Health Financia	al Syst	ems	HANCOCK REGIONAL H	IOSPI TAL			In Lieu	u of Form	CMS-	-2552-10
This report is	requi r	red by law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	ire to report can r	esul t	in all	interim	FORM APP	ROVE	D
payments made :	since 1	the beginning of the co	st reporting period being o	leemed overpayments	s (42 l	JSC 1395	g).	OMB NO.	0938	-0050
HOSPITAL AND H	OSPI TAL	HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provi der CCN: 1500	037 F	Peri od:		Workshee	t S	
AND SETTLEMENT SUMMARY										
					1	Γo 12/	31/2015	Date/Tim		
								5/26/201	<u>6 2:</u>	54 pm
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	5/26/20	16 Tin	ne:	2:54 pm
use only	2. [] Manually submitted co	st report							
			report enter the number of		er res	ubmi tted	d this co	ost report	t	
	4. [F] Medicare Utilization.	Enter "F" for full or "L"	for low.						
Contractor	5. [1	1Cost Report Status	6. Date Received:		10. NP	R Date:				
use only		As Submitted					's Vendo			4
	(2)	Settled without Audit	8. [N] Initial Report for	this Provider CCN	12. [0]If li	ne 5, co	lumn 1 is	4:	Enter
		Settled with Audit	9. [N] Final Report for the	nis Provider CCN				es reopen		
	(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 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 HANCOCK REGIONAL HOSPITAL (150037) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

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

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	35, 607	-8, 047	268, 684	391, 421	1.00
2.00	Subprovider - IPF	0	469	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		3, 720		0	10.00
200.00	Total	0	36, 076	-4, 327	268, 684	391, 421	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150037 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 2:22 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: . 10 NORTH STATE STREET 1.00 PO Box: 1.00 2.00 City: GREENFIELD State: IN Zip Code: 46140-County: HANCOCK 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal HANCOCK REGIONAL 150037 26900 07/01/1966 Ν Р 0 3.00 1 HOSPI TAI HANCOCK REGIONAL GERO Р 4.00 Subprovider - IPF 15S037 26900 12/01/1996 N N 4 4.00 PSYCH UNIT 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF Swing Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce HANCOCK REGIONAL 151547 02/02/1996 14 00 26900 14 00 HOSPI CE 15.00 Hospital-Based Health Clinic - RHC KNI GHTSTOWN RURAL 153987 26900 09/22/1998 N 0 Ν 15.00 HEALTH 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 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 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 Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for yes or "N" fo<u>r no</u> In-State In-State Out-of Out-of Medi cai d Other Medi cai d Medi cai d State State HMO days Medi cai d Medi cai d paid days el i gi bl e Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 | If this provider is an IPPS hospital, enter the 584 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Heal th	Financial Systems HANCOCK	K REGIONAL	HOSPI TAL			In Lie	u of For	m CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der	CCN: 150037	Peri od: From 01/0	11/2015	Worksho Part I	eet S-2	
						31/2015	Date/Ti		
		In-State	In-State	Out-of	Out-of	Medi ca	nid 0	016 2:2 ther	Z piii
		Medicaid paid days	Medicaid eligible	State Medicaid	State Medicaid	HMO da		di cai d days	
		para dayo	unpai d	pai d days	el i gi bl e			aayo	
		1.00	2. 00	3.00	unpai d 4. 00	5. 00) /	5. 00	
25. 00	If this provider is an IRF, enter the in-state	1.00			0		0	3. 00	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.								
						Rural S 00	Date of 2.		
26. 00	Enter your standard geographic classification (not w		at the beg	ginning of t		1		00	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w		s at the end	d of the cos	it	1	-		27. 00
27.00	reporting period. Enter in column 1, "1" for urban o	r"2" for r	rural. If ap						27.00
35. 00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter the			CH status in		0			35. 00
	effect in the cost reporting period.		<u> </u>		Begi n	ni na:	Endi	na:	
					1.	00 00	2.		
36. 00	Enter applicable beginning and ending dates of SCH's of periods in excess of one and enter subsequent date		script line	36 for numb	er				36. 00
37. 00	If this is a Medicare dependent hospital (MDH), ente		er of period	ds MDH statu	s	0			37. 00
38. 00	is in effect in the cost reporting period. If line 37 is 1, enter the beginning and ending date	s of MDH st	atus. If li	ine 37 is					38. 00
	greater than 1, subscript this line for the number of								
	enter subsequent dates.				Y,	/N	Υ/	'N	
39. 00	Does this facility qualify for the inpatient hospita	l novmont o	diustmont f	For Low volu	1.	00	2. Y		39. 00
39.00	hospitals in accordance with 42 CFR §412.101(b)(2)(i	i)? Enter i	n column 1	"Y" for yes			· '		37.00
	or "N" for no. Does the facility meet the mileage reCFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)				
40. 00	Is this hospital subject to the HAC program reduction	n adjustmer	nt? Enter "\	Y" for yes o	r N	N	N	I	40. 00
	"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1			yes or "N" T	or				
						1. 00	XVIII) 2.00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital								
45. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	proporti onat	te share in	accordance	N	N	N	45. 00
46. 00	Is this facility eligible for additional payment exc	eption for	extraordi na	ary circumst	ances	N	N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. I	II and WKS1	t. L-1, Pt.	i through				
	Is this a new hospital under 42 CFR §412.300 PPS cap Is the facility electing full federal capital paymen					N N	N N	N N	47. 00 48. 00
46.00	Teaching Hospitals	t? Elitei	1 TOT yes	OI N TOI	HO.	IV	IN	IV	46.00
56. 00	Is this a hospital involved in training residents in or "N" for no.	approved 0	GME programs	s? Enter "Y	" for yes	N			56. 00
57. 00	If line 56 is yes, is this the first cost reporting								57. 00
	GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon								
	for yes or "N" for no in column 2. If column 2 is "			t E-4. If co	lumn 2 is				
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim	bursement f	for physicia	ans' service	s as	N			58. 00
59. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye			Pt. I.		N			59. 00
60. 00	Are you claiming nursing school and/or allied health	costs for	a program t	that meets t		Y			60.00
	provider-operated criteria under §413.85? Enter "Y"	for yes or	"N" for no	o. (see inst Direct GM		ЛE	Di rec	t GME	
61. 00	Did your hospital receive FTE slots under ACA	1. 00	2. 00	3. 00	4.	0. 00	5.		61.00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)								
61. 01	Enter the average number of unweighted primary care		0.00	d	0. 00				61. 01
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								
,,	instructions)								
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0.00) (0. 00				61. 02
	and primary care FTEs added under section 5503 of								
	ACA). (see instructions)	1		I	I		I		I

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPL			Provi der		eriod: rom 01/01/2015	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 5/26/2016 2:2	pared:
			Y/N	I ME	Direct GME	IME	Direct GME	, p
			1. 00	2. 00	3. 00	4.00	5.00	
51. 03	Enter the base line FTE count for and/or general surgery residents, determining compliance with the 7 instructions)	which is used for		0.00	0.00			61. 03
1. 04	Enter the number of unweighted pr surgery allopathic and/or osteopa current cost reporting period.(se	nthic FTEs in the		0.00	0.00			61. 04
	Enter the difference between the and/or general surgery FTEs and primary care and/or general surge 61.04 minus line 61.03). (see ins	the current year's ery FTE counts (line		0.00	0.00			61. 05
	Enter the amount of ACA §5503 awa used for cap relief and/or FTEs t care or general surgery. (see ins	ard that is being that are nonprimary		0. 00				61. 06
			Pr	ogram Name	Program Code		Direct GME FTE Count	
1 10	Of the FTEs in line 61.05, specif	a oach now program		1. 00	2. 00	3.00	4.00	61. 10
o1. 20	for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count. Of the FTEs in line 61.05, specific program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program column 2, the IME FTE unweighted count 4, direct GME FTE unweighted cour	tin column 2, the the IME FTE umn 4, direct GME Ty each expanded the number of FTE tram. (see the program name, ode, enter in column and enter in column				0. 00	0.00	61. 20
							1.00	
2 00	ACA Provisions Affecting the Heal Enter the number of FTE residents					od for which	0.00	62. 00
	your hospital received HRSA PCRE Enter the number of FTE residents during in this cost reporting per	funding (see instructs that rotated from a riod of HRSA THC prog	tions) Teachi ram. (:	ing Health Cent see instruction	er (THC) into			62. 01
53. 00	Teaching Hospitals that Claim Res Has your facility trained resider "Y" for yes or "N" for no in colu	nts in nonprovider se	ttings	during this co		period? Enter	N	63. 00
					Unwei ghted FTEs Nonprovi der Si te 1.00	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year					is your cost r		
	period that begins on or after Ju Enter in column 1, if line 63 is in the base year period, the number resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in your footbase.	yes, or your facilit per of unweighted non cations occurring in number of unweighted ur hospital. Enter in	y train -priman all non non-pr column	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.00
	of (column 1 divided by (column 1	+ column 2)). (see Program Name		ctions) ogram Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
					FTEs	FTEs in	(col. 3 + col.	

2.00

1.00

Unweighted FTEs Nonprovider Site

3. 00

Unweighted FTEs in Hospital

4.00

Ratio (col. 3/ (col. 3 + col. 4))

5.00

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150037 Peri od: Worksheet S-2 From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/26/2016 2: 22 pm Ratio (col. 3/ Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs (col. 3 + col FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col. Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTFs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column

	o, the ratio of (corullin s									
	divided by (column 3 + column									
	4)). (see instructions)									
						1. 00	2.00	3.00		
	Inpatient Psychiatric Facility PPS									
70.00	Is this facility an Inpatient Ps	rovi der?	Υ			70. 00				
	Enter "Y" for yes or "N" for no).								
71.00	If line 70 yes: Column 1: Did th	ne facility have an ap	oproved GME teaching p	orogram in the	most	N	N	0	71. 00	
	recent cost report filed on or b	efore November 15, 20	004? Enter "Y" for ye	es or "N" for n	o. (see					
	42 CFR 412.424(d)(1)(iii)(c)) Co	olumn 2: Did this faci	lity train residents	in a new teach	i ng					
	program in accordance with 42 CF	R 412.424 (d)(1)(iii))(D)? Enter "Y" for ye	es or "N" for n	Ο.					
	Column 3: If column 2 is Y, indi	cate which program ye	ear began during this	cost reporting	peri od.					
	(see instructions)									
	Inpatient Rehabilitation Facilit	cy PPS								
75.00	Is this facility an Inpatient Re	ehabilitation Facility	y (IRF), or does it co	ontain an IRF		N			75. 00	
	subprovider? Enter "Y" for yes	and "N" for no.								
76.00	If line 75 yes: Column 1: Did th	ne facility have an ap	oproved GME teaching p	orogram in the	most	N	N	0	76. 00	
	recent cost reporting period end	ling on or before Nove	ember 15, 2004? Enter	"Y" for yes or	"N" for					
	no. Column 2: Did this facility	train residents in a	new teaching program	in accordance	with 42					
	CFR 412.424 (d)(1)(iii)(D)? Ente	er "Y" for yes or "N"	for no. Column 3: If	column 2 is Y,						
	lindicate which program year bega	n durina this cost re	eportina period. (see	instructions)						

5, the ratio of (column 3

Health Financial Systems HANCOCK REGION	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150037	Peri od: From 01/01/2015	Worksheet S-2 Part I	2
			To 12/31/2015	Date/Time Pre	epared:
				5/26/2016 2:2	22 pm
				1. 00	
Long Term Care Hospital PPS	and "N" for			N.	00.00
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part c "Y" for yes and "N" for no.			ng period? Enter	N N	80.00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude				N	85. 00 86. 00
\$413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87. 00 Is this hospital a "subclause (II)" LTCH classified under se for yes or "N" for no.	ection 1886(d)	(1)(B)(iv)(II)? Enter "Y"	N	87. 00
iror yes or in ror no.			V	XI X	
Title Ward WV Comices			1. 00	2. 00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospita	al services? Fi	nter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through t	the cost repor	t either in	N	Y	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificat			N	92. 00
93.00 instructions) Enter "Y" for yes or "N" for no in the applica 93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	N	N	93. 00		
94. 00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the app. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			O. OC N	O. OC N	95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the app	olicable colum	n.	0.00	0. 00	97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CA)	λΗ)?		N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		hod of paymer	1		106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst 25 and the p	ructions) If rogram is cos	st		107. 00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRIVA TEE SCHE	uure? see 42	Z IN		108.00
	Physi cal	Occupati ona		Respiratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1. 00 N	2. 00 N	3. 00 N	4. 00 N	109. 00
for yes or "N" for no for each therapy.					
				1. 00	
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"	al Demonstration for no.	on project (4	410A Demo)for	N	110. 00
			1.00	2.00 3.00	-
Miscellaneous Cost Reporting Information			1.00	0 2.00 3.00	
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 int for long te	is "E", enter rm care (incl	rin column udes	0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insuring.			N Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	y is 2		118. 00
		Premi ums	Losses	Insurance	
		1.00	2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 558, 0	2. 00 042 C	3.00	118. 01

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CM	MS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I DEN		Provi der CCN:		eri od:	Worksheet :	
			Fr To	rom 01/01/2015 12/31/2015	Part Date/Time	Prepared:
				12, 01, 2010	5/26/2016	
				1. 00	2.00	
118.02 Are mal practice premiums and paid losse	s reported in a cost ce	enter other than	the	N	2.00	118. 02
Administrative and General? If yes, su	bmit supporting schedul	le listing cost o	centers			
and amounts contained therein. 119.00D0 NOT USE THIS LINE						119. 00
120.00 Is this a SCH or EACH that qualifies fo	r the Outpatient Hold H	Harmless provisio	on in ACA	N	N	120. 00
§3121 and applicable amendments? (see i						
"N" for no. Is this a rural hospital wi Hold Harmless provision in ACA §3121 an						
Enter in column 2, "Y" for yes or "N" f	or no.	•	ŕ			
121.00 Did this facility incur and report cost patients? Enter "Y" for yes or "N" for		table devices cha	arged to	Y		121. 00
Transplant Center Information	no.					
125.00 Does this facility operate a transplant		yes and "N" for	no. If	N		125. 00
yes, enter certification date(s) (mm/dd 126.00 If this is a Medicare certified kidney		ar the certifica	tion data			126. 00
in column 1 and termination date, if ap	plicable, in column 2.					120.00
127.00 If this is a Medicare certified heart t		r the certificati	ion date			127. 00
in column 1 and termination date, if ap 128.00 f this is a Medicare certified liver t	•	r the certificati	ion date			128. 00
in column 1 and termination date, if ap		the continuati	TOTT GGTC			120.00
129.00 If this is a Medicare certified lung tr		the certification	on date in			129. 00
column 1 and termination date, if appli 130.00 If this is a Medicare certified pancrea		nter the certific	cation			130. 00
date in column 1 and termination date,	if applicable, in colur	mn 2.				
131.00 If this is a Medicare certified intesti date in column 1 and termination date,			fi cati on			131. 00
132.00 If this is a Medicare certified islet t			ion date			132. 00
in column 1 and termination date, if ap						122 00
133.00 If this is a Medicare certified other t in column 1 and termination date, if ap		r the certificati	ion date			133. 00
134.00 If this is an organ procurement organiz	ation (OPO), enter the	OPO number in co	olumn 1			134. 00
and termination date, if applicable, in	column 2.					
ALL Providors				•		
All Providers 140.00 Are there any related organization or h		fined in CMS Pub.	. 15-1,	N		140. 00
140.00 Are there any related organization or h chapter 10? Enter "Y" for yes or "N" fo	ome office costs as det r no in column 1. If ye	es, and home offi	ice costs	N		140. 00
140.00 Are there any related organization or h	ome office costs as det r no in column 1. If yo office chain number.	es, and home offi	ice costs			140. 00
140.00 Are there any related organization or h chapter 10? Enter "Y" for yes or "N" fo are claimed, enter in column 2 the home 1.00 If this facility is part of a chain org	ome office costs as det r no in column 1. If ye office chain number. 2.00 anization, enter on li	es, and home offi (see instructions nes 141 through	ice costs s)	3.00	of the	140. 00
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Health Financial Systems	HANCOCK RE	EGIONAL HOSPITAL			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	From 01/01/2015 To 12/31/2015						epared: 22 pm
						1.00	+
Mul ti campus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	BSAs?	N	165. 00				
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 fline 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. 0	0 166. 00					
						1.00	
U1+b 16+: Tb1 (III.7	-\ !	D	D-!	A-+		1.00	
Health Information Technology (HIT 167.00 sthis provider a meaningful user						Υ	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a mea	aningful user (line			r the		0168. 00
168.01 If this provider is a CAH and is nexception under §413.70(a)(6)(ii)?	'Enter "Y" for yes or	"N" for no. (see i	nstructio	ns)	•		168. 01
169.00 f this provider is a meaningful u transition factor. (see instruction		and is not a CAH (line 105			0. 2	5169. 00
				Be	egi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR because period respectively (mm/dd/yyyy)	eginning date and end	ing date for the re	porting	10	/01/2014	09/30/2015	170. 00
						1. 00	-
171.00 If line 167 is "Y", does this prov Medicare cost plans reported on Wk (see instructions)						N N	171. 00

Heal th	Financial Systems	HANCOCK REGIONAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE			eriod: rom 01/01/2015	Worksheet S-2	
				o 12/31/2015		
				Y/N 1. 00	Date 2.00	
	General Instruction: Enter Y for all YES resp	oonses. Enter N for all NO re	esponses. Enter			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
4 00	Provider Organization and Operation		.,		1	1
1.00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of			N		1.00
			Y/N 1.00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in		N	2.00	5. 55	2. 00
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3, "V" for				
3. 00	Is the provider involved in business transactontracts, with individuals or entities (e.g.	tions, including management	N			3. 00
	or medical supply companies) that are related	d to the provider or its				
	officers, medical staff, management personnel of directors through ownership, control, or 1					
	relationships? (see instructions)		Y/N	Type	Date	
			1. 00	2. 00	3.00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared to the financial statement of the financial statemen	pared by a Certified Public	Υ	А	06/30/2016	4. 00
	Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or					
F 00	column 3. (see instructions) If no, see instr	ructions.	, ,			F 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If y		N			5. 00
				1. 00	Legal Oper. 2.00	
4 00	Approved Educational Activities	10.01	.,		1 2.00	
6. 00	Column 1: Are costs claimed for nursing school the legal operator of the program?	ool? Column 2: IT yes, IS tr	ne provider is	N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health programs'		during the	Y N		7. 00 8. 00
	cost reporting period? If yes, see instruction	ons.	Ü			
9. 00	Are costs claimed for Interns and Residents i program in the current cost report? If yes, s		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME progressors reporting period? If yes, see instruction		the current	N		10. 00
11. 00	Are GME cost directly assigned to cost center	rs other than I & R in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see	Instructions.			Y/N	
	Bad Debts				1. 00	
12.00	Is the provider seeking reimbursement for back			.	Y	12.00
13. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy.	of correction poricy change of	during this cos	t reporting	N	13. 00
14. 00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived? If	yes, see inst	ructi ons.	N	14. 00
15. 00	Did total beds available change from the price	or cost reporting period? If	f		N	15. 00
		Description	Y/N	t A Date	Part B Y/N	
	PS&R Data	0	1.00	2. 00	3. 00	
16. 00	Was the cost report prepared using the PS&R		N		N	16. 00
	Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R					
	Report used in columns 2 and 4 (see instructions)					
17. 00	Was the cost report prepared using the PS&R		Υ	02/09/2016	Y	17. 00
	Report for totals and the provider's records for allocation? If either column 1 or 3 is					
	yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments		N		N	18. 00
	made to PS&R Report data for additional claims that have been billed but are not					
	included on the PS&R Report used to file this cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments		N		N	19. 00
	made to PS&R Report data for corrections of other PS&R Report information? If yes, see					
20. 00	instructions. If line 16 or 17 is yes, were adjustments		N		N	20.00
_0.00	made to PS&R Report data for Other? Describe					
	the other adjustments:	I	I	I	I	1

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 150037 Peri od: Worksheet S-2 From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/26/2016 2: 22 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν N 21 00 provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? 24.00 If yes, see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see 26,00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 33.00 no, see instructions. Provider-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? 36, 00 37.00 | If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00

38. 00	10 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.							
39. 00	If line 36 is yes, did the provider render services to other			39. 00				
40 00	see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see							
	instructions.			10.00				
		1.00	2. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	TI NA	SEVERS	41.00				
	held by the cost report preparer in columns 1, 2, and 3,							
	respectively.							
42.00	Enter the employer/company name of the cost report	BLUE & CO., LLC		42. 00				
	preparer.							
43.00	Enter the telephone number and email address of the cost	317-713-7946	TSEVERS@BLUEANDCO. COM	43. 00				
	report preparer in columns 1 and 2, respectively.							

If yes, see instructions.

	AL AND HOST FAC HEALTH CARE RETWOORSEMENT QUE	STI ONIVAL ILE	Trovi dei		From 01/01/2015 To 12/31/2015	Part II Date/Time Prep 5/26/2016 2:22	
		Part B					
		Date					
		4.00					
	PS&R Data						
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)						16. 00
17. 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)	02/09/2016					17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						18. 00
19. 00	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.						19. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20. 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21. 00
			3.	00			
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		MANAGER				41. 00
42. 00	Enter the employer/company name of the cost r preparer.	report					42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective						43. 00

 Heal th Financial
 Systems
 HANCOCK

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 150037

Component						T T	o 12/31/2015	Date/Time Prep 5/26/2016 2:2:	
Component					1				z piii
1.00									
1.00 Hospit tal Adult s & Peds. (col umns 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 2 2 2 2 2 2 2 2 2		Component		No.	of Beds		CAH Hours	Title V	
8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			1. 00		2.00	3.00	4. 00	5. 00	
Hospice days) (See instructions for col. 2 2 00	1.00		30. 00		37	13, 505	0.00	0	1. 00
For the portion of LDP room available beds) 2.00 0.0									
2.00 HMO and other (see instructions) 2.00 A.00 MO IPF Subprovider 3.00 A.00 HMO IRF Subprovider 4.00 4.00 5.00 HMO IRF Subprovider 4.00 4.00 5.00 HMO IRF Subprovider 6.00 Hospital Adult s& Peds. Swing Bed NF 0.6 5.00 0.5 0.00									
3.00	2 00								2 00
4. 00 HMO IRF Subprovider 5. 00 Hospital Adults & Peds. Swing Bed NF 0 5. 00 6. 00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 0 0 0 0 0 0 0 0 0		` ,							
5.00		•							
6. 00 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) 37 13,505 0.00 0 7.00		•						0	
Total Adults and Peds. (exclude observation beds) (see instructions) See									
8.00 INTENSIVE CARE UNIT 31.00 24 8.760 0.00 0 8.00 9.00 0.00 0.00 0.00 9.00 0.00 0.00 9.00 0.00 0.00 0.00 9.00 0.					37	13, 505	0.00	0	7.00
9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00		beds) (see instructions)							
10.00 BURN INTENSIVE CARE UNIT 11.00 1			31. 00		24	8, 760	0. 00	0	
11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 13.00 NURSERY 15.00 CAH visits 0 14.00 CAH visits 0 15.00 CAH visits 0 16.00 CAH visits									
12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 15. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 16. 00 16. 00 16. 00 17. 00 18. 00 18. 00 18. 00 19		· ·							
13.00 NURSERY 14.00 Total (see instructions) 13.00 14.00 Total (see instructions) 15.00 CAH visits 0.15.00 CAH visits 0.15.00 15.00 CAH visits 0.15.00 15.00									
14. 00 Total (see instructions) 61 22, 265 0.00 0 14. 00 15. 00 CAH visits 0 15. 00 16. 00 SUBPROVI DER - IPF 40. 00 10 3, 650 17. 00 SUBPROVI DER - IRF 41. 00 0 18. 00 SUBPROVI DER - IRF 41. 00 0 19. 00 SKILLED NURSING FACILITY 20. 00 19. 00 NURSING FACILITY 20. 00 10 OTHER LONG TERM CARE 21. 00 11. 00 OTHER LONG TERM CARE 21. 00 12. 00 HOME HEALTH AGENCY 101. 00 13. 00 AMBULATORY SURGI CAL CENTER (D. P.) 14. 00 HOSPI CE 116. 00 7 2, 555 15. 00 CMHC - CMHC 24. 10 15. 00 CMHC - CMHC 25. 00 15. 00 CMHC - CMHC 26. 25 15. 00 CMHC - CMHC 26. 25 15. 00 Observation Bed Days 78 27. 00 15. 00 Observation Bed Days 29. 00 15. 00 Ambulance Trips 30. 00 15. 00 Cmpl oyee discount days (see instruction) 31. 00 15. 00 Empl oyee discount days (see instructions) 32. 00 15. 00 Total (sum of lines 14-26) 33. 00 15. 00									
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF		· ·			61	22 265	0.00	0	
16. 00 SUBPROVIDER - IPF 40. 00 10 3, 650 0 16. 00 17. 00 SUBPROVIDER - IRF 41. 00 0 0 18. 00 SUBPROVIDER 1RF 41. 00 0 19. 00 SKILLED NURSING FACILITY 18. 00 19. 00 ONURSING FACILITY 20. 00 20. 00 NURSING FACILITY 21. 00 21. 00 HOME HEALTH AGENCY 101. 00 22. 00 HOME HEALTH AGENCY 101. 00 24. 00 HOSPICE 116. 00 7 2, 555 24. 10 HOSPICE (non-distinct part) 30. 00 25. 00 CMHC - CMHC 25. 00 26. 00 RURAL HEALTH CLINIC 88. 00 26. 00 27. 00 Total (sum of lines 14-26) 78 27. 00 28. 00 Observation Bed Days 29. 00 30. 00 Employee discount days - IRF 31. 00 32. 00 Labor & delivery days (see instructions) 32. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01					01	22, 203	0.00		
17. 00 SUBPROVI DER - IRF		· ·	40. 00		10	3, 650			
19. 00	17. 00	SUBPROVIDER - IRF	41. 00		0			0	17.00
20.00 NURSING FACILITY 20.00 21.00 21.00 22.00 22.00 22.00 40ME HEALTH AGENCY 101.00 22.00 23.00 4MBULATORY SURGICAL CENTER (D.P.) 23.00 24.10 HOSPICE 116.00 7 2,555 24.00 24.10 40SPICE (non-distinct part) 30.00 24.10 25.00 26.00 RURAL HEALTH CLINIC 25.00 26.00 RURAL HEALTH CLINIC 26.25 27.00 7 27.00 7 27.00 28.00 28.00 29.00	18.00	SUBPROVI DER							18.00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 44.00 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 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) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)		i i							
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 29. 00 Employee discount days (see instruction) 29. 00 Labor & delivery days (see instructions) 20. 01 Total ancillary labor & delivery room outpatient days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions)		1							
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 116. 00 7 2,555 24. 00 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days (see instructions) 30. 00 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions)		1	404.00						
24. 00 HOSPICE		i i	101.00					0	
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 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) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 30. 00 and control outpatient days (see instructions)		, ,	114 00		7	2 555			
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 88. 00 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) Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01		i i			,	2, 555			
26. 00 RURAL HEALTH CLINIC 88. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 31. 00 Employee discount days (see instruction) Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)			30.00						
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 29.00 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) 27.00 28.00 29.00 30.00 30.00 30.00 31.00 32.00		i i	88. 00					0	
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 30.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01	26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
29. 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)	27.00	Total (sum of lines 14-26)			78				27.00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 30.00 31.00 0 0 0 32.00	28. 00	Observation Bed Days						0	
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31.00 0 0 0 32.00									
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.00									
32.01 Total ancillary labor & delivery room outpatient days (see instructions)		. ,			_	_			
outpati ent days (see instructions)					O	0			
	32.01								JZ. U1
55. 00 LIGH HUH-COVERED DAYS	33. 00	LTCH non-covered days							33. 00

						5/26/2016 2:2	2 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time I	·	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	r Production			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	1, 237	177	3, 348			1. 00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	351	1, 143				2. 00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	C)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C)		6.00
7.00	Total Adults and Peds. (exclude observation	1, 237	177	3, 348			7. 00
	beds) (see instructions)	,					
8.00	INTENSIVE CARE UNIT	2, 466	0	5, 230)		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)	3, 703	177	8, 578	0.00	596. 11	14.00
15.00	CAH visits	0	0	C)		15. 00
16.00	SUBPROVI DER - I PF	2, 562	0	2, 610	0.00	18. 64	16. 00
17.00	SUBPROVI DER - I RF	0	0	C	0.00	0.00	17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY	0	0	C	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	1, 009	0.00	18. 27	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	C			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	289	0	1, 698	0.00	3. 03	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	636. 05	27. 00
28. 00	Observation Bed Days		0	2, 098	1		28. 00
29.00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			72			30.00
31.00	Employee discount days - IRF			C)		31.00
32.00	Labor & delivery days (see instructions)	0	25	46			32. 00
32. 01	Total ancillary labor & delivery room			C)		32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150037

			To	12/31/2015	Date/Time Pre 5/26/2016 2: 2	
	Full Time Equivalents	<u>'</u>	Di scha	arges		'
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 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	., 100	40	2, 556	
2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider			98	288 0		2. 00 3. 00
4.00 HMO I RF Subprovi der				0		4. 00
5.00 Hospital Adults & Peds. Swing Bed SNF				O		5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation 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	0	1, 183	40	2, 556	
15.00 CAH visits						15. 00
16. 00 SUBPROVI DER - I PF	0. 00	0		0	222	
17. 00 SUBPROVI DER – I RF	0. 00	0	0	0	0	
18. 00 SUBPROVI DER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20. 00 NURSING FACILITY						20.00
21. 00 OTHER LONG TERM CARE	0.00					21. 00 22. 00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE	0.00					24. 00
24. 00 HOSPICE (non-distinct part)	0.00					24. 00
25. 00 CMHC - CMHC						25. 00
26. 00 RURAL HEALTH CLINIC	0.00					26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00 Total (sum of lines 14-26)	0.00					27. 00
28.00 Observation Bed Days	0.00					28.00
29. 00 Ambul ance Tri ps						29. 00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - 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						33. 00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared:

					Т	o 12/31/2015	Date/Time Pre 5/26/2016 2:2	
		Worksheet A	Amount	Reclassi fi cati	Adj usted		Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	SALARI ES							1
1. 00	Total salaries (see instructions)	200. 00	37, 540, 824	0	37, 540, 824	1, 181, 434. 76	31. 78	1. 00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2.00
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3.00
	В		-					
4. 00	Physician-Part A - Administrative		Ü	0	0	0.00	0.00	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0	0	0	0. 00 0. 00		
6. 00	Non-physician-Part B		175, 440	0	175, 440		l .	
7. 00	Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	О	О	0.00	0. 00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel		0	0	o	0.00		
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	5, 052, 593	0 103, 971	0 5, 156, 564	0. 00 144, 939. 00		
10.00	instructions)		0,002,070	100, 771	0, 100, 001	111, 707.00	00.00	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		283, 759	0	283, 759	5, 140. 00	55 21	11. 00
	Care		·					
12. 00	Contract labor: Top level management and other		0	0	0	0.00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		377, 685	0	377, 685	3, 112. 00	121. 36	13. 00
14. 00	A - Administrative Home office salaries &		0	0	0	0.00	0.00	14.00
	wage-related costs		O					
15. 00	Home office: Physician Part A - Administrative		0	0	0	0.00	0. 00	15. 00
16. 00	Home office and Contract		0	0	О	0.00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		7, 316, 302	0	7, 316, 302			17. 00
18. 00	instructions) Wage-related costs (other)		0	О	О			18. 00
19. 00	(see instructions) Excluded areas		1, 294, 280	0	1, 294, 280			19.00
20. 00	Non-physician anesthetist Part		1, 2,44, 200	ő	1, 2, 4, 200			20.00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
	В		-					
22. 00	Physician Part A - Administrative		U	0	0			22. 00
22. 01	Physician Part A - Teaching		40, 212	0				22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		40, 313 0	0	40, 313 0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	317, 830 6, 686, 229		317, 830 6, 582, 258			
28. 00	Administrative & General under	5.00	870, 210		870, 210			
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0	0	,	0.00	0. 00	29.00
30. 00	Operation of Plant	7. 00	902, 194	Ö	902, 194		l .	
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32. 00 33. 00	Housekeeping under contract	9. 00	861, 408 0	0	861, 408 0	60, 820. 00 0. 00	l .	
34. 00	(see instructions) Dietary	10. 00	1, 098, 122	-733, 832	364, 290	22, 118. 00	16. 47	34.00
34. 00 35. 00	Dietary under contract (see	10.00	1, 098, 122	- /33, 832	304, 290	22, 118. 00 0. 00	l .	1
36. 00	instructions) Cafeteria	11. 00	0	733, 832	733, 832	45, 490. 00	16. 13	36.00
37.00	Maintenance of Personnel	12. 00	0	733, 632	733, 632	45, 490. 00		37.00
	Nursing Administration	13. 00	918, 199		918, 199			38.00
39. 00 40. 00	Central Services and Supply Pharmacy	14. 00 15. 00	60, 848 1, 463, 372		60, 848 1, 447, 422			39. 00 40. 00
			,	,	, , , , , , , , , , , , , , , , , , , ,			

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 150037			Period: Worksheet S-3			
			rom 01/01/2015 o 12/31/2015		nared:		
					0 12/31/2013	5/26/2016 2: 2:	
	Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3.00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	591, 131	C	591, 13°	23, 815. 00	24. 82	41.00
Records Library							
42.00 Social Service	17. 00	0) C	(0.00	0.00	42.00
43.00 Other General Service	18. 00	0) c)	0.00	0.00	43. 00

iour tir i riiurior ur Oyo tomo		13 11 10 0 0 11 11 L 0 1 0 1	11712 11001 1 1712		111 21 00 01 101 111 01110 2002 10			
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 150037	Peri od:	Worksheet S-3		
					From 01/01/2015	Part III		
					To 12/31/2015	Date/Time Prep		
						5/26/2016 2: 22	2 pm	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly		
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
			(from	(col.2 ± col	. Salaries in	col . 5)		

1.00
2.00
3.00
4.00
5.00
6.00
7.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150037	From 01/01/2015 Part IV
		To 12/31/2015 Date/Time Prepared:

PART I V - WAGE RELATED COSTS 1.00 1.0		To 12/31/2015	Date/Time Prep 5/26/2016 2:22	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Empl oyer Contributions 0 1.00 2.00 7.00			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
2.00	1.00	401K Empl oyer Contributions	0	1. 00
A. 00	2.00		0	2.00
A. 00	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 266, 053	3.00
5.00 401K/TSA PI an Administration fees 0 6.00 1	4.00	Qualified Defined Benefit Plan Cost (see instructions)		4. 00
Legal / Accounting / Management Fees-Pension Plan		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	4, 860	6.00
8.00 Heal th Insurance (Purchased or Self Funded) 4, 111, 358 8.00 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 197, 349 10.00 10.00 Life Insurance (If employee is owner or beneficiary) 158, 754 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 62, 219 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 62, 219 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 62, 219 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 62, 219 13.00 15.00 Workers' Compensation Insurance 48, 017 15.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 2, 680, 300 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 Medicare Taxes - Employers Portion Only 0 18.00 Unemployment Insurance 23, 302 19.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 21.00 This instructions) 22.00 Day Care Cost and Allowances 9, 113 22.00 23.00 Total Wage Related cost (Sum of Lines 1 -23) 8, 638, 394 24.00 Part B - Other than Core Related Cost	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 197, 349 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 158,754 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 62,219 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 48.017 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 FICA-Employers Portion Only 2,680,300 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 10.00 Tuit ion Rei mbursement 77,069 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 8,		HEALTH AND INSURANCE COST		
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 197, 349 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 158, 754 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 62, 219 13.00 13.00 Lisability Insurance (If employee is owner or beneficiary) 62, 219 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 48, 017 15.00 15.00 Workers' Compensation Insurance 48, 017 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 2, 680, 300 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 23, 302 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 0THER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 21.00 22.00 Tuit tion Rei mbursement 77, 069 23.00 <td>8.00</td> <td>Health Insurance (Purchased or Self Funded)</td> <td>4, 111, 358</td> <td>8. 00</td>	8.00	Health Insurance (Purchased or Self Funded)	4, 111, 358	8. 00
11.00 Life Insurance (If employee is owner or beneficiary) 158,754 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 62,219 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 48,017 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 2,680,300 17.00 18.00 18.00 18.00 18.00 19.00	9.00			
11.00 Life Insurance (If employee is owner or beneficiary) 158,754 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 62,219 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 48,017 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 2,680,300 17.00 18.00 18.00 18.00 18.00 19.00	10.00	Dental, Hearing and Vision Plan	197, 349	10.00
13. 00 Disability Insurance (If employee is owner or beneficiary) 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 17. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Titition Reimbursement 77, 069 23. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	11.00		158, 754	11.00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15. 00 Workers' Compensation Insurance 48, 017 15. 00	13.00	Disability Insurance (If employee is owner or beneficiary)	62, 219	13.00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 17. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion TAXES	15.00	'Workers' Compensation Insurance	48, 017	15.00
TAXES	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00 FICA-Employers Portion Only 2,680,300 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 23,302 19. 00 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 9,113 22. 00 23. 00 Tuition Reimbursement 77,069 23. 00 24. 00 Other Than Core Related Cost 24. 00 Other				
18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 23, 302 19. 00 20. 00 State or Federal Unemployment Taxes 0 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21. 00 22. 00 Day Care Cost and Allowances 9, 113 22. 00 23. 00 Tuition Reimbursement 77, 069 23. 00 24. 00 Total Wage Related cost (Sum of Lines 1 -23) 8, 638, 394 24. 00 Part B - Other than Core Related Cost 0 18. 00 18. 00 19. 00 20. 00				
19.00 Unemployment Insurance 23,302 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 9,113 22.00 23.00 Tuition Reimbursement 77,069 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 8,638,394 24.00 Part B - Other than Core Related Cost 24.00 25.00	17.00	FICA-Employers Portion Only	2, 680, 300	17. 00
20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 9, 113 22.00 23.00 Tuition Reimbursement 77, 069 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 8, 638, 394 24.00 Part B - Other than Core Related Cost	18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost	19. 00	Unempl oyment Insurance	23, 302	19. 00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 77,069 23.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20.00		0	20. 00
instructions)) 22.00 Day Care Cost and Allowances 9, 113 22.00 23.00 Tuition Reimbursement 77,069 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 8,638,394 Part B - Other than Core Related Cost		OTHER		
22. 00 Day Care Cost and Allowances 9, 113 22. 00 23. 00 Tuition Reimbursement 77, 069 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 8, 638, 394 24. 00 Part B - Other than Core Related Cost 9, 113 22. 00 24. 00	21. 00		0	21. 00
23. 00 Tuition Reimbursement 77, 069 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 8, 638, 394 Part B - Other than Core Related Cost				
24.00 Total Wage Related cost (Sum of lines 1 -23) 8,638,394 Part B - Other than Core Related Cost				
Part B - Other than Core Related Cost				
	24. 00		8, 638, 394	24. 00
25. 00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25. 00				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Heal th	Financial Systems HA	ANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der CCN: 15003		ri od: om 01/01/2015 12/31/2015	Worksheet S-3 Part V Date/Time Pre 5/26/2016 2:2	pared:
	Cost Center Description			С	ontract Labor	Benefit Cost	
					1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identific	ati on:					
1.00	Total facility's contract labor and benefit cos	it			0	0	1. 00
2.00	Hospi tal				0	0	2. 00
3.00	Subprovi der - I PF				0	0	3. 00
4.00	Subprovi der - I RF				0	0	4. 00
5.00	Subprovi der - (Other)				0	0	5. 00
6.00	Swing Beds - SNF				0	0	6. 00
7.00	Swing Beds - NF				0	0	7. 00
8.00	Hospi tal -Based SNF						8. 00
9.00	Hospi tal -Based NF						9. 00
10.00	Hospi tal -Based OLTC						10.00
11.00	Hospi tal -Based HHA				o	0	11. 00
	1				ı		

12.00

13.00 14. 00 15.00 16.00 17. 00 0 18. 00

12.00 Separately Certified ASC

13.00 | Separately Certified ASC 13.00 | Hospital - Based Hospice 14.00 | Hospital - Based Health Clinic RHC 15.00 | Hospital - Based Health Clinic FQHC 16.00 | Hospital - Based - CMHC 17.00 | Renal Dialysis 18.00 | Other

	n Financial Systems TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	HANCOCK REGIO		CCN: 150037	Peri od:	eu of Form CMS- Worksheet S-8	
STATIS	STICAL DATA	IED HEALIH CEN		t CCN: 153987	From 01/01/2015 To 12/31/2015		pared
					Rural Health Clinic (RHC) I	Cost	<u> </u>
					1	00	-
	Clinic Address and Identification					00	
. 00	Street				224 WEST MAIN	STREET	1.
			Ci	ty	State	ZIP Code	1
				00	2. 00	3.00	
. 00	City, State, ZIP Code, County		KNI GHTSTOWN		IN	46148	2.
						1.00	
. 00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for ur	ban			0	3.
					Grant Award	Date	
					1. 00	2. 00	
	Source of Federal Funds						
. 00	Community Health Center (Section 330(d), PHS				137, 632	07/01/2015	4.
00	Migrant Health Center (Section 329(d), PHS Ad				0	•	5.
. 00	Health Services for the Homeless (Section 340	O(d), PHS Act)			0	1	6.
. 00	Appal achi an Regi onal Commissi on				0	1	7.
. 00	Look-Alikes				0	1	8.
. 00	OTHER (SPECIFY)				0		9.
					1 00	2.00	
0. 00	Does this facility operate as other than an I	DUC or FOUC2 En	tor "V" for w	s or "N" for	1. 00 N	2. 00	10.
J. 00	no in column 1. If yes, indicate number of or subscripts of line 11 the type of other oper.	ther operations	s in column 2. ((Enter in	IN		10.
	peased the of the transcripts of ether open		day	<u> </u>	onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4. 00	5. 00	
	Facility hours of operations (1)						
1. 00	Clinic			08: 00	16: 00	08: 00	11.
					1. 00	2.00	
2. 00	Have you received an approval for an exception	on to the produ	ictivity stand	rd2	1.00 N	2.00	12.
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colur	9, section nn 2 the	N	0	
	numbers below.				der name	CCN	
				Provi		I CCN Dumber	
					1. 00	CCN number 2.00	
4. 00	Provider name, CCN number					+	14.
4. 00	Provider name, CCN number	Y/N	V			+	14.
4. 00		Y/N 1.00	V 2.00		1. 00	2. 00	
4. 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.	1.00		XVIII	1. 00 XI X	2.00 Total Visits	15.
	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	1.00	2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
	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.	1.00	2.00 Cou	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
5. 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)	1.00	2.00 Cou	XVIII 3.00	1. 00 XI X	2.00 Total Visits	15.
5. 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.	1.00	2.00 Cot 4. HANCOCK	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits 5.00	15.
5. 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)	1.00	2.00 Cou 4. HANCOCK Wedn	XVIII 3.00 unty 00 esday	1. 00 XI X 4. 00 Thur	2.00 Total Visits 5.00	15.
	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)	Tuesday	2.00 Cou 4. HANCOCK Wedn from	XVIII 3.00 Inty 00 esday to	1.00 XIX 4.00 Thur	2.00 Total Visits 5.00	
5. 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)	1.00	2.00 Cou 4. HANCOCK Wedn	XVIII 3.00 unty 00 esday	1. 00 XI X 4. 00 Thur	2.00 Total Visits 5.00	15.

Health Financial Systems	HANCOCK REGIONAL HOSPITAL				In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH CEN	TER P	Provi der	CCN: 150037	Peri od:	Worksheet S-8		
STATISTICAL DATA		С	Component	t CCN: 153987	From 01/01/2015 To 12/31/2015			
					Rural Health	Cost		
					Clinic (RHC) I			
	Fri	day		Sa	turday			
	from		to	from	to			
	11. 00	12	2. 00	13. 00	14. 00			
Facility hours of operations (1)								
11. 00 Clinic	08: 00	14: 00					11. 00	

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-255		
HOSPITAL IDENTIFICATION DATA	Provi der CCN: 150037	Period: Worksheet S-9 From 01/01/2015 Parts I & II		
	Component CCN: 151547	To 12/31/2015 Date/Time Prepar 5/26/2016 2:22 p		

							0. =0. =0.0 =. =	
						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	4, 734	0	270	0	129	4, 863	2.00
3.00	Inpatient Respite Care	278	0	5	0	14	292	3.00
4.00	General Inpatient Care	528	o	0	0	27	555	4.00
5.00	Total Hospice Days	5, 540	o	275	0	170	5, 710	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	247	0	6	0	18	265	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0. 00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	22. 43	0.00	45. 83	0.00	9. 44	21. 55	8.00
	5/line 6)							
9.00	Unduplicated Census Count	233	o	6	0	18	251	9.00
		•					•	

Heal th	Financial Systems HANCOCK REGION	NAI HOSPITAI		In lie	u of Form CMS-2	2552-10			
	TAL UNCOMPENSATED AND INDIGENT CARE DATA		CCN: 150037	Peri od:	Worksheet S-10				
	The Ground Englished with the region of the same	11.001.001		From 01/01/2015 To 12/31/2015		pared:			
					0,20,2010 2.2.	2 0111			
					1. 00				
	Uncompensated and indigent care cost computation								
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3	divided by li	ne 202 columr	n 8)	0. 291566	1.00			
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				10, 220, 233	2. 00			
3.00	Did you receive DSH or supplemental payments from Medicaid?					3. 00			
4.00	If line 3 is "yes", does line 2 include all DSH or suppleme	l?		4. 00					
5.00	If line 4 is "no", then enter DSH or supplemental payments	from Medicaid			0	5. 00			
6.00	Medi cai d charges				12, 578, 583				
7.00	Medicaid cost (line 1 times line 6)		3, 667, 487 0	7. 00 8. 00					
8. 00	< zero then enter zero)								
	State Children's Health Insurance Program (SCHIP) (see inst	ructions for ea	ach line)						
9.00	Net revenue from stand-alone SCHIP				0				
10.00	Stand-alone SCHIP charges Stand-alone SCHIP cost (line 1 times line 10)				0	10. 00 11. 00			
11. 00 12. 00	Difference between net revenue and costs for stand-alone SC	CUID (line 11 m	inus lino O	if a zoro thon	0	12.00			
12.00	enter zero)	·			0	12.00			
	Other state or local government indigent care program (see								
13. 00	Net revenue from state or local indigent care program (Not				-	13. 00			
14. 00	Charges for patients covered under state or local indigent 10)		Not included	in lines 6 or	0	14. 00			
15. 00	State or local indigent care program cost (line 1 times lin	,			0				
16. 00	Difference between net revenue and costs for state or local 13; if < zero then enter zero)	indigent care	program (lir	ne 15 minus line	0	16. 00			
	Uncompensated care (see instructions for each line)								
17. 00	Private grants, donations, or endowment income restricted t	9	,			17. 00			
18. 00	Government grants, appropriations or transfers for support				0				
19. 00	Total unreimbursed cost for Medicaid, SCHIP and state and 8, 12 and 16)	local indigent	care program	ns (sum of lines	0	19. 00			
			Uni nsured	Insured	Total (col. 1				
			pati ents	pati ents	+ col . 2)				
			1. 00	2. 00	3. 00				
20. 00	Total initial obligation of patients approved for charity of		4, 253, 6	53 0	4, 253, 653	20. 00			
21. 00	charges excluding non-reimbursable cost centers) for the er Cost of initial obligation of patients approved for charity		1, 240, 22	21 0	1, 240, 221	21. 00			
00.00	times line 20)					00.00			
22. 00	Partial payment by patients approved for charity care		1 240 2	0 0	0				
23. 00	Cost of charity care (line 21 minus line 22)		1, 240, 22	21 0	1, 240, 221	23. 00			
					1. 00				
24. 00	Does the amount in line 20 column 2 include charges for pat		nd a Length o	of stay limit		24. 00			
25 22	imposed on patients covered by Medicaid or other indigent of		oamomic i	h of oten limit		25. 00			
26. 00	Total bad debt expense for the entire hospital complex (see				9, 655, 240				
27. 00	Medicare bad debts for the entire hospital complex (see ins		c line 27)		135, 503				
28. 00 29. 00	Non-Medicare and non-reimbursable Medicare bad debt expense			. 20)	9, 519, 737				
30.00	Cost of non-Medicare and non-reimbursable Medicare bad debt Cost of uncompensated care (line 23 column 3 plus line 29)	expense (iine	i tilles line	: 20)	2, 775, 632 4, 015, 853				
	Total unreimbursed and uncompensated care cost (line 19 plu	is line 30)			4, 015, 853				
31.00	Trotal dilicilibal sed and uncompensated care cost (Title 19 pro	3 THE 30)			4,010,000	31.00			

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (HANCOCK REGIONA		CCN: 150037 I	In Lie Period:	u of Form CMS-: Worksheet A	2552-10
RECEAS	STITION TO ADSOLUTE OF THE DELINGE V	OI EXILENSES	Trovider	1	From 01/01/2015 Fo 12/31/2015	Date/Time Pre 5/26/2016 2:2	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	317, 830	8, 719, 372 6, 332, 293			8, 719, 372 6, 650, 123	
5. 00	00500 ADMINISTRATIVE & GENERAL	6, 686, 229	10, 426, 279			16, 527, 916	
7.00	00700 OPERATION OF PLANT	902, 194	3, 999, 085	4, 901, 27	3, 379	4, 904, 658	7. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	861, 408 1, 098, 122	692, 604 919, 457			1, 554, 012 669, 310	1
11. 00	01100 CAFETERI A	1, 096, 122	919, 457		1, 348, 269	1, 348, 269	1
13.00	01300 NURSING ADMINISTRATION	918, 199	164, 967		6 0	1, 083, 166	13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	60, 848	50, 513			111, 361	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 463, 372 591, 131	6, 746, 713 302, 433			8, 193, 603 904, 546	1
23. 00	02300 PARAMED ED PRGM	75, 985	14, 666			90, 651	1
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2 401 524	583, 972	3, 075, 50	4	2 075 504	30.00
31. 00	03100 I NTENSI VE CARE UNI T	2, 491, 534 3, 017, 324	652, 001			3, 075, 506 3, 669, 325	1
40.00	04000 SUBPROVI DER - I PF	1, 149, 395	223, 548			1, 372, 943	
41. 00	04100 SUBPROVI DER - I RF	0	0		0	0	41. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	2, 776, 698	2, 057, 653	4, 834, 35	1 0	4, 834, 351	50.00
51. 00	05100 RECOVERY ROOM	222, 953	33, 427			256, 380	•
53.00	05300 ANESTHESI OLOGY	0	138, 838			138, 838	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	2, 475, 821 1, 568, 564	1, 572, 296 2, 444, 688			4, 048, 117 4, 018, 823	1
65. 00	06500 RESPIRATORY THERAPY	1, 134, 178	258, 543			1, 399, 897	
66. 00	06600 PHYSI CAL THERAPY	946, 390	203, 449			1, 149, 839	1
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	265, 128 159, 111	23, 568 19, 302			288, 696 178, 413	1
68. 01	06801 OCCUPATI ONAL HEALTH	0	17, 302	170, 41		170, 413	68. 01
69. 00	06900 ELECTROCARDI OLOGY	498, 355	184, 844			706, 621	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 162, 361 2, 290, 960			3, 160, 652 2, 290, 960	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö	2,270,700	2, 2,0, 70		2, 270, 700	1
76. 00	03020 CARDI AC	0	0		0	0	
76. 01	O3160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	52, 839	33, 833	86, 67	2 0	86, 672	76. 01
88. 00	08800 RURAL HEALTH CLINIC	175, 440	93, 344	268, 78	4 0	268, 784	88. 00
90.00	09000 CLI NI C	0	0		0	0	
90. 01 90. 02	09001 WOUND CLINIC 09002 DIABETES CLINIC	617, 220 39, 768	253, 155 8, 585			870, 375 48, 353	1
90. 03	09003 ASTHMA CLINIC	0	0	.5, 55	0	0	1
	09004 ANDIS CLINIC	42, 375	48, 887				90. 04
	09005 PRIME TIME 09006 SHELBYVILLE WOUND CLINIC	0 195, 115	102, 303 176, 533			102, 303 371, 648	
90. 07	04951 ONCOLOGY	500, 884	1, 027, 770			1, 528, 654	•
	04950 ANDERSON WOMENS CENTER	254, 104	32, 720			286, 824	•
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 155, 097	519, 515	2, 674, 61	0	2, 674, 612	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	0	0	(0	0	101. 00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	1, 098, 036	1, 639, 714	2, 737, 750	0 0	2, 737, 750	116 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	34, 811, 647	56, 154, 191				
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		587, 218	•	0 3 -32, 339	554, 879	190. 00 190. 01
190. 02	19002 PHYSICIAN BUILDING	O	50, 185			· ·	190. 02
	19003 PRI VATE DUTY	144, 151	199, 405			343, 556	1
	19004 MARKETING 19005 SPORTS PHYSICALS	23, 937	0 4, 528		584, 592 5 0	584, 592 28, 465	190. 04
	19006 FOUNDATI ON	127, 827	53, 094			180, 921	
	1907 ASC	0	806	1			190. 07
	3 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19009 HANCOCK OB	1, 261, 258	2, 305, 317		0 5 0	3, 566, 575	190. 08 190. 09
190. 10	19010 HANCOCK WELLNESS	900, 938	563, 931			1, 464, 869	190. 10
	19011 MORRI STOWN CLINI C	0 E7 190	0 E1 443		0		190. 11
	2 19012 03PUREMED 3 19013 MCCORD WELLNESS	57, 189 59, 817	-51, 662 144, 753			5, 527 204, 570	190. 12 190. 13
190. 14	19014 3 WEST UNIT	154, 060	189, 437	343, 49	7 0	343, 497	190. 14
	19015 NEUROLOGY PHYSI CLAN	27 540 924	78, 000				190. 15
200.00	TOTAL (SUM OF LINES 118-199)	37, 540, 824	60, 279, 203	97, 820, 02	7 0	97, 820, 027	₁ 200.00

Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/26/2016 2:22 pm

			5/26/2016 2: 2	22 pm
Cost Center Description		Net Expenses		
		or Allocation		
OFNEDAL CEDIU OF COCT OFNITEDO	6. 00	7. 00		
GENERAL SERVICE COST CENTERS	4 007 000	7 (00 0(0		4 00
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	-1, 036, 303	7, 683, 069		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 613, 654	5, 036, 469		4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-4, 370, 885	12, 157, 031		5. 00
7. 00 00700 OPERATION OF PLANT	-43, 909	4, 860, 749		7. 00
9. 00 00900 HOUSEKEEPI NG	-67, 600	1, 486, 412		9.00
10. 00 01000 DI ETARY	-378, 054	291, 256		10.00
11. 00 01100 CAFETERI A	-32, 896	1, 315, 373		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-18, 615	1, 064, 551		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	-28, 995	82, 366		14. 00
15. 00 01500 PHARMACY	-708, 005	7, 485, 598		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	-69, 173	835, 373		16. 00
23. 00 02300 PARAMED ED PRGM	-53, 132	37, 519		23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				4
30. 00 03000 ADULTS & PEDI ATRI CS	-1, 337	3, 074, 169		30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	3, 669, 325		31. 00
40. 00 04000 SUBPROVI DER - I PF	-96, 000	1, 276, 943		40. 00
41. 00 04100 SUBPROVI DER - RF	0	0		41. 00
ANCILLARY SERVICE COST CENTERS	1			4
50. 00 05000 OPERATING ROOM	-8, 435	4, 825, 916		50.00
51.00 05100 RECOVERY ROOM	0	256, 380		51. 00
53. 00 05300 ANESTHESI OLOGY	0	138, 838		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-527, 420	3, 520, 697		54. 00
60. 00 06000 LABORATORY	-214, 469	3, 804, 354		60.00
65. 00 06500 RESPIRATORY THERAPY	-196, 925	1, 202, 972		65. 00
66. 00 06600 PHYSI CAL THERAPY	41	1, 149, 880		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	288, 696		67. 00
68.00 06800 SPEECH PATHOLOGY	-375	178, 038		68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0		68. 01
69. 00 06900 ELECTROCARDI OLOGY	-341	706, 280		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 160, 652		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 290, 960		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
76. 00 03020 CARDI AC	0	0		76. 00
76. 01 03160 CARDI OPULMONARY	0	86, 672		76. 01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	-6, 757	262, 027		88. 00
90. 00 09000 CLI NI C	0	0		90.00
90. 01 09001 WOUND CLINIC	-719	869, 656		90. 01
90. 02 09002 DI ABETES CLINIC	0	48, 353		90. 02
90. 03 09003 ASTHMA CLINIC	o	0		90. 03
90. 04 09004 ANDIS CLINIC	-3, 375	87, 887		90. 04
90. 05 09005 PRIME TIME	0	102, 303		90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	-26, 487	345, 161		90.06
90. 07 04951 ONCOLOGY	-474, 877	1, 053, 777		90. 07
90.08 04950 ANDERSON WOMENS CENTER	-1, 071	285, 753		90. 08
91. 00 09100 EMERGENCY	-60, 962	2, 613, 650		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		, ,		92.00
OTHER REIMBURSABLE COST CENTERS				1
101. 00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS	, <u> </u>	<u> </u>		1
116. 00 11600 HOSPI CE	-1, 166	2, 736, 584		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-10, 041, 896	80, 371, 689		118. 00
NONREI MBURSABLE COST CENTERS				1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190. 01 19001 PROFESSI ONAL BUILDING		554, 879		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG		50, 185		190. 01
190. 03 19003 PRI VATE DUTY		343, 556		190. 02
190. 04 19004 MARKETI NG	0	584, 592		190. 04
190. 05 19005 SPORTS PHYSI CALS		28, 465		190. 05
190. 06 19006 FOUNDATION		180, 921		190.05
190. 07 19007 ASC		806		190. 00
190.08 19007 ASC 190.08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		008		190. 07
190.08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		-1		190. 08
	- 1	3, 566, 575		
190. 10 19010 HANCOCK WELLNESS	0	1, 464, 869		190. 10
190. 11 19011 MORRI STOWN CLINI C		0		190. 11
190. 12 19012 03PUREMED	0	5, 527		190. 12
190. 13 19013 MCCORD WELLNESS	0	204, 570		190. 13
190. 14 19014 3 WEST UNIT	0	343, 497		190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	0	78, 000		190. 15
200.00 TOTAL (SUM OF LINES 118-199)	-10, 041, 896	87, 778, 131		200. 00

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 150037 Period: From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/26/2016 2: 22 pm

					5/26/2016 2:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
	A - CAFETERIA					
1.00	CAFETERI A	11. 00	73 <u>3, 8</u> 32	61 <u>4, 4</u> 37		1. 00
	TOTALS		733, 832	614, 437		
	B - PLANT					
1.00	OPERATION OF PLANT	7.00	0	3, 379		1. 00
2.00	MEDICAL RECORDS & LIBRARY	16. 00	0	10, 982		2. 00
3.00	ELECTROCARDI OLOGY	69. 00	0	10, 802		3. 00
4.00	RESPIRATORY THERAPY	<u>65.</u> 00	0_	<u>7, 1</u> 76		4. 00
	TOTALS		0	32, 339		
	C - MARKETING					
1.00	MARKETI NG	1 <u>90.</u> 04	10 <u>3, 9</u> 71	48 <u>0, 6</u> 21		1. 00
	TOTALS		103, 971	480, 621		_
	D - OUTPATIENT PROCEDURES					
1.00	LABORATORY	60.00	4, 885	686		1. 00
2.00	ELECTROCARDI OLOGY	6900	1 <u>1, 0</u> 65	<u>1, 5</u> 55	╡	2. 00
	TOTALS		15, 950	2, 241		
500.00	Grand Total: Increases		853, 753	1, 129, 638	3	500.00

Health Financial Systems RECLASSIFICATIONS HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150037

						5/26/2016 2:	22 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETERIA						
1.00	DI ETARY	1000	733, 832	614, 437	0		1. 00
	TOTALS		733, 832	614, 437			
	B - PLANT						
1.00	PROFESSI ONAL BUILDING	190. 01	0	32, 339	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0)	4. 00
	TOTALS		0	32, 339			
	C - MARKETING						
1.00	ADMI NI STRATI VE & GENERAL	5. 00	103, 971	480, 621	0		1. 00
	TOTALS		103, 971	480, 621			
	D - OUTPATIENT PROCEDURES						
1.00	PHARMACY	15. 00	15, 950	532	. 0		1. 00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 709	0		2. 00
	PATI ENTS						
	TOTALS		15, 950	2, 241			
500.00	Grand Total: Decreases		853, 753	1, 129, 638			500.00

					o 12/31/2015		
				Acqui si ti ons		3/20/2010 2.2.	Z piii
		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 ASSET						
1.00	Land	1, 241, 194	0	C	0	0	1. 00
2.00	Land Improvements	5, 505, 951	1, 072, 303	C	1, 072, 303		2. 00
3.00	Buildings and Fixtures	43, 186, 865	2, 195, 256	C	2, 195, 256	126, 052	3. 00
4.00	Building Improvements	0	0	C	0	0	4. 00
5.00	Fi xed Equipment	56, 277, 169	3, 005, 519	C	3, 005, 519		5. 00
6.00	Movable Equipment	62, 233, 410	9, 426, 740	C	9, 426, 740	125, 199	
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	168, 444, 589	15, 699, 818	C	15, 699, 818	278, 151	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	168, 444, 589	15, 699, 818	C	15, 699, 818	278, 151	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 241, 194	0				1. 00
2.00	Land Improvements	6, 578, 254	0				2. 00
3.00	Buildings and Fixtures	45, 256, 069	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	59, 255, 788	0				5. 00
6.00	Movable Equipment	71, 534, 951	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	183, 866, 256	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	183, 866, 256	0				10.00

Heal th	Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150037	Peri od:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015		narod:
					10 12/31/2013	5/26/2016 2: 2	
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	8, 719, 372	0		0 0	0	1. 00
3.00	Total (sum of lines 1-2)	8, 719, 372	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	8, 719, 372				1. 00
3.00	Total (sum of lines 1-2)	0	8, 719, 372				3. 00

Provider CCN: 150037	Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	552-10
Cost Center Description	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der				
COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL							ared:
Cost Center Description							2 pm
Leases For Ratio		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Col. 1 - col. 2 1.00 2.00 3.00 4.00 5.00	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS			Leases	for Ratio	instructions)		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00				(col. 1 - col.			
PART - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT 45, 256, 069 0 45, 256, 069 1.000000 0 3.00			2. 00	3. 00	4. 00	5. 00	
Total (sum of lines 1-2)							
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
Cost Center Description	3.00 Total (sum of lines 1-2)						3. 00
Capital -Relate Cols. 5 through 7) 6.00 7.00 8.00 9.00 10.00		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
Capital -Relate Cols. 5 through 7) 6.00 7.00 8.00 9.00 10.00							
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	Cost Center Description				Depreciation	Lease	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 8,719,372 -663,271 1.00 0 8,719,372 -663,271 3.00 0 8,719,372 -663,271 3.00 0 8,719,372 -663,271 3.00 0 8,719,372 -663,271 3.00 0 0 8,719,372 -663,271 3.00 0 0 8,719,372 -663,271 3.00 0 0 8,719,372 -663,271 3.00 0 0 8,719,372 -663,271 3.00 0 0 0 0 0 0 0 0 0	DART 111 DECONOLITATION OF CARLEY COOTS O		7.00	8.00	9. 00	10.00	
3.00 Total (sum of lines 1-2)					0.710.070	//0.074	
Cost Center Description Interest Insurance (see instructions) Instructions Instruc				(
Cost Center Description Interest Insurance (see instructions) Instructions Instructions (Capital - Relate of Costs (see instructions) Instructions (Capital - Relate of Costs (see instructions) Instructions (Capital - Relate of Costs (see instructions) Instructions) PART III - RECONCILIATION OF CAPITAL COSTS CENTERS New Cap Rel Costs - Blog & FIXT -373,032 0 0 0 7,683,069 1.00	3.00 lotal (sum of lines 1-2)	0		(-663, 271	3.00
instructions capital -Relate of cols. 9 through 14			St	JMMARY OF CAPI	IAL		
d Costs (see instructions) 11.00 12.00 13.00 14.00 15.00	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
11. 00 12. 00 13. 00 14. 00 15. 00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1. 00 NEW CAP REL COSTS-BLDG & FIXT -373, 032 0 0 0 7, 683, 069 1. 00					d Costs (see	through 14)	
PART - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT -373, 032 0 0 7, 683, 069 1.00			12.00	13.00	14. 00	15. 00	
3.00 Total (sum of lines 1-2) -373,032 0 0 0 7,683,069 3.00							
	3.00 Total (sum of lines 1-2)	-373, 032	0		0 (C	7, 683, 069	3.00

Peri od: Worksheet A-8 From 01/01/2015 Date/Time Prepared: 5/24/2016 2: 22 pm

				To	12/31/2015	Date/Time Prep 5/26/2016 2:22	
				Expense Classification on		072072010 2.2.	Z piii
				To/From Which the Amount is 1	to be Adjusted		
	Cost Conton Decemintion	Dania (Cada (2)	Amount	Cost Conton	lino#	Micot A 7 Dof	
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0. 00	O	7. 00
8. 00	Television and radio service		0		0. 00	0	8. 00
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 362, 595		0. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.	A-0-2	-1, 302, 343		0. 00	0	
12. 00	(chapter 23)	A-8-1	0		0.00	0	
13. 00	transactions (chapter 10)		0		0.00	0	
14. 00 15. 00			0		0. 00 0. 00	0	14. 00 15. 00
16. 00	Sale of medical and surgical supplies to other than patients		0		0. 00	O	16. 00
17. 00			0		0.00	0	17. 00
18. 00	1.		0		0. 00	0	18. 00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20. 00 21. 00	Vending machines		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)		0				
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22. 00
23. 00		A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00				NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP			FIXT *** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00	0	28. 00
29. 00 30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99			0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 150037

					To 12/31/2015	Date/Time Prep 5/26/2016 2:22	pared: 2 pm
				Expense Classification of		0, 20, 2010 2. 2.	_ рііі
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1. 00	2.00	3. 00	4. 00	5. 00	
33. 00	HRH MMO RENTAL INCOME	В	-652, 525	NEW CAP REL COSTS-BLDG &	1.00	10	33. 00
33. 01	HRH OTHER REVENUE SALES TAX	В	41 126	FIXT ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	HRH OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00		33. 02
22.02	MI SCELLANEOUS REVE	D	40	ADMINISTRATIVE & CENEDAL	F 00		22.02
33. 03	HRH OTHER REVENUE CHARGE CARD-OTHER	В	-40	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	HRH MED STAFF SERV QA	В	-15, 750	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	APPLICATION FE HRH MEDICAL DUES MEDICAL STAFF	В	10 100	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33. 03	DUES	Б	- 16, 100	ADMINISTRATIVE & GENERAL	5.00	l o	33.00
33. 06	HRH PAT FIN. SERV. BUSINESS	В	-1, 790	ADMINISTRATIVE & GENERAL	5. 00	o	33. 06
33. 07	SERV-COP HRH PAT FIN. SERV. EXPENSE	В	47 620	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33.07	REIMBURSE	В	-47,039	ADMINISTRATIVE & GENERAL	5.00		33.07
33. 08	HRH INFO SERVICES	В	-373, 772	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	MI SCELLANEOUS REVE HRH ACCOUNTING MI SCELLANEOUS	В	-9 567	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
00.07	REVENUE		7, 007	ALDINI WI STICKTI VE & SENEROLE	0.00	Ĭ	00.07
33. 10	HRH ACCOUNTING MANAGEMENT FEES	1		ADMINISTRATIVE & GENERAL	5.00		33. 10
33. 11	HRH EXEC ADMIN MISCELLANEOUS REVENUE	В	-932	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	HRH COMMUNI CATI ONS	В	-8, 925	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
22 12	MI SCELLANEOUS REV	В	104 747	ADMINISTRATIVE & CENEDAL	F 00	0	22 12
33. 13	HRH COMMUNICATIONS PHONE LEASE REVEN	В	-184, 747	ADMINISTRATIVE & GENERAL	5. 00	U	33. 13
33. 14	HRH COMM EDUCATION	В	-315	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	MISCELLANEOUS REV HRH COMM EDUCATION EDUCATION	В	0.700	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. IS	SERVICE	Б	-9, 199	ADMINISTRATIVE & GENERAL	5.00	l o	33. 13
33. 16	HRH GAIN/LOSS INVENTORY	В		ADMINISTRATIVE & GENERAL	5. 00	1	33. 16
33. 17	HRH GAIN/LOSS GROSS VARIANCE INVENTO	В	74, 686	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	HRH SECURITY MISCELLANEOUS	В	-1, 200	ADMINISTRATIVE & GENERAL	5.00	0	33. 18
	REVENUE	_					
33. 19 33. 20	HRH HPN IT DEPT MISC REVENUE HRH PLANT OFFSITE SERVICES	B B		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	1	33. 19 33. 20
33. 21	HRH HOUSEKEEPING ENVIRONMENTAL	В	·	HOUSEKEEPI NG	9.00	1	33. 21
	SERVI	_				_	
33. 22	HRH NUTRITIONAL SER REBATES/REFUNDS	В	-2, 623	DI ETARY	10.00	0	33. 22
33. 23	HRH NUTRITIONAL SER LTACH	В	-62, 639	DI ETARY	10.00	О	33. 23
22.24	REVENUE	D	10 405	NUIDCI NO. ADMINI CTDATI ON	12.00		22 24
33. 24	HRH CLINICAL EDUCAT AHA COURSE	В	- 18, 495	NURSING ADMINISTRATION	13. 00	0	33. 24
33. 25	HRH CLINICAL EDUCAT EDUCATION	В	-120	NURSING ADMINISTRATION	13. 00	0	33. 25
33. 26	SERVIC HRH OTHER REVENUE	В	_22 104	CENTRAL SERVICES & SUPPLY	14.00	0	33. 26
JJ. ZU	REBATES/REFUNDS		-22, 104	DENTINAL SERVICES & SUFFLI	14.00		JJ. ZU
33. 27	HRH OTHER REVENUE DISCOUNTS	В	-6, 891	CENTRAL SERVICES & SUPPLY	14. 00	О	33. 27
33. 28	EARNED 0 HRH PHARMACY MI SCELLANEOUS	В	_3 820	PHARMACY	15. 00	0	33. 28
00.20	REVENUE		0,02,				
33. 29	HRH PHARMACY REBATES/REFUNDS	В		PHARMACY	15.00		33. 29
33. 30	HRH ASSOCIATE PHARM RETAIL PHARMACY-	В	-602, 196	PHARMACY	15. 00	0	33. 30
33. 31	HRH ASSOCIATE PHARM HOSPICE	В	-71, 847	PHARMACY	15.00	О	33. 31
22 22	PHARMACY HRH ASSOCIATE PHARM	В	10 05/	DHADMACV	15. 00	0	22 22
33. 32	MI SCELLANEOUS RE	D	- 12, 856	PHARMACY	15.00		33. 32
33. 33	HRH HEALTH INFO SER MEDICAL	В	-2, 966	MEDICAL RECORDS & LIBRARY	16. 00	o	33. 33
33. 34	RECORDS- HRH HEALTH INFO SER	В	-66 207	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 34
55.54	MI SCELLANEOUS RE		30, 207		10.00		55. 54
33. 35	XRAY SCHOOL TUITION REVENUE	В		PARAMED ED PRGM	23.00	1	33. 35
33. 36 33. 37	HRH ANDIS UNIT REBATES/REFUNDS HRH SURGERY REBATES/REFUNDS	B B		ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	1	33. 36 33. 37
33. 38	SALE OF USED EQUIP	В	·	RADI OLOGY-DI AGNOSTI C	54.00	1	
33. 39	HRH DIAG IMAGING HEARTBEATS	В	-6, 476	RADI OLOGY-DI AGNOSTI C	54. 00	o	33. 39
33. 40	REVENUE HRH MMO-RAD HEARTBEATS REVENUE	В	-198	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 40
	,		. 70		1 266	. ~	

Provi der CCN: 150037 Peri od: Worksheet A-8 From 01/01/2015 | Worksheet A-8 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

	10 12/31/2015						pareu: 2 pm
		Expense Classification on Worksheet A				7 07 207 2010 212	<u> </u>
		To/From Which the Amount is to be Adjusted			to be Adjusted		
					·		
					·		
Cost Center Description			Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1	1.00	2. 00	3.00	4. 00	5. 00	
33. 41	HRH MMO EXPENSE REIMBURSEMENT	В	•	RADI OLOGY-DI AGNOSTI C	54. 00	0	
33. 42	HRH MMO-DEXA HEARTBEATS	В	-420	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 42
00.40	REVENUE		/ / 505	LABORATORY/			00.40
33. 43	HRH LAB WATER TESTING	B B		LABORATORY	60.00	0	
33. 44 33. 45	HRH LAB HEARTBEATS REVENUE HRH SLEEP STUDY CLINIC	B B		LABORATORY RESPIRATORY THERAPY	60.00	0	
33. 45	MANAGMENT	В	-80, 790	RESPIRATORY THERAPY	65. 00	0	33. 45
33. 46	HRH SLEEP STUDY SLEEP STUDY	В	_00 135	RESPIRATORY THERAPY	65.00	0	33. 46
33. 40	FFFS	J 5	- 70, 133	INEST TRATORT THERAIT	05.00	0	33.40
33. 47	HRH WELLNESS PT WELLNESS	В	41	PHYSICAL THERAPY	66.00	0	33. 47
33. 47	REVENUE		71	I THOTOAL THERAIT	00.00		33. 47
33. 48	HRH CARDIO SERV HEARTBEATS	В	-341	ELECTROCARDI OLOGY	69. 00	0	33. 48
00. 10	REVENUE		011		071.00	Ĭ	00.10
33. 49	HRH SHELBY WOUND PHYS OTHER	В	-25, 144	SHELBYVILLE WOUND CLINIC	90.06	0	33. 49
	REVENUE						
33. 50	HRH AWC GENERAL BOUTIQUE	В	-581	ANDERSON WOMENS CENTER	90. 08	0	33. 50
	SERVI CES						
33. 51	HRH MMO-US HEARTBEATS REVENUE	В	-490	ANDERSON WOMENS CENTER	90. 08	0	33. 51
33. 52	HRH E R REBATES/REFUNDS	В		EMERGENCY	91.00	0	
33. 53	HRH HOSPICE MISCELLANEOUS	В	-20	HOSPI CE	116. 00	0	33. 53
	REVENUE						
33. 54	MOW	A	-312, 792		10. 00	0	
33. 55	CAFETERIA GUEST MEALS	A	•	CAFETERI A	11. 00	0	33. 55
33. 56	PHYSICIAN RECRUITMENT FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 57	DONATIONS & SPONSORSHIPS	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 57
33. 58	ADVERTISING FEE	A	•	ADMI NI STRATI VE & GENERAL	5. 00	0	
33. 59	ADVERTISING FEE	A	•	OPERATION OF PLANT	7. 00	0	
33. 60	ADVERTISING FEE	A		WOUND CLINIC	90. 01	0	33. 60
33. 61	ADVERTISING FEE	A		SHELBYVILLE WOUND CLINIC	90. 06	0	
33. 62	ADVERTISING FEE	A		ONCOLOGY	90. 07	0	33. 62
33. 63	I HA LOBBYING EXPENSE	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 63
33. 64	AHA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 64
33. 65	PHY OFFICE BLDG	A	-3/3,032	NEW CAP REL COSTS-BLDG &	1.00	11	33. 65
33. 66	PHY OFFICE BLDG	A	1/ 50/	FIXT RADI OLOGY-DI AGNOSTI C	54.00	0	33. 66
33. 66	PHY OFFICE BLDG	A	•	RURAL HEALTH CLINIC	88. 00	0	
33. 68	RENTAL PROPERTIES EXPENSE	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 68
33. 69	RENTAL PROPERTIES EXPENSE	A		NEW CAP REL COSTS-BLDG &	1.00	10	1
33.07	RENTAL PROFERTIES EXPENSE	, A	-10, 740	FLXT	1.00	10	33.09
33. 70	RENTAL PROPERTIES EXPENSE	A	-9 826	OPERATION OF PLANT	7. 00	0	33. 70
33. 71	TELEPHONE SERVICES	Ä	•	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 72	HAF EXPENSE	Ä		ADMINISTRATIVE & GENERAL	5. 00	0	33. 72
33. 72	SELF INSURANCE CLAIM EXPENSE	Ä		EMPLOYEE BENEFITS DEPARTMENT	4.00	Ö	1
33. 74	HRH MARKETING MOVING EXPENSES	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 75	ADVERTISING FEE	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 75
33. 76	ADVERTISING FEE	A		HOSPI CE	116. 00	0	33. 76
50. 00	TOTAL (sum of lines 1 thru 49)		-10, 041, 896	1			50.00
	(Transfer to Worksheet A,		, , . , . , . ,				
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Peri od: Worksheet A-8-2 From 01/01/2015 To 12/31/2015 Date/Time Prepared:

						12/01/2010	5/26/2016 2: 2	22 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1, 00	2, 00	3.00	4. 00	5, 00	6, 00	7. 00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	292, 774	292, 77	'4 C		0	1. 00
2.00		ADULTS & PEDIATRICS	497					2. 00
3.00		SUBPROVI DER - I PF	96, 000					3. 00
4. 00		OPERATING ROOM	3, 490					4. 00
5. 00	0. 00 AGGREGATE-		3, 470		0 0			5. 00
6.00		RADI OLOGY-DI AGNOSTI C	303, 617	303, 61	٦			6.00
7. 00		LABORATORY	145, 833			253, 900	1	7. 00
						253, 900		
8.00		RESPI RATORY THERAPY	18, 000				0	8. 00
9.00		SPEECH PATHOLOGY	375				1	9. 00
10.00		ANDIS CLINIC	3, 375)	0	10. 00
11. 00		ONCOLOGY	474, 577	474, 57) C	0	11. 00
12. 00	91. 00	EMERGENCY	60, 000) C	0	12. 00
200.00			1, 398, 538				401	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
		ldenti fi er	Limit		E Memberships &		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		ADMINISTRATIVE & GENERAL	0		0			
2.00		ADULTS & PEDIATRICS	0		0) c		2. 00
3.00	40. 00 SUBPROVI DER - I PF		0		0) C	0	3. 00
4.00	50.00	OPERATING ROOM	0		0) c	0	4. 00
5.00	0.00	AGGREGATE-	0		0) c	0	5. 00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0 0) (0	6. 00
7.00	60. 00 LABORATORY		48, 949	2, 44	17) (0	7. 00
8.00	65. 00	RESPI RATORY THERAPY	0		0) c	0	8. 00
9.00	68. 00	SPEECH PATHOLOGY	0		0 0) c	o o	9. 00
10.00	90. 04	ANDIS CLINIC	0		0 0) c	o o	10. 00
11. 00	90. 07	ONCOLOGY	0		o c	ol c	ol o	11. 00
12.00	91. OO EMERGENCY		l 0		ol c		ol o	12. 00
200.00			48, 949	2, 44	17		ol o	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	,		
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	1	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	0		0 0		1	1. 00
2.00	30. 00 ADULTS & PEDIATRICS		0		o c	497	/	2. 00
3.00	40. 00 SUBPROVI DER - I PF		l o		ol c	96, 000	ار	3. 00
4.00	50. OO OPERATI NG ROOM		0		0	3, 490		4. 00
5. 00	O. OO AGGREGATE-		1 0		0		1	5. 00
6.00	54. OORADI OLOGY-DI AGNOSTI C		0			303, 617	1	6. 00
7. 00	60. 00 LABORATORY		0	48, 94	-	109, 890	•	7. 00
8. 00	65. OOIRESPI RATORY THERAPY			70, 75	0	18,000		8. 00
9. 00	68. OOISPEECH PATHOLOGY					375	•	9. 00
10. 00	90. 04 ANDIS CLINIC					3, 375	•	10.00
11. 00						474, 577		11.00
12. 00	90. 07 ONCOLOGY 91. OO EMERGENCY					60,000		12.00
200.00	91.00	LINERGEINGT		48, 94	19 (•	200.00
200.00	1		1	1 48, 92	17	rj 1,30∠,595	ין	200.00

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150037

				Ť	o 12/31/2015	Date/Time Pre 5/26/2016 2:2	
			CAPI TAL			372072010 2.2	Z piii
	Cook Cooks Doors at at	Nat Francisco	RELATED COSTS	EMDLOVEE	C	ADMINI CTDATINE	
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		Allocation	1171	DEPARTMENT		a GENERAL	
		(from Wkst A					
		col . 7)	1.00			5.00	
	GENERAL SERVICE COST CENTERS	0	1.00	4. 00	4A	5. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	7, 683, 069	7, 683, 069				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 036, 469					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	12, 157, 031					5. 00
7.00	00700 OPERATION OF PLANT	4, 860, 749					7. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 486, 412 291, 256		1		303, 542 76, 557	9. 00 10. 00
11. 00	01100 CAFETERI A	1, 315, 373					11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 064, 551	8, 057	125, 113		219, 767	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	82, 366		8, 291		16, 634	14. 00
15. 00	01500 PHARMACY	7, 485, 598					15. 00
16. 00 23. 00	01600 MEDICAL RECORDS & LIBRARY 02300 PARAMED ED PRGM	835, 373 37, 519				181, 305 13, 619	16. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	37,319	26, 348	10, 354	74, 221	13,019	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	3, 074, 169	438, 113	339, 494	3, 851, 776	706, 755	30. 00
31. 00	03100 INTENSIVE CARE UNIT	3, 669, 325	467, 558	411, 138	4, 548, 021	834, 507	31.00
40. 00	04000 SUBPROVI DER - I PF	1, 276, 943				1	40.00
41. 00	04100 SUBPROVI DER - I RF ANCI LLARY SERVI CE COST CENTERS	0	0	C	0	0	41. 00
50. 00	05000 OPERATING ROOM	4, 825, 916	493, 024	378, 350	5, 697, 290	1, 045, 384	50.00
51. 00	05100 RECOVERY ROOM	256, 380		30, 379			51.00
53.00	05300 ANESTHESI OLOGY	138, 838	0	C	138, 838	25, 475	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 520, 697					54.00
60.00	06000 LABORATORY	3, 804, 354				758, 414	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 202, 972 1, 149, 880				257, 555 248, 640	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	288, 696		36, 126			
68. 00	06800 SPEECH PATHOLOGY	178, 038		21, 680			68. 00
68. 01	06801 OCCUPATI ONAL HEALTH	0	0	C	0	0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	706, 280				169, 284	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENT	3, 160, 652 2, 290, 960			-,-:,	604, 028 420, 364	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2,270,700			2, 270, 700	0	73.00
76. 00	03020 CARDI AC	0	0	C	0	0	76. 00
76. 01	03160 CARDI OPULMONARY	86, 672	44, 678	7, 200	138, 550	25, 422	76. 01
00.00	OUTPATIENT SERVICE COST CENTERS	2/2 027	1 0	22.005	205 022	E2 4/E	00.00
88. 00 90. 00	08800 RURAL HEALTH CLINIC 09000 CLINIC	262, 027 0	0	23, 905		52, 465 0	88. 00 90. 00
90. 01	09001 WOUND CLINIC	869, 656			_		90. 01
90. 02	09002 DI ABETES CLINIC	48, 353		5, 419		9, 867	90. 02
90. 03	09003 ASTHMA CLINIC	0		0	0	0	90. 03
90. 04 90. 05	09004 ANDIS CLINIC 09005 PRIME TIME	87, 887		5, 774		1	1
90.05	09006 SHELBYVILLE WOUND CLINIC	102, 303 345, 161		26, 586	102, 303 371, 747	18, 771 68, 211	1
90. 07	04951 ONCOLOGY	1, 053, 777			· ·		90. 07
90. 08	04950 ANDERSON WOMENS CENTER	285, 753		34, 624		58, 785	90. 08
91. 00	09100 EMERGENCY	2, 613, 650	433, 349	293, 651	3, 340, 650	612, 969	•
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92. 00
101 00	10100 HOME HEALTH AGENCY	0	0	С	0	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS						11011.00
116.00	11600 H0SPI CE	2, 736, 584	173, 026	149, 617	3, 059, 227	561, 331	116. 00
118.00		80, 371, 689	5, 692, 858	4, 685, 908	77, 995, 434	11, 814, 086	118. 00
100.00	NONREI MBURSABLE COST CENTERS						100 00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1900 PROFESSIONAL BUILDING	0 554, 879				l e	190.00
	19002 PHYSI CLAN BUI LDI NG	50, 185			50, 185		190. 01
	19003 PRI VATE DUTY	343, 556		19, 642			190. 03
	19004 MARKETI NG	584, 592		14, 167			
	19005 SPORTS PHYSI CALS	28, 465		3, 262			190. 05
	19006	180, 921 806		17, 418	198, 339 806		190. 06 190. 07
	19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	806		i d		l e	190. 07
	19009 HANCOCK OB	3, 566, 575			_	l .	
190. 10	19010 HANCOCK WELLNESS	1, 464, 869	0	122, 761		291, 311	190. 10
	19011 MORRI STOWN CLINIC	0		0	_	•	190. 11
	19012 03PUREMED 19013 MCCORD WELLNESS	5, 527 204, 570		7, 793 9 151			190. 12 190. 13
	19013 MCCORD WELLNESS 19014 3 WEST UNIT	343, 497		8, 151 20, 992			
		0 10, 177	210, 147	20,772	010, 000	1 112,040	1.70.17

Health Financial Systems	HANCOCK REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 150037		CCN: 150037	Peri od:	Worksheet B		
				From 01/01/2015 To 12/31/2015		narodi	
			10 12/31/2015	12/31/2015 Date/Time Prepared: 5/26/2016 2:22 pm			
		CAPI TAL					
		RELATED COSTS					
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE		
	for Cost	FLXT	BENEFITS		& GENERAL		
	Allocation		DEPARTMENT				
	(from Wkst A						
	col . 7)						
	0	1. 00	4. 00	4A	5. 00		
190. 15 19015 NEUROLOGY PHYSI CI AN	78, 000	0		0 78, 000	14, 312	190. 15	
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0 0	0	201. 00	
202.00 TOTAL (sum lines 118-201)	87, 778, 131	7, 683, 069	5, 071, 95	87, 778, 131	13, 609, 094	202. 00	

Provider CCN: 150037

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 2:22 pm

				7 12/31/2013	5/26/2016 2: 2:	
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMI NI STRATI ON	
	7. 00	9. 00	10.00	11. 00	13. 00	
GENERAL SERVICE COST CENTERS	1				T	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL	7 150 177					5.00
7. 00 00700 OPERATION OF PLANT	7, 152, 177	2 017 700				7. 00
9. 00 00900 HOUSEKEEPI NG	59, 969	2, 017, 798				9.00
10. 00 01000 DI ETARY	90, 652	33, 521	617, 962	2 007 020		10.00
11. 00 01100 CAFETERI A	179, 115	55, 238	0	2, 087, 930		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	9, 568	02.700	0	60, 644		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	83, 789	0	9, 479		14.00
15. 00 01500 PHARMACY	43, 952	61, 119	0	105, 113		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	85, 716	73, 517	0	66, 061	0	16. 00
23. 00 02300 PARAMED ED PRGM	31, 288	84, 685	0	5, 409	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F21 00/	E/1 0E4	172 (21	207 710		20.00
30. 00 03000 ADULTS & PEDI ATRI CS	521, 096	561, 854	173, 621	207, 718		30.00
31. 00 03100 I NTENSI VE CARE UNI T	555, 225	115, 834	262, 741	288, 783		31.00
40. 00 04000 SUBPROVI DER - PF	148, 432	92, 703	130, 969	100, 830		40.00
41. 00 O4100 SUBPROVIDER - IRF	0	0	0	0	0	41. 00
ANCILLARY SERVICE COST CENTERS	E0E 44E	224 004		120 022		E0 00
50. 00 05000 0PERATING ROOM	585, 465	224, 906	0	138, 833		50.00
51. 00 05100 RECOVERY ROOM	49, 353	82, 815	0	15, 509		51.00
53. 00 05300 ANESTHESI OLOGY	0 (05.127	0	0	104 701	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	605, 137	82, 329	0	194, 731		54.00
60. 00 06000 LABORATORY	136, 047	78, 563	0	170, 486		60.00
65. 00 06500 RESPIRATORY THERAPY	54, 801	60, 171	0	93, 834		65. 00
66. 00 06600 PHYSI CAL THERAPY	90, 535	69, 931	0	72, 156		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	22, 910		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	12, 652		68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	40/ 050	0	40.000	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	174, 436	136, 352	0	40, 888		69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	155, 882	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 03020 CARDI AC	0	0	0	(05.4	0	76. 00
76. 01 03160 CARDI OPULMONARY	53, 055	O	0	6, 854	0	76. 01
	00,000		-		•	
OUTPATIENT SERVICE COST CENTERS				·		
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0	0	0	0	0	88. 00 90. 00
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535	0	-	0 0 38, 416	0	88. 00 90. 00 90. 01
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0	0 0 0 0	0	0	0	88. 00 90. 00 90. 01 90. 02
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0	0 0 0	0	0 0 38, 416 4, 497 0	0 0	88. 00 90. 00 90. 01 90. 02 90. 03
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 90. 01 09000 CLINIC 90. 01 09001 WOUND CLINIC 90. 02 09002 DIABETES CLINIC 90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC	0 0 67, 535 0 0 60, 621	0 0 0 0 0	0	0 0 38, 416	0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 90. 01 09000 CLINIC 90. 02 09002 DIABETES CLINIC 90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC 90. 05 09005 PRIME TIME	0 0 67, 535 0	0 0 0 0 0 0	0	0 0 38, 416 4, 497 0	0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0	0 0 0 0 0 0	0	0 0 38, 416 4, 497 0 4, 402	0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621	0 0 0 0 0 0 0	0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247	0 0 0 0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 90. 01 09000 CLINIC 90. 01 09001 WOUND CLINIC 90. 02 09002 DIABETES CLINIC 90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC 90. 05 09005 PRIME TIME 90. 06 09006 SHELBYVILLE WOUND CLINIC 90. 07 04951 ONCOLOGY 90. 08 04950 ANDERSON WOMENS CENTER	0 0 67, 535 0 0 60, 621 0 0 323, 427	0 0 0 0 0 0	0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817	0 0 0 0 0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0	0 0 0 0 0 0 0 0 0 0	0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247	0 0 0 0 0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0 0 323, 427	0 0 0 0 0 0	0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817	0 0 0 0 0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 0 120, 471	0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843	0 0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0 0 323, 427	0 0 0 0 0 0 0 0 0 120, 471	0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817	0 0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 0 120, 471	0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843	0 0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471	0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843	0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 03 90. 06 90. 07 90. 08 91. 00 92. 00 101. 00
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 0 120, 471	0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843	0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 101. 00
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 120, 471 0	0 0 0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843	0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 101. 00 116. 00 118. 00
0UTPATIENT SERVICE COST CENTERS 88. 00	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843	0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 101. 00 116. 00 118. 00
OUTPATIENT SERVICE COST CENTERS	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843	0 0 0 0 0 0 0 0 456, 976 0 262, 771 1, 487, 700	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 101. 00 116. 00 118. 00 190. 00 190. 01
SECOND S	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 42, 247 23, 817 171, 843 0 98, 813 1, 996, 925	0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 101. 00 116. 00 118. 00 190. 01 190. 02
OUTPATIENT SERVICE COST CENTERS	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925	0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 101. 00 116. 00 118. 00 190. 00 190. 00 190. 00 190. 03
OUTPATIENT SERVICE COST CENTERS	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 42, 247 23, 817 171, 843 0 98, 813 1, 996, 925	0 0 0 0 0 0 0 0 456, 976 0 262, 771 1, 487, 700	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 91. 00 92. 00 101. 00 116. 00 118. 00 190. 01 190. 01 190. 03 190. 03 190. 04
OUTPATIENT SERVICE COST CENTERS	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843 0 98, 813 1, 996, 925 0 0 0 21, 135 7, 376	0 0 0 0 0 0 0 0 456, 976 0 262, 771 1, 487, 700	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 101. 00 116. 00 118. 00 190. 01 190. 02 190. 03 190. 04 190. 05
SUMPRISON SUMP	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925	0 0 0 0 0 0 0 0 456, 976 0 262, 771 1, 487, 700 0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 101. 00 116. 00 118. 00 190. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06
SEC AUTO	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843 0 98, 813 1, 996, 925 0 0 0 21, 135 7, 376	0 0 0 0 0 0 0 0 456, 976 0 262, 771 1, 487, 700 0 0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 101. 00 116. 00 118. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 05 190. 06 190. 07
SECOND SUPPLY SERVICE COST CENTERS	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925 00 01, 10, 818 00 01, 818 01, 918 01, 918 010, 818 00 010, 818	0 0 0 0 0 0 0 0 456, 976 0 262, 771 1, 487, 700 0 0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 101. 00 116. 00 118. 00 190. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 05 190. 06 190. 07 190. 08
Section Sect	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 38, 416 4, 497 0 4, 402 0 0 42, 247 23, 817 171, 843 0 98, 813 1, 996, 925 0 0 0 21, 135 7, 376	0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 101. 00 116. 00 118. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 06 190. 07 190. 08 190. 09
SECOND SURPLIFIED SURPLIFIED	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805 0 1, 965, 356 0 0 0 0 0 0 1, 965, 356	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925 00 01, 10, 818 00 01, 818 01, 918 01, 918 010, 818 00 010, 818	0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 116. 00 118. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 06 190. 07 190. 08 190. 09 190. 09
SUBTOTALS SUM OF LINES	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925 7, 376 0 0 27, 049 0 0 42, 247 23, 817 171, 843	0 0 0 0 0 0 0 0 456, 976 0 456, 976 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 116. 00 118. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 07 190. 08 190. 01 190. 01 190. 07 190. 08 190. 01 190. 10
SUPPORT SERVICE COST CENTERS	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805 0 1, 965, 356 0 0 0 0 0 0 1, 965, 356	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925 0 0 0 42, 247 23, 817 171, 843 0 0 21, 135 7, 376 0 10, 818 0 0 27, 049	0 0 0 0 0 0 0 0 0 456, 976 0 262, 771 1, 487, 700 0 0 0 0 0 0	88. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 116. 00 118. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 07 190. 08 190. 09 190. 11 190. 12
SECOND SUPPORT SERVICE COST CENTERS	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805 0 1, 965, 356 0 0 0 0 0 0 0 0 1, 965, 356	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925 10, 818 0 27, 049 0 0 42, 247 23, 817 171, 843 0 0 21, 135 7, 376 0 0 21, 135 7, 376 0 0 0 0 27, 049	0 0 0 0 0 0 0 0 0 456, 976 0 262, 771 1, 487, 700 0 0 0 0 0 0	88. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 116. 00 118. 00 1190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 01 190. 01 190. 01 190. 02 190. 03 190. 04 190. 05 190. 01 190. 04 190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11 190. 12 190. 13
SEC AUTOM STATE	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805 0 1, 965, 356 0 0 0 0 0 0 1, 965, 356	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925 0 0 0 42, 247 23, 817 171, 843 0 0 21, 135 7, 376 0 10, 818 0 0 27, 049	0 0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 101. 00 116. 00 118. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 10 190. 11 190. 12 190. 13 190. 14
Section	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805 0 1, 965, 356 0 0 0 0 0 0 0 0 1, 965, 356	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925 10, 818 0 27, 049 0 0 42, 247 23, 817 171, 843 0 0 21, 135 7, 376 0 0 21, 135 7, 376 0 0 0 0 27, 049	0 0 0 0 0 0 0 0 0 456, 976	88. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 101. 00 116. 00 118. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 01 190. 01 190. 01 190. 01 190. 05 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 05 190. 07 190. 08 190. 09 190. 10 190. 11 190. 12 190. 13 190. 14 190. 15
Second Color Second Color	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805 0 1, 965, 356 0 0 0 0 0 0 0 0 1, 965, 356	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925 10, 818 0 27, 049 0 0 42, 247 23, 817 171, 843 0 0 21, 135 7, 376 0 0 21, 135 7, 376 0 0 0 0 27, 049	0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 116. 00 118. 00 1190. 01 190. 01 190. 05 190. 06 190. 07 190. 08 190. 01 190. 01 190. 10 190. 10 190. 11 190. 12 190. 13 190. 15 200. 00
Second S	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805 0 1, 965, 356 0 0 0 0 0 0 0 0 0 292, 302 0	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50, 631 617, 962	98, 813 1, 996, 925 10, 552 13, 520 0	0 0 0 0 0 0 0 0 0 456, 976 0 262, 771 1, 487, 700 0 0 0 0 0 0 0	88. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 116. 00 118. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11 190. 12 190. 13 190. 14 190. 15 200. 00 201. 00
Second Color Second Color	0 0 67, 535 0 0 60, 621 0 323, 427 0 514, 601 0 192, 897 4, 788, 805 0 1, 965, 356 0 0 0 0 0 0 0 0 1, 965, 356	0 0 0 0 0 0 0 0 120, 471 0 0 2, 017, 798 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	98, 813 1, 996, 925 10, 818 0 27, 049 0 0 42, 247 23, 817 171, 843 0 0 21, 135 7, 376 0 0 21, 135 7, 376 0 0 0 0 27, 049	0 0 0 0 0 0 0 0 456, 976	88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 116. 00 118. 00 1190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11 190. 12 190. 13 190. 14 190. 15 200. 00 201. 00

Provider CCN: 150037

			To	12/31/2015	Date/Time Pre 5/26/2016 2: 2	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	- piii
	SERVICES &		RECORDS &	PRGM		
	SUPPLY 14. 00	15. 00	16. 00	23. 00	24.00	
GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	23.00	24.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A						11. 00
13. 00 01300 NURSING ADMINISTRATION						13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	200, 559					14. 00
15. 00 01500 PHARMACY	3, 693	9, 350, 175				15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY 23. 00 02300 PARAMED ED PRGM	0	0	1, 394, 701 0	209, 222		16. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	209, 222		23.00
30. 00 03000 ADULTS & PEDIATRICS	3, 779	0	375, 180	0	6, 401, 779	30. 00
31.00 03100 INTENSIVE CARE UNIT	8, 176	O	46, 846	0	7, 428, 086	31. 00
40. 00 04000 SUBPROVI DER - I PF	589	0	38, 628	0	2, 356, 681	40. 00
41. 00 O4100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	7, 927	ol	493, 117	ol	8, 192, 922	50.00
51. 00 05100 RECOVERY ROOM	250	ő	0	0	536, 490	51.00
53. 00 05300 ANESTHESI OLOGY	0	O	0	0	164, 313	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 609	0	56, 298	209, 222	6, 319, 374	54. 00
60. 00 06000 LABORATORY	44, 563	0	124, 923	0	5, 446, 313	•
65. 00 06500 RESPIRATORY THERAPY	671	0	0	0	1, 870, 694	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	70 45	0	0	0	1, 836, 406 407, 378	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	178	Ö	0	o	249, 194	
68. 01 06801 OCCUPATI ONAL HEALTH	0	O	0	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	1, 555	0	64, 105	0	1, 509, 207	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	116, 443	0	0	0	4, 168, 274	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0 250 175	0	0	2, 711, 324	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CARDI AC	0	9, 350, 175	2, 877 0	0	9, 353, 052 0	73. 00 76. 00
76. 00 03020 CARDI AC 76. 01 03160 CARDI OPULMONARY	31	0	0	0	223, 912	76. 00
OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	<u> </u>	220, 7.12	
88.00 08800 RURAL HEALTH CLINIC	72	0	0	0	338, 469	88. 00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 WOUND CLINIC 90. 02 09002 DIABETES CLINIC	591	0	0	0	1, 302, 610	90. 01
90. 02 09002 DI ABETES CLINI C 90. 03 09003 ASTHMA CLINI C		0	0	0	68, 137 0	90. 02 90. 03
90. 04 09004 ANDIS CLINIC	11	o	0	0	236, 297	90. 04
90.05 09005 PRIME TIME	O	o	0	0	121, 074	90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	228	0	0	0	440, 186	
90. 07 04951 ONCOLOGY	1	0	0	0	2, 015, 915	1
90. 08 04950 ANDERSON WOMENS CENTER 91. 00 09100 EMERGENCY	125 6, 755	0	0 192, 727	0	403, 104 5, 416, 992	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 755	o _l	192, 727	U	5, 410, 992	91.00
OTHER REIMBURSABLE COST CENTERS						72.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS				-1		l
116. 00 11600 HOSPI CE	1, 995	0 250 175	0	0	4, 227, 665	
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	200, 358	9, 350, 175	1, 394, 701	209, 222	73, 745, 848	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190. 01 19001 PROFESSI ONAL BUILDING	o o	o	0	0	4, 580, 769	1
190. 02 19002 PHYSI CI AN BUILDING	0	o	0	0	59, 393	
190. 03 19003 PRI VATE DUTY	68	0	0	0	451, 043	1
190. 04 19004 MARKETI NG	0	0	0	0	716, 000	1
190. 05 19005 SPORTS PHYSICALS 190. 06 19006 FOUNDATION	0	0	0	O	37, 549 245, 550	1
190. 07 19007 ASC		0	0	0		190. 00
190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	ol	o	ol		190. 07
190. 09 19009 HANCOCK OB	124	o	Ō	o	4, 662, 634	
190. 10 19010 HANCOCK WELLNESS	0	o	0	o	1, 878, 941	1
190. 11 19011 MORRI STOWN CLINIC	0	0	0	0		190. 11
190. 12 19012 03PUREMED		ol Ol	0	0	16, 319 262, 305	1
190. 13 19013 MCCORD WELLNESS 190. 14 19014 3 WEST UNIT		0	0	0	262, 305 1, 028, 512	1
190. 15 19015 NEUROLOGY PHYSI CI AN	o o	ol	o	ol	92, 312	
200.00 Cross Foot Adjustments		1		o	0	200. 00
201.00 Negative Cost Centers	0	O	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	200, 559	9, 350, 175	1, 394, 701	209, 222	87, 778, 131	<u> 1</u> 202. 00

HANCOCK REGIONAL HOSPITAL

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150037

			To 12/31/2015 Date/Time Prep 5/26/2016 2: 22	
Cost Center Description	Intern &	Total	372072010 2.22	2 piii
	Residents Cost			
	& Post Stepdown			
	Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS				4 00
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT				1. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00 00700 OPERATION OF PLANT				7. 00
9. 00 00900 HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	1			11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16. 00
23. 00 O2300 PARAMED ED PRGM				23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	6, 401, 779		30. 00
31. 00 03100 NTENSI VE CARE UNI T	0	7, 428, 086		31. 00
40. 00 04000 SUBPROVI DER - I PF	0	2, 356, 681		40.00
41. 00 04100 SUBPROVI DER - I RF	0	0		41. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM	O	0 102 022		50. 00
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM	0	8, 192, 922 536, 490		51. 00
53. 00 05300 ANESTHESI OLOGY	O	164, 313		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	6, 319, 374		54.00
60. 00 06000 LABORATORY	0	5, 446, 313		60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 0	1, 870, 694 1, 836, 406		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	407, 378		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	249, 194		68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0		68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	1, 509, 207		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	4, 168, 274 2, 711, 324		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		9, 353, 052		73. 00
76. 00 03020 CARDI AC	0	0		76. 00
76. 01 03160 CARDI OPULMONARY	0	223, 912		76. 01
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	O	220 440		88. 00
90. 00 09000 CLINIC	0	338, 469 0		90.00
90. 01 09001 WOUND CLINIC	o o	1, 302, 610		90. 01
90. 02 09002 DI ABETES CLINIC	0	68, 137		90. 02
90. 03 09003 ASTHMA CLINIC	0	0		90. 03
90. 04 09004 ANDIS CLINIC 90. 05 09005 PRIME TIME		236, 297 121, 074		90. 04 90. 05
90. 06 09006 SHELBYVILLE WOUND CLINIC		440, 186		90.06
90. 07 04951 ONCOLOGY	0	2, 015, 915		90. 07
90. 08 04950 ANDERSON WOMENS CENTER	0	403, 104		90. 08
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0	5, 416, 992		91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			92.00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE	0	4, 227, 665		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	73, 745, 848		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190. 01 19001 PROFESSI ONAL BUILDING	0	4, 580, 769		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	59, 393		190. 02
190. 03 19003 PRI VATE DUTY 190. 04 19004 MARKETI NG	0	451, 043		190. 03 190. 04
190. 04 19004 MARKETTING 190. 05 19005 SPORTS PHYSICALS	0	716, 000 37, 549		190. 04
190. 06 19006 FOUNDATION	o o	245, 550		190.06
190. 07 19007 ASC	0	956		190. 07
190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 08
190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS	0	4, 662, 634 1, 878, 941		190. 09 190. 10
190. 10 19010 HANCOCK WELLNESS 190. 11 19011 MORRI STOWN CLINIC		1, 878, 941		190. 10
190. 12 19012 03PUREMED	l ő	16, 319		190. 12
190. 13 19013 MCCORD WELLNESS	0	262, 305		190. 13
190. 14 19014 3 WEST UNIT	0	1, 028, 512		190. 14
190. 15 19015 NEUROLOGY PHYSICIAN 200. 00 Cross Foot Adjustments	0 0	92, 312 0		190. 15 200. 00
200. 00 01 000 1 001 ray ustiments	ı Y	O _I	!	

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150037	Peri od: From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/26/2016 2: 2:	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	25. 00	26.00				
201.00 Negative Cost Centers	0	0				201. 00
202.00 TOTAL (sum lines 118-201)	o	87, 778, 131				202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | Part II | Part II | Prepared: | Part II | Prepared: | Part II | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150037

				o 12/31/2015	Date/lime Prep 5/26/2016 2:2	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	<u> </u>
	0	1. 00	2A	4. 00	5. 00	
1. 00 GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT	I		T			1.00
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY	0 0 0 0 0 0	35, 483 555, 189 1, 059, 622 50, 500 76, 338 150, 834 8, 057	555, 189 1, 059, 622 50, 500 76, 338 150, 834 8, 057	6, 286 860 821 347 699	45, 748 12, 523 3, 158 11, 856 9, 067	1. 00 4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00
15. 00 01500 PHARMACY	0	37, 013	37, 013	1, 379	58, 456	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	72, 182			7, 480	16. 00
23. 00 O2300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	26, 348	26, 348	72	562	23. 00
30. 00 O3000 ADULTS & PEDIATRICS	0	438, 113	438, 113	2, 374	29, 158	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	467, 558				31. 00
40. 00 04000 SUBPROVI DER - PF	0	124, 996	124, 996	1, 095	11, 798	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	C	0	0	41.00
ANCILLARY SERVICE COST CENTERS 50. 00 O5000 OPERATING ROOM	0	493, 024	493, 024	2, 646	43, 128	50. 00
51. 00 05100 RECOVERY ROOM	0	41, 561	41, 561	2, 040	2, 485	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	C	0	1, 051	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	509, 589				54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	114, 566				60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	46, 148 76, 240			10, 626 10, 258	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0, 240	70, 240		2, 459	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	C	152	1, 512	68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	C	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	146, 894			6, 984	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	131, 269 0	131, 269	0	24, 920 17, 343	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	ď	0	0	73. 00
76. 00 03020 CARDI AC	0	0	C	0	0	76. 00
76. 01 03160 CARDI OPULMONARY	0	44, 678	44, 678	50	1, 049	76. 01
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0		167	2, 165	88. 00
90. 00 09000 CLI NI C	0	0	Ö	0	l	90.00
90. 01 09001 WOUND CLINIC	0	56, 872	56, 872	588	7, 650	90. 01
90. 02 09002 DI ABETES CLI NI C	0	0	C	38		90. 02
90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC	0	0 51, 049	51, 049	40	0 1, 095	90. 03 90. 04
90. 05 09005 PRI ME TI ME	0	0 0 0	31, 049			90.04
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	0	d	186		
90. 07 04951 0NCOLOGY	0	272, 360	272, 360		10, 556	
90. 08 04950 ANDERSON WOMENS CENTER 91. 00 09100 EMERGENCY	0	0 433, 349	433, 349	242 2, 054		90. 08 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	433, 349	433, 349	2, 054	25, 269	91.00
OTHER REIMBURSABLE COST CENTERS	1			1		
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE	0	173, 026	173, 026	1, 046	23, 158	11/ 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	5, 692, 858				
NONREI MBURSABLE COST CENTERS		0,0,2,000	0,072,000	027702	1077 121	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190. 00
190. 01 19001 PROFESSI ONAL BUI LDI NG	0	1, 655, 040	1, 655, 040	0	16, 729	
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY	0	0		137		190. 02 190. 03
190. 04 19004 MARKETI NG	0	0		99		190. 03
190. 05 19005 SPORTS PHYSI CALS	0	0	d	23		190. 05
190. 06 19006 FOUNDATION	0	0	C	122		190. 06
190. 07 19007 ASC	0	0	0	0		190. 07 190. 08
190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB		89, 022	89, 022	1, 202		
190. 10 19010 HANCOCK WELLNESS	0	0	07, 322	859		
190. 11 19011 MORRISTOWN CLINIC	0	0	0	0	0	190. 11
190. 12 19012 03PUREMED	0	0		55		190. 12
190. 13 19013 MCCORD WELLNESS 190. 14 19014 3 WEST UNIT	0	246, 149	246, 149	57 147		190. 13 190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	0	2 70, 147	2 70, 147	0		190. 15
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Health Financial Systems	HANCOCK REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 150037			Worksheet B	
				From 01/01/2015 To 12/31/2015		narod:
				10 12/31/2013	5/26/2016 2: 2	2 pm
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	Assigned New	FLXT		BENEFI TS	& GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4. 00	5. 00	
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	c	7, 683, 069	7, 683, 06	35, 483	561, 475	202. 00

Provider CCN: 150037

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 2:22 pm

				12/31/2013	5/26/2016 2: 2	
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMI NI STRATI ON	
	7. 00	9. 00	10. 00	11. 00	13. 00	
GENERAL SERVICE COST CENTERS	1				T	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	4 404 000					5. 00
7. 00 00700 OPERATION OF PLANT	1, 106, 230	70.440				7. 00
9. 00 00900 HOUSEKEEPI NG	9, 275	73, 119	05 070			9. 00
10. 00 01000 DI ETARY	14, 021	1, 215	95, 079			10.00
11. 00 01100 CAFETERI A	27, 704	2, 002	0	193, 095		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 480	0	0	5, 608		13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	3, 036	0	877	0	14. 00
15. 00 01500 PHARMACY	6, 798	2, 215	0	9, 721	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	13, 258	2, 664	0	6, 109		16. 00
23. 00 02300 PARAMED ED PRGM	4, 839	3, 069	0	500	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					_	
30. 00 03000 ADULTS & PEDI ATRI CS	80, 598	20, 361	26, 713	19, 210		30.00
31. 00 03100 INTENSIVE CARE UNIT	85, 877	4, 197	40, 425	26, 709		31. 00
40. 00 04000 SUBPROVI DER - PF	22, 958	3, 359	20, 151	9, 325		40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
ANCILLARY SERVICE COST CENTERS			_1		1 -	
50. 00 05000 OPERATI NG ROOM	90, 554	8, 150	0	12, 839	-	50.00
51. 00 05100 RECOVERY ROOM	7, 633	3, 001	0	1, 434	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	93, 597	2, 983	0	18, 009		54.00
60. 00 06000 LABORATORY	21, 043	2, 847	0	15, 767	0	60. 00
65. 00 06500 RESPI RATORY THERAPY	8, 476	2, 180	0	8, 678		65. 00
66. 00 06600 PHYSI CAL THERAPY	14, 003	2, 534	0	6, 673		66. 00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	2, 119		67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1, 170		68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	26, 980	4, 941	0	3, 781	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 110	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 00 03020 CARDI AC	0	0	0	0	0	76. 00
76. 01 03160 CARDI OPULMONARY	8, 206	0	0	634	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 09001 WOUND CLINIC	10, 446	0	0	3, 553		90. 01
90. 02 09002 DI ABETES CLINI C	0	0	0	416		90. 02
90.03 09003 ASTHMA CLINIC	0	0	0	0	0	90. 03
90. 04 09004 ANDIS CLINIC	9, 376	0	0	407	0	90. 04
90. 05 09005 PRI ME TI ME	0	0	0	0	0	90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90. 06
90. 07 04951 ONCOLOGY	50, 025	0	0	3, 907		90. 07
90.08 04950 ANDERSON WOMENS CENTER	0	0	0	2, 203		90. 08
91. 00 09100 EMERGENCY	79, 594	4, 365	0	15, 892	7, 706	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	29, 835	0	7, 790	9, 138		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	740, 686	73, 119	95, 079	184, 679	25, 087	118. 00
NONREI MBURSABLE COST CENTERS	1				1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190. 01 19001 PROFESSI ONAL BUILDING	303, 983	0	0	0		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	0	0	0		190. 02
190. 03 19003 PRI VATE DUTY	0	0	0	1, 955		190. 03
190. 04 19004 MARKETI NG	0	0	0	682		190. 04
190. 05 19005 SPORTS PHYSI CALS	0	0	0	0		190. 05
190. 06 19006 FOUNDATI ON	0	0	0	1, 000		190. 06
190. 07 19007 ASC	0	0	0	0		190. 07
190.08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 08
190. 09 19009 HANCOCK OB	16, 351	0	0	2, 502		190. 09
190. 10 19010 HANCOCK WELLNESS	0	0	0	0		190. 10
190.11 19011 MORRI STOWN CLINIC	0	0	0	0		190. 11
190. 12 19012 03PUREMED	0	0	0	51		190. 12
190. 13 19013 MCCORD WELLNESS	o	o	0	976		190. 13
190.14 19014 3 WEST UNIT	45, 210	o	0	1, 250		190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	0	o	0	0	0	190. 15
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	1, 106, 230	73, 119	95, 079	193, 095	1 25.097	202. 00
202.00 101.12 (00 11.100 110 201)	1, 100, 230	73, 117	75, 077	173, 073	25,007	1202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150037

Period: Worksheet B From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared:

5/26/2016 2:22 pm Cost Center Description CENTRAL PHARMACY MEDI CAL PARAMED ED Subtotal SERVICES & RECORDS & **PRGM SUPPLY** LI BRARY 15.00 23.00 24.00 14.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11 00 13.00 01300 NURSING ADMINISTRATION 13.00 14 00 01400 CENTRAL SERVICES & SUPPLY 4,657 14.00 01500 PHARMACY 15.00 15.00 86 115, 668 01600 MEDICAL RECORDS & LIBRARY 16.00 0 102, 256 16.00 23.00 02300 PARAMED ED PRGM 35, 390 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 644, 122 30.00 27.507 30.00 88 31.00 03100 INTENSIVE CARE UNIT 190 C 3, 435 678, 646 31.00 40.00 04000 SUBPROVI DER - I PF 40.00 14 0 2,832 196, 528 04100 SUBPROVI DER - I RF 41.00 0 41.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 184 36, 154 686, 679 50.00 05100 RECOVERY ROOM 51.00 0 0 56, 332 51.00 6 05300 ANESTHESI OLOGY 53.00 0 0 1.051 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 61 0 4, 128 663, 789 54.00 60.00 06000 LABORATORY 034 0 9, 159 197, 204 60.00 06500 RESPIRATORY THERAPY 65.00 77, 205 65.00 16 C 66 00 06600 PHYSI CAL THERAPY 2 Ω O 66 00 110, 612 06700 OCCUPATIONAL THERAPY 67.00 C 0 4,832 67.00 06800 SPEECH PATHOLOGY 0 2, 838 68.00 68.00 0 06801 OCCUPATIONAL HEALTH 68.01 0 0 C 68.01 0 06900 ELECTROCARDI OLOGY 194, 801 69.00 36 C 4, 700 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2,702 0 183,001 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 17, 343 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 0 115, 668 211 115, 879 73 00 03020 CARDI AC 0 76.00 0 Λ 76.00 03160 CARDI OPULMONARY 0 54<u>, 618</u> 76.01 76.01 0 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 Ω 0 2, 334 0 90.00 09000 CLI NI C 0 0 0 90.00 09001 WOUND CLINIC 14 79, 123 90.01 90.01 90.02 09002 DIABETES CLINIC 0 0 0 0 861 90.02 09003 ASTHMA CLINIC 0 90.03 0 0 90 03 90.04 09004 ANDIS CLINIC 0 61, 967 90.04 90.05 09005 PRIME TIME 0 5 0 0 774 90.05 09006 SHELBYVILLE WOUND CLINIC 90.06 0 0 90.06 3.005 90.07 04951 ONCOLOGY 0 0 337.325 90 07 90.08 04950 ANDERSON WOMENS CENTER 3 0 0 4,873 90.08 91.00 09100 EMERGENCY 157 14, 130 582, 536 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 0 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 248, 470 116, 00 46 0 SUBTOTALS (SUM OF LINES 1-117) 118.00 4,652 115, 668 102, 256 5, 206, 748 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 190. 01 19001 PROFESSI ONAL BUILDING 0 1, 975, 752 190. 01 0 C 190. 02 19002 PHYSI CI AN BUI LDI NG 0 380 190. 02 02000030000 190. 03 19003 PRI VATE DUTY 0 0 4, 843 190. 03 190. 04 19004 MARKETI NG 5, 314 190. 04 0 0 190. 05 19005 SPORTS PHYSI CALS 0 C 263 190.05 190. 06 19006 FOUNDATI ON 2, 623 190. 06 190. 07 19007 ASC 0 0 6 190. 07 190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 190 08 C 190. 09 19009 HANCOCK OB 138, 054 190. 09 190. 10 19010 HANCOCK WELLNESS 12, 877 190. 10 190. 11 19011 MORRI STOWN CLINIC 0 0 0 190, 11 190. 12 19012 03PUREMED 207 190. 12 0 0 190. 13 19013 MCCORD WELLNESS 0 0 0 2, 643 190. 13 190. 14 19014 3 WEST UNIT 0 0 297, 379 190. 14 190. 15 19015 NEUROLOGY PHYSICIAN 0 O 590 190. 15 200.00 Cross Foot Adjustments 35, 390 35, 390 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 4,657 115, 668 102, 256 35, 390 7, 683, 069 202. 00

HANCOCK REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2015	Part II
To 12/31/2015	Date/Time Prepared:
5/26/2016 2:22 pm	Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150037

			5/26/2016 2: 2	
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS	20.00	20.00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00 00500 ADMINISTRATIVE & GENERAL				5. 00
7.00 00700 OPERATION OF PLANT				7. 00
9. 00 00900 HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY				10. 00
11. 00 01100 CAFETERI A				11. 00
13.00 01300 NURSING ADMINISTRATION				13. 00
14.00 01400 CENTRAL SERVI CES & SUPPLY				14. 00
15. 00 01500 PHARMACY				15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY				16. 00
23. 00 02300 PARAMED ED PRGM				23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	644, 122		30.00
31. 00 03100 INTENSIVE CARE UNIT	0	678, 646		31.00
40. 00 04000 SUBPROVI DER - PF	0	196, 528		40.00
41.00 O4100 SUBPROVIDER - IRF	0	0		41. 00
ANCILLARY SERVICE COST CENTERS 50. 00 O5000 OPERATING ROOM	0	686, 679		50.00
51. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0	56, 332		50.00
53. 00 05300 ANESTHESI OLOGY		1, 051		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		663, 789		54.00
60. 00 06000 LABORATORY	l o	197, 204		60.00
65. 00 06500 RESPIRATORY THERAPY		77, 205		65.00
66. 00 06600 PHYSI CAL THERAPY		110, 612		66.00
67. 00 06700 OCCUPATI ONAL THERAPY		4, 832		67.00
68. 00 06800 SPEECH PATHOLOGY	o	2, 838		68.00
68. 01 06801 0CCUPATI ONAL HEALTH	o	0		68. 01
69. 00 06900 ELECTROCARDI OLOGY	o	194, 801		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	183, 001		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	O	17, 343		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	115, 879		73. 00
76. 00 03020 CARDI AC	0	0		76. 00
76. 01 03160 CARDI OPULMONARY	0	54, 618		76. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0	2, 334		88. 00
90. 00 09000 CLI NI C	0	0		90. 00
90. 01 09001 WOUND CLINIC	0	79, 123		90. 01
90. 02 09002 DI ABETES CLI NI C	0	861		90. 02
90. 03 09003 ASTHMA CLINIC	0	0		90. 03
90. 04 09004 ANDIS CLINIC	0	61, 967		90. 04
90. 05 09005 PRI ME TI ME	0	774		90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	3, 005		90.06
90. 07 04951 0NCOLOGY 90. 08 04950 ANDERSON WOMENS CENTER		337, 325 4, 873		90. 07 90. 08
91. 00 09100 EMERGENCY	0	582, 536		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		362, 330		92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	I		72.00
101. 00 10100 HOME HEALTH AGENCY	O	0		101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	O _I		1.51.55
116. 00 11600 HOSPI CE	0	248, 470		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	o o	5, 206, 748		118.00
NONREI MBURSABLE COST CENTERS		,		1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190. 01 19001 PROFESSI ONAL BUI LDI NG	O	1, 975, 752		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	O	380		190. 02
190. 03 19003 PRI VATE DUTY	O	4, 843		190. 03
190. 04 19004 MARKETI NG	0	5, 314		190. 04
190. 05 19005 SPORTS PHYSI CALS	0	263		190. 05
190. 06 19006 FOUNDATI ON	0	2, 623		190. 06
190. 07 19007 ASC	0	6		190. 07
190.08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	O		190. 08
190. 09 19009 HANCOCK OB	0	138, 054		190. 09
190. 10 19010 HANCOCK WELLNESS	0	12, 877		190. 10
190. 11 19011 MORRISTOWN CLINIC	0	o		190. 11
190. 12 19012 03PUREMED	0	207		190. 12
190. 13 19013 MCCORD WELLNESS	0	2, 643		190. 13
190. 14 19014 3 WEST UNIT	0	297, 379		190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	0	590		190. 15
200.00 Cross Foot Adjustments	0	35, 390		200. 00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150037	Peri od: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Pre 5/26/2016 2:2	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	25. 00	26.00				
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118-201)	o	7, 683, 069				202.00

	Financial Systems	HANCOCK REGION				u of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Pre 5/26/2016 2:2	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)		
		1.00	4.00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	391, 911					1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 810	37, 222, 994	1			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	28, 320	6, 582, 258				5. 00
7. 00	00700 OPERATION OF PLANT	54, 051	902, 194	1	-, ,		1
9.00	00900 HOUSEKEEPI NG	2, 576	861, 408	1		2, 576	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	3, 894	364, 290 733, 832		417, 232	3, 894	1
13. 00	01300 NURSING ADMINISTRATION	7, 694 411	918, 199		1, 566, 198 1, 197, 721	7, 694 411	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	60, 848	1		0	1
15. 00	01500 PHARMACY	1, 888	1, 447, 422	1		1, 888	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	3, 682	591, 131	1			1
	02300 PARAMED ED PRGM	1, 344	75, 985	1		1, 344	1
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>. </u>		•			1
30. 00	03000 ADULTS & PEDIATRICS	22, 348	2, 491, 534	1 0	3, 851, 776	22, 384	30. 00
31. 00	03100 INTENSIVE CARE UNIT	23, 850	3, 017, 324	1		23, 850	1
40. 00	04000 SUBPROVI DER - I PF	6, 376	1, 149, 395			6, 376	
41. 00	04100 SUBPROVI DER - I RF	0	0) 0	0	0	41. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	25, 149	2, 776, 698	3 0	5, 697, 290	25, 149	50.00
51. 00	05100 RECOVERY ROOM	25, 149	2, 776, 696	1			
53. 00	05300 ANESTHESI OLOGY	2, 120	222, 755				1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	25, 994	2, 475, 821				
60. 00	06000 LABORATORY	5, 844	1, 573, 449	1		5, 844	•
65.00	06500 RESPI RATORY THERAPY	2, 354	1, 134, 178	1		2, 354	•
66.00	06600 PHYSI CAL THERAPY	3, 889	946, 390	0	1, 355, 074	3, 889	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	265, 128	3 0	324, 822	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	159, 111	0	199, 718	0	
68. 01	06801 OCCUPATI ONAL HEALTH	0	0	0	_	0	
69. 00	06900 ELECTROCARDI OLOGY	7, 493	509, 420	1	,	7, 493	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 696	0	0		6, 696	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0			0	
76. 00	03020 CARDI AC		0		-	0	76.00
76. 01	03160 CARDI OPULMONARY	2, 279	52, 839	1	_	2, 279	
	OUTPATIENT SERVICE COST CENTERS			-		_,	1
88. 00	08800 RURAL HEALTH CLINIC	0	175, 440	0	285, 932	0	88. 00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 WOUND CLINIC	2, 901	617, 220				
	09002 DI ABETES CLI NI C	0	39, 768	1			90. 02
	09003 ASTHMA CLINIC	0	42.275	1			90. 03
90. 04 90. 05	09004 ANDIS CLINIC 09005 PRIME TIME	2, 604	42, 375	0		2, 604 0	1
	09006 SHELBYVILLE WOUND CLINIC		195, 115	5 0	102, 303 371, 747	0	1
90. 07	04951 ONCOLOGY	13, 893	500, 884	•		13, 893	1
	04950 ANDERSON WOMENS CENTER	0	254, 104	1			1
91.00		22, 105	2, 155, 097				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS			_			
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
11/ 0/	SPECIAL PURPOSE COST CENTERS	0.00/	1 000 02/		2 050 227	0.207	11/ 00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	8, 826 290, 391	1, 098, 036 34, 389, 846	1			116.00
110.00	NONREI MBURSABLE COST CENTERS	290, 391	34, 309, 040	0 -13, 009, 094	04, 300, 340	203, 700]110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19001 PROFESSI ONAL BUILDING	84, 423	0	ol o			190. 01
190. 02	19002 PHYSICIAN BUILDING	0	0	0	50, 185	0	190. 02
190. 03	3 19003 PRI VATE DUTY	0	144, 151	0	363, 198	0	190. 03
	1 19004 MARKETI NG	0	103, 971	1	598, 759		190. 04
	19005 SPORTS PHYSI CALS	0	23, 937	1	,		190. 05
	19006 FOUNDATION	0	127, 827	0	,		190.06
	7 19007 ASC	0	0		806		190. 07
	3 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19009 HANCOCK OB	4, 541	1, 261, 258	0	_		190. 08 190. 09
	19009 HANCOCK OB 19010 HANCOCK WELLNESS	4, 541	900, 938	1			190. 09
	19011 MORRI STOWN CLINIC		900, 938	i	1, 337, 030		190. 10
	19012 03PUREMED		57, 189	1 °	13, 320		190. 12
190. 13	19013 MCCORD WELLNESS	0	59, 817	1			190. 13
190. 14	19014 3 WEST UNIT	12, 556	154, 060	o	610, 638	12, 556	190. 14

Heal th Fina	Health Financial Systems HANCOCK REGIONAL HOSPITAL					In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CCN: 150037			Worksheet B-1			
					From 01/01/2015 To 12/31/2015				
		CAPI TAL							
		RELATED COSTS							
	Cost Center Description	NEW BLDG &		Reconciliation	on ADMI NI STRATI VE				
		FLXT	BENEFITS		& GENERAL	PLANT			
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE			
		FEET)	(GROSS		COST)	FEET)			
			SALARI ES)						
		1.00	4.00	5A	5. 00	7. 00			
190. 15 1901!	NEUROLOGY PHYSICIAN	0	0		0 78, 000	0	190. 15		
200. 00	Cross Foot Adjustments						200.00		
201. 00	Negative Cost Centers						201. 00		
202. 00	Cost to be allocated (per Wkst. B, Part I)	7, 683, 069	5, 071, 952		13, 609, 094	7, 152, 177	202. 00		
203. 00	Unit cost multiplier (Wkst. B, Part I)	19. 604117	0. 136259		0. 183488	23. 279856	203.00		
204. 00	Cost to be allocated (per Wkst. B, Part II)		35, 483		561, 475	1, 106, 230	204. 00		
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000953		0. 007570	3. 600704	205. 00		

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150037 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/26/2016 2:22 pm Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL (HOURS OF (MANHOURS) SERVICES & (PATI ENT ADMI NI STRATI ON SERVICE) DAYS) **SUPPLY** (MANHOURS) (COSTED REQUIS.) 9.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 9.00 00900 HOUSEKEEPI NG 393, 860 9.00 6,543 01000 DI ETARY 10.00 12, 315 10.00 11.00 01100 CAFETERI A 10, 782 752, 695 11.00 13.00 01300 NURSING ADMINISTRATION 21, 862 201, 677 13.00 01400 CENTRAL SERVICES & SUPPLY 16.355 5, 450, 180 14 00 Ω 3 417 14 00 01500 PHARMACY 15.00 11,930 C 37, 893 0 100, 365 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 14, 350 C 23, 815 0 0 16.00 02300 PARAMED ED PRGM 23.00 16,530 0 1, 950 0 8 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 109,670 3, 460 74,882 102, 703 30.00 03100 INTENSIVE CARE UNIT 31.00 22, 610 5, 236 104, 106 104, 106 222, 175 31.00 04000 SUBPROVIDER - IPF 36, 349 15, 994 40 00 18,095 2,610 40 00 04100 SUBPROVIDER - IRF 41.00 0 41.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 43, 900 50, 049 215, 403 50.00 05100 RECOVERY ROOM 5, 591 0 6, 801 51.00 16, 165 Ω 51 00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 16,070 70, 200 0 70, 907 54.00 54.00 60.00 06000 LABORATORY 15, 335 0 61, 460 0 1, 210, 971 60.00 06500 RESPIRATORY THERAPY 11, 745 0 33.827 18, 238 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 13,650 0 26, 012 1, 894 66.00 06700 OCCUPATIONAL THERAPY 8, 259 0 1, 210 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 0 4, 561 4,836 68.00 06801 OCCUPATIONAL HEALTH 0 68.01 0 C0 68.01 06900 ELECTROCARDI OLOGY 26, 615 0 14, 740 42, 253 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 3, 164, 404 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 0 73 00 03020 CARDI AC 0 0 76.00 0 76.00 03160 CARDI OPULMONARY o 76. 01 0 0 2, 471 850 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 O 0 1, 957 88.00 90.00 09000 CLI NI C 000000000 0 C 0 0 90.00 0 09001 WOUND CLINIC 13, 849 16, 058 90.01 90.01 0 09002 DIABETES CLINIC 0 90.02 90.02 1,621 21 90.03 09003 ASTHMA CLINIC 0 0 0 0 90.03 90. 04 09004 ANDIS CLINIC 0 1,587 303 90.04 09005 PRIME TIME 0 90.05 0 0 90.05 90.06 09006 SHELBYVILLE WOUND CLINIC 0 0 6, 203 90.06 90.07 04951 ONCOLOGY 15, 230 0 33 90.07 OAGED ANDEDSON WOMENS CENTED 2 200 80 n 0

90. 08 04950	D ANDERSON WOMENS CENTER	0	0	8, 586	0	3, 398	90.08
91.00 09100	EMERGENCY	23, 515	o	61, 949	61, 949	183, 559	91.00
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER	R REIMBURSABLE COST CENTERS						
101. 00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECI	AL PURPOSE COST CENTERS						
116. 00 11600	HOSPI CE	0	1, 009	35, 622	35, 622	54, 205	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	393, 860	12, 315	719, 888	201, 677	5, 444, 749	118. 00
NONRE	I MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190. 01 19001	PROFESSIONAL BUILDING	0	0	0	0	0	190. 01
190. 02 19002	PHYSICIAN BUILDING	0	0	0	0	0	190. 02
190. 03 19003	PRI VATE DUTY	0	0	7, 619	0	1, 852	190. 03
190. 04 19004	4 MARKETI NG	0	0	2, 659	0	0	190. 04
190. 05 19005	SPORTS PHYSICALS	0	0	0	0	0	190. 05
190. 06 19006	FOUNDATION	0	0	3, 900	0	0	190. 06
190. 07 19007	7 ASC	0	0	0	0	42	190. 07
190. 08 19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 08
190. 09 19009	HANCOCK OB	0	0	9, 751	0	3, 358	190. 09
190. 10 19010	HANCOCK WELLNESS	0	0	0	0	0	190. 10
190. 11 19011	MORRISTOWN CLINIC	0	0	0	0	0	190. 11
190. 12 19012	03PUREMED	0	0	200	0	0	190. 12
190. 13 19013	MCCORD WELLNESS	0	0	3, 804	0	0	190. 13
190. 14 19014	4 3 WEST UNIT	0	0	4, 874	0	179	190. 14

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0 190. 15

200.00

200.00

190. 15 19015 NEUROLOGY PHYSI CI AN

Cross Foot Adjustments

Health Fir	nancial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/26/2016 2:2	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI ON		
		SERVICE)	DAYS)			SUPPLY	
					(MANHOURS)	(COSTED	
						REQUIS.)	
		9.00	10.00	11. 00	13.00	14.00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	2, 017, 798	617, 962	2, 087, 930	1, 487, 700	200, 559	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	5. 123135	50. 179618	2. 773939	7. 376647	0. 036799	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	73, 119	95, 079	193, 095	25, 087	4, 657	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 185647	7. 720585	0. 256538	0. 124392	0. 000854	205. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Peri od: Worksheet B-1 From 01/01/2015 To 12/31/2015 Date/Ti me Prepared:

5/26/2016 2:22 pm Cost Center Description **PHARMACY** MEDI CAL PARAMED ED (COSTED RECORDS & PRGM REQUIS.) LI BRARY (ASSI GNED (TIME TIME) SPENT) 15.00 23.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 01500 PHARMACY 15.00 100 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 394 16.00 02300 PARAMED ED PRGM 0 23.00 100 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 913 0 30.00 03100 INTENSIVE CARE UNIT 0 0 31.00 114 31.00 04000 SUBPROVIDER - IPF 0 40 00 94 40 00 04100 SUBPROVIDER - IRF 41.00 0 C 0 41.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 1, 200 0 50.00 05100 RECOVERY ROOM 0 00000000000 51 00 51.00 53.00 05300 ANESTHESI OLOGY C 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 137 100 54.00 54.00 60.00 06000 LABORATORY 304 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 C 65 00 0 66.00 06600 PHYSI CAL THERAPY C 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 0 06801 OCCUPATIONAL HEALTH 68.01 C 68.01 06900 ELECTROCARDI OLOGY 156 0 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 0 72.00 0 0 72.00 0 73 00 100 73 00 03020 CARDI AC 0 0 76.00 76.00 03160 CARDI OPULMONARY 0 0 76. 01 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 n 0 88.00 90.00 09000 CLI NI C 0000000000 0 0 90.00 90. 01 09001 WOUND CLINIC 0 90.01 0 09002 DIABETES CLINIC 0 90.02 0 90.02 90.03 09003 ASTHMA CLINIC 0 90.03 90. 04 09004 ANDIS CLINIC 0 90.04 09005 PRIME TIME 0 90.05 0 90.05 09006 SHELBYVILLE WOUND CLINIC 0 90.06 C 90.06 90.07 04951 ONCOLOGY 90.07 90.08 04950 ANDERSON WOMENS CENTER 0 90.08 09100 EMERGENCY 0 91 00 469 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117) <u>3,</u> 394 118.00 100 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 190. 01 19001 PROFESSI ONAL BUILDING 0 0 0 190. 01 190. 02 19002 PHYSICIAN BUILDING 0 0000000000000 0 190. 02 190. 03 19003 PRI VATE DUTY Ω 0 190 03 190. 04 19004 MARKETI NG 0 190.04 190. 05 19005 SPORTS PHYSI CALS 0 0 190.05 190. 06 19006 FOUNDATI ON 0 0 190.06 0 190.07 190. 07 19007 ASC 0 0 190.08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 190.08 190. 09 19009 HANCOCK OB 190.09 190. 10 19010 HANCOCK WELLNESS 0 0 190. 10 190. 11 19011 MORRISTOWN CLINIC 0 0 190.11 190. 12 19012 03PUREMED 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 190. 13 0 190. 14 19014 3 WEST UNIT 190 14 0 190. 15 19015 NEUROLOGY PHYSI CI AN 0 190. 15 200.00 Cross Foot Adjustments 200.00

Heal th Fi	nancial Systems	HANCOCK REGION	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLC	CATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	1
					From 01/01/2015 To 12/31/2015	Date/Time Pro 5/26/2016 2:2	
	Cost Center Description	PHARMACY	MEDI CAL	PARAMED ED			
		(COSTED	RECORDS &	PRGM			
		REQUIS.)	LI BRARY	(ASSI GNED			
			(TIME	TIME)			
			SPENT)				
		15. 00	16. 00	23. 00			
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	9, 350, 175	1, 394, 701	209, 22	22		202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	93, 501. 750000	410. 931349	2, 092. 22000	00		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	115, 668	102, 256	35, 39	90		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1, 156. 680000	30. 128462	353. 90000	00		205. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150037	Peri od: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared:

					To 12/31/2015	Date/Time Pre 5/26/2016 2:2	
			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
				7,,,,,,	Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost conten bosci i pti on	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10141 00313	
		Part I, col.	, rug .		Di Sai i Gwance		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00		6, 401, 779		6, 401, 7	79 0	6, 401, 779	30. 00
31. 00	03100 NTENSI VE CARE UNI T	7, 428, 086	ł	7, 428, 08			
40. 00	04000 SUBPROVI DER - I PF	2, 356, 681	ł	2, 356, 68			40.00
	04100 SUBPROVI DER - I RF	2, 330, 001		2, 330, 00	o o	_, _,	
41.00	ANCI LLARY SERVI CE COST CENTERS				0 0	0	41.00
50. 00	05000 OPERATING ROOM	8, 192, 922		8, 192, 92	22 0	8, 192, 922	50.00
51. 00	05100 RECOVERY ROOM	536, 490	ł	536, 49			1
53. 00	05300 ANESTHESI OLOGY	164, 313		164, 3		1 000, 170	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 319, 374		6, 319, 3			
60.00	06000 LABORATORY	5, 446, 313	ŀ	5, 446, 3		5, 446, 313	
65. 00	06500 RESPIRATORY THERAPY	1, 870, 694					
66. 00	06600 PHYSI CAL THERAPY		l e			1, 836, 406	
67.00	06700 OCCUPATIONAL THERAPY	1, 836, 406		1,000,			
	06800 SPEECH PATHOLOGY	407, 378	-	,			
68. 00 68. 01		249, 194	l e	249, 19		249, 194 0	
	06801 OCCUPATI ONAL HEALTH	_	0	1 500 00	0 0	-	
69. 00	06900 ELECTROCARDI OLOGY	1, 509, 207		1, 509, 20		1, 509, 207	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 168, 274	l	4, 168, 27		4, 168, 274	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	2, 711, 324		2, 711, 32		2, 711, 324	
73. 00	07300 DRUGS CHARGED TO PATIENTS	9, 353, 052	l .	9, 353, 0		9, 353, 052	
76. 00	03020 CARDI AC	0	l		0 0	_	76. 00
76. 01	03160 CARDI OPULMONARY	223, 912		223, 9	2 0	223, 912	76. 01
	OUTPATIENT SERVICE COST CENTERS		1		_		
88. 00	08800 RURAL HEALTH CLINIC	338, 469	l	338, 40			
90.00	09000 CLI NI C	0	l		0		90. 00
90. 01	09001 WOUND CLINIC	1, 302, 610		1, 302, 6		1, 302, 610	1
90. 02	09002 DI ABETES CLINIC	68, 137		68, 13		,	
90. 03	09003 ASTHMA CLINIC	0			0	0	90. 03
90. 04	09004 ANDIS CLINIC	236, 297		236, 29			
90. 05	09005 PRIME TIME	121, 074		121, 0		121, 074	
90. 06	09006 SHELBYVILLE WOUND CLINIC	440, 186		440, 18		440, 186	
90. 07	O4951 ONCOLOGY	2, 015, 915	l e	2, 015, 9°		2, 015, 915	
90. 08	04950 ANDERSON WOMENS CENTER	403, 104	l e	403, 10		403, 104	
91. 00	09100 EMERGENCY	5, 416, 992	l e	5, 416, 9	0 0	5, 416, 992	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 466, 199		2, 466, 19	99	2, 466, 199	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0			0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	_					
	11600 H0SPI CE	4, 227, 665		4, 227, 60	5	4, 227, 665	
200.00		76, 212, 047	0	76, 212, 04	17 O	,,	
201.00		2, 466, 199		2, 466, 19	99	2, 466, 199	
202.00	Total (see instructions)	73, 745, 848	0	73, 745, 84	18 0	73, 745, 848	202. 00

					10 12/31/2015	Date/IIme Pre 5/26/2016 2:2	
			Ti tl	e XVIII	Hospi tal	PPS	2 piii
			Charges	<u> </u>	noopi tai		
	Cost Center Description	I npati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	cost contor boson per on	patront	output. o	+ col . 7)	Ratio	Inpatient	
				,		Ratio	
		6.00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 178, 359		6, 178, 35	9		30. 00
31.00	03100 INTENSIVE CARE UNIT	9, 704, 524		9, 704, 52	4		31. 00
40.00	04000 SUBPROVI DER - I PF	3, 214, 429		3, 214, 42	9		40. 00
41.00	04100 SUBPROVI DER - I RF	0			O		41. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	7, 130, 433	8, 498, 377	15, 628, 81	0. 524219	0.000000	50. 00
51.00	05100 RECOVERY ROOM	1, 013, 815	1, 192, 674	2, 206, 48	9 0. 243142	0.000000	51.00
53.00	05300 ANESTHESI OLOGY	15, 901	1, 010	16, 91	9. 716338	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 584, 387	45, 819, 268	50, 403, 65	0. 125375	0.000000	54. 00
60.00	06000 LABORATORY	6, 232, 901	29, 588, 765	35, 821, 66	0. 152040	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	3, 025, 557	4, 930, 296	7, 955, 85	0. 235134	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	820, 120	3, 529, 051	4, 349, 17	0. 422243	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	502, 595	594, 925	1, 097, 52	0. 371180	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	107, 532	375, 811	483, 34	0. 515563	0.000000	68. 00
68. 01	06801 OCCUPATI ONAL HEALTH	0	0		0.000000	0.000000	68. 01
69.00	06900 ELECTROCARDI OLOGY	3, 380, 544	10, 664, 231	14, 044, 77	0. 107457	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 250, 439	3, 233, 961	5, 484, 40	0. 760024	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	5, 819, 505	1, 224, 884	7, 044, 38	9 0. 384891	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 173, 548	33, 939, 847	44, 113, 39	0. 212023	0.000000	73. 00
76.00	03020 CARDI AC	0	0		0.000000	0.000000	76. 00
76. 01	03160 CARDI OPULMONARY	259	316, 757	317, 01	0. 706311	0.000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	354, 794	354, 79	4		88. 00
90.00	09000 CLI NI C	0	0	1	0.000000	0.000000	90. 00
90. 01	09001 WOUND CLINIC	24, 711	4, 792, 390	4, 817, 10	0. 270414	0.000000	
90. 02	09002 DI ABETES CLINIC	0	76, 281	76, 28	0. 893237	0.000000	90. 02
90. 03	09003 ASTHMA CLINIC	0	0)	0.000000	0.000000	90. 03
90. 04	09004 ANDIS CLINIC	0	49, 336	49, 33	4. 789545	0.000000	90. 04
90. 05	09005 PRIME TIME	54	352, 453	352, 50	0. 343466	0.000000	90. 05
90.06	09006 SHELBYVILLE WOUND CLINIC	0	1, 784, 052	1, 784, 05	0. 246734	0.000000	90. 06
90. 07	04951 ONCOLOGY	27, 473	3, 352, 659	3, 380, 13	0. 596401	0.000000	90. 07
90. 08	04950 ANDERSON WOMENS CENTER	6, 964	3, 155, 099	3, 162, 06	0. 127481	0.000000	90. 08
91.00	09100 EMERGENCY	3, 802, 157	22, 151, 620	25, 953, 77	7 0. 208717	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	253, 510	2, 409, 237	2, 662, 74	0. 926186	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	1)		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	893, 280	1, 379, 647		1		116. 00
200.00		69, 162, 997	183, 767, 425	252, 930, 42	2		200. 00
201.00							201. 00
202.00	Total (see instructions)	69, 162, 997	183, 767, 425	252, 930, 42	2		202. 00

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037 | Period: From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/26/2016 2:22 pm

INPATIENT ROUTI NE SERVICE COST CENTERS 11.00						5/26/2016 2: 22 pm
INPATIENT ROUTINE SERVICE COST CENTERS 11.00				Title XVIII	Hospi tal	PPS
NPATIENT ROUTINE SERVICE COST CENTERS 30.00 030000 AUILTS & PEDI ATRI CS 31.00		Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 310.00 3000 ADULTS & PEDIATRIC S 31.00 310.00 31000 ADULTS & PEDIATRIC S 31.00 310.00 31000 SUBPROVIDER - I PF 40.00 41.00 41.00 5UBPROVIDER - I PF 40.00 41.00 41.00 5UBPROVIDER - I PF 40.00 41.00 41.00 41.00 5UBPROVIDER - I PF 40.00 41.00 41.00 41.00 41.00 5UBPROVIDER - I RF 40.00 41			Ratio			
30.00 30.000 ADULTS & PEDI ATRIC S 30.00 40.00 0.000 NITENSIN ECARE UNIT			11. 00			
31.00 03100 INTENSIVE CARE UNIT 31.00 04100 SUBPROVIDER - I PF 40.00 40.00 40.00 SUBPROVIDER - I PF		INPATIENT ROUTINE SERVICE COST CENTERS				
A0, 00 04000 SUBPROVI DER - I PF 41, 00	30.00	03000 ADULTS & PEDIATRICS				30.00
A1. 00	31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS 50.00	40.00	04000 SUBPROVI DER - I PF				40.00
50.00 05000 0PERATI NG ROOM	41.00	04100 SUBPROVI DER - I RF				41.00
51 00		ANCILLARY SERVICE COST CENTERS				
S3.00 05300 ARSTHESI OLOGY 9, 716338 53.00 05400 RADIOLOGY-DI AGNOSTI C 0.125375 54.00 05400 RADIOLOGY-DI AGNOSTI C 0.125375 54.00 05000 RADIOLOGY-DI AGNOSTI C 0.125375 65.00 05000 RADIOLOGY-DI AGNOSTI C 0.125474 65.00 05600 RADIOLOGY-DI AGNOSTI C 0.125474 65.00 05600 RADIOLOGY-DI AGNOSTI C 0.235134 65.00 05600 RADIOLOGY-DI AGNOSTI C 0.245734 65.00 05600 RADIOLOGY-DI AGNOSTI C 0.245734 65.00 05600 RADIOLOGY-DI AGNOSTI C 0.245734 65.00 05600 RADIOLOGY-DI AGNOSTI C 0.270414 0.270	50.00	05000 OPERATING ROOM	0. 524219			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 125375 54. 00 06000 LABORATORY 0. 152040 66. 00 06500 RESPIRATORY THERAPY 0. 235134 65. 00 06500 RESPIRATORY THERAPY 0. 422243 66. 00 06600 PHYSI CAL THERAPY 0. 422243 66. 00 06600 PHYSI CAL THERAPY 0. 422243 66. 00 06800 SPEECH PATHOLOGY 0. 515563 68. 00 06800 SPEECH PATHOLOGY 0. 515563 68. 00 06801 OSCUPATIONAL THEALTH 0. 0000000 06801 06801 06801 05801 06801 05801 06801	51.00	05100 RECOVERY ROOM	0. 243142			51.00
60. 00 06.00 06.0000 06.000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.0000 06.00000 06.00000 06.00000 06.00000 06.00000 06.000000 06.000000 06.000000 06.0000000	53.00	05300 ANESTHESI OLOGY	9. 716338			53.00
65. 00 6500 RESPIRATORY THERAPY 0. 225134 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 422243 66. 00 67. 00 106700 OCCUPATI ONAL THERAPY 0. 371180 67. 00 68. 00 106800 SPEECH PATHOLOGY 0. 515563 68. 00 68. 01 066801 SCCUPATI ONAL HEALTH 0. 0000000 68. 01 69. 00 106900 ELECTROCARDI OLOGY 0. 107457 69. 00 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 760224 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 384891 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 384891 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 212023 73. 00 76. 01 03020 CARDI AC 0. 0000000 76. 01 03160 CARDI OPULMONARY 0. 706311 76. 01 04100 07100 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 76. 01 05160 07100 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 77. 00 0700 07000 0700 IMPL. DEV. CHARGED TO PATI ENTS 0. 212023 77. 00 0710 00710 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 77. 00 0710 00710 07100 MEDIC CHARGED TO PATI ENTS 0. 212023 77. 00 0710 00710 0710 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 77. 00 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 77. 00 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 270414 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 270414 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 270414 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 0710 0710 0710 0710 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 125375			54.00
65. 00 6500 RESPIRATORY THERAPY 0. 225134 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 422243 66. 00 67. 00 106700 OCCUPATI ONAL THERAPY 0. 371180 67. 00 68. 00 106800 SPEECH PATHOLOGY 0. 515563 68. 00 68. 01 066801 SCCUPATI ONAL HEALTH 0. 0000000 68. 01 69. 00 106900 ELECTROCARDI OLOGY 0. 107457 69. 00 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 760224 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 384891 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 384891 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 212023 73. 00 76. 01 03020 CARDI AC 0. 0000000 76. 01 03160 CARDI OPULMONARY 0. 706311 76. 01 04100 07100 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 76. 01 05160 07100 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 77. 00 0700 07000 0700 IMPL. DEV. CHARGED TO PATI ENTS 0. 212023 77. 00 0710 00710 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 77. 00 0710 00710 07100 MEDIC CHARGED TO PATI ENTS 0. 212023 77. 00 0710 00710 0710 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 77. 00 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 212023 77. 00 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 270414 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 270414 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 270414 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 0710 MEDIC CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 90. 01 0710 0710 0710 0710 0710 0710 0710 0	60.00	06000 LABORATORY	0. 152040			60.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 371180 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 515563 68. 00 68. 01 06801 OCCUPATI ONAL HEALTH 0. 000000 68. 01 06801 OCCUPATI ONAL HEALTH 0. 000000 68. 01 07000 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 107457 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 760024 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0. 384891 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 212023 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 212023 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 700000 76. 00 03020 CARDI AC 0. 000000 76. 00 03020 CARDI AC 0. 000000 76. 00 030800 RURAL HEALTH CLINI C 0. 000000 76. 01 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 00000000	65.00					65. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 371180 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 515563 68. 00 68. 01 06801 OCCUPATI ONAL HEALTH 0. 000000 68. 01 06801 OCCUPATI ONAL HEALTH 0. 000000 68. 01 07000 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 107457 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 760024 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0. 384891 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 212023 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 212023 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 700000 76. 00 03020 CARDI AC 0. 000000 76. 00 03020 CARDI AC 0. 000000 76. 00 030800 RURAL HEALTH CLINI C 0. 000000 76. 01 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 00000000	66. 00	06600 PHYSI CAL THERAPY	0. 422243			66.00
68. 01 06801 OCCUPATI ONAL HEALTH 0.000000 69. 00 6900 ELECTROCARDI OLOGY 0.107457 67. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.760024 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.384891 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.212023 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.212023 76. 00 03020 CARDI AC 0.000000 76. 00 03020 CARDI AC 0.000000 0.706311 0.000000 0.706311 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	67.00	06700 OCCUPATI ONAL THERAPY				67.00
68. 01 06801 OCCUPATI ONAL HEALTH 0.000000 69. 00 6900 ELECTROCARDI OLOGY 0.107457 67. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.760024 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.384891 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.212023 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.212023 76. 00 03020 CARDI AC 0.000000 76. 00 03020 CARDI AC 0.000000 0.706311 0.000000 0.706311 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	68. 00	l i				
69. 00 06900 ELECTROCARDIOLOGY			1			
71. 00			1			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 384891 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 212023 73. 00 76. 00 03020 CARDI AC 0. 000000 76. 00 03020 CARDI AC 0. 000000 76. 00 03160 CARDI OPULMONARY 0. 706311 76. 01 0017471 ENT SERVI CE COST CENTERS 88. 00 88. 00 80800 RURAL HEALTH CLINI C 0. 000000 90. 01 09000 CLINI C 0. 270414 99. 00 90. 02 09002 DI ABETES CLINI C 0. 893237 90. 02 90. 02 90. 02 90. 03 ASTHMA CLINI C 0. 893237 90. 03 90903 ASTHMA CLINI C 0. 000000 90. 03 90. 04 09004 ANDI S CLINI C 4. 789545 90. 04 90. 05		l l				
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.212023 73. 00 76. 00 03020 CARDI AC 0. 000000 76. 00 03020 CARDI OPULMONARY 0. 706311 76. 01 000000 000000 000000			1			
76. 00 03020 CARDI AC 0.000000 0.76. 01 76. 01 03160 CARDI OPULMONARY 0.706311 76. 01 88. 00 08800 RURAL HEALTH CLINI C 90. 00 90. 00 09000 CLINI C 0.000000 90. 00 90. 01 09001 WOUND CLINI C 0.270414 90. 01 90. 02 09002 DI ABETES CLINI C 0.893237 90. 02 90. 03 09003 ASTHMA CLINI C 0.343466 90. 03 90. 04 09004 ANDI S CLINI C 4.789545 90. 04 90. 05 09005 PRI ME TIME 0.343466 90. 05 90. 06 09006 SHELBYVI LLE WOUND CLINI C 0.246734 90. 06 90. 07 04951 0NCOLOGY 0.596401 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0.127481 90. 08 91. 00 09100 BMERGENCY 90. 05 92. 00 09200 DSSERVATI ON BEDS (NON-DISTINCT PART) 0.926186 92. 00 0THER REIMBURSABLE COST CENTERS 101. 00 101. 00 10100 HOME HEALTH AGENCY 5PECI AL PURPOSE COST CENTERS 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00			1			
76. 01 03160 CARDI OPULMONARY 0. 706311 0 76. 01			1			76.00
SECTION SERVICE COST CENTERS SERVICE CO			1			
88. 00 90. 00 90. 00 90. 00 90. 01 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 90. 09 90. 01 90. 00 90. 01 90. 00 90						
90. 00 90. 01 90. 01 90. 01 90. 01 90. 02 90. 01 90. 02 90. 03 90. 03 90. 03 90. 03 90. 04 90. 05 90. 05 90. 06 90. 06 90. 06 90. 07 90. 08 90. 07 90. 08 90. 09 90. 08 90. 09 90. 08 90. 09 90. 09 90. 08 90. 09 90	88. 00					88. 00
90. 01 09001 WOUND CLINIC 0. 270414 90. 01 90. 02 09002 DI ABETES CLINIC 0. 893237 90. 02 90. 03 09003 ASTHMA CLINIC 0. 000000 90. 03 90. 04 09004 ANDIS CLINIC 4. 789545 90. 04 90. 05 09005 PRIME TIME 0. 343466 90. 05 90. 06 09006 SHELBYVILLE WOUND CLINIC 0. 246734 90. 06 90. 07 04951 0NCOLOGY 0. 596401 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0. 127481 90. 08 91. 00 09100 EMERGENCY 0. 208717 91. 00 92. 00 OTHER REIMBURSABLE COST CENTERS 0. 926186 92. 00 101. 00 THER REIMBURSABLE COST CENTERS 101. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 Less Observation Beds 201. 00			0. 000000			
90. 02						
90. 03						90. 02
90. 04			1			90. 03
90. 05 09005 09005 09006						
90. 06 09006 SHELBYVI LLE WOUND CLINI C 0. 246734 90. 06 90. 07 04951 0NCOLOGY 0. 596401 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0. 127481 90. 08 91. 00 09100 EMERGENCY 0. 208717 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 926186 92. 00 OTHER REI MBURSABLE COST CENTERS 101. 00 OTHER REI MBURSABLE COST CENTERS 101. 00 SPECIAL PURPOSE COST CENTERS 101. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00			1			
90. 07			1			
90. 08 04950 ANDERSON WOMENS CENTER 0. 127481 90. 08 91. 00 9100 EMERGENCY 0. 208717 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 926186 92. 00 0THER REI MBURSABLE COST CENTERS 101. 00 OBSERVATION BEDS (NON-DI STI NCT PART) 101. 00 OBSERVATION BEDS (NON-DI	90. 07		I I			
91. 00			1			90. 08
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 926186 92. 00 OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 92. 00			1			
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
101. 00 10100 HOME HEALTH AGENCY						
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	101 00					101 00
116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00			<u> </u>			101.00
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	116 00					116 00
201.00 Less Observation Beds 201.00						

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150037	Peri od: Worksheet C
		From 01/01/2015 Part To 12/31/2015 Date/Time Prepared

				0 12/31/2015		
		Ti +	le XIX	Hospi tal	5/26/2016 2: 2 Cost	2 piii
		111	I E XIX	Costs	COST	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.	Total Costs	Di sal I owance	TOTAL COSTS	
	Part I, col.	Auj .		Di Sai i Owance		
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	6, 401, 779		6, 401, 779	ol	6, 401, 779	30.00
31. 00 03100 NTENSI VE CARE UNI T	7, 428, 086		7, 428, 086	o	7, 428, 086	
40. 00 04000 SUBPROVI DER - PF	2, 356, 681		2, 356, 681	o	2, 356, 681	
41. 00 04100 SUBPROVIDER - I FF	2, 330, 081		2, 330, 001	0	2, 330, 001	41. 00
ANCI LLARY SERVI CE COST CENTERS	1 0			<u> </u>	0	41.00
50. 00 05000 OPERATING ROOM	8, 192, 922	Ι	8, 192, 922	ol	8, 192, 922	50.00
51. 00 05100 RECOVERY ROOM	536, 490			0		
i i			536, 490	o	536, 490	1
	164, 313		164, 313	_	164, 313	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 319, 374		6, 319, 374	0	6, 319, 374	
60. 00 06000 LABORATORY	5, 446, 313		5, 446, 313	0	5, 446, 313	
65. 00 06500 RESPI RATORY THERAPY	1, 870, 694		.,	0	1, 870, 694	
66. 00 06600 PHYSI CAL THERAPY	1, 836, 406		1, 836, 406	0	1, 836, 406	
67. 00 06700 OCCUPATI ONAL THERAPY	407, 378		407, 378	0	407, 378	
68. 00 06800 SPEECH PATHOLOGY	249, 194	0	249, 194	0	249, 194	
68. 01 06801 OCCUPATIONAL HEALTH	0	0	0	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	1, 509, 207		1, 509, 207	0	1, 509, 207	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 168, 274		4, 168, 274	0	4, 168, 274	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 711, 324		2, 711, 324	0	2, 711, 324	
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 353, 052		9, 353, 052	0	9, 353, 052	
76. 00 03020 CARDI AC	0		0	0	0	76. 00
76. 01 03160 CARDI OPULMONARY	223, 912		223, 912	0	223, 912	76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	338, 469		338, 469	0	338, 469	88. 00
90. 00 09000 CLI NI C	0		0	0	0	90.00
90. 01 09001 WOUND CLINIC	1, 302, 610		1, 302, 610	0	1, 302, 610	
90. 02 09002 DIABETES CLINIC	68, 137		68, 137	0	68, 137	90. 02
90. 03 09003 ASTHMA CLINIC	0		0	0	0	90. 03
90. 04 09004 ANDIS CLINIC	236, 297		236, 297	0	236, 297	90. 04
90.05 09005 PRIME TIME	121, 074		121, 074	0	121, 074	90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	440, 186		440, 186	0	440, 186	90. 06
90. 07 04951 ONCOLOGY	2, 015, 915		2, 015, 915	0	2, 015, 915	90. 07
90.08 04950 ANDERSON WOMENS CENTER	403, 104		403, 104	0	403, 104	90. 08
91. 00 09100 EMERGENCY	5, 416, 992		5, 416, 992	0	5, 416, 992	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 466, 199		2, 466, 199		2, 466, 199	92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0		0		0	101. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	4, 227, 665		4, 227, 665		4, 227, 665	116. 00
200.00 Subtotal (see instructions)	76, 212, 047	0	76, 212, 047	o	76, 212, 047	200.00
201.00 Less Observation Beds	2, 466, 199		2, 466, 199		2, 466, 199	201.00
202.00 Total (see instructions)	73, 745, 848		73, 745, 848	o	73, 745, 848	202. 00
	•	•	•	· '		•

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2015	Part
To 12/31/2015	Date/Time Prepared:
5/26/2016 2:22 pm	

						5/26/2016 2:2	2 pm
			Ti t	le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	I npati ent	
						Rati o	
		6.00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 178, 359		6, 178, 35	9		30.00
31.00	03100 INTENSIVE CARE UNIT	9, 704, 524		9, 704, 52	4		31. 00
40.00	04000 SUBPROVI DER - I PF	3, 214, 429		3, 214, 42	9		40. 00
41.00	04100 SUBPROVI DER - I RF	0			0		41.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 130, 433	8, 498, 377	15, 628, 81	0. 524219	0.000000	50.00
51.00	05100 RECOVERY ROOM	1, 013, 815	1, 192, 674	2, 206, 48	9 0. 243142	0.000000	51.00
53.00	05300 ANESTHESI OLOGY	15, 901	1, 010	16, 91	9. 716338	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 584, 387	45, 819, 268	50, 403, 65	0. 125375	0.000000	54.00
60.00	06000 LABORATORY	6, 232, 901	29, 588, 765	35, 821, 66	6 0. 152040	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	3, 025, 557	4, 930, 296	7, 955, 85	0. 235134	0. 000000	65. 00
66.00	06600 PHYSI CAL THERAPY	820, 120	3, 529, 051	4, 349, 17	1 0. 422243	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	502, 595	594, 925	1, 097, 52	0. 371180	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	107, 532	375, 811	483, 34	0. 515563	0.000000	68. 00
68. 01	06801 OCCUPATI ONAL HEALTH	O	0		0. 000000	0. 000000	68. 01
69.00	06900 ELECTROCARDI OLOGY	3, 380, 544	10, 664, 231	14, 044, 77	0. 107457	0. 000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 250, 439	3, 233, 961		0. 760024	0. 000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	5, 819, 505	1, 224, 884		9 0. 384891	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 173, 548	33, 939, 847			0. 000000	
76.00	03020 CARDI AC	O	0		0. 000000	0. 000000	76. 00
76. 01	03160 CARDI OPULMONARY	259	316, 757	317, 01	6 0. 706311	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS		•				1
88. 00	08800 RURAL HEALTH CLINIC	0	354, 794	354, 79	4 0. 953987	0.000000	88. 00
90.00	09000 CLI NI C	0	0		0. 000000	0. 000000	90.00
90. 01	09001 WOUND CLINIC	24, 711	4, 792, 390	4, 817, 10	0. 270414	0.000000	90. 01
90. 02	09002 DI ABETES CLINIC	0	76, 281	76, 28	0. 893237	0.000000	90. 02
90. 03	09003 ASTHMA CLINIC	o	0		0. 000000	0. 000000	90. 03
90. 04	09004 ANDIS CLINIC	o	49, 336	49, 33	6 4. 789545	0. 000000	90. 04
90. 05	09005 PRIME TIME	54	352, 453			0. 000000	1
90. 06	09006 SHELBYVILLE WOUND CLINIC	0	1, 784, 052			0.000000	
90. 07	04951 ONCOLOGY	27, 473	3, 352, 659			0.000000	
90. 08	04950 ANDERSON WOMENS CENTER	6, 964	3, 155, 099			0. 000000	
91.00	09100 EMERGENCY	3, 802, 157	22, 151, 620			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	253, 510	2, 409, 237				1
,2,00	OTHER REIMBURSABLE COST CENTERS	200/010	2/ 107/ 207	2,002,7.	7 0.720.00	0,000000	1 /2:00
101 00	10100 HOME HEALTH AGENCY	0	0		0		101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>		1	-		1.333
116, 00	11600 HOSPI CE	893, 280	1, 379, 647	2, 272, 92	7		116. 00
200.00		69, 162, 997	183, 767, 425				200. 00
201.00	, ,	37,132,771		202, 700, 12			201.00
202.00		69, 162, 997	183, 767, 425	252, 930, 42	2		202. 00
	1.222. (333 1.132. 432. 31.3)	0.7.02,777	.00, .0., 120	202,700,12	=1	1	1=32.00

Heal th Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037
Feriod:
From 01/01/2015
To 12/31/2015
Date/Time Prepared:
Date

31. 00 03100 NTENSI VE CARE UNIT				12.01.21.0	5/26/2016 2:22 pm
Inpatient Routine Service COST CENTERS 11.00			Title XIX	Hospi tal	Cost
INPATIENT ROUTINE SERVICE COST CENTERS	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 ADULTS & PEDIATRIC S 31.1 31		Ratio			
30.0 03000 ADULTS & PEDIATRICS 30.		11.00			
31.00 03100 INTENSIVE CARE UNIT 40.00 40000 SUBPROVIDER - I PF 40.01 40.00 40000 SUBPROVIDER - I RF 40.01 40.00 40100 SUBPROVIDER - I RF 40.01 40.00 40100 SUBPROVIDER - I RF 40.00 40	INPATIENT ROUTINE SERVICE COST CENTERS				
40. 0. 0. 0. 0. 0. 0. 0.	30. 00 03000 ADULTS & PEDI ATRI CS				30.00
41.0 04100 SUBPROVI DER - I RF	31.00 03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS	40. 00 04000 SUBPROVI DER - I PF				40.00
50.00 05000 05000 05EQATI NG ROOM 0.000000 51. 51.00 05300 RECOVERY ROOM 0.000000 53. 53.00 05300 ANESTHESI OLOGY 0.000000 53. 54.00 05400 RADI OLOGY -DI AGNOSTI C 0.000000 54. 60.00 06000 LABORATORY 0.000000 66. 65.00 06500 RESPI RATORY THERAPY 0.000000 66. 66.00 06600 PRYSI CAL THERAPY 0.000000 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 68.00 06800 SPECH PATHOLOGY 0.000000 68. 68.01 06801 SPECH PATHOLOGY 0.000000 68. 69.00 06900 ELECTROCARDI OLOGY 0.000000 69. 69.01 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 77. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 77. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 77. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 77. 74.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 77. 75.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 77. 76.01 03202 CARDI AC 0.000000 77. 76.01 03160 CARDI OPULMONARY 0.000000 77. 76.00 09000 CLI NI C 0.000000 77. 76.00 09000 DI ABETES CLI NI C 0.000000 90. 90.01 09000 DI ABETES CLI NI C 0.000000 90. 90.02 09002 DI ABETES CLI NI C 0.000000 90. 90.03 09005 PRI ME TI ME 0.000000 90. 90.04 09004 ANDIS CLI NI C 0.000000 90. 90.05 09005 PRI ME TI ME 0.000000 90. 90.07 04950 ANDERSON WOMENS CENTER 0.000000 90. 90.08 04950 ANDERSON WOMENS CENTER 0.000000 90. 90.09 09000 DI ABETES CLI NI C 0.000000 90. 90.00 09000 DI ABETES CLIN DI C 0.000000 90. 90.01 09000 EHERCENCY 0.000000 90. 90.02 09000 DI ABETES CLIN DI C 0.000000 90. 90.03 09005 PRI ME TI ME 0.000000 90. 90.04 09005 PRI ME TI ME 0.000000 90. 90.05 09005 PRI ME TI ME 0.000000 90. 90.06 09006 09006 09006 09006 09006 09006 09006 09006	41. 00 04100 SUBPROVI DER - I RF				41. 00
51.00 05100 RECOVERY ROOM 0.000000 53.	ANCILLARY SERVICE COST CENTERS				
53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 54.000 CABORATORY 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
54. 00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 660. 06000 LABORATORY 0.000000 665. 00 06500 RESPIRATORY THERAPY 0.000000 655. 00 06500 RESPIRATORY THERAPY 0.000000 655. 00 06600 PHYSICAL THERAPY 0.000000 665. 00 06600 PHYSICAL THERAPY 0.000000 666. 00 06600 SPEECH PATHOLOGY 0.000000 668. 00 06800 SPEECH PATHOLOGY 0.000000 668. 00 06800 SPEECH PATHOLOGY 0.000000 668. 00 06900 ELECTROCARDIOLOGY 0.000000 668. 00 06900 ELECTROCARDIOLOGY 0.000000 671. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 772. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0.000000 772. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 772. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 772. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 773. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 773. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 774. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 775. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 775. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 775. 00 07000 IMPL DEV. CHARGED TO PATIENTS 0.000000 775. 00 07000 0 0700 0 0 0700 0 0700 0 0700 0 0700 0 0700 0 0 0700 0 0 0700 0 0 0700 0 0 0700 0 0 0 0700 0 0 0 0700 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 05100 RECOVERY ROOM	0. 000000			51.00
60. 00 06000 LABORATORY 0.000000 66. 00 06500 RESPI RATORY THERAPY 0.000000 66. 00 06500 RESPI RATORY THERAPY 0.000000 66. 00 06000 PHYSI CAL THERAPY 0.000000 66. 00 06000 PHYSI CAL THERAPY 0.000000 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 68. 00 06800 SPECCH PATHOLOGY 0.000000 68. 0681 0CCUPATI ONAL HEALTH 0.000000 68. 0681 0CCUPATI ONAL HEALTH 0.000000 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 77. 00 07200 MPLD DEV. CHARGED TO PATI ENTS 0.000000 77. 00 07200 MPLD DEV. CHARGED TO PATI ENTS 0.000000 77. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 77. 00 07300 CARDI AC 0.000000 77. 00 07300 CARDI AC 0.000000 77. 00 07300 CARDI AC 0.000000 77. 00 073000 073000 073000 073000 073000 073000 07300	53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
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66.00 06600 PHYSI CAL THERAPY 0.000000 66.6 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 68.00 06800 SPEECH PATHOLOGY 0.000000 68. 68.01 06801 OCCUPATI ONAL HEALTH 0.000000 68. 69.00 06900 ELECTROCARDI OLOGY 0.000000 71. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 77. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 77. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 77. 76.00 03020 CARDI OPULMONARY 0.000000 76. 76.01 03160 CARDI OPULMONARY 0.000000 76. 76.01 0800 RURBAL HEALTH CLINI C 0.000000 76. 77. 88.00 0800 RURBAL HEALTH CLINI C 0.000000 90. 90.01 09001 WOUND CLINI C 0.000000 90. 90.02 09002 DASETES CLINI C 0.000000 90. 90.03 09003 ASTHMA CLINI C 0.000000 90. 90.04 09004 ANDIS CLINI C 0.000000 90. 90.05 09005 PRIME TIME 0.000000 90. 90.06 09006 SHELBYVILLE WOUND CLINI C 0.000000 90. 90.07 04951 ONCOLOGY 0.000000 90. 90.08 04950 ANDERSON WOMENS CENTER 0.000000 90. 90.09 04950 ANDERSON WOMENS CENTER 0.000000 90. 90.00 09200 OBSERVATI ON BEDS ((NON-DISTINCT PART) 0.000000 0.00000 91. 90.00 OTHER REIMBURSABLE COST CENTERS 90.000000 90. 90.00 00100 DESERVATION BEDS ((NON-DISTINCT PART) 0.000000 90. 90.01 00100 OBSERVATION BEDS ((NON-DISTINCT PART) 0.000000 90.					65. 00
67. 00 06700 0CCUPATIONAL THERAPY 0.000000 67. 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 69. 01 06801 0CCUPATIONAL HEALTH 0.0000000 68. 69. 00 06900 ELECTROCARDIOLOGY 0.000000 77. 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 77. 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 77. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 77. 74. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 77. 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 77. 76. 01 03020 CARDIOPULMONARY 0.000000 77. 77. 88. 00 08800 RURAL HEALTH CLINIC 0.000000 88. 89. 00 09000 CLINIC 0.000000 99. 90. 01 09001 WOUND CLINIC 0.000000 99. 90. 02 09002 DIABETES CLINIC 0.000000 99. 90. 03 09003 ASTHMA CLINIC 0.000000 99. 90. 04 09004 ANDIS CLINIC 0.000000 99. 90. 05 09005 PRIME TIME 0.000000 99. 90. 06 09006 SHELEFYVILLE WOUND CLINIC 0.000000 99. 90. 07 09951 ONCOLOGY 0.000000 99. 90. 08 04950 ANDERSON WOMENS CENTER 0.000000 99. 91. 00 09000 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 99. 91. 00 09000 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 99. 91. 00 07000 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 97. 91. 00 07001 OLIONE HEALTH AGENCY 92.					66. 00
68. 00					67. 00
68. 01 06801 OCCUPATI ONAL HEALTH					68. 00
69. 00 06900 ELECTROCARDIOLOGY 0. 000000 69. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 712. 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 76. 00 03020 CARDIAC 0. 000000 76. 001741 ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0. 0.00000 90. 90. 01 09001 WOUND CLINIC 0. 0.00000 90. 90. 01 09001 WOUND CLINIC 0. 0.00000 90. 90. 03 09003 ASTHMA CLINIC 0. 0.00000 90. 90. 04 09004 ANDIS CLINIC 0. 0.00000 90. 90. 05 09005 PRIME TIME 0. 0.00000 90. 90. 06 09006 SHELBYVILLE WOUND CLINIC 0. 0.00000 90. 90. 07 04951 ONCOLOGY 0. 000000 90. 90. 08 04950 ANDERSON WOMENS CENTER 0. 0.000000 90. 90. 08 04950 ANDERSON WOMENS CENTER 0. 0.000000 90. 90. 08 04950 ANDERSON WOMENS CENTER 0. 0.000000 90. 90. 08 04950 ANDERSON WOMENS CENTER 0. 0.000000 90. 90. 08 04950 ANDERSON WOMENS CENTER 0. 0.000000 90. 90. 08 04950 OBSERVATION BEDS (NON-DISTINCT PART) 0. 0.000000 000 0000 0000 0000 0000 0					68. 01
71. 00					69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 76					71. 00
73. 00		1 1			72.00
76. 00		1 1			73. 00
76. 01 03160 CARDI OPULMONARY 0.000000 76. 0179ATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0.000000 990. 90. 01 09000 CLINI C 0.000000 990. 90. 02 09002 DI ABETES CLINI C 0.000000 990. 90. 03 09003 ASTHMA CLINI C 0.000000 990. 90. 04 09004 ANDI S CLINI C 0.000000 990. 90. 05 09005 PRI ME TI ME 0.000000 990. 90. 06 09006 SHELBYVI LLE WOUND CLINI C 0.000000 990. 90. 07 04951 ONCOLOGY 0.000000 990. 90. 08 04950 ANDERSON WOMENS CENTER 0.000000 990. 91. 00 09100 EMERGENCY 0.000000 990. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 920. 0THER REIMBURSABLE COST CENTERS					76.00
SECTION SUPPRINTENT SERVICE COST CENTERS					76. 01
88. 00		0.000000			70.01
90. 00 09000 CLINIC 0.000000 90. 90. 01 09001 WOUND CLINIC 0.000000 90. 90. 02 09002 DIABETES CLINIC 0.000000 90. 90. 03 09003 ASTHMA CLINIC 0.000000 90. 90. 04 09004 ANDIS CLINIC 0.000000 90. 90. 05 09005 PRIME TIME 0.000000 90. 90. 06 09006 PRIME TIME 0.000000 90. 90. 07 04951 ONCOLOGY 0.000000 90. 90. 08 04950 ANDERSON WOMENS CENTER 0.000000 90. 90. 08 04950 ANDERSON WOMENS CENTER 0.000000 91. 91. 00 09100 EMERGENCY 0.000000 92. 92. 00 OTHER REIMBURSABLE COST CENTERS 0.000000 92. 101. 00 10100 HOME HEALTH AGENCY 101.		0.000000			88. 00
90. 01					90.00
90. 02					90. 01
90. 03	· · · · · · · · · · · · · · · · · · ·	1			90. 02
90. 04	· · · · · · · · · · · · · · · · · · ·	1			90. 03
90. 05		1			90.04
90. 06					90.05
90. 07					90.06
90. 08					
91. 00 09100 EMERGENCY 0.000000 91. 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92. 0THER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 101.					
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 92. 0THER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 101.					
OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 101.					
101. 00 10100 HOME HEALTH AGENCY 101.		0.000000			92.00
					101 00
ISPECIAL PURPOSE COST CENTERS					101.00
					116. 00
					•
					200.00
	1 I				201. 00 202. 00
202. 00 Total (see instructions)	202. 00 [TOTAL (SEE THSTINCTIONS)	1			J202. 00

Health Financial Sy	ystems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF IN	NPATIENT ROUTINE SERVICE CAPI	TAL COSTS		F	Period: From 01/01/2015 To 12/31/2015	5/26/2016 2:2	pared: 2 pm
				e XVIII	Hospi tal	PPS	
Cost Co	enter Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
		Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col. 1 - col.			
		26)		2)			
		1.00	2.00	3.00	4. 00	5. 00	
INPATIENT RO	UTINE SERVICE COST CENTERS						
30.00 ADULTS & PED	OI ATRI CS	644, 122	0	644, 122	5, 446	118. 27	30.00
31.00 INTENSIVE CA	ARE UNIT	678, 646		678, 646	5, 230	129. 76	31. 00
40. 00 SUBPROVI DER	- IPF	196, 528	0	196, 528	2, 610	75. 30	40.00
41. 00 SUBPROVI DER	- IRF	0	0		0	0.00	41. 00
200.00 Total (lines	30-199)	1, 519, 296		1, 519, 296	13, 286		200. 00
Cost Co	enter Description	I npati ent	Inpati ent		•		
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6. 00	7. 00				
INPATIENT RO	UTINE SERVICE COST CENTERS						
30.00 ADULTS & PED	OI ATRI CS	1, 237	146, 300				30. 00
31.00 INTENSIVE CA	ARE UNIT	2, 466	319, 988	3			31.00
40. 00 SUBPROVI DER	- IPF	2, 562	192, 919				40. 00
41. 00 SUBPROVI DER	- IRF	0					41.00
200.00 Total (lines	30-199)	6, 265	659, 207	·[200. 00

Health Financial Systems	HANCOCK REGIONAL H	OSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provider CCN: 150037	Peri od:	Worksheet D

Heal th F	Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTI (ONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Peri od:	Worksheet D	
					From 01/01/2015	Part II	
					To 12/31/2015		pared:
			T' 11	\0.41.1.1		5/26/2016 2: 2	2 pm
		1 2 11 1		e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	·		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	0.00	4.00	F 00	
	WALL ARV OFFICE OF SOME OFFICE	1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	104 470	15 (00 040			104 444	
	D5000 OPERATI NG ROOM	686, 679				106, 661	
	D5100 RECOVERY ROOM	56, 332					51. 00
	D5300 ANESTHESI OLOGY	1, 051					53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	663, 789		1		·	
	06000 LABORATORY	197, 204				·	
	06500 RESPI RATORY THERAPY	77, 205					
66.00	06600 PHYSI CAL THERAPY	110, 612	4, 349, 171	0. 02543	431, 207	10, 967	66. 00
67. 00 C	06700 OCCUPATI ONAL THERAPY	4, 832	1, 097, 520	0.00440	241, 842	1, 065	67. 00
68.00	06800 SPEECH PATHOLOGY	2, 838	483, 343	0. 00587	69, 844	410	68. 00
68. 01 0	06801 OCCUPATIONAL HEALTH	0	l c	0. 00000	0 0	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	194, 801	14, 044, 775	0. 01387	1, 486, 368	20, 616	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	183, 001	5, 484, 400	0. 03336	897, 592	29, 951	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	17, 343	7, 044, 389	0.00246			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	115, 879	44, 113, 395	0. 00262	4, 291, 185	11, 273	73. 00
	03020 CARDI AC	0		1		0	76. 00
	03160 CARDI OPULMONARY	54, 618	317, 016	1		0	76. 01
	OUTPATIENT SERVICE COST CENTERS					_	
	D8800 RURAL HEALTH CLINIC	2, 334	354, 794	0. 00657	'8 0	0	88. 00
	09000 CLI NI C	2,001		1		0	90. 00
	09001 WOUND CLINIC	79, 123	4, 817, 101			55	
	09002 DIABETES CLINIC	861	76, 281	1		0	
	09003 ASTHMA CLINIC	001	70, 201	1		l 0	90. 03
	09004 ANDIS CLINIC	61, 967				0	90. 04
	09005 PRIME TIME	774				0	90.05
	09006 SHELBYVILLE WOUND CLINIC	3,005				0	90.06
	04951 ONCOLOGY	337, 325		1		131	90.00
				1		8	90.07
	04950 ANDERSON WOMENS CENTER	4, 873					
	09100 EMERGENCY	582, 536					
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	248, 139				22	
200. 00	Total (lines 50-199)	3, 687, 121	231, 560, 183	5	22, 307, 438	311, 055	J200. 00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Period: From 01/01/2015		
				To 12/31/2015	5/26/2016 2: 2:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40. 00 04000 SUBPROVI DER - I PF	0	0		0 0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0		0 0	0	41.00
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 446	0.00	1, 23	7 0	,	30.00
31.00 03100 INTENSIVE CARE UNIT	5, 230	0.00	2, 46	6 0	,	31.00
40. 00 04000 SUBPROVI DER - I PF	2, 610	0.00	2, 56	2 0	,	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0.00)	0 0		41.00
200.00 Total (lines 30-199)	13, 286		6, 26	5 0		200. 00

Health Financial Systems	HANCOCK REGIONAL H	OSPI TAL	In Lieu of Form CMS-2		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150037	From 01/01/2015	Worksheet D Part IV Date/Time Prepared:	

				'	0 12/31/2013	5/26/2016 2: 2	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	9	
						4)	
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	(0	0	51.00
53. 00	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	209, 222	. 0	209, 222	54.00
60.00	06000 LABORATORY	0	0	(0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	68. 00
68. 01	06801 OCCUPATI ONAL HEALTH	0	0	(0	0	68. 01
	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	(0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
	03020 CARDI AC	0	0	(0	0	76. 00
76. 01	03160 CARDI OPULMONARY	U U	0) 0	0	76. 01
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0		N 0	0	88. 00
	09000 CLINIC		0			0	90.00
90. 00	09001 WOUND CLINIC		0			0	90.00
	09002 DI ABETES CLI NI C		0			0	90.01
90. 02	109002 DIABETES CLINIC		0			0	90.02
90. 03	109004 ANDIS CLINIC		0			0	90.03
90. 04	09005 PRIME TIME		0			0	90.04
90.06	09006 SHELBYVILLE WOUND CLINIC		0			0	90.06
90. 07	04951 ONCOLOGY		0			0	90.07
90. 07	04950 ANDERSON WOMENS CENTER		0			0	90.08
91. 00	09100 EMERGENCY		0			0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			0	92. 00
200.00			0	209, 222	0	Ŭ	
200.00	1 1.2.2. (1 9	Ü	1 207,222	-1		

Health Financial Systems	HANCOCK REGIONAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150037	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/26/2016 2:22 pm

				'	0 12/31/2015	5/26/2016 2:2:	pared: 2 nm
			Ti tl	e XVIII	Hospi tal	PPS	2 piii
Cost Center Description	Total	Total		Ratio of Cost		Inpatient	
,	Outpati ent		Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of				to Charges	Charges	
	col. 2, 3 and		8)	7)	(col. 6 ÷ col.	ŭ	
	4)			·	7)		
	6. 00		7. 00	8.00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATI NG ROOM	0		5, 628, 810			2, 427, 583	
51.00 05100 RECOVERY ROOM	0		2, 206, 489			356, 568	
53. 00 05300 ANESTHESI OLOGY	0		16, 911			1, 398	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	209, 222		0, 403, 655			2, 390, 663	
60. 00 06000 LABORATORY	0		5, 821, 666			3, 101, 328	
65. 00 06500 RESPI RATORY THERAPY	0		7, 955, 853			1, 631, 468	
66. 00 06600 PHYSI CAL THERAPY	0		4, 349, 171			431, 207	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		1, 097, 520			241, 842	67. 00
68. 00 06800 SPEECH PATHOLOGY	0		483, 343			69, 844	
68. 01 06801 OCCUPATI ONAL HEALTH	0		0	0. 000000		0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0		4, 044, 775			1, 486, 368	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		5, 484, 400			897, 592	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		7, 044, 389			2, 763, 994	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4	4, 113, 395			4, 291, 185	73. 00
76. 00 03020 CARDI AC	0		0	0. 000000		0	76. 00
76. 01 03160 CARDI OPULMONARY	0		317, 016	0. 000000	0. 000000	0	76. 01
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0		354, 794			0	88. 00
90. 00 09000 CLI NI C	0	1	0	0.00000		0	90. 00
90. 01 09001 WOUND CLINIC	0		4, 817, 101	0. 000000		3, 335	90. 01
90. 02 09002 DI ABETES CLINI C	0		76, 281	0. 000000		0	90. 02
90. 03 09003 ASTHMA CLINIC	0		0	0. 000000		0	90. 03
90. 04 09004 ANDIS CLINIC	0		49, 336			0	90. 04
90. 05 09005 PRIME TIME	0		352, 507	0. 000000		47	90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	0		1, 784, 052			0	90. 06
90. 07 04951 ONCOLOGY	0		3, 380, 132			1, 314	90. 07
90.08 04950 ANDERSON WOMENS CENTER	0		3, 162, 063			5, 507	90. 08
91. 00 09100 EMERGENCY	0		5, 953, 777			2, 205, 964	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		2, 662, 747		0. 000000	231	92.00
200.00 Total (lines 50-199)	209, 222	23	1, 560, 183			22, 307, 438	200. 00

Health Financial Systems

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

HANCOCK REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

Period:
From 01/01/2015
To 12/31/2015

Part IV
Date/Time Prepared:

			'		5/26/2016 2:2	22 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	2, 099, 687	0			50.00
51.00 05100 RECOVERY ROOM	0	322, 564	0			51. 00
53. 00 05300 ANESTHESI OLOGY	0	753	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 924	13, 377, 487	55, 530			54.00
60. 00 06000 LABORATORY	0	4, 243, 245	0			60.00
65. 00 06500 RESPIRATORY THERAPY	0	1, 518, 324	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	5, 821	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 548	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	67, 361	0			68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0			68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	4, 045, 448	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	833, 765	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	399, 998	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	12, 996, 732	2			73. 00
76. 00 03020 CARDI AC	0	0	0			76. 00
76. 01 03160 CARDI OPULMONARY	0	92, 204	0			76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0			88. 00
90. 00 09000 CLI NI C	0	0	0			90.00
90. 01 09001 WOUND CLINIC	0	2, 619, 971	0			90. 01
90. 02 09002 DI ABETES CLINIC	0	53	0			90. 02
90.03 09003 ASTHMA CLINIC	0	0	0			90. 03
90. 04 09004 ANDIS CLINIC	0	3, 354	0			90. 04
90.05 09005 PRIME TIME	0	20, 028	0			90. 05
90.06 O9006 SHELBYVILLE WOUND CLINIC	0	327, 352	2 0			90.06
90. 07 04951 ONCOLOGY	0	471, 755	0			90. 07
90.08 04950 ANDERSON WOMENS CENTER	0	687	0			90. 08
91. 00 09100 EMERGENCY	0	4, 960, 858	0			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 522, 375	0			92.00
200.00 Total (lines 50-199)	9, 924	49, 933, 370	55, 530			200. 00

					1	o 12/31/2015	Date/Time Pre 5/26/2016 2:2	
				Ti tl	e XVIII	Hospi tal	PPS	•
					Charges		Costs	
		Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
			Worksheet C,	inst.)	Servi ces	Services Not		
			Part I, col. 9		Subject To	Subject To		
					Ded. & Coins.	Ded. & Coins.		
					(see inst.)	(see inst.)		
			1. 00	2. 00	3. 00	4. 00	5. 00	
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	0. 524219			-	1, 100, 696	1
51. 00		RECOVERY ROOM	0. 243142				78, 429	
53.00		ANESTHESI OLOGY	9. 716338			0	7, 316	l
54.00		RADI OLOGY-DI AGNOSTI C	0. 125375			0	1, 677, 202	
60.00		LABORATORY	0. 152040	4, 243, 245	0	0	645, 143	60.00
65.00	06500	RESPI RATORY THERAPY	0. 235134	1, 518, 324	0	0	357, 010	65. 00
66.00	06600	PHYSI CAL THERAPY	0. 422243	5, 821	0	0	2, 458	66. 00
67.00	06700	OCCUPATIONAL THERAPY	0. 371180	3, 548	0	0	1, 317	67. 00
68. 00	06800	SPEECH PATHOLOGY	0. 515563	67, 361	0	0	34, 729	68. 00
68. 01	06801	OCCUPATIONAL HEALTH	0. 000000	0	0	0	0	68. 01
69. 00	06900	ELECTROCARDI OLOGY	0. 107457	4, 045, 448	0	0	434, 712	69. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 760024	833, 765	0	0	633, 681	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENT	0. 384891	399, 998	0	0	153, 956	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0. 212023	12, 996, 732	258	29, 629	2, 755, 606	73. 00
76.00	03020	CARDI AC	0. 000000	0	0	0	0	76. 00
76. 01	03160	CARDI OPULMONARY	0. 706311	92, 204	0	0	65, 125	76. 01
		TIENT SERVICE COST CENTERS						
88. 00		RURAL HEALTH CLINIC	0. 000000				0	88. 00
90.00	09000	CLINIC	0. 000000	0	0	0	0	90. 00
90. 01	09001	WOUND CLINIC	0. 270414	2, 619, 971	0	0	708, 477	90. 01
90. 02	09002	DIABETES CLINIC	0. 893237	53	0	0	47	90. 02
90. 03	09003	ASTHMA CLINIC	0. 000000	0	0	0	0	90. 03
90. 04	09004	ANDIS CLINIC	4. 789545	3, 354	0	0	16, 064	90. 04
90. 05	09005	PRIME TIME	0. 343466	20, 028	0	0	6, 879	90. 05
90.06	09006	SHELBYVILLE WOUND CLINIC	0. 246734	327, 352	0	0	80, 769	90.06
90. 07	04951	ONCOLOGY	0. 596401	471, 755	0	0	281, 355	90. 07
90. 08	04950	ANDERSON WOMENS CENTER	0. 127481	687	0	0	88	90. 08
91.00	09100	EMERGENCY	0. 208717	4, 960, 858	0	0	1, 035, 415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0. 926186	1, 522, 375	0	0	1, 410, 002	92. 00
200.00)	Subtotal (see instructions)		49, 933, 370	258	29, 629	11, 486, 476	200. 00
201.00)	Less PBP Clinic Lab. Services-Program			0	0		201. 00
		Only Charges						
202.00)	Net Charges (line 200 +/- line 201)		49, 933, 370	258	29, 629	11, 486, 476	202. 00

 Heal th Financial
 Systems
 HANCOCK
 REGIO

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 HANCOCK REGIONAL HOSPITAL Provider CCN: 150037

| Period: | Worksheet D | From 01/01/2015 | Part V | Date/Time Prepared: | 5/26/2016 2:22 pm

Cost Cost Cost Cost Cost Cost Cost Relimbursed Services Subject To Ded & Coins (See inst.) Cost Relimbursed Services Subject To Ded & Coins (See inst.) Cost Relimbursed Services Subject To Ded & Coins (See inst.) Cost Relimbursed Services Subject To Ded & Coins (See inst.) Cost Relimbursed Services Servic							5/26/2016 2: 2	2 pm
Cost Center Description					e XVIII	Hospi tal	PPS	
Reinbursed Services Subject To Ded. & Coln Services Subject To Ded. & Coln Services Sevices Sevi								
Servi ces Not Subject To Ded. & Coi ns. (see i nst.) Ded. & Coi ns. (see i nst.)		Cost Center Description	Cost					
Subject To Ded & Coins								
Ded. & Coins. (see inst.)								
See inst. See								
ANCILLARY SERVICE COST CENTERS								
ANCI LLARY SERVICE COST CENTERS 50.00			(see inst.)					
50. 00 05000 OPERATI NG ROOM 0 0 0 0 51. 00			6. 00	7. 00				
51.00 05100 RECOVERY ROOM 0 0 0 0 0 53.00 S3.00 S3.00 S3.00 S3.00 S3.00 S3.00 S4.00 S4								
53. 00 05300 ANESTHESI OLOGY 0 0 0 54. 00 54. 00 54. 00 65. 00 65. 00 65. 00 65. 00 66. 00 6	50.00		0	0				
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 0 0 0 0 0 0 0 0	51.00	05100 RECOVERY ROOM	0	0				51.00
60. 00 6000 LABORATORY 0 0 0 65.00 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 0 65.00 RESPI RATORY THERAPY 0 0 0 0 66.00 0 66.00 0 66.00 PHYSI CAL THERAPY 0 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 0 66.00 PHYSI CAL THERAPY 0 0 0 0 0 68.00 SPEECH PATHOLOGY 0 0 0 0 68.00 SPEECH PATHOLOGY 0 0 0 0 68.00 SPEECH PATHOLOGY 0 0 0 68.01 OCCUPATI ONAL HEALTH 0 0 0 0 68.01 OCCUPATI ONAL HEALTH 0 0 0 0 68.01 OCCUPATI ONAL HEALTH 0 0 0 0 0 69.00 ELECTROCARDI OLOGY 0 0 0 0 0 0 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72.00 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 IMPL. DEV. CHARGED TO PATI ENTS 55 6, 282 73.00 73.00 DRUGS CHARGED TO PATI ENTS 55 6, 282 73.00 76.01 0 3020 CARDI AC 0 0 0 0 76.01 76.01 0 0 0 76.01 0 0 0 0 76.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	53.00	05300 ANESTHESI OLOGY	0	0				53.00
65. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY	0	0				60.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0	65.00	06500 RESPIRATORY THERAPY	0	0				65. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0			0	0				
68. 00 06800 SPEECH PATHOLOGY 0 0 0 68. 00 68. 01 06801 0CCUPATI ONAL HEALTH 0 0 0 0 68. 01 690. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 771. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 772. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 55 6, 282 73. 00 07300 DRUGS CHARGED TO PATI ENTS 55 6, 282 73. 00 07300 DRUGS CHARGED TO PATI ENTS 55 6, 282 73. 00 074. 00 074. 00 074. 00 075. 00			0	0				
68. 01 06801 0CCUPATI ONAL HEALTH 0 0 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 55 6, 282 73. 00 76. 00 03020 CARDI AC 0 0 0 76. 00 76. 01 03160 CARDI OPULMONARY 0 0 0 76. 01 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 90. 01 90. 01 09001 WOUND CLINI C 0 0 0 90. 01 90. 01 09001 WOUND CLINI C 0 0 0 90. 01 90. 02 09002 DI ABETES CLINI C 0 0 0 90. 02 90. 03 09003 ASTHMA CLINI C 0 0 0 90. 03 90. 04 09004 ANDIS CLINI C 0 0 0 90. 03 90. 05 09005 PRI ME TIME 0 0 0 0 90. 05 90. 06 09006 SHELBYVI LLE WOUND CLINI C 0 0 0 90. 05 90. 07 04951 0NCOLOGY 0 0 0 90. 08 91. 00 09100 EMERGENCY 0 0 0 0 90. 08			0	0				
69. 00			0	0				
71. 00		1 1	0	ĺ				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0			0	0				
73. 00			0	_	1			
76. 00			55	-				
76. 01 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		1			
SECTION SERVICE COST CENTERS			0					
88. 00	70.01		U	0				70.01
90. 00	88 00		0	0				88 00
90. 01			0		•			
90. 02				0				
90. 03			0	0				
90. 04 09004 ANDIS CLINIC 0 0 0 90. 04 90. 05 90. 05 90. 06 09005 PRIME TIME 0 0 0 0 90. 05 90. 06 90. 07 04951 0NCOLOGY 0 0 0 0 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0 0 0 90. 08 91. 00 0 91. 00 0 91. 00 91. 00 91. 00 0 0 0 0 0 0 0 0 0			0	0				
90. 05			0	0				1
90. 06 09006 SHELBYVILLE WOUND CLINIC 0 0 90. 06 90. 07 04951 0NCOLOGY 0 0 0 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0 0 0 90. 08 91. 00 9			0	0				1
90. 07 04951 ONCOLOGY 0 0 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0 0 91. 00			0	0				
90. 08 04950 ANDERSON WOMENS CENTER 0 0 0 91. 00 91. 00 91. 00 91. 00 91. 00			0	0				
91. 00 09100 EMERGENCY 0 0 91. 00			0	0				
			0	0				
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00			0	0				
			0		1			
200.00 Subtotal (see instructions) 55 6,282 200.00			55	6, 282				1
201.00 Less PBP Clinic Lab. Services-Program 0 201.00	201.00		0					201. 00
Only Charges								
202.00 Net Charges (line 200 +/- line 201) 55 6,282 202.00	202.00	Net Charges (line 200 +/- line 201)	55	6, 282				J202. 00

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10								
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150037	Peri od:	Worksheet D	2552-10		
		Component	t CCN: 15S037	From 01/01/2015 To 12/31/2015	Part II Date/Time Pre 5/26/2016 2:2	pared: 2 pm		
		Ti tl	e XVIII	Subprovi der - PPS I PF				
Cost Center Description	Capi tal	Total Charges			Capital Costs			
		(from Wkst. C,		Program	(column 3 x			
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)			
	Part II, col.	8)	2)					
	26)			4.00				
ANOLLI ADV. CEDVI OF COCT. OFNITEDO	1. 00	2.00	3. 00	4. 00	5. 00			
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	/0/ /70	15 (20 010	0. 04393	37 22, 548	991	FO 00		
	686, 679					50.00		
51. 00 05100 RECOVERY ROOM	56, 332				59	51.00		
53. 00 05300 ANESTHESI OLOGY	1, 051				2	53.00		
54. 00 05400 RADI OLOGY - DI AGNOSTI C	663, 789				1, 503	54.00		
60. 00 06000 LABORATORY	197, 204				2, 284	60.00		
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	77, 205					65. 00 66. 00		
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	110, 612 4, 832		1		1, 120 348			
68.00 06800 SPEECH PATHOLOGY	2, 838					68.00		
68. 01 06800 SPEECH PATHOLOGY 68. 01 06801 0CCUPATI ONAL HEALTH	2,030	1	1		0	68. 01		
69. 00 06900 ELECTROCARDI OLOGY	194, 801					•		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	183, 001	5, 484, 400	1		1, 808			
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 343				1, 808	1		
73. 00 07300 DRUGS CHARGED TO PATIENTS	115, 879				1, 081	•		
76. 00 03020 CARDI AC	113, 679	1	i		0	•		
76. 01 03160 CARDI OPULMONARY	54, 618				0			
OUTPATIENT SERVICE COST CENTERS	34,010	317,010	0.17220	0		70.01		
88. 00 08800 RURAL HEALTH CLINIC	2, 334	354, 794	0.00657	78 0	0	88. 00		
90. 00 09000 CLI NI C	0		1		Ö	90.00		
90. 01 09001 WOUND CLI NI C	79, 123	1	1		13	90. 01		
90. 02 09002 DI ABETES CLI NI C	861	76, 281			0	ł		
90. 03 09003 ASTHMA CLINIC	0	1	1		0	•		
90. 04 09004 ANDIS CLINIC	61, 967	49, 336			0	90. 04		
90. 05 09005 PRIME TIME	774				0	90. 05		
90.06 09006 SHELBYVILLE WOUND CLINIC	3, 005				0	90.06		
90. 07 04951 ONCOLOGY	337, 325		1		0	90. 07		
90. 08 04950 ANDERSON WOMENS CENTER	4, 873	3, 162, 063	0. 00154	1, 457	2	90. 08		
91. 00 09100 EMERGENCY	582, 536				1, 319	91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 662, 747	0.00000	00	0	92. 00		
200.00 Total (lines 50-199)	3, 438, 982	231, 560, 183		1, 400, 804	12, 483	200. 00		

	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	HANCOCK REGION		CCN: 150037	Peri od:	w of Form CMS-: Worksheet D	2552-10
	TUNMENT OF INPATTENT/OUTPATTENT ANCILLARY SEI H COSTS	RVICE UTHER PASS	Provi der	CCN: 150037	From 01/01/2015		
TTIKOOC	11 00313		Componen	t CCN: 15SO37	To 12/31/2015	Date/Time Pre	pared:
			Ti +I	e XVIII	Subprovi der -	5/26/2016 2: 2 PPS	2 pm
			11 (1	e xviii	I PF	FF3	
	Cost Center Description	Non Physician N	lursing School	Allied Heal		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
		1, 00	2.00	3.00	4. 00	4) 5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATI NG ROOM	0	C		0 0	0	50.00
51.00	05100 RECOVERY ROOM	o	C		0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	o	C		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	C	209, 2	22 0	209, 222	54.00
60.00	06000 LABORATORY	0	C		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	C		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	C		0	0	
68. 01	06801 OCCUPATI ONAL HEALTH	0	C		0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	()	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(2	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	()	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(0 0	0	
76. 00 76. 01	03020 CARDI AC 03160 CARDI OPULMONARY	0	((0 0	0	
76.01	OUTPATIENT SERVICE COST CENTERS	J U		ή	0	0	76.01
88. 00	08800 RURAL HEALTH CLINIC	O	C		0 0	0	88. 00
90.00	09000 CLINIC		(1	0	o o	
90. 01	09001 WOUND CLINIC	ol	C		0	Ō	
90. 02	09002 DI ABETES CLINIC	o	C		0 0	0	1
90. 03	09003 ASTHMA CLINIC	o	C		0 0	0	90. 03
90.04	09004 ANDIS CLINIC	o	C		0	0	90. 04
90.05	09005 PRIME TIME	o	C		0	0	90. 05
90.06	09006 SHELBYVILLE WOUND CLINIC	0	C		0 0	0	90. 06
90. 07	04951 ONCOLOGY	0	C		0 0	0	90. 07
90. 08	04950 ANDERSON WOMENS CENTER	0	C)	0 0	0	
91.00	09100 EMERGENCY	0	C)	0	0	
92. 00 200. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 0	0	
	Total (lines 50-199)	ı 01	(209, 2	22 0	209, 222	1200 00

Hool th Fir	nancial Systems	HANCOCK REGIO	NAL HOSDI TAL		ln lio	eu of Form CMS-2	DEE2 10
	IMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF		S Provi der		Period: From 01/01/2015	Worksheet D Part IV	
			Componen	t CCN: 15S037	To 12/31/2015	Date/Time Prep 5/26/2016 2: 2:	pared: 2 pm
			Ti tl	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Total	Total Charges	Dotio of Cos	I PF t Outpatient	Inpati ent	
	Cost Center Description	Outpatient	(from Wkst. C,		Ratio of Cost		
		Cost (sum of		(col. 5 ÷ col		Charges	
		col . 2, 3 and	8)	7)	(col . 6 ÷ col .	onal ges	
		4)		'	7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
ANG	CILLARY SERVICE COST CENTERS			•	<u>'</u>		
50.00 050	OOO OPERATING ROOM	0	15, 628, 810	0.00000	0. 000000	22, 548	50.00
51.00 05	100 RECOVERY ROOM	0	2, 206, 489	0.00000	0. 000000	2, 295	51.00
53.00 053	300 ANESTHESI OLOGY	0	16, 911	0.00000	0. 000000	37	53.00
	400 RADI OLOGY-DI AGNOSTI C	209, 222	50, 403, 655				54.00
	000 LABORATORY	0					
	500 RESPIRATORY THERAPY	0	.,,				
	600 PHYSI CAL THERAPY	0	., ,				66. 00
	700 OCCUPATI ONAL THERAPY	0					
	800 SPEECH PATHOLOGY	0	,				68. 00
	801 OCCUPATIONAL HEALTH	0	1	1 0.0000			68. 01
	900 ELECTROCARDI OLOGY	0	, ,				
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 484, 400				71.00
	200 I MPL. DEV. CHARGED TO PATIENT	0	.,,				
	300 DRUGS CHARGED TO PATIENTS	0	, ,				
	020 CARDI AC	0		1 0.0000			76. 00
	160 CARDIOPULMONARY TPATIENT SERVICE COST CENTERS	0	317, 016	0.00000	0. 000000	0	76. 01
	800 RURAL HEALTH CLINIC	T 0	354, 794	0.00000	0. 000000	0	88. 00
	000 CLINIC			1			90.00
	DOT WOUND CLINIC	0		1			90.00
	002 DIABETES CLINIC	0		1			90.01
	003 ASTHMA CLINIC	0	70, 201	1			90.02
	004 ANDIS CLINIC	0	49, 336	1			90.04
	005 PRIME TIME	0					90.05
	006 SHELBYVILLE WOUND CLINIC	0					90.06
	951 ONCOLOGY	0					90. 07
	950 ANDERSON WOMENS CENTER	0		•			90. 08
	100 EMERGENCY	0					
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0		•			92.00
200. 00	Total (lines 50-199)	209, 222	231, 560, 183	3		1, 400, 804	200. 00

Health Financial Systems	HANCOCK REGIONAL H	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150037	Peri od: From 01/01/2015	Worksheet D
THROUGH COSTS		Component CCN: 15SO37		
		Title XVIII	Subprovi der -	PPS

			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent	IFI		
	oost conter bescription	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	9	Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0		50.00
51.00	05100 RECOVERY ROOM	0	C		0		51.00
53.00	05300 ANESTHESI OLOGY	0	C		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	474	C		0		54.00
60.00	06000 LABORATORY	0	C		0		60.00
65.00	06500 RESPI RATORY THERAPY	0	C)	0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	C)	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	C)	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C)	0		68. 00
	06801 OCCUPATI ONAL HEALTH	0	C)	0		68. 01
	06900 ELECTROCARDI OLOGY	0	C)	0		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	C)	0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	C)	0		73. 00
76. 00	03020 CARDI AC	0	C	1	0		76. 00
76. 01	03160 CARDI OPULMONARY	0)	0		76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	C	1	0		88. 00
90. 00	09000 CLI NI C	0	C)	0		90. 00
	09001 WOUND CLINIC	0	()	0		90. 01
	09002 DI ABETES CLINI C	0	(0		90. 02
	09003 ASTHMA CLINIC	0	()	0		90. 03
	09004 ANDIS CLINIC	0	()	0		90. 04
	09005 PRIME TIME	0	()	0		90. 05
	09006 SHELBYVILLE WOUND CLINIC	0	(2	0		90.06
	04951 ONCOLOGY	0	(<u>'</u>	U		90. 07
	04950 ANDERSON WOMENS CENTER	0	(2	O		90. 08
91.00	09100 EMERGENCY	0	(<u>'</u>	U		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(<u>'</u>	U		92.00
200.00	Total (lines 50-199)	474	C	기	이		200. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL In Lieu			of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN	From 01	/01/2015		
		To 12.		Date/Time Prep 5/26/2016 2: 2:	
	Title XV	/III Hosp	oi tal	PPS	
Cook Cooker December 1					

		Title XVIII	Hospi tal	PPS	2 piii	
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS					
4 00	I NPATI ENT DAYS		T	E 444	4 00	
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be	9 ,		5, 446 5, 446	1. 00 2. 00	
3.00						
	do not complete this line.	, j j p			3. 00	
4.00	Semi-private room days (excluding swing-bed and observation bed		- 24 -6	3, 348	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through becembe	r 31 or the cost	0	5. 00	
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00	
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	dave) through Docombor	21 of the cost	0	7. 00	
7.00	reporting period	uays) tili ougii becellibei	31 of the cost	١	7.00	
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-hed and	1, 237	9. 00	
7. 00	newborn days)	the frogram (exeruating	Swifing bed dild	1, 237	7. 00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10. 00	
11. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		oom davs) after	0	11. 00	
	December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00	
	after December 31 of the cost reporting period (if calendar yea			_		
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	14. 00 15. 00	
16. 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 services reporting period	through December 31 o	f the cost	0. 00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00	
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00	
21. 00	reporting period Total general inpatient routine service cost (see instructions)			6, 401, 779	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	a ported (Line 4	0	23. 00	
23.00	x line 18)	i or the cost reporting	g perrou (Trile 6		23.00	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00	
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	neriod (line 8	0	25. 00	
20.00	x line 20)	or the cost reporting	perrod (rriie o		20.00	
26. 00	Total swing-bed cost (see instructions)	. 04 . 1. 07)		0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus iine 26)		6, 401, 779	27. 00	
28. 00		and observation bed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)	Line 20)		0. 000000	30. 00 31. 00	
32.00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	111le 20)		0.00000	32.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00	
34. 00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0. 00	34. 00	
35. 00	Average per diem private room cost differential (line 34 x line		,	0.00	35. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	ŕ		0	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	6, 401, 779	37. 00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 175. 50	38. 00	
39. 00					39. 00	
40. 00					40. 00	
41. 00	.00 Total Program general inpatient routine service cost (line 39 + line 40)					

Heal th	Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				Peri od:	Worksheet D-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
			T: +1	e XVIII	Hospi tal	5/26/2016 2: 22 PPS	2 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	'	Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)		21.00	0.00		0.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	7 420 007	F 220	1 420 2	2 4//	2 502 410	42.00
43. 00 44. 00	INTENSIVE CARE UNIT	7, 428, 086	5, 230	1, 420. 2	2, 466	3, 502, 410	43. 00 44. 00
45. 00							45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			one)		6, 114, 202 11, 070, 706	48. 00 49. 00
49.00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 46) (see mstructio	JIIS)		11,070,708	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sum	of Parts I and	466, 288	50.00
51. 00	<pre> </pre>	atient ancillar	v services (fr	rom Wkst D s	um of Parts II	320, 979	51. 00
01.00	and IV)	atront anorra	y 301 V1 003 (11	om mor. b, s	am or rares in	020, 777	01.00
52. 00	Total Program excludable cost (sum of lines					787, 267	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-pny	ysician anestn	etist, and	10, 283, 439	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	- ,					
54. 00 55. 00	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	56. 00
57. 00	,	ing cost and ta	arget amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	ending 1996 ı	indated and co	mnounded by the	0.00	58. 00 59. 00
37.00	market basket	por tring perrou	enaring 1770, t	apuateu anu co	ilipourided by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the emount by	0.00	60.00
61. 00	which operating costs (line 53) are less than					U	61. 00
	amount (line 56), otherwise enter zero (see				. .	0	
62. 00 63. 00	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST						03.00
64. 00	64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	per 31 of the o	cost reporting	period (See	o	65. 00
	instructions) (title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19)						68. 00
00.00	OD Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						00.00
69. 00	Total title V or XIX swing-bed NF inpatient		`			0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil		•				70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (I					71. 00
72. 00 73. 00	, ,						72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from V	Worksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	,					77. 00
78. 00 79. 00							78. 00 79. 00
80.00							80. 00
81.00	On Inpatient routine service cost per diem limitation						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (· .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		-/				84.00
85.00	Utilization review - physician compensation						85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ıı ouyıı 85)				86. 00
87. 00	Total observation bed days (see instructions)				2, 098	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 175. 50 2, 466, 199	
57.00	10000. Validit bod cost (Title of A Title oo) (Se	o motruoti uis)				2, 700, 199	57.00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	644, 122	6, 401, 779	0. 10061	6 2, 466, 199	248, 139	90.00
91.00 Nursing School cost	0	6, 401, 779	0.00000	2, 466, 199	0	91.00
92.00 Allied health cost	0	6, 401, 779	0.00000	2, 466, 199	0	92.00
93.00 All other Medical Education	0	6, 401, 779	0.00000	2, 466, 199	0	93.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150037		Worksheet D-1
	Component CCN: 15SO3	From 01/01/2015 To 12/31/2015	Date/Time Prepared: 5/26/2016 2:22 pm
	Title XVIII	Subprovider -	PPS

		II LIE AVIII	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			2, 610	
2.00	Inpatient days (including private room days, excluding swing-be			2, 610	
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.). IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		2, 610	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5.00
4 00	reporting period	daya) after Dagambar ()1 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember s	or the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 562	9. 00
7. 00	newborn days)	the riegiam (exerauring	oming bod and	2, 332	7. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		om days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enti-	er 0 on this line)	Join days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13. 00
14. 00	Medically necessary private room days applicable to the Program	-	, I	0	14. 00
15. 00	Total nursery days (title V or XIX only)	. 5 5	,	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 services	through Docombor 21 of	the cost	0.00	17. 00
17.00	reporting period	till odgir becelliber 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	the cost	0. 00	18. 00
10.00	reporting period			0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	inrough becember 31 or	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost reporti	ng poriod (line	2, 356, 681 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	ng perrod (Trie	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reportino	period (line 6	0	23.00
04.00	x line 18)				04.00
24. 00	Swing-bed cost applicable to NF type services through December 17 x line 19)	31 of the cost reportir	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	no 21 minuo lino 24)		0	
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus iine 20)		2, 356, 681	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	ine 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruct	i ons)	0.00	
35.00	Average per diem private room cost differential (line 34 x line	31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and 27 minus line 36)	d private room cost dit	Terential (line	2, 356, 681	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				
38. 00	Adjusted general inpatient routine service cost per diem (see in	*		902. 94	
39. 00	Program general inpatient routine service cost (line 9 x line 3: Medically necessary private room cost applicable to the Program			2, 313, 332 0	39. 00 40. 00
40. 00 41. 00	Total Program general inpatient routine service cost (line 39 +	•		2, 313, 332	
00	1	,	1	_, 0.0, 002	50

	Financial Systems	HANCOCK REGIONA			In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST			F	eriod: rom 01/01/2015	Worksheet D-1	
					o 12/31/2015	5/26/2016 2: 2	
			liti		Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+; +Lo V & VLV only)	1.00	2.00	3.00	4. 00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00 44. 00
45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Lino 200)			1. 00 325, 941	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		2, 639, 273	
50. 00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sum	of Parts I and	192, 919	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (fr	rom Wkst. D, su	m of Parts II	12, 957	51. 00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				205, 876	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anesthe	tist, and	2, 433, 397	53. 00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0. 00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus l	ine 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	S			ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period e	enaing 1996, u	ipdated and com	pounded by the	0. 00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				he amount by	0. 00 0	60. 00 61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos			cost reportin	a period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	Ü		·		0	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi				,	0	
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin		•			0	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	9		•	0 .	0	
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient			•	triig perrod	0	
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID	ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service contents.						70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)		•			72. 00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	•	,		rt II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	,		1-3			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.				s line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on			ŕ		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (,					82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	- <i>'</i>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)				87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00

Health Financial Systems	ealth Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of F					2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2015 To 12/31/2015	Date/Time Prep 5/26/2016 2: 2:	
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	196, 528	2, 356, 681	0. 08339	2 0	0	90.00
91.00 Nursing School cost	0	2, 356, 681	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 356, 681	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 356, 681	0.00000	0 0	0	93. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150037	From 01/01/2015	
		To 12/31/2015	Date/Time Prepared: 5/26/2016 2:22 pm
	Title XIX	Hospi tal	Cost
Cost Center Description			

-		Title XIX	Hospi tal	5/26/2016 2: 2 Cost	2 pm
	Cost Center Description	TITLE XIX	nospi tai	COST	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newhorn)		5, 446	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			5, 446	
3. 00	Private room days (excluding swing-bed and observation bed days		vate room days,	0	3. 00
	do not complete this line.	3 1	, ,		
4.00	Semi-private room days (excluding swing-bed and observation bed			3, 348	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	131 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December (21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) at tel becember .	of the cost		0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3°	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (eveluding	swing had and	177	9. 00
9.00	newborn days)	the Program (excluding	Swifig-bed and	177	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private ro	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruction	ons)	3 ,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
12 00	December 31 of the cost reporting period (if calendar year, ent		a maam daya)	0	12. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (flictually private	e 100iii uays)	U	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	f the cost	0.00	17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
10.00	reporting period	through Docombon 21 of	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	till ought beceiliber 31 of	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)	21 of the cost reports	ng poriod (line	6, 401, 779	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reportion	ng period (line	0	24. 00
25. 00	X Time 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perrod (Trie o	, and the second se	20.00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		6, 401, 779	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation had ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed ch	ii ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	s line 22)(see instruc	tions)	0.00	•
35. 00	Average per diem private room cost differential (line 34 x line	, ,	ti ons)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	3.7		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	6, 401, 779	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	FMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST Adjusted general inpatient routine service cost per diem (see i			1, 175. 50	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1	-		208, 064	
40. 00	Medically necessary private room cost applicable to the Program	•		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		208, 064	41. 00

	Financial Systems	HANCOCK REGIONA		00N 450005		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150037	Peri od: From 01/01/2015	Worksheet D-1	
					To 12/31/2015	Date/Time Pre 5/26/2016 2:2	pared: 2 pm
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		·		col . 2)		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 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	7, 428, 086	5, 230	1, 420. 2	28 0	0	43.00
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	
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			une)		183, 357 391, 421	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 40) (s	see mstructro	1115)		371, 421	49.00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	ı Wkst. D, sur	n of Parts I and	0	50.00
51. 00		atient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	0	51.00
	and IV)		•			_	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-phy	rsician anesth	netist and	0	
00.00	medical education costs (line 49 minus line] 00.00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55. 00
	Target amount (line 54 x line 55)				50)		56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	rget amount (i	ine 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	endi ng 1996, ເ	pdated and co	ompounded by the		59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report upo	dated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 e	enter the less	er of 50% of		0	1
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	f the target		
62. 00	Relief payment (see instructions)	111311 4011 0113)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Necembe	or 31 of the c	ost reporting	n nerind (See	0	65. 00
	instructions)(title XVIII only)			,		0	03.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
40 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs often Do	scombor 21 of	the cost rone	orting poriod	0	40.00
00.00	(line 13 x line 20)	e costs after be	ecember 31 01	the cost repo	ortring perrod	U	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				<u> </u>		70.00
71. 00	Adjusted general inpatient routine service c	ost per diem (li					71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72. 00 73. 00
	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (from W	orksheet B, F	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line	,					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi der record	ls)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the co		•	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (,					83. 00
84.00	Program inpatient ancillary services (see in		ne)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	<i>,</i>				
87. 00	Total observation bed days (see instructions	•	0			2, 098	
88. 00	Adjusted general inpatient routine cost per	alem (line 2/ ÷	line 2)			1, 175. 50	1 88. ()()

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	644, 122	6, 401, 779	0. 10061	6 2, 466, 199	248, 139	90.00
91.00 Nursing School cost	0	6, 401, 779	0.00000	0 2, 466, 199	0	91.00
92.00 Allied health cost	0	6, 401, 779	0.00000	0 2, 466, 199	0	92.00
93.00 All other Medical Education	0	6, 401, 779	0.00000	0 2, 466, 199	0	93.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
			From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
				5/26/2016 2: 2	2 pm
0 1 0 1 0 1	litl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost To Charges	t Inpatient Program	Inpatient Program Costs	
		To charges	Charges	(col. 1 x col.	
			charges	2)	
		1, 00	2, 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•		
30. 00 03000 ADULTS & PEDIATRICS			927, 404		30. 00
31.00 03100 INTENSIVE CARE UNIT			4, 840, 942		31. 00
40. 00 04000 SUBPROVI DER - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 52421		1, 272, 585	
51. 00 05100 RECOVERY ROOM		0. 24314	•		51.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		9. 71633 0. 12537			
60. 00 06000 LABORATORY		0. 12537			60.00
65. 00 06500 RESPI RATORY THERAPY		0. 13204			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 42224		182, 074	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37118		89, 767	67. 00
68.00 06800 SPEECH PATHOLOGY		0. 51556		36, 009	68. 00
68. 01 06801 OCCUPATI ONAL HEALTH		0. 00000	0 0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY		0. 10745	7 1, 486, 368	159, 721	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 76002		682, 191	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 38489		1, 063, 836	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 21202		909, 830	
76. 00 03020 CARDI AC		0. 00000		0	76. 00
76. 01 03160 CARDI OPULMONARY		0. 70631	1 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS		0.00000		0	00.00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC		0. 00000 0. 00000		0	88. 00 90. 00
90. 01 09001 WOUND CLINIC		0. 00000		902	90.00
90. 02 09002 DI ABETES CLI NI C		0. 27041	•	0	90.01
90. 03 09003 ASTHMA CLI NI C		0.00000		0	90. 02
90. 04 09004 ANDIS CLINIC		4. 78954		Ö	90. 04
90. 05 09005 PRIME TIME		0. 34346		16	90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC		0. 24673		0	
90. 07 04951 0NC0L0GY		0. 59640	1 1.314	784	90. 07

0. 246734 0. 596401

0. 127481

0.208717

0. 926186

1, 314

5, 507

231

2, 205, 964

22, 307, 438

22, 307, 438

90. 06 90. 07 0

90.08

91.00

92.00

201. 00

202. 00

784

702

214

6, 114, 202 200. 00

460, 422

04951 ONCOLOGY

91. 00 09100 EMERGENCY

04950 ANDERSON WOMENS CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

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

90.07

90.08

201.00

202.00

	Financial Systems HANCOCK REGIONAL HOS		0011 450007		eu of Form CMS-	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	rovi der	CCN: 150037	Period: From 01/01/2015	Worksheet D-3	
	C	omponent	t CCN: 15SO37	To 12/31/2015		pared: 2 pm
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		T			
30.00	03000 ADULTS & PEDI ATRI CS				1	30.00
31.00	03100 INTENSIVE CARE UNIT			0 407 ((1	31.00
40.00	04000 SUBPROVI DER - I PF			3, 137, 669		40.00
41. 00	04100 SUBPROVIDER - I RF				η	41. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0. 5242	19 22, 548	11, 820	50.00
51. 00	05100 RECOVERY ROOM		0. 3242		1	1
53.00	05300 ANESTHESI OLOGY		9. 7163		1	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1253		1	1
60.00	06000 LABORATORY		0. 1233		l	1
65. 00	06500 RESPI RATORY THERAPY		0. 1320			1
66. 00	06600 PHYSI CAL THERAPY		0. 4222		l	1
67. 00	06700 OCCUPATI ONAL THERAPY		0. 3711			
68. 00	06800 SPEECH PATHOLOGY		0. 5155	1		
68. 01	06801 OCCUPATI ONAL HEALTH		0.0000		0	1
69.00	06900 ELECTROCARDI OLOGY		0. 1074		2, 102	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7600		l	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 3848			1
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 2120	23 411, 557	87, 260	73. 00
76.00	03020 CARDI AC		0.0000	00	0	76. 00
76. 01	03160 CARDI OPULMONARY		0. 7063	11 (0	76. 01
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 00
90.00	09000 CLI NI C		0.0000			
90. 01	09001 WOUND CLINIC		0. 2704		1	1
90. 02	09002 DI ABETES CLINI C		0. 8932			1
90. 03	09003 ASTHMA CLINIC		0.0000		1	
90. 04	09004 ANDIS CLINIC		4. 7895		0	
90. 05	09005 PRI ME_TI ME_		0. 3434		2	1
90.06	09006 SHELBYVILLE WOUND CLINIC		0. 2467		0	
90. 07	04951 ONCOLOGY		0. 5964		ή	
90.08	04950 ANDERSON WOMENS CENTER		0. 1274		1	1
91.00	09100 EMERGENCY		0. 2087		1	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9261		0	
200.00	Total (sum of lines 50-94 and 96-98)	no 41)		1, 400, 804	325, 941	1
201.00	Less PBP Clinic Laboratory Services-Program only charges (li	ne 01)		1 400 904	í	201. 00 202. 00
202. 00	Net Charges (line 200 minus line 201)		I	1, 400, 804	1	1202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150037	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Pre 5/26/2016 2:2	pared:
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1. 00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			311, 107		30.00
31. 00 03100 NTENSI VE CARE UNI T			99, 558		31.00
40. 00 04000 SUBPROVI DER - PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 52421	99, 514	52, 167	50.00
51. 00 05100 RECOVERY ROOM		0. 24314	12 14, 349	3, 489	51.00
53. 00 05300 ANESTHESI OLOGY		9. 71633	38 628	6, 102	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12537	75 51, 618	6, 472	54.00
60. 00 06000 LABORATORY		0. 15204		15, 814	
65. 00 06500 RESPI RATORY THERAPY		0. 23513		9, 080	
66. 00 06600 PHYSI CAL THERAPY		0. 42224		1, 408	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37118		591	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 51556		446	68. 00
68. 01 06801 0CCUPATI ONAL HEALTH		0.00000		0	68. 01
69. 00 06900 ELECTROCARDI OLOGY		0. 10745		3, 476	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 76002		40, 870	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 38489 0. 21202		0 34, 175	72. 00 73. 00
73. 00 07300 DROGS CHARGED TO PATTENTS 76. 00 03020 CARDI AC				34, 175	76.00
76. 00 03020 CARDI AC 76. 01 03160 CARDI OPULMONARY		0. 00000 0. 70631		0	76.00
OUTPATIENT SERVICE COST CENTERS		0. 7003	11 0	U	76.01
88. 00 08800 RURAL HEALTH CLINIC		0. 95398	37 0	0	88. 00
90. 00 09000 CLI NI C		0. 00000		0	90.00
90. 01 09001 WOUND CLINIC		0. 27041		0	90.01
90. 02 09002 DI ABETES CLINI C		0. 89323		0	90.02
90. 03 09003 ASTHMA CLINIC		0. 00000		0	90. 03
90. 04 09004 ANDIS CLINIC		4. 78954		0	90. 04
90. 05 09005 PRI ME TI ME		0. 34346		0	90. 05
90. 06 09006 SHELBYVILLE WOUND CLINIC		0. 24673		0	90.06
90. 07 04951 ONCOLOGY		0. 59640	245	146	90. 07
90.08 04950 ANDERSON WOMENS CENTER		0. 12748	31 0	0	90.08
91 00 09100 EMERCENCY		0 20871	17 /3 608	0 121	01 00

91.00

92.00 0 183, 357 200. 00

201. 00 202. 00

9, 121

43, 698

605, 774

0.208717

0. 926186

201.00 202.00

91. 00 09100 EMERGENCY

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

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

			T	o 12/31/2015	Date/Time Pre 5/26/2016 2:2	
		Title	e XVIII	Hospi tal	PPS	.z piii
			0	1 00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1. 00	2. 00	
1.00	DRG Amounts Other than Outlier Payments			0		1. 00
1. 01	DRG amounts other than outlier payments for discharges occurrin	g prior		6, 594, 732		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		2, 198, 244		1. 02
02	after October 1 (see instructions)	9 0 0.		2, 1, 0, 2 1 1		
1. 03	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1. 04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
1.01	discharges occurring on or after October 1 (see instructions)			Ĭ		1.01
2.00	Outlier payments for discharges. (see instructions)			56, 089		2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructio	nc)		0		2. 01 2. 02
3. 00	Managed Care Simulated Payments	115)		0		3. 00
4. 00	Bed days available divided by number of days in the cost report	i ng		55. 25		4. 00
	period (see instructions)					
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent		0.00		5. 00
5.00	cost reporting period ending on or before 12/31/1996. (see instr			0.00		3.00
6.00	FTE count for allopathic and osteopathic programs which meet th			0.00		6. 00
	criteria for an add-on to the cap for new programs in accordanc CFR 413.79(e)	e with 42				
7. 00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7. 00
	CFR §412.105(f)(1)(iv)(B)(1)					
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u			0.00		7. 01
	CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July then see instructions.	1, 2011				
8.00	Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8. 00
	osteopathic programs for affiliated programs in accordance with					
	413.75(b), 413.79(c)(2)(i v), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).	FR 50069				
8. 01	The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 2					
0.00	instructions.	o from o		0.00		0.00
8. 02	The amount of increase if the hospital was awarded FTE cap slot closed teaching hospital under section 5506 of ACA. (see instru			0.00		8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
40.00	and 8,02) (see instructions)			0.00		10.00
10. 00	FTE count for allopathic and osteopathic programs in the curren from your records	t year		0.00		10. 00
11. 00	FTE count for residents in dental and podiatric programs.			0.00		11. 00
	Current year allowable FTE (see instructions)			0.00		12. 00
13.00	Total allowable FTE count for the prior year.	andad an		0. 00 0. 00		13. 00 14. 00
14. 00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	ended on		0.00		14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00		15. 00
16.00	Adjustment for residents in initial years of the program			0.00		16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closu Adjusted rolling average FTE count	re		0. 00 0. 00		17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000		19.00
	Prior year resident to bed ratio (see instructions)			0. 000000		20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000		21. 00
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0		22. 00 22. 01
22.01	Indirect Medical Education Adjustment for the Add-on for Section	n 422 of th	he MMA			22.01
23. 00	Number of additional allopathic and osteopathic IME FTE residen			0.00		23. 00
24.00	slots under 42 Sec. 412.105 (f)(1)(iv)(C).			0.00		24.00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lo	wer of		0. 00 0. 00		24. 00 25. 00
23.00	line 23 or line 24 (see instructions)	wei oi		0.00		25.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
	IME payments adjustment factor. (see instructions)			0. 000000		27. 00 28. 00
28. 00	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0		28. 00
29. 00	Total IME payment (sum of lines 22 and 28)			o		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	ient dave		1 41		30 00
30.00	(see instructions)	rent days		1. 61		30. 00
31. 00	Percentage of Medicaid patient days (see instructions)			15. 47		31. 00
32.00	Sum of lines 30 and 31			17. 08		32.00
	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			3. 85 84, 632		33. 00 34. 00
5 1. 00	1-1 (300 Filet detroils)	I	ı	54, 652		1 0 1. 00

From 01/01/2015 Part A Date/Time Prepared: 12/31/2015 5/26/2016 2: 22 pm Title XVIII Hospi tal Prior to On/After October 1 October 1 n 1 00 2 00 Uncompensated Care Adjustment 35.00 7, 647, 644, 885 6, 406, 145, 534 Total uncompensated care amount (see instructions) 35.00 35. 01 Factor 3 (see instructions) 0.000039112 0.000038334 35.01 299, 118 Hospital uncompensated care payment (If line 34 is zero, 35.02 245, 574 35.02 enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment 61, 729 223, 724 35.03 amount (see instructions) 36.00 Total uncompensated care (sum of columns 1 and 2 on line 285, 453 36.00 35 ()3) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) Total Medicare discharges on Worksheet S-3, Part I 0 40.00 excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 41.00 0 682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding 41.01 0 41.01 MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not 42.00 0.00 42.00 qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 0 43.00 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 0.000000 44 00 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see 0.00 45.00 instructions) 46.00 Total additional payment (line 45 times line 44 times line 0 46, 00 41.01) 47 00 Subtotal (see instructions) 9, 219, 150 47 00 Hospital specific payments (to be completed by SCH and 48.00 48.00 MDH, small rural hospitals only. (see instructions) 49.00 Total payment for inpatient operating costs (see 9, 219, 150 49.00 instructions) Payment for inpatient program capital (from Wkst. L, Pt. I 50.00 50.00 704.862 and Pt. II, as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L, 51.00 0 Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4, 52.00 0 52.00 line 49 see instructions) Nursing and Allied Health Managed Care payment 53.00 53.00 2, 216 54.00 Special add-on payments for new technologies 54.00 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, 0 55.00 line 69) 56 00 Cost of physicians' services in a teaching hospital (see O 56 00 intructions) 57.00 Routine service other pass through costs (from Wkst. D, 0 57 00 Pt. III, column 9, lines 30 through 35) 58.00 Ancillary service other pass through costs from Wkst. D, 9, 924 58.00 Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) 59 00 9, 936, 152 59 00 60.00 Primary payer payments 5,001 60.00 Total amount payable for program beneficiaries (line 59 9, 931, 151 61.00 61.00 minus line 60) 62.00 Deductibles billed to program beneficiaries 1, 124, 696 62.00 Coinsurance billed to program beneficiaries 63.00 2,835 63.00 64.00 Allowable bad debts (see instructions) 58, 120 64.00 65.00 Adjusted reimbursable bad debts (see instructions) 37, 778 65.00 Allowable bad debts for dual eligible beneficiaries (see 66.00 66.00 instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 8, 841, 398 67.00 Credits received from manufacturers for replaced devices 68.00 68.00 for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 69.00 96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.00 70 00 RURAL DEMONSTRATION PROJECT 0 70.50 70.50 70.89 Pioneer ACO demonstration payment adjustment amount (see 70.89 instructions) HSP bonus payment HVBP adjustment amount (see 70.90 70.90 0 instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 0 70.91 Bundled Model 1 discount amount (see instructions) 70.92 HVBP payment adjustment amount (see instructions) 13, 781 70.93 70.93 HRR adjustment amount (see instructions) 70.94 70 94 -463 70.95 Recovery of accelerated depreciation 70.95

	Financial Systems HANCOCK REGI	DNAL H			u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT			Peri od: From 01/01/2015 To 12/31/2015		pared:
			Title XVIII	Hospi tal	PPS	
	· · · · · · · · · · · · · · · · · · ·			Prior to	On/After	
				October 1	October 1	
			0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)			0 0		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		20^	79, 747		70. 97
70. 98	Low Volume Payment-3	İ		0		70. 98
70. 99	HAC adjustment amount (see instructions)	İ		0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			8, 934, 463		71. 00
71. 01	Sequestration adjustment (see instructions)			178, 689		71. 01
72.00	Interim payments			8, 720, 167		72.00
73.00	Tentative settlement (for contractor use only)			0		73.00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			35, 607		74. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1, 399, 047		75. 00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0		90.00
91.00	Capital outlier from Wkst. L. Pt. I. line 2	İ		0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)			0		92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)			0		93. 00
94. 00	The rate used to calculate the time value of money (see instructions)			0.00		94. 00
95. 00	Time value of money for operating expenses (see instructions)			0		95. 00
96. 00	Time value of money for capital related expenses (see instructions)			0		96. 00
	Thisti dott ons)	1		Prior to 10/1	0 (16) 10(1	_

	F1101 to 10/1	UII/AI LEI TU/T	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100.00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2015 | Part A Exhibit 4 | To 12/31/2015 | Date/Time Prepared: 5/26/2016 2:22 pm Provider CCN: 150037

				Ti +1	e XVIII	Hospi tal	5/26/2016 2: 2 PPS	2 pm
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
1. 00	DRG amounts other than outlier	0 1, 00	1.00	2. 00	3.00	4. 00	5. 00	1. 00
	payments			J			_	
1. 01	DRG amounts other than outlier payments for discharges	1. 01	6, 594, 732	0	6, 594, 732	0	6, 594, 732	1. 01
	occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	2, 198, 244	0	C	2, 198, 244	2, 198, 244	1. 02
	payments for discharges occurring on or after October							
	1							
1.03	DRG for Federal specific	1. 03	0	0	C	0	0	1. 03
	operating payment for Model 4 BPCI occurring prior to							
	October 1							
1. 04	DRG for Federal specific operating payment for Model 4	1. 04	0	0	C	0	0	1. 04
	BPCI occurring on or after							
0.00	October 1	0.00	F		40.043	44.000	5, 000	0.00
2. 00	Outlier payments for discharges (see instructions)	2. 00	56, 089	0	42, 067	14, 022	56, 089	2.00
2. 01	Outlier payments for	2. 02	0	0	С	0	О	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	_	0	0	3.00
3.00	reconciliation	2.01	O	O		0		3.00
4.00	Managed care simulated	3. 00	0	0	C	0	0	4. 00
	payments Indirect Medical Education Adju	L ustment						1
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0.000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	_	0	0	6. 00
0.00	instructions)	22.00	O	O		0		0.00
6. 01	IME payment adjustment for	22. 01	0	0	C	0	0	6. 01
	managed care (see instructions)							
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see	28. 00	0	0	C	0	0	8. 00
0.01	instructions)	00.04						0.01
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	O		0	0	8. 01
	instructions)							
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	C	0	0	9. 00
9. 01	Total IME payment for managed	29. 01	0	0	C	0	0	9. 01
	care (sum of lines 6.01 and							
	8.01) Disproportionate Share Adjustme	l ent						1
10.00	Allowable disproportionate	33.00	0. 0385	0. 0385	0. 0385	0. 0385		10.00
	share percentage (see instructions)							
11.00	Di sproporti onate share	34.00	84, 632	0	63, 474	21, 158	84, 632	11.00
11. 01	adjustment (see instructions) Uncompensated care payments	36. 00	285, 453	0	214, 090	71, 363	285, 453	11 01
11.01	Additional payment for high per				214, 090	71, 303	200, 400] 11.01]
12.00	Total ESRD additional payment	46. 00	0	0	C	0	0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	9, 219, 150	0	6, 914, 363	2, 304, 787	9, 219, 150	13 00
14. 00	Hospital specific payments	48. 00	0	0	0, 711, 000	0	0	14. 00
	(completed by SCH and MDH, small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	9, 219, 150	0	6, 914, 363	2, 304, 787	9, 219, 150	15. 00
	operating costs (see instructions)							
16. 00	Payment for inpatient program	50. 00	704, 862	0	528, 647	176, 215	704, 862	16. 00
17 00	capital Special add-on payments for	E4 00		2	_	_		17 00
17. 00	new technologies	54. 00	0	Ü			0	17. 00
17. 01	Net organ aquisition cost	55.00	0	0	C	0	0	17. 01
17. 02	Credits received from manufacturers for replaced	68. 00	0	0	C	0	0	17. 02
	devices for applicable MS-DRGs							
18. 00	Capital outlier reconciliation	93. 00	0	0	C	0	0	18. 00
	adjustment amount (see instructions)							
	·	•			•	•		•

					Т	o 12/31/2015	Date/Time Pre 5/26/2016 2: 2:	
				Ti tl	e XVIII	Hospi tal	PPS	_ p
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
19.00	SUBTOTAL			0	7, 443, 010	2, 481, 002	9, 924, 012	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	703, 798	0	527, 849	175, 949	703, 798	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	C	0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	1, 064	0	798	266	1, 064	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	(0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0.0000	0. 0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0	(0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10. 00	0. 0000	0. 0000	0.0000	0. 0000		24. 00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	0	0	(0	0	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	704, 862	0	528, 647	176, 215	704, 862	26. 00
_	payments (see instructions)							
		W/S E, Part A						
		line	Part A)	0.00	0.00	4.00	F 00	
27.00	1	0	1. 00	2. 00	3.00	4. 00	5. 00	07.00
27. 00	Low volume adjustment factor				0. 000000	0. 032143	_	27. 00
28. 00	Low volume adjustment	70. 96			()	0	28. 00
	(transfer amount to Wkst. E,							
00.00	Pt. A, line)	70.07				70 747	70 747	00.00
29. 00	Low volume adjustment	70. 97				79, 747	19, 141	29. 00
	(transfer amount to Wkst. E,							
100.00	Pt. A, line)		V					100 00
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.	I			l			l

Health Financial Systems	HANCOCK REGIO	NAL H	OSPI TAL			In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		Provi der	CCN: 150037	Peri From To	n 01/01/2015	Worksheet E Part A Exhibi Date/Time Pre 5/26/2016 2:2	oared:
			Ti tl	e XVIII		Hospi tal	PPS	
	Wkst. E, Pt.	Am	t. from	Period to		Peri od on	Total (cols. 2	
	A, line	Wkst	t. E, Pt.	10/01	а	fter 10/01	and 3)	
			A)					
	0		1.00	2. 00		3. 00	4. 00	
1.00 DRG amounts other than outlier payments	1.00							1. 00

Wkst. E, Pt. Amt. from Period to after 10/01 Total (cols. 2 and 3)	1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
A O 1.00 2.00 3.00 4.00	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
1.00 DRG amounts other than outlier payments 1.00 1.00 2.00 3.00 4.00 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.01 6.594,732 0 0 0 1.02 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 2.198,244 8,792,976 8,792,976 8,792,976 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.03 0 0 0 0 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 0 0 0 0 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 0 0 0 0 1.05 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 0 0 0 0 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 0 0 0 0 0 2.00 Outlier payments for discharges (see 2.00 56,089 0 56,089 56,089 56,089 3.00 Outlier payments for discharges for Model 4 2.02 0 0 0 0 0 3.00 Operating outlier reconciliation 2.01 0 0 0 0 0 4.00 Managed care simulated payments 3.00 0 0 0 0 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, Line 21 21.00 0.000000 0.000000 0.000000 6.00 IME payment adjustment (see instructions) 22.00 0 0 0 0 IME payment adjustment for managed care (see 22.01 0 0 0 0 0 Instructions) 0 0 0 0 Instructions 0 0 0 0	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
1.00 DRG amounts other than outlier payments 1.00 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 2,198,244 8,792,976 8,792,976 8,792,976 1.03 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 O O O O O O O O O	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 2,198,244 8,792,976 8,792,976 8,792,976 1.03 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1 1.04 O O O O O O O O O	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring or or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 DRG for Federal specific operating on or after October 1 1.05 DRG for Federal specific operating payment 1.04 DRG for Federal speci	1. 02 1. 03 1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1 1.04 O	1. 03 1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see	1. 03 1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see	1. 03 1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment 1.04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see	1. 04 2. 00 2. 01 3. 00 4. 00 5. 00
1.04 DRG for Federal specific operating payment 1.04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 2. 01 3. 00 4. 00 5. 00
for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 56,089 0 56,089 56,089 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 2. 01 3. 00 4. 00 5. 00
for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 56,089 0 56,089 56,089 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 2. 01 3. 00 4. 00 5. 00
October 1 Outlier payments for discharges (see 2.00 56,089 0 56,089 56,089 instructions)	2. 01 3. 00 4. 00 5. 00
2.00 Outlier payments for discharges (see	2. 01 3. 00 4. 00 5. 00
Instructions	2. 01 3. 00 4. 00 5. 00
2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00
BPCI	3. 00 4. 00 5. 00
3.00 Operating outlier reconciliation 2.01 0 0 0 0 0 0 0 0 0	4. 00
4.00 Managed care simulated payments 3.00 0 0 0 0 0 0 0 1 ndirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, Line 21 21.00 0.000000 0.000000 0.000000 0.000000 0.000000	4. 00
Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00
5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 0.000000 0.000000	
(see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 0 0 IME payment adjustment for managed care (see instructions) 22.01 0 0 0 instructions)	
6.00 IME payment adjustment (see instructions) 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
6.01 IME payment adjustment for managed care (see 22.01 0 0 0 instructions)	
instructions)	
	6. 01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	
	4
7.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 0.000000	7. 00
instructions)	
8.00 IME adjustment (see instructions) 28.00 0 0 0	8. 00
8.01 IME payment adjustment add on for managed 28.01 0 0 0	8. 01
care (see instructions)	
9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0	9. 00
9.01 Total IME payment for managed care (sum of 29.01 0 0 0 0	9. 01
lines 6.01 and 8.01)	
Disproportionate Share Adjustment	1
10.00 Allowable disproportionate share percentage 33.00 0.0385 0.0385 0.0385	10. 00
(see instructions)	
11.00 Disproportionate share adjustment (see 34.00 84,632 0 84,632 84,632	11.00
instructions)	
11.01 Uncompensated care payments 36.00 285,453 223,724 61,729 285,453	11. 01
Additional payment for high percentage of ESRD beneficiary discharges	1
12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0	12. 00
instructions)	12.00
13.00 Subtotal (see instructions) 47.00 9,219,150 223,724 8,995,426 9,219,150	13. 00
14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0	10.00
and MDH, small rural hospitals only.) (see	14.00
instructions)	14. 00
	14. 00
15.00 Total payment for inpatient operating costs 49.00 9,219,150 223,724 8,995,426 9,219,150	
(see instructions)	15. 00
(see instructions) 16.00 Payment for inpatient program capital 50.00 704,862 796 704,066 704,862	15. 00 16. 00
(see instructions) 16.00 Payment for inpatient program capital 50.00 704,862 796 704,066 704,066 17.00 Special add-on payments for new technologies 54.00 0 0 0 0	15. 00 16. 00 17. 00
(see instructions) 16.00 Payment for inpatient program capital 50.00 704,862 796 704,066 704,066 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.01 Net organ aquisition cost 55.00 0 0 0 0	15. 00 16. 00 17. 00 17. 01
(see instructions) 16.00 Payment for inpatient program capital 50.00 704,862 796 704,066 704,066 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.01 Net organ aquisition cost 55.00 0 0 0 0 17.02 Credits received from manufacturers for 68.00 0 0 0 0	15. 00 16. 00 17. 00 17. 01
(see instructions) 16.00 Payment for inpatient program capital 50.00 704,862 796 704,066 704,862 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.01 Net organ aquisition cost 55.00 0 0 0 0 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0	15. 00 16. 00 17. 00 17. 01 17. 02
(see instructions) 16.00 Payment for inpatient program capital 50.00 704,862 796 704,066 704,862 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0	15. 00 16. 00 17. 00 17. 01 17. 02
(see instructions) 16.00 Payment for inpatient program capital 50.00 704,862 796 704,066 704,862 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.01 Net organ aquisition cost 55.00 0 0 0 0 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0	15. 00 16. 00 17. 00 17. 01 17. 02 18. 00

Health Financial Systems	HANCOCK REGION	NAL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5		Provi der	CCN: 150037	Peri od: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibi Date/Time Pre 5/26/2016 2:2	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	Wkst. L, line		mt. from kst. L)				
	0		1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00		703, 798		0 703, 798	703, 798	20.00

		Ti tl	e XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1. 00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1. 00	703, 798	0	703, 798	703, 798	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	1, 064	796	268	1, 064	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0.0000	0. 0000	0. 0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	0	0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0. 0000	0. 0000		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0	0	0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	704, 862	796	704, 066	704, 862	26. 00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1.00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0	0		0	28.00
29.00 Low volume adjustment on or after October 1	70. 97	79, 747		79, 747	79, 747	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	13, 781	0	13, 781	13, 781	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-463	0	-463	-463	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1. 00	2. 00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99		0	0	0	32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	HANCOCK REGIONAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150037		Worksheet E Part B Date/Time Prepared: 5/26/2016 2:22 pm
		T' 11 \0.0111	11 1 1	DDC

			10 12/31/2015	5/26/2016 2:2:			
		Title XVIII	Hospi tal	PPS	Σ μιι		
				1. 00			
	PART B - MEDICAL AND OTHER HEALTH SERVICES			(227	1 00		
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructi	one)		6, 337 11, 430, 946	1. 00 2. 00		
3.00	PPS payments	uis)		8, 686, 527	3.00		
4.00	Outlier payment (see instructions)			66, 203			
5.00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0. 000			
6.00	Line 2 times line 5	10113)		0.000	1		
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00			
8.00	Transitional corridor payment (see instructions)			0			
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		55, 530	9.00		
	Organ acqui si ti ons			0	10.00		
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6, 337	11. 00		
	COMPUTATION OF LESSER OF COST OR CHARGES						
	Reasonable charges						
	Ancillary service charges	>		29, 887			
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0			
14. 00	Total reasonable charges (sum of lines 12 and 13)			29, 887	14. 00		
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	ymant for carvices on	a charge basis	0	15. 00		
	Amounts that would have been realized from patients liable for			0	16. 00		
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		ii a chargebasis	O	10.00		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00		
	Total customary charges (see instructions)			29, 887	18. 00		
	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	23, 550	19.00		
	instructions)		, ,				
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00		
	instructions)						
	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		6, 337			
	Interns and residents (see instructions)			0			
	Cost of physicians' services in a teaching hospital (see instru	Ctrons)		0 000 240	23. 00 24. 00		
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			8, 808, 260	24.00		
25 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00		
					26. 00		
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see				27. 00		
	instructions)						
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00		
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0			
	Subtotal (sum of lines 27 through 29)			6, 922, 820			
	Primary payer payments			383			
	Subtotal (line 30 minus line 31)	C)		6, 922, 437	32.00		
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE: Composite rate ESRD (from Wkst. I-5, line 11)	5)		0	33. 00		
	Allowable bad debts (see instructions)			150, 346			
	Adjusted reimbursable bad debts (see instructions)			97, 725			
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0			
	Subtotal (see instructions)	,		7, 020, 162			
38. 00	MSP-LCC reconciliation amount from PS&R			0	1		
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00		
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50		
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98		
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99		
	Subtotal (see instructions)			7, 020, 162			
1	Sequestration adjustment (see instructions)			140, 403			
	Interim payments			6, 887, 806			
	Tentative settlement (for contractors use only)			0			
	Balance due provider/program (see instructions)	o with CMC Duty 4E C	abantar 1	-8, 047 0			
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,				44.00		
44. 00		e witti ome rab. 10 2,	§115. 2				
44. 00	§115. 2	or with one rab. 10 2,	·		-		
	§115.2 TO BE COMPLETED BY CONTRACTOR	- WI CH SING F 4B. 10 2,	·		90 00		
90. 00	§115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	- W 11 300 1 db. 13 2,		0			
90. 00 91. 00	§115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	- III (III (III (III (III (III (III (II		0			
90. 00 91. 00 92. 00	§115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	C III (III GIIIG TAB). 10 2,	·	0	91. 00 92. 00		

Health Financial Systems HANC ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Period: Worksheet E-1
From 01/01/2015 Part I
To 12/31/2015 Date/Time Prepared: 5/26/2016 2: 22 pm Provi der CCN: 150037

2.00		I npati en	e XVIII t Part A	Hospi tal Par	PPS T B	
2.00		·	t Part A	Par	rt B	
2.00		/ 1 1 /				
2.00		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
2.00		1.00	2.00	3. 00	4. 00	
	Total interim payments paid to provider		8, 675, 947	/	6, 724, 632	1. 00
	Interim payments payable on individual bills, either		C)	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)					
Ī	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2015	44, 220	12/31/2015	163, 174	3. 01
3. 02			C)	0	3. 02
3. 03			C	ו	0	3. 03
3. 04			C)	0	3. 04
3. 05			C)	l ol	3. 05
	Provider to Program					
	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51			C)	l ol	3. 51
3. 52			C)	l ol	3. 52
3. 53			C)	0	3. 53
3. 54			C)	0	3. 54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines		44, 220)	163, 174	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 720, 167	·	6, 887, 806	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
T T	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C)	0	5. 01
5. 02			C)	0	5. 02
5. 03			C)	0	5. 03
[Provider to Program					
5. 50	TENTATI VE TO PROGRAM		C)	0	5. 50
5. 51			C)	0	5. 51
5. 52			C)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
	SETTLEMENT TO PROVIDER		35, 607	1	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		C		8, 047	6. 02
7. 00	Total Medicare program liability (see instructions)		8, 755, 774		6, 879, 759	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Inpatient Part A			וו דו	e XVIII	Subprovider -	PPS	
1.00			Innatien	t Part Δ		-+ R	
1.00 1.00 1.00 3.00 4.00 1.00			Impatren		Tai		
Total interim payments paid to provider 2,225,983			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1.00	2.00	3. 00	4. 00	
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				2, 225, 983	3		
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero.	2.00			()	0	2. 00
write "NONE" or enter a zero							
1. 1. 1. 1. 1. 1. 1. 1.		1 91					
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 ADJUSTMENTS TO PROVIDER DO 0 0 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM ADJUSTMENTS	0.00						0.00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							<u> </u>
3.02 3.03 3.04 3.05 3.03 3.04 3.05 3.03 3.04 3.05	3 01)	0	3 01
3.03 0 0 0 3.03 3.04 3.05 0 0 0 3.05 3.04 3.05 0 0 0 3.05		THE STATE OF THE TREET OF THE STATE OF THE S					
3. 04 0 0 0 3. 04 3. 05							
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.51 3.52 3.53 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 0 0 0 0 0 0 0 0 0				d		0	
3.50 ADJUSTMENTS TO PROGRAM						0	3. 05
3.51		Provider to Program	•	•			
3.52 3.53 3.54 3.99 3.50	3.50	ADJUSTMENTS TO PROGRAM		C)	0	3. 50
3.53 3.54 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 0 0 0 3.59 0 0 0 0 0 0 0 0 0	3.51			C)	0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 3.54 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,225,883 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR				C)	-	
3. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 3. 99 3. 50-3.98 0 4. 00 0 3. 59-3.98 0 4. 00 0 4. 00 0 4. 00 0 0 4. 00 0 0 0 0 0 0 0 0 0	3.53			C)		3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR							
A. 00 Total interim payments (sum of lines 1, 2, and 3.99) 2,225,983 0 4.00	3. 99	,		(0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR						_	
appropriate To BE COMPLETED BY CONTRACTOR	4.00			2, 225, 983	8	0	4.00
TO BE COMPLETED BY CONTRACTOR S. 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 O		1 ·					
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1) Program to Provider	0.00						0.00
Program to Provider							
5. 02							
Description Description	5.01	TENTATI VE TO PROVI DER		()	0	5. 01
Provider to Program	5.02			C)	0	5. 02
TENTATIVE TO PROGRAM 0	5.03			()	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) Contractor Number (Mo/Day/Yr) O 1.00 2.00							
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) Contractor Number (Mo/Day/Yr) O 1.00 2.00		TENTATI VE 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 469 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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) Contractor Number (Mo/Day/Yr) O 1. 00 2. 00				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) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			()	0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	6 00						6 00
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	0.00						0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6 01			460			6 01
7.00 Total Medicare program liability (see instructions) 2,226,452 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1			
0 1.00 2.00						NPR Date	
					Number	(Mo/Day/Yr)	
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8.00

Heal th	Financial Systems HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150037 Period: Work From 01/01/2015 Part					
			To 12/31/2015	Date/Time Pre		
		Title XVIII	Hospi tal	5/26/2016 2: 22 PPS	<u> 2 piii </u>	
		TI LIE AVIII	1103pi tai	113		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S	S-3, Pt. I col. 15 line	14	2, 556	1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-			3, 703	2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			351	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		8, 578	4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			252, 930, 422	5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lim	ne 20		4, 253, 653	6. 00	
7.00	CAH only - The reasonable cost incurred for the purchase of cer	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
	line 168					
8. 00	Calculation of the HIT incentive payment (see instructions)			274, 167	8. 00	
9. 00	Sequestration adjustment amount (see instructions)			5, 483	9. 00	
10. 00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		268, 684	10. 00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)			0	30. 00	
	Other Adjustment (specify)	242 ()	,	0	31. 00	
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	s)	268, 684	32. 00	

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150037	Peri od: From 01/01/2015	Worksheet E-3
	Component CCN: 15SO37		
	Title XVIII	Subprovi der -	PPS
		LDE	

	I PF		
		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2, 431, 272	1. 00
2.00	Net IPF PPS Outlier Payments	15, 064	2. 00
3.00	Net IPF PPS ECT Payments	0	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	4. 01
5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6. 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0. 00	7. 00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9.00	Average Daily Census (see instructions)	7. 150685	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	0	11. 00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2, 446, 336	12. 00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13. 00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14. 00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	15. 00
16. 00	Subtotal (see instructions)	2, 446, 336	
17. 00	Pri mary payer payments	0	17. 00
18. 00	Subtotal (line 16 less line 17).	2, 446, 336	
19. 00	Deducti bl es	174, 920	
20. 00	Subtotal (line 18 minus line 19)	2, 271, 416	
21. 00	Coi nsurance	0	21. 00
22. 00	Subtotal (line 20 minus line 21)	2, 271, 416	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23. 00
24. 00	Adjusted reimbursable bad debts (see instructions)	0	24. 00
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25. 00
26. 00	Subtotal (sum of lines 22 and 24)	2, 271, 416	
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
28. 00	Other pass through costs (see instructions)	474	28. 00
29. 00	Outlier payments reconciliation	0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50	Proneer ACO demonstration payment adjustment (see instructions)	0	30. 50 30. 99
30. 99	Recovery of Accelerated Depreciation	0	
31.00	Total amount payable to the provider (see instructions)	2, 271, 890	
31. 01 32. 00	Sequestration adjustment (see instructions)	45, 438	
32.00	Interim payments Tentative settlement (for contractor use only)	2, 225, 983 0	32.00
34.00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	469	34.00
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	409	35. 00
33.00	§115. 2		35.00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Worksheet E-3, Part II, line 2	15, 064	
	Outlier reconciliation adjustment amount (see instructions)	0	51. 00
52. 00	,	1	52. 00
53. 00	Time Value of Money (see instructions)	0	53. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150037		Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 2:22 pm

			10 12/31/2013	5/26/2016 2: 2	2 pm
		Title XIX	Hospi tal	Cost	
	<u> </u>		Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		_		
1. 00	Inpatient hospital/SNF/NF services		391, 421		1. 00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		391, 421	0	
5.00	Inpatient primary payer payments		0	0	5. 00
6.00	Outpatient primary payer payments		201 421	0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		391, 421	0	7. 00
	Reasonable Charges				1
8.00	Routine service charges		0		8.00
9. 00	Ancillary service charges		605, 774	0	
10.00	Organ acquisition charges, net of revenue		000,771	· ·	10.00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		605, 774	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)	0.00000	0.00000	45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	
16. 00 17. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 14 exceeds	605, 774 214, 353	0	
17.00	line 4) (see instructions)	IT TITLE TO exceeds	214, 333	U	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
.0.00	16) (see instructions)	e . execuee		Ü	10.00
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16		391, 421	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	ompleted for PPS provid			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
25. 00	Program capital payments Capital exception payments (see instructions)		0		24. 00 25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		391, 421	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
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)		391, 421	0	31. 00
32.00	Deducti bl es		0	0	
33. 00	Coi nsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35. 00
36. 00			391, 421	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		391, 421	0	
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		371, 421	O	39.00
40. 00			391, 421	0	1
41. 00	1 , , , , , , , , , , , , , , , , , , ,		0,1,121	0	
42. 00	Balance due provider/program (line 40 minus line 41)		391, 421	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	
	chapter 1, §115.2				[

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

| Peri od: | From 01/01/2015 | To 12/31/2015 | Worksheet G | Date/Time Prepared: | 5/26/2016 2: 22 pm

				12/01/2010	5/26/2016 2: 2	2 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
	AUDDENT AGGETS	1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	/ 511 02/			0	1 00
1.00	Cash on hand in banks	6, 511, 826		0	0	1.00
2.00	Temporary investments	0		-	0	2.00
3.00	Notes recei vabl e Accounts recei vabl e	11 2/4 2/1	1	0	0	3.00
4.00		11, 264, 261		0	0	4.00
5. 00 6. 00	Other receivable	0		0	0	5. 00 6. 00
7. 00	Allowances for uncollectible notes and accounts receivable	21 204 740	1		0	7. 00
8. 00	Inventory Prepaid expenses	21, 304, 760			0	8.00
9. 00	Other current assets	37, 024, 241			0	9.00
10. 00	Due from other funds	37,024,241			0	10.00
11. 00	Total current assets (sum of lines 1-10)	76, 105, 088	1	-		11.00
11.00	FIXED ASSETS	70, 103, 000	9	<u> </u>	U	11.00
12. 00	Land	7, 819, 448	3	0	0	12. 00
13. 00	Land improvements	7,017,440			0	13. 00
14. 00	Accumulated depreciation		1			14. 00
15. 00	Buildings	104, 511, 857		-	0	15. 00
16. 00	Accumulated depreciation	-120, 470, 188	1	-	Ö	16. 00
17. 00	Leasehold improvements	0		-	ő	17. 00
18. 00	Accumulated depreciation	0			ő	18. 00
19. 00	Fi xed equipment	0		0	Ō	19. 00
20. 00	Accumulated depreciation	0		0	Ō	20. 00
21. 00	Automobiles and trucks	Ö		o o	Ō	21. 00
22. 00	Accumulated depreciation	0		0	Ō	22. 00
23. 00	Major movable equipment	77, 558, 187		o o	Ō	23. 00
24. 00	Accumulated depreciation	0		0	0	24. 00
25. 00	Mi nor equi pment depreci able	0		0	0	25. 00
26. 00	Accumul ated depreciation	O		0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumul ated depreciation	0		o	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	69, 419, 304		0	0	30.00
	OTHER ASSETS					1
31.00	Investments	0) (0	0	31. 00
32.00	Deposits on Leases	0) (0	0	32. 00
33.00	Due from owners/officers	0) (0	0	33. 00
34.00	Other assets	7, 829, 435	i (0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7, 829, 435	5	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	153, 353, 827	' (0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	3, 501, 499	1	0		37. 00
38. 00	Salaries, wages, and fees payable	4, 378, 121	1	-	0	38. 00
39. 00	Payroll taxes payable	0)	0	0	39. 00
40. 00	Notes and Loans payable (short term)	0)	0	0	40. 00
41. 00	Deferred income	0)	0	0	41. 00
42. 00	Accel erated payments	0)			42. 00
43. 00	Due to other funds	0)	0	0	43. 00
44. 00	Other current liabilities	5, 190, 094	1	1	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	13, 069, 714	. (0	0	45. 00
47.00	LONG TERM LIABILITIES					4, 00
46. 00	Mortgage payable	0		·	0	46. 00
47. 00	Notes payable	0	1	0		47. 00
48. 00	Unsecured Loans	0		-	0	48. 00
49. 00	Other long term liabilities	0		-	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	12 0/0 714				50.00
51. 00	Total liabilites (sum of lines 45 and 50)	13, 069, 714		0	0	51.00
E2 00	CAPITAL ACCOUNTS	140 204 112	,			F2 00
52.00	General fund balance	140, 284, 113				52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted			´		53. 00 54. 00
				0		•
55. 00 56. 00	Donor created - endowment fund balance - unrestricted					55. 00 56. 00
56.00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
JO. UU	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	140, 284, 113		n	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	153, 353, 827		ol o	Ö	60.00
	[59]		1		l	
		•	•	•	•	

Provi der CCN: 150037

| Peri od: | Worksheet G-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

					То	12/31/2015	Date/Time Prep 5/26/2016 2: 2:	
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		119, 245, 763			0		1. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		21, 038, 350 140, 284, 113			0		2. 00 3. 00
4.00	Additions (credit adjustments) (specify)	0	140, 204, 113		0	0	0	4. 00
5. 00	(apart)	Ö			0		Ō	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8. 00 9. 00		0			0		0	8. 00 9. 00
10. 00	Total additions (sum of line 4-9)	٥	0		٥	0		10.00
11. 00	Subtotal (line 3 plus line 10)		140, 284, 113			0		11. 00
12.00	Deductions (debit adjustments) (specify)	o			0		0	
13.00		0			0		0	13.00
14. 00 15. 00		0			0		0	14. 00 15. 00
16. 00					0			16. 00
17. 00		o			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		140, 284, 113			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	L Fund				
	I -	6.00	7. 00	8. 00				
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1. 00 2. 00
3.00	Total (sum of line 1 and line 2)	٥			0			3. 00
4. 00	Additions (credit adjustments) (specify)	١	0					4. 00
5.00			0					5. 00
6.00			0					6. 00
7. 00 8. 00			0					7. 00 8. 00
9. 00			0					9. 00
10. 00	Total additions (sum of line 4-9)	o	Ŭ		0			10. 00
11. 00	Subtotal (line 3 plus line 10)	o			0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13. 00 14. 00			0					13. 00 14. 00
15. 00			0					15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	O			0			19. 00
	Isheer (Time II IIIIIus IIIIe 10)	l l		I	- 1		l	

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150037

			To 12/31/2015	Date/Time Prep 5/26/2016 2: 2:	
	Cost Center Description	Inpatient	Outpati ent	Total	<u> 2 piii</u>
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	7, 122, 93	5	7, 122, 935	1.00
2.00	SUBPROVI DER - I PF	3, 214, 42	9	3, 214, 429	2.00
3.00	SUBPROVI DER - I RF		0	0	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	•	0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7. 00	SKILLED NURSING FACILITY				7. 00
8.00	NURSI NG FACI LITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	10, 337, 36	4	10, 337, 364	10. 00
44 00	Intensive Care Type Inpatient Hospital Services	11 100 00		44 400 000	44.00
11.00	INTENSIVE CARE UNIT	11, 483, 20	3	11, 483, 203	11.00
12. 00 13. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT				12. 00 13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT	ł			14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)	ł			15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	s 11, 483, 20	2	11, 483, 203	16. 00
10.00	11-15)	11, 403, 20	3	11, 403, 203	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	21, 820, 56	7	21, 820, 567	17. 00
18. 00	Ancillary services	45, 427, 56		190, 714, 973	
19. 00	Outpati ent servi ces	3, 869, 07		39, 889, 377	19. 00
20. 00	RURAL HEALTH CLINIC		0 357, 009	357, 009	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	İ	o	0	21. 00
22. 00	HOME HEALTH AGENCY	İ	-387	-387	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	907, 14	0 1, 441, 531	2, 348, 671	26.00
27. 00	PRI VATE DUTY/ DI ETARY	9		333, 060	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wh	kst. 72, 024, 43	7 183, 438, 833	255, 463, 270	28.00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		07.000.007		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		97, 820, 027		29. 00
30.00	ADD (SPECIFY)		0		30.00
31. 00 32. 00			0		31.00
32.00			0		32. 00 33. 00
34. 00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)				36. 00
37. 00	DEDUCT (SPECIFY)		o		37. 00
38. 00	52555. (5. 25)		0		38. 00
39. 00			0		39. 00
40. 00			o I		40. 00
41. 00			o l		41. 00
42. 00	Total deductions (sum of lines 37-41)		o		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ansfer	97, 820, 027		43.00
	to Wkst. G-3, line 4)				

	FI I I G I			C.E. OHO.	NEED 40
	Financial Systems HANCOCK REGIONAL HOSPITAL MENT OF REVENUES AND EXPENSES Provider	CCN: 150037	Peri od:	u of Form CMS-2 Worksheet G-3	2552-10
STATE	MENT OF REVENUES AND EXPENSES PROVIDER	CCN: 150037	From 01/01/2015	worksneet G-3	
			To 12/31/2015	Date/Time Pre	
				5/26/2016 2: 22	2 pm
				1 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			1. 00 255, 463, 270	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			160, 544, 108	2. 00
3.00	Net patient revenues (line 1 minus line 2)			94, 919, 162	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			97, 820, 027	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-2, 900, 865	5. 00
0.00	OTHER I NCOME			27 7007 000	0.00
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication services			0	8. 00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00				0	12.00
13. 00	1			0	13.00
14.00				0	14.00
15. 00					15.00
	Revenue from sale of medical and surgical supplies to other than patients				16. 00
17. 00	1				17. 00
	Revenue from sale of medical records and abstracts				18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)				19. 00
20. 00				0	20. 00
21. 00	J			0	21. 00
22. 00	! !			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00				7, 503, 643	24. 00
24. 01				16, 390, 123	
	Total other income (sum of lines 6-24)			23, 893, 766	
	Total (line 5 plus line 25)			20, 992, 901	
27. 00				-45, 449	
28. 00	Total other expenses (sum of line 27 and subscripts) Net income (or loss) for the period (line 26 minus line 28)			-45, 449 21, 038, 350	
29.00	The Circume (or 1055) for the period (Title 20 III has Title 28)		ļ	21,030,350	∠9. UU

Health Financial Systems	HANCOCK REGIONAL HOSPITAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der 0	CCN: 150037	Peri od: From 01/01/2015	Worksheet K
	Hospi ce CC			Date/Time Prepared:

			Hospi ce (CCN: 151547 T	o 12/31/2015		
					Hospi ce I	5/26/2016 2: 2	2 piii
		Salaries (from	Employee	Transportation		Other	
			Benefits (from		Services (from	other	
		WKSL. K-1)	Wkst. K-2)	(See Hist.)	Wkst. K-3)		
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	7.00	3.00	
1.00	Capital Related Costs-Bldg and Fixt.			1 0		0	1.00
2. 00	Capital Related Costs-Movable Equip.			0		0	
3. 00	Plant Operation and Maintenance		0	١	٥	0	
4. 00	Transportation - Staff		0			0	
5. 00	Volunteer Service Coordination		0	1	٥	0	
6. 00	Administrative and General	203, 694	0	0	Ö	0	
0.00	I NPATI ENT CARE SERVI CE	203, 074		1	<u> </u>		0.00
7. 00	Inpatient - General Care	O	0	0	ol	0	7.00
8. 00	Inpatient - Respite Care	0	0		l ol	0	
0.00	VI SI TI NG SERVI CES			1	<u> </u>		0.00
9. 00	Physi ci an Servi ces	143, 561	0	0	ol	0	9.00
10. 00	Nursing Care	563, 565	0		ol ol	0	
11. 00	Nursing Care-Continuous Home Care	0	0	0	o	0	
12. 00	Physical Therapy		0	0	o	0	
13. 00	Occupational Therapy		0		٥	0	1
14. 00	Speech/ Language Pathology		0	0	o	0	
15. 00	Medical Social Services	91, 322	0	0	Ö	0	
16. 00	Spiritual Counseling	0	0	0	o	0	
	Di etary Counsel i ng		0	0	o	0	1
18. 00	Counseling - Other		0	0	o	0	
19. 00	Home Health Aide and Homemaker	95, 895	0	0	ol	0	
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0	Ō	ol	0	
21. 00	Other	o	0		ol	0	
	OTHER HOSPICE SERVICE COSTS	-1	-		-1		1
22. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22. 00
23.00	Anal gesi cs	o	0	0	o	0	23. 00
24.00	Sedatives / Hypnotics	o	0	0	o	0	24.00
25. 00	Other - Specify	o	0	0	o	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	o	0	Ó	o	0	26. 00
27. 00	Patient Transportation	o	0	Ó	o	0	1
28. 00	Imaging Services	o	0	Ó	o	0	28. 00
29. 00	Labs and Diagnostics	o	0	Ó	o	0	1
30.00	Medical Supplies	o	0	0	o	0	30.00
31.00	Outpatient Services (including E/R Dept.)	o	0	0	o	0	1
32.00	Radi ati on Therapy	o	0	0	o	0	32. 00
33.00	Chemotherapy	o	0	0	o	0	33. 00
34.00	Other	o	0	0	o	1, 639, 714	34.00
	HOSPICE NONREIMBURSABLE SERVICE]
35.00	Bereavement Program Costs	0	0	0	0	0	35. 00
36.00	Volunteer Program Costs	0	0	0	o	0	36. 00
37. 00	Fundrai si ng	0	0	0	o	0	37. 00
38. 00	Other Program Costs	0	0	0	0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	1, 098, 037	0	0	o	1, 639, 714	39.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150037	Peri od: Worksheet K From 01/01/2015
	Hospi ce CCN: 151547	To 12/31/2015 Date/Time Prepared:

			Hospi ce CCI	N: 151547 To	12/31/2015	Date/Time Pre 5/26/2016 2:2	
					Hospi ce I	0, 20, 2010 212	
		Total (cols.	Reclassi fi cati Su	,	Adjustments	Total (col. 8	
		1-5)		6 ± col . 7)		± col. 9)	
	OFNEDAL CEDIU OF COST OFNITEDS	6. 00	7.00	8. 00	9. 00	10. 00	
1 00	GENERAL SERVICE COST CENTERS			0	٥	0	1 00
1. 00 2. 00	Capital Related Costs-Bldg and Fixt. Capital Related Costs-Movable Equip.			0	0	0	1. 00 2. 00
3.00	Plant Operation and Maintenance			0	0	0	3. 00
4.00	Transportation - Staff			0	0	0	4.00
5.00	Volunteer Service Coordination			0	0	0	5. 00
6. 00	Administrative and General	203, 694		203, 694	0	203, 694	6.00
0.00	I NPATI ENT CARE SERVI CE	203, 07-	τ_	203, 074	<u> </u>	203, 074	0.00
7.00	Inpatient - General Care		0	0	0	0	7.00
8. 00	Inpatient - Respite Care		1 1	0	0	0	8. 00
	VI SI TI NG SERVI CES		-1 -1	-1	-1		
9.00	Physi ci an Servi ces	143, 561	0	143, 561	0	143, 561	9. 00
10.00	Nursing Care	563, 565	5 0	563, 565	0	563, 565	10.00
11. 00	Nursing Care-Continuous Home Care		ol ol	0	0	0	11. 00
12.00	Physi cal Therapy		ol ol	0	0	0	12. 00
13.00	Occupational Therapy		ol ol	0	0	0	13. 00
14.00	Speech/ Language Pathology		0	0	0	0	14. 00
15.00	Medical Social Services	91, 322	0	91, 322	0	91, 322	15. 00
16.00	Spiritual Counseling		o o	0	0	0	16. 00
17. 00	Di etary Counsel i ng		이	0	0	0	17. 00
18. 00			0	0	0	0	18. 00
19. 00	Home Health Aide and Homemaker	95, 895	i i	95, 895	0	95, 895	
20. 00	HH Aide & Homemaker - Cont. Home Care		1	0	0	0	20. 00
21. 00			0	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS		J al		al		
22. 00	Drugs, Biological and Infusion Therapy		1	0	0	0	22. 00
23. 00	3 - 3			0	0	0	23. 00
24. 00 25. 00				0	0	0	24. 00 25. 00
26. 00	Other - Specify Durable Medical Equipment/Oxygen			0	0	0	26.00
	Pati ent Transportati on			0	0	0	27. 00
28. 00	Imaging Services			0	0	0	28.00
29. 00				0	0	0	29. 00
30. 00	Medical Supplies			0	0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)			0	0	0	31.00
32. 00	Radi ati on Therapy			0	0	0	32. 00
33. 00	Chemotherapy		ol ol	0	0	0	33. 00
34. 00	Other	1, 639, 714	1	1, 639, 714	-1, 167	1, 638, 547	34. 00
5 50	HOSPI CE NONREI MBURSABLE SERVI CE	.,,,,,		.,, , , , , ,	., 107	., 555, 617	1 55
35. 00	Bereavement Program Costs		0	0	O	0	35. 00
36. 00	, and the second		ol ol	0	o	0	36. 00
37. 00	Fundrai si ng			0	o	0	37. 00
38. 00	Other Program Costs			0	o	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	2, 737, 751	0	2, 737, 751	-1, 167	2, 736, 584	39. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Provi der CCN: 150037	Period: Worksheet K-1 From 01/01/2015

Hospi ce CCN: 151547 To 12/31/2015 Date/Time Prepared:

			1.00p. 00			5/26/2016 2:2	2 pm
					Hospi ce I		
		Admi ni strator	Di rector	Soci al	Supervi sors	Nurses	
				Servi ces			
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1. 00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance	0	C		0	0	
4.00	Transportation - Staff	0	C		0	0	4. 00
5.00	Volunteer Service Coordination	0	C		0	0	5. 00
6.00	Administrative and General	203, 694	C)	0	0	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	C		0		1
8.00	Inpatient - Respite Care	0	C		0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	143, 561	C		0 0	0	
10.00	Nursi ng Care	0	C		0 0	563, 565	10.00
11.00	Nursing Care-Continuous Home Care	0	C		0	0	11. 00
12.00	Physi cal Therapy	0	C		0	0	12. 00
13.00	Occupational Therapy	0	C		0	0	13. 00
14.00	Speech/ Language Pathology	O	C		0	0	14. 00
15.00	Medical Social Services	O	C	91, 32	2 0	0	15. 00
16.00	Spiritual Counseling	o	C		0	0	16. 00
17.00	Di etary Counsel i ng	o	C		0	0	17. 00
18.00	Counseling - Other	0	C		0	0	18. 00
19.00	Home Health Aide and Homemaker	0	C		0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	o	C		0	0	20.00
21.00	Other	o	C		0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						1
22.00	Drugs, Biological and Infusion Therapy						22. 00
23.00	Anal gesi cs						23. 00
24.00	Sedatives / Hypnotics						24. 00
25.00	Other - Specify						25. 00
26.00	Durable Medical Equipment/Oxygen						26. 00
27.00	Patient Transportation	0	C		0	0	27. 00
28.00	I maging Services	0	C		0	0	28. 00
29.00	Labs and Diagnostics	0	C		0	0	29. 00
30.00	Medical Supplies	0	C		0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	C		0	0	31.00
32.00	Radiation Therapy	O	C		0	0	32.00
33.00	Chemotherapy	0	C		0	0	33. 00
34.00	Other	0	C		0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	<u> </u>					1
35.00	Bereavement Program Costs	0	C		0 0	0	35. 00
36.00	Volunteer Program Costs	o	C		0	0	36.00
37. 00	Fundrai si ng	o	C		0	0	37. 00
38. 00	Other Program Costs	o	C		0	0	1
39.00	Total (sum of lines 1 thru 38)	347, 255	C	91, 32	2 0	563, 565	39. 00
				•	, '		•

Health Financial Systems	HANCOCK REGION	NAL HO	SPI TAL			In Lie	u of Form CMS-:	2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES			Provi der	CCN:	150037	Peri od:	Worksheet K-1	
			Hospi ce	CCN:	151547	From 01/01/2015 To 12/31/2015		
						Hospi ce I		
	Total	Δ	li des	ΔI	L-Other	Total (1)		

						5/26/2016 2: 22 pm
					Hospi ce I	
		Total Therapists	Ai des	All-Other	Total (1)	
		6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS				•	
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0		0 0	3.00
4.00	Transportation - Staff		0		0 0	4.00
5.00	Volunteer Service Coordination		0		0 0	5. 00
6.00	Administrative and General		0		0 203, 694	
	I NPATI ENT CARE SERVI CE					
7.00	Inpatient - General Care		0		0 0	7. 00
8. 00	Inpatient - Respite Care		Ö		0 0	
	VI SI TI NG SERVI CES				-	3, 3,
9.00	Physi ci an Servi ces		0		0 143, 561	9, 00
10.00	Nursing Care		0		0 563, 565	
11. 00	Nursing Care-Continuous Home Care		0		0 0	11.00
12. 00	Physical Therapy	0	0		0 0	12.00
13. 00	Occupational Therapy	0	0		0 0	13.00
14. 00	Speech/ Language Pathology	0	0		o o	14. 00
15. 00	Medical Social Services		0		0 91, 322	· ·
16. 00	Spiritual Counseling		0		0 71, 322	16.00
17. 00	Di etary Counsel i ng		0		0 0	17.00
18. 00	Counseling - Other		0		0 0	
19. 00	Home Health Aide and Homemaker		95, 895		0 95, 895	
20.00	HH Ai de & Homemaker - Cont. Home Care		75, 675		0 75, 875	
21.00	Other		0		0 0	
21.00	OTHER HOSPICE SERVICE COSTS		0		0	21.00
22. 00	Drugs, Biological and Infusion Therapy					22. 00
23. 00	Anal gesi cs					23. 00
24. 00	Sedatives / Hypnotics					24.00
25. 00	Other - Specify					25. 00
26. 00	Durable Medical Equipment/Oxygen					26.00
27. 00	Pati ent Transportation		0		0 0	
28. 00	Imaging Services		0		0	28.00
29. 00	Labs and Diagnostics		0		0 0	
30.00	Medical Supplies		0		0 0	30.00
31. 00	Outpatient Services (including E/R Dept.)		0		0 0	
32. 00	Radiation Therapy		0		0 0	
33. 00			0		0 0	
34. 00	Chemotherapy		0		0 0	
34.00	Other		0		0 0	34.00
25 00	HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs		0		0 0	35.00
35. 00 36. 00	Volunteer Program Costs		0		0 0	· ·
			0			
37. 00	Fundrai si ng		0		0	
38.00	Other Program Costs	0	05.005		0 0 1, 098, 037	38.00
37.00	Total (sum of lines 1 thru 38)	1	95, 895	I	0 1, 098, 037	1 39.00

			Hospi ce (CCN: 151547	Γο 12/31/2015	Date/Time Pre 5/26/2016 2:2	
					Hospi ce I	0/20/2010 2:2	2 piii
			CAPITAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATI ON	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1. 00	2. 00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1. 00
2.00	Capital Related Costs-Movable Equip.	0			O		2. 00
3.00	Plant Operation and Maintenance	0	0		0		3. 00
4.00	Transportation - Staff	0	0		0	0	
5.00	Volunteer Service Coordination	0	0		0	0	
6.00	Administrative and General	203, 694	0	(0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0	l .	
8.00	Inpatient - Respite Care	0	0	(0	0	8. 00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	143, 561	0		0	0	9. 00
10.00	Nursi ng Care	563, 565	0		0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12. 00
13.00	Occupational Therapy	0	0		0	0	13. 00
14.00	Speech/ Language Pathology	0	0		0	0	14. 00
15.00	Medical Social Services	91, 322	0		0	0	15. 00
16.00	Spiritual Counseling	0	0		0	0	16. 00
17.00	Di etary Counsel i ng	0	0		0	0	17. 00
18. 00	Counseling - Other	0	0		0	0	
19. 00	Home Health Aide and Homemaker	95, 895	0		0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	20. 00
21. 00	Other	0	0	(0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0		0		
23. 00	Anal gesi cs	0	0	1	0	0	
24. 00	Sedatives / Hypnotics	0	0		0	0	
25. 00	Other - Specify	0	0		0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		0	0	
27. 00	Patient Transportation	0	0		0	0	
28. 00	I maging Services	0	0		0	0	
29. 00	Labs and Diagnostics	0	0		0	0	
30.00	Medical Supplies	0	0		0	0	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	
32.00	Radi ati on Therapy	0	0		0	0	
33. 00	Chemotherapy	0	0		0	0	
34.00	Other	1, 638, 547	0	(0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35. 00	Bereavement Program Costs	0	0	•	0	0	
36. 00	Volunteer Program Costs	0	0		0	0	
37. 00	Fundrai si ng	0	0		0	0	
38. 00	Other Program Costs	0	0		0	0	
39. 00	Total (sum of lines 1 thru 38)	2, 736, 584	0	(0	0	39. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPICE GENERAL SERVICE COST	Provi der CCN: 150037	Period: Worksheet K-4

Hospi ce CCN: 151547 To 12/31/2015 Date/Time Prepared:

VOLUNTEER SERVICE SUBTOTAL Col. SA CENERAL E Col. SA E COMBINATOR SERVICES SUBTOTAL Col. SA E COMBINATOR E COMB				1.00p. 00		12, 01, 2010	5/26/2016 2: 22 pm
SERVICES COORDINATOR SA 6.00 7.00						Hospi ce I	•
COORDINATOR COORDINATOR		·	VOLUNTEER	SUBTOTAL	ADMI NI STRATI VI	TOTAL (col. 5A	
			SERVI CES	(cols. 0 - 5)	& GENERAL	± col. 6)	
CENERAL SERVICE COST CENTERS			COORDI NATOR				
1.00			5. 00	5A	6. 00	7. 00	
2.00		GENERAL SERVICE COST CENTERS					
Plant Operation and Maintenance	1.00	Capital Related Costs-Bldg and Fixt.					1. 00
A. 00	2.00	Capital Related Costs-Movable Equip.					2. 00
S. 00 Volunteer Service Coordination O Administrative and General O 203, 694 203, 694 S. 00 Administrative and General O O O O O O O O O	3.00	Plant Operation and Maintenance					3. 00
Administrative and General 0 203, 694	4.00	Transportation - Staff					4. 00
INPATIENT CARE SERVICE	5.00	Volunteer Service Coordination	0				5. 00
INPATIENT CARE SERVICE	6.00	Administrative and General	0	203, 694	203, 694	1	6. 00
1.00		I NPATI ENT CARE SERVI CE	<u>'</u>			<u>'</u>	
English Engl	7.00		0	C	(0	7. 00
VISITING SERVICES Physician Services 0	8.00	1 .	0	l o		o	8. 00
9.00 Physician Services			<u>'</u>	<u> </u>	•	<u>'</u>	
10.00 Nursing Care	9.00		0	143, 561	11, 545	155, 106	9. 00
11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 11.00	10.00	Nursing Care	0	563, 565	45, 322	608, 887	10.00
12.00 Physical Therapy 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 15.00 Medical Social Services 0 91,322 7,344 98,666 15.00 16.00 Spiritual Counseling 0 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 19.00 Home Health Aide and Homemaker 0 95,895 7,712 103,607 19.00 11.00 Other 0 0 0 0 0 0 12.00 Other 0 0 0 0 0 13.00 Other 0 0 0 0 14.00 Other 0 0 0 0 18.00 Other 0 0 0 0 19.00 Other 0 0 0 0 19.00 Other 0 0 0 0 22.00 Other 0 0 0 0 23.00 Other Service Costs 0 0 0 0 24.00 Sedatives / Hypnotics 0 0 0 0 25.00 Other - Specify 0 0 0 0 26.00 Other - Specify 0 0 0 0 26.00 Other - Specify 0 0 0 0 27.00 Patient Transportation 0 0 0 0 28.00 Imaging Services 0 0 0 0 29.00 Labs and Diagnostics 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services (including E/R Dept.) 0 0 0 0 20.00 Other - Services	11.00		0				11. 00
13.00	12.00		0	l o		o	12. 00
14. 00 Speech / Language Pathology 0 0 0 0 14. 00 15. 00 Medical Social Services 0 91,322 7,344 98,666 15. 00 16. 00 Spiritual Counseling 0 0 0 0 0 17. 00 Dietary Counseling 0 0 0 0 0 18. 00 Counseling - Other 0 0 0 0 0 19. 00 Home Heal th Aide and Homemaker 0 95,895 7,712 103,607 19,00 20. 00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 21. 00 Other 0 0 0 0 0 22. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 23. 00 Other - Specify 0 0 0 0 0 24. 00 Sedatives / Hypnotics 0 0 0 0 25. 00 Other - Specify 0 0 0 0 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 26. 00 Darable Medical Equipment (Oxygen 0 0 0 0 28. 00 Imaging Services 0 0 0 0 29. 00 Labs and Diagnostics 0 0 0 0 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 32. 00 Radiation Therapy 0 0 0 0 0 33. 00 Chemotherapy 0 0 0 0 0 34. 00 Other Drugs (Medical Supplies 0 0 0 0 35. 00 Bereavement Program Costs 0 0 0 0 35. 00 Bereavement Program Costs 0 0 0 0 36. 00 Bereavement Program Costs 0 0 0 0 37. 00 Drugs (Medical Supplies 0 0 0 0 38. 00 Other 0 0 0 39. 00 Other 0 0 0 30. 00 Other 0 0 30. 00 Other 0 0 0 0 30. 00 Other 0 0 0 30. 00 Other 0 0 0 30. 00 Other 0 0 0 30. 00 Other 0 0 0 30. 00 Other 0 0 0 30. 00 Other 0 0 30. 00 Other 0 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30. 00 Other 0 0 30	13.00		0	l o		o	13. 00
15. 00 Medical Social Services 0 91,322 7,344 98,666 15. 00 16. 00 Spiritual Counseling 0 0 0 0 17. 00 Dietary Counseling 0 0 0 0 18. 00 Counseling - Other 0 0 0 0 19. 00 Home Health Aide and Homemaker 0 95,895 7,712 103,607 19,00 20. 00 Hill Aide & Homemaker - Cont. Home Care 0 0 0 0 21. 00 Other 0 0 0 0 22. 00 Other 0 0 0 0 23. 00 Anal gesics 0 0 0 0 24. 00 Sedatives / Hypnotics 0 0 0 0 25. 00 Other - Specify 0 0 0 0 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 27. 00 Patient Transportation 0 0 0 0 28. 00 Imaging Services 0 0 0 0 29. 00 Labs and Diagnostics 0 0 0 0 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 32. 00 Other 0 0 0 0 33. 00 Other 0 0 0 0 34. 00 Other 0 0 0 35. 00 Other 0 0 0 36. 00 Other 0 0 0 37. 00 Other 0 0 0 38. 00 Other 0 0 0 39. 00 Other 0 0 0 30. 00 Other 0 0 0 31. 00 Other 0 0 0 32. 00 Other 0 0 0 33. 00 Other 0 0 0 34. 00 Other 0 0 35. 00 Other 0 0 36. 00 Other 0 0 37. 00 Other 0 0 38. 00 Other 0 0 39. 00 Other 0 0 30. 00 Other 0 30. 00 Other 0 0 30. 00 Other 0 30. 00 Other 0	14.00		0	l o		o	14. 00
16. 00 Spiritual Counseling 0 0 0 0 0 16. 00 17. 00 Dietary Counseling 0 0 0 0 0 17. 00 18. 00 Counseling - Other 0 0 0 0 0 19. 00 Home Heal th Aide and Homemaker 0 95,895 7,712 103,607 19. 00 High Heal th Aide and Homemaker 0 95,895 7,712 103,607 20. 00 High Heal th Aide & Homemaker - Cont. Home Care 0 0 0 0 0 21. 00 Other 0 0 0 0 0 22. 00 OTHER HOSPICE SERVICE COSTS 22. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 23. 00 Anal gesics 0 0 0 0 0 24. 00 Sedatives / Hypnotics 0 0 0 0 25. 00 Other - Specify 0 0 0 0 26. 00 Other - Specify 0 0 0 0 27. 00 Patient Transportation 0 0 0 0 28. 00 Imaging Services 0 0 0 0 29. 00 Labs and Diagnostics 0 0 0 0 31. 00 Medical Supplies 0 0 0 32. 00 Radiation Therapy 0 0 0 0 33. 00 Radiation Therapy 0 0 0 0 34. 00 Other MosPice Normal Murssable Service 35. 00 Bereavement Program Costs 0 0 0 0 35. 00 Bereavement Program Costs 0 0 0 36. 00 Derable MosPice Normal Murssable Service 0 0 0 36. 00 Other Other Other Other 37. 00 Other Other Other Other 38. 00 Other Other Other 39. 00 Other Other Other 39. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 31. 00 Other Other 32. 00 Other Other 33. 00 Other Other 34. 00 Other Other 35. 00 Other Other 36. 00 Other Other 37. 00 Other Other 38. 00 Other Other 39. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Other Other 30. 00 Oth	15. 00		0	91, 322	7. 344	98, 666	15. 00
17. 00 Di etary Counseling 0 0 0 0 0 17. 00 18. 00 Counseling - Other 0 0 0 0 0 18. 00 19. 00 Home Heal th Aide and Homemaker 0 95,895 7,712 103,607 19. 00 19. 00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 21. 00 Other 0 0 0 0 0 22. 00 Other Other Other Other Other 22. 00 Other Other Other Other 23. 00 Anal gesics Other - Specify Other - Stephalom Other - Ste			0	1	1		
18.00 Counseling - Other 0 0 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 0 95,895 7,712 103,607 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 20.00 21.00 Other 0 0 0 0 0 21.00 22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 23.00 Anal gesics 0 0 0 0 22.00 24.00 Sedatives / Hypnotics 0 0 0 0 23.00 25.00 Other - Specify 0 0 0 0 24.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 25.00 27.00 Patient Transportation 0 0 0 0 27.00 28.00 Imaging Services 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 30.00 31.00 Outpat		, '	0			0	
19.00 Home Heal th Ai de and Homemaker 0 95,895 7,712 103,607 20.00 Combined to the Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			0	
20.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 0		3	0	95, 895	7. 712	103, 607	
21.00 Other O O O O O O O O O O O O O O O O O O					1		
22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 22.00			0		1	1	
Drugs, Biological and Infusion Therapy 0							
23. 00	22.00		0	0	(0	22.00
24. 00 Sedatives / Hypnotics 0 0 0 0 24. 00 25. 00 Other - Specify 0 0 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 33. 00 0 ther 0 0 0 0 0 33. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 0			0				
25. 00 Other - Specify 0 0 0 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 0 33. 00 34. 00 Other 0 1,638,547 131,771 1,770,318 34. 00 HOSPICE NONREIMBURSABLE SERVICE			0				
26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 27. 00 28. 00 I maging Services 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 33. 00 34. 00 Other 0 1, 638, 547 131, 771 1, 770, 318 34. 00 HOSPICE NONREI MBURSABLE SERVI CE 35. 00 Bereavement Program Costs 0 0 0 0 0		7.	0			0	
27. 00 Pati ent Transportation 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 33. 00 34. 00 Other 0 1, 638, 547 131, 771 1, 770, 318 34. 00 HOSPICE NONREI MBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 0 35. 00			0		1	-	
28. 00 Imaging Services 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 33. 00 34. 00 Other 0 1, 638, 547 131, 771 1, 770, 318 34. 00 HOSPICE NONREI MBURSABLE SERVI CE 35. 00 Bereavement Program Costs 0 0 0 0 0					1	-	
29. 00 Labs and Diagnostics 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 33. 00 34. 00 Other 0 1, 638, 547 131, 771 1, 770, 318 34. 00 HOSPICE NONREI MBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 35. 00		•			1	-	
30.00 Medical Supplies 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 33.00 Other 0 1,638,547 131,771 1,770,318 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00							
31. 00 Outpati ent Services (including E/R Dept.) 0 0 0 0 0 31. 00 32. 00 Radi ati on Therapy 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 0 33. 00 34. 00 Other 0 1,638,547 131,771 1,770,318 34. 00 Other Othe							
32. 00 Radi ati on Therapy 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 33. 00 34. 00 Other 0 1,638,547 131,771 1,770,318 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 0 35. 00					1	-	
33. 00 Chemotherapy 0 0 0 0 0 33. 00 34. 00 Other 0 1,638,547 131,771 1,770,318 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 0 35. 00					`	1	
34. 00 Other 0 1,638,547 131,771 1,770,318 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 35. 00							
HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 35.00		1		1 638 547	1	-	
35. 00 Bereavement Program Costs 0 0 0 0 35. 00	34.00			1,030,347	131,77	1,770,310	34.00
	35 00			0	(0	35 00
	36. 00	Volunteer Program Costs					36.00
							37.00
					1	1	38.00
38. 00 Other Program Costs 0 0 39. 00 39. 00 Total (sum of lines 1 thru 38) 0 2,736,584 2,736,584 39. 00				2 736 504	1		
0, 30 10 tal. (3am 3, 11103) 0 2,730,304 2,750,304 37.00	37.00	Trotal (Sum of Filles I till a So)	1	2, 730, 304	I	2, 730, 304	37.00

	/26/2016 2: 22	DIII
Hospi ce I		
CAPITAL RELATED COST		
FIXTURES (SQ. EQUIPMENT (\$ OPERATION & (MILEAGE)	VOLUNTEER SERVI CES COORDI NATOR (HOURS)	
1.00 2.00 3.00 4.00	5. 00	
GENERAL SERVICE COST CENTERS		
1.00 Capital Related Costs-Bldg and Fixt.		1. 00
2.00 Capital Related Costs-Movable Equip.		2. 00
3.00 Plant Operation and Maintenance 0 0 0		3. 00
4.00 Transportation - Staff 0 0 0 0		4. 00
5.00 Volunteer Service Coordination 0 0 0	0	5. 00
6.00 Administrative and General 0 0 0	ō	6. 00
INPATIENT CARE SERVICE	_	
7.00 Inpatient - General Care O O O O	0	7. 00
8.00 Inpatient - Respite Care 0 0 0	ő	8. 00
VI SI TI NG SERVI CES		0.00
9. 00 Physician Services 0 0 0 0	0	9. 00
10. 00 Nursi ng Care	o o	10.00
11.00 Nursing Care-Continuous Home Care		11. 00
12.00 Physical Therapy 0 0 0 0	- 1	12. 00
13. 00 Occupational Therapy 0 0 0	o o	13. 00
14. 00 Speech/ Language Pathology 0 0 0		14. 00
15. 00 Medi cal Soci al Servi ces 0 0 0		15. 00
16. 00 Spiritual Counseling 0 0 0	0	16. 00
17. 00 Di etary Counsel i ng 0 0 0	٠,	17. 00
18. 00 Counseling - Other 0 0 0	o o	18. 00
19. 00 Home Heal th Ai de and Homemaker 0 0 0 0		19. 00
20.00 HH Ai de & Homemaker - Cont. Home Care	ő	20. 00
21. 00 Other 0 0 0	o o	21.00
OTHER HOSPI CE SERVI CE COSTS	0	21.00
22. 00 Drugs, Bi ol ogi cal and Infusi on Therapy 0 0 0	0	22. 00
23. 00 Anal gesi cs 0 0 0	o o	23. 00
24. 00 Sedatives / Hypnotics 0 0 0	o o	24. 00
25. 00 Other - Speci fy 0 0 0	Ö	25. 00
26.00 Durable Medical Equipment/Oxygen 0 0 0	Ö	26. 00
27. 00 Patient Transportation 0 0 0	Ö	27. 00
28. 00 I magi ng Servi ces	Ö	28. 00
29.00 Labs and Di agnostics	0	29. 00
30. 00 Medi cal Suppl i es 0 0 0	ő	30.00
31.00 Outpatient Services (including E/R Dept.)	o o	31.00
32. 00 Radi ati on Therapy 0 0 0	o o	32.00
33. 00 Chemotherapy	o o	33. 00
34. 00 Other	o	34. 00
HOSPI CE NONREI MBURSABLE SERVI CE	0	34.00
35.00 Bereavement Program Costs 0 0 0 0	0	35.00
36.00 Volunteer Program Costs 0 0 0 0	0	36.00
37.00 Fundraising 0 0 0 0	0	37.00
38.00 Other Program Costs 0 0 0 0	0	38.00
39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0	0	39.00
40.00 Unit Cost Multiplier 0.00000 0.000000 0.000000 0.000000	0. 000000	40. 00

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037 | Period: From 01/01/2015 | Part II Date/Time Prepared: 5/26/2016 2:22 pm

					5/26/2016 2: 3	22 pm
				Hospi ce I		
		RECONCI LI ATI ON				
			& GENERAL			
			(ACC. COST)			
	I	6A	6. 00			
	GENERAL SERVICE COST CENTERS	, ,				4
1. 00	Capital Related Costs-Bldg and Fixt.	0				1. 00
2.00	Capital Related Costs-Movable Equip.	0				2. 00
3.00	Plant Operation and Maintenance	0				3. 00
4.00	Transportation - Staff	0				4. 00
5.00	Volunteer Service Coordination					5. 00
6.00	Administrative and General	-203, 694	2, 532, 890			6. 00
	I NPATI ENT CARE SERVI CE					
7. 00	Inpatient - General Care	0	0			7. 00
8.00	Inpatient - Respite Care	0	0			8. 00
	VI SI TI NG SERVI CES					
9.00	Physi ci an Servi ces	0	143, 561			9. 00
10. 00	Nursing Care	0	563, 565			10.00
	Nursing Care-Continuous Home Care	0	0			11. 00
		0	0			12. 00
13.00	Occupational Therapy	0	0			13. 00
14.00	Speech/ Language Pathology	0	0			14. 00
15. 00	Medical Social Services	0	91, 322			15. 00
16. 00	Spiritual Counseling	0	0			16. 00
17. 00	Di etary Counsel i ng	0	0			17. 00
18. 00		0	0			18. 00
19. 00	Home Health Aide and Homemaker	0	95, 895			19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0			20. 00
21. 00		0	0			21. 00
	OTHER HOSPICE SERVICE COSTS					
22. 00	Drugs, Biological and Infusion Therapy	0	0			22. 00
	Anal gesi cs	0	0			23. 00
24.00	Sedatives / Hypnotics	0	0			24. 00
25.00	Other - Specify	0	0			25. 00
26.00	Durable Medical Equipment/Oxygen	0	0			26. 00
27. 00	Patient Transportation	0	0			27. 00
28. 00	I maging Services	0	0			28. 00
29. 00	Labs and Diagnostics	0	0			29. 00
30.00	Medical Supplies	0	0			30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0			31. 00
32.00	Radiation Therapy	0	0			32. 00
33. 00	Chemotherapy	0	0			33. 00
34.00	Other	0	1, 638, 547			34. 00
	HOSPICE NONREIMBURSABLE SERVICE					
	Bereavement Program Costs	0	0			35. 00
36. 00	Volunteer Program Costs	0	0			36. 00
37. 00	Fundrai si ng	0	0			37. 00
38. 00	Other Program Costs	0	0			38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		203, 694			39. 00
40.00	Unit Cost Multiplier		0. 080420			40. 00

Heal th Financial SystemsHANCOCKALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 150037 Hospi ce CCN:

						5/26/2016 2: 22	2 pm
					Hospi ce I		
	·		CAPI TAL				
			RELATED COSTS				
	Cost Center Description	Hospi ce Tri al	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		Bal ance (1)	FLXT	BENEFITS		& GENERAL	
				DEPARTMENT			
		0	1. 00	4. 00	4A	5. 00	
1.00	Administrative and General		173, 026	149, 61	7 322, 643	59, 201	1. 00
2.00	Inpatient - General Care	0	0		0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	0	3. 00
4.00	Physi ci an Servi ces	155, 106	0		155, 106		
5.00	Nursi ng Care	608, 887	0		608, 887	111, 723	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	6. 00
7.00	Physi cal Therapy	0	0		0	0	7. 00
8.00	Occupational Therapy	0	0		0	0	8. 00
9.00	Speech/ Language Pathology	0	0		0	0	9. 00
10.00	Medical Social Services	98, 666	0		98, 666	18, 104	10.00
11. 00	Spiritual Counseling	0	0		0	0	11. 00
12.00	Di etary Counseling	0	0		0	0	12.00
13.00	Counseling - Other	0	0		0	0	13.00
14.00	Home Health Aide and Homemaker	103, 607	0		103, 607	19, 011	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15.00
16. 00	Other	0	0		0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18. 00	Anal gesi cs	0	0		0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0		0	0	19. 00
20.00	Other - Specify	0	0		0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
22. 00	Patient Transportation	0	0		0	0	22. 00
23. 00	I maging Services	0	0		0	0	23. 00
24. 00	Labs and Diagnostics	0	0		0	0	24. 00
25. 00	Medical Supplies	0	0		0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	26. 00
27. 00	Radiation Therapy	0	0		0	0	27. 00
28. 00	Chemotherapy	0	0		0	0	28. 00
29. 00	0ther	1, 770, 318	0		1, 770, 318		29. 00
30. 00	Bereavement Program Costs	0	0		0	0	30. 00
31. 00	Volunteer Program Costs	0	0		0	0	31. 00
32. 00	Fundrai si ng	0	0		0	0	32. 00
33. 00	Other Program Costs	0	0		0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	2, 736, 584	173, 026	149, 61			34. 00
35. 00	Unit Cost Multiplier (see instructions)	1			0. 000000		35. 00

Heal th Financial SystemsHANCOCKALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS 150037 | Period: | Worksheet K-5 | From 01/01/2015 | Part | | To 12/31/2015 | Date/Time Prepared: 5/26/2016 2: 22 pm Provi der CCN: 150037 Hospi ce CCN:

						5/20/2010 2:2	<u> 2 piii </u>
					Hospi ce I		
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		PLANT				ADMI NI STRATI ON	
		7. 00	9. 00	10.00	11. 00	13. 00	
1.00	Administrative and General	192, 897	C	50, 63	98, 813	262, 771	1. 00
2.00	Inpatient - General Care	0	C)	0	0	2. 00
3.00	Inpatient - Respite Care	0	C)	0	0	3. 00
4.00	Physi ci an Servi ces	0	C)	0	0	4. 00
5.00	Nursi ng Care	0	C)	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	C)	0	0	6. 00
7.00	Physi cal Therapy	0	C)	0	0	7. 00
8.00	Occupational Therapy	0	C)	0	0	8. 00
9.00	Speech/ Language Pathology	0	C)	0	0	9. 00
10.00	Medical Social Services	0	C)	0	0	10.00
11.00	Spiritual Counseling	0	C)	0	0	11. 00
12.00	Di etary Counsel i ng	0)	0	0	12. 00
13.00	Counseling - Other	0)	0	0	13. 00
14.00	Home Health Aide and Homemaker	0)	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0)	0	0	15. 00
16.00	Other	0)	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0)	0	0	17. 00
18.00	Anal gesi cs	0)	0	0	18. 00
19.00	Sedatives / Hypnotics	0)	0	0	19. 00
20.00	Other - Specify	0	l)	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	l)	0	0	21. 00
22.00	Pati ent Transportation	0	()	0	0	22. 00
23.00	I maging Services	0)	0	0	23. 00
24.00	Labs and Diagnostics	0	l)	0	0	24. 00
25.00	Medical Supplies	0)	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0)	0	0	26. 00
27.00	Radiation Therapy	0)	0	0	27. 00
28.00	Chemotherapy	0)	0	0	28. 00
29.00	Other	0)	0	0	29. 00
30.00	Bereavement Program Costs	0)	0	0	30.00
31.00	Volunteer Program Costs	0)	0	0	31. 00
32.00	Fundrai si ng	0)	0	0	32. 00
33.00	Other Program Costs	0)	o o	0	
34.00	Total (sum of lines 1 thru 33) (2)	192, 897		50, 63	98, 813	262, 771	34.00
35.00							35. 00
	· · · · · · · · · · · · · · · · · · ·		•		•	•	

OSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 150037 | Period: From 01/01/2015 | Part I |

Hospice CCN: 151547 | To 12/31/2015 | Date/Time Prepared: 5/26/2016 2:22 pm

						5/26/2016 2: 2	2 pm
					Hospi ce I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
		SERVICES &		RECORDS &	PRGM	(cols. 4A-23)	
		SUPPLY		LI BRARY			
		14. 00	15. 00	16. 00	23. 00	24. 00	
1.00	Administrative and General	1, 995	0	0	0	988, 951	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	183, 566	4.00
5.00	Nursi ng Care	0	0	0	0	720, 610	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	116, 770	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	122, 618	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18.00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29.00	Other	0	0	0	0	2, 095, 150	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1, 995	0	0	0	4, 227, 665	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00
		•					

OSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 150037 | Period: | Worksheet K-5 | Part I |

Hospice CCN: 151547 | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 2:22 pm

Cost Center Description				·			5/26/2016 2: 22	2 pm
Residents Cost Cols. 24 ± Hospice A&G Costs (Cols. 26 ± 27) Residents Costs (Costs						Hospi ce I		
1.00		Cost Center Description	Intern &	Subtotal	Allocated	Total Hospice		
1.00			Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.		
Adj ustments 25.00 27.00 28.00				25)	(See Part II)	26 ± 27)		
1.00								
1.00								
2.00 Inpatient - General Care 0 0 0 0 0 0 0 0 0 0 3.00 1,00 0			25. 00	26. 00	27. 00	28. 00		
3.00								
4.00 Physician Services 0 183,566 56,052 239,618 4.00			0	0	0	0		
5. OD Nursing Care 0 720,610 220,040 940,650 5.00 6. 00 Nursing Care-Continuous Home Care 0 11.00 0 0 0 0 0 0 0 0 0 0 11.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td>Inpatient - Respite Care</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>3.00</td>		Inpatient - Respite Care	0	0	0	0		3.00
6. 00 Nursing Care-Continuous Home Care			0					4.00
7. 00 Physical Therapy 0 0 0 0 0 7. 00 8. 00 Occupational Therapy 0 0 0 0 0 0 8. 00 9. 00 Speech/ Language Pathology 0 0 0 0 0 9.00 11. 00 Medical Social Services 0 116,770 35,656 152,426 10.00 12. 00 Dietary Counseling 0 0 0 0 0 0 11.00 13. 00 Counseling - Other 0 0 0 0 0 0 12.00 13. 00 Counseling - Other 0 0 0 0 0 0 13.00 14. 00 Home Healt h Aide and Homemaker 0 122,618 37,442 160,060 14.00 15. 00 Other 0 0 0 0 0 15.00 16. 00 Other 0 0 0 0 0 15.00 <t< td=""><td>5.00</td><td></td><td>0</td><td>720, 610</td><td>220, 040</td><td>940, 650</td><td></td><td>5.00</td></t<>	5.00		0	720, 610	220, 040	940, 650		5.00
8.00 Occupational Therapy 0 0 0 0 0 0 9.00 9	6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
9.00 Speech / Language Pathology 0 0 0 0 0 0 0 0 0		Physi cal Therapy	0	0	0	0		7.00
10.00 Medical Social Services	8.00	Occupational Therapy	0	0	0	0		8.00
11.00 Spiritual Counseling 0	9.00	Speech/ Language Pathology	0	0	0	0		9.00
12.00 Dietary Counseling 0 0 0 0 0 0 0 0 0	10.00	Medical Social Services	0	116, 770	35, 656	152, 426		10.00
13.00 Counseling - Other 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 122,618 37,442 160,060 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 16.00 Other 0 0 0 0 0 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 18.00 Analgesics 0 0 0 0 0 19.00 Sedatives / Hypnotics 0 0 0 0 20.00 Other - Specify 0 0 0 0 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 22.00 Patient Transportation 0 0 0 0 23.00 Imaging Services 0 0 0 0 24.00 Labs and Diagnostics 0 0 0 0 25.00 Medical Supplies 0 0 0 0 26.00 Outpatient Services (including E/R Dept.) 0 0 0 27.00 Radiation Therapy 0 0 0 28.00 Chemotherapy 0 0 0 0 29.00 Ereavement Program Costs 0 0 0 31.00 Other Program Costs 0 0 0 32.00 Other Program Costs 0 0 0 33.00 Other Program Costs 0 0 0 34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	11. 00	Spiritual Counseling	0	0	0	0		11.00
14. 00 Home Heal th Ai de and Homemaker 0 122,618 37,442 160,060 14.00 15. 00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 15.00 16. 00 Other 0 0 0 0 0 16.00 17. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00 18. 00 Anal gesics 0 0 0 0 0 18.00 19. 00 Sedatives / Hypnotics 0 0 0 0 0 18.00 20. 00 Other - Specify 0 0 0 0 0 19.00 20. 00 Other - Specify 0 0 0 0 0 0 20.00 21. 00 Durable Medical Equipment/0xygen 0 0 0 0 0 21.00 22. 00 Patient Transportation 0 0 0 0 0 22.00 23. 00 Labs and Diagnostics 0 0 0 0 22.00	12.00	Di etary Counsel i ng	0	0	0	0		12.00
15.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 20.00 0 20.00 0 0 20.00 0 20.00 0 20.00 0 21.00 22.00 0 0 0 0 21.00 22.00 0 0 0 22.00 0 0 22.00 0 0 22.00 0 0 22.00 0 0 22.00 0 0 22.00 0 0 22.00 0 0 0 22.00 0 0 0 22.00 0 0 0 <td< td=""><td>13.00</td><td>Counseling - Other</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>13.00</td></td<>	13.00	Counseling - Other	0	0	0	0		13.00
16.00 Other 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 20.00 22.00 Patient Transportation 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 22.00 24.00 Labs and Diagnostics 0 0 0 0 23.00 25.00 Medical Supplies 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0	14.00	Home Health Aide and Homemaker	0	122, 618	37, 442	160, 060		14.00
17. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 17. 00 18. 00 Anal gesics 0 0 0 0 0 18. 00 19. 00 Sedati ves / Hypnotics 0 0 0 0 19. 00 20. 00 Other - Specify 0 0 0 0 0 20. 00 21. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 22. 00 22. 00 Pati ent Transportation 0 0 0 0 0 22. 00 23. 00 Imaging Services 0 0 0 0 0 22. 00 24. 00 Labs and Di agnostics 0 0 0 0 22. 00 24. 00 Labs and Di agnostics 0 0 0 0 23. 00 25. 00 Medical Supplies 0 0 0 0 24. 00 25. 00 Medical Supplies 0 0 0 0 25. 00 28. 00 Outpatient Services (including E/R Dept.) 0 </td <td>15.00</td> <td>HH Aide & Homemaker - Cont. Home Care</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>15.00</td>	15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
18.00 Analgesics 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 21.00 22.00 Patient Transportation 0 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 23.00 25.00 Medical Supplies 0 0 0 0 25.00 0 0 25.00 0 0 25.00 0 25.00 0 0 25.00 0 0 25.00 0 0 26.00 0 0 0 26.00 0 27.00 0 26.00 0 0 0 27.00 0 0 0 27.00 <t< td=""><td>16.00</td><td>Other</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>16.00</td></t<>	16.00	Other	0	0	0	0		16.00
19.00 Sedatives / Hypnotics 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 22.00 Patient Transportation 0 0 0 0 23.00 Imaging Services 0 0 0 0 24.00 Labs and Diagnostics 0 0 0 0 25.00 Medical Supplies 0 0 0 0 26.00 Outpatient Services (including E/R Dept.) 0 0 0 27.00 Radiation Therapy 0 0 0 28.00 Chemotherapy 0 0 0 29.00 Other 0 0 0 30.00 Bereavement Program Costs 0 0 0 31.00 Volunteer Program Costs 0 0 0 32.00 Total (sum of lines 1 thru 33) (2) 0 4, 227, 665 4, 227, 665 34.00	17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
20.00 Other - Specify 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 21.00 22.00 Patient Transportation 0 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 23.00 25.00 Medical Supplies 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 27.00 28.00 Other 0 0 0 0 0 29.00 31.00 Vol unteer Program Costs 0 0 0 0 30.00 32.00 Total (su	18.00	Anal gesi cs	0	0	0	0		18.00
21.00 Durable Medical Equipment/Oxygen 0 0 0 0 21.00 22.00 Patient Transportation 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 24.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 25.00 27.00 Radiation Therapy 0 0 0 0 0 26.00 0 0 0 26.00 0 0 27.00 0 0 0 27.00 0 0 0 0 0 0 27.00 0 0 0 0 28.00 0 0 0 0 0 0 28.00 0 0 0 0 0 0 0 0 0 0 <t< td=""><td>19. 00</td><td>Sedatives / Hypnotics</td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>19.00</td></t<>	19. 00	Sedatives / Hypnotics	0	0	0	0		19.00
22.00 Patient Transportation 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 30.00 31.00 Vol unteer Program Costs 0 0 0 0 32.00 32.00 Other Program Costs 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 0	20.00		0	0	0	0		20.00
23.00 Imaging Services 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 31.00 31.00 Volunteer Program Costs 0 0 0 0 0 32.00 32.00 Fundraising 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
24.00 Labs and Diagnostics 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 27.34,911 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	22. 00	Patient Transportation	0	0	0	0		22.00
25. 00 Medical Supplies 0 0 0 0 0 25. 00 26. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 26. 00 27. 00 Radiation Therapy 0 0 0 0 0 27. 00 28. 00 Chemotherapy 0 0 0 0 0 28. 00 29. 00 Other 0 2, 095, 150 639, 761 2, 734, 911 29. 00 30. 00 Bereavement Program Costs 0 0 0 0 30. 00 31. 00 Volunteer Program Costs 0 0 0 0 31. 00 32. 00 Fundraising 0 0 0 0 0 32. 00 33. 00 Other Program Costs 0 0 0 0 0 33. 00 34. 00 Total (sum of lines 1 thru 33) (2) 0 4, 227, 665 4, 227, 665 34. 00	23.00	I maging Services	0	0	0	0		23.00
26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 28.00 29.00 Other 0 2,095,150 639,761 2,734,911 29.00 30.00 Bereavement Program Costs 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	24.00		0	0	0	0		24.00
27.00 Radiation Therapy 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 28.00 29.00 Other 0 2,095,150 639,761 2,734,911 29.00 30.00 Bereavement Program Costs 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	25.00	Medical Supplies	0	0	0	0		25.00
28.00 Chemotherapy 0 0 0 0 0 28.00 29.00 Other 0 2,095,150 639,761 2,734,911 29.00 30.00 Bereavement Program Costs 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
29.00 Other 0 2,095,150 639,761 2,734,911 29.00 30.00 Bereavement Program Costs 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	27. 00	Radi ati on Therapy	0	0	0	0		27.00
30.00 Bereavement Program Costs 0 0 0 0 0 30.00 31.00 31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 33.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	28.00	Chemotherapy	0	0	0	0		28.00
31.00 Volunteer Program Costs 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	29.00	Other	0	2, 095, 150	639, 761	2, 734, 911		29.00
32.00 Fundraising	30.00	Bereavement Program Costs	0	0	0	0		30.00
33.00 Other Program Costs 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	31.00	Volunteer Program Costs	0	0	0	0		31.00
34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	32.00		0	0	0	o		32.00
34.00 Total (sum of lines 1 thru 33) (2) 0 4,227,665 4,227,665 34.00	33.00	Other Program Costs	0	0	0	o		33.00
35.00 Unit Cost Multiplier (see instructions) 0.305353 35.00	34.00	Total (sum of lines 1 thru 33) (2)	0	4, 227, 665		4, 227, 665		34.00
	35. 00	Unit Cost Multiplier (see instructions)			0. 305353		ı	35. 00

Hospi ce CCN:

						5/26/2016 2: 2	2 pm
					Hospi ce I		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		·	SALARI ES)				
		1.00	4. 00	5A	5. 00	7. 00	
1.00	Administrative and General	9, 240	1, 098, 036	0	322, 643	9, 240	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	o	0	0	0	0	3.00
4.00	Physi ci an Servi ces	o	0	0	155, 106	0	4.00
5.00	Nursing Care	o	0	0	608, 887	0	5.00
6.00	Nursing Care-Continuous Home Care	o	0	0	. 0	0	6.00
7.00	Physical Therapy	l ol	0	0	0	0	7.00
8.00	Occupational Therapy	o	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	o	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	98, 666	0	10.00
11. 00	Spiritual Counseling	o	0	0	0	0	11. 00
12. 00	Di etary Counsel i ng	o	0	0	0	0	12. 00
13. 00	Counseling - Other	o	0	0	0	0	13. 00
14. 00	Home Health Aide and Homemaker	o	0	0	103, 607	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	o	0		0	0	15. 00
16. 00	Other		0		0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy		0		0	0	17. 00
18. 00	Anal gesi cs	0	0		0	0	18. 00
19. 00	Sedatives / Hypnotics		0		0	0	19. 00
20. 00	Other - Specify		0		0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
22. 00	Patient Transportation		0		0	0	22. 00
23. 00	Imaging Services		0		0	0	23. 00
24. 00	Labs and Diagnostics		0		0	o o	24. 00
25. 00	Medical Supplies		0		0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)		0		0	0	26. 00
27. 00	Radi ati on Therapy		0		0	0	27. 00
28. 00	Chemotherapy		0		0	0	28. 00
29. 00	Other		0		1, 770, 318	0	29. 00
			0		1, 770, 310	0	
30.00	Bereavement Program Costs		0			0	30.00
31. 00 32. 00	Volunteer Program Costs Fundraising		0			0	31. 00 32. 00
			0			0	32.00
33. 00	Other Program Costs	0 240	1 000 007	ή	2 050 227		
34.00	Total (sum of lines 1 thru 33) (2)	9, 240	1, 098, 036		3, 059, 227	9, 240	34.00
35. 00	Total cost to be allocated	173, 026	149, 617	1	561, 331	192, 897	35. 00
30. UU	Unit Cost Multiplier (see instructions)	18. 725758	0. 136259	Ί	0. 183488	20. 876299	36. UU

Hospi ce CCN: 151547

						3/20/2010 2.2.	2 piii
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI ON	SERVICES &	
		SERVI CE)	DAYS)			SUPPLY	
					(MANHOURS)	(COSTED	
						REQUIS.)	
	To a contract of the contract	9. 00	10. 00	11. 00	13. 00	14. 00	
1. 00	Administrative and General	0	1, 009	35, 622	35, 622	54, 205	1. 00
2.00	Inpatient - General Care	0	0	(이	0	2. 00
3.00	Inpatient - Respite Care	0	0	(이	0	3. 00
4.00	Physician Services	0	0	(이	0	4. 00
5.00	Nursing Care	0	0	(이	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	(0	0	6. 00
7.00	Physi cal Therapy	0	0	(0	0	7. 00
8.00	Occupational Therapy	0	0	(0	0	8. 00
9.00	Speech/ Language Pathology	0	0	(0	0	
10.00	Medical Social Services	0	0	(0	0	10. 00
11. 00	Spiritual Counseling	0	0	(0	0	11. 00
12. 00	Dietary Counseling	0	0	(0	0	12. 00
13.00	Counseling - Other	0	0	(0	0	13. 00
14. 00	Home Health Aide and Homemaker	0	0	(0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	(0	0	15. 00
16. 00	Other	0	0	(0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	(0	0	17. 00
18. 00	Anal gesi cs	0	0	(0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	(0	0	19. 00
20.00	Other - Specify	0	0	(0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	(0	0	21. 00
22. 00	Pati ent Transportation	0	0	(0	0	22. 00
23. 00	I maging Services	0	0	(0	0	23. 00
24. 00	Labs and Diagnostics	0	0	(0	0	24. 00
25. 00	Medical Supplies	0	0	(0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	(o o	0	26. 00
27. 00	Radiation Therapy	0	0	(0	0	27. 00
28. 00	Chemotherapy	0	0	(0	0	28. 00
29. 00	Other	0	0	(0	0	29. 00
30.00	Bereavement Program Costs	0	0	(0	0	30. 00
31.00	Volunteer Program Costs	0	0	(0	0	31.00
32.00	Fundrai si ng	0	0	(0	0	32.00
33.00	Other Program Costs	0	0	(ol ol	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	1, 009	35, 622	35, 622	54, 205	34.00
35.00	Total cost to be allocated	0	50, 631			1, 995	
36.00	Unit Cost Multiplier (see instructions)	0. 000000	50. 179386	2. 773932	7. 376649	0. 036805	36. 00

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150037
 Period: From 01/01/2015 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/26/2016 2:22 pm

 Heal th Financial Systems
 HANCOCK

 ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
 HANCOCK REGIONAL HOSPITAL

STATISTICAL BASIS

						5/26/2016 2:22 pm
					Hospi ce I	
	Cost Center Description	PHARMACY	MEDI CAL	PARAMED ED		
		(COSTED	RECORDS &	PRGM		
		REQUIS.)	LI BRARY	(ASSI GNED		
			(TIME	TIME)		
			SPENT)			
		15. 00	16.00	23. 00		
1.00	Administrative and General	0	0	0		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	o	0	0		3.00
4.00	Physi ci an Servi ces	o	0	0		4. 00
5.00	Nursing Care	o	0	0		5. 00
6.00	Nursing Care-Continuous Home Care	o	0	0		6. 00
7.00	Physical Therapy	o	0	0		7.00
8.00	Occupational Therapy	0	0	0		8. 00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11. 00	Spiritual Counseling	0	0	0		11.00
12. 00	Di etary Counsel i ng	0	0	0		12. 00
13. 00	Counseling - Other	0	0	0		13. 00
14. 00	Home Health Aide and Homemaker	0	0	0		14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15. 00
16. 00	Other	0	0	0		16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	١		17. 00
18. 00	Anal gesics	0	0	١		18. 00
19. 00	Sedatives / Hypnotics	0	0	١		19. 00
20. 00	Other - Specify	0	0	١		20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	0		21. 00
22. 00	Patient Transportation	0	0	١		22. 00
23. 00	Imaging Services	0	0	0		23. 00
24. 00	Labs and Diagnostics	0	0	0		24.00
25. 00	Medical Supplies		0	0		25.00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0		26. 00
27. 00	Radi ati on Therapy		0	0		27.00
28. 00	Chemotherapy	0	0	0		28.00
29. 00	Other		0	0		29. 00
30. 00	Bereavement Program Costs		0			30.00
30.00	Volunteer Program Costs		0			30.00
31.00	Fundrai si ng		0			32.00
32.00		0	0			32.00
	Other Program Costs	-	0			
34. 00	Total (sum of lines 1 thru 33) (2)	0	0			34.00
35. 00	Total cost to be allocated	0 000000	0 000000	0 000000		35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 000000	l	36.00

	riod: om 01/01/2015	Worksheet K-5	
	om 01/01/2015		
	10/01/0015		
Hospi ce CCN: 151547 To	12/31/2015	Date/Time Prep 5/26/2016 2:22	
	Hospi ce I	0/20/2010 2:22	_ piii
		Hospi ce Shared	
I, col. 11 Ratio	Charges	Ánci I I ary	
line	(Provi der	Costs (cols. 1	
	Records)	x 2)	
0 1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS			
1. 00 PHYSI CAL THERAPY 66. 00 0. 422243	0	0	1. 00
2. 00 OCCUPATI ONAL THERAPY 67. 00 0. 371180	0	0	2. 00
3. 00 SPEECH PATHOLOGY 68. 00 0. 515563	0	0	3. 00
3. 01 OCCUPATI ONAL HEALTH 68. 01 0. 000000	0	0	3. 01
4. 00 DRUGS CHARGED TO PATIENTS 73. 00 0. 212023	0	0	4. 00
5. 00 DURABLE MEDI CAL EQUI P-RENTED 96. 00			5.00
6. 00 LABORATORY 60. 00 0. 152040	0	0	6. 00
6. 01 BLOOD LABORATORY 60. 01			6. 01
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 71. 00 0. 760024	0	0	7. 00
8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00			8. 00
9. 00 RADI OLOGY-THERAPEUTI C 55. 00			9. 00
10. 00 CARDI AC 76. 00 0. 000000	0	0	
10. 01 CARDI OPULMONARY 76. 01 0. 706311	0	0	10. 01
11.00 Totals (sum of lines 1-10)		0	11. 00

Heal th	Financial Systems HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
CALCUL	ATION OF HOSPICE PER DIEM COST	Provi der	CCN: 150037	Peri od: From 01/01/2015	Worksheet K-6	
		Hospi ce	CCN: 151547			
				Hospi ce I		
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3. 00	4. 00	
1.00	Total cost (see instructions)				4, 227, 665	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				5, 710	2. 00
3.00	Average cost per diem (line 1 divided by line 2)				740. 40	3. 00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	5, 540				4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)	4, 101, 816	5			5. 00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			0		6. 00
7.00	Aggregate Medicaid cost (line 3 time line 60)			0		7. 00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	275	5			8. 00
9.00	Aggregate SNF cost (line 3 time line 8)	203, 610	D			9. 00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10. 00
11. 00	Aggregate NF cost (line 3 times line 10)			0		11. 00
12 00	Other Undunlicated days (Worksheet S-9 column 5 line 5)		1	170		12 00

12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)
13.00 Aggregate cost for other days (line 3 times line 12)

170

125, 868

12.00

13.00

near tr	Financial Systems HANCOCK REGIONAL	L HOSPITAL	In Lie	u of Form CMS-2	<u>2552-10</u>	
CALCUI	ATION OF CAPITAL PAYMENT	Provi der CCN: 150037	Peri od: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Pre 5/26/2016 2:2		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD			11.00		
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier			703, 798	1.00	
1. 01	Model 4 BPCI Capital DRG other than outlier			1 0/4	1. 01	
2. 00 2. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			1, 064 0	1	
3. 00	Total inpatient days divided by number of days in the cost re	enorting period (see inst	ructions)	23. 82	-	
4. 00	Number of interns & residents (see instructions)	r do tr ons)	0.00			
5. 00	Indirect medical education percentage (see instructions)			0.00		
6.00	Indirect medical education adjustment (multiply line 5 by the	, columns 1 and	0	6. 00		
	1.01)(see instructions)					
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	, part A line	0. 00	7. 00		
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see instru	0. 00	8. 00			
9. 00	Sum of lines 7 and 8		0.00			
10.00	Allowable disproportionate share percentage (see instructions	0.00				
11.00			0	11.00		
12.00			704, 862	12. 00		
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST			1.00		
1.00	Program inpatient routine capital cost (see instructions)			0	1.00	
2.00	Program inpatient ancillary capital cost (see instructions)			0		
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	l	
4.00	Capital cost payment factor (see instructions)			0		
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00	
				1. 00		
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 4 00	
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	os (sos instructions)		0		
3. 00	Net program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2)	Les (see Thistructions)		0		
4. 00	Applicable exception percentage (see instructions)			0.00		
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00	
6.00	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0.00	6. 00	
7.00	Adjustment to capital minimum payment level for extraordinary	, circumstances (line 2 x	line 6)	0		
	Capital minimum payment level (line 5 plus line 7)			0		
8.00			0			
8. 00 9. 00	Current year capital payments (from Part I, line 12, as appli					
8.00	Current year comparison of capital minimum payment level to c			0		
8. 00 9. 00 10. 00 11. 00	Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 00	
8. 00 9. 00 10. 00 11. 00	Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa	capital payment (from pri ayments (line 10 plus lin	or year e 11)	0	11. 00 12. 00	
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter	capital payment (from pri ayments (line 10 plus lin the amount on this line	or year e 11)	0	11. 00 12. 00 13. 00	
8. 00 9. 00 10. 00 11. 00	Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over of	capital payment (from pri ayments (line 10 plus lin the amount on this line	or year e 11)	0	11. 00 12. 00 13. 00	
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pacurrent year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over of (if line 12 is negative, enter the amount on this line)	capital payment (from pri ayments (line 10 plus line the amount on this line capital payment for the f	or year e 11)	0	11. 00 12. 00 13. 00 14. 00	
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pacurrent year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over of (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see ins	capital payment (from pri ayments (line 10 plus line the amount on this line capital payment for the f	or year e 11)	0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00	

	SIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDEI I CENTER COSTS	RALLY QUALIFIED		CCN: 150037	Peri od: From 01/01/2015	Worksheet M-1	
			Component	CCN: 153987	To 12/31/2015	Date/Time Pre 5/26/2016 2:2	
					Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs		1 Reclassificati	Reclassified Trial Balance	
				+ col . 2)	ons	(col. 3 + col.	
						4)	
	FACILITY HEALTH CADE STAFE COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
. 00	FACILITY HEALTH CARE STAFF COSTS Physician	0	14, 280	14, 28	30 0	14, 280	1. (
. 00	Physician Assistant	0	14, 200			14, 200	1
. 00	Nurse Practitioner	120, 576	0			120, 576	
. 00	Visiting Nurse	120, 070	0	120, 0		0	4.
. 00	Other Nurse	0	0			0	
. 00	Clinical Psychologist	0	0			0	
. 00	Clinical Social Worker	0	0		ol ol	0	
.00	Laboratory Techni ci an	0	0		o o	0	8.
00	Other Facility Health Care Staff Costs	24, 653	0	24, 65	53 0	24, 653	9.
0. 00	Subtotal (sum of lines 1 through 9)	145, 229	14, 280	159, 50	09	159, 509	10.
1. 00	Physician Services Under Agreement	0	0		0 0	0	11.
2. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.
3. 00	Other Costs Under Agreement	0	0		0 0	0	13.
4. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.
5. 00	Medical Supplies	0	0		o o	0	15.
5. 00	Transportation (Health Care Staff)	0	0		o o	0	16.
7. 00	Depreciation-Medical Equipment	0	0		o o	0	17.
3. 00	Professional Liability Insurance	0	0		0 0	0	18.
9. 00	Other Health Care Costs	0	0		0 0	0	19.
00 .C	Allowable GME Costs	0	0		0 0	0	20.
1. 00	Subtotal (sum of lines 15 through 20)	0	0		0 0	0	21.
2. 00	Total Cost of Health Care Services (sum of	145, 229	14, 280	159, 50	09	159, 509	22.
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS		_		-1 -1		
3. 00	Pharmacy	0	0		0 0	0	
4. 00	Dental	0	0		0 0	0	
5. 00	Optometry	0	0		0 0	0	
6. 00	All other nonreimbursable costs	0	0		0	0	26.
7.00	Nonallowable GME costs	0	0		0 0	0	· ·
3. 00	Total Nonreimbursable Costs (sum of lines 23	0	0			0	28.
	through 27) FACI LI TY OVERHEAD						
9. 00	Facility Costs	0	0		ol ol	0	29.
0.00	Administrative Costs	30, 213	79, 062			109, 275	
1. 00	Total Facility Overhead (sum of lines 29 and	30, 213				109, 275	
1.00	30)	30, 213	17,002	109, 2	, 3	107, 273	31.
2. 00	Total facility costs (sum of lines 22, 28	175, 442	93, 342	268, 78	34 0	268, 784	32.
00	and 31)	170, 442	,5,542	200, 70	- 'I	200, 704	52.

Health Financial Systems	HANCOCK REGIONAL H	OSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CENTER COSTS	HEALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 150037	Peri od: From 01/01/2015	Worksheet M-1
HEALITI CENTER COSTS		Component CCN: 153987		
			Rural Health	Cost

				Clinic (RHC) I	L
		Adjustments	Net Expenses	CITIIC (KIIC) I	
			for Allocation		
			(col . 5 + col .		
			6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00		
1.00	Physi ci an	0	14, 280		1, 00
2.00	Physician Assistant	0	0	•	2.00
3.00	Nurse Practitioner	0	120, 576	1	3. 00
4.00	Visiting Nurse	0	120,070		4.00
5.00	Other Nurse	0	0		5. 00
6.00	Clinical Psychologist	0			6.00
7. 00	Clinical Social Worker	0	0		7. 00
8. 00	Laboratory Techni ci an	0		1	8. 00
		0	-	l .	
9.00	Other Facility Health Care Staff Costs	0	24, 653		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	159, 509	l .	10.00
11.00	Physician Services Under Agreement	0	0	•	11. 00
12.00	Physician Supervision Under Agreement	0	0	•	12.00
13.00	Other Costs Under Agreement	0	0	l .	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	·	14. 00
15. 00	Medical Supplies	0	0	l .	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	l .	18. 00
19. 00	Other Health Care Costs	0	0		19. 00
20.00	Allowable GME Costs	0	0		20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	0	1	21. 00
22. 00	Total Cost of Health Care Services (sum of	0	159, 509		22. 00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICS				
23. 00	Pharmacy	0	0		23. 00
24. 00	Dental	0	0		24. 00
25.00	Optometry	0	0		25. 00
26.00	All other nonreimbursable costs	0	0		26. 00
27. 00	Nonallowable GME costs	0	0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
	through 27)				
	FACILITY OVERHEAD				
29. 00	1	0	1	1	29. 00
30.00	Administrative Costs	-6, 757			30. 00
31.00	Total Facility Overhead (sum of lines 29 and	-6, 757	102, 518		31.00
	30)				
32. 00	Total facility costs (sum of lines 22, 28	-6, 757	262, 027		32. 00
	and 31)				1

	Financial Systems	HANCOCK REGIO	NAL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES				Provi der	CCN: 150037	Peri od:	Worksheet M-2	
				Component	CCN: 153987	From 01/01/2015 To 12/31/2015	Date/Time Pre	narod:
				Component	CCN. 155707	10 12/31/2013	5/26/2016 2: 2	
						Rural Health	Cost	
						Clinic (RHC) I		
		Number of FTE	Tota	al Visits		/ Minimum Visits		
		Personnel			Standard (1)	(col. 1 x col.		
		1.00		2. 00	3.00	3) 4, 00	5. 00	
	VISITS AND PRODUCTIVITY	1.00		2.00	3.00	4.00	5.00	
	Posi ti ons							1
1. 00	Physi ci an	0, 00		0	4, 20	00 0		1.00
2. 00	Physician Assistant	0.00		0	•			2.00
3. 00	Nurse Practitioner	1. 13		1, 674				3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 13		1, 674		2, 373		
5.00	Visiting Nurse	0.00		0			0	5.00
6.00	Clinical Psychologist	0.00		0			0	6.00
7.00	Clinical Social Worker	0.00		0			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0. 00		0			0	7. 02
	onl y)							
8.00	Total FTEs and Visits (sum of lines 4	1. 13		1, 674			2, 373	8. 00
0.00	through 7)			2.4			2.4	0.00
9. 00	Physician Services Under Agreements			24			24	9. 00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O RHC/FQHC SERV	/I CES				1.00	
10.00				ne 22)			159, 509	
11. 00							0	11. 00
12.00	Cost of all services (excluding overhead) (s		and 1	11)			159, 509	
13. 00	Ratio of RHC/FQHC services (line 10 divided						1. 000000	
14. 00				_			102, 518	
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions	s)			76, 442	
16.00							178, 960	
17.00	Allowable GME overhead (see instructions)						170.040	17.00
18. 00 19. 00		no 12 v lino 10))				178, 960 178, 960	
	Total allowable cost of RHC/FQHC services (s		,	10)			338, 469	
∠∪. ∪∪	Tiotal allowable cost of knc/runc services (S	uiii 01 111165 10	anu	17)			J 330, 409	₁ 20.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	HOSPITAL Provider CCN: 150037	Peri od:	u of Form CMS-2 Worksheet M-3	
		Component CCN: 153987	From 01/01/2015 To 12/31/2015	Date/Time Prep 5/26/2016 2:2	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
				1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1. 00	
. 00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, li	ne 20)		338, 469	1. (
. 00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		8, 307	2.
. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			330, 162	
. 00	Total Visits (from Wkst. M-2, column 5, line 8)	1: 0)		2, 373	
. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	line 9)		24 2. 397	5. 6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			137. 74	
. 00	haj asted east per visit (The 3 drivided by The 9)		Cal cul ati on		,.
			Prior to	On on After	
			January 1	January 1	
			1. 00	2. 00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	80. 44	
00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	80. 44	9.
. 00	Program covered visits excluding mental health services (from	contractor records)	0	289	10
. 00	Program cost excluding costs for mental health services (line		0	23, 247	
	Program covered visits for mental health services (from contra		0	0	12
3. 00	Program covered cost from mental health services (line 9 x li	,	0	0	
1. 00	Limit adjustment for mental health services (see instructions		0	0	
5. 00 5. 00	Graduate Medical Education Pass Through Cost (see instruction: Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 23, 247	
5. 00 5. 01	Total program charges (see instructions)(from contractor's re			65, 083	
5. 02	Total program preventive charges (see instructions)(from provi			03, 003	16.
6. 03	Total program preventive costs ((line 16.02/line 16.01) times			0	
5. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)			14, 478	
5. 05	Total program cost (see instructions)			14, 478	16.
7. 00	Primary payer amounts			0	17.
3. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		5, 150	18.
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		11, 987	19.
0. 00	Net Medicare cost excluding vaccines (see instructions)			14, 478	
	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		3, 347	
2. 00	Total reimbursable Program cost (line 20 plus line 21)			17, 825	
	Allowable bad debts (see instructions)			0	23.
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
5. 50	Pi oneer ACO demonstration payment adjustment (see instructions	s)		0	1
	Net reimbursable amount (see instructions)	- /		17, 825	
6. 01	Sequestration adjustment (see instructions)			357	
7. 00	Interim payments			13, 748	27.
8. 00	Tentative settlement (for contractor use only)			0	28.
	Balance due component/program (line 26 minus lines 26.01, 27,			3, 720	
0.00	Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub 15-11		0	30.

Heal th	ealth Financial Systems HANCOCK REGIONAL HOSPITAL		In Lie	In Lieu of Form CMS-2552-10			
COMPUT	ATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provi der CCN: 150037	Peri od:	Worksheet M-4			
			From 01/01/2015				
		Component CCN: 153987	To 12/31/2015				
	Title XVIII			5/26/2016 2: 2:	2 pm		
				Cost			
			Clinic (RHC) I				
			Pneumococcal	I nfl uenza			
			1. 00	2. 00			
1.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff ti Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		159, 509	159, 509	1. 00		
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	health care staff time	e 0. 000821	0.007011	2.00		
3.00	Pneumococcal and influenza vaccine health care staff cost (line	1 x line 2)	131	1, 118	3.00		
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fro	m your records)	903	1, 763	4. 00		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	1, 034	2, 881	5. 00		
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line	22)	159, 509	159, 509	6. 00		
7.00	Total overhead (from Wkst. M-2, line 16)	•	178, 960	178, 960	7. 00		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tota	direct cost (line 5	0. 006482	0. 018062	8. 00		
	divided by line 6)						
9.00				3, 232	9. 00		
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of			6, 113	10. 00		
	lines 5 and 9)			,			
11. 00	Total number of pneumococcal and influenza vaccine injections (from your records)	13	111	11. 00		
12. 00			168. 77	55. 07	12.00		
	10.000 10.	·	1				

12

2, 025

24

1, 322

8, 307

3, 347

13.00

14.00

15.00

16.00

Number of pneumococcal and influenza vaccine injections administered to Program

16.00 Total Program cost of pneumococcal and influenza vaccine and its (their)

Program cost of pneumococcal and influenza vaccine and its (their) administration

Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)

administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,

13.00

14.00

15.00

benefi ci ari es

line 21)

(line 12 x line 13)

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVIDER FOR SERVICE	Provider CCN: 150037		Worksheet M-5		
RENDERED TO PROGRAM BENEFICIARIES		Component CCN: 153987	From 01/01/2015 To 12/31/2015			
			Rural Health	Cost		

			Rural Health	Cost	
			Clinic (RHC) I		
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to provider			13, 748	1
00	Interim payments payable on individual bills, either submit			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	t based on subsequent			3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider			,	
01				0	3
02				0	3
03				0	3
04				0	3
05				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	,
54				0	,
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	,
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		13, 748	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date of	-		Ę
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	í
02				0	í
03				0	Ę
	Provider to Program				
50				0	Ę
51				0	Ę
52				0	É
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	į
00	Determined net settlement amount (balance due) based on the cost report. (1)				6
01	SETTLEMENT TO PROVIDER			3, 720	
02	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			17, 468	-
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
00	Name of Contractor				8