   |
| 44. 00 04400 SKILLED NURSING FACILITY            | 10, 307          | 120, 323     | 11, 720       |               | 0              | 44.00   |
| ANCILLARY SERVICE COST CENTERS                   | <u> </u>         | <u>_</u>     |               | U             | U              | 44.00   |
| 50. 00 05000 OPERATING ROOM                      | 340, 849         | 338, 834     | 0             | 84, 774       | 0              | 50.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 407, 838         | •            |               | 58, 066       | 0              | 54.00   |
|  |                  | 232, 085     |               |               | 0              |         |
| 54. 03   05401   NUCLEAR   MEDICINE-DI AGNOSTI C | 46, 888          | 27, 882      | 0             | 6, 976        |                | 54.03   |
| 60. 00   06000   LABORATORY                      | 786, 621         | 101, 571     | 0             | 25, 412       | 0              | 60.00   |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 18, 422          | 0            | 0             | 0 774         | 0              | 62.00   |
| 65. 00 06500 RESPIRATORY THERAPY                 | 287, 936         | 107, 014     | 0             | ,             | 0              | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                   | 333, 685         | 186, 611     | 0             | ,             | 0              | 66.00   |
| 67. 00 06700 OCCUPATI ONAL THERAPY               | 94, 275          | 54, 304      | 0             |               | 0              | 67.00   |
| 68. 00 06800 SPEECH PATHOLOGY                    | 34, 716          | 4, 116       | 0             | 1, 030        | 0              | 68.00   |
| 69. 00 06900 ELECTROCARDI OLOGY                  | 0                | 0            | 0             | 0             | 0              | 69.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 113, 658         | 238, 259     | 0             | 59, 611       | 0              | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS       | 130, 934         | 0            | 0             | 0             | 0              | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 558, 447         | 89, 090      |               | ,             |                | 73.00   |
| 76.00 03480 INFUSION THERAPY                     | 52, 245          | 70, 834      | 0             | 17, 722       | 0              | 76.00   |
| OUTPATIENT SERVICE COST CENTERS                  |                  |              |               |               |                |         |
| 88. 00   08800   FORT BRANCH RHC                 | 113, 899         | 0            | 0             |               | 0              | 88. 00  |
| 88.01 08801 CLARK & WELLS RHC                    | 94, 368          | 27, 882      | 0             | 6, 976        | 0              | 88. 01  |
| 90. 00  09000   CLI NI C                         | 4, 428           | 0            | 0             | 0             | 0              | 90.00   |
| 90. 01  09001  DI ABETES                         | 57               | 0            | 0             | 0             | 0              | 90. 01  |
| 90. 02  09002  OP PSYCH                          | 0                | 0            | 0             | 0             | 0              | 90. 02  |
| 90. 03   09003   PAI N MANAGEMENT                | 132, 587         | 104, 558     | 0             | 26, 160       | 0              | 90. 03  |
| 91. 00 09100 EMERGENCY                           | 886, 823         | 516, 616     | 0             | 129, 253      | 0              | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART  |                  |              |               |               |                | 92.00   |
| OTHER REIMBURSABLE COST CENTERS                  |                  |              |               |               |                | 1       |
| 101. 00 10100 HOME HEALTH AGENCY                 | 248, 192         | 33, 525      | 0             | 8, 388        | 0              | 101.00  |
| SPECIAL PURPOSE COST CENTERS                     |                  |              | •             |               |                | 1       |
| 113. 00 11300   NTEREST EXPENSE                  |                  |              |               |               |                | 113.00  |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)    | 7, 713, 952      | 3, 423, 989  | 283, 454      | 814, 301      | 759, 642       | 118.00  |
| NONREI MBURSABLE COST CENTERS                    | , , , , ,        |              |               |               |                |         |
| 194. 00 07950 MOB                                | 1, 507, 905      | 543, 037     | 0             | 135, 864      | 0              | 194. 00 |
| 194. 01 07951 FOUNDATI ON                        | 30, 334          | 86, 899      | 0             |               |                | 194. 01 |
| 194. 02 07952 ASC                                | 00,001           | 00,077       | ١             | 2.,,,12       |                | 194. 02 |
| 194. 03 07953 SNF - PERRY CO.                    |                  | 0            |               | l o           |                | 194. 03 |
| 194. 04 07954 TELE BEHAVI ORAL                   | 14, 939          | 0            | ١             | n             |                | 194.04  |
| 200.00 Cross Foot Adjustments                    | 14, 737          | O            | I             |               |                | 200.00  |
| 201.00 Negative Cost Centers                     |                  | 0            | _             | ۸             | 0              | 200.00  |
| 202.00 TOTAL (sum lines 118 through 201)         | 9, 267, 130      | 4, 053, 925  | 283, 454      | 971, 907      |                |         |
| 202.00   TOTAL (Sum TITIES TTO EMOUGH 201)       | 7, 207, 130      | 7,000,720    | 1 200, 404    | 771, 707      | 137,042        | 1202.00 |

Peri od: Worksheet B From 10/01/2019 Part I To 09/30/2020 Date/Time Prepared: 4/28/2021 8:15 am Provider CCN: 15-1319

|        |   |            |                                   |                                 |                  | 4/28/2021 8:1                     | 5 am    |
|--------|---|------------|-----------------------------------|---------------------------------|------------------|-----------------------------------|---------|
|        | Cost Center Description   | CAFETERI A | NURSI NG<br>ADMI NI STRATI O<br>N | CENTRAL<br>SERVI CE &<br>SUPPLY | PHARMACY         | MEDI CAL<br>RECORDS &<br>LI BRARY |         |
|        |   | 11. 00     | 13. 00                            | 14. 00                          | 15. 00           | 16. 00                            |         |
|        | GENERAL SERVICE COST CENTERS                                      | 11.00      | 13.00                             | 14.00                           | 13.00            | 10.00                             |         |
| 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  | 711, 310   |                                   |                                 |                  |                                   | 11.00   |
| 13. 00 | 01300 NURSING ADMINISTRATION                                      | 0          | 425, 588                          |                                 |                  |                                   | 13.00   |
| 14. 00 | 01400 CENTRAL SERVICE & SUPPLY                                    | 12, 308    |                                   | 432, 097                        |                  |                                   | 14.00   |
| 15. 00 | 01500 PHARMACY  | 9, 864     | l ol                              | 2, 908                          | 1, 450, 023      |                                   | 15.00   |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY                                   | 16, 000    | l ol                              | 22                              | 0                | 713, 142                          | 1       |
|        | INPATIENT ROUTINE SERVICE COST CENTERS                            |            | -1                                | <u> </u>                        | -,               |                                   |         |
| 30.00  | 03000 ADULTS & PEDIATRICS   | 105, 252   | 166, 200                          | 11, 933                         | 0                | 30, 970                           | 30.00   |
| 31.00  | 03100 INTENSIVE CARE UNIT   | 0          | o                                 | 19                              | 0                | 963                               | 31.00   |
| 44.00  | 04400 SKILLED NURSING FACILITY                                    | 0          | 0                                 | 0                               | 0                | 0                                 | 44.00   |
|        | ANCILLARY SERVICE COST CENTERS                                    |            |                                   |                                 |                  |                                   |         |
| 50.00  | 05000 OPERATING ROOM  | 71, 280    | 32, 192                           | 35, 931                         | 0                | 73, 036                           | 50.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C                                     | 46, 003    | 0                                 | 9, 014                          | 0                | 125, 796                          | 54.00   |
| 54.03  | 05401 NUCLEAR MEDICINE-DIAGNOSTIC                                 | 0          | 0                                 | 8, 549                          | 0                | 5, 648                            | 54.03   |
| 60.00  | 06000 LABORATORY  | 45, 762    | 15                                | 118, 995                        | 0                | 89, 044                           | 60.00   |
| 62.00  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                        | 0          | 0                                 | 13, 964                         | 0                | 1, 787                            | 62.00   |
| 65.00  | 06500 RESPI RATORY THERAPY  | 25, 941    | 8, 979                            | 3, 584                          | 0                | 33, 349                           | 65.00   |
| 66. 00 | 06600 PHYSI CAL THERAPY   | 40, 514    | 0                                 | 7, 230                          | 0                | 50, 192                           | 66. 00  |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY                                       | 13, 277    | 0                                 | 633                             | 0                | 18, 269                           | 67.00   |
| 68. 00 | 06800 SPEECH PATHOLOGY  | 5, 217     | 0                                 | 90                              | 0                | 5, 760                            | 1       |
| 69. 00 | 06900 ELECTROCARDI OLOGY  | 0          | 0                                 | 0                               | 0                | 0                                 | 69.00   |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                         | 0          | 0                                 | 64, 401                         | 0                | 0                                 | 71.00   |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS                             | 0          | 12 520                            | 101, 413                        | 1 450 000        | 0                                 | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATI ENTS                                  | ( 114      | 12, 528                           | 0                               | 1, 450, 023<br>0 | 90, 090                           | 1       |
| 76. 00 | 03480   I NFUSI ON THERAPY<br>  OUTPATI ENT SERVI CE COST CENTERS | 6, 116     | 14, 413                           | 2, 857                          | U                | 5, 567                            | 76. 00  |
| 88. 00 | 08800 FORT BRANCH RHC   | 12, 671    | l ol                              | 1, 120                          | 0                | 4, 216                            | 88. 00  |
| 88. 01 | 08801 CLARK & WELLS RHC   | 13, 430    | 1                                 | 1, 006                          | o                | 4, 644                            | 88. 01  |
| 90. 00 | 09000 CLINIC  | 540        | 1, 212                            | 363                             | o o              | 7, 044                            | 90.00   |
| 90. 01 | 09001 DI ABETES   | 0          | 1, 212                            | 0                               | 0                | 52                                | 90. 01  |
| 90. 02 | 09002 OP PSYCH  | 0          |                                   | 0                               | Ö                | 0                                 | 90. 02  |
| 90. 03 | 09003 PAIN MANAGEMENT   | 10, 178    | 6, 772                            | 12, 310                         | o                | 15, 501                           | 90. 03  |
| 91. 00 | 09100 EMERGENCY   | 60, 733    |                                   | 17, 311                         | 0                | 73, 013                           | 91.00   |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART                         |            |                                   | ,                               |                  | ,                                 | 92.00   |
|        | OTHER REIMBURSABLE COST CENTERS                                   |            | '                                 | <u>"</u>                        |                  |                                   |         |
| 101.00 | 10100 HOME HEALTH AGENCY  | 30, 942    | 42, 646                           | 3, 283                          | 0                | 8, 926                            | 101.00  |
|        | SPECIAL PURPOSE COST CENTERS                                      |            |                                   |                                 |                  |                                   | 1       |
| 113.00 | 11300 I NTEREST EXPENSE   |            |                                   |                                 |                  |                                   | 113.00  |
| 118.00 |   | 526, 028   | 425, 588                          | 416, 936                        | 1, 450, 023      | 636, 823                          | 118. 00 |
|        | NONREI MBURSABLE COST CENTERS                                     |            |                                   |                                 |                  |                                   |         |
|        | 07950 MOB   | 181, 817   | 0                                 | 15, 161                         | 0                | 76, 240                           |         |
|        | 07951 FOUNDATI ON   | 3, 151     | 0                                 | 0                               | 0                |                                   | 194. 01 |
|        | 2 07952 ASC   | 0          | 1                                 | 0                               | 0                |                                   | 194. 02 |
|        | 3 07953 SNF - PERRY CO.   | 0          | -1                                | 0                               | 0                |                                   | 194. 03 |
|        | 107954 TELE BEHAVI ORAL   | 314        | 0                                 | 0                               | 0                | 79                                | 194.04  |
| 200.00 |   | ^          |                                   |                                 | ٦                | ^                                 | 200.00  |
| 201.00 |   | 711 210    | 425 500                           | 422 007                         | 1 450 023        |                                   | 201.00  |
| 202.00 | of Trotal (Suil Titles 118 through 201)                           | 711, 310   | 425, 588                          | 432, 097                        | 1, 450, 023      | 713, 142                          | 1202.00 |

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1319 Period: Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1319 Peri od: Worksheet B From 10/01/2019 Part I 09/30/2020 Date/Time Prepared: 4/28/2021 8:15 am Cost Center Description Subtotal Intern & Total Resi dents Cost & Post Stepdown Adj ustments 24. 00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 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 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11 00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 717, 880 5, 717, 880 30.00 03100 INTENSIVE CARE UNIT 0 275, 093 31.00 31.00 275, 093 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 079, 927 2, 079, 927 50.00 05400 RADI OLOGY-DI AGNOSTI C 2, 198, 620 2, 198, 620 54.00 0 54.00 54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 247, 680 0 247, 680 54.03 06000 LABORATORY 60.00 3, 713, 030 3, 713, 030 60.00 93, 789 93, 789 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06500 RESPIRATORY THERAPY 65.00 1, 425, 376 0 1, 425, 376 65.00 66.00 06600 PHYSI CAL THERAPY 1, 744, 768 1, 744, 768 66.00 06700 OCCUPATI ONAL THERAPY 499, 430 67.00 499, 430 0 67.00 06800 SPEECH PATHOLOGY 68 00 163, 273 163, 273 68 00 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 843, 741 0 843, 741 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 656, 067 0 656, 067 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 029, 677 0 4, 029, 677 73 00 73 00 03480 INFUSION THERAPY 76.00 338, 825 0 338, 825 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 FORT BRANCH RHC 500, 498 500, 498 88.00 08801 CLARK & WELLS RHC 453, 694 453, 694 88.01 0 88.01 90.00 09000 CLI NI C 20, 873 0 20,873 90.00 90.01 09001 DI ABETES 295 0 295 90.01 09002 OP PSYCH 90.02 0 90.02 0 0 09003 PAIN MANAGEMENT 90.03 737, 136 Ω 737, 136 90.03 91.00 09100 EMERGENCY 4, 694, 256 0 4, 694, 256 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 1, 179, 083 0 1, 179, 083 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 613, 011 0 31, 613, 011 118.00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MOB 7, 339, 795 7, 339, 795 194.00 194. 01 07951 FOUNDATI ON 240, 291 240, 291 194. 01 0 194. 02 07952 ASC 0  $\cap$ 194.02 194.03 07953 SNF - PERRY CO. -19, 818 0 -19, 818 194. 03 194. 04 07954 TELE BEHAVI ORAL 0 194.04 63.678 63.678 200.00 200.00 Cross Foot Adjustments 0 0  $\cap$ 201.00 Negative Cost Centers 0 0 0 201.00 TOTAL (sum lines 118 through 201) 202.00 39, 236, 957 39, 236, 957 202.00

| Peri od: | Worksheet B | From 10/01/2019 | Part | I | To 09/30/2020 | Date/Time Prepared: Provider CCN: 15-1319

|                  |       |  |                    |                    | То          | 09/30/2020         | Date/Time Pre<br>4/28/2021 8:1 | pared:             |
|------------------|-------|--|--------------------|--------------------|-------------|--------------------|--------------------------------|--------------------|
|                  |       |  |                    | CAPI TAL REI       | LATED COSTS |                    | 4/20/2021 0.1                  | J alli             |
|                  |       |  |                    |                    |             |                    |                                |                    |
|                  |       | Cost Center Description                                  | Di rectly          | BLDG & FIXT        | MVBLE EQUIP | Subtotal           | EMPLOYEE                       |                    |
|                  |       |  | Assigned New       |                    |             |                    | BENEFI TS                      |                    |
|                  |       |  | Capi tal           |                    |             |                    | DEPARTMENT                     |                    |
|                  |       |  | Related Costs<br>0 | 1. 00              | 2.00        | 2A                 | 4. 00                          |                    |
|                  | GENER | AL SERVICE COST CENTERS                                  | 0                  | 1.00               | 2.00        | 2/1                | 1. 00                          |                    |
| 1.00             |       | CAP REL COSTS-BLDG & FIXT                                |                    |                    |             |                    |                                | 1. 00              |
| 2.00             |       | CAP REL COSTS-MVBLE EQUIP                                |                    |                    |             |                    |                                | 2.00               |
| 4.00             | 1     | EMPLOYEE BENEFITS DEPARTMENT                             | 0                  | 19, 212            |             | 19, 212            | 19, 212                        | 4.00               |
| 5.00             |       | ADMINISTRATIVE & GENERAL                                 | 0                  | 136, 868           |             | 136, 868           | 2, 372                         | 5.00               |
| 7. 00            |       | OPERATION OF PLANT                                       | 0                  | 686, 476           |             | 686, 476           | 267                            | 7. 00              |
| 8.00             | 1     | LAUNDRY & LINEN SERVICE                                  | 0                  | 44, 672            |             | 44, 672            | 67                             | 8.00               |
| 9. 00<br>10. 00  | 1     | HOUSEKEEPI NG<br>DI ETARY                                | 0                  | 25, 214<br>90, 770 |             | 25, 214<br>90, 770 | 387<br>107                     | 9. 00<br>10. 00    |
| 11. 00           |       | CAFETERI A   | 0                  | 23, 926            |             | 23, 926            | 405                            | 10.00              |
| 13. 00           |       | NURSING ADMINISTRATION                                   | 0                  | 7, 564             |             | 7, 564             | 0                              | 13.00              |
| 14. 00           |       | CENTRAL SERVICE & SUPPLY                                 | 0                  | ,,,,,,             |             | 0                  | 270                            | 14. 00             |
| 15.00            |       | PHARMACY   | 0                  | 0                  | 0           | o                  | 216                            | 15.00              |
| 16.00            | 01600 | MEDICAL RECORDS & LIBRARY                                | 0                  | 36, 533            | 0           | 36, 533            | 350                            | 16.00              |
|                  |       | IENT ROUTINE SERVICE COST CENTERS                        | ,                  |                    |             |                    |                                |                    |
| 30.00            | 1     | ADULTS & PEDIATRICS                                      | 0                  |                    | i l         | 251, 153           | 2, 306                         | 30.00              |
| 31. 00           |       | INTENSIVE CARE UNIT                                      | 0                  |                    |             | 53, 059            | 0                              | 31.00              |
| 44. 00           |       | SKILLED NURSING FACILITY                                 | 0                  | 0                  | 0           | 0                  | 0                              | 44. 00             |
| 50. 00           |       | LARY SERVICE COST CENTERS OPERATING ROOM                 |                    | 139, 882           | O           | 139, 882           | 1, 561                         | 50. 00             |
| 54.00            | 1     | RADI OLOGY-DI AGNOSTI C                                  | 0                  | 95, 813            | i l         | 95, 813            | 1, 008                         | 54.00              |
| 54. 03           |       | NUCLEAR MEDICINE-DIAGNOSTIC                              | 0                  | 11, 511            | i i         | 11, 511            | 1,008                          | 54.00              |
| 60.00            |       | LABORATORY   | 0                  | 41, 932            |             | 41, 932            | 1, 002                         | 60.00              |
| 62. 00           | 1     | WHOLE BLOOD & PACKED RED BLOOD CELLS                     | 0                  | 0                  |             | 0                  | 0                              | 62.00              |
| 65.00            | 06500 | RESPI RATORY THERAPY                                     | 0                  | 44, 179            | 0           | 44, 179            | 568                            | 65.00              |
| 66.00            | 06600 | PHYSI CAL THERAPY  | 0                  | 77, 039            | 0           | 77, 039            | 888                            | 66.00              |
| 67.00            |       | OCCUPATI ONAL THERAPY                                    | 0                  | 22, 418            |             | 22, 418            | 291                            | 67.00              |
| 68. 00           |       | SPEECH PATHOLOGY   | 0                  | 1, 699             |             | 1, 699             | 114                            | 68. 00             |
| 69.00            | 1     | ELECTROCARDI OLOGY                                       | 0                  | 0                  | 0           | 0                  | 0                              | 69.00              |
| 71.00            |       | MEDICAL SUPPLIES CHARGED TO PATIENT                      | 0                  | 98, 362            |             | 98, 362            | 0                              | 71.00              |
| 72. 00<br>73. 00 |       | IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS | 0                  | 0<br>36, 779       | -           | 36, 779            | 0                              | 72. 00<br>73. 00   |
| 76.00            |       | INFUSION THERAPY   | 0                  | 29, 243            |             | 29, 243            | 134                            | 76. 00             |
| 70.00            |       | TIENT SERVICE COST CENTERS                               | J                  | 27,210             | 9           | 27,210             | 101                            | 70.00              |
| 88.00            | 08800 | FORT BRANCH RHC  | 0                  | 0                  | 0           | 0                  | 278                            | 88. 00             |
| 88. 01           |       | CLARK & WELLS RHC  | 0                  | 11, 511            | 0           | 11, 511            | 294                            | 88. 01             |
| 90.00            |       | CLINIC   | 0                  | 0                  | 0           | 0                  | 12                             | 90.00              |
| 90. 01           |       | DI ABETES  | 0                  | 0                  | 0           | 0                  | 0                              | 90. 01             |
| 90. 02           | 1     | OP PSYCH   | 0                  | 0                  | 0           | 0                  | 0                              | 90. 02             |
| 90. 03<br>91. 00 |       | PAIN MANAGEMENT<br>  EMERGENCY                           | 0                  | 43, 165            | i l         | 43, 165            | 223                            | 90.03              |
| 91.00            |       | OBSERVATION BEDS (NON-DISTINCT PART                      | U                  | 213, 277           | 0           | 213, 277<br>0      | 1, 330                         | 91. 00<br>92. 00   |
| 72.00            |       | REIMBURSABLE COST CENTERS                                |                    |                    |             | <u> </u>           |                                | 92.00              |
| 101.00           |       | HOME HEALTH AGENCY                                       | 0                  | 13, 840            | 0           | 13, 840            | 678                            | 101. 00            |
|                  |       | AL PURPOSE COST CENTERS                                  |                    |                    | -1          |                    |                                |                    |
| 113.00           |       | INTEREST EXPENSE   |                    |                    |             |                    |                                | 113. 00            |
| 118.00           | )     | SUBTOTALS (SUM OF LINES 1 through 117)                   | 0                  | 2, 256, 097        | 0           | 2, 256, 097        | 15, 128                        | 118. 00            |
|                  |       | MBURSABLE COST CENTERS                                   |                    |                    |             |                    |                                |                    |
|                  | 07950 |  | 0                  | 224, 185           |             | 224, 185           |                                | 194.00             |
|                  |       | FOUNDATI ON  | 0                  | 35, 875            |             | 35, 875            |                                | 194. 01            |
|                  | 07952 |  | 0                  | 0                  |             | 0                  |                                | 194. 02<br>194. 03 |
|                  |       | SNF - PERRY CO.<br>TELE BEHAVI ORAL                      |                    | 0                  | 0           | 0                  |                                | 194. 03<br>194. 04 |
| 200.00           |       | Cross Foot Adjustments                                   |                    |                    | "           | 0                  | /                              | 200. 00            |
| 201.00           | 1     | Negative Cost Centers                                    |                    | n                  | o           | o<br>O             | Ω                              | 200.00             |
| 202.00           | 1     | TOTAL (sum lines 118 through 201)                        | 0                  | 2, 516, 157        |             | 2, 516, 157        | 19, 212                        |                    |
|                  |       |  | , -,               |                    | , -1        | ,,                 |                                |                    |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2019 | Part II | To 09/30/2020 | Date/Time Prepared:

|         |  |                  |                    | 10            | 09/30/2020      | 4/28/2021 8: 1 |                    |
|---------|--|------------------|--------------------|---------------|-----------------|----------------|--------------------|
|         | Cost Center Description                    | ADMI NI STRATI V | OPERATION OF       | LAUNDRY &     | HOUSEKEEPI NG   | DI ETARY       | Jani               |
|         | door conton booth per on                   | E & GENERAL      | PLANT              | LINEN SERVICE | 110002112211110 | 512171111      |                    |
|         |  | 5. 00            | 7. 00              | 8. 00         | 9. 00           | 10. 00         |                    |
|         | GENERAL SERVICE COST CENTERS               |                  |                    |               | '               |                |                    |
| 1.00    | 00100 CAP REL COSTS-BLDG & FIXT            |                  |                    |               |                 |                | 1.00               |
|         | 00200 CAP REL COSTS-MVBLE EQUIP            |                  |                    |               |                 |                | 2.00               |
| 4.00    | 00400 EMPLOYEE BENEFITS DEPARTMENT         |                  |                    |               |                 |                | 4.00               |
| 5.00    | 00500 ADMINISTRATIVE & GENERAL             | 139, 240         |                    |               |                 |                | 5.00               |
| 7. 00   | 00700 OPERATION OF PLANT                   | 14, 379          | 701, 122           |               |                 |                | 7. 00              |
| 8. 00   | 00800 LAUNDRY & LINEN SERVICE              | 622              | 18, 715            |               |                 |                | 8. 00              |
| 9. 00   | 00900 HOUSEKEEPI NG                        | 3, 231           | 10, 563            |               | 39, 395         |                | 9.00               |
| 10.00   | 01000 DI ETARY                             | 1, 719           | 38, 026            |               | 2, 230          | 132, 852       | 10.00              |
|         | 01100 CAFETERI A                           | 2, 266           | 10, 023            |               | 588             | 0              | 11.00              |
|         | 01300 NURSI NG ADMI NI STRATI ON           | 1, 428           | 3, 169             |               | 186             | 0              | 13.00              |
| 14. 00  | 01400 CENTRAL SERVI CE & SUPPLY            | 1, 489           | 0                  | 1             | 0               | 0              | 14.00              |
|         | 01500 PHARMACY                             | 5, 098           | 0                  |               | ol              | 0              | 15.00              |
| 16. 00  | 01600 MEDICAL RECORDS & LIBRARY            | 2, 080           | 15, 305            |               | 897             | 0              | 16.00              |
|         | INPATIENT ROUTINE SERVICE COST CENTERS     | _,,              |                    |               |                 | _              |                    |
| 30.00   | 03000 ADULTS & PEDI ATRI CS                | 12, 922          | 105, 214           | 61, 425       | 6, 171          | 127, 355       | 30.00              |
| 31.00   | 03100 INTENSIVE CARE UNIT                  | 249              | 22, 228            |               | 1, 303          | 5, 497         | 31.00              |
|         | 04400 SKILLED NURSING FACILITY             | 0                | 0                  |               | 0               | 0              | 44.00              |
|         | ANCILLARY SERVICE COST CENTERS             |                  |                    |               | -,              |                |                    |
| 50.00   | 05000 OPERATI NG ROOM                      | 5, 121           | 58, 601            | 0             | 3, 436          | 0              | 50.00              |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C              | 6, 128           | 40, 139            | 0             | 2, 354          | 0              | 54.00              |
| 54.03   | 05401 NUCLEAR MEDICINE-DIAGNOSTIC          | 705              | 4, 822             | 0             | 283             | 0              | 54.03              |
| 60.00   | 06000 LABORATORY                           | 11, 819          | 17, 567            | 0             | 1, 030          | 0              | 60.00              |
| 62.00   | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 277              | 0                  | 0             | 0               | 0              | 62.00              |
| 65.00   | 06500 RESPI RATORY THERAPY                 | 4, 326           | 18, 508            |               | 1, 085          | 0              | 65.00              |
| 66.00   | 06600 PHYSI CAL THERAPY                    | 5, 014           | 32, 274            |               | 1, 892          | 0              | 66.00              |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY                | 1, 417           | 9, 392             |               | 551             | 0              | 67. 00             |
| 68. 00  | 06800 SPEECH PATHOLOGY                     | 522              | 712                |               | 42              | 0              | 68. 00             |
| 69. 00  | 06900 ELECTROCARDI OLOGY                   | 0                | 0                  |               | 0               | 0              | 69.00              |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 1, 708           | 41, 207            | 0             | 2, 416          | 0              | 71.00              |
|         | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 1, 967           | 0                  |               | o               | 0              | 72.00              |
|         | 07300 DRUGS CHARGED TO PATIENTS            | 8, 391           | 15, 408            |               | 903             | 0              | 73.00              |
|         | 03480 I NFUSI ON THERAPY                   | 785              | 12, 251            | 0             | 718             | 0              | 76.00              |
|         | OUTPATIENT SERVICE COST CENTERS            |                  |                    |               | '               |                |                    |
| 88.00   | 08800 FORT BRANCH RHC                      | 1, 711           | 0                  | 0             | 0               | 0              | 88. 00             |
| 88. 01  | 08801 CLARK & WELLS RHC                    | 1, 418           | 4, 822             | 0             | 283             | 0              | 88. 01             |
| 90.00   | 09000 CLI NI C                             | 67               | 0                  | 0             | 0               | 0              | 90.00              |
| 90. 01  | 09001 DI ABETES                            | 1                | 0                  | 0             | 0               | 0              | 90. 01             |
| 90.02   | 09002 OP PSYCH                             | 0                | 0                  | 0             | 0               | 0              | 90. 02             |
| 90. 03  | 09003 PAIN MANAGEMENT                      | 1, 992           | 18, 083            | 0             | 1, 060          | 0              | 90. 03             |
| 91.00   | 09100 EMERGENCY                            | 13, 325          | 89, 348            | 0             | 5, 239          | 0              | 91.00              |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART  |                  |                    |               |                 |                | 92. 00             |
|         | OTHER REIMBURSABLE COST CENTERS            |                  |                    |               |                 |                |                    |
| 101. 00 | 10100 HOME HEALTH AGENCY                   | 3, 729           | 5, 798             | 0             | 340             | 0              | 101. 00            |
|         | SPECIAL PURPOSE COST CENTERS               |                  |                    | T             |                 |                |                    |
|         | 11300 I NTEREST EXPENSE                    | 445.007          | 500 475            |               |                 | 100 050        | 113. 00            |
| 118. 00 |  | 115, 906         | 592, 175           | 64, 076       | 33, 007         | 132, 852       | 118.00             |
| 104 00  | NONREI MBURSABLE COST CENTERS              | 22.454           | 02.010             |               | E E07           |                | 104 00             |
|         | 07950 MOB<br>07951 FOUNDATI ON             | 22, 654<br>456   | 93, 918<br>15, 029 |               | 5, 507<br>881   |                | 194. 00<br>194. 01 |
|         | 107951 FOUNDATT ON<br>207952 ASC           | 450              |                    |               |                 |                | 194. 01            |
|         | 07952 ASC<br>07953 SNF - PERRY CO.         |                  | 0                  | _             | 0               |                | 194. 02<br>194. 03 |
|         | 07954 TELE BEHAVI ORAL                     | 224              | 0                  | 0             | 0               |                | 194. 03            |
| 200.00  | 1 1  | 224              | 0                  | ا             | Ч               | U              | 200.00             |
| 200.00  | J  |                  | 0                  | 0             | 0               | ^              | 200.00             |
| 201.00  |  | 139, 240         |                    | 64, 076       | 39, 395         | 132, 852       |                    |
| 202.00  | TOTAL (Sum TINGS THE CHILDUGH ZUT)         | 137, 240         | 101, 122           | 1 04,070      | 37, 370         | 132, 032       | 202.00             |

Provider CCN: 15-1319

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2019 | Part II | To 09/30/2020 | Date/Time Prepared:

|         |  |            |                  | 10        | 09/30/2020 | 4/28/2021 8:1 |         |
|---------|--|------------|------------------|-----------|------------|---------------|---------|
|         | Cost Center Description                                  | CAFETERI A | NURSI NG         | CENTRAL   | PHARMACY   | MEDI CAL      |         |
|         | , , , , , , , , , , , , , , , , , , ,                    |            | ADMI NI STRATI O | SERVICE & |            | RECORDS &     |         |
|         |  |            | N                | SUPPLY    |            | LI BRARY      |         |
|         |  | 11. 00     | 13. 00           | 14.00     | 15. 00     | 16. 00        |         |
|         | GENERAL SERVICE COST CENTERS                             |            |                  |           |            |               |         |
| 1.00    | 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  | 37, 208    |                  |           |            |               | 11.00   |
| 13.00   | 01300 NURSI NG ADMI NI STRATI ON                         | 0          | 12, 347          |           |            |               | 13.00   |
| 14.00   | 01400 CENTRAL SERVICE & SUPPLY                           | 644        | 0                | 2, 403    |            |               | 14.00   |
| 15.00   | 01500 PHARMACY   | 516        | 0                | 16        | 5, 846     |               | 15.00   |
| 16. 00  | 01600 MEDICAL RECORDS & LIBRARY                          | 837        | 0                | 0         | 0          | 56, 002       | 16.00   |
|         | INPATIENT ROUTINE SERVICE COST CENTERS                   |            |                  |           |            |               |         |
| 30.00   | 03000 ADULTS & PEDIATRICS                                | 5, 506     | 4, 824           | 66        | 0          | 2, 432        | 30.00   |
| 31.00   | 03100 INTENSIVE CARE UNIT                                | 0          | 0                | 0         | 0          | 76            | 31.00   |
| 44. 00  | 04400 SKILLED NURSING FACILITY                           | 0          | 0                | 0         | 0          | 0             | 44.00   |
|         | ANCILLARY SERVICE COST CENTERS                           |            |                  |           |            |               |         |
| 50.00   | O5000   OPERATI NG ROOM                                  | 3, 729     | 934              | 200       | 0          | 5, 736        | 50.00   |
| 54.00   | 05400   RADI OLOGY-DI AGNOSTI C                          | 2, 407     | 0                | 50        | 0          | 9, 873        | 54.00   |
| 54. 03  | 05401   NUCLEAR   MEDICINE-DI AGNOSTI C                  | 0          | 0                | 48        | 0          | 444           | 54. 03  |
| 60.00   | 06000 LABORATORY   | 2, 394     | 0                | 662       | 0          | 6, 994        | 60.00   |
| 62. 00  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS               | 0          | 0                | 78        | 0          | 140           | 62.00   |
| 65.00   | 06500 RESPI RATORY THERAPY                               | 1, 357     | 260              | 20        | 0          | 2, 619        | 65.00   |
| 66. 00  | 06600 PHYSI CAL THERAPY                                  | 2, 119     |                  | 40        | 0          | 3, 942        | 66. 00  |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY                              | 695        |                  | 4         | 0          | 1, 435        | 1       |
| 68. 00  | 06800 SPEECH PATHOLOGY                                   | 273        |                  | 1         | 0          | 452           | 68. 00  |
| 69. 00  | 06900 ELECTROCARDI OLOGY                                 | 0          | 1                | 0         | 0          | 0             | 69. 00  |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                | 0          | 0                | 358       | 0          | 0             | 71.00   |
| 72. 00  | 07200 I MPL. DEV. CHARGED TO PATIENTS                    | 0          | 0                | 564       | 0          | 0             | 72.00   |
| 73. 00  | 07300 DRUGS CHARGED TO PATIENTS                          | 0          | 363              | 0         | 5, 846     | 7, 076        | 73.00   |
| 76. 00  | 03480 I NFUSI ON THERAPY                                 | 320        | 418              | 16        | 0          | 437           | 76. 00  |
| 00.00   | OUTPATIENT SERVICE COST CENTERS                          |            |                  | ,         | ما         | 224           | 00.00   |
| 88. 00  | 08800 FORT BRANCH RHC                                    | 663        |                  | 6         | 0          | 331           | 88.00   |
| 88. 01  | 08801 CLARK & WELLS RHC                                  | 703        |                  | 6         | 0          | 365           | 88. 01  |
| 90.00   | 09000 CLINIC   | 28         |                  | 2         | 0          | 0             | 90.00   |
| 90. 01  | 09001 DI ABETES  | 0          | · ·              | 0         | 0          | 4             | 90. 01  |
| 90. 02  | 09002 OP PSYCH   | 0          | 0                | 0         | 0          | 1 217         | 90.02   |
| 90. 03  | 09003 PAIN MANAGEMENT                                    | 532        | 196              | 68        | 0          | 1, 217        | 90.03   |
| 91.00   | 09100 EMERGENCY  | 3, 177     | 4, 080           | 96        | 0          | 5, 734        | 91.00   |
| 92. 00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART                |            |                  |           |            |               | 92.00   |
| 101 00  | OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY | 1, 619     | 1, 237           | 18        | ol         | 701           | 101. 00 |
| 101.00  | SPECIAL PURPOSE COST CENTERS                             | 1,019      | 1, 23/           | 10        | <u> </u>   | 701           | 101.00  |
| 113 00  | 11300 INTEREST EXPENSE                                   |            |                  |           |            |               | 113.00  |
| 118. 00 | 1  | 27, 519    | 12, 347          | 2, 319    | 5, 846     |               | 118.00  |
| 110.00  | NONREI MBURSABLE COST CENTERS                            | 27, 317    | 12, 347          | 2, 317    | 3, 040     | 30,000        | 1110.00 |
| 194 00  | 07950 MOB  | 9, 508     | ol               | 84        | O          | 5 988         | 194. 00 |
|         | 07951 FOUNDATI ON  | 165        |                  | 0         | 0          |               | 194. 01 |
|         | 07952 ASC  | 0          |                  | 0         | o          |               | 194. 02 |
|         | 07953 SNF - PERRY CO.                                    | 0          |                  | 0         | n          |               | 194. 03 |
|         | 07954 TELE BEHAVI ORAL                                   | 16         |                  | 0         | o          |               | 194. 04 |
| 200.00  |  |            |                  | ٦         | ٦          | ū             | 200.00  |
| 201.00  |  | 0          | o                | 0         | o          | 0             | 201.00  |
| 202.00  |  | 37, 208    |                  | 2, 403    | 5, 846     |               | 202.00  |
|         | , , , , ,  |            | ,                |           |            | •             |         |

| Health Financial Systems            | GIBSON GENERAL HOSPITAL | In Li    | In Lieu of Form CMS-2552-10 |  |  |
|-------------------------------------|-------------------------|----------|-----------------------------|--|--|
| ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319   | Peri od: | Worksheet B                 |  |  |

From 10/01/2019 Part II 09/30/2020 Date/Time Prepared: 4/28/2021 8:15 am Cost Center Description Subtotal Intern & Total Resi dents Cost & Post Stepdown Adj ustments 24. 00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 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 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11 00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 579, 374 579, 374 30.00 03100 INTENSIVE CARE UNIT 0 85, 063 31.00 31.00 85, 063 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 219, 200 219, 200 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 157, 772 0 157, 772 54.00 54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC 17,813 0 17,813 54.03 06000 LABORATORY 60.00 83, 400 83, 400 60.00 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 495 0 495 62 00 06500 RESPIRATORY THERAPY 72, 922 65.00 72, 922 C 65.00 66.00 06600 PHYSI CAL THERAPY 123, 208 123, 208 66.00 06700 OCCUPATI ONAL THERAPY 67.00 36, 203 0 36, 203 67.00 06800 SPEECH PATHOLOGY 68 00 3, 815 3, 815 68 00 06900 ELECTROCARDI OLOGY 69.00 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 144, 051 0 144, 051 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 2,531 0 2, 531 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 74.766 74, 766 73 00 03480 INFUSION THERAPY 76.00 44, 322 0 44, 322 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 FORT BRANCH RHC 2, 989 2, 989 88.00 08801 CLARK & WELLS RHC 88.01 19, 402 0 19, 402 88.01 90.00 09000 CLI NI C 144 0 144 90.00 90.01 09001 DI ABETES 5 0 5 90.01 09002 OP PSYCH 90.02 90.02 0 0 0 09003 PAIN MANAGEMENT 90.03 66, 536 0 66, 536 90.03 91.00 09100 EMERGENCY 335, 606 0 335, 606 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 27, 960 0 27, 960 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 097, 577 2, 097, 577 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 MOB 365, 852 365, 852 194.00 194. 01 07951 FOUNDATI ON 52, 475 194. 01 0 52, 475 194. 02 07952 ASC 0 0 0 194.02 194.03 07953 SNF - PERRY CO. 0 0 0 194. 03 194. 04 07954 TELE BEHAVI ORAL 253 0 253 194.04 200.00 200.00 Cross Foot Adjustments 0 0  $\cap$ 201.00 Negative Cost Centers 0 0 0 201.00 TOTAL (sum lines 118 through 201) 202.00 2, 516, 157 2, 516, 157 202.00

| 0001 7           | LLCOTT | TON STATISTICAL BASIS   |   | Trovider of                           |   | rom 10/01/2019<br>o 09/30/2020 | Date/Time Pre 4/28/2021 8:1                   |                    |
|------------------|--------|---|---|---------------------------------------|---|--------------------------------|---|--------------------|
|                  |        | Cost Center Description   | CAPITAL REL<br>BLDG & FIXT<br>(SQUARE FEET) | ATED COSTS  MVBLE EQUIP (SQUARE FEET) | EMPLOYEE<br>BENEFITS<br>DEPARTMENT<br>(GROSS<br>SALARIES) | Reconciliatio<br>n             | ADMINISTRATIV<br>E & GENERAL<br>(ACCUM. COST) |                    |
|                  |        |   | 1. 00                                       | 2.00                                  | 4.00  | 5A                             | 5. 00   |                    |
| 4 00             |        | AL SERVICE COST CENTERS   | 04.000                                      |                                       |   |                                |   |                    |
| 1. 00<br>2. 00   |        | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP                       | 91, 809                                     | 91, 809                               |   |                                |   | 1.00<br>2.00       |
| 4. 00            |        | EMPLOYEE BENEFITS DEPARTMENT  | 701   | 701                                   |   |                                |   | 4.00               |
| 5. 00            |        | ADMINISTRATIVE & GENERAL  | 4, 994                                      | 4, 994                                |   |                                | 29, 989, 645                                  | 1                  |
| 7. 00            | 1      | OPERATION OF PLANT  | 25, 048                                     | 25, 048                               |   |                                | 3, 096, 937                                   | 1                  |
| 8. 00            |        | LAUNDRY & LINEN SERVICE   | 1, 630                                      | 1, 630                                |   |                                | 133, 876                                      | 1                  |
| 9.00             |        | HOUSEKEEPI NG   | 920   | 920                                   |   |                                | 695, 817                                      | 1                  |
| 10. 00<br>11. 00 | 1      | DI ETARY<br>CAFETERI A  | 3, 312<br>873                               | 3, 312<br>873                         |   |                                | 370, 327<br>488, 044                          | 1                  |
| 13. 00           | 1      | NURSING ADMINISTRATION  | 276   | 276                                   |   |                                | 307, 622                                      | 1                  |
| 14. 00           |        | CENTRAL SERVICE & SUPPLY  | 0   | 0                                     |   |                                | 320, 692                                      | 1                  |
| 15.00            |        | PHARMACY  | 0   | 0                                     | 146, 600  | 0                              | 1, 097, 967                                   | 15. 00             |
| 16. 00           |        | MEDICAL RECORDS & LIBRARY   | 1, 333                                      | 1, 333                                | 237, 784  | 0                              | 448, 039                                      | 16. 00             |
| 30. 00           |        | I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS                    | 9, 164                                      | 9, 164                                | 1 544 040   | 0                              | 2, 783, 035                                   | 30.00              |
| 31. 00           |        | INTENSIVE CARE UNIT   | 1, 936                                      | 1, 936                                |   |                                | 53, 684                                       | 1                  |
| 44. 00           |        | SKILLED NURSING FACILITY  | 0   | 0                                     |   |                                | 0   | 1                  |
|                  | ANCI L | LARY SERVICE COST CENTERS   |   |                                       |   |                                |   |                    |
| 50.00            | 1      | OPERATING ROOM  | 5, 104                                      | 5, 104                                |   |                                | 1, 103, 031                                   | 1                  |
| 54.00            |        | RADI OLOGY-DI AGNOSTI C   | 3, 496                                      | 3, 496                                |   |                                | 1, 319, 818                                   | 1                  |
| 54. 03<br>60. 00 | 1      | NUCLEAR MEDICINE-DIAGNOSTIC<br>LABORATORY                                 | 420<br>1, 530                               | 420<br>1, 530                         |   |                                | 151, 737<br>2, 545, 610                       |                    |
| 62. 00           |        | WHOLE BLOOD & PACKED RED BLOOD CELLS                                      | 1, 330                                      | 1, 550                                |   |                                | 59, 616                                       | 1                  |
| 65. 00           |        | RESPI RATORY THERAPY  | 1, 612                                      | 1, 612                                | 385, 539  | 0                              | 931, 799                                      | 1                  |
| 66. 00           | 1      | PHYSI CAL THERAPY   | 2, 811                                      | 2, 811                                |   |                                | 1, 079, 847                                   | 1                  |
| 67. 00           |        | OCCUPATI ONAL THERAPY   | 818   | 818                                   |   |                                | 305, 086                                      | 1                  |
| 68. 00<br>69. 00 |        | SPEECH PATHOLOGY<br>ELECTROCARDI OLOGY                                    | 62  | 62<br>0                               |   |                                | 112, 344<br>0                                 | 1                  |
| 71.00            |        | MEDICAL SUPPLIES CHARGED TO PATIENT                                       | 3, 589                                      | 3, 589                                | 1   | 0                              | 367, 812                                      |                    |
| 72. 00           |        | IMPL. DEV. CHARGED TO PATIENTS  | 0, 337                                      | 0,007                                 |   | · ·                            | 423, 720                                      | 1                  |
| 73.00            | 07300  | DRUGS CHARGED TO PATIENTS   | 1, 342                                      | 1, 342                                | C   | 0                              | 1, 807, 209                                   |                    |
| 76. 00           |        | INFUSION THERAPY  | 1, 067                                      | 1, 067                                | 90, 896   | 0                              | 169, 071                                      | 76. 00             |
| 88. 00           |        | TIENT SERVICE COST CENTERS FORT BRANCH RHC                                | O   | 0                                     | 188, 314  | 0                              | 240 502                                       | 88. 00             |
| 88. 00           |        | CLARK & WELLS RHC   | 420   | 420                                   |   |                                | 368, 592<br>305, 388                          | 1                  |
| 90.00            | 09000  | CLI NI C  | 0   | 0                                     |   |                                | 14, 330                                       |                    |
| 90. 01           |        | DI ABETES   | 0   | 0                                     |   |                                | 186   | 90. 01             |
| 90. 02           |        | OP PSYCH  | 0   | 0                                     | 1   |                                | 0   |                    |
| 90. 03<br>91. 00 |        | PAIN MANAGEMENT<br>EMERGENCY  | 1, 575                                      | 1, 575                                |   |                                | 429, 070                                      | 1                  |
|                  |        | OBSERVATION BEDS (NON-DISTINCT PART                                       | 7, 782                                      | 7, 782                                | 902, 611  | 0                              | 2, 869, 876                                   | 92.00              |
| 72.00            |        | REIMBURSABLE COST CENTERS   |   |                                       |   | 1                              |   | 72.00              |
| 101.00           | 10100  | HOME HEALTH AGENCY  | 505   | 505                                   | 459, 861  | 0                              | 803, 181                                      | 101. 00            |
|                  |        | AL PURPOSE COST CENTERS   |   |                                       | T   | 1                              |   |                    |
| 113.00           |        | INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)                   | 82, 320                                     | ດາ ລາດ                                | 10 242 77   | 0 247 120                      | 24 042 242                                    | 113.00             |
| 110.00           |        | IMBURSABLE COST CENTERS   | 02, 320                                     | 82, 320                               | 10, 262, 772  | -9, 267, 130                   | 24, 963, 363                                  | 1110.00            |
| 194.00           |        |   | 8, 180                                      | 8, 180                                | 2, 720, 398   | 0                              | 4, 879, 771                                   | 194. 00            |
|                  | 1      | FOUNDATI ON   | 1, 309                                      | 1, 309                                | 46, 825   | 0                              |   | 194. 01            |
| 194. 02          |        |   | 0   | 0                                     | C   | 0                              |   | 194. 02            |
|                  |        | SNF - PERRY CO.<br>TELE BEHAVIORAL  | 0   | 0                                     | 1 666   | 19, 818                        |   | 194. 03<br>194. 04 |
| 200.00           |        | Cross Foot Adjustments  | U   | 0                                     | 4, 666  | 0                              | 40, 340                                       | 200.00             |
| 201.00           | 1      | Negative Cost Centers   |   |                                       |   |                                | •   | 201.00             |
| 202.00           |        | Cost to be allocated (per Wkst. B,  | 2, 516, 157                                 | 0                                     | 2, 301, 162   | !                              | 9, 267, 130                                   | 202. 00            |
| 000.00           |        | Part I)   | 07.407404                                   | 0.00000                               | 0.47/546  |                                | 0 000044                                      | 000 00             |
| 203.00<br>204.00 | 1      | Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, | 27. 406431                                  | 0. 000000                             | 0. 176542<br>19, 212                                      |                                | 0. 309011                                     |                    |
| 204.00           | 1      | Part II)  |   |                                       | 19, 212   |                                | 139, 240                                      | 204.00             |
| 205.00           |        | Unit cost multiplier (Wkst. B, Part                                       |   |                                       | 0. 001474   |                                | 0. 004643                                     | 205.00             |
|                  |        | [11]  |   |                                       |   |                                |   |                    |
| 206.00           | '      | NAHE adjustment amount to be allocated (per Wkst. B-2)                    |   |                                       |   |                                |   | 206. 00            |
| 207.00           | )      | NAHE unit cost multiplier (Wkst. D,                                       |   |                                       |   |                                |   | 207. 00            |
|                  | I      | Parts III and IV)   |   |                                       | I   | I                              | I   | I                  |

|  | Financial Systems  | GIBSON GENER                           |   |                               |  | u of Form CMS-                            |  |
|--|--|--|---|-------------------------------|--|---|--|
| COST A   | LLOCATION - STATISTICAL BASIS  |  | Provi der C                                     |                               | eriod:<br>rom 10/01/2019<br>o 09/30/2020 | Worksheet B-1 Date/Time Pre 4/28/2021 8:1 | pared:                                       |
|  | Cost Center Description  | OPERATION OF<br>PLANT<br>(SQUARE FEET) | LAUNDRY &<br>LINEN SERVICE<br>(PATIENT<br>DAYS) | HOUSEKEEPING<br>(SQUARE FEET) | DI ETARY<br>(PATI ENT<br>DAYS)           | CAFETERI A<br>(GROSS<br>SALARI ES)        |  |
|  |  | 7. 00                                  | 8.00  | 9. 00                         | 10.00                                    | 11. 00                                    |  |
|  | GENERAL SERVICE COST CENTERS   |  |   |                               |  |   |  |
| 1. 00<br>2. 00<br>4. 00<br>5. 00<br>7. 00<br>8. 00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE | 61, 066<br>1, 630                      | 1, 861  |                               |  |   | 1.00<br>2.00<br>4.00<br>5.00<br>7.00<br>8.00 |
| 9.00   | 00900 HOUSEKEEPI NG  | 920                                    | 1   | 58, 516                       | <b>I</b>                                 |   | 9.00   |
| 10. 00<br>11. 00                                   | 01000 DI ETARY<br>01100 CAFETERI A   | 3, 312<br>873                          | 1   | 3, 312<br>873                 |  | 10, 571, 423                              | 10.00  |
| 13.00  | 01300 NURSING ADMINISTRATION   | 276                                    |   | 276                           |  | 10, 371, 423                              | 1  |
| 14. 00   | 01400 CENTRAL SERVI CE & SUPPLY  | 2,0                                    | ł   | 0                             | o  | 182, 914                                  |  |
|  | 01500 PHARMACY   | 0                                      |   |                               | Ö  | 146, 600                                  |  |
| 16.00  | 01600 MEDICAL RECORDS & LIBRARY  | 1, 333                                 | 0   | 1, 333                        | 0  | 237, 784                                  | 16. 00                                       |
|  | INPATIENT ROUTINE SERVICE COST CENTERS   |  |   |                               |  |   |  |
| 30.00  | 03000 ADULTS & PEDIATRICS  | 9, 164                                 | 1   | · ·                           |  | 1, 564, 242                               |  |
|  | 03100 INTENSIVE CARE UNIT  | 1, 936                                 |   | 1, 936<br>0                   |  | 0   |  |
| 44. 00   | 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS  | 0                                      | 0   | 0                             | 0  | 0   | 44.00  |
| 50.00  | 05000 OPERATING ROOM   | 5, 104                                 | . 0   | 5, 104                        | 0  | 1, 059, 352                               | 50.00  |
| 54. 00   | 05400 RADI OLOGY-DI AGNOSTI C  | 3, 496                                 | l .   |                               |  | 683, 689                                  |  |
| 54.03  | 05401 NUCLEAR MEDICINE-DIAGNOSTIC  | 420                                    | 0   | 420                           | 0  | 0   | 54.03  |
| 60.00  | 06000 LABORATORY   | 1, 530                                 | 0   | 1, 530                        | 0  | 680, 119                                  |  |
| 62.00  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS   | 0                                      |   | 0                             | 0  | 0   |  |
| 65.00  | 06500 RESPIRATORY THERAPY  | 1, 612                                 |   | 1, 612                        | 0  | 385, 539                                  | 1  |
| 66. 00<br>67. 00                                   | 06600 PHYSI CAL THERAPY<br>06700 OCCUPATI ONAL THERAPY   | 2, 811<br>818                          | 1   | 2, 811<br>818                 | 0<br>0                                   | 602, 110<br>197, 318                      |  |
| 68. 00   | 06800 SPEECH PATHOLOGY   | 62                                     | l .   | 62                            | 0  | 77, 535                                   |  |
| 69. 00   | 06900 ELECTROCARDI OLOGY   | 0                                      | 1   | 0                             | o  | 0   | 1  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 3, 589                                 | 0   | 3, 589                        | 0  | 0   | 71. 00                                       |
|  | 07200 IMPL. DEV. CHARGED TO PATIENTS   | 0                                      | 1   | 0                             | O  | 0   | 72.00  |
|  | 07300 DRUGS CHARGED TO PATIENTS  | 1, 342                                 |   | 1, 342                        | 0  | 0   | 73.00  |
| 76. 00   | 03480 I NFUSI ON THERAPY   | 1, 067                                 | 0   | 1, 067                        | 0  | 90, 896                                   | 76.00  |
| 88. 00   | OUTPATIENT SERVICE COST CENTERS  08800 FORT BRANCH RHC   |  | 0   | 0                             | o  | 188, 314                                  | 88. 00                                       |
| 88. 01   | 08801 CLARK & WELLS RHC  | 420                                    | 1   |                               |  | 199, 591                                  |  |
| 90.00  | 09000 CLI NI C   | 0                                      | ł   |                               | O  | 8, 019                                    |  |
| 90. 01   | 09001 DI ABETES  | 0                                      | 0   | 0                             | 0  | 0   |  |
| 90. 02   | 09002 OP PSYCH   | 0                                      | 0   | 0                             | 0  | 0   | 90. 02                                       |
| 90. 03   | 09003 PAIN MANAGEMENT  | 1, 575                                 |   | 1, 575                        |  | 151, 263                                  |  |
| 91. 00<br>92. 00                                   | 09100 EMERGENCY<br>09200 OBSERVATION BEDS (NON-DISTINCT PART   | 7, 782                                 | 0   | 7, 782                        | 0  | 902, 611                                  | 91.00  |
| 72.00  | OTHER REIMBURSABLE COST CENTERS  |  | 1   |                               | I  |   | 72.00  |
| 101.00   | 10100 HOME HEALTH AGENCY   | 505                                    | 0   | 505                           | 0  | 459, 861                                  | 101.00                                       |
|  | SPECIAL PURPOSE COST CENTERS   |  |   |                               |  |   |  |
|  | 11300 I NTEREST EXPENSE  |  |   | 40.007                        | 4 0/4                                    | 7 047 757                                 | 113.00                                       |
| 118. 00  | , , ,  | 51, 577                                | 1, 861  | 49, 027                       | 1, 861                                   | 7, 817, 757                               | 1118.00                                      |
| 10/ 00   | NONREI MBURSABLE COST CENTERS  07950 MOB   | 8, 180                                 |   | 8, 180                        | ol                                       | 2, 702, 175                               | 104 00                                       |
|  | 07951 FOUNDATI ON  | 1, 309                                 |   | 1, 309                        |  |   | 194. 01                                      |
|  | 07952 ASC  | 0                                      | 1   | 0                             |  |   | 194. 02                                      |
|  | 07953 SNF - PERRY CO.  | 0                                      | 0   | 0                             | О  |   | 194. 03                                      |
|  | 07954 TELE BEHAVI ORAL   | 0                                      | 0   | 0                             | 0  | 4, 666                                    | 194. 04                                      |
| 200.00   | , ,  |  |   |                               |  |   | 200.00                                       |
| 201.00   |  | 4 052 025                              | 202 454   | 071 007                       | 750 (40                                  | 711 010                                   | 201.00                                       |
| 202. 00  | Cost to be allocated (per Wkst. B, Part I)   | 4, 053, 925                            | 283, 454  | 971, 907                      | 759, 642                                 | 711, 310                                  | 202.00                                       |
| 203. 00  |  | 66. 385959                             | 152. 312735                                     | 16. 609252                    | 408. 190220                              | 0. 067286                                 | 203 00                                       |
| 204.00   |  | 701, 122                               | 1   |                               |  |   | 204.00                                       |
|  | Part II)   |  |   | ·                             | ·  |   |  |
| 205. 00  |  | 11. 481381                             | 34. 430951                                      | 0. 673235                     | 71. 387426                               | 0. 003520                                 | 205.00                                       |
| 206. 00  |  |  |   |                               |  |   | 206. 00                                      |
| 200.00   | (per Wkst. B-2)  |  |   |                               |  |   | 200.00                                       |
| 207. 00  | NAHE unit cost multiplier (Wkst. D,  |  |   |                               |  |   | 207. 00                                      |
|  | Parts III and IV)  | l                                      | I   |                               |  |   | I  |
|  |  |  |   |                               |  |   |  |

|                    |        |   |   |  | F)                              | rom 10/01/2019<br>0 09/30/2020                          | Date/Time Prepared:<br>4/28/2021 8:15 am |
|--------------------|--------|---|---|--|---------------------------------|---|--|
|                    |        | Cost Center Description                                       | NURSI NG<br>ADMI NI STRATI O<br>N<br>(NURSE<br>SALARI ES) | CENTRAL<br>SERVI CE &<br>SUPPLY<br>(COSTED<br>REQUI S. ) | PHARMACY<br>(COSTED<br>REQUIS.) | MEDI CAL<br>RECORDS &<br>LI BRARY<br>(GROSS<br>PATI ENT | 4/28/2021 8: 15 alli                     |
|                    |        |   | 13. 00  | 14. 00   | 15. 00                          | REVENUE)<br>16. 00                                      |  |
|                    |        | AL SERVICE COST CENTERS                                       |   |  |                                 |   | 1.00                                     |
|                    |        | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP           |   |  |                                 |   | 1.00                                     |
| 4.00               | 00400  | EMPLOYEE BENEFITS DEPARTMENT                                  |   |  |                                 |   | 4.00                                     |
|                    |        | ADMINISTRATIVE & GENERAL                                      |   |  |                                 |   | 5.00                                     |
|                    |        | OPERATION OF PLANT<br>LAUNDRY & LINEN SERVICE                 |   |  |                                 |   | 7. 00<br>8. 00                           |
|                    |        | HOUSEKEEPI NG   |   |  |                                 |   | 9.00                                     |
|                    |        | DI ETARY<br>CAFETERI A  |   |  |                                 |   | 10.00                                    |
| 13.00              | 01300  | NURSING ADMINISTRATION  | 2, 671, 125   |  |                                 |   | 13. 00                                   |
|                    |        | CENTRAL SERVICE & SUPPLY PHARMACY                             | 0   | 1, 805, 368<br>12, 149                                   | 1, 828, 057                     |   | 14. 00<br>15. 00                         |
|                    |        | MEDICAL RECORDS & LIBRARY                                     | 0   | 90   | 1, 828, 037                     | 67, 240, 256  | 16. 00                                   |
| 20.00              |        | ENT ROUTINE SERVICE COST CENTERS                              | 1 042 112   | 40.057   | -                               | 2 020 051   | 20.00                                    |
|                    | 1 1    | ADULTS & PEDIATRICS<br>INTENSIVE CARE UNIT                    | 1, 043, 112<br>0  | 49, 856<br>79  | 0                               | 2, 920, 051<br>90, 809                                  | 30. 00<br>31. 00                         |
| 44.00              | 04400  | SKILLED NURSING FACILITY                                      | 0   | 0  | 0                               | 0   | 44. 00                                   |
|                    |        | ARY SERVICE COST CENTERS OPERATING ROOM                       | 202, 046  | 150, 124   | 0                               | 6, 886, 277   | 50.00                                    |
| 54.00              | 05400  | RADI OLOGY-DI AGNOSTI C                                       | 0   | 37, 661  | 0                               | 11, 861, 557  | 54.00                                    |
|                    |        | NUCLEAR MEDICINE-DIAGNOSTIC<br>LABORATORY                     | 0<br>97   | 35, 721<br>497, 179                                      | 0                               | 532, 563<br>8, 395, 624                                 | 54. 03<br>60. 00                         |
|                    |        | WHOLE BLOOD & PACKED RED BLOOD CELLS                          | 0   | 58, 345  | 0                               | 168, 487  | 62.00                                    |
|                    |        | RESPI RATORY THERAPY  | 56, 357   | 14, 974  | 0                               | 3, 144, 388   | 65.00                                    |
|                    |        | PHYSI CAL THERAPY<br>OCCUPATI ONAL THERAPY                    | 0   | 30, 210<br>2, 646  | 0                               | 4, 732, 425<br>1, 722, 469                              | 66. 00<br>67. 00                         |
|                    |        | SPEECH PATHOLOGY  | 0   | 376  | 0                               | 543, 069  | 68.00                                    |
|                    |        | ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT         | 0   | 0<br>269, 079  | 0                               | 0   | 69. 00<br>71. 00                         |
| 72.00              | 07200  | IMPL. DEV. CHARGED TO PATIENTS                                | 0   | 423, 720   | 0                               | ō   | 72. 00                                   |
|                    |        | DRUGS CHARGED TO PATIENTS<br>INFUSION THERAPY                 | 78, 631<br>90, 463  | 0<br>11, 939   | 1, 828, 057<br>0                | 8, 494, 227<br>524, 872                                 | 73. 00<br>76. 00                         |
|                    | OUTPAT | TIENT SERVICE COST CENTERS                                    | 707 100   |  |                                 |   |  |
|                    |        | FORT BRANCH RHC<br>CLARK & WELLS RHC                          | 0   | 4, 680<br>4, 204   | 0                               | 397, 482<br>437, 900                                    | 88. 00<br>  88. 01                       |
| 90.00              | 09000  | CLI NI C  | 7, 609  | 1, 517   | 0                               | O   | 90.00                                    |
|                    | 1 1    | DI ABETES<br>OP PSYCH   | 0   | 0  | 0                               | 4, 878  | 90. 01                                   |
|                    |        | PAIN MANAGEMENT   | 42, 506   | 51, 433  | 0                               | 1, 461, 549   | 90. 03                                   |
|                    |        | EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART                 | 882, 645  | 72, 326  | 0                               | 6, 884, 130   | 91. 00<br>92. 00                         |
|                    |        | REIMBURSABLE COST CENTERS                                     |   |  |                                 |   | 72.00                                    |
|                    |        | HOME HEALTH AGENCY AL PURPOSE COST CENTERS                    | 267, 659  | 13, 717  | 0                               | 841, 639  | 101.00                                   |
|                    |        | INTEREST EXPENSE  |   |  |                                 |   | 113.00                                   |
| 118. 00            |        | SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS | 2, 671, 125   | 1, 742, 025  | 1, 828, 057                     | 60, 044, 396  | 118. 00                                  |
| 194. 00            |        |   | 0   | 63, 343  | 0                               | 7, 188, 374   | 194. 00                                  |
|                    |        | FOUNDATI ON   | 0   | 0  | 0                               | 0   | 194. 01                                  |
| 194. 02<br>194. 03 |        | SNF - PERRY CO.   | 0   | 0  | 0                               | 0   | 194. 02<br>194. 03                       |
|                    |        | TELE BEHAVI ORAL  | 0   | 0  | 0                               | 7, 486  | 194.04                                   |
| 200. 00<br>201. 00 |        | Cross Foot Adjustments<br>Negative Cost Centers               |   |  |                                 |   | 200. 00<br>201. 00                       |
| 202. 00            |        | Cost to be allocated (per Wkst. B,                            | 425, 588  | 432, 097   | 1, 450, 023                     | 713, 142  | 202. 00                                  |
| 203. 00            |        | Part I)<br>Unit cost multiplier (Wkst. B, Part I)             | 0. 159329   | 0. 239340  | 0. 793204                       | 0. 010606   | 203.00                                   |
| 204. 00            |        | Cost to be allocated (per Wkst. B,                            | 12, 347   | 2, 403   | 5, 846                          | 56, 002   | 204. 00                                  |
| 205. 00            |        | Part II)<br>Unit cost multiplier (Wkst. B, Part               | 0. 004622   | 0. 001331  | 0. 003198                       | 0. 000833   | 205. 00                                  |
| 206. 00            |        | II) NAHE adjustment amount to be allocated                    |   |  |                                 |   | 206. 00                                  |
|                    |        | (per Wkst. B-2)   |   |  |                                 |   |  |
| 207. 00            | 1 1    | NAHE unit cost multiplier (Wkst. D,<br>Parts III and IV)      |   |  |                                 |   | 207. 00                                  |
|                    |        |   |   |  |                                 |   |  |

| Health Financial Systems                 | GI BSON GENERAL HOSPI TAL | In Lie          | u of Form CMS-2552-10   |
|--|---------------------------|-----------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-1319    | From 10/01/2019 | Worksheet C<br>Part I<br>Date/Time Prepared:<br>4/28/2021 8:15 am |
|  |                           |                 |   |

|        |  |              |               |             | To 09/30/2020   | Date/Time Pre<br>4/28/2021 8:1 |         |
|--------|--|--------------|---------------|-------------|-----------------|--------------------------------|---------|
|        |  |              | 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                          |         |
|        | INPATIENT ROUTINE SERVICE COST CENTERS     |              |               |             |                 |                                |         |
|        | 03000 ADULTS & PEDIATRICS                  | 5, 717, 880  |               | 5, 717, 88  | 0 0             | 0                              | 30.00   |
|        | 03100 INTENSIVE CARE UNIT                  | 275, 093     |               | 275, 09     | 3 0             | 0                              | 31.00   |
|        | 04400 SKILLED NURSING FACILITY             | 0            |               |             | 0               | 0                              | 44.00   |
|        | ANCILLARY SERVICE COST CENTERS             |              |               |             |                 |                                |         |
|        | 05000 OPERATING ROOM                       | 2, 079, 927  |               | 2, 079, 92  |                 | 0                              | 50.00   |
|        | 05400 RADI OLOGY-DI AGNOSTI C              | 2, 198, 620  |               | 2, 198, 62  | 0 0             | 0                              | 54.00   |
|        | 05401 NUCLEAR MEDICINE-DIAGNOSTIC          | 247, 680     |               | 247, 68     | 0 0             | 0                              | 54.03   |
|        | 06000 LABORATORY                           | 3, 713, 030  |               | 3, 713, 03  | 0               | 0                              | 60.00   |
|        | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 93, 789      |               | 93, 78      | 9 0             | 0                              | 62.00   |
|        | 06500 RESPI RATORY THERAPY                 | 1, 425, 376  | 0             | 1, 425, 37  | 6 0             | 0                              | 65.00   |
| 66. 00 | 06600 PHYSI CAL THERAPY                    | 1, 744, 768  | 0             | 1, 744, 76  | 8 0             | 0                              | 66.00   |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY                | 499, 430     | 0             | 499, 43     | 0 0             | 0                              | 67.00   |
| 68. 00 | 06800 SPEECH PATHOLOGY                     | 163, 273     | 0             | 163, 27     | 3 0             | 0                              | 68.00   |
| 69. 00 | 06900 ELECTROCARDI OLOGY                   | 0            |               |             | 0               | 0                              | 69.00   |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 843, 741     |               | 843, 74     | 1 0             | 0                              | 71.00   |
| 72. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 656, 067     |               | 656, 06     | 7 0             | 0                              | 72.00   |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS            | 4, 029, 677  |               | 4, 029, 67  | 7 0             | 0                              | 73.00   |
| 76. 00 | 03480 INFUSION THERAPY                     | 338, 825     |               | 338, 82     | 5 0             | 0                              | 76.00   |
|        | OUTPATIENT SERVICE COST CENTERS            |              |               |             |                 |                                |         |
| 88. 00 | 08800 FORT BRANCH RHC                      | 500, 498     |               | 500, 49     | 8 0             | 0                              | 88. 00  |
|        | 08801 CLARK & WELLS RHC                    | 453, 694     |               | 453, 69     | 4 0             | 0                              | 88. 01  |
| 90.00  | 09000 CLI NI C                             | 20, 873      |               | 20, 87      | 3 0             | 0                              | 90.00   |
| 90. 01 | 09001 DI ABETES                            | 295          |               | 29          | 5 0             | 0                              | 90. 01  |
| 90. 02 | 09002 OP PSYCH                             | 0            |               |             | 0               | 0                              | 90. 02  |
| 90. 03 | 09003 PAIN MANAGEMENT                      | 737, 136     |               | 737, 13     | 6 0             | 0                              | 90. 03  |
| 91.00  | 09100 EMERGENCY                            | 4, 694, 256  |               | 4, 694, 25  | 6 0             | 0                              | 91.00   |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 1, 596, 670  |               | 1, 596, 67  | O               | 0                              | 92.00   |
|        | OTHER REIMBURSABLE COST CENTERS            |              |               |             |                 |                                |         |
|        | 10100 HOME HEALTH AGENCY                   | 1, 179, 083  |               | 1, 179, 08  | 3               | 0                              | 101.00  |
|        | SPECIAL PURPOSE COST CENTERS               |              |               |             |                 |                                |         |
|        | 11300 I NTEREST EXPENSE                    |              |               |             |                 |                                | 113. 00 |
| 200.00 | Subtotal (see instructions)                | 33, 209, 681 | 0             | ,           |                 |                                | 200. 00 |
| 201.00 | Less Observation Beds                      | 1, 596, 670  |               | 1, 596, 67  | 0               |                                | 201. 00 |
| 202.00 | Total (see instructions)                   | 31, 613, 011 | 0             | 31, 613, 01 | 1  0            | 0                              | 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 10/01/2019   Part      |

|          |  |             |              | Т             | o 09/30/2020  | Date/Time Pre<br>4/28/2021 8:1 | pared:<br>5 am |
|----------|--|-------------|--------------|---------------|---------------|--------------------------------|----------------|
|          |  |             | Title        | XVIII         | 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                          |                |
|          | NPATIENT ROUTINE SERVICE COST CENTERS      |             |              |               |               |                                |                |
|          | 3000 ADULTS & PEDIATRICS                   | 2, 049, 038 |              | 2, 049, 038   |               |                                | 30.00          |
|          | 03100 INTENSIVE CARE UNIT                  | 86, 649     |              | 86, 649       | 1             |                                | 31.00          |
|          | 04400 SKILLED NURSING FACILITY             | 0           |              | C             |               |                                | 44.00          |
|          | NCILLARY SERVICE COST CENTERS              |             |              |               |               |                                |                |
|          | 05000 OPERATING ROOM                       | 134, 252    | 5, 088, 371  |               |               | 0.000000                       |                |
|          | 05400 RADI OLOGY-DI AGNOSTI C              | 348, 873    | 10, 976, 388 | 11, 325, 261  |               | 0.000000                       | 54.00          |
|          | 05401 NUCLEAR MEDICINE-DIAGNOSTIC          | 2, 632      | 529, 010     | 531, 642      | 0. 465877     | 0.000000                       | 54.03          |
|          | 06000 LABORATORY                           | 635, 368    | 7, 760, 256  | 8, 395, 624   |               | 0.000000                       | 60.00          |
| 62.00 0  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 64, 170     | 162, 343     | 226, 513      | 0. 414056     | 0.000000                       | 62.00          |
|          | 06500 RESPI RATORY THERAPY                 | 428, 770    | 2, 393, 993  | 2, 822, 763   | 0. 504958     | 0.000000                       | 65.00          |
| 66.00 0  | 06600 PHYSI CAL THERAPY                    | 739, 152    | 3, 991, 651  | 4, 730, 803   | 0. 368810     | 0.000000                       | 66.00          |
| 67.00 0  | 06700 OCCUPATI ONAL THERAPY                | 390, 865    | 1, 328, 507  | 1, 719, 372   | 0. 290472     | 0.000000                       | 67.00          |
| 68.00 0  | 06800 SPEECH PATHOLOGY                     | 59, 053     | 484, 016     | 543, 069      | 0. 300649     | 0.000000                       | 68.00          |
| 69.00 0  | 06900 ELECTROCARDI OLOGY                   | 0           | 0            | C             | 0. 000000     | 0.000000                       | 69.00          |
| 71.00 0  | 7100 MEDICAL SUPPLIES CHARGED TO PATIENT   | 257, 404    | 684, 373     | 941, 777      | 0. 895903     | 0.000000                       | 71.00          |
| 72.00 0  | 7200 IMPL. DEV. CHARGED TO PATIENTS        | 4, 724      | 679, 438     | 684, 162      | 0. 958935     | 0.000000                       | 72.00          |
| 73.00 0  | 07300 DRUGS CHARGED TO PATIENTS            | 1, 464, 347 | 7, 586, 848  | 9, 051, 195   | 0. 445209     | 0.000000                       | 73.00          |
| 76.00 0  | 3480 INFUSION THERAPY                      | 27, 266     | 722, 501     | 749, 767      | 0. 451907     | 0.000000                       | 76.00          |
| 0        | UTPATIENT SERVICE COST CENTERS             |             |              |               |               |                                |                |
| 88. 00 0 | 98800 FORT BRANCH RHC                      | 0           | 397, 482     | 397, 482      |               |                                | 88. 00         |
| 88. 01 0 | 08801 CLARK & WELLS RHC                    | 0           | 437, 900     | 437, 900      |               |                                | 88. 01         |
| 90.00 0  | 99000 CLI NI C                             | 0           | 0            | C             | 0.000000      | 0.000000                       | 90.00          |
| 90. 01 0 | 99001 DI ABETES                            | 0           | 4, 878       | 4, 878        | 0. 060476     | 0.000000                       | 90. 01         |
|          | 09002 OP PSYCH                             | 0           | 0            | C             | 0. 000000     | 0.000000                       | 90. 02         |
| 90. 03 0 | 99003 PAIN MANAGEMENT                      | 0           | 1, 187, 040  | 1, 187, 040   | 0. 620987     | 0.000000                       | 90. 03         |
|          | 9100 EMERGENCY                             | 220, 220    | 6, 330, 859  | 6, 551, 079   | 0. 716562     | 0.000000                       | 91.00          |
| 92.00 0  | 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 37, 087     | 842, 478     | 879, 565      | 1. 815295     | 0. 000000                      | 92.00          |
| 0        | THER REIMBURSABLE COST CENTERS             |             |              |               |               |                                |                |
|          | 0100 HOME HEALTH AGENCY                    | 0           | 841, 639     | 841, 639      |               |                                | 101. 00        |
|          | PECIAL PURPOSE COST CENTERS                |             |              |               |               |                                |                |
|          | 1300 I NTEREST EXPENSE                     |             |              |               |               |                                | 113.00         |
| 200.00   | Subtotal (see instructions)                | 6, 949, 870 | 52, 429, 971 | 59, 379, 841  |               |                                | 200. 00        |
| 201.00   | Less Observation Beds                      |             |              |               |               |                                | 201.00         |
| 202.00   | Total (see instructions)                   | 6, 949, 870 | 52, 429, 971 | 59, 379, 841  |               |                                | 202.00         |

| Health Financial Systems                 | GIBSON GENERAL                  | HOSPI TAL             | In Lieu                          | u of Form CMS-2   | 2552-10 |
|--|---------------------------------|-----------------------|----------------------------------|---|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES |                                 | Provider CCN: 15-1319 | From 10/01/2019<br>To 09/30/2020 | Worksheet C<br>Part I<br>Date/Time Pre<br>4/28/2021 8:1 |         |
|  |                                 | Title XVIII           | Hospi tal                        | Cost  |         |
| Cost Center Description                  | PPS Inpatient<br>Ratio<br>11.00 |                       |                                  |   |         |

|  |               | TI LIE AVIII | nospi tai | 0031    | _ |
|--|---------------|--------------|-----------|---------|---|
| Cost Center Description                          | PPS Inpatient |              |           |         |   |
|  | Ratio         |              |           |         |   |
|  | 11. 00        |              |           |         |   |
| INPATIENT ROUTINE SERVICE COST CENTERS           |               |              |           |         |   |
| 30. 00   03000   ADULTS & PEDI ATRI CS           |               |              |           | 30.00   |   |
| 31.00 03100 INTENSIVE CARE UNIT                  |               |              |           | 31.00   |   |
| 44.00 O4400 SKILLED NURSING FACILITY             |               |              |           | 44.00   | 0 |
| ANCILLARY SERVICE COST CENTERS                   |               |              |           |         |   |
| 50.00 05000 OPERATING ROOM                       | 0. 000000     |              |           | 50.00   |   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 0. 000000     |              |           | 54.00   |   |
| 54. 03   05401   NUCLEAR MEDICINE-DIAGNOSTIC     | 0. 000000     |              |           | 54.03   |   |
| 60. 00   06000   LABORATORY                      | 0. 000000     |              |           | 60.00   |   |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000     |              |           | 62.00   |   |
| 65. 00 06500 RESPI RATORY THERAPY                | 0. 000000     |              |           | 65.00   |   |
| 66. 00 06600 PHYSI CAL THERAPY                   | 0. 000000     |              |           | 66.00   |   |
| 67. 00 06700 OCCUPATI ONAL THERAPY               | 0. 000000     |              |           | 67.00   |   |
| 68. 00 06800 SPEECH PATHOLOGY                    | 0. 000000     |              |           | 68.00   |   |
| 69. 00   06900   ELECTROCARDI OLOGY              | 0. 000000     |              |           | 69.00   |   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0. 000000     |              |           | 71.00   |   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0. 000000     |              |           | 72.00   |   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 0. 000000     |              |           | 73.00   |   |
| 76. 00 03480 I NFUSI ON THERAPY                  | 0. 000000     |              |           | 76. 00  | 0 |
| OUTPATIENT SERVICE COST CENTERS                  |               |              |           |         |   |
| 88. 00   08800   FORT BRANCH RHC                 |               |              |           | 88.00   |   |
| 88.01   08801   CLARK & WELLS RHC                |               |              |           | 88. 01  |   |
| 90. 00 09000 CLI NI C                            | 0. 000000     |              |           | 90.00   |   |
| 90. 01  09001   DI ABETES                        | 0. 000000     |              |           | 90.01   |   |
| 90. 02   09002   0P PSYCH                        | 0. 000000     |              |           | 90. 02  |   |
| 90. 03   09003   PALN MANAGEMENT                 | 0. 000000     |              |           | 90. 03  |   |
| 91. 00   09100   EMERGENCY                       | 0. 000000     |              |           | 91.00   |   |
| 92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 000000     |              |           | 92.00   | 0 |
| OTHER REIMBURSABLE COST CENTERS                  |               |              |           |         | _ |
| 101. 00 10100 HOME HEALTH AGENCY                 |               |              |           | 101.00  | O |
| SPECIAL PURPOSE COST CENTERS                     |               |              |           | 410.00  | _ |
| 113. 00 11300 I NTEREST EXPENSE                  |               |              |           | 113.00  |   |
| 200.00 Subtotal (see instructions)               |               |              |           | 200.00  |   |
| 201.00 Less Observation Beds                     |               |              |           | 201. 00 |   |
| 202.00 Total (see instructions)                  |               |              |           | 202.00  | U |

| Health Financial Systems                 | GIBSON GENERAL HOSPITAL | In Lieu         | u of Form CMS-2552-10   |
|--|-------------------------|-----------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES |                         | From 10/01/2019 | Worksheet C<br>Part I<br>Date/Time Prepared:<br>4/28/2021 8:15 am |
|  | T                       |                 | 0 1   |

|        |   |              |               |             | Го 09/30/2020   | Date/Time Pre<br>4/28/2021 8:1 |                  |
|--------|---|--------------|---------------|-------------|-----------------|--------------------------------|------------------|
|        |   |              | Ti tl         | e XIX       | Hospi tal       | Cost                           |                  |
|        |   |              |               |             | Costs           |                                |                  |
|        | Cost Center Description                                   |              | 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                          |                  |
|        | INPATIENT ROUTINE SERVICE COST CENTERS                    |              |               |             | . 1             |                                |                  |
|        | 03000 ADULTS & PEDIATRICS                                 | 5, 717, 880  |               | 5, 717, 88  | 1               | 5, 717, 880                    |                  |
|        | 03100 INTENSIVE CARE UNIT                                 | 275, 093     |               | 275, 09     | 1               | 275, 093                       |                  |
|        | 04400 SKILLED NURSING FACILITY                            | 0            |               |             | 0               | 0                              | 44. 00           |
|        | ANCILLARY SERVICE COST CENTERS                            |              |               |             | 1               |                                |                  |
|        | 05000 OPERATING ROOM                                      | 2, 079, 927  |               | 2, 079, 92  | 1               | 2, 079, 927                    | 1                |
|        | 05400 RADI OLOGY-DI AGNOSTI C                             | 2, 198, 620  |               | 2, 198, 62  | 1               | 2, 198, 620                    | 1                |
|        | 05401 NUCLEAR MEDICINE-DIAGNOSTIC                         | 247, 680     |               | 247, 68     | 1               | 247, 680                       |                  |
|        | 06000 LABORATORY  | 3, 713, 030  |               | 3, 713, 03  |                 | 3, 713, 030                    |                  |
|        | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                | 93, 789      | _             | 93, 78      | 1               | 93, 789                        | 1                |
|        | 06500 RESPI RATORY THERAPY                                | 1, 425, 376  | 0             | ., .20,0,   |                 | 1, 425, 376                    |                  |
|        | 06600 PHYSI CAL THERAPY                                   | 1, 744, 768  | 0             | 1, 744, 76  | 1               | 1, 744, 768                    |                  |
|        | 06700 OCCUPATI ONAL THERAPY                               | 499, 430     | 0             | 499, 43     | 1               | 499, 430                       |                  |
|        | 06800 SPEECH PATHOLOGY                                    | 163, 273     | 0             | 163, 27     |                 | 163, 273                       |                  |
|        | 06900 ELECTROCARDI OLOGY                                  | 0            |               |             | 0               | 0                              |                  |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                 | 843, 741     |               | 843, 74     |                 | 843, 741                       | 1                |
|        | 07200 I MPL. DEV. CHARGED TO PATIENTS                     | 656, 067     |               | 656, 06     | 1               | 656, 067                       | 1                |
|        | 07300 DRUGS CHARGED TO PATIENTS                           | 4, 029, 677  |               | 4, 029, 67  |                 | 4, 029, 677                    |                  |
|        | 03480   NFUSI ON THERAPY                                  | 338, 825     |               | 338, 82     | 5 0             | 338, 825                       | 76. 00           |
|        | OUTPATIENT SERVICE COST CENTERS                           | F00 400      |               | F00.40      |                 | F00 400                        | 00.00            |
|        | 08800 FORT BRANCH RHC                                     | 500, 498     |               | 500, 49     |                 | 500, 498                       |                  |
|        | 08801 CLARK & WELLS RHC                                   | 453, 694     |               | 453, 69     |                 | 453, 694                       | 1                |
|        | 09000 CLI NI C<br>09001 DI ABETES                         | 20, 873      |               | 20, 87      |                 | 20, 873                        |                  |
|        |   | 295          |               | 29          |                 | 295                            | 90. 01<br>90. 02 |
|        | 09002 OP PSYCH  | 707 104      |               |             | 9               | 727 127                        |                  |
|        | 09003 PAIN MANAGEMENT                                     | 737, 136     |               | 737, 13     |                 | 737, 136                       |                  |
|        | 09100 EMERGENCY   | 4, 694, 256  |               | 4, 694, 25  |                 | 4, 694, 256                    |                  |
|        | 09200 OBSERVATION BEDS (NON-DISTINCT PART                 | 1, 596, 670  |               | 1, 596, 67  | )               | 1, 596, 670                    | 92.00            |
|        | OTHER REIMBURSABLE COST CENTERS  10100 HOME HEALTH AGENCY | 1 170 000    |               | 1 170 00    |                 | 1 170 000                      | 101 00           |
|        | SPECIAL PURPOSE COST CENTERS                              | 1, 179, 083  |               | 1, 179, 08  | 3               | 1, 179, 083                    | 101.00           |
|        | 11300 INTEREST EXPENSE                                    |              |               |             |                 |                                | 113.00           |
| 200.00 |   | 33, 209, 681 | 0             | 33, 209, 68 | 1 0             | 33, 209, 681                   |                  |
| 200.00 |   | 1, 596, 670  | Ü             | 1, 596, 67  | 1               | 1, 596, 670                    |                  |
| 201.00 |   | 31, 613, 011 | 0             |             | 1               |                                |                  |
| 202.00 | Total (see Histructions)                                  | 31,013,011   | 0             | 31,013,01   | il O            | 31,013,011                     | 1202.00          |

| 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    | Peri od: Worksheet C             |
|  |                           | From 10/01/2019 Part I           |
|  |                           | To 00/20/2020 Data/Time Dropared |

|        |   |             |                       | Т              | o 09/30/2020  | Date/Time Pre<br>4/28/2021 8:1 |              |
|--------|---|-------------|-----------------------|----------------|---------------|--------------------------------|--------------|
|        |   |             | Ti tl                 | e XIX          | Hospi tal     | Cost                           |              |
|        | Cost Center Description                               | Inpatient   | Charges<br>Outpatient | Total (ool (   | Cost or Other | TEFRA                          |              |
|        | Cost Center Description                               | пранен      | outpatrent            | + col. 7)      | Ratio         | Inpatient                      |              |
|        |   |             |                       | + COI. 7)      | Ratio         | Ratio                          |              |
|        |   | 6. 00       | 7. 00                 | 8.00           | 9. 00         | 10.00                          |              |
|        | INPATIENT ROUTINE SERVICE COST CENTERS                | 0.00        | 7.00                  | 0.00           | 7. 00         | 10.00                          |              |
|        | 03000 ADULTS & PEDIATRICS                             | 2, 049, 038 |                       | 2, 049, 038    | 3             |                                | 30.00        |
|        | 03100 I NTENSI VE CARE UNI T                          | 86, 649     |                       | 86, 649        |               |                                | 31.00        |
|        | 04400 SKILLED NURSING FACILITY                        | 0           |                       | C C            |               |                                | 44.00        |
|        | ANCILLARY SERVICE COST CENTERS                        |             |                       |                |               |                                |              |
| 50.00  | 05000 OPERATING ROOM                                  | 134, 252    | 5, 088, 371           | 5, 222, 623    | 0. 398253     | 0.000000                       | 50.00        |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C                         | 348, 873    | 10, 976, 388          | 11, 325, 261   | 0. 194134     | 0.000000                       | 54.00        |
| 54.03  | 05401 NUCLEAR MEDICINE-DIAGNOSTIC                     | 2, 632      | 529, 010              | 531, 642       | 0. 465877     | 0.000000                       | 54.03        |
| 60.00  | 06000 LABORATORY                                      | 635, 368    | 7, 760, 256           | 8, 395, 624    | 0. 442258     | 0.000000                       | 60.00        |
| 62.00  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS            | 64, 170     | 162, 343              | 226, 513       | 0. 414056     | 0.000000                       | 62.00        |
| 65.00  | 06500 RESPI RATORY THERAPY                            | 428, 770    | 2, 393, 993           | 2, 822, 763    | 0. 504958     | 0.000000                       | 65.00        |
| 66.00  | 06600 PHYSI CAL THERAPY                               | 739, 152    | 3, 991, 651           | 4, 730, 803    | 0. 368810     | 0.000000                       | 66.00        |
|        | 06700 OCCUPATI ONAL THERAPY                           | 390, 865    | 1, 328, 507           | 1, 719, 372    |               | 0.000000                       | 67.00        |
|        | 06800 SPEECH PATHOLOGY                                | 59, 053     | 484, 016              | 543, 069       |               | 0.000000                       |              |
|        | 06900 ELECTROCARDI OLOGY                              | 0           | 0                     |                |               | 0.000000                       |              |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT             | 257, 404    | 684, 373              |                |               | 0.000000                       |              |
|        | 07200 IMPL. DEV. CHARGED TO PATIENTS                  | 4, 724      | 679, 438              |                |               | 0.000000                       |              |
|        | 07300 DRUGS CHARGED TO PATIENTS                       | 1, 464, 347 | 7, 586, 848           |                |               | 0.000000                       |              |
|        | 03480 I NFUSI ON THERAPY                              | 27, 266     | 722, 501              | 749, 767       | 0. 451907     | 0. 000000                      | 76. 00       |
|        | OUTPATIENT SERVICE COST CENTERS                       | .1          |                       |                |               |                                |              |
|        | 08800 FORT BRANCH RHC                                 | 0           | 397, 482              |                |               | 0. 000000                      |              |
|        | 08801 CLARK & WELLS RHC                               | 0           | 437, 900              |                |               | 0. 000000                      |              |
|        | 09000 CLINIC  | 0           | 0                     | C              |               | 0. 000000                      |              |
|        | 09001 DI ABETES                                       | 0           | 4, 878                | i .            |               | 0. 000000                      |              |
|        | 09002 OP PSYCH  | 0           | 0                     |                |               | 0.000000                       | 90.02        |
|        | 09003 PAIN MANAGEMENT                                 | 000 000     | 1, 187, 040           |                |               | 0.000000                       |              |
|        | 09100 EMERGENCY                                       | 220, 220    | 6, 330, 859           |                |               | 0.000000                       |              |
|        | 09200 OBSERVATION BEDS (NON-DISTINCT PART             | 37, 087     | 842, 478              | 879, 565       | 1. 815295     | 0. 000000                      | 92.00        |
|        | OTHER REIMBURSABLE COST CENTERS                       |             | 0.41 (20              | 0.41 (20       |               |                                | 101 00       |
|        | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 0           | 841, 639              | 841, 639       | <u>'</u>      |                                | 101. 00      |
|        | 11300 INTEREST EXPENSE                                |             |                       |                |               |                                | 1<br>113. 00 |
| 200.00 | Subtotal (see instructions)                           | 6, 949, 870 | 52, 429, 971          | 59, 379, 841   |               |                                | 200.00       |
| 200.00 |   | 0, 949, 870 | 32, 429, 971          | 09, 3/9, 841   |               |                                | 200.00       |
| 201.00 |   | 6, 949, 870 | 52, 429, 971          | 59, 379, 841   |               |                                | 201.00       |
| 202.00 | Tiotal (See Histiactions)                             | 0, 949, 870 | 32, 429, 9/1          | 1 37, 3/7, 841 | 1             |                                | 1202.00      |

| Health Financial Systems  | GI BSON GENERAL        | HOSPI TAL             | In Lie                                       | u of Form CMS-  | 2552-10          |
|---|------------------------|-----------------------|--|---|------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES  |                        | Provider CCN: 15-1319 | Peri od:<br>From 10/01/2019<br>To 09/30/2020 | Worksheet C<br>Part I<br>Date/Time Pre<br>4/28/2021 8:1 |                  |
|   |                        | Title XIX             | Hospi tal                                    | Cost  |                  |
| Cost Center Description   | PPS Inpatient<br>Ratio |                       |  |   |                  |
| INPATIENT ROUTINE SERVICE COST CENTERS  | 11. 00                 |                       |  |   |                  |
| 30. 00   03000   ADULTS & PEDI ATRI CS<br>31. 00   03100   NTENSI VE CARE UNI T |                        |                       |  |   | 30. 00<br>31. 00 |

|  |               | II LI O AIA | 1105pi tui | 0031   |
|--|---------------|-------------|------------|--------|
| Cost Center Description                          | PPS Inpatient |             |            |        |
|  | Ratio         |             |            |        |
|  | 11. 00        |             |            |        |
| INPATIENT ROUTINE SERVICE COST CENTERS           |               |             |            |        |
| 30. 00   03000   ADULTS & PEDI ATRI CS           |               |             |            | 30.0   |
| 31.00   03100   INTENSIVE CARE UNIT              |               |             |            | 31. (  |
| 44.00 04400 SKILLED NURSING FACILITY             |               |             |            | 44. (  |
| ANCILLARY SERVICE COST CENTERS                   |               |             |            |        |
| 50.00   05000   OPERATING ROOM                   | 0. 000000     |             |            | 50.0   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 0. 000000     |             |            | 54.0   |
| 54. 03   05401   NUCLEAR MEDICINE-DIAGNOSTIC     | 0. 000000     |             |            | 54.0   |
| 50. 00  06000 LABORATORY                         | 0. 000000     |             |            | 60.0   |
| 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000     |             |            | 62.0   |
| 55. 00 06500 RESPIRATORY THERAPY                 | 0. 000000     |             |            | 65. (  |
| 66. 00 06600 PHYSI CAL THERAPY                   | 0. 000000     |             |            | 66. (  |
| 57. 00  06700 OCCUPATI ONAL THERAPY              | 0. 000000     |             |            | 67. (  |
| 8. 00 06800 SPEECH PATHOLOGY                     | 0. 000000     |             |            | 68. (  |
| 9. 00  06900 ELECTROCARDI OLOGY                  | 0. 000000     |             |            | 69. (  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0. 000000     |             |            | 71. (  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0. 000000     |             |            | 72. (  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 0. 000000     |             |            | 73. (  |
| 76.00 03480 INFUSION THERAPY                     | 0. 000000     |             |            | 76. (  |
| OUTPATIENT SERVICE COST CENTERS                  |               |             |            |        |
| 38. 00 08800 FORT BRANCH RHC                     | 0. 000000     |             |            | 88. (  |
| 38.01   08801   CLARK & WELLS RHC                | 0. 000000     |             |            | 88.0   |
| 00. 00  09000  CLI NI C                          | 0. 000000     |             |            | 90.0   |
| 00. 01   09001   DI ABETES                       | 0. 000000     |             |            | 90.0   |
| 90. 02   09002   OP PSYCH                        | 0. 000000     |             |            | 90.0   |
| PO. 03 09003 PAIN MANAGEMENT                     | 0. 000000     |             |            | 90.0   |
| 91. 00   09100   EMERGENCY                       | 0. 000000     |             |            | 91. (  |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 0. 000000     |             |            | 92. (  |
| OTHER REIMBURSABLE COST CENTERS                  |               |             |            |        |
| 101.00 10100 HOME HEALTH AGENCY                  |               |             |            | 101. ( |
| SPECIAL PURPOSE COST CENTERS                     |               |             |            |        |
| 113.00 11300 INTEREST EXPENSE                    |               |             |            | 113. ( |
| 200.00 Subtotal (see instructions)               |               |             |            | 200. ( |
| 201.00 Less Observation Beds                     |               |             |            | 201. ( |
| 202.00 Total (see instructions)                  |               |             |            | 202. ( |

| Health Financial Systems                            | GI BSON GENERA | AL HOSPITAL   |            | In Lie                           | u of Form CMS- | 2552-10 |
|---|----------------|---------------|------------|----------------------------------|----------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS       | Provi der C   |            | Peri od:                         | Worksheet D    |         |
|   |                |               |            | From 10/01/2019<br>To 09/30/2020 |                | nared.  |
|   |                |               |            | 10 077 007 2020                  | 4/28/2021 8: 1 | 5 am    |
|   |                |               | XVIII      | Hospi tal                        | Cost           |         |
| Cost Center Description                             | Capi tal       | Total Charges |            |                                  | Capital Costs  |         |
|   | Related Cost   | (from Wkst.   | to Charges | Program                          | (column 3 x    |         |
|   | (from Wkst.    | C, Part I,    | (col. 1 ÷  | Charges                          | column 4)      |         |
|   | B, Part II,    | col. 8)       | col . 2)   |                                  |                |         |
|   | col. 26)       |               |            |                                  |                |         |
|   | 1. 00          | 2.00          | 3. 00      | 4. 00                            | 5. 00          |         |
| ANCILLARY SERVICE COST CENTERS                      | 040.000        | 5 000 (00     |            | 17.004                           | 4 005          |         |
| 50. 00   05000   OPERATING ROOM                     | 219, 200       |               |            |                                  | 1, 985         |         |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 157, 772       |               |            |                                  |                |         |
| 54. 03   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C  | 17, 813        |               |            |                                  |                |         |
| 60. 00   06000   LABORATORY                         | 83, 400        |               |            |                                  |                |         |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 495            |               | 1          |                                  | •              |         |
| 65. 00 06500 RESPIRATORY THERAPY                    | 72, 922        |               | 1          |                                  |                |         |
| 66. 00 06600 PHYSI CAL THERAPY                      | 123, 208       |               |            |                                  |                |         |
| 67. 00 06700 OCCUPATI ONAL THERAPY                  | 36, 203        |               |            |                                  |                |         |
| 68.00 06800 SPEECH PATHOLOGY                        | 3, 815         |               |            |                                  | 40             |         |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0              | 0             | 0.00000    |                                  | 0              |         |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 144, 051       | 941, 777      |            |                                  | 12, 007        |         |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 2, 531         | 684, 162      |            |                                  | 6              |         |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 74, 766        | 9, 051, 195   | 0. 00826   | 316, 807                         | 2, 617         | 73.00   |
| 76.00 03480 INFUSION THERAPY                        | 44, 322        | 749, 767      | 0. 05911   | 4 347                            | 21             | 76.00   |
| OUTPATIENT SERVICE COST CENTERS                     |                |               |            |                                  |                |         |
| 88. 00   08800   FORT BRANCH RHC                    | 2, 989         |               |            |                                  | 0              | 00.00   |
| 88. 01   08801   CLARK & WELLS RHC                  | 19, 402        | 437, 900      | 1          |                                  | 0              | 00.0.   |
| 90. 00  09000   CLI NI C                            | 144            | 0             | 0. 00000   | 0 0                              | 0              | 1 ,0.00 |
| 90. 01   09001   DI ABETES                          | 5              | 4, 878        | 0. 00102   | 25 0                             | 0              | 1       |
| 90. 02  09002  OP PSYCH                             | 0              | 0             | 0.00000    | 00                               | 0              | 90.02   |
| 90. 03   09003   PAI N   MANAGEMENT                 | 66, 536        | 1, 187, 040   | 0. 05605   | 52 0                             | 0              | 90.03   |
| 91. 00 09100 EMERGENCY                              | 335, 606       | 6, 551, 079   | 0. 05122   | 29, 040                          | 1, 488         | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 161, 786       | 879, 565      | 0. 18393   | 5, 209                           |                |         |
| 200.00   Total (lines 50 through 199)               | 1, 566, 966    | 56, 402, 515  |            | 985, 890                         | 27, 358        | 200.00  |

| Health Financial Systems                          | GI BSON GENERAL HOSPI TAL                               | In Lieu         | u of Form CMS-2552-10                   |
|---|---|-----------------|---|
| APPORTIONMENT OF INPATIENT/OUTPA<br>THROUGH COSTS | TENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1319 | From 10/01/2019 | Worksheet D Part IV Date/Time Prepared: |

|         |  |               |               | 1        | 0 09/30/2020  | 4/28/2021 8:1 |         |
|---------|--|---------------|---------------|----------|---------------|---------------|---------|
|         |  |               | Title         | XVIII    | Hospi tal     | Cost          |         |
|         | Cost Center Description                    | Non Physician | Nursi ng      | Nursi ng | Allied Health | Allied Health |         |
|         |  | Anesthetist   | School        | School   | Post-Stepdown |               |         |
|         |  | Cost          | Post-Stepdown |          | Adjustments   |               |         |
|         |  |               | Adjustments   |          |               |               |         |
|         |  | 1. 00         | 2A            | 2.00     | 3A            | 3. 00         |         |
|         | ANCILLARY SERVICE COST CENTERS             | 1             |               |          | 1             |               |         |
|         | 05000 OPERATI NG ROOM                      | 0             | 0             | 0        | 0             | 0             |         |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C              | 0             | 0             | 0        | 0             | 0             | 54.00   |
|         | 05401   NUCLEAR   MEDICINE-DIAGNOSTIC      | 0             | 0             | 0        | 0             | 0             | 54. 03  |
|         | 06000 LABORATORY                           | 0             | 0             | 0        | 0             | 0             | 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             | 0             | 0        | 0             | 0             | 65.00   |
| 66. 00  | 06600 PHYSI CAL THERAPY                    | 0             | 0             | 0        | 0             | 0             | 66.00   |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY                | 0             | 0             | 0        | 0             | 0             | 67.00   |
| 68. 00  | 06800 SPEECH PATHOLOGY                     | 0             | 0             | 0        | 0             | 0             | 68. 00  |
| 69. 00  | 06900 ELECTROCARDI OLOGY                   | 0             | 0             | 0        | 0             | 0             | 69.00   |
|         | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0             | 0             | 0        | 0             | 0             | 71.00   |
|         | 07200 I MPL. DEV. CHARGED TO PATIENTS      | 0             | 0             | 0        | 0             | 0             | 72.00   |
|         | 07300 DRUGS CHARGED TO PATIENTS            | 0             | 0             | 0        | 0             | 0             | 73.00   |
| 76. 00  | 03480 I NFUSI ON THERAPY                   | 0             | 0             | 0        | 0             | 0             | 76. 00  |
|         | OUTPATIENT SERVICE COST CENTERS            | 1             | T _           | 1 _      | _             |               |         |
|         | 08800 FORT BRANCH RHC                      | 0             | 0             | 0        | 0             | 0             |         |
| 88. 01  | 08801 CLARK & WELLS RHC                    | 0             | 0             | 0        | 0             | 0             | 88. 01  |
|         | 09000 CLINIC                               | 0             | 0             | 0        | 0             | 0             | 90.00   |
|         | 09001 DI ABETES                            | 0             | 0             | 0        | 0             | 0             | 90. 01  |
|         | 09002 OP PSYCH                             | 0             | 0             | 0        | 0             | 0             | 90. 02  |
|         | 09003 PAIN MANAGEMENT                      | 0             | 0             | 0        | 0             | 0             | 90. 03  |
|         | 09100 EMERGENCY                            | 0             | 0             | 0        | 0             | 0             | 91.00   |
|         | 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 0             |               | 0        | _             | 0             | 92.00   |
| 200. 00 | Total (lines 50 through 199)               | 0             | 1 0           | 1 0      | 0             | 0             | 200. 00 |

| Health Financial Systems              | GIBSON GENERAL HOSPITAL              | In Lieu         | of Form CMS-2552-10 |
|---------------------------------------|--------------------------------------|-----------------|---------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS Provide |                 | Worksheet D         |
| TUDOLICU COSTS                        |                                      | From 10/01/2019 | Part IV             |

THROUGH COSTS To 09/30/2020 Date/Time Prepared: 4/28/2021 8:15 am Title XVIII Hospi tal Cost Cost Center Description All Other Total Charges Ratio of Cost Total Cost Total Medi cal (sum of cols. to Charges Outpati ent (from Wkst. 1, 2, 3, and 4) (col. 5 ÷ Educati on Cost (sum of C, Part I, Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 7. 00 8.00 4. 00 5.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 5, 222, 623 0.000000 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 11, 325, 261 0.000000 54.00 54.00 0 0 0 0 0 0 0 0 0 0 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 531, 642 0.000000 54.03 54.03 06000 LABORATORY 0 8, 395, 624 0.000000 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 226, 513 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 0 2, 822, 763 0.000000 65.00 01 66.00 06600 PHYSI CAL THERAPY 0 4, 730, 803 0.000000 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0 1, 719, 372 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 543, 069 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 941, 777 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 684, 162 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 9, 051, 195 0.000000 73.00 73.00 03480 INFUSION THERAPY 0 749, 767 76.00 0 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 FORT BRANCH RHC 0 0 0 397, 482 0.000000 88.00 08801 CLARK & WELLS RHC 88. 01 0000000 0 0 437, 900 0.000000 88.01 09000 CLI NI C 0 0 90 00 0.000000 90 00 0 09001 DI ABETES 0 90.01 4, 878 0.000000 90.01 90. 02 09002 OP PSYCH 0.000000 90.02 90. 03 09003 PAIN MANAGEMENT 0 0 1, 187, 040 0.000000 90.03 0 91. 00 09100 EMERGENCY 0 6, 551, 079 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 879, 565 0.000000 92.00

56, 402, 515

200.00

200.00

Total (lines 50 through 199)

| Health Financial Systems                            | GIBSON GENERAL HOSPITAL                          | In Lieu of Form CMS-2552-10  |
|---|--|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS | ANCILLARY SERVICE OTHER PASS Provider CCN: 15-13 | R19 Peri od: Worksheet D From 10/01/2019 Part IV To 09/30/2020 Date/Time Prepared: 4/28/2021 8:15 am |

|        | 999.10                                     |               |             | To            | 09/30/2020  | Date/Time Pre<br>4/28/2021 8:1 |        |
|--------|--|---------------|-------------|---------------|-------------|--------------------------------|--------|
|        |  |               | Title       | XVIII         | Hospi tal   | Cost                           |        |
|        | Cost Center Description                    | Outpati ent   | I npati ent | Inpati ent    | Outpati ent | Outpati ent                    |        |
|        |  | Ratio of Cost | Program     | Program       | Program     | Program                        |        |
|        |  | to Charges    | Charges     | Pass-Through  | Charges     | Pass-Through                   |        |
|        |  | (col. 6 ÷     |             | Costs (col. 8 | -           | Costs (col. 9                  |        |
|        |  | col. 7)       |             | x col. 10)    |             | x col. 12)                     |        |
|        |  | 9. 00         | 10. 00      | 11. 00        | 12.00       | 13. 00                         |        |
|        | ANCILLARY SERVICE COST CENTERS             |               |             |               |             |                                |        |
| 50.00  | 05000 OPERATING ROOM                       | 0. 000000     | 47, 301     | 0             | 0           | 0                              | 50.00  |
| 54.00  | 05400  RADI OLOGY-DI AGNOSTI C             | 0. 000000     | 95, 834     | 0             | 0           | 0                              | 54.00  |
| 54. 03 | 05401  NUCLEAR MEDICINE-DIAGNOSTIC         | 0. 000000     | 0           | 0             | 0           | 0                              | 54.03  |
| 60.00  | 06000 LABORATORY                           | 0. 000000     | 177, 478    |               | 0           | 0                              | 60.00  |
| 62.00  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000     | 26, 724     |               | 0           | 0                              | 62.00  |
| 65.00  | 06500 RESPI RATORY THERAPY                 | 0. 000000     | 122, 976    |               | 0           | 0                              | 65.00  |
| 66. 00 | 06600 PHYSI CAL THERAPY                    | 0. 000000     | 51, 272     |               | 0           | 0                              | 66.00  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 0. 000000     | 26, 970     |               | 0           | 0                              | 67. 00 |
| 68. 00 | 06800 SPEECH PATHOLOGY                     | 0. 000000     | 5, 707      | 0             | 0           | 0                              | 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY                   | 0. 000000     | 0           | 0             | 0           | 0                              | 69. 00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0. 000000     | 78, 498     |               | 0           | 0                              | 71.00  |
| 72.00  | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0. 000000     | 1, 727      |               | 0           | 0                              | 72.00  |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS            | 0. 000000     | 316, 807    |               | 0           | 0                              | 73.00  |
| 76. 00 | 03480 I NFUSI ON THERAPY                   | 0. 000000     | 347         | 0             | 0           | 0                              | 76. 00 |
|        | OUTPATIENT SERVICE COST CENTERS            |               |             |               |             |                                |        |
| 88. 00 | 08800 FORT BRANCH RHC                      | 0. 000000     | 0           | 0             | 0           | 0                              | 88. 00 |
| 88. 01 | 08801 CLARK & WELLS RHC                    | 0. 000000     | 0           | 0             | 0           | 0                              | 88. 01 |
| 90.00  | 09000 CLI NI C                             | 0. 000000     | 0           | 0             | 0           | 0                              | 90.00  |
| 90. 01 | 09001 DI ABETES                            | 0. 000000     | 0           | 0             | 0           | 0                              | 90. 01 |
| 90. 02 | 09002 OP PSYCH                             | 0. 000000     | 0           | 0             | 0           | 0                              | 90. 02 |
|        | 09003 PAIN MANAGEMENT                      | 0. 000000     | 0           | 0             | 0           | 0                              | 90. 03 |
| 91.00  | 09100 EMERGENCY                            | 0. 000000     | 29, 040     |               | 0           | 0                              | 91.00  |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 0. 000000     | 5, 209      |               | 0           | 0                              | 92.00  |
| 200.00 | Total (lines 50 through 199)               |               | 985, 890    | 0             | 0           | 0                              | 200.00 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1319 Worksheet D From 10/01/2019 To 09/30/2020 Part V Date/Time Prepared: 4/28/2021 8:15 am 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 4.00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 398253 1, 765, 457 05400 RADI OLOGY-DI AGNOSTI C 2, 919, 431 0 54.00 0.194134 54.00 0 0 54. 03 | 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0. 465877 0 163, 917 0 54.03 60.00 06000 LABORATORY 0.442258 1,816,370 0 0 0 0 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.414056 33, 493 0 62.00 06500 RESPIRATORY THERAPY 0. 504958 65.00 821, 515 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.368810 0 1, 329, 390 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 290472 260, 247 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.300649 0 59, 814 0 68.00 0 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.895903 0 203, 727 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 958935 0 257, 960 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 3.318.347 881 73 00 0 445209 0 73 00 03480 INFUSION THERAPY 76.00 0. 451907 0 261, 027 0 76.00 OUTPATIENT SERVICE COST CENTERS 08800 FORT BRANCH RHC 88.00 88.00 08801 CLARK & WELLS RHC 88 01 88 01 09000 CLI NI C 0.000000 90.00 0 0 0 90.00 90.01 09001 DI ABETES 0.060476 487 0 90.01 0 90.02 09002 OP PSYCH 0.000000 0 0 90.02 0 09003 PAIN MANAGEMENT 307, 662 90 03 0.620987 0 90.03 0 91.00 09100 EMERGENCY 0.716562 0 1, 327, 728 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.815295 309, 828 30 0 92.00 200.00 Subtotal (see instructions) 200.00 15, 156, 400 0 Less PBP Clinic Lab. Services-Program 201.00 Ω 201.00 0 Only Charges

15, 156, 400

911

0 202.00

202.00

Net Charges (line 200 - line 201)

| Health Financial Systems    | GI BSON GENERAL                        | HOSPI TAL              | In Lieu         | of Form CMS-2552-10                    |
|-----------------------------|--|------------------------|-----------------|--|
| APPORTI ONMENT OF MEDI CAL, | OTHER HEALTH SERVICES AND VACCINE COST | Provi der CCN: 15-1319 | From 10/01/2019 | Worksheet D Part V Date/Time Prepared: |

|  |               |               |       | To 09/30/2020 |      |         |
|--|---------------|---------------|-------|---------------|------|---------|
|  |               | Title         | XVIII | Hospi tal     | Cost |         |
|  | Cos           | sts           |       |               |      |         |
| Cost Center Description                          | Cost          | Cost          |       |               |      |         |
|  | Rei mbursed   | Rei mbursed   |       |               |      |         |
|  | Servi ces     | Services Not  |       |               |      |         |
|  | Subject To    | Subject To    |       |               |      |         |
|  | Ded. & Coins. | Ded. & Coins. |       |               |      |         |
|  | (see inst.)   | (see inst.)   |       |               |      |         |
|  | 6. 00         | 7. 00         |       |               |      |         |
| ANCILLARY SERVICE COST CENTERS                   |               |               |       |               |      |         |
| 50.00   05000   OPERATING ROOM                   | 703, 099      |               |       |               |      | 50.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 566, 761      | 0             |       |               |      | 54.00   |
| 54. 03   05401   NUCLEAR MEDICINE-DIAGNOSTIC     | 76, 365       | 0             |       |               |      | 54. 03  |
| 60. 00   06000   LABORATORY                      | 803, 304      | 0             |       |               |      | 60.00   |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 13, 868       | 0             |       |               |      | 62.00   |
| 65. 00 06500 RESPI RATORY THERAPY                | 414, 831      | 0             |       |               |      | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                   | 490, 292      | 0             |       |               |      | 66. 00  |
| 67. 00 06700 OCCUPATI ONAL THERAPY               | 75, 594       | 0             |       |               |      | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                     | 17, 983       | 0             |       |               |      | 68. 00  |
| 69. 00   06900   ELECTROCARDI OLOGY              | 0             | 0             |       |               |      | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 182, 520      |               |       |               |      | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS       | 247, 367      | 0             |       |               |      | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 1, 477, 358   |               | 1     |               |      | 73.00   |
| 76. 00 03480 I NFUSI ON THERAPY                  | 117, 960      | 0             |       |               |      | 76. 00  |
| OUTPATIENT SERVICE COST CENTERS                  |               |               |       |               |      |         |
| 88.00 08800 FORT BRANCH RHC                      |               |               |       |               |      | 88. 00  |
| 88.01   08801   CLARK & WELLS RHC                |               |               |       |               |      | 88. 01  |
| 90. 00  09000   CLI NI C                         | 0             | 0             |       |               |      | 90.00   |
| 90. 01  09001   DI ABETES                        | 29            | 0             |       |               |      | 90. 01  |
| 90. 02   09002   0P PSYCH                        | 0             | 0             |       |               |      | 90. 02  |
| 90. 03   09003   PAI N MANAGEMENT                | 191, 054      |               |       |               |      | 90. 03  |
| 91. 00   09100   EMERGENCY                       | 951, 399      |               |       |               |      | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 562, 429      |               |       |               |      | 92.00   |
| 200.00 Subtotal (see instructions)               | 6, 892, 213   | 446           |       |               |      | 200.00  |
| 201.00 Less PBP Clinic Lab. Services-Program     | 0             |               |       |               |      | 201.00  |
| Only Charges                                     |               |               |       |               |      |         |
| 202.00   Net Charges (line 200 - line 201)       | 6, 892, 213   | 446           |       |               |      | 202. 00 |

| Health Financial Systems                | GIBSON GENERAL HOSPITAL | In Lie                      | u of Form CMS-2                | 2552-10 |
|---|-------------------------|-----------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-1319  | Peri od:<br>From 10/01/2019 | Worksheet D-1                  |         |
|   |                         |                             | Date/Time Pre<br>4/28/2021 8:1 |         |
|   | Title XVIII             | Hospi tal                   | Cost                           |         |
| Cost Center Description                 |                         |                             |                                |         |
|   |                         |                             | 1 00                           |         |

| -                |  | Title XVIII                | Hospi tal          | 4/28/2021 8: 1<br>Cost | o alli           |
|------------------|--|----------------------------|--------------------|------------------------|------------------|
|                  | Cost Center Description  |                            | 110001 (41         | 3331                   |                  |
|                  |  |                            |                    | 1. 00                  |                  |
|                  | PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS  |                            |                    |                        |                  |
| 1. 00            | Inpatient days (including private room days and swing-bed day  | s. excluding newborn)      |                    | 3, 115                 | 1.00             |
| 2. 00            | Inpatient days (including private room days, excluding swing-  |                            |                    | 1, 434                 | 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.   |                            |                    | 700                    | 4 00             |
| 4. 00<br>5. 00   | Semi-private room days (excluding swing-bed and observation b<br>Total swing-bed SNF type inpatient days (including private ro |                            | or 21 of the cost  | 729<br>0               | 4. 00<br>5. 00   |
| 5.00             | reporting period   | on days) through becembe   | si 31 oi the cost  | U                      | 3.00             |
| 6. 00            | Total swing-bed SNF type inpatient days (including private ro  | om days) after December    | 31 of the cost     | 1, 055                 | 6.00             |
|                  | reporting period (if calendar year, enter 0 on this line)  |                            |                    |                        |                  |
| 7. 00            | Total swing-bed NF type inpatient days (including private roo reporting period   | m days) through December   | 31 of the cost     | 626                    | 7. 00            |
| 8. 00            | Total swing-bed NF type inpatient days (including private roo  | m davs) after December 3   | 31 of the cost     | 0                      | 8.00             |
| 0.00             | reporting period (if calendar year, enter 0 on this line)  | dayo, arto. boodbor        |                    | · ·                    | 0.00             |
| 9. 00            | Total inpatient days including private room days applicable t  | o the Program (excluding   | swing-bed and      | 373                    | 9. 00            |
| 10.00            | newborn days) (see instructions)   | nly (including private r   | soom dovo)         | 0                      | 10 00            |
| 10. 00           | Swing-bed SNF type inpatient days applicable to title XVIII o<br>through December 31 of the cost reporting period (see instruc |                            | oom days)          | 0                      | 10.00            |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII o  |                            | room days) after   | 1, 055                 | 11.00            |
|                  | December 31 of the cost reporting period (if calendar year, e  | nter O on this line)       | <i>3</i> ,         |                        |                  |
| 12.00            | Swing-bed NF type inpatient days applicable to titles V or XI  | X only (including privat   | e room days)       | 0                      | 12.00            |
| 13. 00           | through December 31 of the cost reporting period<br>Swing-bed NF type inpatient days applicable to titles V or XI              | X only (including privat   | e room days)       | 0                      | 13.00            |
| 13.00            | 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)   |                            |                    | 0                      | 15.00            |
| 16. 00           | Nursery days (title V or XIX only)   |                            |                    | 0                      | 16.00            |
| 17 00            | SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service   | os through Docombor 21 o   | of the cost        |                        | 17. 00           |
| 17.00            | reporting period   | es till ough becember 31 c | or the cost        |                        | 17.00            |
| 18.00            | Medicare rate for swing-bed SNF services applicable to servic  | es after December 31 of    | the cost           |                        | 18.00            |
|                  | reporting period   |                            |                    |                        |                  |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to service  | s through December 31 of   | the cost           | 129. 14                | 19. 00           |
| 20. 00           | reporting period<br>Medicaid rate for swing-bed NF services applicable to service  | s after December 31 of t   | he cost            | 129. 14                | 20.00            |
|                  | reporting period   |                            |                    |                        |                  |
| 21. 00           | Total general inpatient routine service cost (see instruction  |                            |                    | 5, 717, 880            | 1                |
| 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)<br>Swing-bed cost applicable to SNF type services after December  | 31 of the cost reportin    | na neriod (line A  | 0                      | 23. 00           |
| 20.00            | x line 18)   | or or the cost reportin    | ig period (iiiie d |                        | 20.00            |
| 24.00            | 1 3 11 31  | r 31 of the cost reporti   | ng period (line    | 80, 842                | 24.00            |
| 05.00            | 7 x line 19)   |                            |                    |                        |                  |
| 25. 00           | Swing-bed cost applicable to NF type services after December x line 20)  | 31 of the cost reporting   | period (line 8     | 0                      | 25.00            |
| 26. 00           |  |                            |                    | 2, 470, 185            | 26.00            |
| 27. 00           | General inpatient routine service cost net of swing-bed cost   | (line 21 minus line 26)    |                    | 3, 247, 695            |                  |
|                  | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   |                            |                    |                        |                  |
|                  | General inpatient routine service charges (excluding swing-be  | d and observation bed ch   | narges)            | 0                      | 28.00            |
| 29. 00<br>30. 00 | Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)                     |                            |                    | 0                      | 29. 00<br>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                  | 1                |
| 33.00            | Average semi-private room per diem charge (line 30 ÷ line 4)   |                            |                    | 0. 00                  | 1                |
| 34.00            | Average per diem private room charge differential (line 32 mi  |                            | ctions)            | 0.00                   | 1                |
| 35. 00<br>36. 00 | Average per diem private room cost differential (line 34 x li<br>Private room cost differential adjustment (line 3 x line 35)  | ne 31)                     |                    | 0.00                   | 35. 00<br>36. 00 |
| 37. 00           | General inpatient routine service cost net of swing-bed cost   | and private room cost di   | fferential (line   |                        | 1                |
| 200              | 27 minus line 36)  |                            |                    |                        |                  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                            |                    |                        |                  |
| 20.00            | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ  |                            |                    | 2 2/4 72               | 20.00            |
| 38. 00<br>39. 00 | Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line    | ,                          |                    | 2, 264. 78<br>844, 763 |                  |
| 40.00            | Medically necessary private room cost applicable to the Progr  | •                          |                    | 044, 703               | 40.00            |
|                  | Total Program general inpatient routine service cost (line 39  |                            |                    | 844, 763               |                  |
|                  | ·  |                            | '                  | '                      |                  |

|                  | Financial Systems  | GIBSON GENERA     |                   |                           |                             | u of Form CMS-2                |                  |
|------------------|--|-------------------|-------------------|---------------------------|-----------------------------|--------------------------------|------------------|
| COMPUT           | ATION OF INPATIENT OPERATING COST  |                   | Provi der C       | CN: 15-1319               | Peri od:<br>From 10/01/2019 | Worksheet D-1                  |                  |
|                  |  |                   |                   |                           | To 09/30/2020               | Date/Time Pre<br>4/28/2021 8:1 |                  |
|                  |  |                   |                   | e XVIII                   | Hospi tal                   | Cost                           |                  |
|                  | Cost Center Description  | Total             | Total             | Average Per               | Program Days                | Program Cost                   |                  |
|                  |  | Inpatient<br>Cost | Inpatient<br>Days | Diem (col. 1<br>÷ col. 2) |                             | (col. 3 x col. 4)              |                  |
|                  |  | 1. 00             | 2. 00             | 3.00                      | 4.00                        | 5. 00                          |                  |
| 42. 00           | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units                    |                   |                   |                           |                             |                                | 42.00            |
| 43. 00           | INTENSIVE CARE UNIT  | 275, 093          | 77                | 3, 572. 6                 | 4 22                        | 78, 598                        | 43.00            |
| 44.00            | CORONARY CARE UNIT   |                   |                   |                           |                             |                                | 44.00            |
| 45. 00<br>46. 00 | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT  |                   |                   |                           |                             |                                | 45. 00<br>46. 00 |
|                  | OTHER SPECIAL CARE (SPECIFY)   |                   |                   |                           |                             |                                | 47.00            |
|                  | Cost Center Description  |                   |                   |                           |                             | 1.00                           |                  |
| 48. 00           | Program inpatient ancillary service cost (Wk   | st D-3 col 3      | R Line 200)       |                           |                             | 1. 00<br>461, 007              | 48. 00           |
|                  | Total Program inpatient costs (sum of lines  |                   |                   | ons)                      |                             | 1, 384, 368                    | 1                |
| FO 00            | PASS THROUGH COST ADJUSTMENTS  | ationt mouting    | assulass (fra     | m Wko+ D ou               | m of Donto L one            | 0                              | FO 00            |
| 50. 00           | Pass through costs applicable to Program inp   | atient routine    | services (Tro     | m wkst. D, Su             | m or Parts I and            | 0                              | 50.00            |
| 51.00            | Pass through costs applicable to Program inp   | atient ancillar   | ry services (f    | rom Wkst. D,              | sum of Parts II             | 0                              | 51.00            |
| 52. 00           | and IV) Total Program excludable cost (sum of lines  | 50 and 51)        |                   |                           |                             | 0                              | 52.00            |
| 53. 00           | Total Program inpatient operating cost exclu   |                   | elated, non-ph    | ysician anest             | hetist, and                 | o o                            |                  |
|                  | medical education costs (line 49 minus line  | 52)               | ·                 |                           |                             |                                |                  |
| 54 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)  | ing cost and to   | wast smallet (    | lino E/ minuo             | Line E2)                    | 0                              |                  |
| 58.00            | Difference between adjusted inpatient operat<br>Bonus payment (see instructions)             | ing cost and ta   | irget amount (    | Time 56 III nus           | 111le 53)                   | 0                              | 1                |
| 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<br>Lesser of lines 53/54 or 55 from prior year                                 | cost report ur    | ndated by the     | markat haskat             |                             | 0.00                           | 60.00            |
|                  | If line 53/54 is less than the lower of line   |                   |                   |                           |                             | 0.00                           | 1                |
|                  | which operating costs (line 53) are less tha   |                   | s (lines 54 x     | 60), or 1% o              | f the target                |                                |                  |
| 62. 00           | amount (line 56), otherwise enter zero (see Relief payment (see instructions)                | Instructions)     |                   |                           |                             | 0                              | 62.00            |
|                  | Allowable Inpatient cost plus incentive paym   | ent (see instru   | ıcti ons)         |                           |                             | 0                              | 1                |
| 44.00            | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos        | ts through Doos   | mbor 21 of th     | a cost rapart             | ing ported (See             | 0                              | 64.00            |
| 64. 00           | instructions)(title XVIII only)  | ts through bece   | amber 31 OF th    | e cost report             | riig perrou (see            |                                | 04.00            |
| 65. 00           | Medicare swing-bed SNF inpatient routine cos   | ts after Decemb   | oer 31 of the     | cost reportin             | g period (See               | 2, 389, 343                    | 65.00            |
| 66. 00           | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi                 | ne costs (line    | 64 plus line      | 65)(title XVI             | II only). For               | 2, 389, 343                    | 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   | December 31       | of the cost n             | eporting period             | 0                              | 67.00            |
| 68. 00           | Title V or XIX swing-bed NF inpatient routin   | e costs after [   | December 31 of    | the cost rep              | orting period               | 0                              | 68.00            |
| 40.00            | (line 13 x line 20)  | routing costs (   | ilina (7 . lin    | o (0)                     |                             |                                | 40.00            |
| 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   | ity/ICF/IID rou   | ıtine service     | cost (line 37             | )                           |                                | 70.00            |
| 71. 00<br>72. 00 | Adjusted general inpatient routine service c<br>Program routine service cost (line 9 x line  |                   | ine 70 ÷ line     | 2)                        |                             |                                | 71. 00<br>72. 00 |
| 73. 00           | Medically necessary private room cost applic   | ,                 | n (line 14 x l    | ine 35)                   |                             |                                | 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 (from     | Worksheet B,              | Part II, column             |                                | 75.00            |
| 76. 00           | Per diem capital-related costs (line 75 ÷ li   |                   |                   |                           |                             |                                | 76.00            |
| 77. 00<br>78. 00 | Program capital-related costs (line 9 x line   Inpatient routine service cost (line 74 minu  | ,                 |                   |                           |                             |                                | 77. 00<br>78. 00 |
| 79. 00           | Aggregate charges to beneficiaries for exces   | ,                 | provi der recor   | ds)                       |                             |                                | 79.00            |
| 80.00            | Total Program routine service costs for comp   |                   | cost limitatio    | n (line 78 mi             | nus line 79)                |                                | 80.00            |
| 81. 00<br>82. 00 | Inpatient routine service cost per diem limi<br>Inpatient routine service cost limitation (I |                   | 1)                |                           |                             |                                | 81. 00<br>82. 00 |
| 83. 00           | Reasonable inpatient routine service costs (   |                   | * .               |                           |                             |                                | 83.00            |
| 84.00            | Program inpatient ancillary services (see in   | structions)       |                   |                           |                             |                                | 84.00            |
| 85. 00<br>86. 00 | Utilization review - physician compensation<br>Total Program inpatient operating costs (sum  | •                 |                   |                           |                             |                                | 85. 00<br>86. 00 |
|                  | PART IV - COMPUTATION OF OBSERVATION BED PAS   |                   |                   |                           |                             |                                |                  |
| 87. 00<br>88. 00 | Total observation bed days (see instructions   | •                 | Line 2)           |                           |                             | 705                            |                  |
| 88. 00<br>89. 00 | Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se     | ,                 |                   |                           |                             | 2, 264. 78<br>1, 596, 670      |                  |
|                  |  |                   |                   |                           |                             | ,                              |                  |

| Health Financial Systems                    | GI BSON 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 10/01/2019<br>To 09/30/2020 |                 |         |
|   |                | 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                 | 579, 374       | 5, 717, 880  | 0. 10132   | 7 1, 596, 670                    | 161, 786        | 90.00   |
| 91.00 Nursing School cost                   | 0              | 5, 717, 880  | 0.00000    | 0 1, 596, 670                    | 0               | 91.00   |
| 92.00 Allied health cost                    | 0              | 5, 717, 880  | 0.00000    | 0 1, 596, 670                    | 0               | 92.00   |
| 93.00 All other Medical Education           | o              | 5, 717, 880  | 0.00000    | 0 1, 596, 670                    | 0               | 93.00   |

| Health Financial Systems                | GI BSON GENERAL HOSPI TAL | In Lie                      | u of Form CMS-2                | 2552-10 |
|---|---------------------------|-----------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-1319    | Peri od:<br>From 10/01/2019 | Worksheet D-1                  |         |
|   |                           |                             | Date/Time Pre<br>4/28/2021 8:1 |         |
|   | Title XIX                 | Hospi tal                   | Cost                           |         |
| Cost Center Description                 |                           |                             |                                |         |
|   |                           |                             | 1. 00                          |         |

|                  |  | Title XIX                     | Hospi tal         | 4/28/2021 8: 1<br>Cost | o alli           |
|------------------|--|-------------------------------|-------------------|------------------------|------------------|
|                  | Cost Center Description  | THE ONLY                      | 110001 (41        | 3331                   |                  |
|                  | E  |                               |                   | 1. 00                  |                  |
|                  | PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS  |                               |                   |                        |                  |
| 1. 00            | Inpatient days (including private room days and swing-bed day  | s. excluding newborn)         |                   | 3, 115                 | 1.00             |
| 2. 00            | Inpatient days (including private room days, excluding swing-  | ,                             |                   | 1, 434                 | 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             |
|                  | do not complete this line.   |                               |                   |                        |                  |
| 4.00             | Semi-private room days (excluding swing-bed and observation b  |                               | v≈ 21 of the coet | 729                    | 4.00             |
| 5. 00            | Total swing-bed SNF type inpatient days (including private ro  | on days) through becembe      | er or the cost    | 264                    | 5.00             |
| 6. 00            | Total swing-bed SNF type inpatient days (including private ro  | om days) after December       | 31 of the cost    | 791                    | 6.00             |
|                  | reporting period (if calendar year, enter 0 on this line)  | 3 7                           |                   |                        |                  |
| 7.00             | Total swing-bed NF type inpatient days (including private roo  | m days) through December      | 31 of the cost    | 203                    | 7. 00            |
| 8. 00            | reporting period Total swing-bed NF type inpatient days (including private roo   | m days) after December 3      | of the cost       | 423                    | 8.00             |
| 6.00             | reporting period (if calendar year, enter 0 on this line)  | ill days) at tel becelliber 3 | of the cost       | 423                    | 8.00             |
| 9. 00            | Total inpatient days including private room days applicable t  | o the Program (excluding      | swing-bed and     | 18                     | 9. 00            |
|                  | newborn days) (see instructions)   |                               | , c               |                        |                  |
| 10. 00           | Swing-bed SNF type inpatient days applicable to title XVIII o  |                               | room days)        | 0                      | 10.00            |
| 11. 00           | through December 31 of the cost reporting period (see instruc<br>Swing-bed SNF type inpatient days applicable to title XVIII o |                               | coom days) after  | 0                      | 11.00            |
| 11.00            | December 31 of the cost reporting period (if calendar year, e  |                               | oom days) arter   |                        | 11.00            |
| 12.00            | Swing-bed NF type inpatient days applicable to titles V or XI  |                               | e room days)      | 0                      | 12.00            |
|                  | through December 31 of the cost reporting period   |                               |                   |                        |                  |
| 13. 00           |  |                               |                   | 0                      | 13.00            |
| 14. 00           | after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr    |                               |                   | 0                      | 14.00            |
| 15. 00           | Total nursery days (title V or XIX only)   | all (excluding swing-bed      | uays)             | 0                      | 15.00            |
|                  | Nursery days (title V or XIX only)   |                               |                   | 0                      | 16.00            |
|                  | SWING BED ADJUSTMENT   |                               |                   |                        |                  |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to servic  | es through December 31 c      | of the cost       |                        | 17. 00           |
| 10.00            | reporting period   | <del></del>                   | 46                |                        | 10.00            |
| 18. 00           | Medicare rate for swing-bed SNF services applicable to servic reporting period   | es arter becember 31 of       | the cost          |                        | 18. 00           |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to service  | s through December 31 of      | the cost          | 0. 00                  | 19.00            |
|                  | reporting period   | · ·                           |                   |                        |                  |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to service  | s after December 31 of t      | the cost          | 0. 00                  | 20.00            |
| 21. 00           | reporting period Total general inpatient routine service cost (see instruction   | 6)                            |                   | 5, 717, 880            | 21.00            |
| 22. 00           | Swing-bed cost applicable to SNF type services through Decemb  |                               | ing period (line  |                        | 22.00            |
| 22.00            | 5 x line 17)   | o. o. o. t doot rope. t       | ing portou (init  |                        | 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            |
| 04.00            | x line 18)   | 24 - 6 11 1                   |                   |                        | 04.00            |
| 24. 00           | Swing-bed cost applicable to NF type services through Decembe $ 7 \times  $ Line 19)   | r 31 of the cost reporti      | ng period (line   | 0                      | 24.00            |
| 25. 00           | Swing-bed cost applicable to NF type services after December   | 31 of the cost reporting      | period (line 8    | 0                      | 25. 00           |
| 20.00            | x line 20)   | or or the door roper tring    | , por ou (11110 0 | · ·                    | 20.00            |
| 26. 00           | 9 ( ,  |                               |                   | 2, 423, 609            |                  |
| 27. 00           | General inpatient routine service cost net of swing-bed cost   | (line 21 minus line 26)       |                   | 3, 294, 271            | 27. 00           |
| 20 00            | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be                             | d and observation had sh      | argos)            | 0                      | 28. 00           |
| 29.00            |  | d and observation bed cr      | iai yes)          | 0                      |                  |
| 30.00            | Semi - pri vate room charges (excluding swing-bed charges)   |                               |                   | 0                      | 30.00            |
| 31.00            | General inpatient routine service cost/charge ratio (line 27   | ÷ line 28)                    |                   | 0. 000000              |                  |
| 32.00            | Average private room per diem charge (line 29 ÷ line 3)  |                               |                   | 0. 00                  | 1                |
| 33.00            | Average semi-private room per diem charge (line 30 ÷ line 4)   |                               |                   | 0.00                   | 1                |
| 34.00            | Average per diem private room charge differential (line 32 mi  |                               | CTI ONS)          | 0.00                   | 1                |
| 35. 00<br>36. 00 | Average per diem private room cost differential (line 34 x li<br>Private room cost differential adjustment (line 3 x line 35)  | ile 31)                       |                   | 0.00                   | 35. 00<br>36. 00 |
| 37.00            | General inpatient routine service cost net of swing-bed cost   | and private room cost di      | fferential (line  |                        | 37.00            |
|                  | 27 minus line 36)  |                               |                   |                        |                  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                               |                   |                        |                  |
| 00.05            | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ  |                               |                   | 0.007.5                | 00.05            |
| 38.00            | ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '  | •                             |                   | 2, 297. 26             |                  |
| 39. 00<br>40. 00 | Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr    | •                             |                   | 41, 351<br>0           | 39. 00<br>40. 00 |
|                  | Total Program general inpatient routine service cost (line 39  |                               |                   | 41, 351                |                  |
|                  |  | ,                             | ,                 |                        |                  |

|   | Financial Systems   | GIBSON GENERA      |                    |                             |                             | u of Form CMS-2                |                  |
|---|---|--------------------|--------------------|-----------------------------|-----------------------------|--------------------------------|------------------|
| COMPUT  | TATION OF INPATIENT OPERATING COST  |                    | Provider C         | CN: 15-1319                 | Peri od:<br>From 10/01/2019 | Worksheet D-1                  |                  |
|   |   |                    |                    |                             | To 09/30/2020               | Date/Time Pre<br>4/28/2021 8:1 |                  |
|   |   | T. I. I            |                    | e XIX                       | Hospi tal                   | Cost                           |                  |
|   | Cost Center Description   | Total<br>Inpatient | Total<br>Inpatient | Average Per<br>Diem (col. 1 | Program Days                | Program Cost<br>(col. 3 x      |                  |
|   |   | Cost               | Days               | ÷ col . 2)                  | 1.00                        | col . 4)                       |                  |
| 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<br>44. 00  | INTENSIVE CARE UNIT   | 275, 093           | 77                 | 3, 572. 6                   | 0                           | 0                              | 43. 00<br>44. 00 |
| 45. 00  | BURN INTENSIVE CARE UNIT  |                    |                    |                             |                             |                                | 45. 00           |
|   | SURGICAL INTENSIVE CARE UNIT  |                    |                    |                             |                             |                                | 46.00            |
| 47.00   | OTHER SPECIAL CARE (SPECIFY)  Cost Center Description   |                    |                    |                             |                             |                                | 47.00            |
|   | <u> </u>  |                    |                    |                             |                             | 1.00                           |                  |
| 48. 00<br>49. 00  | Program inpatient ancillary service cost (Wk<br>Total Program inpatient costs (sum of lines   |                    |                    | ons)                        |                             | 20, 996<br>62, 347             | 1                |
| 47.00   | PASS THROUGH COST ADJUSTMENTS   | +1 till odgil +0)  | (See Thatructi     | 01137                       |                             | 02, 347                        | 47.00            |
| 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    | ry services (f     | rom Wkst. D,                | sum of Parts II             | 0                              | 51.00            |
| F0 00   | and IV)   | FO   F4)           |                    |                             |                             |                                | F0 00            |
| 52. 00<br>53. 00  | Total Program excludable cost (sum of lines<br>Total Program inpatient operating cost exclu   |                    | elated, non-ph     | vsician anest               | hetist. and                 | 0                              |                  |
|   | medical education costs (line 49 minus line   |                    |                    |                             |                             | _                              |                  |
| 54 00   | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges  |                    |                    |                             |                             | 0                              | 54.00            |
|   | Target amount per discharge   |                    |                    |                             |                             |                                | 55.00            |
| 56. 00<br>57. 00  | Target amount (line 54 x line 55) Difference between adjusted inpatient operat                | ing cost and to    | argot amount (     | lino 56 minus               | lino 52)                    | 0                              |                  |
| 58. 00  | Bonus payment (see instructions)  | ing cost and ta    | arget amount (     | Title 50 illitius           | 111le 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                           | 59. 00           |
| 60. 00  | market basket<br>Lesser of lines 53/54 or 55 from prior year                                  | cost report, up    | odated by the      | market basket               |                             | 0.00                           | 60.00            |
| 61.00   | If line 53/54 is less than the lower of line  | s 55, 59 or 60     | enter the les      | ser of 50% of               | the amount by               | 0                              | 61.00            |
|   | which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see      |                    |                    |                             |                             |                                |                  |
| 62.00   | 62.00 Relief payment (see instructions)   |                    |                    |                             |                             |                                |                  |
| 63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST |   |                    |                    |                             |                             |                                | 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  | <pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>       | ts after Decemb    | ner 31 of the      | cost renortin               | n neriod (See               | 0                              | 65.00            |
|   | instructions)(title XVIII only)   |                    |                    | ·                           |                             |                                |                  |
| 66. 00  | Total Medicare swing-bed SNF inpatient routi CAH (see instructions)                           | ne costs (line     | 64 plus line       | 65)(title XVI               | II only). For               | 0                              | 66.00            |
| 67.00   | ,   | e costs through    | n December 31      | of the cost r               | eporting period             | 0                              | 67.00            |
| 68. 00  | (line 12 x line 19) Title V or XIX swing-bed NF inpatient routin                              | o costs after [    | Docombor 21 of     | the cost ron                | orting ported               | _                              | 68. 00           |
| 08.00   | (line 13 x line 20)   | e costs after t    | December 31 of     | the cost rep                | or tring perrou             |                                | 08.00            |
| 69. 00  | Total title V or XIX swing-bed NF inpatient<br>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  |                    | line 70 ÷ line     | 2)                          |                             |                                | 71.00            |
| 72. 00<br>73. 00  | Program routine service cost (line 9 x line Medically necessary private room cost applic      | ,                  | m (line 14 x l     | ine 35)                     |                             |                                | 72. 00<br>73. 00 |
| 74.00   | Total Program general inpatient routine serv  | •                  |                    | •                           |                             |                                | 74.00            |
| 75. 00  | Capital-related cost allocated to inpatient 26, line 45)                                      | routine service    | e costs (from      | Worksheet B,                | Part II, column             |                                | 75.00            |
| 76. 00  | Per diem capital-related costs (line 75 ÷ li  |                    |                    |                             |                             |                                | 76. 00           |
| 77. 00<br>78. 00  | Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu     | ,                  |                    |                             |                             |                                | 77. 00<br>78. 00 |
| 79. 00  | Aggregate charges to beneficiaries for exces  | ,                  | orovi der recor    | ds)                         |                             |                                | 79.00            |
| 80. 00<br>81. 00  | Total Program routine service costs for comp<br>Inpatient routine service cost per diem limi  |                    | cost limitatio     | n (line 78 mi               | nus line 79)                |                                | 80. 00<br>81. 00 |
| 82. 00  | Inpatient routine service cost per drem rimi  |                    | 1)                 |                             |                             |                                | 82.00            |
| 83.00   | Reasonable inpatient routine service costs (  |                    | ns)                |                             |                             |                                | 83.00            |
| 84. 00<br>85. 00  | Program inpatient ancillary services (see in Utilization review - physician compensation      |                    | ons)               |                             |                             |                                | 84. 00<br>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<br>Total observation bed days (see instructions |                    |                    |                             |                             | 705                            | 87.00            |
| 88. 00  | Adjusted general inpatient routine cost per   | diem (line 27 =    |                    |                             |                             | 2, 297. 26                     | 88. 00           |
| 89. 00  | Observation bed cost (line 87 x line 88) (se  | e instructions)    | )                  |                             |                             | 1, 619, 568                    | 89. 00           |

| Health Financial Systems                    | GI BSON 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 10/01/2019<br>To 09/30/2020 |                 |         |
|   |                |              | 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                 | 579, 374       | 5, 717, 880  | 0. 10132   | 1, 619, 568                      | 164, 106        | 90.00   |
| 91.00 Nursing School cost                   | 0              | 5, 717, 880  | 0.00000    | 1, 619, 568                      | 0               | 91.00   |
| 92.00 Allied health cost                    | 0              | 5, 717, 880  | 0.00000    | 1, 619, 568                      | 0               | 92.00   |
| 93.00 All other Medical Education           | o              | 5, 717, 880  | 0.00000    | 1, 619, 568                      | 0               | 93. 00  |

| Health Fina        | ncial Systems GIBSON GENERAL  | HOSPI TAI   |                            | In lie                                  | u of Form CMS-:                           | 2552-10             |
|--------------------|---|-------------|----------------------------|---|---|---------------------|
|                    | ANCILLARY SERVICE COST APPORTIONMENT  | Provi der C | CN: 15-1319                | Peri od:                                | Worksheet D-3                             |                     |
|                    |   |             |                            | From 10/01/2019<br>To 09/30/2020        | Date/Time Pre<br>4/28/2021 8:1            |                     |
|                    |   | Title       | XVIII                      | Hospi tal                               | Cost                                      |                     |
|                    | Cost Center Description   |             | Ratio of Cos<br>To Charges | Program<br>Charges                      | Inpatient Program Costs (col. 1 x col. 2) |                     |
|                    |   |             | 1. 00                      | 2. 00                                   | 3. 00                                     |                     |
|                    | TIENT ROUTINE SERVICE COST CENTERS  |             |                            |   |   |                     |
|                    | O ADULTS & PEDIATRICS   |             |                            | 345, 997                                |   | 30.00               |
|                    | O INTENSIVE CARE UNIT   |             |                            | 44, 872                                 |   | 31.00               |
|                    | LLARY SERVICE COST CENTERS  |             |                            |   |   |                     |
|                    | OPERATING ROOM  |             | 0. 3982                    |   | 18, 838                                   |                     |
|                    | O RADI OLOGY-DI AGNOSTI C   |             | 0. 1941:                   |   | 18, 605                                   |                     |
|                    | 1 NUCLEAR MEDICINE-DIAGNOSTIC   |             | 0. 4658                    |   | 0   | 54. 03              |
|                    | O LABORATORY  |             | 0. 4422!                   |   | 78, 491                                   | 60.00               |
|                    | O WHOLE BLOOD & PACKED RED BLOOD CELLS  |             | 0. 4140                    |   | 11, 065                                   |                     |
|                    | RESPI RATORY THERAPY  |             | 0. 5049!                   |   | 62, 098                                   | 1                   |
|                    | O PHYSI CAL THERAPY   |             | 0. 3688                    |   | 18, 910                                   |                     |
|                    | O OCCUPATI ONAL THERAPY   |             | 0. 2904                    |   | 7, 834                                    | 1                   |
|                    | O SPEECH PATHOLOGY  |             | 0. 3006                    |   | 1, 716                                    |                     |
|                    | 0 ELECTROCARDI OLOGY  |             | 0. 00000                   |   | 0   |                     |
|                    | O MEDICAL SUPPLIES CHARGED TO PATIENT   |             | 0. 89590                   |   | 70, 327                                   | 1                   |
|                    | O IMPL. DEV. CHARGED TO PATIENTS  |             | 0. 95893                   |   | 1, 656                                    |                     |
|                    | DRUGS CHARGED TO PATIENTS   |             | 0. 44520                   |   | 141, 045                                  |                     |
|                    | O I NFUSI ON THERAPY  |             | 0. 45190                   | 07 347                                  | 157                                       | 76. 00              |
|                    | ATIENT SERVICE COST CENTERS   |             | 0.0000                     | 20                                      |   | 00.00               |
|                    | O FORT BRANCH RHC   |             | 0.00000                    |   | 0   |                     |
|                    | 1 CLARK & WELLS RHC   |             | 0.00000                    |   | 0   |                     |
|                    | O CLINIC  |             | 0.00000                    |   | 0   |                     |
|                    | 1 DI ABETES<br>2 OP PSYCH   |             | 0.0604                     |   | 0   |                     |
|                    | ZIOP PSYCH<br>3IPAIN MANAGEMENT   |             | 0.0000                     |   | 0   |                     |
|                    | O EMERGENCY   |             | 0. 62098                   |   | 0   |                     |
|                    |   |             | 0. 7165                    | · ·                                     | 20, 809                                   |                     |
|                    | O OBSERVATION BEDS (NON-DISTINCT PART   |             | 1. 8152                    |   | 9, 456                                    |                     |
| 200.00             | Total (sum of lines 50 through 94 and 96 through 98)  | (line (1)   |                            | 985, 890<br>0                           | 461, 007                                  |                     |
| 201. 00<br>202. 00 | Less PBP Clinic Laboratory Services-Program only charges<br>Net charges (line 200 minus line 201) | s (Tine 61) |                            | 985, 890                                |   | 201. 00<br>202. 00  |
| 202.00             | 1.10 C 5.10. 955 (11110 200 IIII 1100 11110 201)  |             | 1                          | , | I   | <sub>1</sub> -32.00 |

| Health Financial Systems   |                                     | ERAL HOSPITAL |                      |                             | u of Form CMS-2 |        |
|--|-------------------------------------|---------------|----------------------|-----------------------------|-----------------|--------|
| INPATIENT ANCILLARY SERVICE  | COST APPORTIONMENT                  | Provi der C   | CN: 15-1319          | Peri od:<br>From 10/01/2019 | Worksheet D-3   |        |
|  |                                     | Component     | CCN: 15-Z319         | To 09/30/2020               |                 | nared. |
|  |                                     | 00p0110111    |                      |                             | 4/28/2021 8: 1  |        |
|  |                                     | Ti tl e       | XVIII                | Swing Beds - SNF            |                 |        |
| Cost Center Desc   | i pti on                            |               | 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 SERV   |                                     |               | 1                    |                             |                 |        |
| 30. 00   03000 ADULTS & PEDI ATR                                   |                                     |               |                      | 0                           |                 | 30.00  |
| 31. 00 03100   NTENSI VE CARE U                                    |                                     |               |                      | 0                           |                 | 31.00  |
| ANCILLARY SERVICE COST   | CENTERS                             |               | 0.0000               | - 0                         | 0.000           |        |
| 50. 00   05000   OPERATING ROOM                                    | 271.0                               |               | 0. 39825             |                             |                 |        |
| 54. 00   05400   RADI OLOGY-DI AGNO                                |                                     |               | 0. 19413             |                             | l '             |        |
| 54. 03   05401 NUCLEAR MEDICINE                                    | DIAGNOSTIC                          |               | 0. 4658              |                             |                 |        |
| 60. 00   06000   LABORATORY  | OVED DED BLOOD CELLC                |               | 0. 44225             |                             |                 |        |
| 62.00   06200   WHOLE BLOOD & PA<br>65.00   06500 RESPIRATORY THER |                                     |               | 0. 41405<br>0. 50495 |                             | 806<br>68, 050  |        |
| 66. 00   06600 PHYSI CAL THERAPY                                   | APY                                 |               | 0. 3688              | · ·                         |                 |        |
| 67. 00 06600 PHYSICAL THERAPY                                      | DADV                                |               | 0. 3688              |                             |                 |        |
| 68. 00 06800 SPEECH PATHOLOGY                                      | APT                                 |               | 0. 30064             |                             | 9, 647          |        |
| 69. 00   06900   ELECTROCARDI OLOG                                 | ,                                   |               | 0. 00000             |                             | 9,647           |        |
| 71. 00 07100 MEDICAL SUPPLIES                                      |                                     |               | 0. 89590             |                             |                 |        |
| 72. 00 07200 I MPL. DEV. CHARG                                     |                                     |               | 0. 95893             |                             | l               | •      |
| 73. 00 07300 DRUGS CHARGED TO                                      |                                     |               | 0. 44520             |                             |                 |        |
| 76. 00 03480 I NFUSI ON THERAPY                                    | TATIENTS                            |               | 0. 45190             |                             |                 |        |
| OUTPATIENT SERVICE COS   | T CENTERS                           |               | 0.43170              | 1, 430                      | 000             | 70.00  |
| 88. 00 08800 FORT BRANCH RHC                                       | CENTERO                             |               | 0.00000              | 00                          | 0               | 88.00  |
| 88. 01   08801   CLARK & WELLS RH                                  |                                     |               | 0.00000              |                             | 0               |        |
| 90. 00 09000 CLI NI C  |                                     |               | 0. 00000             |                             | 0               | 90.00  |
| 90. 01 09001 DI ABETES   |                                     |               | 0.0604               |                             | 0               | 90.0   |
| 90. 02 09002 OP PSYCH  |                                     |               | 0.00000              |                             | Ō               |        |
| 90. 03   09003   PAI N MANAGEMENT                                  |                                     |               | 0. 62098             |                             | 0               |        |
| 91.00 09100 EMERGENCY  |                                     |               | 0. 71656             |                             | 0               | 91.0   |
| 92.00 09200 OBSERVATION BEDS                                       | (NON-DISTINCT PART                  |               | 1. 81529             | 95 585                      | 1, 062          | 92.0   |
|  | nes 50 through 94 and 96 through 98 | 3)            |                      | 1, 536, 329                 |                 |        |
|  | aboratory Services-Program only ch  |               |                      | 0                           |                 | 201.00 |
|  | e 200 minus line 201)               | · , ,         |                      | 1, 536, 329                 |                 | 202.00 |

|               | and all Contract                                       | OLDCON OFNEDAL HOCDITAL            |                            | 111  | G F ONG  | 2552.40          |
|---------------|--|------------------------------------|----------------------------|--|--|------------------|
|               | nncial Systems<br>ANCILLARY SERVICE COST APPORTIONMENT | GIBSON GENERAL HOSPITAL Provider C | CN: 15-1319                | Peri od:<br>From 10/01/2019<br>To 09/30/2020 | u of Form CMS-2<br>Worksheet D-3<br>Date/Time Pre<br>4/28/2021 8:1 | pared:           |
|               |  | Ti tl                              | e XIX                      | Hospi tal                                    | Cost   |                  |
|               | Cost Center Description                                |                                    | Ratio of Cos<br>To Charges | t Inpatient<br>Program<br>Charges            | Inpatient Program Costs (col. 1 x col. 2)                          |                  |
|               |  |                                    | 1. 00                      | 2. 00  | 3. 00  |                  |
|               | TIENT ROUTINE SERVICE COST CENTERS                     |                                    |                            |  |  |                  |
|               | O ADULTS & PEDIATRICS<br>O INTENSIVE CARE UNIT         |                                    |                            | 14, 404<br>1, 824                            |  | 30. 00<br>31. 00 |
|               | LLARY SERVICE COST CENTERS                             |                                    |                            |  |  |                  |
|               | O OPERATING ROOM<br>O RADIOLOGY-DIAGNOSTIC             |                                    | 0. 39825<br>0. 19413       |  |  |                  |
|               | 1 NUCLEAR MEDICINE-DIAGNOSTIC                          |                                    | 0. 4658                    |  | 277  | 54.03            |
|               | O LABORATORY   |                                    | 0. 4422!                   |  | 7, 693   | 60.00            |
|               | O WHOLE BLOOD & PACKED RED BLOOD CELLS                 |                                    | 0. 4140                    |  | 137  | 62.00            |
|               | O RESPIRATORY THERAPY                                  |                                    | 0. 5049                    |  | 3, 910   |                  |
|               | O PHYSI CAL THERAPY                                    |                                    | 0. 3688                    |  | 190  | 66.00            |
| 67. 00 0670   | O OCCUPATI ONAL THERAPY                                |                                    | 0. 2904                    | 72 0   | 0  | 67.00            |
| 68. 00 0680   | O SPEECH PATHOLOGY                                     |                                    | 0. 30064                   | 19 0   | 0  | 68.00            |
| 69. 00 0690   | O ELECTROCARDI OLOGY                                   |                                    | 0.00000                    | 00   | 0  | 69.00            |
| 71.00 0710    | O MEDICAL SUPPLIES CHARGED TO PATIENT                  |                                    | 0. 89590                   | 03   | 0  | 71.00            |
| 72. 00 0720   | O IMPL. DEV. CHARGED TO PATIENTS                       |                                    | 0. 95893                   | 35 0   | 0  | 72.00            |
| 73. 00 0730   | O DRUGS CHARGED TO PATIENTS                            |                                    | 0. 44520                   | 0  | 0  | 73.00            |
| 76. 00   0348 | O INFUSION THERAPY                                     |                                    | 0. 45190                   | 07   | 0  | 76.00            |
|               | ATLENT SERVICE COST CENTERS                            |                                    |                            |  |  |                  |
|               | O FORT BRANCH RHC                                      |                                    | 1. 2591                    | 71 0   | 0  | 88. 00           |
|               | 1 CLARK & WELLS RHC                                    |                                    | 1. 0360                    |  | 0  | 88. 01           |
|               | O CLI NI C   |                                    | 0. 00000                   |  | 0  | 90.00            |
|               | 1 DI ABETES  |                                    | 0. 0604                    |  | 0  | 90. 01           |
| 90. 02   0900 |  |                                    | 0. 00000                   |  | 0  | 90. 02           |
|               | 3 PAIN MANAGEMENT                                      |                                    | 0. 62098                   |  | 0  | 90. 03           |
|               | O EMERGENCY  |                                    | 0. 71656                   |  | 4, 773   | 91.00            |
|               | O OBSERVATION BEDS (NON-DISTINCT PART                  |                                    | 1. 81529                   |  | 0  | 92.00            |
| 200. 00       | Total (sum of lines 50 through 94 and 9                |                                    |                            | 47, 308                                      | 20, 996  |                  |
| 201. 00       | Less PBP Clinic Laboratory Services-Pro                | ogram only charges (line 61)       |                            | 0  |  | 201.00           |
| 202. 00       | Net charges (line 200 minus line 201)                  |                                    |                            | 47, 308                                      |  | 202. 00          |

| Health Financial Systems                | GIBSON GENERAL HOSPITAL | In Lie          | u of Form CMS-2552-10   |
|---|-------------------------|-----------------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-131   | From 10/01/2019 | Worksheet E<br>Part B<br>Date/Time Prepared:<br>4/28/2021 8:15 am |
|   |                         |                 |   |

| Moderal and other services (see Instructions)  |          |   | Title XVIII          | Hospi tal       | 4/28/2021 8:1<br>Cost | <u>5 am</u> |
|--|----------|---|----------------------|-----------------|-----------------------|-------------|
| PART B. WEDICAL AND OTHER WEAT IN SERVICES   0.000     |          |   | THE AVIII            | nospi tui       |                       |             |
| Medical and other services (see Instructions)  |          | DADT D. MEDICAL AND OTHER HEALTH CERVICES                         |                      |                 | 1. 00                 |             |
| Medical and other services relapureed under Day's (see Instructions)   | 1 00     |   |                      |                 | 6 892 659             | 1 00        |
| BPS payments   |          | 1   | s)                   |                 |                       | 1           |
| 0.011   pr   reconcil   atten amount (see instructions)   0.000   4.50   |          |   | /                    |                 |                       | 1           |
| Enter the hospit tal space if ic payment to cost ratio (see instructions)  | 4.00     | Outlier payment (see instructions)                                |                      |                 | 0                     | 4.00        |
| Line 2 times line 5  |          | 1   |                      |                 | _                     | 1           |
|  |          |   | ns)                  |                 |                       | 1           |
| 1.00   Content   |          |   |                      |                 | _                     | 1           |
|  |          |   |                      |                 |                       | 1           |
| 10.00   Organ acquist inos   10.00   Organ acquist inos   6,892,659   11.00   Organization for LESSER OF COST OR CHARGES   11.00   Organization for LESSER OF COST OR CHARGES   12.00   Acquisite acquisite    |          | ,   | col. 13. Line 200    |                 | _                     | 1           |
| Computation for Easses of Cost On Charges  |          |   |                      |                 | 0                     | 1           |
| Reasonable charges   | 11.00    | Total cost (sum of lines 1 and 10) (see instructions)             |                      |                 | 6, 892, 659           | 11.00       |
| 12.00   Ancillary service charges   0   12.00   13.00   Organ acquisition charges (from Wist. D-4, Pt. III), col. 4, line 69)   0   14.00   13.00   13.00   13.00   15.00      |          |   |                      |                 |                       | 1           |
| 3.00   Organ acquisition charges (from Wist, D.4, Pt. III, col. 4, line 69)  | 10.00    |   |                      |                 | 0                     | 10.00       |
| 14. 00   Total reasonable charges (sum of lines 12 and 13)   |          |   | 60)                  |                 | _                     |             |
| Customary charges  |          |   | 07)                  |                 | _                     | 1           |
| 15.00   Aggregate amount actually collected from patients   Table for payment for services on a charge basis   0   15.00   | 00       |   |                      |                 |                       | 1           |
| had such payment been made in accordance with 42 CFR \$413.13(e)   | 15.00    |   | ent for services on  | a charge basis  | 0                     | 15. 00      |
| 17.00   Ratio of line 1s to line 16 (not to exceed 1.000000)   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   | 16.00    |   | yment for services o | n a chargebasis | 0                     | 16.00       |
| 18.00   Total customary charges (see instructions)   0   18.00   19.   | 17.00    |   |                      |                 | 0.000000              | 17.00       |
| 19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00   Instructions)   6.961,586   21.00   22.00   Instructions   6.961,586   21.00   22.00   Cost of charges (see instructions)   6.961,586   21.00   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0   23.00   23.00   24.00   Cost of physicians' services in a teaching hospital (see instructions)   0   24.00   Computation of Retimburschemistry of lines 3, 4, 4.01, 8 and 9)   0   24.00   Computation of Retimburschemistry of lines 2, 4.01, 8 and 9)   0   24.00   Computation of Retimburschemistry of lines 2, 4.01, 8 and 9)   0   24.00   Computation of Retimburschemistry of lines 2, 4.01, 8 and 9)   0   24.00   Computation of Retimburschemistry of lines 2, 4.01, 8 and 9)   0   24.00   Computation of Retimburschemistry of lines 2, 4.01, 8 and 9)   0   24.00   Computation of Retimburschemistry of lines 2, 4.01, 8 and 26)   10   10   10   10   10   10   10   1  |          |   |                      |                 |                       | 1           |
| Instructions   |          |   | f line 18 exceeds li | ne 11) (see     |                       | 1           |
| Instructions   | . , . 00 | , ,   | o io onocodo         | , (555          |                       | .,          |
| 21.00   Lesser of cost or charges (see instructions)   0.20.00     | 20.00    | Excess of reasonable cost over customary charges (complete only i | f line 11 exceeds li | ne 18) (see     | 0                     | 20.00       |
| 22.00   Interns and residents (see instructions)   0.22.00   0.23.00   0.23.00   0.23.00   0.23.00   0.23.00   0.23.00   0.23.00   0.23.00   0.23.00   0.23.00   0.23.00   0.23.00   0.23.00   0.24.00   0.2   |          |   |                      |                 |                       |             |
| 23.00   Cost of physicians' services in a teaching hospital (see instructions)   0 23.00   24.00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   0 24.00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   0 24.00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   0 24.00   Deductibles and coinsurance amounts (for CAH, see instructions)   2,630,331   26.00   Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2,630,331   26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2,630,331   26.00   Destructions   2,7,786   26.00   Destructions   2,7,786   26.00   28.00   29.00   ESRD direct medical education costs (from West. E-4, line 36)   29.00   |          | ,   |                      |                 |                       | 1           |
| 24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   |          | 1   | ions)                |                 | _                     |             |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT   S.   33,48   25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   33,48   25.00   Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2,630,331   26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2,630,331   26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2,630,331   26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2,630,331   26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2,630,331   26.00   Deductible seed and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   28.00   Deductible seed and coinsurance amounts (from Wkst. E-4, line 36)   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   29.00   28.00   29.00     |          | ,                           | 10113)               |                 | 0                     | 1           |
| 26.00   Deductible and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2,630,331   26.00   28.00   28.00   Instructions)   4,277.87   78.77   78.77   78.77   78.00   28.00   28.00   ESRD direct medical education payments (from Wkst. E-4, line 50)   0.28.00   29.00   29.00   28.00   29.00   2   |          |   |                      |                 |                       | 1           |
| 27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23   (see   4,297,787   27.00  | 25.00    | Deductibles and coinsurance amounts (for CAH, see instructions)   |                      |                 | 33, 468               | 25. 00      |
| Instructions   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0.28.00   29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0.29.00   29   |          |   |                      |                 |                       | 1           |
| 28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28.00   0   29.00   | 27. 00   |   | the sum of lines 22  | ! and 23] (see  | 4, 297, 787           | 27.00       |
| 29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   3.00   | 28 00    |   | 50)                  |                 | 0                     | 28 00       |
| 30.00   Subtotal (sum of lines 27 through 29)   30.00   Primary payer payments   1.143   31.00   31.00   Subtotal (line 30 minus line 31)   4.296, 644   42.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from West 1-5, line 11)   0   33.00   Composite rate ESRD (from West 1-5, line 11)   0   33.00   Allowable bad debts (see instructions)   277, 786   34.00   35.00   Allowable bad debts (see instructions)   38.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   276, 135   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   4.477, 205   37.00   Subtotal (see instructions)   4.477, 205   37.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.90   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.90   99.97   Demonstration payment adjustment (see instructions)   0   39.97   99.97   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   99.90   99.    |          |   | 30)                  |                 |                       | 1           |
| 32.00   Subtortal (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)   0   33.00   Allowable bad debts (see instructions)   180,561   35.00   Adjusted reimbursable bad debts (see instructions)   277,786   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   276,135   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   276,135   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   276,135   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   4,477,205   37.00   Subtotal (see instructions)   4,477,205   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   Pioneer ACO demonstration payment adjustment sequestration   0   39.97   99.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   99.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   4,477,205   40.00   40.0   |          | ,   |                      |                 | 4, 297, 787           | 1           |
| ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   0   0   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   0   34.00   Allowable bad debts (see instructions)   277, 786   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   180, 561   35.00   37.00   Subtotal (see instructions)   276, 135   36.00   37.00   Subtotal (see instructions)   276, 135   36.00   37.00   MSP-LCC reconcilitation amount from PS&R   0   38.00   MSP-LCC reconcilitation amount from PS&R   0   39.00   MSP-LCC reconcilitation amount from PS&R   0   39.00   97.00   | 31.00    | Primary payer payments  |                      |                 | 1, 143                | 31.00       |
| 33.00   Composite rate ESRD (from Wkst. 1-5, line 11)  | 32. 00   |   |                      |                 | 4, 296, 644           | 32.00       |
| 34.00   All owable bad debts (see instructions)   277, 786   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   180, 561   35.00   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   276, 135   36.00   37.00   Subtotal (see instructions)   4,477,205   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97   Demonstration payment adjustment before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   4.477,205   40.00   40.01   Sequestration adjustment (see instructions)   4.477,205   40.01   40.02   Demonstration payment adjustment amount after sequestration   51,936   40.01   40.02   Demonstration payment adjustment amount after sequestration   4.260,089   41.00   41.01   Interim payments   4.260,089   41.00   42.00   Tentative settlement (for contractors use only)   42.00   Tentative settlement (for contractor use only)   42.01   Tentative settlement (for contractor use only)   42.01   43.00   Bal ance due provider/program (see instructions)   43.01   43.00   Bal ance due provider/program-PARHM (see instructions)   43.01   44.00   51.52   7.00   51.52   7.00      | 22.00    |   |                      |                 | 0                     | 22 00       |
| 35. 00   Adjusted reimbursable bad debts (see instructions)   180,561   35. 00   36. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   276,135   36. 00   37. 00   Subtotal (see instructions)   4,477,205   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 50   Ploneer ACO demonstration payment adjustment (see instructions)   39. 50   Ploneer ACO demonstration payment adjustment amount before sequestration   39. 97   Ploneer ACO demonstration payment adjustment amount before sequestration   39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   39. 97   99. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   4,477,205   40. 00   40. 03   4,477,205   40. 00   40. 03   4,477,205   40. 00   40. 03   4,477,205   40. 00   40. 02   Demonstration adjustment (see instructions)   51,936   40. 01   40. 02   40. 03   50. 04   40. 0   |          |   |                      |                 |                       |             |
| 36.00  |          |   |                      |                 |                       |             |
| 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)       39. 90         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 97         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         40. 00       Subtotal (see instructions)       4, 477, 205       40. 00         40. 01       Sequestration adjustment (see instructions)       51, 936       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       51, 936       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       40. 02       40. 03         40. 02       Demonstration payments       4, 260, 089       41. 00         41. 01       Interim payments       4, 260, 089       41. 00         41. 01       Interim payments-PARHM       42. 00       42. 00         42. 01       Tentative settlement (for contractor use only)       42. 01         43. 01       Bal ance due provider/program (see instructions)       165, 180         44. 00       Prote  |          | · · · · · · · · · · · · · · · · · · ·                             | i ons)               |                 |                       |             |
| 39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   91.00   39.00   39.50   92.00   39.50   92.00   39.50   93.90   39.50   93.90   94.00   94.   |          |   |                      |                 |                       |             |
| 39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   39.97   Demonstration payment adjustment amount before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   Accelerated Depreciation   0   39.98   Accovery of Accelerated Depreciation   0   39.98   Accovery of Accelerated Depreciation   0   39.98   Accovery of Accelerated Depreciation   0   39.98   Accovery of Accelerated Depreciation   0   39.98   Accovery of Accelerated Depreciation   0   39.99   Accovery of Accelerated Depreciation   0   39.99   Accovery of Accelerated Depreciation   0   39.99   Accovery of Accelerated Depreciation   0   40.01   According to According    |          |   |                      |                 |                       |             |
| 39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 4, 477, 205 40. 00 40. 01 Sequestration adjustment (see instructions) 51, 936 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 41. 00 Interim payments 41. 00 41. 01 Interim payments 42. 00 42. 01 Tentative settlement (for contractors use only) 41. 01 42. 00 Tentative settlement (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 165, 180 43. 01 Balance due provider/program (see instructions) 165, 180 43. 01 Balance due provider/program (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 915. 15. 2 TO 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 93. 00 93. 00 Time Value of Money (see instructions) 0 93. 00  |          | , , , ,   |                      |                 | 0                     |             |
| 39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       4, 477, 205       40. 00         40. 01       Sequestration adjustment (see instructions)       51, 36       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       51, 936       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 03       41. 00         41. 01       Interim payments       4, 260, 089       41. 00         41. 01       Interim payments-PARHM       41. 01       41. 01         42. 01       Tentative settlement (for contractors use only)       0       42. 01         43. 00       Bal ance due provider/program (see instructions)       165, 180       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       44. 00         41. 01       Ten BE COMPLETED BY CONTRACTOR       0       90. 00       90. 00       90. 00       90. 00         90. 00       The rate used to calculate the Time Value of Money       0. 00       92. 00         93. 00       Time Value of Money   |          | 1   |                      |                 | 0                     | 1           |
| 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 4, 477, 205 40. 00 40. 01 Sequestration adjustment (see instructions) 51, 936 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 41. 01 Interim payments-PARHM (for contractors use only) 41. 01 Tentative settlement (for contractor use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 Bal ance due provider/program (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Fortiested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 91. 02 44. 00 91. 00 Ottlier amount (see instructions) 91. 00 Outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money (see instructions) 0 93. 00 93. 00  |          |   | devices (see instruc | tions)          |                       |             |
| 40.01       Sequestration adjustment (see instructions)       51,936       40.01         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         40.03       Sequestration adjustment-PARHM pass-throughs       40.03         41.00       Interim payments       4,260,089       41.00         41.01       Interim payments-PARHM       41.00       41.00         42.01       Tentative settlement (for contractor use only)       0       42.00         43.00       Balance due provider/program (see instructions)       165,180       43.00         43.01       Balance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2       0       44.00         70.02       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0       93.00  |          |   |                      | ,,              | _                     |             |
| 40.02   Demonstration payment adjustment amount after sequestration   40.02   40.03   Sequestration adjustment-PARHM pass-throughs   4,260,089   41.00   1nterim payments   4,260,089   41.00   41.01   1nterim payments-PARHM   42.00   Tentative settlement (for contractors use only)   42.01   Tentative settlement (for contractor use only)   42.01   43.00   Balance due provider/program (see instructions)   43.01   Balance due provider/program-PARHM (see instructions)   43.01   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00   91.50   0   0   0   0   0   0   0   0   0  |          |   |                      |                 | 4, 477, 205           | 1           |
| 40.03   Sequestration adjustment-PARHM pass-throughs   40.03   41.00   Interim payments   4,260,089   41.00   41.01   42.00   Tentative settlement (for contractors use only)   42.00   42.00   43.00   8al ance due provider/program (see instructions)   43.00   8al ance due provider/program (see instructions)   43.01   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00   44.00   67.0 |          |   |                      |                 |                       | •           |
| 41.00   Interim payments   4, 260, 089   41.00   41.01   Interim payments-PARHM   41.01   42.00   Tentative settlement (for contractors use only)   42.00   42.01   Tentative settlement-PARHM (for contractor use only)   42.01   43.00   Bal ance due provider/program (see instructions)   165, 180   43.01   43.01   Bal ance due provider/program-PARHM (see instructions)   43.01   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   Very contractor   44.00   44.00   Very contractor   44.00   45.115.2   70   70   70   70   70   70   70   70   |          |   |                      |                 | 0                     |             |
| 41.01   Interim payments-PARHM   |          | , ,   |                      |                 | 4 240 000             | 1           |
| 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Value of Money (see instructions) 95.00 Value of Money (see instructions) 96.00 Value of Money (see instructions) 97.00 Value of Money (see instructions)   |          | 1   |                      |                 | 4, 200, 009           | 1           |
| 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 The rate used to calculate the Time Value of Money 0 Using Value of Money (see instructions) 0 93.00   |          |   |                      |                 | 0                     |             |
| 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{115.2}{5115.2}\$  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 93.00   |          |   |                      |                 |                       |             |
| 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5}{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  73.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  |          | , , ,   |                      |                 | 165, 180              | 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 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)  |          |   |                      |                 | _                     |             |
| 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 Original outlier 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)   | 44. 00   |   | with CMS Pub. 15-2,  | cnapter 1,      | 0                     | 44.00       |
| 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00   |          |   |                      |                 |                       | 1           |
| 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 0.00 92.00 0.00 93.00   | 90.00    |   |                      |                 | 0                     | 90.00       |
| 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00   |          |   |                      |                 | _                     | 1           |
|  |          | 1   |                      |                 | 0.00                  | 1           |
| 94.00   lotal (sum of lines 91 and 93)   |          |   |                      |                 |                       |             |
|  | 94.00    | Total (Sum OT Lines 91 and 93)                                    |                      |                 | 0                     | 94.00       |

Health Financial Systems GIBS ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 10/01/2019 | Part | To 09/30/2020 | Date/Time Prepared: Provi der CCN: 15-1319

| Title XVIII   Hospital   Cost  |       |   |             |           | 10 09/30/2020 | 4/28/2021 8: 1 |       |
|--|-------|---|-------------|-----------|---------------|----------------|-------|
| 1.00   |       |   | Ti tI       | e XVIII   | Hospi tal     |                |       |
| 1.00   |       |   | Inpatie     | nt Part A | Par           | t B            |       |
| 1.00   |       |   | mm/dd/\\\\\ | Amount    | mm/dd/\\\\\   | Amount         |       |
| 1.00   |       |   |             |           |               |                |       |
| InterIm payments payable on individual bills, either submitted or to be submitted or to be submitted or to be submitted or to be submitted or to be submitted or to be submitted or to be submitted or to be submitted or to be submitted or to be submitted or to be submitted or to be submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "Note" or enter a zero.    Just 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 "Note" or enter a zero. (1)    Program to Provider   Just Note   Ju   | 1 00  | Total interim payments paid to provider                 | 1.00        |           |               |                | 1. 00 |
| Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero   3.00  |       |   |             | 1,70,0    |               |                | 2. 00 |
| Services rendered in the cost reporting period. If none, write "NONE" or enter a zero  | 2.00  |   |             |           |               |                | 2.00  |
| write "NONE" or enter a zero   |       |   |             |           |               |                |       |
| List separately each retroactive lump sum adjustment amount based on subsequent revisi on 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   AJUSTMENTS TO PROVIDER   0 0 0 3.3   |       |   |             |           |               |                |       |
| 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  ADJUSTMENTS TO PROVIDER  3. 01 3. 03 3. 04 3. 05 3. 05 3. 05 3. 05 3. 05 3. 07 3. 07 3. 07 3. 08 3. 09 3. 09 4. 00 3 | 3.00  |   |             |           |               |                | 3.00  |
| Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider  |       | amount based on subsequent revision of the interim rate |             |           |               |                |       |
| Program to Provider  |       | for the cost reporting period. Also show date of each   |             |           |               |                |       |
| Program to Provider  |       | payment. If none, write "NONE" or enter a zero. (1)     |             |           |               |                |       |
| 3.03   0   |       |   |             |           |               |                |       |
| 3.04   0   | 3. 01 | ADJUSTMENTS TO PROVIDER                                 |             |           | 0             | 0              | 3. 01 |
| 3.05   | 3.02  |   |             |           | 0             | 0              | 3. 02 |
| 3.05   | 3.03  |   |             |           | 0             | 0              | 3. 03 |
| Provider to Program   ADJUSTMENTS TO PROGRAM   0   | 3.04  |   |             |           | 0             | o              | 3. 04 |
| ADJUSTMENTS TO PROGRAM   | 3.05  |   |             |           | 0             | o              | 3.05  |
| 3.51   |       | Provi der to Program                                    |             |           |               |                |       |
| 3.52   3.53   3.54   3.64   3.65      | 3.50  | ADJUSTMENTS TO PROGRAM                                  |             |           | 0             | 0              | 3.50  |
| 3.53   3.54   0  | 3.51  |   |             |           | 0             | 0              | 3. 51 |
| 3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   770,344   4,260,089   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR  | 3.52  |   |             |           | 0             | 0              | 3. 52 |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   | 3.53  |   |             |           | 0             | 0              | 3. 53 |
| 3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   | 3.54  |   |             |           | 0             | 0              | 3.54  |
| 4.00   Total interim payments (sum of lines 1, 2, and 3.99)   770, 344   4, 260, 089   4.00  | 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines     |             |           | 0             | 0              | 3. 99 |
| (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR   |       | 3. 50-3. 98)  |             |           |               |                |       |
| appropriate   TO BE COMPLETED BY CONTRACTOR  | 4.00  | Total interim payments (sum of lines 1, 2, and 3.99)    |             | 770, 3    | 44            | 4, 260, 089    | 4.00  |
| TO BE COMPLETED BY CONTRACTOR  |       | (transfer to Wkst. E or Wkst. E-3, line and column as   |             |           |               |                |       |
| 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  5.01 TENTATIVE TO PROVIDER  5.02 0 0 0 5.6  5.03 Provider to Program  5.50 TENTATIVE TO PROGRAM  5.50 0 0 0 0 5.6  5.51 0 0 0 0 5.6  5.52 0 0 0 0 5.6  5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  6.00 Determined net settlement amount (balance due) based on the cost report. (1)  6.01 SETTLEMENT TO PROGRAM  6.02 SETTLEMENT TO PROGRAM  7.00 Total Medicare program liability (see instructions)  5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |       |   |             |           |               |                |       |
| desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider  |       |   |             |           |               |                |       |
| Write "NONE" or enter a zero. (1)   Program to Provider  | 5.00  |   |             |           |               |                | 5.00  |
| Program to Provider  |       |   |             |           |               |                |       |
| 5. 01       TENTATI VE TO PROVIDER       0       0       5. 0         5. 02       0       0       0       5. 0         5. 03       Provider to Program       0       0       5. 0         5. 50       TENTATI VE TO PROGRAM       0       0       5. 5         5. 51       0       0       0       5. 5         5. 52       0       0       0       5. 5         5. 99       Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 5. 50-5. 98)       0       0       0       5. 5         6. 00       Determined net settlement amount (balance due) based on the cost report. (1)       6. 0       6  |       |   |             |           |               |                |       |
| 5. 02 5. 03  Provider to Program  5. 50 TENTATIVE TO PROGRAM  5. 51 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5.   |       |   |             |           |               |                |       |
| 5.03 Provider to Program  5.50 TENTATIVE TO PROGRAM  5.51 5.52 0 0 0 0 5.5  5.52 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  6.00 Determined net settlement amount (balance due) based on the cost report. (1)  6.01 SETTLEMENT TO PROVIDER  6.02 SETTLEMENT TO PROGRAM  7.00 Total Medicare program liability (see instructions)  6.60 5.60 5.60 5.60 5.60 5.60 6.60 6.60  |       | TENTATI VE TO PROVI DER                                 |             |           |               |                | 5. 01 |
| Provider to Program  |       |   |             |           |               |                | 5. 02 |
| 5. 50       TENTATI VE TO PROGRAM       0       0       5. 5.         5. 51       0       0       0       5. 5.         5. 52       0       0       0       5. 5.         5. 99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5. 50-5.98)       0       0       0       5. 50-5.98)         6. 00       Determined net settlement amount (balance due) based on the cost report. (1)       6. 0       508,322       165,180       6. 0         6. 01       SETTLEMENT TO PROGRAM       0       0       6. 0         6. 02       SETTLEMENT TO PROGRAM       0       0       6. 0         7. 00       Total Medicare program liability (see instructions)       1, 278, 666       4, 425, 269       7. 0  | 5. 03 |   |             |           | 0             | 0              | 5. 03 |
| 5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 0 5.5 0 0 0 5.5 0 0 0 6.6 0 5.5 0 0 0 0 6.6 0 5.5 0 0 0 0 6.6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   | F F0  |   |             |           |               |                | F F.  |
| 5.52   0 0 5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROGRAM   508,322   165,180   6.02   SETTLEMENT TO PROGRAM   0 0   6.04   6.05   6.05   Control of the cost report. (1)   1,278,666   1,278,678,678,678,678,678,678,678,678,678,6   |       | TENTATIVE TO PROGRAM                                    |             |           |               |                |       |
| 5. 99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 0 0 6.0 7.00 Total Medicare program liability (see instructions) 1, 278, 666 4, 425, 269 7.0   |       |   |             |           |               |                |       |
| 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 6.00 Total Medicare program liability (see instructions)   |       | 6 1 1 1 1 1 6 1 1 1 1 1 1 1 1 1 1 1 1 1                 |             |           |               |                |       |
| 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 6.00 Total Medicare program liability (see instructions)   | 5. 99 |   |             |           | 0             | 0              | 5. 99 |
| the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 508, 322 165, 180 6.0 0 0 0 4, 425, 269 7.0   | 4 00  | 1   |             |           |               |                | 4 00  |
| 6.01 SETTLEMENT TO PROVIDER 508, 322 165, 180 6.0 SETTLEMENT TO PROGRAM 0 0 6.0 Total Medicare program liability (see instructions) 1, 278, 666 4, 425, 269 7.0  | 0.00  | · · · · · · · · · · · · · · · · · · ·                   |             |           |               |                | 0.00  |
| 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 6.0 1, 278, 666 4, 425, 269 7.0  | 6 01  |   |             | EU0 3     | 22            | 145 100        | 6. 01 |
| 7.00 Total Medicare program liability (see instructions) 1, 278, 666 4, 425, 269 7.0   |       |   |             | 300, 3.   | 0             | 100, 100       | 6. 02 |
|  |       |   |             | 1 278 6   | 56            | 4 425 260      | 7. 00 |
|  | 7.00  | Trotal mearcare program traditity (see Instructions)    |             | 1,270,0   |               |                | 7.00  |
| Number (Mo/Day/Yr)   |       |   |             |           |               |                |       |
| 0 1.00 2.00  |       |   |             | 0         |               |                |       |
|  | 8. 00 | Name of Contractor                                      |             |           |               |                | 8. 00 |

|   | Component  | 3014. 10 2017 | 0 077 007 2020  | 4/28/2021 8: 1      | 5 am  |
|---|------------|---------------|-----------------|---------------------|-------|
|   |            |               | ving Beds - SNF |                     |       |
|   | I npati en | t Part A      | Par             | t B                 |       |
|   | mm/dd/yyyy | Amount        | mm/dd/yyyy      | Amount              |       |
|   | 1.00       | 2.00          | 3. 00           | 4. 00               |       |
| 1.00 Total interim payments paid to provider  |            | 1, 896, 377   |                 | 0                   | 1.00  |
| 2.00 Interim payments payable on individual bills, either   |            | 0             |                 | 0                   | 2.00  |
| submitted or to be submitted to the contractor for  |            |               |                 |                     |       |
| services rendered in the cost reporting period. If none,  |            |               |                 |                     |       |
| write "NONE" or enter a zero  |            |               |                 |                     |       |
| 3.00 List separately each retroactive lump sum adjustment   |            |               |                 |                     | 3.00  |
| amount based on subsequent revision of the interim rate   |            |               |                 |                     |       |
| for the cost reporting period. Also show date of each   |            |               |                 |                     |       |
| payment. If none, write "NONE" or enter a zero. (1)   |            |               |                 |                     |       |
| Program to Provider   |            |               |                 |                     |       |
| 3. 01 ADJUSTMENTS TO PROVIDER   |            | 0             |                 | 0                   | 3. 01 |
| 3. 02   |            | 0             |                 | 0                   | 3. 02 |
| 3. 03   |            | 0             |                 | 0                   | 3.03  |
| 3. 04   |            | 0             |                 | 0                   | 3. 04 |
| 3. 05   |            | 0             |                 | 0                   | 3.05  |
| Provider to Program   |            |               | 1               |                     |       |
| 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   |            | 0             |                 | 0                   | 3. 54 |
| 3. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines   |            | 0             |                 | 0                   | 3. 99 |
| 3. 50-3. 98)  |            | 1 00/ 277     |                 | 0                   | 4 00  |
| 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as |            | 1, 896, 377   |                 | 0                   | 4. 00 |
| appropriate)  |            |               |                 |                     |       |
| TO BE COMPLETED BY CONTRACTOR   |            |               |                 |                     |       |
| 5.00 List separately each tentative settlement payment after  |            |               |                 |                     | 5.00  |
| desk review. Also show date of each payment. If none,   |            |               |                 |                     | 3.00  |
| write "NONE" or enter a zero. (1)   |            |               |                 |                     |       |
| Program to Provider   |            |               |                 |                     |       |
| 5. 01 TENTATI VE TO PROVI DER   |            | 0             |                 | 0                   | 5. 01 |
| 5. 02   |            | Ö             |                 | o                   | 5. 02 |
| 5. 03   |            | 0             |                 | ol                  | 5.03  |
| Provider to Program   |            |               |                 |                     |       |
| 5.50 TENTATI VE TO PROGRAM  |            | 0             |                 | 0                   | 5. 50 |
| 5. 51   |            | 0             |                 | 0                   | 5. 51 |
| 5. 52   |            | 0             |                 | 0                   | 5. 52 |
| 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines  |            | 0             |                 | 0                   | 5. 99 |
| 5. 50-5. 98)  |            |               |                 |                     |       |
| 5.00 Determined net settlement amount (balance due) based on  |            |               |                 |                     | 6. 00 |
| the cost report. (1)  |            |               |                 |                     |       |
| 5. 01 SETTLEMENT TO PROVIDER  |            | 1, 107, 582   |                 | 0                   | 6. 01 |
| 5. 02 SETTLEMENT TO PROGRAM   |            | 0             |                 | 0                   | 6. 02 |
| 7.00   Total Medicare program liability (see instructions)  |            | 3, 003, 959   |                 | 0                   | 7. 00 |
|   |            |               | Contractor      | NPR Date            |       |
| · · · · · · · · · · · · · · · · · · ·   |            |               |                 |                     |       |
|   |            |               | Number          | (Mo/Day/Yr)         |       |
| 3.00 Name of Contractor   | (          | )             | Number<br>1.00  | (Mo/Day/Yr)<br>2.00 | 8. 00 |

| Heal th | Financial Systems GIBSON GENERAL   | HOSPI TAL                | In Lie                           | u of Form CMS-             | 2552-10 |  |
|---------|--|--------------------------|----------------------------------|----------------------------|---------|--|
| CALCUL  | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT  | Provider CCN: 15-1319    | Peri od:                         | Worksheet E-1              |         |  |
|         |  |                          | From 10/01/2019<br>To 09/30/2020 | Part II<br>  Date/Time Pre | nared:  |  |
|         |  |                          | 10 077 307 2020                  | 4/28/2021 8: 1             |         |  |
|         |  | 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   |                          | e 14                             |                            | 1.00    |  |
| 2. 00   | Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,  | 8-12                     |                                  |                            | 2.00    |  |
| 3.00    | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  |                          |                                  |                            | 3.00    |  |
| 4.00    | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,  | 8-12                     |                                  |                            | 4.00    |  |
| 5. 00   | Total hospital charges from Wkst C, Pt. I, col. 8 line 200   |                          |                                  |                            | 5. 00   |  |
| 6. 00   | Total hospital charity care charges from Wkst. S-10, col. 3  | line 20                  |                                  |                            | 6.00    |  |
| 7.00    | 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I |                          |                                  |                            |         |  |
|         | line 168   |                          |                                  |                            |         |  |
| 8.00    | 8.00   Calculation of the HIT incentive payment (see instructions)   |                          |                                  |                            |         |  |
| 9.00    | 9.00   Sequestration adjustment amount (see instructions)  |                          |                                  |                            |         |  |
| 10.00   |  |                          |                                  |                            |         |  |
|         | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH   |                          |                                  |                            |         |  |
| 30.00   | Initial/interim HIT payment adjustment (see instructions)  |                          |                                  |                            | 30.00   |  |
| 31.00   | Other Adjustment (specify)   |                          |                                  |                            | 31.00   |  |
| 32.00   | Balance due provider (line 8 (or line 10) minus line 30 and  | line 31) (see instructio | ns)                              |                            | 32.00   |  |
|         |  |                          |                                  |                            | •       |  |

| Health Financial Systems                  | GI BSON GENERAL I | HOSPI TAL              | In Lie          | u of Form CMS-2552-10 |
|---|-------------------|------------------------|-----------------|-----------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT - | SWING BEDS        | Provider CCN: 15-1319  | Peri od:        | Worksheet E-2         |
|   |                   |                        | From 10/01/2019 |                       |
|   |                   | Component CCN: 15-Z319 | To 09/30/2020   | Date/Time Prepared:   |
|   |                   | ·                      |                 | 4/28/2021 8:15 am     |
|   |                   | T1 11 100011           | 0 1 0 1 01/5    | 0 1                   |

|                | Cc   | omponent CCN: 15-Z319                                   | To 09/30/2020      | Date/Time Pre<br>4/28/2021 8:1 |                  |
|----------------|--|---|--------------------|--------------------------------|------------------|
|                |  | Title XVIII   | Swing Beds - SNF   |                                | <u> </u>         |
|                |  |   | Part A             | Part B                         |                  |
|                | [  |   | 1. 00              | 2. 00                          |                  |
| 1 00           | COMPUTATION OF NET COST OF COVERED SERVICES  |   | 2, 413, 236        | 0                              | 1 00             |
| 1. 00<br>2. 00 | Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions) |   | 2, 413, 230        | U                              | 1.00<br>2.00     |
| 3. 00          | Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A   | A and sum of Wkst D                                     | 658, 709           | 0                              | 3.00             |
| 0.00           | Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-   |   |                    | O                              | 0.00             |
|                | instructions)  | , , , ,   |                    |                                |                  |
| 3. 01          | Nursing and allied health payment-PARHM (see instructions)   |   |                    |                                | 3. 01            |
| 4. 00          | Per diem cost for interns and residents not in approved teaching   | g program (see  |                    | 0. 00                          | 4.00             |
| F 00           | instructions)  |   | 1 055              | 0                              | F 00             |
| 5. 00<br>6. 00 | Program days Interns and residents not in approved teaching program (see inst  | tructions)  | 1, 055             | 0                              | 5. 00<br>6. 00   |
| 7. 00          | Utilization review - physician compensation - SNF optional metho   |   | 0                  | Ü                              | 7.00             |
| 8. 00          | Subtotal (sum of lines 1 through 3 plus lines 6 and 7)   | od om y   | 3, 071, 945        | 0                              | 8.00             |
| 9. 00          | Primary payer payments (see instructions)  |   | 0                  | 0                              | 9.00             |
| 10.00          | Subtotal (line 8 minus line 9)   |   | 3, 071, 945        | 0                              | 10.00            |
| 11. 00         | Deductibles billed to program patients (exclude amounts applicate  | ole to physician  | 0                  | 0                              | 11. 00           |
|                | professional services)   |   |                    | _                              |                  |
| 12.00          | Subtotal (line 10 minus line 11)   | (ld:  | 3, 071, 945        | 0                              | 12.00            |
| 13. 00         | Coinsurance billed to program patients (from provider records) (for physician professional services)                       | exclude collisurance                                    | 32, 731            | 0                              | 13.00            |
| 14. 00         | 80% of Part B costs (line 12 x 80%)  |   |                    | 0                              | 14. 00           |
|                | Subtotal (see instructions)  |   | 3, 039, 214        | 0                              | 15.00            |
|                | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |   | 0                  | 0                              | 16.00            |
| 16. 50         | Pioneer ACO demonstration payment adjustment (see instructions)  |   |                    |                                | 16. 50           |
| 16. 55         | Rural community hospital demonstration project (§410A Demonstrat   | tion) payment   | 0                  |                                | 16. 55           |
| 47.00          | adjustment (see instructions)  |   |                    | 0                              | 47.00            |
|                | Demonstration payment adjustment amount before sequestration   |   | 0                  | 0                              | 16. 99<br>17. 00 |
|                | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)                                  |   |                    | 0                              |                  |
|                | Allowable bad debts for dual eligible beneficiaries (see instruc   | ctions)   |                    | 0                              | 18. 00           |
|                | Total (see instructions)   | J. J. J. J. J. J. J. J. J. J. J. J. J. J                | 3, 039, 214        | 0                              |                  |
|                | Sequestration adjustment (see instructions)  |   | 35, 255            | 0                              | 19. 01           |
|                | Demonstration payment adjustment amount after sequestration)   |   | O                  | 0                              | 19.02            |
|                | Sequestration adjustment-PARHM pass-throughs   |   |                    |                                | 19. 03           |
|                | Interim payments   |   | 1, 896, 377        | 0                              | 20.00            |
|                | Interim payments-PARHM   |   |                    | 0                              | 20.01            |
| 21.00          | Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)                        |   | 0                  | 0                              | 21. 00<br>21. 01 |
| 22. 00         | Balance due provider/program (line 19 minus lines 19.01, 20, and   | 1 21)   | 1, 107, 582        | 0                              | 22.00            |
| 22. 01         | Balance due provider/program-PARHM (see instructions)  | 21)   | 1, 107, 002        | · ·                            | 22. 01           |
| 23.00          | Protested amounts (nonallowable cost report items) in accordance   | e with CMS Pub. 15-2,                                   | o                  | 0                              | 23.00            |
|                | chapter 1, §115.2  |   |                    |                                |                  |
|                | Rural Community Hospital Demonstration Project (§410A Demonstrat   |   |                    |                                |                  |
| 200.00         | Is this the first year of the current 5-year demonstration period  | od under the 21st                                       |                    |                                | 200. 00          |
|                | Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement   |   |                    |                                |                  |
| 201 00         | Medicare swing-bed SNF inpatient routine service costs (from Wks   | st D-1 Pt II line                                       |                    |                                | 201. 00          |
| 201.00         | 66 (title XVIII hospital))   | se. 5 ., . e,e  |                    |                                |                  |
| 202.00         | Medicare swing-bed SNF inpatient ancillary service costs (from V   | Wkst. D-3, col. 3, lir                                  | ne                 |                                | 202.00           |
|                | 200 (title XVIII swing-bed SNF))   |   |                    |                                |                  |
|                | Total (sum of lines 201 and 202)   |   |                    |                                | 203.00           |
| 204.00         | Medicare swing-bed SNF discharges (see instructions)   |   |                    |                                | 204. 00          |
|                | Computation of Demonstration Target Amount Limitation (N/A in fiperiod)  | ist year or the curre                                   | erit 5-year demons | tration                        |                  |
| 205 00         | Medicare swing-bed SNF target amount   |   |                    |                                | 205. 00          |
|                | Medicare swing-bed SNF inpatient routine cost cap (line 205 time   | es line 204)  |                    |                                | 206.00           |
|                | Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem   |   |                    |                                |                  |
| 207.00         | Program reimbursement under the §410A Demonstration (see instruc   | ctions)   |                    |                                | 207. 00          |
| 208.00         | Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,  | $\operatorname{col}$ . 1, $\operatorname{sum}$ of lines | 1                  |                                | 208. 00          |
| 000 5          | and 3)   |   |                    |                                | 000 0-           |
|                | Adjustment to Medicare swing-bed SNF PPS payments (see instructi   | ons)  |                    |                                | 209.00           |
| 210.00         | Reserved for future use Comparision of PPS versus Cost Reimbursement   |   |                    |                                | 210. 00          |
| 215 00         | Total adjustment to Medicare swing-bed SNF PPS payment (line 209   | 9 plus line 210) (see                                   |                    |                                | 215. 00          |
| 5. 50          | instructions)  | . p. 40 210) (300                                       |                    |                                |                  |
|                | •  |   | . '                |                                | •                |

| Health Financial Systems                | GIBSON GENERAL HOSPITAL | In Lie                                       | u of Form CMS-2   | 2552-10 |
|---|-------------------------|--|---|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-1319  | Peri od:<br>From 10/01/2019<br>To 09/30/2020 | Worksheet E-3<br>Part V<br>Date/Time Pre<br>4/28/2021 8:1 | pared:  |
|   | Title XVIII             | Hospi tal                                    | Cost  |         |
|   |                         |  |   |         |
|   |                         |  | 1.00  |         |

|        |   | Title XVIII                           | Hospi tal        | Cost        | J dili           |
|--------|---|---------------------------------------|------------------|-------------|------------------|
|        |   | THE XITT                              | nospi tui        | 0031        |                  |
|        |   |                                       |                  | 1. 00       |                  |
|        | PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE               | PART A SERVICES - COST                | RELMBURSEMENT    |             |                  |
| 1.00   | Inpatient services  |                                       |                  | 1, 384, 368 | 1.00             |
| 2.00   | Nursing and Allied Health Managed Care payment (see instruction             | ons)                                  |                  | 0           | 2.00             |
| 3.00   | Organ acquisition   | ,                                     |                  | 0           | 3.00             |
| 4.00   | Subtotal (sum of lines 1 through 3)   |                                       |                  | 1, 384, 368 | 4. 00            |
| 5.00   | Primary payer payments  |                                       |                  | 0           | 5.00             |
| 6.00   | Total cost (line 4 less line 5). For CAH (see instructions)                 |                                       |                  | 1, 398, 212 | 6.00             |
|        | COMPUTATION OF LESSER OF COST OR CHARGES                                    |                                       |                  |             |                  |
|        | Reasonable charges  |                                       |                  |             |                  |
| 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 p              |                                       |                  | 0           |                  |
| 12. 00 | Amounts that would have been realized from patients liable for              |                                       | n a charge basis | 0           | 12. 00           |
| 10.00  | had such payment been made in accordance with 42 CFR 413.13(e)              | 1                                     |                  | 0.000000    | 40.00            |
| 13.00  | Ratio of line 11 to line 12 (not to exceed 1.000000)                        |                                       |                  | 0. 000000   |                  |
| 14.00  | Total customary charges (see instructions)                                  | v if line 14 evenede li               | no () (ooo       | 0           | 14.00            |
| 15. 00 | Excess of customary charges over reasonable cost (complete onlinstructions) | y IT Time 14 exceeds IT               | ne 6) (see       | 0           | 15. 00           |
| 16. 00 | Excess of reasonable cost over customary charges (complete onl              | vifling 6 avenads lin                 | 0 14) (600       | 0           | 16. 00           |
| 10.00  | instructions)   | y II IIIle o exceeds IIII             | e 14) (See       | U           | 10.00            |
| 17. 00 | Cost of physicians' services in a teaching hospital (see instr              | ructions)                             |                  | 0           | 17. 00           |
| 17.00  | COMPUTATION OF REIMBURSEMENT SETTLEMENT                                     | 4011 0113)                            |                  | Ü           | 17.00            |
| 18. 00 | Direct graduate medical education payments (from Worksheet E-4              | 1. line 49)                           |                  | 0           | 18. 00           |
| 19. 00 | Cost of covered services (sum of lines 6, 17 and 18)                        | .,                                    |                  | 1, 398, 212 |                  |
| 20.00  | Deductibles (exclude professional component)                                |                                       |                  | 110, 308    |                  |
| 21. 00 | Excess reasonable cost (from line 16)                                       |                                       |                  | 0           | 21.00            |
| 22.00  | Subtotal (line 19 minus line 20 and 21)                                     |                                       |                  | 1, 287, 904 | 22. 00           |
| 23.00  | Coinsurance   |                                       |                  | 0           |                  |
| 24.00  | Subtotal (line 22 minus line 23)  |                                       |                  | 1, 287, 904 | 24.00            |
| 25.00  | Allowable bad debts (exclude bad debts for professional service             | ces) (see instructions)               |                  | 8, 875      | 25.00            |
| 26.00  | Adjusted reimbursable bad debts (see instructions)                          |                                       |                  | 5, 769      | 26.00            |
| 27.00  | Allowable bad debts for dual eligible beneficiaries (see instr              | ructions)                             |                  | 7, 511      | 27. 00           |
| 28. 00 | Subtotal (sum of lines 24 and 25, or line 26)                               |                                       |                  | 1, 293, 673 | 28. 00           |
| 29. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)                              |                                       |                  | 0           |                  |
| 29. 50 | Pioneer ACO demonstration payment adjustment (see instructions              | 5)                                    |                  | 0           |                  |
| 29. 99 | Demonstration payment adjustment amount before sequestration                |                                       |                  | 0           |                  |
| 30.00  | Subtotal (see instructions)   |                                       |                  | 1, 293, 673 |                  |
| 30. 01 | Sequestration adjustment (see instructions)                                 |                                       |                  | 15, 007     |                  |
| 30. 02 | Demonstration payment adjustment amount after sequestration                 |                                       |                  | 0           |                  |
| 30. 03 | Sequestration adjustment-PARHM  |                                       |                  |             | 30. 03           |
| 31.00  | Interim payments  |                                       |                  | 770, 344    |                  |
| 31. 01 | Interim payments-PARHM  |                                       |                  |             | 31.01            |
| 32.00  | Tentative settlement (for contractor use only)                              |                                       |                  | 0           |                  |
| 32. 01 | Tentative settlement-PARHM (for contractor use only)                        | 21 and 22)                            |                  | F00 000     | 32. 01           |
| 33.00  | Balance due provider/program (line 30 minus lines 30.01, 30.02              |                                       | and 22 01)       | 508, 322    |                  |
| 33. 01 | Balance due provider/program-PARHM (lines 2, 3, 18, and 26, mi              | · · · · · · · · · · · · · · · · · · · | ,                | 0           | 33. 01<br>34. 00 |
| 34. 00 | Protested amounts (nonallowable cost report items) in accordar §115.2       | ice with two Pub. 15-2,               | chapter 1,       | U           | 34.00            |
|        | [3110.2   |                                       |                  |             | I                |

| Health Financial Systems                | GIBSON GENERAL HOSPITAL | In Lieu         | of Form CMS-2552-10   |
|---|-------------------------|-----------------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der               | From 10/01/2019 | Worksheet E-3<br>Part VII<br>Date/Time Prepared:<br>4/28/2021 8:15 am |

|        |   |                           | 0 09/30/2020 | 4/28/2021 8: 1 |        |
|--------|---|---------------------------|--------------|----------------|--------|
|        |   | Title XIX                 | Hospi tal    | Cost           |        |
|        |   |                           | Inpatient    | Outpati ent    |        |
|        |   |                           | 1.00         | 2.00           |        |
|        | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEI  | RVICES FOR TITLES V OR XI | X SERVICES   |                |        |
|        | COMPUTATION OF NET COST OF COVERED SERVICES                     |                           |              |                | 1      |
| 1.00   | Inpatient hospital/SNF/NF services                              |                           | 62, 347      |                | 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)                              |                           | 62, 347      | 0              | 4.00   |
| 5.00   | Inpatient primary payer payments                                |                           | o            |                | 5.00   |
| 6.00   | Outpatient primary payer payments                               |                           |              | 0              | 6.00   |
| 7.00   | Subtotal (line 4 less sum of lines 5 and 6)                     |                           | 62, 347      | 0              | 7.00   |
|        | COMPUTATION OF LESSER OF COST OR CHARGES                        |                           |              |                |        |
|        | Reasonable Charges  |                           |              |                |        |
| 8.00   | Routi ne servi ce charges                                       |                           | 16, 228      |                | 8.00   |
| 9.00   | Ancillary service charges                                       |                           | 47, 308      | 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)            |                           | 63, 536      | 0              | 12.00  |
|        | CUSTOMARY CHARGES   |                           |              |                |        |
| 13.00  | Amount actually collected from patients liable for payment fo   | r services on a charge    | 0            | 0              | 13.00  |
|        | basi s  |                           |              |                |        |
| 14. 00 | Amounts that would have been realized from patients liable fo   | 1 3                       | 0            | 0              | 14.00  |
|        | a charge basis had such payment been made in accordance with    | 42 CFR §413.13(e)         |              |                |        |
| 15. 00 | Ratio of line 13 to line 14 (not to exceed 1.000000)            |                           | 0.000000     | 0. 000000      |        |
| 16.00  | Total customary charges (see instructions)                      |                           | 63, 536      | 0              | 16.00  |
| 17. 00 | Excess of customary charges over reasonable cost (complete on   | ly if line 16 exceeds     | 1, 189       | 0              | 17.00  |
| 10.00  | line 4) (see instructions)                                      | l : €   : == 4 ====       | 0            | 0              | 10 00  |
| 18. 00 | Excess of reasonable cost over customary charges (complete on   | Ty IT Time 4 exceeds Time | ١            | 0              | 18. 00 |
| 19. 00 | 16) (see instructions) Interns and Residents (see instructions) |                           | 0            | 0              | 19.00  |
| 20. 00 | Cost of physicians' services in a teaching hospital (see inst   | ructions)                 | 0            | 0              | 20.00  |
| 21. 00 | Cost of covered services (enter the lesser of line 4 or line    |                           | 62, 347      | 0              | 21.00  |
| 21.00  | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be   |                           |              | 0              | 21.00  |
| 22. 00 | Other than outlier payments                                     | compreted for 113 provid  | 0            | 0              | 22.00  |
| 23. 00 | Outlier payments  |                           | l o          | 0              | 23.00  |
| 24. 00 | Program capital payments  |                           | o o          | Ü              | 24.00  |
| 25. 00 | Capital exception payments (see instructions)                   |                           |              |                | 25. 00 |
| 26. 00 | Routine and Ancillary service other pass through costs          |                           | 0            | 0              | 26.00  |
| 27. 00 | Subtotal (sum of lines 22 through 26)                           |                           | o            | 0              | 27. 00 |
| 28. 00 | Customary charges (title V or XIX PPS covered services only)    |                           | 0            | 0              | 28. 00 |
| 29. 00 | Titles V or XIX (sum of lines 21 and 27)                        |                           | 62, 347      | 0              | 29.00  |
|        | COMPUTATION OF REIMBURSEMENT SETTLEMENT                         |                           | <u>'</u>     |                | ĺ      |
| 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   | )                         | 62, 347      | 0              | 31.00  |
| 32.00  | Deducti bl es   |                           | O            | 0              | 32.00  |
| 33.00  | Coi nsurance  |                           | o            | 0              | 33.00  |
| 34.00  | Allowable bad debts (see instructions)                          |                           | 0            | 0              | 34.00  |
| 35.00  | Utilization review  |                           | 0            |                | 35.00  |
| 36.00  | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and  | d 33)                     | 62, 347      | 0              | 36.00  |
| 37.00  | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)                  |                           | 0            | 0              | 37.00  |
| 38. 00 | Subtotal (line 36 ± line 37)                                    |                           | 62, 347      | 0              | 38. 00 |
| 39. 00 | Direct graduate medical education payments (from Wkst. E-4)     |                           | 0            |                | 39. 00 |
| 40.00  | Total amount payable to the provider (sum of lines 38 and 39)   |                           | 62, 347      | 0              | 40. 00 |
| 41.00  | Interim payments  |                           | 35, 766      | 0              | 41.00  |
| 42.00  | Balance due provider/program (line 40 minus line 41)            |                           | 26, 581      | 0              | 42.00  |
| 43.00  | Protested amounts (nonallowable cost report items) in accorda   | nce with CMS Pub 15-2,    | 0            | 0              | 43.00  |
|        | chapter 1, §115.2   |                           |              |                | l      |

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

Provi der CCN: 15-1319

Peri od: Worksheet G
From 10/01/2019
To 09/30/2020 Date/Time Prepared: 4/28/2021 8:15 am

| —————————————————————————————————————— |   |                            |                      |               | 4/28/2021 8: 1 | 5 am             |
|--|---|----------------------------|----------------------|---------------|----------------|------------------|
|  |   | General Fund               | Speci fi c           | Endowment     | Plant Fund     |                  |
|  |   | 1.00                       | Purpose Fund<br>2.00 | Fund<br>3. 00 | 4. 00          |                  |
|  | CURRENT ASSETS  | 1.00                       | 2.00                 | 0.00          | 1. 00          |                  |
| 1.00                                   | Cash on hand in banks   | 11, 062, 325               | 0                    | 0             | 0              | 1.00             |
| 2.00                                   | Temporary investments   | 0                          | 0                    | 0             | 0              | 2.00             |
| 3. 00                                  | Notes receivable  | 0                          | 0                    | 0             | 0              | 3.00             |
| 4.00                                   | Accounts receivable   | 6, 310, 059                |                      | 0             | 0              | 4.00             |
| 5. 00<br>6. 00                         | Other receivable Allowances for uncollectible notes and accounts receivable                               | 790, 580<br>-2, 342, 829   |                      | 0             | 0              | 5. 00<br>6. 00   |
| 7. 00                                  | Inventory   | 725, 941                   | 0                    | 0             | 0              | 7.00             |
| 8. 00                                  | Prepai d expenses   | 672, 033                   | -                    | 0             | 0              | 8.00             |
| 9.00                                   | Other current assets  | 0                          | 0                    | 0             | 0              | 9. 00            |
| 10.00                                  | Due from other funds  | 0                          | 0                    | 0             | 0              | 10.00            |
| 11. 00                                 | Total current assets (sum of lines 1-10)  | 17, 218, 109               | 0                    | 0             | 0              | 11.00            |
| 12 00                                  | FI XED ASSETS   | 421 244                    |                      | 0             | 0              | 12.00            |
| 12. 00<br>13. 00                       | Land improvements   | 421, 244<br>258, 790       | 0                    | 0             | 0              | 12. 00<br>13. 00 |
| 14. 00                                 | Accumulated depreciation  | -192, 820                  |                      | 0             | 0              | 14.00            |
| 15. 00                                 | Bui I di ngs  | 20, 557, 040               |                      | 0             | 0              | 15.00            |
| 16.00                                  | Accumulated depreciation  | -13, 224, 880              |                      | 0             | 0              | 16.00            |
| 17.00                                  | Leasehold improvements  | 0                          | 0                    | 0             | 0              | 17. 00           |
| 18. 00                                 | Accumulated depreciation  | 0                          | 0                    | 0             | 0              | 18. 00           |
| 19. 00                                 | Fi xed equipment  | 5, 808, 455                |                      | 0             | 0              | 19.00            |
| 20.00                                  | Accumulated depreciation  | -3, 846, 085               |                      | 0             | 0              | 20.00            |
| 21. 00<br>22. 00                       | Automobiles and trucks  | 0                          | 0                    | 0             | 0              | 21. 00<br>22. 00 |
| 23. 00                                 | Accumulated depreciation Major movable equipment  | 15, 104, 168               | -                    | 0             | 0              | 23.00            |
| 24. 00                                 | Accumul ated depreciation   | -9, 233, 700               |                      | 0             | 0              | 24.00            |
| 25. 00                                 | Mi nor equi pment depreci abl e   | 1, 256, 504                |                      | 0             | 0              | 25.00            |
| 26. 00                                 | Accumulated depreciation  | -777, 204                  | Ö                    | 0             | 0              | 26.00            |
| 27.00                                  | HIT designated Assets   | 0                          | 0                    | 0             | 0              | 27.00            |
| 28. 00                                 | Accumulated depreciation  | 0                          | 0                    | 0             | 0              | 28. 00           |
| 29. 00                                 | Mi nor equi pment-nondepreci abl e  | 0                          | 0                    | 0             | 0              | 29. 00           |
| 30. 00                                 | Total fixed assets (sum of lines 12-29)   | 16, 131, 512               | 0                    | 0             | 0              | 30.00            |
| 31. 00                                 | OTHER ASSETS Investments  | 2, 618, 180                | O                    | 0             | 0              | 31.00            |
| 32.00                                  | Deposits on Leases  | 2,010,100                  | 0                    | 0             | 0              | 32.00            |
| 33. 00                                 | Due from owners/officers  | Ö                          | Ö                    | 0             | 0              | 33.00            |
| 34.00                                  | Other assets  | 0                          | 0                    | 0             | 0              | 34.00            |
| 35.00                                  | Total other assets (sum of lines 31-34)   | 2, 618, 180                | 0                    | 0             | 0              | 35.00            |
| 36.00                                  | Total assets (sum of lines 11, 30, and 35)  | 35, 967, 801               | 0                    | 0             | 0              | 36.00            |
| 07.00                                  | CURRENT LI ABI LI TI ES   | 0.074.000                  | I al                 | 0             |                | 1 07 00          |
| 37. 00<br>38. 00                       | Accounts payable Salaries, wages, and fees payable  | 2, 874, 983<br>2, 001, 826 |                      | 0             | 0              | 37. 00<br>38. 00 |
| 39.00                                  | Payroll taxes payable   | 2,001,626                  | 0                    | 0             | 0              | 39.00            |
| 40. 00                                 | Notes and Loans payable (short term)  | 1, 111, 313                | 0                    | 0             | Ö              | 40.00            |
| 41. 00                                 | Deferred income   | 4, 347, 609                |                      | 0             | 0              | 41.00            |
| 42.00                                  | Accel erated payments   | 0                          |                      |               |                | 42.00            |
| 43.00                                  | Due to other funds  | 0                          | 0                    | 0             | 0              | 43.00            |
| 44.00                                  | Other current liabilities   | 5, 643, 280                |                      | 0             | 0              | 44.00            |
| 45. 00                                 | Total current liabilities (sum of lines 37 thru 44)   | 15, 979, 011               | 0                    | 0             | 0              | 45. 00           |
| 46. 00                                 | LONG TERM LIABILITIES  Mortgage payable   |                            | O                    | 0             | 0              | 46. 00           |
| 47. 00                                 | Notes payable   | 11, 271, 242               | - 1                  | 0             | 0              | 47.00            |
| 48. 00                                 | Unsecured Loans   | 0                          |                      | 0             | Ö              | 48.00            |
| 49. 00                                 | Other long term liabilities   | Ö                          | Ö                    | 0             | 0              | 49.00            |
| 50.00                                  | Total long term liabilities (sum of lines 46 thru 49)   | 11, 271, 242               | 0                    | 0             | 0              | 50.00            |
| 51.00                                  | Total liabilities (sum of lines 45 and 50)  | 27, 250, 253               | 0                    | 0             | 0              | 51.00            |
|  | CAPITAL ACCOUNTS  |                            |                      |               |                |                  |
| 52.00                                  | General fund balance  | 8, 717, 548                |                      |               |                | 52.00            |
| 53.00                                  | Specific purpose fund   |                            | 0                    | 0             |                | 53.00            |
| 54. 00<br>55. 00                       | Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted |                            |                      | 0             |                | 54. 00<br>55. 00 |
| 56.00                                  | Governing body created - endowment fund balance   |                            |                      | 0             |                | 56.00            |
| 57. 00                                 | Plant fund balance - invested in plant  |                            |                      | J             | 0              | 57.00            |
| 58. 00                                 | Plant fund balance - reserve for plant improvement,   |                            |                      |               | 0              | 58.00            |
|  | repl acement, and expansion   |                            |                      |               |                |                  |
| 59. 00                                 | Total fund balances (sum of lines 52 thru 58)   | 8, 717, 548                |                      | 0             | 0              | 59.00            |
| 60. 00                                 | Total liabilities and fund balances (sum of lines 51 and  | 35, 967, 801               | 0                    | 0             | 0              | 60.00            |
|  | [59]  | ļ                          | ı                    |               |                | I                |

GIBSON GENERAL HOSPITAL

In Lieu of Form CMS-2552-10
Period: Worksheet G-1
From 10/01/2019 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-1319

|  |   |                   |  |           | From 10/01/2019<br>To 09/30/2020        | Date/Time Pre<br>4/28/2021 8:1 |  |
|--|---|-------------------|--|-----------|---|--------------------------------|--|
|  |   | Genera            | I Fund   | Special P | urpose Fund                             | Endowment<br>Fund              |  |
|  |   | 1. 00             | 2. 00  | 3. 00     | 4.00                                    | 5. 00                          |  |
| 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00  | Fund balances at beginning of period<br>Net income (loss) (from Wkst. G-3, line 29)<br>Total (sum of line 1 and line 2)<br>Additions (credit adjustments) (specify) | 0 0 0             | 2, 00<br>10, 283, 001<br>-1, 565, 453<br>8, 717, 548 |           | 4.00<br>0<br>0<br>0<br>0<br>0           |                                | 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00  |
| 8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00                             | Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)   | 0 0 0 0 0 0 0 0   | 0<br>8, 717, 548                                     |           | 0 | 0<br>0<br>0<br>0<br>0          | 13. 00<br>14. 00<br>15. 00<br>16. 00   |
| 17. 00<br>18. 00<br>19. 00   | Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)   | 0                 | 0<br>8, 717, 548                                     |           | 0 0                                     | l                              | 17. 00<br>18. 00<br>19. 00   |
|  |   | Endowment<br>Fund | PI ant   | Fund      |   |                                |  |
|  |   | 6. 00             | 7. 00  | 8. 00     | _                                       |                                |  |
| 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00  | Fund balances at beginning of period<br>Net income (loss) (from Wkst. G-3, line 29)<br>Total (sum of line 1 and line 2)<br>Additions (credit adjustments) (specify) | 0                 | 0  |           | 0                                       |                                | 1.00<br>2.00<br>3.00<br>4.00<br>5.00   |
| 6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00 | Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)   | 0                 | 0<br>0<br>0<br>0<br>0<br>0<br>0                      |           | 0                                       |                                | 6.00<br>7.00<br>8.00<br>9.00<br>10.00<br>11.00<br>12.00<br>13.00<br>14.00<br>15.00<br>16.00<br>17.00 |
| 18. 00<br>19. 00   | Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)   | 0                 |  |           | 0                                       |                                | 18. 00<br>19. 00   |

| Peri od: | Worksheet G-2 | From 10/01/2019 | Parts | & II | To 09/30/2020 | Date/Time Prepared: Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-1319

|                  |  |           |            | Го 09/30/2020    | Date/Time Pre 4/28/2021 8:1 |                |
|------------------|--|-----------|------------|------------------|-----------------------------|----------------|
|                  | Cost Center Description  |           | Inpatient  | Outpati ent      | Total                       | o din          |
|                  |  | Γ         | 1.00       | 2.00             | 3. 00                       |                |
|                  | PART I - PATIENT REVENUES                                      |           |            |                  |                             |                |
|                  | General Inpatient Routine Services                             |           |            |                  |                             |                |
| 1.00             | Hospi tal  |           | 2, 049, 03 | 3                | 2, 049, 038                 | 1.00           |
| 2.00             | SUBPROVI DER - I PF  |           |            |                  |                             | 2.00           |
| 3. 00            | SUBPROVI DER - I RF  |           |            |                  |                             | 3. 00          |
| 4.00             | SUBPROVI DER   |           |            |                  |                             | 4.00           |
| 5.00             | Swing bed - SNF  |           |            |                  | 0                           | 5.00           |
| 6.00             | Swing bed - NF   |           |            |                  | 0                           | 6.00           |
| 7.00             | SKILLED NURSING FACILITY                                       |           |            | O .              | 0                           | 7. 00<br>8. 00 |
| 8. 00<br>9. 00   | NURSING FACILITY OTHER LONG TERM CARE                          |           |            |                  |                             | 9. 00          |
| 10.00            | Total general inpatient care services (sum of lines 1-9)       |           | 2, 049, 03 |                  | 2, 049, 038                 |                |
| 10.00            | Intensive Care Type Inpatient Hospital Services                |           | 2,047,03   | 기                | 2,047,030                   | 10.00          |
| 11. 00           | INTENSIVE CARE UNIT  |           | 86, 64     | 9                | 86, 649                     | 11. 00         |
| 12.00            | CORONARY CARE UNIT   |           | 00, 04     |                  | 00, 047                     | 12.00          |
| 13. 00           | BURN INTENSIVE CARE UNIT                                       |           |            |                  |                             | 13. 00         |
| 14. 00           | SURGI CAL INTENSI VE CARE UNI T                                |           |            |                  |                             | 14. 00         |
| 15. 00           | OTHER SPECIAL CARE (SPECIFY)                                   |           |            |                  |                             | 15. 00         |
| 16. 00           | Total intensive care type inpatient hospital services (sum of  | lines     | 86, 64     | 9                | 86, 649                     | 16. 00         |
|                  | 11-15)   |           |            |                  |                             |                |
| 17.00            | Total inpatient routine care services (sum of lines 10 and 16) |           | 2, 135, 68 | 7                | 2, 135, 687                 | 17.00          |
| 18.00            | Ancillary services   |           | 4, 556, 87 | 42, 387, 693     | 46, 944, 569                | 18.00          |
| 19.00            | Outpatient services  |           | 257, 30    | 8, 365, 256      | 8, 622, 563                 | 19.00          |
| 20.00            | FORT BRANCH RHC  |           |            | 397, 482         | 397, 482                    | 20.00          |
| 20. 01           | CLARK & WELLS RHC  |           |            | 437, 900         | 437, 900                    | 20. 01         |
| 21.00            | FEDERALLY QUALIFIED HEALTH CENTER                              |           |            | 0                | 0                           | 21.00          |
| 22.00            | HOME HEALTH AGENCY   |           |            | 841, 639         | 841, 639                    | 22.00          |
| 23.00            | AMBULANCE SERVICES   |           |            |                  |                             | 23.00          |
| 24.00            | CMHC   |           |            |                  |                             | 24.00          |
| 25. 00           | AMBULATORY SURGICAL CENTER (D. P. )                            |           |            |                  |                             | 25.00          |
| 26. 00           | HOSPI CE   |           |            |                  |                             | 26.00          |
| 27. 00           | MOB  |           |            | 7, 188, 374      | 7, 188, 374                 |                |
| 27. 01           | SNF PERRY CO   |           |            | 0                | 0                           | 27. 01         |
| 27. 02           | PRO FEES   |           |            | 0                | 0                           | 27. 02         |
| 27. 03           | PROFESSI ONAL  |           |            | 664, 553         | 664, 553                    |                |
| 27. 04<br>27. 05 | 199<br>TELE BH   |           |            | 6, 678<br>7, 490 | 6, 678                      |                |
| 28.00            | Total patient revenues (sum of lines 17-27)(transfer column 3  | to Wkst   | 6, 949, 87 | · ·              | 7, 490<br>67, 246, 935      |                |
| 26.00            | G-3, line 1)   | to wkst.  | 0, 949, 07 | 00, 297, 003     | 07, 240, 933                | 26.00          |
|                  | PART II - OPERATING EXPENSES                                   |           |            |                  |                             |                |
| 29. 00           | Operating expenses (per Wkst. A, column 3, line 200)           |           |            | 36, 246, 103     |                             | 29. 00         |
| 30.00            | ADD (SPECIFY)  |           |            | 00,210,100       |                             | 30. 00         |
| 31. 00           | (0. 20)  |           |            |                  |                             | 31. 00         |
| 32.00            |  |           |            |                  |                             | 32.00          |
| 33.00            |  |           |            | )                |                             | 33.00          |
| 34.00            |  |           |            | O                |                             | 34.00          |
| 35.00            |  |           |            | D                |                             | 35.00          |
| 36.00            | Total additions (sum of lines 30-35)                           |           |            | 0                |                             | 36.00          |
| 37.00            | DEDUCT (SPECIFY)   |           |            | D                |                             | 37.00          |
| 38.00            |  |           |            | O                |                             | 38.00          |
| 39. 00           |  |           |            | D                |                             | 39. 00         |
| 40.00            |  |           |            |                  |                             | 40.00          |
| 41.00            |  |           |            | )                |                             | 41.00          |
| 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 |            | 36, 246, 103     |                             | 43.00          |
|                  | to Wkst. G-3, line 4)  |           |            | T                |                             |                |
|                  |  |           |            |                  |                             |                |

| Health Financial Systems CLDCON CENERAL HOCDITAL In Liquide Fo  | cm CMC 2             | EEO 10           |
|---|----------------------|------------------|
| Health Financial Systems GIBSON GENERAL HOSPITAL In Lieu of Fo<br>STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1319 Period: Worksh | eet G-3              | .552-10          |
| From 10/01/2019   |                      |                  |
|   | ime Prep<br>021 8:15 |                  |
| 19720/2   | 021 0.1              | o aiii           |
| 1.  | 00                   |                  |
| 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 67,   | 246, 935             | 1. 00            |
| 2.00 Less contractual allowances and discounts on patients' accounts 33,  | 591, 255             | 2.00             |
|   | 655, 680             | 3.00             |
|   | 246, 103             | 4.00             |
|   | 590, 423             | 5.00             |
| OTHER I NCOME   |                      |                  |
|   | 463, 791             | 6.00             |
| 7.00 Income from investments  | 52, 326              | 7.00             |
| 8.00 Revenues from telephone and other miscellaneous communication services   | 0                    | 8.00             |
| 9.00 Revenue from television and radio service  | 0                    | 9.00             |
| 10.00 Purchase discounts 11.00 Rebates and refunds of expenses  | 0                    | 10. 00<br>11. 00 |
| 12.00 Parking Lot receipts  | 0                    | 12.00            |
| 13.00 Revenue from Laundry and Linen service  | 0                    | 13.00            |
|   | 112, 360             | 14.00            |
| 15.00 Revenue from rental of living quarters  | 0                    | 15. 00           |
| 16.00 Revenue from sale of medical and surgical supplies to other than patients   | o                    | 16.00            |
| 17.00 Revenue from sale of drugs to other than patients   | ő                    | 17. 00           |
| 18.00 Revenue from sale of medical records and abstracts  | 0                    | 18. 00           |
| 19.00 Tuition (fees, sale of textbooks, uniforms, etc.)   | ō                    | 19. 00           |
| 20.00 Revenue from gifts, flowers, coffee shops, and canteen  | 0                    | 20.00            |
| 21.00 Rental of vending machines  | 0                    | 21.00            |
| 22.00 Rental of hospital space  | 63, 921              | 22.00            |
| 23.00 Governmental appropriations   | 0                    | 23.00            |
| 24.00 MISCELLANEOUS INCOME  | 267, 976             | 24.00            |
| 24.50 COVI D-19 PHE Fundi ng  | 64, 596              | 24.50            |
|   | 024, 970             | 25.00            |
|   | 565, 453             | 26.00            |
| 27.00 OTHER EXPENSES (SPECIFY)  | 0                    | 27.00            |
| 28.00 Total other expenses (sum of line 27 and subscripts)  | 0                    | 28.00            |
| 29.00 Net income (or loss) for the period (line 26 minus line 28)   | 565, 453             | 29. 00           |

| Heal th          | Financial Systems                                       |                              | GIBSON GENERA         | I HOSPLTAL  |                      | In lie                           | u of Form CMS-2         | 2552-10          |
|------------------|---|------------------------------|-----------------------|-------------|----------------------|----------------------------------|-------------------------|------------------|
|                  | ILLOCATION - HHA GENERAL SERVICE                        | COST                         | OF BOOK CENTERY       | Provi der C |                      | Peri od:                         | Worksheet H-1           |                  |
|                  |   |                              |                       | HHA CCN:    |                      | From 10/01/2019<br>To 09/30/2020 | Date/Time Pre           | pared:           |
|                  |   |                              |                       |             |                      | Home Health                      | 4/28/2021 8: 1<br>PPS   | <u> 5 am</u>     |
|                  |   |                              | Capital Rela          | atad Costs  |                      | Agency I                         |                         |                  |
|                  |   |                              | Сарітаі кет           | ateu costs  |                      |                                  |                         |                  |
|                  |   | Net Expenses<br>for Cost     | Bl dgs &<br>Fi xtures | Movable     | Plant<br>Operation & | Transportati o                   | Subtotal<br>(cols. 0-4) |                  |
|                  |   | Allocation                   | Fixtures              | Equi pment  | Mai ntenance         | n                                | (COLS. 0-4)             |                  |
|                  |   | (from Wkst.<br>H, col. 10)   |                       |             |                      |                                  |                         |                  |
|                  |   | 0                            | 1. 00                 | 2. 00       | 3.00                 | 4. 00                            | 4A. 00                  |                  |
| 1. 00            | GENERAL SERVICE COST CENTERS  Capital Related - Bldg. & | 0                            | 0                     |             | I                    |                                  | 0                       | 1.00             |
| 1.00             | Fixtures  |                              |                       |             |                      |                                  | 0                       | 1.00             |
| 2. 00            | Capital Related - Movable<br>Equipment                  | 0                            |                       | 0           |                      |                                  | 0                       | 2. 00            |
| 3.00             | Plant Operation & Maintenance                           | 0                            | 0                     | 0           |                      | 0                                | 0                       | 3.00             |
| 4. 00<br>5. 00   | Transportation Administrative and General               | 0<br>265, 977                | 0                     | 0           | 1                    | 0 0                              | 265, 977                | 4. 00<br>5. 00   |
| 5.00             | HHA REIMBURSABLE SERVICES                               | 205, 911                     | 0                     |             |                      | 0                                | 203, 411                | 3.00             |
| 6.00             | Skilled Nursing Care Physical Therapy                   | 302, 163                     | 0                     | 0           | 1                    | 0 0                              | 302, 163                | •                |
| 7. 00<br>8. 00   | Occupational Therapy                                    | 70, 299<br>25, 214           | 0                     | 0           | 1                    | 0 0                              | 70, 299<br>25, 214      | •                |
| 9.00             | Speech Pathology  | 7, 203                       | 0                     | 0           |                      | 0                                | 7, 203                  |                  |
| 10. 00<br>11. 00 | Medical Social Services Home Health Aide                | 0<br>37, 300                 | 0                     | 0           |                      | 0<br>0 0                         | 0<br>37, 300            |                  |
| 12.00            | Supplies (see instructions)                             | O                            | 0                     | 0           |                      | 0 0                              | 0                       | 12.00            |
| 13. 00<br>14. 00 | Drugs<br>DME  | 0<br>0                       | 0                     | 0           |                      | 0 0                              | 0                       | 13. 00<br>14. 00 |
|                  | HHA NONREIMBURSABLE SERVICES                            |                              |                       |             |                      |                                  |                         |                  |
| 15. 00<br>16. 00 | Home Dialysis Aide Services<br>Respiratory Therapy      | 0                            | 0                     | 0           | •                    | 0 0                              | 0                       | 15. 00<br>16. 00 |
| 17. 00           | Private Duty Nursing                                    | O                            | o                     | 0           |                      | 0 0                              | Ō                       | 17. 00           |
| 18. 00<br>19. 00 | Clinic<br>Health Promotion Activities                   | 0                            | 0                     | 0           |                      | 0 0                              | 0                       | 18. 00<br>19. 00 |
| 20.00            | Day Care Program  | 0                            | 0                     | 0           |                      | 0 0                              | 0                       | 20.00            |
| 21.00            | 1   | 0                            | 0                     | 0           |                      | 0 0                              | 0                       | 21.00            |
| 22. 00<br>23. 00 | Homemaker Service All Others (specify)                  | 0                            | 0                     | 0           |                      | 0 0                              | 0                       | 22. 00<br>23. 00 |
| 23. 50           | Tel emedi ci ne   | 0                            | 0                     | 0           |                      | 0                                | 700 454                 | 23.50            |
| 24.00            | Total (sum of lines 1-23)                               | 708, 156<br>Admi ni strati v | Total (cols.          | 0           |                      | 0 0                              | 708, 156                | 24.00            |
|                  |   | e & General<br>5.00          | 4A + 5)               |             |                      |                                  |                         |                  |
|                  | GENERAL SERVICE COST CENTERS                            | 5.00                         | 6. 00                 |             |                      |                                  |                         |                  |
| 1. 00            | Capital Related - Bldg. & Fixtures                      |                              |                       |             |                      |                                  |                         | 1.00             |
| 2. 00            | Capital Related - Movable                               |                              |                       |             |                      |                                  |                         | 2. 00            |
| 3. 00            | Equipment Plant Operation & Maintenance                 |                              |                       |             |                      |                                  |                         | 3. 00            |
| 4. 00            | Transportation  |                              |                       |             |                      |                                  |                         | 4.00             |
| 5. 00            | Administrative and General HHA REIMBURSABLE SERVICES    | 265, 977                     |                       |             |                      |                                  |                         | 5. 00            |
| 6. 00            | Skilled Nursing Care                                    | 181, 755                     | 483, 918              |             |                      |                                  |                         | 6. 00            |
| 7. 00<br>8. 00   | Physical Therapy Occupational Therapy                   | 42, 286<br>15, 167           | 112, 585<br>40, 381   |             |                      |                                  |                         | 7. 00<br>8. 00   |
| 9. 00            | Speech Pathology  | 4, 333                       | 11, 536               |             |                      |                                  |                         | 9. 00            |
| 10. 00<br>11. 00 | Medical Social Services<br>Home Health Aide             | 0<br>22, 436                 | 0<br>59, 736          |             |                      |                                  |                         | 10. 00<br>11. 00 |
| 12. 00           | Supplies (see instructions)                             | 22, 430                      | 59, 730               |             |                      |                                  |                         | 12.00            |
| 13.00            | Drugs   | 0                            | 0                     |             |                      |                                  |                         | 13.00            |
| 14. 00           | DME HHA NONREI MBURSABLE SERVI CES                      | 0                            | U <sub>I</sub>        |             |                      |                                  |                         | 14.00            |
| 15.00            | 1   | 0                            | 0                     |             |                      | -                                |                         | 15.00            |
| 16. 00<br>17. 00 |   | 0                            | 0                     |             |                      |                                  |                         | 16. 00<br>17. 00 |
| 18.00            | Clinic  | 0                            | 0                     |             |                      |                                  |                         | 18. 00           |
| 19. 00<br>20. 00 | Health Promotion Activities Day Care Program            | 0                            | 0                     |             |                      |                                  |                         | 19. 00<br>20. 00 |
| 21.00            | Home Delivered Meals Program                            | 0                            | 0                     |             |                      |                                  |                         | 21.00            |
|                  | Homemaker Service<br>All Others (specify)               | 0                            | 0                     |             |                      |                                  |                         | 22. 00<br>23. 00 |
| 23. 50           | Tel emedi ci ne   | o o                          | 0                     |             |                      |                                  |                         | 23. 50           |
| 24. 00           | Total (sum of lines 1-23)                               |                              | 708, 156              |             |                      |                                  |                         | 24. 00           |

| Heal th | n Financial Systems                                  |                                       | GIBSON GENERA                   | AL HOSPITAL                         |                          | In Lie                                      | u of Form CMS-2   | 2552-10 |
|---------|--|---------------------------------------|---------------------------------|-------------------------------------|--------------------------|---|---|---------|
| COST    | ALLOCATION - HHA STATISTICAL BAS                     | SIS                                   |                                 | Provider C                          |                          | Period:<br>From 10/01/2019<br>To 09/30/2020 | Worksheet H-1<br>Part II<br>Date/Time Pre<br>4/28/2021 8:19 | pared:  |
|         |  |                                       |                                 |                                     |                          | Home Health<br>Agency I                     | PPS   |         |
|         |  | Capital Rel                           | ated Costs                      | ·                                   |                          |   |   |         |
|         |  | BI dgs &<br>Fixtures<br>(SQUARE FEET) | Movable<br>Equipment<br>(DOLLAR | Plant<br>Operation &<br>Maintenance | Transportation (MILEAGE) | Reconciliatio<br>n                          | Administrativ<br>e & General<br>(ACCUM. COST)               |         |
|         |  | 1. 00                                 | VALUE)<br>2. 00                 | (SQUARE FEET)<br>3.00               | 4.00                     | 5A. 00                                      | 5. 00   |         |
|         | GENERAL SERVICE COST CENTERS                         | 11.00                                 | 2.00                            | 0.00                                | 1.00                     | 1 07.11 00                                  | 0.00  |         |
| 1.00    | Capital Related - Bldg. &                            | 0                                     |                                 |                                     |                          | 0   |   | 1. 00   |
| 2. 00   | Fixtures Capital Related - Movable Equipment         |                                       | 0                               |                                     |                          | 0   |   | 2. 00   |
| 3.00    | Plant Operation & Maintenance                        | 0                                     | 0                               | c                                   |                          | 0   |   | 3.00    |
| 4. 00   | Transportation (see instructions)                    | 0                                     | 0                               | C                                   | )                        | 0   |   | 4. 00   |
| 5.00    | Administrative and General HHA REIMBURSABLE SERVICES | 0                                     | 0                               |                                     |                          | 0 -265, 977                                 | 442, 179  | 5. 00   |
| 6. 00   | Skilled Nursing Care                                 | 0                                     | 0                               |                                     | )                        | 0   | 302, 163  | 6.00    |
| 7. 00   | Physical Therapy                                     | l ő                                   | 0                               |                                     |                          | ol o  | 70, 299   |         |
| 8. 00   | Occupational Therapy                                 | O                                     | 0                               |                                     |                          | o o   | 25, 214   |         |
| 0 00    | Carack Dathalam.                                     | ا ما                                  | 0                               | ۱ .                                 | J                        |   | 7 202   | 0 00    |

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Speech Pathology Medical Social Services

Supplies (see instructions)

HHA NONREIMBURSABLE SERVICES

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-23) Cost To Be Allocated (per

Worksheet H-1, Part I) 26.00 Unit Cost Multiplier

Home Health Aide

Respiratory Therapy

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

Private Duty Nursing

Drugs

Clinic

Worksheet H-2 Part I Date/Time Prepared: 4/28/2021 8:15 am From 10/01/2019 To 09/30/2020 HHA CCN: 15-7445 Home Health

|   |   |   |   |  |  | Agency I   |   |   |
|---|---|---|---|--|--|--|---|---|
|   |   |   | CAPI TAL REL  | ATED COSTS   |  | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |   |   |
|   | Cost Center Description   | HHA Trial<br>Balance (1)  | BLDG & FIXT   | MVBLE EQUIP  | EMPLOYEE<br>BENEFITS<br>DEPARTMENT   | Subtotal   | ADMINISTRATIV<br>E & GENERAL  |   |
|   |   | 0   | 1. 00   | 2. 00  | 4. 00  | 4A   | 5. 00   |   |
| 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00<br>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 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 | 0<br>483, 918<br>112, 585<br>40, 381<br>11, 536<br>0<br>59, 736<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 13, 840<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 000000000000000000000000000000000000000  | 81, 185<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 95, 025 483, 918 112, 585 40, 381 11, 536 0 59, 736 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0              | 29, 364<br>149, 536<br>34, 790<br>12, 478<br>3, 565<br>0  | 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00<br>21. 00 |
|   | 6 decimal places.  Cost Center Description  | OPERATION OF PLANT  | LAUNDRY &<br>LINEN SERVICE  | HOUSEKEEPI NG  | DI ETARY   | CAFETERI A   | NURSI NG<br>ADMI NI STRATI O<br>N   |   |
|   |   | 7. 00   | 8. 00   | 9. 00  | 10.00  | 11. 00   | 13. 00  |   |
| 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00<br>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 6 decimal places.                                     | 33, 525<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0       | 8, 388<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 0  | 30, 942<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 42, 646<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 17. 00<br>18. 00<br>19. 00<br>19. 50  |

<sup>(1)</sup> 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.

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Unit Cost Multiplier: column

6 decimal places.

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

<sup>(1)</sup> 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.

| ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-1319 Period: Worksheet H.   | IS-2552-10 |
|--|------------|
| BASIS HHA CCN: 15-7445 From 10/01/2019 Part II To 09/30/2020 Date/Time Production Produc | Prepared:  |

|  | CAPI TAL REL   |   |   |   |   |   |   |
|--|--|---|---|---|---|---|---|
|  |  | ATED COSTS  | ·   |   | Agency I  |   |   |
| Cost Center Description  | BLDG & FIXT<br>(SQUARE FEET)   | MVBLE EQUIP<br>(SQUARE FEET)  | EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)                       | Reconciliatio<br>n                                    | ADMINISTRATIV<br>E & GENERAL<br>(ACCUM. COST)   | OPERATION OF<br>PLANT<br>(SQUARE FEET)  |   |
|  | 1. 00  | 2. 00   | 4. 00   | 5A  | 5. 00   | 7. 00   |   |
| 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier | 505<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 505<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                          | 459, 861<br>00<br>00<br>00<br>00<br>00<br>00<br>00<br>00<br>00<br>0 | 0<br>0<br>0<br>0<br>0<br>0<br>0                       | 95, 025<br>483, 918<br>112, 585<br>40, 381<br>11, 536<br>0<br>59, 736<br>0<br>0<br>0<br>0<br>0<br>0     | 7. 00  505  0  0  0  0  0  0  0  0  0  0  0   | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00<br>21. 00 |
|  | DAYS)  |   |   |   | (NURSE<br>SALARI ES)  | (COSTED<br>REQUIS.)   |   |
|  | 8. 00  | 9. 00   | 10. 00  | 11.00   | 13. 00  | 14.00   |   |
| 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated                            | 000000000000000000000000000000000000000                              | 505<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0       | 459, 861<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 267, 659<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 13, 717<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>19. 00<br>19. 50   |

| Health Financial Systems   |  | GIBSON GENERAL  | HOSPI TAL |                         | In Lie                                       | u of Form CMS-:  | 2552-10   |
|--|--|---|-----------|-------------------------|--|--|---|
| ALLOCATION OF GENERAL SERVICE COSTS T<br>BASIS   | O HHA COST CEN   | TERS STATISTICAL  | Provider  | CCN: 15-1319<br>15-7445 | Peri od:<br>From 10/01/2019<br>To 09/30/2020 | Worksheet H-2<br>Part II<br>Date/Time Pre<br>4/28/2021 8:1 | pared:  |
|  |  |   |           |                         | Home Health<br>Agency I                      | PPS  |   |
| Cost Center Description  | PHARMACY<br>(COSTED<br>REQUIS.)                                    | MEDI CAL RECORDS & LI BRARY (GROSS PATI ENT REVENUE)    |           |                         | ingoney i                                    |  |   |
| 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier | 15. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 16. 00  841, 639  0  0  0  0  0  0  0  0  0  0  0  0  0 |           |                         |  |  | 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00<br>21. 00<br>22. 00 |

| Hool +h    | Financial Systems                                  |  | CLDSON CENED                          | AL HOSDITAL                        |                                    | In Lie                           | u of Form CMS 3                        | DEE2 10  |
|------------|--|--|---------------------------------------|------------------------------------|------------------------------------|----------------------------------|--|--|
|            | Financial Systems TIONMENT OF PATIENT SERVICE COST | ς  | GI BSON GENERA                        | Provi der C                        | ^N: 15_1310                        | Peri od:                         | u of Form CMS-2<br>Worksheet H-3       |  |
| 711 1 0101 | TONNENT OF TATTENT SERVICE GOST                    |  |                                       | HHA CCN:                           | 15-7445                            | From 10/01/2019<br>To 09/30/2020 | Part I<br>Date/Time Pre                | pared:   |
|            |  |  |                                       | Titl€                              | XVIII                              | Home Health<br>Agency I          | 4/28/2021 8: 1<br>PPS                  | <u> 3 aiii                                </u> |
|            | Cost Center Description                            | From, Wkst.<br>H-2, Part I,<br>col. 28, line | Facility<br>Costs (from<br>Wkst. H-2, | Shared<br>Ancillary<br>Costs (from | Total HHA<br>Costs (cols<br>1 + 2) | Total Visits                     | Average Cost<br>Per Visit<br>(col. 3 ÷ |  |
|            |  |  | Part I)                               | Part II)                           |                                    |                                  | col . 4)                               |  |
|            |  | 0  | 1. 00                                 | 2. 00                              | 3. 00                              | 4. 00                            | 5. 00                                  |  |
|            | PART I - COMPUTATION OF LESSER COST LIMITATION     | OF AGGREGATE                                 | PROGRAM COST, A                       | AGGREGATE OF T                     | HE PROGRAM LI                      | MITATION COST, C                 | OR BENEFICIARY                         |  |
|            | Cost Per Visit Computation                         |  |                                       |                                    |                                    |                                  |  |  |
| 1. 00      | Skilled Nursing Care                               | 2. 00  |                                       |                                    | 805, 7                             |                                  |  |  |
| 2.00       | Physi cal Therapy                                  | 3. 00  |                                       | l e                                |                                    |                                  | 107. 92                                |  |
| 3. 00      | Occupational Therapy                               | 4. 00  | · ·                                   |                                    | ,-                                 |                                  |  |  |
| 4.00       | Speech Pathology                                   | 5. 00  |                                       | 0                                  | 19, 20                             |                                  | 107. 91                                |  |
| 5.00       | Medical Social Services                            | 6. 00  |                                       | l                                  |                                    | 0                                | 0. 00                                  | 1  |
| 6.00       | Home Health Aide                                   | 7. 00  | 99, 461                               |                                    | 99, 4                              |                                  | 346. 55                                | 6.00   |
| 7. 00      | Total (sum of lines 1-6)                           |  | 1, 179, 083                           | 0                                  | 1, 179, 0                          | 5, 498                           |  | 7. 00  |
|            |  |  |                                       |                                    | Program Visi                       |                                  |  |  |
|            |  |  |                                       |                                    | Р                                  | art B                            |  |  |
|            | Cost Center Description                            | Cost Limits                                  | CBSA No. (1)                          | Part A                             | Not Subject                        |                                  |  |  |
|            | , , , , , , , , , , , , , , , , , , ,              |  |                                       |                                    | to                                 | Deducti bl es                    |  |  |
|            |  |  |                                       |                                    | Deductibles                        | &                                |  |  |
|            |  |  |                                       |                                    | Coi nsurance                       |                                  |  |  |
|            |  | 0  | 1. 00                                 | 2.00                               | 3.00                               | 4. 00                            | 5. 00                                  |  |
|            | Limitation Cost Computation                        |  |                                       |                                    |                                    |                                  |  |  |
| 8.00       | Skilled Nursing Care                               |  | 99915                                 | 0                                  | 1, 6                               | 03                               |  | 8. 00  |
| 9.00       | Physi cal Therapy                                  |  | 99915                                 | 0                                  | 1, 1                               | 17                               |  | 9.00   |
| 10.00      | Occupational Therapy                               |  | 99915                                 | 0                                  | 3                                  | 76                               |  | 10.00  |
| 11.00      | Speech Pathology                                   |  | 99915                                 | 0                                  | 1                                  | 50                               |  | 11.00  |
| 12.00      | Medical Social Services                            |  | 99915                                 | 0                                  |                                    | 0                                |  | 12.00  |
| 13.00      | Home Health Aide                                   |  | 99915                                 | 0                                  | 2                                  | 30                               |  | 13.00  |
| 14.00      | Total (sum of lines 8-13)                          |  |                                       | 0                                  | 3, 4                               | 76                               |  | 14.00  |
|            | Cost Center Description                            | From Wkst.<br>H-2 Part I,<br>col. 28, line   | Facility Costs (from Wkst. H-2,       | Shared Ancillary Costs (from       | Total HHA<br>Costs (cols<br>1 + 2) |                                  | Ratio (col. 3<br>÷ col. 4)             |  |
|            |  | 0  | Part I)<br>1.00                       | Part II)<br>2.00                   | 3.00                               | 4.00                             | 5. 00                                  |  |
|            | Supplies and Drugs Cost Comput                     |  | 1.00                                  | 2.00                               | 3.00                               | 4.00                             | 5.00                                   |  |
| 15 00      | Cost of Medical Supplies                           | 8. 00  | 0                                     | 0                                  |                                    | 0 0                              | 0. 000000                              | 15 00  |
|            | Cost of Drugs                                      | 9. 00  | 0                                     | 0                                  |                                    | 0 0                              |  | 1  |
|            |  |  | Program Visits                        |                                    | Cost of<br>Services                |                                  |  |  |
|            |  |  | Par                                   |                                    |                                    | 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  | .,                                    | l                                  |                                    | 0 483, 192                       |  | 1.00   |
| 2.00       | Physi cal Therapy                                  | 0  | 1, 117                                | ł                                  |                                    | 0 120, 547                       |  | 2.00   |
| 3.00       | Occupational Therapy                               | 0  | 376                                   |                                    |                                    | 0 40, 578                        |  | 3.00   |
| 4.00       | Speech Pathology                                   | 0  | 150                                   | ł                                  |                                    | 0 16, 187                        |  | 4.00   |
| 5.00       | Medical Social Services                            | 0  | 0                                     | l .                                |                                    | 0                                |  | 5.00   |
| 6.00       | Home Health Aide                                   | 0  | 230                                   |                                    | 1                                  | 0 79, 707                        |  | 6.00   |
|            |  |  |                                       |                                    | •                                  |                                  |  | •  |
| 7. 00      | Total (sum of lines 1-6)                           | 0  |                                       |                                    |                                    | 0 740, 211                       |  | 7. 00  |

| Heal th | Financial Systems  |               | GIBSON GENER   | AL HOSPITAL     |              | In Lie                           | u of Form CMS-                           | 2552-10 |
|---------|--|---------------|----------------|-----------------|--------------|----------------------------------|--|---------|
|         | TIONMENT OF PATIENT SERVICE COST                           | ΓS            |                | Provi der C     | CN: 15-1319  | Peri od:                         | Worksheet H-3                            |         |
|         |  |               |                | HHA CCN:        | 15-7445      | From 10/01/2019<br>To 09/30/2020 | Part I<br>Date/Time Pre<br>4/28/2021 8:1 |         |
|         |  |               |                | Title           | XVIII        | Home Health                      | PPS                                      |         |
|         | Cost Center Description                                    |               |                |                 |              | Agency I                         |  |         |
|         | cost center bescription                                    | 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   | Physical Therapy   |               |                |                 |              |                                  |  | 9.00    |
| 10.00   | Occupational Therapy                                       |               |                |                 |              |                                  |  | 10.00   |
| 11. 00  | Speech Pathology   |               |                |                 |              |                                  |  | 11.00   |
| 12.00   | Medical Social Services                                    |               |                |                 |              |                                  |  | 12.00   |
| 13.00   | Home Health Aide   |               |                |                 |              |                                  |  | 13.00   |
| 14.00   | Total (sum of lines 8-13)                                  |               |                |                 |              |                                  |  | 14.00   |
|         |  | Progi         | ram Covered Ch | arges           | Cost of      |                                  |  |         |
|         |  |               |                |                 | Servi ces    |                                  |  |         |
|         |  |               |                |                 |              |                                  |  |         |
|         |  |               |                | 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                             |         |
|         |  | / 00          | Coi nsurance   | 0.00            | 0.00         | Coi nsurance                     | 44.00                                    |         |
|         | Cupplies and Drugs Cost Comput                             | 6.00          | 7. 00          | 8. 00           | 9. 00        | 10.00                            | 11. 00                                   |         |
| 15 00   | Supplies and Drugs Cost Comput<br>Cost of Medical Supplies | 0             | C              | 0               |              | 0 0                              | C  | 15.00   |
|         | Cost of Drugs  | 0             |                | l .             |              | 0                                |  |         |
| 10.00   | Cost Center Description                                    | Total Program |                | 0               |              | 0                                | C  | 10.00   |
|         | cost center beserration                                    | Cost (sum of  |                |                 |              |                                  |  |         |
|         |  | col s. 9-10)  |                |                 |              |                                  |  |         |
|         |  | 12. 00        |                |                 |              |                                  |  |         |
|         | PART I - COMPUTATION OF LESSER                             | OF AGGREGATE  | PROGRAM COST,  | AGGREGATE OF TH | HE PROGRAM L | IMITATION COST, C                | R BENEFICIARY                            |         |
|         | COST LIMITATION  |               |                |                 |              |                                  |  |         |
|         | Cost Per Visit Computation                                 |               |                |                 |              |                                  |  |         |
| 1.00    | Skilled Nursing Care                                       | 483, 192      |                |                 |              |                                  |  | 1.00    |
| 2. 00   | Physi cal Therapy  | 120, 547      |                |                 |              |                                  |  | 2.00    |
| 3. 00   | Occupational Therapy                                       | 40, 578       |                |                 |              |                                  |  | 3. 00   |
| 4. 00   | Speech Pathology   | 16, 187       | 4              |                 |              |                                  |  | 4. 00   |
| 5. 00   | Medical Social Services                                    | 0             |                |                 |              |                                  |  | 5. 00   |
| 6.00    | Home Heal th Ai de   | 79, 707       |                |                 |              |                                  |  | 6.00    |
| 7. 00   | Total (sum of lines 1-6)                                   | 740, 211      |                |                 |              |                                  |  | 7. 00   |
|         | Cost Center Description                                    | 12. 00        | -              |                 |              |                                  |  | -       |
|         | Limitation Cost Computation                                | 12.00         |                |                 |              |                                  |  |         |
| 8. 00   | Skilled Nursing Care                                       |               |                |                 |              |                                  |  | 8.00    |
| 9. 00   | Physical Therapy   |               |                |                 |              |                                  |  | 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 Aide  |               |                |                 |              |                                  |  | 13.00   |
|         | Total (sum of lines 8-13)                                  |               |                |                 |              |                                  |  | 14.00   |
| 20      | (  | 1             | I              |                 |              |                                  |  | 1       |

| Heal th | Financial Systems               |                | GI BSON GENERA  | AL HOSPITAL    |              | In Lieu of Form CMS-2552         |               |      |
|---------|---------------------------------|----------------|-----------------|----------------|--------------|----------------------------------|---------------|------|
| APP0R1  | TIONMENT OF PATIENT SERVICE COS | ΓS             |                 | Provi der C    | CN: 15-1319  | Peri od:                         | Worksheet H-3 |      |
|         |                                 |                |                 | HHA CCN:       | 15-7445      | From 10/01/2019<br>To 09/30/2020 |               |      |
|         |                                 |                |                 | 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 E | BY SHARED HOSP | TAL DEPARTME | ENTS                             |               |      |
| 1.00    | Physi cal Therapy               | 66.00          | 0. 368810       | 0              |              | 0 col. 2, line 2                 | . 00          | 1.00 |
| 2.00    | Occupational Therapy            | 67.00          | 0. 290472       | 0              |              | 0 col. 2, line 3                 | . 00          | 2.00 |
| 3.00    | Speech Pathology                | 68.00          | 0. 300649       | 0              |              | Ocol. 2, line 4                  | . 00          | 3.00 |
| 4.00    | Cost of Medical Supplies        | 71.00          | 0. 895903       | 0              |              | 0 col. 2, line 1                 | 5. 00         | 4.00 |
| 5.00    | Cost of Drugs                   | 73.00          | 0. 445209       | 0              |              | 0 col. 2, line 1                 | 6. 00         | 5.00 |

|                         | Financial Systems GIBSON GENI<br>LATION OF HHA REIMBURSEMENT SETTLEMENT  | ERAL HOSPITAL  Provider C | ^N· 15_1310 | In Lie                             | u of Form CMS-2552<br>Worksheet H-4        |             |
|-------------------------|--|---------------------------|-------------|------------------------------------|--|-------------|
| ALCUL                   | ATTON OF THE RETWINDORSEMENT SETTLEMENT  | HHA CCN:                  | 15-7445     | From 10/01/2019<br>To 09/30/2020   | Part I-II<br>Date/Time Pre                 | pared       |
|                         |  | Title                     | XVIII       | Home Health                        | 4/28/2021 8: 1<br>PPS                      | <u>5 am</u> |
|                         |  |                           |             | Agency I                           | t B  |             |
|                         |  |                           | Part A      | Not Subject<br>to<br>Deductibles & | Subject to<br>Deductibles &<br>Coinsurance |             |
|                         |  |                           | 4.00        | Coi nsurance                       |  |             |
|                         | PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR   | CUSTOMARY CHARGE          | 1.00<br>-s  | 2. 00                              | 3. 00                                      |             |
|                         | Reasonable Cost of Part A & Part B Services  | OCOTOMARCI OTARCO         |             |                                    |  | 1           |
| 00                      | Reasonable cost of services (see instructions)   |                           |             | 0 0                                | 0  | 1.          |
| . 00                    | Total charges  |                           |             | 0 0                                | 0  | 2.          |
| 00                      | Customary Charges  | -+ <i>6</i>               |             |                                    | 0  | ١,          |
| . 00                    | Amount actually collected from patients liable for paymer on a charge basis (from your records)  | nt for services           |             | 0 0                                | 0  | 3.          |
| . 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      | 0. 000000                          | 0.000000                                   | 5.          |
| . 00                    | Total customary charges (see instructions)   |                           |             | 0 0                                | 0  |             |
| . 00                    | Excess of total customary charges over total reasonable  | cost (complete            |             | 0 0                                | 0  | 7.          |
| . 00                    | only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (comple 1 exceeds line 6)                                  | te only if line           |             | 0 0                                | 0  | 8.          |
| . 00                    | Primary payer amounts  |                           |             | 0 0                                | 0  | 9.          |
|                         |  |                           |             | Part A<br>Services                 | Part B<br>Services                         |             |
|                         | DART III GOURNITATION OF THE RELIGIOUS OF THE RESIDENT   |                           |             | 1. 00                              | 2. 00                                      |             |
| 0. 00                   | PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)   |                           |             | 0                                  | 0  | 10.         |
| 1. 00                   | Total PPS Reimbursement - Full Episodes without Outliers   |                           |             | 0                                  | 455, 080                                   |             |
| 2. 00                   | Total PPS Reimbursement - Full Episodes with Outliers  |                           |             | 0                                  | 37, 084                                    |             |
| 3. 00                   | Total PPS Reimbursement - LUPA Episodes  |                           |             | 0                                  | 7, 881                                     | 13.         |
| 1. 00                   | Total PPS Reimbursement - PEP Episodes   |                           |             | 0                                  | 483  |             |
| 5. 00                   | Total PPS Outlier Reimbursement - Full Episodes with Out   | liers                     |             | 0                                  | 8, 852                                     |             |
| o. 00<br>'. 00          | Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  |                           |             | 0                                  | 0  |             |
| 3. 00                   | DME Payments   |                           |             | 0                                  | 0  | 1           |
| . 00                    |  |                           |             | 0                                  | 0  | 1           |
| . 00                    |  |                           |             | 0                                  | 0  | 20          |
| . 00                    | ,  | coi nsurance)             |             |                                    | 0  |             |
| 2. 00                   | ,  |                           |             | 0                                  | 509, 380                                   |             |
| 3. 00<br>1. 00          |  |                           |             | 0                                  | 0<br>509, 380                              |             |
| 5. 00                   |  | s)                        |             | 0                                  | 0  | 1           |
| 5. 00                   |  | 3)                        |             | 0                                  | 509, 380                                   |             |
| 7. 00                   | Reimbursable bad debts (from your records)   |                           |             |                                    |  | 27          |
| 3. 00                   |  |                           | )           |                                    |  | 28          |
| 9. 00                   | Total costs - current cost reporting period (line 26 plus  | s line 27)                |             | 0                                  | 509, 380                                   |             |
| 0.00                    | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   | -+!>                      |             | 0                                  | 0  |             |
| ). 50<br>). 99          | Pioneer ACO demonstration payment adjustment (see instru-<br>Demonstration payment adjustment amount before sequestra                      |                           |             | 0                                  | 0  | 1           |
| 1. 00                   | 1 7 7  | LI OII                    |             | 0                                  | 509, 380                                   |             |
| 1. 01                   | Sequestration adjustment (see instructions)  |                           |             | 0                                  | 5, 692                                     |             |
| 1. 02                   | Demonstration payment adjustment amount after sequestrat   | i on                      |             | 0                                  | 0  | 1           |
| 2. 00                   | 1  |                           |             | 0                                  | 503, 688                                   |             |
|                         | Tentative settlement (for contractor use only)   |                           |             | 0                                  | 0  | 33.         |
| 3. 00                   | ,  |                           |             |                                    |  | 1 -         |
| 3. 00<br>4. 00<br>5. 00 | Balance due provider/program (line 31 minus lines 31.01,   |                           | C D. L 45 C | 0                                  | 0  | 1           |

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1319 | Period: From 10/01/2019 | To 09/30/2020 | Date/Time Prepared:

4/28/2021 8:15 am

8.00

Home Health PPS Agency I Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1. 00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 503, 688 1.00 O 2.00 Interim payments payable on individual bills, either 2.00 0 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 0 3.01 0 3.02 3.02 0 3.03 0 3.03 3.04 0 0 3.04 0 3.05 0 3.05 Provider to Program 3.50 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 3.99 3. 50-3. 98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 503, 688 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 O n 5.01 0 5.02 0 5.02 5.03 0 0 5.03 Provider to Program 5.50 O n 5 50 5.51 0 0 5.51 0 0 5.52 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5, 50-5, 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 6.01 0 SETTLEMENT TO PROGRAM 6.02 6.02 0 Total Medicare program liability (see instructions) n 503, 688 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00

8.00 Name of Contractor

|                  | Financial Systems   | GI BSON GENERA     |                    |              |                                  | eu of Form CMS-   |                  |
|------------------|---|--------------------|--------------------|--------------|----------------------------------|-------------------|------------------|
| ANALYS           | SIS OF HOSPITAL-BASED RHC/FQHC COSTS                            |                    | Provi der C        | CN: 15-1319  | Peri od:                         | Worksheet M-1     |                  |
|                  |   |                    | Component          | CCN: 15-8524 | From 10/01/2019<br>To 09/30/2020 |                   | pared:           |
|                  |   |                    |                    |              |                                  | 4/28/2021 8: 1    |                  |
|                  |   |                    |                    | 1            | RHC I                            | Cost              |                  |
|                  |   | Compensation       | Other Costs        | ,            | 1 Reclassificat                  |                   |                  |
|                  |   |                    |                    | + 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              | 2.00               | 0.00         | 1. 00                            | 0.00              |                  |
| 1.00             | Physi ci an   | 0                  | 0                  |              | 0 18, 304                        | 18, 304           | 1.00             |
| 2.00             | Physi ci an Assi stant  | 0                  | 0                  |              | 0 0                              | 0                 | 2.00             |
| 3.00             | Nurse Practitioner  | 121, 141           | 0                  | 121, 1       | 41 -18, 224                      | 102, 917          | 3.00             |
| 4.00             | Visiting Nurse  | 0                  | 0                  |              | 0 0                              | 0                 | 4.00             |
| 5.00             | Other Nurse   | 27, 545            | 0                  | 27, 5        | 45 C                             | 27, 545           | 5.00             |
| 6.00             | Clinical Psychologist   | 0                  | 0                  |              | 0 0                              | 0                 | 6.00             |
| 7.00             | Clinical Social Worker  | 0                  | 0                  |              | 0 0                              | 0                 | 7.00             |
| 8.00             | Laboratory Techni ci an   | 0                  | 0                  |              | 0                                | 0                 |                  |
| 9.00             | Other Facility Health Care Staff Costs                          | 0                  | 0                  |              | 0 0                              | ή                 |                  |
| 10.00            | Subtotal (sum of lines 1 through 9)                             | 148, 686           | 0                  | 148, 6       |                                  |                   |                  |
| 11.00            | Physician Services Under Agreement                              | 0                  | 0                  |              | 0                                | 0                 |                  |
| 12.00            | Physician Supervision Under Agreement                           | 0                  | 0                  |              | 0                                | 0                 |                  |
| 13.00            | Other Costs Under Agreement                                     | 0                  | 0                  |              | 0                                | 1                 |                  |
| 14.00            | Subtotal (sum of lines 11 through 13)                           | 0                  | 0                  | 00.0         | 0 0                              | ή                 |                  |
| 15.00            | Medical Supplies  | 0                  | 22, 845            | 22, 8        | -22, 845                         | 1                 |                  |
| 16.00            | Transportation (Health Care Staff)                              | U                  | 0                  |              |                                  | 0                 |                  |
| 17. 00<br>18. 00 | Depreciation-Medical Equipment Professional Liability Insurance | 0                  | 0                  |              |                                  | 0                 | 17. 00<br>18. 00 |
| 19. 00           | Other Health Care Costs   | 0                  | 0                  |              |                                  |                   |                  |
| 20. 00           | Allowable GME Costs   | U                  | O                  |              |                                  | ,                 | 20.00            |
| 21. 00           | Subtotal (sum of lines 15 through 20)                           | 0                  | 22, 845            | 22, 8        | 45 -22, 845                      | 0                 |                  |
| 22. 00           | Total Cost of Health Care Services (sum of                      | 148, 686           | 22, 845            |              |                                  | 1                 | 1                |
|                  | lines 10, 14, and 21)   |                    | ,                  |              |                                  |                   |                  |
|                  | COSTS OTHER THAN RHC/FQHC SERVICES                              |                    |                    | •            | •                                |                   | 1                |
| 23.00            | Pharmacy  | 0                  | 0                  |              | 0 0                              | 0                 | 23.00            |
| 24.00            | Dental  | 0                  | 0                  |              | 0                                | 0                 | 24.00            |
| 25.00            | Optometry   | 0                  | 0                  |              | 0                                | 0                 |                  |
| 25. 01           | Tel eheal th  | 0                  | 0                  |              | 0 0                              | 0                 |                  |
| 25. 02           | Chronic Care Management   | 0                  | 0                  |              | 0                                | 0                 |                  |
| 26. 00           | All other nonreimbursable costs                                 | 0                  | 0                  |              | 0                                | 0                 | 26. 00           |
| 27. 00           | Nonallowable GME costs  |                    |                    |              | _                                |                   | 27.00            |
| 28. 00           | Total Nonreimbursable Costs (sum of lines 23                    | 0                  | 0                  | 1            | 0                                | 0                 | 28.00            |
|                  | through 27)   |                    |                    |              |                                  |                   | 1                |
| 20.00            | FACILITY OVERHEAD   | O                  | 7 700              | 7, 7         | 09                               | 7, 709            | 29.00            |
| 29. 00<br>30. 00 | Facility Costs<br>Administrative Costs                          | 57, 852            | 7, 709<br>112, 034 |              |                                  |                   |                  |
|                  | Total Facility Overhead (sum of lines 29 and                    | 57, 852<br>57, 852 | 112,034            |              |                                  |                   |                  |

57, 852

206, 538

119, 743

142, 588

177, 595

349, 126

8, 986

-13, 779

186, 581

335, 347

31.00

32.00

Total Facility Overhead (sum of lines 29 and

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

| Health Financial Systems                  | GI BSON GENERA | AL HOSPITAL |                 | In Lie                      | u of Form CMS-                 | 2552-10        |
|---|----------------|-------------|-----------------|-----------------------------|--------------------------------|----------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |                | Provi de    | r CCN: 15-1319  | Peri od:<br>From 10/01/2019 | Worksheet M-1                  |                |
|   |                | Compone     | nt CCN: 15-8524 | To 09/30/2020               | Date/Time Pre<br>4/28/2021 8:1 | pared:<br>5 am |
|   |                |             |                 | RHC I                       | Cost                           |                |
|   | Adjustments    | Net Expens  | es              |                             |                                |                |
|   |                | for         |                 |                             |                                |                |
|   |                | Allocatio   | n               |                             |                                |                |
|   |                | (col. 5     | +               |                             |                                |                |
|   |                | col. 6)     |                 |                             |                                |                |

|        |  | Adjustments | Net Expenses |     |        |
|--------|--|-------------|--------------|-----|--------|
|        |  |             | for          |     |        |
|        |  |             | Allocation   |     |        |
|        |  |             | (col. 5 +    |     |        |
|        |  |             | col. 6)      |     |        |
|        |  | 6. 00       | 7. 00        |     |        |
|        | FACILITY HEALTH CARE STAFF COSTS             |             |              |     |        |
| 1.00   | Physi ci an                                  | 0           | 18, 304      |     | 1.00   |
| 2.00   | Physi ci an Assi stant                       | 0           | 0            |     | 2.00   |
| 3.00   | Nurse Practitioner                           | 0           | 102, 917     |     | 3.00   |
| 4.00   | Visiting Nurse                               | 0           | 0            |     | 4.00   |
| 5. 00  | Other Nurse                                  | 0           | 27, 545      |     | 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           | l ő          | l . | 8.00   |
| 9. 00  | Other Facility Health Care Staff Costs       | 0           | 0            |     | 9.00   |
| 10.00  | Subtotal (sum of lines 1 through 9)          | 0           | 148, 766     | l . | 10.00  |
| 11. 00 | Physician Services Under Agreement           | 0           | 0            | l . | 11.00  |
| 12. 00 | Physician Supervision Under Agreement        | 0           | 0            |     | 12.00  |
| 13. 00 | Other Costs Under Agreement                  | 0           | 0            | l . | 13.00  |
|        |  | 0           | 0            |     |        |
| 14.00  | Subtotal (sum of lines 11 through 13)        | 0           | · -          |     | 14.00  |
| 15.00  | Medical Supplies                             | 0           | 0            |     | 15.00  |
| 16.00  | Transportation (Health Care Staff)           | 0           | 0            |     | 16.00  |
| 17.00  | Depreciation-Medical Equipment               | 0           | 0            |     | 17.00  |
| 18.00  | Professional Liability Insurance             | 0           | 0            |     | 18.00  |
| 19. 00 | Other Health Care Costs                      | 0           | 0            |     | 19.00  |
| 20. 00 | Allowable GME Costs                          |             |              |     | 20.00  |
| 21. 00 | Subtotal (sum of lines 15 through 20)        | 0           | 0            |     | 21.00  |
| 22. 00 | Total Cost of Health Care Services (sum of   | 0           | 148, 766     |     | 22. 00 |
|        | lines 10, 14, and 21)                        |             |              |     | 1      |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             | _            | T   |        |
| 23. 00 | Pharmacy                                     | 0           | 0            |     | 23. 00 |
| 24. 00 | Dental                                       | 0           | 0            |     | 24.00  |
| 25. 00 | Optometry                                    | 0           | 0            |     | 25. 00 |
| 25. 01 | Tel eheal th                                 | 0           | 0            |     | 25. 01 |
| 25. 02 | Chronic Care Management                      | 0           | 0            |     | 25. 02 |
| 26. 00 | All other nonreimbursable costs              | 0           | 0            |     | 26. 00 |
| 27. 00 | Nonallowable GME costs                       |             |              |     | 27.00  |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0           | 0            |     | 28. 00 |
|        | through 27)                                  |             |              |     | 1      |
|        | FACILITY OVERHEAD                            |             | T            |     | 1      |
| 29. 00 | Facility Costs                               | 0           | .,           |     | 29. 00 |
| 30.00  | Administrative Costs                         | 0           | ,            |     | 30.00  |
| 31.00  | Total Facility Overhead (sum of lines 29 and | 0           | 186, 581     |     | 31.00  |
|        | 30)  |             |              |     |        |
| 32.00  | Total facility costs (sum of lines 22, 28    | 0           | 335, 347     |     | 32.00  |
|        | and 31)                                      |             |              |     | I      |
|        |  |             |              |     |        |

| Heal th          | Financial Systems  | GI BSON GENERA | ΔΙ ΗΩΩΡΙΤΔΙ |               | In lie                           | u of Form CMS-2                | 2552_10        |
|------------------|--|----------------|-------------|---------------|----------------------------------|--------------------------------|----------------|
|                  | SIS OF HOSPITAL-BASED RHC/FQHC COSTS                                 | OI BOON GENERA | Provi der C |               | Peri od:                         | Worksheet M-1                  |                |
|                  |  |                | Component   |               | From 10/01/2019<br>To 09/30/2020 | Date/Time Pre<br>4/28/2021 8:1 | pared:         |
|                  |  |                |             |               | RHC II                           | Cost                           | o um           |
|                  | ·  | Compensation   | Other Costs | Total (col. 1 | Recl assi 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  | 110, 453       |             |               |                                  | 110, 453                       | 1              |
| 2.00             | Physician Assistant  | 0              | 0           |               | 0                                | 0                              |                |
| 3.00             | Nurse Practitioner   | 30, 151        | 0           | 30, 15        | 1 18, 224                        | 48, 375                        | 1              |
| 4.00             | Visiting Nurse   | 0              | 0           |               | 0                                | 0                              | 4.00           |
| 5.00             | Other Nurse  | 28, 335        | 0           | 28, 33        | 5 0                              | 28, 335                        | 1              |
| 6. 00            | Clinical Psychologist  | 0              | 0           |               | 0                                | 0                              | 0.00           |
| 7. 00            | Clinical Social Worker   | 0              | 0           |               | 0                                | 0                              |                |
| 8. 00            | Laboratory Technician  | 0              | 0           |               | 0                                | 0                              | 8.00           |
| 9.00             | Other Facility Health Care Staff Costs                               | 1/0 020        | 0           | 1/0 02/       | 10 224                           | 107.1(2                        |                |
| 10.00            | Subtotal (sum of lines 1 through 9)                                  | 168, 939       | 0           | 168, 93       | 9 18, 224                        | 187, 163                       | 1              |
| 11.00            | Physician Services Under Agreement                                   | 0              | 0           |               | 0                                | 0                              | 11.00          |
| 12. 00<br>13. 00 | Physician Supervision Under Agreement<br>Other Costs Under Agreement | 0              | 0           |               | 0                                | 0                              | 12.00<br>13.00 |
| 14. 00           | Subtotal (sum of lines 11 through 13)                                | 0              | 0           |               | 0                                | 0                              | 14.00          |
| 15. 00           | Medical Supplies   | 0              | 67, 222     | 67, 22:       | 2 -67, 222                       | 0                              | 15.00          |
| 16. 00           | Transportation (Health Care Staff)                                   | 0              | 07,222      | 07,22.        | -07, 222                         | 0                              | 16.00          |
| 17. 00           | Depreciation-Medical Equipment                                       | 0              |             | ]             |                                  | 0                              | 17.00          |
| 18. 00           | Professional Liability Insurance                                     | 0              |             | ]             |                                  | 0                              | 18.00          |
|                  | Other Health Care Costs  | 0              |             | )             |                                  | 0                              | 19.00          |
| 20. 00           | Allowable GME Costs  | 0              | 0           | `             |                                  | O                              | 20.00          |
| 21. 00           | Subtotal (sum of lines 15 through 20)                                | 0              | 67, 222     | 67, 22        | -67, 222                         | 0                              | 1              |
| 22. 00           | Total Cost of Health Care Services (sum of                           | 168, 939       | ·           | 236, 16       |                                  | _                              | 1              |
| 22.00            | lines 10, 14, and 21)  | 100, 707       | 07,222      | 200, 10       | 10, 770                          | 107, 100                       | 22.00          |
|                  | COSTS OTHER THAN RHC/FQHC SERVICES                                   |                |             |               |                                  |                                | 1              |
| 23.00            | Pharmacy   | 0              | 0           |               | 0 0                              | 0                              | 23. 00         |
| 24.00            | Dental   | 0              | 0           |               | 0                                | 0                              | 24.00          |
| 25.00            | Optometry  | 0              | 0           |               | 0                                | 0                              | 25.00          |
| 25. 01           | Tel eheal th   | 0              | 0           |               | 0                                | 0                              | 25. 01         |
| 25. 02           | Chronic Care Management  | 0              | 0           |               | 0                                | 0                              | 25. 02         |
| 26.00            | All other nonreimbursable costs                                      | 0              | 0           |               | 0                                | 0                              | 26. 00         |
| 27.00            | Nonallowable GME costs   |                |             |               |                                  |                                | 27.00          |
| 28.00            | Total Nonreimbursable Costs (sum of lines 23                         | 0              | 0           |               | 0 0                              | 0                              | 28. 00         |
|                  | through 27)  |                |             |               |                                  |                                |                |
|                  | FACILITY OVERHEAD  |                |             |               |                                  |                                | ļ              |
| 29. 00           | Facility Costs   | 0              | _           |               | 0                                | 0                              |                |
|                  | Administrative Costs   | 12, 429        |             |               |                                  |                                | 30.00          |
| 31.00            | Total Facility Overhead (sum of lines 29 and                         | 12, 429        | 79.348      | 91.77         | 7 -20, 299                       | 71. 478                        | 31.00          |

12, 429

181, 368

Total Facility Overhead (sum of lines 29 and

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

79, 348

146, 570

91, 777

327, 938

-20, 299

-69, 297

31.00

32.00

71, 478 71, 478

258, 641

31.00

32.00

| Health Financial Systems                  | GIBSON GENERAL HOSPITAL | In Lie                      | u of Form CMS-2552-10                 |
|---|-------------------------|-----------------------------|---------------------------------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |                         | Peri od:<br>From 10/01/2019 | Worksheet M-1                         |
|   | Component CCN: 15-8553  | To 09/30/2020               | Date/Time Prepared: 4/28/2021 8:15 am |
|   |                         | RHC II                      | Cost                                  |

|        |  |             |              |    |        | 4/28/2021 8: 1 | 5 am   |
|--------|--|-------------|--------------|----|--------|----------------|--------|
|        |  |             |              |    | RHC II | Cost           |        |
|        |  | Adjustments | Net Expenses |    |        |                |        |
|        |  | •           | for          |    |        |                |        |
|        |  |             | Allocation   |    |        |                |        |
|        |  |             | (col. 5 +    |    |        |                |        |
|        |  |             | col. 6)      |    |        |                |        |
|        |  | 6. 00       | 7. 00        | 1  |        |                |        |
|        | FACILITY HEALTH CARE STAFF COSTS             |             |              | 1  |        |                |        |
| 1.00   | Physi ci an                                  | 0           | 110, 453     | 3  |        |                | 1.00   |
| 2. 00  | Physician Assistant                          | o o         | 110, 100     | 1  |        |                | 2.00   |
| 3. 00  | Nurse Practitioner                           | o o         | 48, 375      |    |        |                | 3.00   |
| 4. 00  | Visiting Nurse                               | 0           | 40, 376      | 1  |        |                | 4.00   |
| 5. 00  | Other Nurse                                  | 0           | 28, 335      | 1  |        |                | 5.00   |
| 6. 00  | 1  | 0           | 20, 330      | 1  |        |                | 6.00   |
|        | Clinical Psychologist                        | 0           | (            | 1  |        |                | 1      |
| 7. 00  | Clinical Social Worker                       | U O         | -            | 1  |        |                | 7.00   |
| 8.00   | Laboratory Technician                        | 0           | (            |    |        |                | 8.00   |
| 9.00   | Other Facility Health Care Staff Costs       | 0           | (            |    |        |                | 9.00   |
| 10.00  | Subtotal (sum of lines 1 through 9)          | 0           | 187, 163     | •  |        |                | 10.00  |
| 11. 00 | Physician Services Under Agreement           | 0           | (            |    |        |                | 11.00  |
| 12. 00 | Physician Supervision Under Agreement        | 0           | (            | 1  |        |                | 12. 00 |
| 13. 00 | Other Costs Under Agreement                  | 0           | (            |    |        |                | 13. 00 |
| 14.00  | Subtotal (sum of lines 11 through 13)        | 0           | (            |    |        |                | 14.00  |
| 15.00  | Medical Supplies                             | 0           | (            |    |        |                | 15.00  |
| 16.00  | Transportation (Health Care Staff)           | 0           | (            |    |        |                | 16.00  |
| 17.00  | Depreciation-Medical Equipment               | o           | (            |    |        |                | 17.00  |
| 18.00  | Professional Liability Insurance             | o           | (            |    |        |                | 18.00  |
| 19.00  | Other Health Care Costs                      | o           | (            |    |        |                | 19.00  |
| 20.00  | Allowable GME Costs                          |             |              |    |        |                | 20.00  |
| 21.00  | Subtotal (sum of lines 15 through 20)        | o           | (            | ol |        |                | 21.00  |
| 22. 00 | Total Cost of Health Care Services (sum of   | 0           | 187, 163     | 3  |        |                | 22.00  |
| 22.00  | lines 10, 14, and 21)                        | Ĭ           | .0.7 .00     | 1  |        |                | 22.00  |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             |              | 1  |        |                |        |
| 23 00  | Pharmacy                                     | 0           | (            |    |        |                | 23. 00 |
| 24. 00 | Dental                                       | o o         | (            |    |        |                | 24.00  |
| 25. 00 | Optometry                                    | o o         | (            |    |        |                | 25.00  |
| 25. 01 | Tel eheal th                                 | 0           |              |    |        |                | 25. 01 |
| 25. 01 | Chronic Care Management                      | 0           |              |    |        |                | 25. 02 |
| 26. 00 | All other nonreimbursable costs              | 0           |              |    |        |                | 26.00  |
| 27. 00 | Nonallowable GME costs                       | ٩           | (            | ή  |        |                | 27.00  |
| 28. 00 | i i  |             | (            |    |        |                |        |
| 28.00  | Total Nonreimbursable Costs (sum of lines 23 | 0           | (            | ή  |        |                | 28. 00 |
|        | through 27)                                  |             |              |    |        |                |        |
| 20.00  | FACILITY OVERHEAD                            | ام          |              | N. |        |                | 20.00  |
|        | Facility Costs                               | 0           | 71 476       |    |        |                | 29.00  |
| 30.00  | Administrative Costs                         | 0           | 71, 478      | 1  |        |                | 30.00  |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | O           | 71, 478      | 3  |        |                | 31.00  |
|        | 30)  | _           | 050          |    |        |                |        |
| 32. 00 | , ,  | O           | 258, 641     |    |        |                | 32.00  |
|        | and 31)                                      |             |              | 1  |        |                |        |
|        |  |             |              |    |        |                |        |

| Heal th | Financial Systems                             | GIBSON GENERA    | AL HOSPITAL     |                | In Lie                           | u of Form CMS-2 | 2552-10        |
|---------|---|------------------|-----------------|----------------|----------------------------------|-----------------|----------------|
| ALLOCA  | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES        | Provi der C     |                | Peri od:                         | Worksheet M-2   |                |
|         |   |                  | Component       |                | From 10/01/2019<br>To 09/30/2020 | Date/Time Pre   | pared:         |
|         |   |                  |                 |                |                                  | 4/28/2021 8:1   |                |
|         |   |                  |                 |                | RHC I                            | Cost            |                |
|         |   | Number of FTE    | Total Visits    | Producti vi ty |                                  | Greater of      |                |
|         |   | Personnel        |                 | Standard (1)   |                                  | col. 2 or       |                |
|         |   |                  |                 |                | 1 x col. 3)                      | col. 4          |                |
|         |   | 1. 00            | 2. 00           | 3. 00          | 4. 00                            | 5. 00           |                |
|         | VISITS AND PRODUCTIVITY                       |                  |                 |                |                                  |                 | -              |
|         | Posi ti ons                                   |                  | 1               | ı              | ما ما                            |                 |                |
| 1.00    | Physi ci an                                   | 0.00             |                 |                | 1 0                              |                 | 1.00           |
| 2.00    | Physician Assistant                           | 0.00             |                 |                | 1 0                              |                 | 2.00           |
| 3.00    | Nurse Practitioner                            | 1. 61            |                 |                | 1 2                              | 4 (00           | 3.00           |
| 4.00    | Subtotal (sum of lines 1 through 3)           | 1. 61            |                 |                | 2                                | 1, 629          |                |
| 5.00    | Visiting Nurse                                | 0.00             |                 |                |                                  | 0               |                |
| 6.00    | Clinical Psychologist                         | 0.00             |                 |                |                                  | 0               | 0.00           |
| 7.00    | Clinical Social Worker                        | 0.00             |                 |                |                                  | 0               | 7.00           |
| 7. 01   | Medical Nutrition Therapist (FOHC only)       | 0.00             |                 |                |                                  | 0               | 7. 01<br>7. 02 |
| 7. 02   | Diabetes Self Management Training (FQHC only) | 0.00             | 0               |                |                                  | Ü               | 7.02           |
| 8. 00   | Total FTEs and Visits (sum of lines 4         | 1. 61            | 1, 629          |                |                                  | 1, 629          | 8.00           |
| 0.00    | through 7)                                    | 1.01             | 1,027           |                |                                  | 1,027           | 0.00           |
| 9. 00   | Physician Services Under Agreements           |                  | 133             |                |                                  | 133             | 9.00           |
| 7.00    | Triysr or air ser vi ees orider high cements  |                  | 100             |                |                                  | 100             | 7.00           |
|         |   |                  |                 |                |                                  | 1. 00           |                |
|         | DETERMINATION OF ALLOWABLE COST APPLICABLE T  | O HOSPI TAL-BASI | ED RHC/FQHC SEI | RVICES         |                                  |                 |                |
|         | Total costs of health care services (from Wk  |                  |                 |                |                                  | 148, 766        | 10.00          |
| 11.00   | Total nonreimbursable costs (from Wkst. M-1,  |                  |                 |                |                                  | 0               |                |
| 12.00   | Cost of all services (excluding overhead) (s  | sum of lines 10  | and 11)         |                |                                  | 148, 766        | 12.00          |
| 13.00   | Ratio of hospital-based RHC/FQHC services (I  | ine 10 divided   | by line 12)     |                |                                  | 1.000000        | 13.00          |
| 14.00   | Total hospital-based RHC/FQHC overhead - (fr  | om Worksheet.    | M-1, col. 7, l  | ine 31)        |                                  | 186, 581        | 14.00          |
| 15.00   | Parent provider overhead allocated to facili  | ty (see instru   | ctions)         |                |                                  | 165, 151        | 15.00          |
| 16.00   | Total overhead (sum of lines 14 and 15)       |                  |                 |                |                                  | 351, 732        | 16.00          |
| 17.00   | Allowable GME overhead (see instructions)     |                  |                 |                |                                  | 0               | 17.00          |
|         | Enter the amount from line 16                 |                  |                 |                |                                  | 351, 732        | 18.00          |
|         | Overhead applicable to hospital-based RHC/FC  |                  |                 |                |                                  | 351, 732        |                |
| 20.00   | Total allowable cost of hospital-based RHC/F  | FQHC services (  | sum of lines 1  | 0 and 19)      |                                  | 500, 498        | 20.00          |

| Heal th          | Financial Systems  | GI BSON GENERA   | AL HOSPITAL    |              | In Lie                           | u of Form CMS-2       | 2552-10      |
|------------------|--|------------------|----------------|--------------|----------------------------------|-----------------------|--------------|
| ALLOCA           | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S  | SERVI CES        | Provi der C    |              | Peri od:                         | Worksheet M-2         |              |
|                  |  |                  | Component      | CCN: 15-8553 | From 10/01/2019<br>To 09/30/2020 |                       |              |
|                  |  |                  |                |              | RHC II                           | Cost                  |              |
|                  |  | Number of FTE    | Total Visits   |              |                                  | Greater of            |              |
|                  |  | Personnel        |                | Standard (1) | ,                                | col. 2 or             |              |
|                  |  |                  |                |              | 1 x col. 3)                      | col. 4                |              |
|                  | LUCITO AND DECRUCTANTA   | 1. 00            | 2.00           | 3. 00        | 4. 00                            | 5. 00                 |              |
|                  | VISITS AND PRODUCTIVITY  |                  |                |              |                                  |                       |              |
| 1 00             | Posi ti ons  | 0.24             | 1 545          | 1 4 20       | 0 1 400                          |                       | 1 00         |
| 1.00             | Physician  | 0. 34<br>0. 00   |                | 1            |                                  |                       | 1.00<br>2.00 |
| 2. 00<br>3. 00   | Physician Assistant<br>Nurse Practitioner  | 0.00             |                |              |                                  |                       | 3.00         |
| 4. 00            | Subtotal (sum of lines 1 through 3)  | 0. 22            |                |              | 1, 890                           | 1. 890                |              |
| 5. 00            | Visiting Nurse   | 0. 00            |                | l .          | 1, 070                           | 1, 370                |              |
| 6. 00            | Clinical Psychologist  | 0.00             |                | 1            |                                  | 0                     | •            |
| 7. 00            | Clinical Social Worker   | 0.00             |                |              |                                  | 0                     | •            |
| 7. 01            | Medical Nutrition Therapist (FQHC only)  | 0.00             |                |              |                                  | Ö                     | 7. 01        |
| 7. 02            | Diabetes Self Management Training (FQHC  | 0.00             |                |              |                                  | 0                     | 7. 02        |
|                  | only)  |                  |                |              |                                  |                       |              |
| 8.00             | Total FTEs and Visits (sum of lines 4  | 0. 56            | 1, 832         |              |                                  | 1, 890                | 8.00         |
|                  | through 7)   |                  |                |              |                                  |                       |              |
| 9. 00            | Physician Services Under Agreements  |                  | 0              |              |                                  | 0                     | 9. 00        |
|                  |  |                  |                |              |                                  |                       |              |
|                  |  |                  |                |              |                                  | 1. 00                 |              |
|                  | DETERMINATION OF ALLOWABLE COST APPLICABLE T   |                  |                | RVICES       |                                  | 407.440               | 1 40 00      |
|                  | Total costs of health care services (from Wk   |                  |                |              |                                  | 187, 163              |              |
| 11. 00           | Total nonreimbursable costs (from Wkst. M-1,   | · ·              | ,              |              |                                  | 107 143               |              |
| 12. 00<br>13. 00 | Cost of all services (excluding overhead) (s<br>Ratio of hospital-based RHC/FQHC services (I |                  |                |              |                                  | 187, 163<br>1, 000000 | 1            |
| 14. 00           | Total hospital-based RHC/FQHC overhead - (fr   |                  |                | ino 21)      |                                  | 71, 478               |              |
| 15. 00           | Parent provider overhead allocated to facili   |                  |                | 1116 31)     |                                  | 195, 053              |              |
| 16. 00           | Total overhead (sum of lines 14 and 15)  | ty (See Thistitu | Cti ons)       |              |                                  | 266, 531              |              |
| 17. 00           | Allowable GME overhead (see instructions)  |                  |                |              |                                  | 0                     | 1            |
|                  | Enter the amount from line 16  |                  |                |              |                                  | 266, 531              |              |
|                  | Overhead applicable to hospital-based RHC/FQ   | MC services (I   | ine 13 x line  | 18)          |                                  | 266, 531              |              |
| 20.00            | Total allowable cost of hospital-based RHC/F   | QHC services (   | sum of lines 1 | o and 19)    |                                  | 453, 694              | 20.00        |
|                  |  |                  |                |              |                                  |                       |              |

| Heal th Financial Systems  | Heal th | Financial Systems GIBSON GENERAL                              | HOSDI TAI               | In lie          | u of Form CMS_1 | 2552_10       |
|--|---------|---|-------------------------|-----------------|-----------------|---------------|
| Determination   Determinatio   |         |   |                         |                 |                 |               |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RIC/FORC SERVICES   1.00  |         |   |                         | From 10/01/2019 | Date/Time Pre   | pared:        |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FORC SERVICES   |         |   | Title XVIII             | RHC I           |                 | <u>3 alli</u> |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FORC SERVICES   1.00   1.   |         |   |                         |                 |                 |               |
| Total Allowable Cost of hospital-based RIC/FORC Services (From Wist. M-2, line 15)   |         | I   |                         |                 | 1. 00           |               |
| 2.00   | 1 00    |   | W+ M 2 1: 20)           |                 | F00, 400        | 1 00          |
| Total allowable cost excluding vaccine (line 1 minus line 2)   |         |   |                         |                 | ·               |               |
| Total Visits (From Wist. M-2, Column 5, line 8)   1.629   4.00   |         | ,   | Tie 15)                 |                 |                 |               |
| Physicians visits under agreement (From Wist. M-2, column 5, line 9)   |         |   |                         |                 |                 |               |
| Adjusted cost per visit (line a divided by line 6)   276.16   7.00   | 5.00    |   | line 9)                 |                 | 133             | 5.00          |
| Calculation of Limit (1)   Prior to Jan. 1 (Rate Period 1)   Prior to Jan. 1 (Rate Period 1)   1.00   2.00   |         | 1   |                         |                 |                 |               |
| Prior to Jan. 1 (Rate   Period 1)   Prior to Jan. 1 (Rate   Period 1)   Prior to Jan. 1 (Rate   Period 1)   Prior to Jan. 1 (Rate   Period 1)   Prior to Jan. 1 (Rate   Period 1)   Propose   Jan. 1 (Rate   Period 1)   Propose   Jan. 1 (Rate   Period 1)   Propose   Jan. 1 (Rate   Period 1)   Propose   Jan. 1 (Rate   Period 1)   Propose   Jan. 1 (Rate   Period 1)   Jan. 1 (Rate   Period 2)   Jan.    | 7. 00   | Adjusted cost per visit (line 3 divided by line 6)            |                         |                 |                 | 7.00          |
| Rate   |         |   |                         | Cal cul ati on  | of Limit (1)    |               |
| Period 1   Period 2    |         |   |                         |                 |                 |               |
| 1.00   |         |   |                         | ,               | 7               |               |
| Per visit payment Limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)   0.00    |         |   |                         |                 |                 |               |
| CALCULATION OF SETILEMENT  | 8. 00   | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 | . 6 or your contractor) |                 |                 | 8. 00         |
| 10.00   Program covered visits excluding mental health services (from contractor records)   0   234   10.00   Program cost excluding costs for mental health services (fine 9 x line 10)   0   64.621   11.00   12.00   Program covered visits for mental health services (from contractor records)   0   0   12.00   13.00   Program covered visits for mental health services (from contractor records)   0   0   12.00   13.00   13.00   Program covered cost from mental health services (ine 9 x line 12)   0   0   13.00   14.00   15.00   Graduate Medical Education Pass Through Cost (see instructions)   0   0   14.00   15.00   Graduate Medical Education Pass Through Cost (see instructions)   15.00   15.00   15.01   Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *   0   64.621   16.00   16.01   Total program charges (see instructions) (from contractor's records)   51,505   16.01   16.02   16.03   17.465   16.02   16.03   17.465   16.02   17.46   | 9.00    | Rate for Program covered visits (see instructions)            |                         | 276. 16         | 276. 16         | 9. 00         |
| 11.00   Program cost excluding costs for mental health services (line 9 x line 10)   0   64,621   11.00   12.00   12.00   12.00   13.00   13.00   14   |         |   |                         |                 |                 |               |
| 12.00   Program covered visits for mental heal th services (from contractor records)   0   0   12.00   |         | , ,   |                         |                 |                 |               |
| 13.00   Program covered cost from mental heal th services (line 9 x line 12)   13.00   Limit adjustment for mental heal th services (see instructions)   0   0   14.00   14.00   15.00   15.00   15.00   16.00   17.00   17.00   17.00   17.00   18.   |         | ,   | •                       |                 |                 |               |
| 14.00   Limit adjustment for mental health services (see instructions)   0   14.00   15.00   Graduate Medical Education Pass Through Cost (see instructions)   15.00   16.01   Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *   0   64, 621   16.00   16.01   Total program charges (see instructions) (from contractor's records)   7, 465   16.02   16.03   16.03   16.04   Total program preventive charges (see instructions) (from provider's records)   7, 465   16.02   16.03   16.04   Total Program preventive costs ((line 16.02/line 16.01) times line 16)   9, 366   16.03   16.04   Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)   41, 230   16.04   16.05   Total program cost (see instructions)   0   50,596   16.05      |         | ,   | *                       |                 | -               |               |
| 15.00  |         |   |                         |                 |                 |               |
| 16. 00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * 0 64, 621 16. 00 16. 01 Total program charges (see instructions) (from contractor's records) 51, 505 16. 01 16. 01 Total program preventive charges (see instructions) (from provider's records) 7, 465 16. 02 16. 03 Total program preventive costs ((line 16. 02/line 16. 01) times line 16) 9, 366 16. 03 16. 04 Total Program non-preventive costs ((line 16 minus lines 16. 03 and 18) times .80) 41, 230 16. 04 (Titles V and XIX see instructions.) 0 50, 596 16. 05 16. 05 Total program cost (see instructions) 0 50, 596 16. 05 17. 00 Primary payer amounts 0 17. 00 Primary payer amounts 0 17. 00 Primary payer amounts 0 17. 00 Primary payer amounts 0 17. 00 Program cost (see instructions) (from contractor records) 19. 00 Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records) 19. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 3, 869 21. 00 16. 00 Total reimbursable Program cost (line 20 plus line 21) 54, 465 22. 00 23. 01 Adjusted reimbursable bad debts (see instructions) 19. 00 23. 01 Adjusted reimbursable bad debts (see instructions) 19. 00 23. 01 Adjusted reimbursable bad debts (see instructions) 19. 02. 02. 01 OTTER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 19. 02. 02. 02. 02. 02. 02. 02. 03. 02. 03. 03. 03. 03. 03. 03. 03. 03. 03. 03  |         | ,   | ,                       |                 | o .             |               |
| 16. 02 Total program preventive charges (see instructions) (from provider's records) 16. 03 Total program preventive costs ((line 16.02/line 16.01) times line 16) 17. 04. 05 Total program preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.) 18. 05 Total program cost (see instructions) 19. 00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19. 00 Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records) 19. 00 Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records) 19. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 20. 00 Not Medicare cost excluding vaccines (see instructions) 21. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 22. 00 Total reimbursable Program cost (line 20 plus line 21) 23. 00 Allowable bad debts (see instructions) 24. 00 Allowable bad debts (see instructions) 25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPCIFY) 25. 00 TOHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPCIFY) 26. 00 Net reimbursable amount (see instructions) 27. 00 Inter in payment adjustment (see instructions) 28. 00 Tentative settlement (for contractor use only) 29. 00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 30. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11,  |         | ,   | •                       | 0               | 64, 621         |               |
| 16. 03 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16. 04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.) 16. 05 Total program cost (see instructions) 17. 00 Primary payer amounts 18. 00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19. 00 Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records) 20. 00 Net Medicare cost excluding vaccines (see instructions) 21. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 22. 00 Total reimbursable Program cost (line 20 plus line 21) 23. 01 Adjusted reimbursable bad debts (see instructions) 24. 00 Allowable bad debts (see instructions) 25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 26. 00 Net reimbursable amount (see instructions) 27. 00 Demonstration payment adjustment (see instructions) 28. 01 Sequestration adjustment (see instructions) 29. 02 Demonstration payments 20. 03 Total reimbursable amount (see instructions) 20. 04. 02 Demonstration payment adjustment amount after sequestration 29. 00 Tentative settlement (for contractor use only) 29. 00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 29. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, 29. 30 Demonstration (nonallowable cost report items) in accordance with CMS Pub. 15-II, 39. 30 Demonstration (nonallowable cost report items) in accordance with CMS Pub. 15-II, 39. 30 Demonstration (nonallowable cost report items) in accordance with CMS Pub. 15-II, 39. 30 Demonstration (nonallowable cost report items) in accordance with CMS Pub. 15-II, 39. 30 Demonstration (nonallowable cost report items) in accordance with CMS Pub. 15-II, 30 Demonstration and the cost report items in accordance with CMS Pub. 15-II, 30 Demonstration and the cost report items in accordance with CMS Pub. 15-II, 30 Demonstration and the cost report items in accordance with CMS | 16. 01  | Total program charges (see instructions)(from contractor's re | cords)                  |                 | 51, 505         | 16. 01        |
| 16. 04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)  10. 05 Total program cost (see instructions)  11. 00 Primary payer amounts  12. 00 Primary payer amounts  13. 01 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19. 00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  19. 00 Net Medicare cost excluding vaccines (see instructions) (from contractor records)  20. 00 Net Medicare cost excluding vaccines (see instructions)  21. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  22. 00 Total reimbursable Program cost (line 20 plus line 21)  23. 00 Allowable bad debts (see instructions)  24. 00 Allowable bad debts (see instructions)  25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  26. 00 Pioneer ACO demonstration payment adjustment (see instructions)  26. 00 Net reimbursable amount (see instructions)  27. 00 Net reimbursable amount (see instructions)  28. 00 Tentative settlement (for contractor use only)  29. 00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)  30. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-II,   |         |   |                         |                 |                 |               |
| (Titles V and XIX see instructions.)  16.05 Total program cost (see instructions)  17.00 Primary payer amounts  20.00 Net Medicare cost excluding vaccines (see instructions)  21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  22.00 Total reimbursable Program cost (line 20 plus line 21)  23.00 Allowable bad debts (see instructions)  24.00 Allowable bad debts (see instructions)  25.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS)  25.90 Demonstration payment adjustment amount before sequestration  26.00 Net reimbursable amount (see instructions)  27.00 Demonstration payment adjustment amount after sequestration  28.01 Total reimbursable amounts  29.00 Net reimbursable amount (see instructions)  20.00 Net reimbursable amount (see instructions)  21.00 Program cost (line 20 plus line 21)  22.00 Total reimbursable bad debts (see instructions)  23.01 Adjusted reimbursable bad debts (see instructions)  24.00 Allowable bad debts (see instructions)  25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  26.00 Demonstration payment adjustment amount before sequestration  26.01 Sequestration adjustment (see instructions)  26.02 Demonstration payment adjustment amount after sequestration  27.00 Interim payments  28.00 Tentative settlement (for contractor use only)  29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)  29.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,   |         | 1 9 1   | *                       |                 |                 |               |
| 16.05 Total program cost (see instructions) 17.00 Primary payer amounts 18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) 20.00 Net Medicare cost excluding vaccines (see instructions) 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 22.00 Total reimbursable Program cost (line 20 plus line 21) 23.00 Allowable bad debts (see instructions) 24.00 Allowable bad debts (see instructions) 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 26.00 Pioneer ACO demonstration payment adjustment (see instructions) 26.01 Sequestration adjustment (see instructions) 27.00 Let reimbursable amount (see instructions) 28.00 Total reimbursable amount (see instructions) 29.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) 29.00 Pioneer ACO demonstration payment adjustment (see instructions) 29.00 Demonstration payment adjustment amount before sequestration 29.00 Demonstration payment adjustment (see instructions) 29.00 Demonstration payment adjustment amount after sequestration 29.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 29.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  | 16. 04  |   | 3 and 18) times .80)    |                 | 41, 230         | 16.04         |
| 17. 00 Primary payer amounts 18. 00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19. 00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) 19. 00 Net Medicare cost excluding vaccines (see instructions) 19. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 19. 00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 19. 00 Allowable bad debts (see instructions) 19. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 19. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 19. 00 Demonstration payment adjustment digustment (see instructions) 19. 00 Demonstration payment adjustment sequestration 19. 00 Demonstration payment adjustment fee instructions) 20. 01 Demonstration payment adjustment amount before sequestration 20. 02 Demonstration payment adjustment amount after sequestration 20. 02 Demonstration payment adjustment fee instructions) 20. 02 Demonstration payment adjustment amount after sequestration 20. 02 Demonstration payment adjustment fee instructions) 21. 00 Demonstration payment adjustment amount after sequestration 22. 02. 03 Demonstration payment adjustment amount after sequestration 23. 04. 05. 05. 05. 05. 06. 05. 06. 07. 07. 07. 07. 07. 07. 07. 07. 07. 07   | 16. 05  | 1 '   |                         | 0               | 50, 596         | 16, 05        |
| records)  Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  22.00 Total reimbursable Program cost (line 20 plus line 21)  23.01 All owable bad debts (see instructions)  23.01 Adjusted reimbursable bad debts (see instructions)  24.00 All owable bad debts for dual eligible beneficiaries (see instructions)  25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  26.00 Pioneer ACO demonstration payment adjustment (see instructions)  26.00 Net reimbursable amount (see instructions)  26.01 Sequestration adjustment (see instructions)  26.02 Demonstration payment adjustment amount after sequestration  27.00 Interim payments  28.00 Tentative settlement (for contractor use only)  29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)  30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,   |         | , ,   |                         |                 |                 |               |
| 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) 20.00 Net Medicare cost excluding vaccines (see instructions) 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 22.00 Total reimbursable Program cost (line 20 plus line 21) 23.01 Aljowable bad debts (see instructions) 23.01 Aljowable bad debts (see instructions) 24.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 26.00 Pioneer ACO demonstration payment adjustment (see instructions) 26.00 Net reimbursable amount (see instructions) 27.00 Sequestration adjustment (see instructions) 28.00 Demonstration payment adjustment fer sequestration 29.00 Demonstration payment adjustment (see instructions) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,   | 18.00   | Less: Beneficiary deductible for RHC only (see instructions)  | (from contractor        |                 | 3, 717          | 18. 00        |
| records)  Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  Total reimbursable Program cost (line 20 plus line 21)  Allowable bad debts (see instructions)  Allowable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instructions)  Net reimbursable amount (see instructions)  Sequestration adjustment (see instructions)  Sequestration adjustment (see instructions)  Line in payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Line in payment adjustment (for contractor use only)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  Demonstration  So, 596 20.00  3, 869 21.00  3, 86 20.00  3, 90 20.00  3, 90 20.00  3, 90 20.00  3, 90 20.00  3, 90 20.00  3, 90 20.00  3, 90 20.00  3, 90  |         |   |                         |                 |                 |               |
| 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  22.00 Total reimbursable Program cost (line 20 plus line 21)  23.00 Allowable bad debts (see instructions)  23.01 Adjusted reimbursable bad debts (see instructions)  24.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25.50 Pioneer ACO demonstration payment adjustment (see instructions)  25.00 Net reimbursable amount (see instructions)  26.00 Sequestration adjustment (see instructions)  26.01 Sequestration adjustment (see instructions)  27.00 Interim payments  Tentative settlement (for contractor use only)  28.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  3,869 21.00  54,465 22.00  54,465 22.00  23.01  24.00 23.01  0 23.01  0 23.01  0 23.01  0 23.01  0 24.00  25.50  0 25.50  0 25.50  0 25.50  0 25.50  0 25.50  0 25.50  0 25.60  0 25.60  0 25.70  0 25.70  1 26.02  27.01 Interim payments  1 26.02  27.02 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)  16,400 29.00  30.00  | 19. 00  |   | ns) (from contractor    |                 | 8, 017          | 19. 00        |
| 22.00 Total reimbursable Program cost (line 20 plus line 21) 23.00 Allowable bad debts (see instructions) 23.01 Adjusted reimbursable bad debts (see instructions) 24.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 26.00 Demonstration payment adjustment amount before sequestration 26.00 Net reimbursable amount (see instructions) 27.00 Interim payment adjustment (see instructions) 28.00 Demonstration payment adjustment amount after sequestration 29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  |         | ,                       |                         |                 | ·               |               |
| 23.00 Allowable bad debts (see instructions)  23.01 Adjusted reimbursable bad debts (see instructions)  24.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25.50 Pioneer ACO demonstration payment adjustment (see instructions)  25.90 Demonstration payment adjustment amount before sequestration  26.00 Net reimbursable amount (see instructions)  26.01 Sequestration adjustment (see instructions)  26.02 Demonstration payment adjustment amount after sequestration  26.02 Demonstration payment adjustment amount after sequestration  27.00 Interim payments  Tentative settlement (for contractor use only)  28.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  23.01  24.00  23.01  24.00  24.00  25.00  25.00  25.00  25.00  26.00  25.00  26.01  26.02  27. and 28)  16.400  29.00  30.00  |         | ,   | M-4, line 16)           |                 |                 |               |
| 23.01 Adjusted reimbursable bad debts (see instructions) 24.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 25.50 Pioneer ACO demonstration payment adjustment (see instructions) 25.99 Demonstration payment adjustment amount before sequestration 26.00 Net reimbursable amount (see instructions) 26.01 Sequestration adjustment (see instructions) 26.02 Demonstration payment adjustment amount after sequestration 27.00 Interim payments 28.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  |         |   |                         |                 |                 |               |
| 24.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  0 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25.00 Demonstration payment adjustment (see instructions)  0 Demonstration payment adjustment amount before sequestration  0 Demonstration payment adjustment (see instructions)  26.01 Sequestration adjustment (see instructions)  26.02 Demonstration payment adjustment amount after sequestration  27.00 Interim payments  1 Tentative settlement (for contractor use only)  28.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  0 24.00  25.00  25.00  25.00  25.00  25.99  54,465  26.00  25.99  54,465  26.00  27.00  28.00  29.00  37,433  37,433  27.00  28.00  30.00  |         | 1   |                         |                 |                 |               |
| 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  25.50 Pioneer ACO demonstration payment adjustment (see instructions)  25.99 Demonstration payment adjustment amount before sequestration  Net reimbursable amount (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  10.26.01  26.02 Demonstration payment adjustment amount after sequestration  11.00 Interim payments  12.00 Tentative settlement (for contractor use only)  28.00 Tentative settlement (for contractor use only)  29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)  30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11,  |         |   | ructions)               |                 | -               |               |
| 25. 50 Pioneer ACO demonstration payment adjustment (see instructions)  25. 99 Demonstration payment adjustment amount before sequestration  26. 00 Net reimbursable amount (see instructions)  26. 01 Sequestration adjustment (see instructions)  26. 02 Demonstration payment adjustment amount after sequestration  27. 00 Interim payments  28. 00 Tentative settlement (for contractor use only)  29. 00 Balance due component/program (line 26 minus lines 26. 01, 26. 02, 27, and 28)  30. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  |         | ,   | 1 4011 0113)            |                 |                 |               |
| 26.00       Net reimbursable amount (see instructions)       54,465       26.00         26.01       Sequestration adjustment (see instructions)       632       26.01         26.02       Demonstration payment adjustment amount after sequestration       0       26.02         27.00       Interim payments       37,433       27.00         28.00       Tentative settlement (for contractor use only)       0       28.00         29.00       Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)       16,400       29.00         30.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,       0       30.00   | 25. 50  | 1 ' ' ' ' ' '   | is)                     |                 | 0               | 25. 50        |
| 26.01 Sequestration adjustment (see instructions) 26.02 Demonstration payment adjustment amount after sequestration 27.00 Interim payments 28.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  632 26.01 0 26.02 37, 433 27.00 16,400 29.00 0 30.00   |         |   |                         |                 |                 |               |
| 26. 02 Demonstration payment adjustment amount after sequestration  27. 00 Interim payments  Tentative settlement (for contractor use only)  29. 00 Balance due component/program (line 26 minus lines 26. 01, 26. 02, 27, and 28)  30. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  26. 02  37, 433  27. 00  28. 00  16, 400  29. 00  30. 00   |         |   |                         |                 |                 |               |
| 27.00 Interim payments 28.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  37, 433 27.00 28.00 16, 400 29.00 30.00  |         | , ,   |                         |                 |                 |               |
| 28.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, 0 30.00  |         | ,                       |                         |                 |                 |               |
| 29.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  16,400 29.00 30.00   |         | 1   |                         |                 | 31, 433<br>N    |               |
| 30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,  |         | ,   | 02, 27, and 28)         |                 | 16, 400         |               |
| chapter I, §115.2  |         |   |                         | ,               |                 |               |
|  |         | chapter I, §115.2   |                         |                 |                 |               |

| Heal th          | Financial Systems GIBSON GENERAL   | HOSDI TAI               | In lia                           | u of Form CMS-2             | 2552_10          |
|------------------|--|-------------------------|----------------------------------|-----------------------------|------------------|
|                  | ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC  |                         | Peri od:                         | Worksheet M-3               |                  |
| SERVI (          |  | Component CCN: 15-8553  | From 10/01/2019<br>To 09/30/2020 | Date/Time Pre 4/28/2021 8:1 | pared:           |
| -                |  | Title XVIII             | RHC II                           | Cost                        | J alli           |
|                  |  |                         |                                  |                             |                  |
|                  | DETERMINATION OF DATE FOR HOCKLIAL DACED BUC /FOUR CED// OFC   |                         |                                  | 1. 00                       |                  |
| 1. 00            | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES  Total Allowable Cost of hospital-based RHC/FQHC Services (fro      | m Wkst M-2 line 20)     |                                  | 453, 694                    | 1.00             |
| 2. 00            | Cost of vaccines and their administration (from Wkst. M-4, li  |                         |                                  | 23, 761                     | 2.00             |
| 3.00             | Total allowable cost excluding vaccine (line 1 minus line 2)   |                         |                                  | 429, 933                    | 3.00             |
| 4.00             | Total Visits (from Wkst. M-2, column 5, line 8)  |                         |                                  | 1, 890                      | 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)   |                         |                                  | 1, 890                      | 6.00             |
| 7. 00            | Adjusted cost per visit (line 3 divided by line 6)   |                         | Cal aul ati an                   | 227. 48                     | 7.00             |
|                  |  |                         | Cal cul ati on                   |                             |                  |
|                  |  |                         | Prior to Jan.                    | On or After                 |                  |
|                  |  |                         | 1 (Rate<br>Period 1)             | Jan. 1 (Rate<br>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)   |                         | 227. 48                          | 227. 48                     | 9. 00            |
|                  | CALCULATION OF SETTLEMENT  |                         |                                  |                             |                  |
| 10.00            | Program covered visits excluding mental health services (from  | •                       | 0                                | 416                         | •                |
| 11.00            | Program cost excluding costs for mental health services (line  |                         | 0                                | 94, 632                     | 1                |
| 12. 00<br>13. 00 | Program covered visits for mental health services (from contr<br>Program covered cost from mental health services (line 9 x li | •                       | 0                                | 0                           | 12.00<br>13.00   |
| 14. 00           | Limit adjustment for mental health services (see instructions  |                         | 0                                | 0                           | 14.00            |
| 15. 00           | Graduate Medical Education Pass Through Cost (see instruction  | ,                       |                                  | · ·                         | 15. 00           |
| 16.00            | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2  | and 3) *                | 0                                | 94, 632                     | 16. 00           |
| 16. 01           | Total program charges (see instructions)(from contractor's re  | ,                       |                                  | 91, 970                     | 1                |
| 16. 02           | Total program preventive charges (see instructions) (from prov   |                         |                                  | 14, 685                     |                  |
| 16. 03           | Total program preventive costs ((line 16.02/line 16.01) times  | *                       |                                  | 15, 110                     | 1                |
| 16. 04           | Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)                             | is and 18) times .80)   |                                  | 61, 413                     | 16. 04           |
| 16. 05           | Total program cost (see instructions)  |                         | 0                                | 76, 523                     | 16. 05           |
| 17. 00           | Primary payer amounts  |                         |                                  | 32                          | 17. 00           |
| 18.00            | Less: Beneficiary deductible for RHC only (see instructions)   | (from contractor        |                                  | 2, 756                      | 18.00            |
|                  | records)   |                         |                                  |                             |                  |
| 19. 00           | Beneficiary coinsurance for RHC/FQHC services (see instruction records)  | ns) (from contractor    |                                  | 14, 876                     | 19. 00           |
| 20.00            | Net Medicare cost excluding vaccines (see instructions)  |                         |                                  | 76, 491                     | 20.00            |
| 21.00            | Program cost of vaccines and their administration (from Wkst.  | M-4, line 16)           |                                  | 8, 877                      | 21.00            |
| 22. 00           | Total reimbursable Program cost (line 20 plus line 21)   |                         |                                  | 85, 368                     | 1                |
| 23. 00<br>23. 01 | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)                                      |                         |                                  | 0                           | 23. 00<br>23. 01 |
| 24. 00           |  | ructions)               |                                  | 0                           | 24.00            |
| 25. 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |                         |                                  | 0                           | 25. 00           |
| 25. 50           | 1 ' ' ' ' ' '  | is)                     |                                  | 0                           | 25. 50           |
|                  | Demonstration payment adjustment amount before sequestration   |                         |                                  | 0                           | 1                |
| 26.00            | Net reimbursable amount (see instructions)   |                         |                                  | 85, 368                     | 1                |
| 26. 01           | Sequestration adjustment (see instructions)  |                         |                                  |                             | 26. 01           |
| 26. 02           | Demonstration payment adjustment amount after sequestration<br>Interim payments  |                         |                                  | 0<br>35, 573                | 26. 02<br>27. 00 |
| 28. 00           | Tentative settlement (for contractor use only)   |                         |                                  | 35, 573                     | 28.00            |
|                  | Balance due component/program (line 26 minus lines 26.01, 26.  | 02, 27, and 28)         |                                  | 48, 805                     | 1                |
| 30.00            | Protested amounts (nonallowable cost report items) in accorda  | •                       | ,                                | 0                           | 1                |
|                  | chapter I, §115.2  |                         |                                  |                             |                  |
|                  |  |                         |                                  |                             |                  |

| Health Financial Systems               | GIBSON GENERAL             | HOSPI TAL              | In Lieu                     | u of Form CMS-2552-10 |
|--|----------------------------|------------------------|-----------------------------|-----------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC | PNEUMOCOCCAL AND INFLUENZA | Provider CCN: 15-1319  | Peri od:<br>From 10/01/2019 | Worksheet M-4         |
| VACCINE COST                           |                            | Component CCN: 15-8524 |                             |                       |
|  |                            | Title XVIII            | RHC I                       | Cost                  |

|        |   | Title XVIII               | RHC I        | Cost        |        |
|--------|---|---------------------------|--------------|-------------|--------|
|        |   |                           | Pneumococcal | I nfl uenza |        |
|        |   |                           | 1.00         | 2. 00       |        |
| 1.00   | Health care staff cost (from Wkst. M-1, col. 7, line 10)  |                           | 148, 766     | 148, 766    | 1.00   |
| 2.00   | Ratio of pneumococcal and influenza vaccine staff time to tot   | al health care staff time | 0. 000445    | 0. 002589   | 2.00   |
| 3.00   | Pneumococcal and influenza vaccine health care staff cost (li   | ne 1 x line 2)            | 66           | 385         | 3.00   |
| 4.00   | Medical supplies cost - pneumococcal and influenza vaccine (f   | rom your records)         | 1, 630       | 2, 052      | 4.00   |
| 5.00   | Direct cost of pneumococcal and influenza vaccine (line 3 plu   | s line 4)                 | 1, 696       | 2, 437      | 5.00   |
| 6.00   | Total direct cost of the hospital-based RHC/FQHC (from Worksh   | eet M-1, col. 7, line 22) | 148, 766     | 148, 766    | 6.00   |
| 7.00   | Total overhead (from Wkst. M-2, line 19)  |                           | 351, 732     | 351, 732    | 7.00   |
| 8.00   | Ratio of pneumococcal and influenza vaccine direct cost to to   | tal direct cost (line 5   | 0. 011400    | 0. 016381   | 8.00   |
|        | divided by line 6)  |                           |              |             |        |
| 9. 00  | Overhead cost - pneumococcal and influenza vaccine (line 7 x  | •                         | 4, 010       | 5, 762      |        |
| 10. 00 | Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)  | administration (sum of    | 5, 706       | 8, 199      | 10. 00 |
| 11.00  | Total number of pneumococcal and influenza vaccine injections   | (from your records)       | 11           | 64          | 11.00  |
| 12.00  | Cost per pneumococcal and influenza vaccine injection (line 1   | 0/line 11)                | 518. 73      | 128. 11     | 12.00  |
| 13. 00 | Number of pneumococcal and influenza vaccine injections admin beneficiaries   | istered to Program        | 4            | 14          | 13. 00 |
| 14. 00 | Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)   | heir) administration      | 2, 075       | 1, 794      | 14. 00 |
| 15. 00 | Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3         | ,                         |              | 13, 905     | 15. 00 |
| 16. 00 | Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21) |                           |              | 3, 869      | 16. 00 |

| Health Financial Systems                            | GIBSON GENERAL             | HOSPI TAL              | In Lieu                     | u of Form CMS-2552-10 |
|---|----------------------------|------------------------|-----------------------------|-----------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | PNEUMOCOCCAL AND INFLUENZA | Provider CCN: 15-1319  | Peri od:<br>From 10/01/2019 | Worksheet M-4         |
| VACCINE COST  |                            | Component CCN: 15-8553 |                             |                       |
|   |                            | Title XVIII            | RHC LT                      | Cost                  |

|        |   |                           |              | 17 207 202 1 0. 10 | J uiii |
|--------|---|---------------------------|--------------|--------------------|--------|
|        |   | Title XVIII               | RHC II       | Cost               |        |
|        |   |                           | Pneumococcal | I nfl uenza        |        |
|        |   |                           | 1. 00        | 2. 00              |        |
| 1.00   | Health care staff cost (from Wkst. M-1, col. 7, line 10)      |                           | 187, 163     | 187, 163           | 1.00   |
| 2.00   | Ratio of pneumococcal and influenza vaccine staff time to tot | al health care staff time | 0. 000670    | 0. 001032          | 2.00   |
| 3.00   | Pneumococcal and influenza vaccine health care staff cost (li | ne 1 x line 2)            | 125          | 193                | 3.00   |
| 4.00   | Medical supplies cost - pneumococcal and influenza vaccine (f | rom your records)         | 7, 112       | 2, 372             | 4.00   |
| 5.00   | Direct cost of pneumococcal and influenza vaccine (line 3 plu | s line 4)                 | 7, 237       | 2, 565             | 5.00   |
| 6.00   | Total direct cost of the hospital-based RHC/FQHC (from Worksh | eet M-1, col. 7, line 22) | 187, 163     | 187, 163           | 6.00   |
| 7.00   | Total overhead (from Wkst. M-2, line 19)                      |                           | 266, 531     | 266, 531           | 7.00   |
| 8.00   | Ratio of pneumococcal and influenza vaccine direct cost to to | tal direct cost (line 5   | 0. 038667    | 0. 013705          | 8.00   |
|        | divided by line 6)  |                           |              |                    | l      |
| 9.00   | Overhead cost - pneumococcal and influenza vaccine (line 7 x  | line 8)                   | 10, 306      | 3, 653             | 9. 00  |
| 10.00  | Total pneumococcal and influenza vaccine cost and its (their) | administration (sum of    | 17, 543      | 6, 218             | 10.00  |
|        | lines 5 and 9)  |                           |              |                    | l      |
| 11. 00 | Total number of pneumococcal and influenza vaccine injections | (from your records)       | 48           | 74                 | 11.00  |
| 12.00  | Cost per pneumococcal and influenza vaccine injection (line 1 | 0/line 11)                | 365. 48      | 84. 03             | 12.00  |
| 13.00  | Number of pneumococcal and influenza vaccine injections admin | istered to Program        | 19           | 23                 | 13.00  |
|        | benefi ci ari es  |                           |              |                    | l      |
| 14.00  | Program cost of pneumococcal and influenza vaccine and its (t | heir) administration      | 6, 944       | 1, 933             | 14.00  |
|        | (line 12 x line 13)   |                           |              |                    | l      |
| 15. 00 |   |                           |              | 23, 761            | 15. 00 |
|        | of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3 |                           |              |                    |        |
| 16. 00 | Total Program cost of pneumococcal and influenza vaccine and  |                           |              | 8, 877             | 16. 00 |
|        | administration (sum of cols. 1 and 2, line 14) (transfer this | amount to Wkst. M-3,      |              |                    |        |
|        | line 21)  |                           |              | ļ                  | I      |
|        |   |                           |              |                    |        |

| Health Financial Systems  | GIBSON GENERAL    | HOSPI TAL |                              | In Lie                                       | u of Form CMS-2552-10 |
|---|-------------------|-----------|------------------------------|--|-----------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/<br>SERVICES RENDERED TO PROGRAM BENEFICIARIES | FQHC PROVIDER FOR |           | CCN: 15-1319<br>CCN: 15-8524 | Peri od:<br>From 10/01/2019<br>To 09/30/2020 | Date/Time Prepared:   |
|   |                   |           |                              | DUO I  | 4/28/2021 8:15 am     |

|        |  |                             |                              | 4/28/2021 8: 15                 | 5 am |
|--------|--|-----------------------------|------------------------------|---------------------------------|------|
|        |  |                             | RHC I                        | Cost                            |      |
|        |  |                             | Par                          | rt B                            |      |
|        |  |                             | mm/dd/yyyy                   | Amount                          |      |
|        |  |                             | 1. 00                        | 2.00                            |      |
| 00     | Total interim payments paid to hospital-based RHC/FQHC           |                             |                              | 37, 433                         | 1.   |
| 00     | Interim payments payable on individual bills, either submit      | tted or to be submitted to  |                              | 0                               | 2.   |
|        | the contractor for services rendered in the cost reporting       | period. If none, write      |                              |                                 |      |
|        | "NONE" or enter a zero   |                             |                              |                                 |      |
| 00     | List separately each retroactive lump sum adjustment amount      |                             |                              |                                 | 3.   |
|        | revision of the interim rate for the cost reporting period.      | Also show date of each      |                              |                                 |      |
|        | payment. If none, write "NONE" or enter a zero. (1)              |                             |                              |                                 |      |
|        | Program to Provider  |                             |                              |                                 |      |
| 01     |  |                             |                              | 0                               | 3.   |
| 02     |  |                             |                              | 0                               | 3.   |
| 03     |  |                             |                              | 0                               | 3    |
| 04     |  |                             |                              | 0                               | 3    |
| 05     |  |                             |                              | 0                               | 3    |
|        | Provider to Program  |                             | _                            |                                 |      |
| 50     |  |                             |                              | 0                               | 3    |
| 51     |  |                             |                              | 0                               | 3    |
| 52     |  |                             |                              | 0                               | 3    |
| 3      |  |                             |                              | 0                               | 3    |
| 54     |  |                             |                              | 0                               | 3    |
| 99     | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.      |                             |                              | 0                               | 3    |
| 00     | Total interim payments (sum of lines 1, 2, and 3.99) (trans      | sfer to Worksheet M-3, line |                              | 37, 433                         | 4    |
|        | 27)  |                             |                              |                                 |      |
|        | TO BE COMPLETED BY CONTRACTOR                                    |                             | - T                          |                                 |      |
| 00     | List separately each tentative settlement payment after des      | sk review. Also show date o | Ť                            |                                 | 5    |
|        | each payment. If none, write "NONE" or enter a zero. (1)         |                             |                              |                                 |      |
| 01     | Program to Provider  |                             |                              | 0                               | 5    |
| )2     |  |                             |                              |                                 | 5    |
| )2     |  |                             |                              | 0                               | 5    |
| )3     | Provider to Program  |                             |                              | 0                               | )    |
| 0      | Frovider to Frogram  |                             |                              | 0                               | 5    |
| 51     |  |                             |                              |                                 | 5    |
| 52     |  |                             |                              |                                 | 5    |
| 9      | <br> Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. | 08)                         |                              |                                 | 5    |
| 00     | Determined net settlement amount (balance due) based on the      |                             |                              |                                 | 6    |
| )1     | SETTLEMENT TO PROVIDER   | e cost report. (1)          |                              | 16, 400                         | 6    |
| )2     | SETTLEMENT TO PROGRAM  |                             |                              | 10, 400                         | 6    |
|        | Total Medicare program liability (see instructions)              |                             |                              | 53, 833                         | 7    |
| $\cap$ | Frotal Medicale Program Frantity (See HistidCt10HS)              |                             |                              |                                 |      |
| 00     |  |                             | Contractor                   | I NDD Data I                    |      |
| 00     |  |                             | Contractor                   | NPR Date                        |      |
| 00     |  | 0                           | Contractor<br>Number<br>1.00 | NPR Date<br>(Mo/Day/Yr)<br>2.00 |      |

| Health Financial Systems   | GI BSON GENERAL | HOSPI TAL |                              | In Lie                                       | u of Form CMS-2552-10             |
|--|-----------------|-----------|------------------------------|--|-----------------------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC<br>SERVICES RENDERED TO PROGRAM BENEFICIARIES |                 |           | CCN: 15-1319<br>CCN: 15-8553 | Peri od:<br>From 10/01/2019<br>To 09/30/2020 | Worksheet M-5 Date/Time Prepared: |
|  |                 | ,         |                              |  | 4/28/2021 8: 15 am                |
|  |                 |           |                              | DUO LI                                       | 0                                 |

|          |  | p                                     |                        | 4/28/2021 8: 15 | 5 am |
|----------|--|---------------------------------------|------------------------|-----------------|------|
|          |  |                                       | RHC II                 | Cost            |      |
|          |  | · · · · · · · · · · · · · · · · · · · | Par                    | rt B            |      |
|          |  |                                       | mm/dd/yyyy             | Amount          |      |
|          |  |                                       | 1. 00                  | 2.00            |      |
| 00       | Total interim payments paid to hospital-based RHC/FQHC           |                                       |                        | 35, 573         | 1.   |
| 00       | Interim payments payable on individual bills, either submit      | ted or to be submitted to             |                        | 0               | 2.   |
|          | the contractor for services rendered in the cost reporting       |                                       |                        |                 |      |
|          | "NONE" or enter a zero   |                                       |                        |                 |      |
| 00       | List separately each retroactive lump sum adjustment amount      | based on subsequent                   |                        |                 | 3.   |
|          | revision of the interim rate for the cost reporting period.      |                                       |                        |                 |      |
|          | payment. If none, write "NONE" or enter a zero. (1)              |                                       |                        |                 |      |
|          | Program to Provider  |                                       | <u>'</u>               | •               |      |
| 01       |  |                                       |                        | 0               | 3.   |
| 02       |  |                                       |                        |                 | 3.   |
| 03       |  |                                       |                        | 0               | 3    |
| 04       |  |                                       |                        | l ol            | 3    |
| 05       |  |                                       |                        | 0               | 3    |
|          | Provider to Program  |                                       |                        |                 |      |
| 50       | - Fredrice - Fredrich  |                                       |                        | 0               | 3    |
| 51       |  |                                       |                        | 0               | 3    |
| 52       |  |                                       |                        | 0               | 3    |
| 3        |  |                                       |                        | 0               | 3    |
| 54       |  |                                       |                        | l ől            | 3    |
| 99       | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.      | 98)                                   |                        | 0               | 3    |
| 00       | Total interim payments (sum of lines 1, 2, and 3.99) (trans      |                                       |                        | 35, 573         | 4    |
| 00       | 27)  | TO TO WOLKSHOOL W. 5, TITIE           |                        | 33, 373         | _    |
|          | TO BE COMPLETED BY CONTRACTOR                                    |                                       |                        |                 |      |
| 00       | List separately each tentative settlement payment after des      | k review Also show date o             | f                      |                 | 5    |
| 00       | each payment. If none, write "NONE" or enter a zero. (1)         | in review. 71130 Show date o          | •                      |                 |      |
|          | Program to Provider  |                                       |                        |                 |      |
| 01       | 11 ogram to 11 ovr der   |                                       |                        | 0               | 5    |
| 2        |  |                                       |                        | l o             | 5    |
| )3       |  |                                       |                        | 0               | 5    |
|          | Provider to Program  |                                       |                        |                 |      |
| 0        | 110VI del 110gi dili   |                                       |                        | 0               | 5    |
| 51       |  |                                       |                        | 0               | 5    |
| 52       |  |                                       |                        | l ől            | 5    |
| 99       | <br> Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5. | 08)                                   |                        |                 | 5    |
| 00       | Determined net settlement amount (balance due) based on the      |                                       |                        |                 | 6    |
| )1       | SETTLEMENT TO PROVIDER   | cost report. (1)                      |                        | 48, 805         | 6    |
|          | SETTLEMENT TO PROVIDER   |                                       |                        | 40, 803         | 6    |
|          |  |                                       |                        |                 |      |
| )2       |  |                                       |                        | 0/ 2701         |      |
| 02       | Total Medicare program liability (see instructions)              |                                       | Contractor             | 84, 378         | /    |
| 02       |  |                                       | Contractor             | NPR Date        | /    |
| 02<br>00 |  | 0                                     | Contractor Number 1.00 |                 | 7.   |