PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANCOCK REGIONAL HOSPITAL (15-0037) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	RI CK EDWARDS
	Officer or Administrator of Provider(s)
	CFO

Title

(Dated when report is electronically signed.)

In Lieu of Form CMS-2552-10

Worksheet S

Parts I-III

number of times reopened = 0-9.

OMB NO. 0938-0050 EXPIRES 03-31-2022

Date/Time Prepared:

1:27 pm

8/28/2020 1:27 pm

Time:

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	113, 037	70, 815	0	-199, 791	1.00
2.00	Subprovider - IPF	0	2, 811	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		10, 582		0	10.00
200.00	Total	0	115, 848	81, 397	0	-199, 791	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 Please note that any correspondence not pertaining to the information collection burden approved Reports Clearance Office. 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.

UJFI	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX	HANCOCK REGIO			15-0037	Peri od:	LICC	Workshe		<u>2552-1</u> ,
	TAL AND HOSFITAL HEALTH CARE COMPLEX	TDENTITICATION DATA	FIOVIC	Jer CON.	15-0057	From 01/01/2 To 12/31/2		Part I Date/Ti	ime Pre	epared
	1.00	2.00		3.00		4	. 00	8/28/20	<u>J20 1: 2</u>	/ pm
	Hospital and Hospital Health Care C									
. 00	Street: 801 NORTH STATE STREET	PO Box:								1.0
. 00	City: GREENFIELD	State: IN	Zip Coc			ty: HANCOCK			(D	2.0
		Component Name	CCN Number	CBSA Numbe		- Date Certified		ent Syst , O, or		
			Number	Numbe	i j iype		V	XVIII		1
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. 00	Subprovider - IPF	HANCOCK REGIONAL GERO PSYCH UNIT	15S037	26900) 4	12/01/1996	Ν	P	N	4.0
. 00	Subprovider - IRF									5.0
. 00	Subprovider - (Other)									6.0
00	Swing Beds - SNF									7.0
. 00	Swing Beds - NF									8.0
00	Hospital-Based SNF									9.0
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3.00 1.00		HANCOCK REGI ONAL	151547	26900		02/02/1996				14. (
+. 00	hospi tai -based hospi ce	HOSPI CE	131347	20700	,	02/02/1990				14.0
5.00	Hospital-Based Health Clinic - RHC	KNI GHTSTOWN RURAL	153987	26900		09/22/1998	Ν	0	N	15.0
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	Cost Reporting Period (mm/dd/yyyy)					01/01/20	19	12/31/	/2019	20.0
1.00	Type of Control (see instructions)					7				21.0
	Inpatient PPS Information				1.00	2.00		3. (00	
2.00		t currently receiving p	avments fo	r	Y	N				22.0
	disproporti onate share hospi tal adju	5	2							22.
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2. 02	facility subject to 42 CFR Section a hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu- the portion of the cost reporting period Enter in column 2, "Y" for yes or "I reporting period occurring on or af Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "I cost reporting period prior to Octol or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in a for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af Does this hospital contain at least counted in accordance with 42 CFR 4 yes or "N" for no.	br yes or "N" for no. Is §412.106(c)(2)(Pickle and pr yes or "N" for no. noompensated care paymer umn 1, "Y" for yes or "N eriod occurring prior to N" for no for the portion ter October 1. (see inst t requires final uncompe eport settlement? (see i N" for no, for the portion of the porting period hic reclassification fro rds for delineating stat column 1, "Y" for yes or ng period prior to Octob no for the portion of the ter October 1. (see inst 100 but not more than 4 12.105)? Enter in column edicaid days on lines 24 of admission, 2 if cens of identifying the days	s this mendment hts for th N" for no o October on of the tructions) ensated ca nstructic on of the 2, "Y" for d on or af bom urban t tistical a c "N" for per 1. Ent the cost tructions) 499 beds (n 3, "Y" f 4 and/or 2 sus days, s in this	is for 1. cost re ns) yes ter o reas no er as cor 5 or 3	Ν	N		Ν	I	22.

DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		OSPITAL Provider CC	N: 15-0037	Peri od:	In Lieu	Workshe		
					31/2019	Part I Date/Ti 8/28/20	020 1:2	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Med	ther li cai d lays	
4.00 If this provider is an LDDS bespital optor the	1.00	<u>2.00</u> 575	3.00	4.00	5.00	548	<u>5.00</u>	24.0
 4.00 If this provider is an IPPS hospital, enter the 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. 5.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 3, 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. 	0	0		0		0		24.0
				Urban/F	Rural S	Date of 2.(-
6.00 Enter your standard geographic classification (not w		at the be	ginning of		1	2.1		26.0
cost reporting period. Enter "1" for urban or "2" for 7.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status or "2" for r	ural. If a		st	1			27.0
5.00 If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	e number of	periods S	CH status in		0	Endi	pa:	35.0
				Begi n 1.		Endi 2. (
6.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for num	ber				36.
7.00 If this is a Medicare dependent hospital (MDH), ente		r of perio	ds MDH statu	ls	0			37.
is in effect in the cost reporting period. 7.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)	he MDH tran for yes or "	sitional pa N" for no.	ayment in (see					37.
3.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.
				Y/ 1.		Y/ 2. (1
9.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet), (ii), or the mileage	(iii)? En requireme	ter in colun nts in	nn	/	Y	×	39. (
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	II)? Enter	In corumn.	2 Y FOF Y					1 10
	on adjustmen ober 1. Ente	t? Enter "' r "Y" for :	Y" for yes (or N	1	Y		40.0
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) D.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo	on adjustmen ober 1. Ente	t? Enter "' r "Y" for :	Y" for yes (or N	V 1.00	XVIII 2,00	XI X 3, 00	40.
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) D.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital	on adjustmen ober 1. Ente . (see inst	t? Enter " r "Y" for <u>;</u> ructions)	Y" for yes o yes or "N"	or M for	1.00	2.00	3.00	-
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) D.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	on adjustmen ober 1. Ente . (see inst	t? Enter " r "Y" for <u>;</u> ructions)	Y" for yes o yes or "N"	or M for	1.00			
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	n adjustmen ber 1. Ente . (see inst nt for disp ception for	t? Enter "' r "Y" for y ructions) roportiona extraordina	Y" for yes o yes or "N" te share in ary circums	accordance	1.00	2.00	3.00	45.
 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octor no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) 0.01 Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS 3.00 Is the facility electing full federal capital paymen 	on adjustmen ober 1. Ente . (see inst ent for disp ception for capital? E	t? Enter " r "Y" for ructions) roportiona extraordina II and Wks nter "Y fo	Y" for yes o yes or "N" te share in ary circums t. L-1, Pt. r yes or "N"	accordances I through	1.00	2.00 N	3.00 N	40. 45. 46. 47. 48.
 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octoon in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment excoupursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 10 Is this a new hospital under 42 CFR §412.300(b) PPS 00 Is the facility electing full federal capital payment Teaching Hospitals 00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you 	on adjustmen bber 1. Ente . (see inst ent for disp eeption for it. L, Pt. I capital? E t? Enter " approved G impacted by	t? Enter " r "Y" for ructions) roportiona extraordina II and Wks nter "Y for Y" for yes ME program CR 11642	Y" for yes or yes or "N" te share in ary circums t. L-1, Pt. r yes or "N" or "N" for s? Enter "Y	or Norman Stranger Norman Stranger Norman Stranger Strang	1.00 N N N N N N N N N N N N	2.00 N N N	3.00 N N	45. 46. 47. 48.
 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octor no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) 5.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS 8.00 Is the facility electing full federal capital paymen Teaching Hospitals 5.00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " 	en adjustmen ber 1. Ente . (see inst ent for disp eeption for st. L, Pt. I capital? E tapproved G impacted by no in colu period duri or yes or "N th of this Y", complet	t? Enter " r "Y" for ructions) roportiona extraordina II and Wks nter "Y for Y" for yes ME program CR 11642 mn 2. ng which re for no i cost repor e Workshee	Y" for yes o yes or "N" te share in ary circums t. L-1, Pt. r yes or "N" or "N" for s? Enter "Y" (or subseque esidents in n column 1. ting period	accordance accordance tances I through ' for no. no. ' for yes o ent CR), MA approved If column ? Enter ")	1.00 → N N N N N N N N N N N N N N	2.00 N N N	3.00 N N	45. 46. 47. 48. 56.
 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octoon in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital 00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) 5.00 Is this facility eligible for additional payment excours pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 7.00 Is the facility electing full federal capital paymen Teaching Hospitals 5.00 Is this a new hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for "Section at this facility? Enter "Y" for is "Y" did residents start training in the first mon 	on adjustmen ober 1. Ente . (see inst ent for disp ception for it. L, Pt. I capital? E tapital? E taproved G impacted by no in colu period duri or yes or "N th of this Y", complet I, if appli	t? Enter " r "Y" for ructions) roportiona extraordina II and Wks nter "Y for Y" for yes ME program CR 11642 mn 2. ng which ru cost repor cost repor c Workshee cable.	Y" for yes or yes or "N" te share in ary circums t. L-1, Pt. r yes or "N" or "N" for s? Enter "Y' (or subseque esidents in n column 1. ting period' t E-4. If co	accordance tances I through ' for no. no. ' for yes o ent CR), MA approved If column 2 Enter ") olumn 2 is	1.00 → N N N N N N N N N N N N N N	2.00 N N N	3.00 N N	45. 46. 47.

ealth Financial Systems HANCOCK IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Pre 8/28/2020 1:2	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
 0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in coll of line 60 is yes, complete columns 2 and 3 for each 	.85? (s Lumn 1. CR) NAHE umn 2.	see If column 1 E MA payment	Y	Y 23.00	1	60. 0 60. 0
instructions)	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	1.00	2.00	3.00	0.00		61.00
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 0 ⁻
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.0
61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
	Pro	gram Name	Program Code	IME FTE Count	Unweighted Direct GME FTE Count	
1 10 Of the ETEC in Line (1 OF energify such as a		1.00	2.00	3.00	4.00	61 1
11.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.1
11.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0.00	0. 00	61.2
the direct GME FTE unweighted count.						
					1.00	
ACA Provisions Affecting the Health Resources and Se 2.00 Enter the number of FTE residents that your hospital				riod for which		62.0
your hospital received HRSA PCRE funding (see instru- 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC pro-	ctions) a Teachi gram. (s	ng Health Cer see instructio	nter (THC) int			62.0
Teaching Hospitals that Claim Residents in Nonprovid 3.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, completion	ettings	during this c			N	63.0

)SPI 1	Financial Systems TAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION D	ATA Provider Co		eriod: com 01/01/2019	Worksheet S-2 Part I	
				Tc			
				Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	-
	Section 5504 of the ACA Base Yea	r FTE Residents in N	lonprovider Settings-				
	period that begins on or after J			-	-		
4. 00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.C
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		5	Ĵ	FTËs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
	-	1.00	0.00	Site	1.00	F 00	-
5.00	Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	65 0
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unweighted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
	Coation FEOA of the ACA Com	Voor FTF Deeldeed	n Nonnovi der Cett	1.00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsErrective r	or cost report	ing periods	
5. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. C
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		. g		FTĔs	FTEs in	3/ (col . 3 +	
				Nonprovi der	Hospi tal	col. 4))	
		1 00	2.00	Si te	4.00	5.00	-
. 00	Enter in column 1, the program	1.00	2.00	3.00	4.00		67 (
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						

Heal th	Financial Systems HANCOCK REGIONAL HOSPITAL	١r	n Lieu	of Form	n CMS-2	2552-10
HOSPI T		eriod: rom 01/01/ o 12/31/	2019 2019	Workshe Part I Date/Ti 8/28/20	me Pre	pared:
				2.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	provi der?	Y			70.00
71.00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportin (see instructions)	no. (see hi ng no.	N	N	0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	r "N" for with 42	N	N	0	76.00
				1.0	0	
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
	Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? E	Inter	N		81.00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectio §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		no.	N		85.00 86.00
	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			Ν		87.00
		V 1.00		XI) 2. 0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Y		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Ν		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		Ν		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0. 0 N		95.00 96.00
	IF line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 Y		0. 0 Y	0	97.00 98.00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N		N		98.03
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N		N		98.04
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y		Y		98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.06
105 00	Rural Providers Does this hospital qualify as a CAH?	N				105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?	N				107.00
107.00	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an	N				107

Health Financial Systems HANCOCK REGIONAL	HOSPI TAL		In Lieu	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		eriod: com 01/01/2019 0 12/31/2019	Worksheet S- Part I Date/Time Pr 8/28/2020 1:	epared:
			V	XIX	
108.00 Is this a rural hospital qualifying for an exception to the C	RNA fee sche	edul e? See 42	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1. 00	2. 00	Speech 3.00	4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
110.00 Did this hospital participate in the Rural Community Hospital	Demenetrati	on project (64	104	1.00 N	110.00
Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work applicable.	" for yes or	"N" for no. It	F yes,	N	110.00
			1.00	2.00	
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting umn 1 is Y, icipating in	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable.	oeriod? "Y", enter e	N	2.00		112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub.15-1, chapter 22, §2208.1.	or E only) B" percent ncludes S) based on				
116.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insura	nce? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre	5	2			118.00
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 813,499	2.00	3.00	0118.01
		010/177			
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.			<u>1.00</u> N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for t	(" for yes or he Outpatient	Ν	Ν	119.00 120.00
121.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	ntable device	es charged to	Y		121.00
122.00 Does the cost report contain heal thcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A Line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, ent	-				126.00
in column 1 and termination date, if applicable, in column 2.					
127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.					127.00
128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.					128.00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	the certifi	cation date in			129.00

SPITAL AND HOSPITAL HEALTH CARE COMPLE		A Provider CC	N: 15-003	From			2
						8/28/2020 1::	
					1.00	2.00	-
0.00 If this is a Medicare certified pa date in column 1 and termination of			tificatio	n			130.0
31.00 If this is a Medicare certified in	ntestinal transplant	center, enter the ce	erti fi cat	i on			131. 0
date in column 1 and termination of 2.00 If this is a Medicare certified is			cation d	ate			132.0
in column 1 and termination date,							
 3.00Removed and reserved 40.00 If this is an organ procurement or and termination date, if applicabl All Providers 		ter the OPO number i	n column	1			133.0 134.0
0.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	'N" for no in column	1. If yes, and home	office c		N		140. 0
1.00		2.00			3.00		
If this facility is part of a chai office and enter the home office of			ugh 143 t	he name a	and address	of the home	
1.00Name:	Contractor's Nam		Contr	actor's I	Number:		141.0
12.00Street: 13.00City:	PO Box: State:		Zip C	ode:			142. C
							_
4.00 Are provider based physicians' cos	sts included in Works	heet A?				1.00 Y	144.0
					1 00	2.00	_
5.00 If costs for renal services are cl	aimed on Wkst. A, li	ne 74, are the costs	s for		1.00	2.00	145.0
 inpatient services only? Enter "Y' no, does the dialysis facility inc period? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes onter the approval data (mm/ 	clude Medicare utiliza for no in column 2. gy changed from the p n column 1. (See CMS)	ation for this cost reviously filed cos [:]	reportin t report?	g	Ν		146. (
yes, enter the approval date (mm/o	dd/yyyy) in column 2.						
jyes, enter the approvar date (mm/d	dd/yyyy) in column 2.					1.00	-
7.00Was there a change in the statisti	cal basis? Enter "Y"					N	147.0
	cal basis? Enter "Y" f allocation? Enter "Y	Y" for yes or "N" fo	or no.	for no.			148.0
7.00Was there a change in the statisti 8.00Was there a change in the order of	cal basis? Enter "Y" f allocation? Enter "Y	Y" for yes or "N" fo od? Enter "Y" for ye Part A	or no. es or "N" Part	В	Title V	N N Title XIX	148.0
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Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-0037	Period:	Worksheet S-2	2
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	nning date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provide	er have any days for indi	viduals enrolled in	N	(171.00
section 1876 Medicare cost plans repo	orted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column	1. If column 1 is yes, e	nter the number of section	on		
1876 Medicare days in column 2. (see	instructions)				

USPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0037	Period: From 01/01/2019 To 12/31/2019	8/28/2020 1:	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N 1 mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ent	1.00 Ter all dates in	2.00 the	
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the l			N		1.00
	reporting period? If yes, enter the date of the change in col	Tumn 2. (see	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Proyec, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.00
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug r or its the board	N			3.00
			Y/N	Туре	Date	
			1.00	2.00	3.00	-
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avail column 3. (see instructions) If no, see instructions.	r Compiled, lable in	Y	A		4.00
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit recom		N			5.00
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:		na nravidar i	s N		
. 00	the legal operator of the program?	ii yes, is ti	në provider i	S N		6.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a		d during the	Y N		7.00 8.00
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved qu	raduate medio	cal educatior	n N		9.00
0.00	program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.			N		10.00
1.00	Are GME cost directly assigned to cost centers other than I a Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.00
					Y/N 1.00	
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection pol period? If yes, submit copy.			cost reporting	Y N	12.00 13.00
	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement				N	14.00
5.00	Did total beds available change from the prior cost reporting		<u>yes, see ins</u> t A	Par	N + P	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.00
7. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	03/05/2019	Y	03/05/2019	17.00
8. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		Ν		18.00
9. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.00

HUGDLI	Financial Systems HANCOCK REGION				u of Form CM	
10341 1	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCI	N: 15-0037	Period: From 01/01/2019 To 12/31/2019		repared:
		Descrip	otion	Y/N	Y/N	
20.00	If line 14 on 17 is use were adjustments made to DCOD	0		1.00 N	3.00 N	20.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
21.00	Wee the east report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	OSPI TALS)			
	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions				22.00
	Have changes occurred in the Medicare depreciation expense		als made du	ring the cost		23.00
	reporting period? If yes, see instructions.					
24.00	Were new leases and/or amendments to existing leases entered If yes, see instructions	ed into during ·	this cost r	eporting period?		24.00
25.00	Have there been new capitalized leases entered into during	the cost repor-	ting period	?lfyes, see		25.00
a (instructions.					
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period?	It yes, see		26.00
27.00	Has the provider's capitalization policy changed during the	e cost reporting	g period? I	fyes, submit		27.00
	copy.					
28.00	Interest Expense Were new Loans, mortgage agreements or letters of credit er	ntered into duri	ing the cos	t reporting		28.00
	period? If yes, see instructions.		C			
29.00	Did the provider have a funded depreciation account and/or		bt Service	Reserve Fund)		29.00
30.00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt?lfve	s. see		30.00
	instructions.	-	-			
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new of	debt? If ye	s, see		31.00
	instructions. Purchased Services					
	Have changes or new agreements occurred in patient care ser		d through c	ontractual		32.00
22 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		a to compot	itiyo biddina? If	-	33.00
55.00	no, see instructions.	bired pertaining	g to compet	r ti ve bi ddi ng: Ti		33.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-b	ased physi ci ans?		34.00
35.00	If line 34 is yes, were there new agreements or amended exi	sting agreemen	ts with the	provi der-based		35.00
	physicians during the cost reporting period? If yes, see in					
				Y/N 1.00	Date 2.00	
	Home Office Costs			1.00	2.00	
	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 pr	repared by the I	home office	?		37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	ice different	from that o	f		38.00
	the provider? If yes, enter in column 2 the fiscal year end					
39.00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compone	ents? If ye	S,		39.00
40.00	If line 36 is yes, did the provider render services to the	home office?	lfyes, see			40.00
40.00	instructions.		-			
40.00		1.0	0	2.	00	_
40.00						
	Cost Report Preparer Contact Information	1.0	0		00	
	Enter the first name, last name and the title/position	TINA	0	SEVERS		41.00
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,					41.00
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.					41.00
41. 00 42. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	TI NA	0			

Heal th	Financial Systems	HANCOCK REGION	NAL HOSPITAL	_	In Lie	u of Form CMS-:	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE	Provi dei	r CCN: 15-0037	Period:	Worksheet S-2	
			_		From 01/01/2019 To 12/31/2019	Part II Date/Time Pre 8/28/2020 1:2	pared: 7 pm
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the ti-	tle/position	MANAGER				41.00
	held by the cost report preparer in columns	s 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cos	t report					42.00
	preparer.						
43.00	Enter the telephone number and email addres	ss of the cost					43.00
	report preparer in columns 1 and 2, respectively	ti vel y.					

HOSPLI	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0037	Peri od:	Worksheet S-3	
1100111			in ovraci o	. 10 0007	From 01/01/2019	Part I	
					To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
						I/P Days /	7 piii
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
1 00		1.00	2.00	3.00	4.00	5.00	1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	37	13, 50	0. 00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF			1		0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		37	13, 50	0. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	24	8,70	50 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00 11.00	BURN INTENSIVE CARE UNIT						10.00 11.00
12.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						12.00
13.00	NURSERY						12.00
14.00	Total (see instructions)		61	22, 20	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3, 65	50	0	16.00
17.00	SUBPROVIDER - IRF	41.00	0		0	0	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	101.00					21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	116.00	7	2, 55			23.00 24.00
24.00	HOSPICE (non-distinct part)	30.00	/	2, 3	55		24.00
25.00	CMHC - CMHC	50.00					24.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		78			-	27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32. 01	Total ancillary labor & delivery room						32.01
33.00	outpatient days (see instructions) LTCH non-covered days						33.00
							JJ. UU

	nancial Systems AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HANCOCK REGIONA	Provider CO		Period: From 01/01/2019		8
					To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
		I/P Davs	/ O/P Visits	/ Trips	Full Time I	Equi val ents	<u>, pm</u>
						1	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Patients	& Residents	Payrol I	
00 11		6.00	7.00	8.00	9.00	10.00	
	ospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and	1, 404	107	3, 68	3		1.
	ospice days)(see instructions for col. 2						
	or the portion of LDP room available beds)						
	10 and other (see instructions)	0	1, 096				2.
	10 I PF Subprovi der	0	1,070				3.
	10 I RF Subprovi der	0	0				4.
	ospital Adults & Peds. Swing Bed SNF	0	0		o		5.
	ospital Adults & Peds. Swing Bed NF	0	0		0		6.
	tal Adults and Peds. (exclude observation	1, 404	107	3, 68	-		7.
	eds) (see instructions)	.,		0,00			''
	ITENSI VE CARE UNI T	1, 973	19	4, 99	2		8.
	DRONARY CARE UNIT						9.
	JRN INTENSIVE CARE UNIT						10.
. 00 SU	JRGI CAL I NTENSI VE CARE UNI T						11
	HER SPECIAL CARE (SPECIFY)						12
3. OO NU	JRSERY						13
I. 00 To	otal (see instructions)	3, 377	126	8, 67	5 0.00	635.66	14
5. 00 CA	AH visits	O	0		0		15
. 00 SU	JBPROVIDER – IPF	1, 683	0	2,45	8 0.00	16. 44	16
. 00 SU	JBPROVIDER – IRF	O	0		0 0.00	0.00	17
. 00 SU	JBPROVI DER						18
. 00 SK	KILLED NURSING FACILITY						19
. OO NU	JRSING FACILITY						20
. 00 OT	HER LONG TERM CARE						21
. OO HO	DME HEALTH AGENCY	0	0		0 0.00	0.00	22
. OO 🛛 AM	IBULATORY SURGI CAL CENTER (D. P.)						23
. 00 HO	OSPI CE	0	0	1, 14	2 0.00	16.65	24
	OSPICE (non-distinct part)				0		24
	IHC – CMHC						25
	JRAL HEALTH CLINIC	297	0	-,			
	DERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
	otal (sum of lines 14-26)				0.00	673.11	
	oservation Bed Days		0	2, 98	6		28
	nbul ance Tri ps	0					29
	nployee discount days (see instruction)			4			30
	ployee discount days - IRF				0		31
	abor & delivery days (see instructions)	0	28		8		32
	otal ancillary labor & delivery room				0		32
	itpatient days (see instructions)						
	CH non-covered days	0					33
. 01 LT	CH site neutral days and discharges	0					33

HOSPI T <i>i</i>	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0037	Period: From 01/01/2019 To 12/31/2019		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00			2, 538	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)				0 316	2,000	2. 0
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider				0		3.0 4.0
6. 00 7. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						5.00 6.00 7.00
9. 00 10. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						8.00 9.00 10.00
12. 00 13. 00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						11.00 12.00 13.00
15.00	Total (see instructions) CAH visits	0.00	C			2, 538	14.00 15.00
17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	0. 00 0. 00	C		0 0 0	227 0	16.00 17.00 18.00
19.00 20.00	SKILLED NURSING FACILITY NURSING FACILITY						19. 0 20. 0
22.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	0.00					21.0 22.0 23.0
24.00 24.10	HOSPICE HOSPICE (non-distinct part)	0.00					24.0 24.1
26.00	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					25.0 26.0 26.2
7.00 8.00	Total (sum of lines 14-26) Observation Bed Days	0.00					27.0 28.0
0.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF						29.0 30.0 31.0
2.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)						32. C 32. C
33.00	LTCH non-covered days LTCH site neutral days and discharges				0		33. C 33. C

SPI T	AL WAGE INDEX INFORMATION			Provider C		eriod: rom 01/01/2019	Worksheet S-3 Part II	
					Ť		Date/Time Pre 8/28/2020 1:2	par
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
00	Total salaries (see	200.00	53, 033, 815	-159, 886	52, 873, 929	1, 394, 181. 38	37.92	1
0	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	
	A				0			
0	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3
0	Physician-Part A - Administrative		0	0	0	0.00	0.00	4
)1	Physicians - Part A - Teaching		0	-	-	0.00		
00	Physician and Non Physician-Part B		1, 990, 147	0	1, 990, 147	15, 601. 55	127.56	5
00	Non-physician-Part B for hospital-based RHC and FQHC services		99, 355	0	99, 355	4, 735. 34	20. 98	6
0	Interns & residents (in an	21.00	0	0	0	0.00	0.00	7
)1	approved program) Contracted interns and residents (in an approved		O	0	0	0.00	0.00	7
00	programs) Home office and/or related organization personnel		0	0	0	0.00	0.00	8
00	SNF	44.00	0	0	-	0.00		
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		9, 418, 240	173, 220	9, 591, 460	205, 158. 00	46. 75	10
00	Contract Labor: Direct Patient Care		52, 294	0	52, 294	899.00	58. 17	11
00	Contract labor: Top level management and other management and administrative		C	0	0	0.00	0.00	12
00	services Contract Labor: Physician-Part		176, 725	0	176, 725	1, 655. 48	106. 75	13
00	A - Administrative Home office and/or related organization salaries and		0	0	0	0.00	0.00	14
01	wage-related costs Home office salaries		0	0	0	0.00	0.00	14
02	Related organization salaries		0	0	0	0.00	0.00	14
00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15
00	Home office and Contract		0	0	0	0.00	0.00	16
01	Physicians Part A - Teaching Home office Physicians Part A		0	o	0	0.00	0.00	16
02	- Teaching Home office contract		0	0		0.00	0.00	14
02	Physicians Part A - Teaching				0	0.00	0.00	
00	WAGE-RELATED COSTS Wage-related costs (core) (see		8, 402, 470	0	8, 402, 470			17
	instructions) Wage-related costs (other) (see instructions)							18
00	Excluded areas Non-physician anesthetist Part		1, 750, 722	0	1, 750, 722			19
00 00	A Non-physician anesthetist Part		26, 155	0	26, 155			20 2
00	B Physician Part A - Administrative		0	0	о			22
	Physician Part A - Teaching		0	0	0			22
00 00 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		212, 010 26, 155 0		212, 010 26, 155 0			23 24 25
50	approved program) Home office wage-related		O	0	0			25
51	(core) Rel ated organi zati on		0	0	0			25
52	wage-related (core) Home office: Physician Part A - Administrative -		O	0	0			25

Heal th	Financial Systems		HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part II Date/Time Pre 8/28/2020 1:2	pared:
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col		(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI				1			
26.00	Employee Benefits Department	4.00	528, 059		020,00		40.97	
27.00	Administrative & General	5.00	10, 477, 716				43.58	
28.00	Administrative & General under		211, 570	0	211, 57	1, 742. 00	121.45	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	1, 109, 744	-8, 881	1, 100, 86		31.80	
31.00	Laundry & Linen Service	8.00	0	0		0 0.00	0.00	
32.00	Housekeepi ng	9.00	1, 646, 808	-1, 513	1, 645, 29			32.00
33.00	Housekeeping under contract		0	0		0 0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	1, 471, 746	-1, 032, 726	439, 02			34.00
35.00	Dietary under contract (see		0	0		0 0.00	0.00	35.00
	instructions)							
36.00	Cafeteria	11.00	0	1, 030, 494	1, 030, 49			36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	
38.00	Nursing Administration	13.00	1, 375, 427				46. 17	38.00
39.00	Central Services and Supply	14.00	179, 191				23.39	
40.00	Pharmacy	15.00	1, 982, 590				46. 78	
41.00	Medical Records & Medical Records Library	16.00	600, 136	-11, 014	589, 12	22 21, 967. 49	26.82	41.00
42.00	Social Service	17.00	Ω	n –		0 0.00	0 00	42.00
	Other General Service	18.00	0			0 0.00		43.00
+5.00		1 10.00	0	0	I	0.00	0.00	1 10.00

Heal th	Financial Systems		HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		51, 155, 883	-159, 886	50, 995, 99	7 1, 375, 586. 49	37.07	1.00
	instructions)							
2.00	Excluded area salaries (see		9, 418, 240	173, 220	9, 591, 46	0 205, 158. 00	46.75	2.00
	instructions)							
3.00	Subtotal salaries (line 1		41, 737, 643	-333, 106	41, 404, 53	7 1, 170, 428. 49	35.38	3.00
	minus line 2)							
4.00	Subtotal other wages & related		229, 019	0	229, 01	9 2, 554. 48	89.65	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 402, 470	0	8, 402, 47	0 0.00	20. 29	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		50, 369, 132	-333, 106	50, 036, 02	6 1, 172, 982. 97	42.66	6.00
7.00	Total overhead cost (see		19, 582, 987	-322, 811	19, 260, 17	6 556, 264. 38	34.62	7.00
	instructions)							
					•		•	•

Heal th	Financial Systems	HANCOCK REGI ONAL	HOSPI TAL				In Lie	u of Form CMS-2	2552-10
	TAL WAGE RELATED COSTS		Provi der	CCN:	15-0037		/01/2019 2/31/2019	Worksheet S-3 Part IV	pared:
								Amount	
								Reported 1.00	
	PART IV - WAGE RELATED COSTS							1.00	
	Part A - Core List								
	RETIREMENT COST								
1.00	401K Employer Contributions							0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contr	i buti on						0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (se	e instructions)						2, 330, 252	3.00
4.00	Qualified Defined Benefit Plan Cost (see i	nstructions)						0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)							
5.00	401K/TSA Plan Administration fees							0	5.00
6.00	Legal /Accounting/Management Fees-Pension P							0	6.00
7.00	Employee Managed Care Program Administrati	on Fees						0	7.00
	HEALTH AND INSURANCE COST								
8.00	Health Insurance (Purchased or Self Funded							0	8.00
8.01	Health Insurance (Self Funded without a Th							0	
8.02	Health Insurance (Self Funded with a Third	Party Administrate	or)					3, 751, 267	
8.03	Health Insurance (Purchased)							0	
9.00	Prescription Drug Plan							0	
10.00	Dental, Hearing and Vision Plan							468, 999	
11.00 12.00	Life Insurance (If employee is owner or be Accident Insurance (If employee is owner o							-96, 300 0	
12.00	Disability Insurance (If employee is owner							301, 528	
14.00	Long-Term Care Insurance (If employee is or		0					301, 528	
15.00	'Workers' Compensation Insurance	when or beneficially						-73, 622	
16.00	Retirement Health Care Cost (Only current	vear not the extra	ordi narv a	accrua	l requir	ed by FA	SB 106	, 3, 022	
	Non cumulative portion)	joar, not the oktro	ior arriar y			ou og in	0.0 1001	Ū	10100
	TAXES								
17.00	FICA-Employers Portion Only							3, 572, 475	17.00
18.00	Medicare Taxes - Employers Portion Only							0	18.00
19.00	Unemployment Insurance							31, 630	19.00
20.00	State or Federal Unemployment Taxes							0	20.00
	OTHER								
21.00	Executive Deferred Compensation (Other Than instructions))	n Retirement Cost R	eported o	n line	es 1 thro	ough 4 ab	ove. (see	0	21.00
22.00	Day Care Cost and Allowances							39, 713	22.00
23.00	Tuition Reimbursement							105, 128	
24.00		3)						10, 431, 070	24.00
	Part B - Other than Core Related Cost								
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						I		25.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0037	Period: From 01/01/2019		
		To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
Cost Center Description		Contract	Benefit Cost	
		Labor 1,00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Ident	i fi cati on:			
1.00 Total facility's contract labor and benefi	cost	52, 294	10, 431, 070	1.00
2.00 Hospital		52, 294	10, 431, 070	2.00
3.00 Subprovider - IPF		0	0	3.00
4.00 Subprovider - IRF		0	0	4.00
5.00 Subprovider - (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 Hospital-Based SNF				8.00
9.00 Hospital-Based NF				9.00
10.00 Hospital-Based OLTC				10.00
11.00 Hospital-Based HHA		0	0	
12.00 Separately Certified ASC				12.00
13.00 Hospital-Based Hospice		0	0	
14.00 Hospital-Based Health Clinic RHC		0	0	14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospital-Based-CMHC				16.00
17.00 Renal Dialysis				17.00
18.00 Other		0	0	18.00

Heal th	Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period: From 01/01/2019	Worksheet S-8	
			Component		To 12/31/2019		
					RHC I	Cost	
					1	. 00	-
	Clinic Address and Identification				•		
1.00	Street		0		224 WEST MAIN		1.00
				ty 00	<u>State</u> 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		KNI GHTSTOWN	00		46148	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "II" for	urban		1.00	3.00
5.00	Those the based tones oner. Designation - entity				Award	Date	3.00
	1				. 00	2.00	
4 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	(10	7(22	07/01/2015	1 4 00
4.00 5.00	Migrant Health Center (Section 330(d), PHS A			13	7632	0770172015	4.00 5.00
6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
7.00							7.00
					1.00	2.00	
10.00	Does this facility operate as other than a hore yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type of hours.)	ate number of	other operatio	ns in column	N	0	10.00
		Sur	nday	Мо	nday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			08: 00	16: 00	08: 00	11.00
					1.00		
12.00	Have you received an approval for an exception	on to the prod	luctivity stand	ard?	1.00	2.00	12.00
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in col- number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Ν	0	
					ler name	CCN number	
14.00	RHC/FQHC name, CCN number			1	. 00	2.00	14.00
14.00		Y/N	V	XVIII	XIX	Total Visits	14.00
	1	1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				unty	-		
2.00	City, State, ZIP Code, County		4. HENRY	00			2.00
1.50		Tuesday		esday	Thu	rsday	
		to	from	to	from	to	
	Facility hours of operations (1)	6.00	7.00	8.00	9.00	10.00	
11.00		16: 00	08: 00	16: 00	08: 00	16: 00	11.00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0037	Period:	Worksheet S-8	
		Component	CCN: 15-3987	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
					8/28/2020 1:2	7 pm
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)			_			
11.00 CLINIC	08: 00	16:00				11.00

	Financial Systems		HANCOCK REGION				u of Form CMS-2	
HOSPI T	AL-BASED HOSPICE IDENTIFICATION	I DATA		Provider CC Hospice CC	CN: 15-0037 N: 15-1547	Period: From 01/01/2019 To 12/31/2019	Worksheet S-9 PARTS I THROU Date/Time Pre 8/28/2020 1:2	GH IV pared:
						Hospi ce I	0/20/2020 1.2	7 pili
		Undupl i cated				110001001		
		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 FOR C	OST REPORTING I	PERIODS BEGINNI	NG BEFORE OCTO	DBER 1, 2015			
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGI NNI NG	BEFORE OCTOBER	R 1, 2015			
5.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8.00
	/line 6)							
9.00	Unduplicated census count							9.00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1	1, 2015		
	Hospice Continuous Home Care			0		0 0	0	10.00
	Hospice Routine Home Care			3, 090		0 0		11.00
	Hospice Inpatient Respite Care			142		0 0		12.00
	Hospice General Inpatient Care			194		0 0		13.00
14.00	Total Hospice Days			3, 426		0 0		14.00
	PART IV - CONTRACTED STATISTIC		ST REPORTING PE	RIODS BEGINNIN	IG ON OR AFTE	ER OCTOBER 1, 201		
	Hospice Inpatient Respite Care			0		0 0	0	15.00
	Hospice General Inpatient Care			0		0 0	0	16.00

<u>Heal</u> th	Financial Systems HANCOCK REGIONAL H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO	CN: 15-0037	Peri od:	Worksheet S-1	0	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 1:2		
					1.00		
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by li	ne 202 colum	in 8)	0. 247842	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				1, 358, 999	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen			ai d?	Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicai	d		0	5.00	
6.00	Medi cai d charges				37, 518, 958	6.00	
7.00	Medicaid cost (line 1 times line 6)	(1) - 7			9, 298, 774	7.00	
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	nes 2 and 5; 11	7, 939, 775	8.00			
0.00	Children's Health Insurance Program (CHIP) (see instructions fo	or each lìr	ne)		0	9.00	
9.00 10.00	0.00 Net revenue from stand-alone CHIP 0.00 Stand-alone CHIP charges						
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	10.00 11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9.	if < zero then			
12.00	enter zero)		nus rine 7,		0	12.00	
	Other state or local government indigent care program (see ins	tructions f	for each line		I		
13.00	Net revenue from state or local indigent care program (Not inc				0	13.00	
14.00	Charges for patients covered under state or local indigent care	e program ((Not included	in lines 6 or	0	14.00	
	10)						
15.00	State or local indigent care program cost (line 1 times line 1				0		
16.00	Difference between net revenue and costs for state or local in	digent care	e program (li	ne 15 minus line	0	16.00	
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	IP and stat	te/local indi	dent care prodra	ame (see		
	instructions for each line)			gent care progra	1113 (366		
17.00	Private grants, donations, or endowment income restricted to f	undi ng char	rity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of	hospital op	perations		0	18.00	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	l indigent	care program	s (sum of lines	7, 939, 775	19.00	
			Uni nsured	Insured	Total (col. 1		
			patients	patients	+ col . 2)		
	Uncompared (and instructions for each line)		1.00	2.00	3.00		
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	ci l i ty	5, 950, 4	3, 261, 957	9, 212, 418	20.00	
20.00	(see instructions)	cirity	5, 750, 40	5, 201, 957	7, 212, 410	20.00	
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	1, 474, 7	3, 261, 957	4, 736, 731	21.00	
	instructions)	,					
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00	
	chari ty care						
23.00	Cost of charity care (line 21 minus line 22)		1, 474, 7	3, 261, 957	4, 736, 731	23.00	
					1.00		
24 00	Does the amount on line 20 column 2, include charges for patien	nt days bey	ond a length	of stay limit	N 1.00	24.00	
24.00	imposed on patients covered by Medicaid or other indigent care	program?	yona a rengti	or stay rimit		24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the stay limit		t care progra	m's length of	0	25.00	
26.00							
27.00							
27.01	Medicare allowable bad debts for the entire hospital complex (•	,		250, 888		
28.00	Non-Medicare bad debt expense (see instructions)		/		11, 708, 886		
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see	instructions)	2, 989, 764		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				7, 726, 495		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			15, 666, 270	31.00	

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	HANCOCK REGIONAL	HOSPITAL	CN: 15-0037 P	In Lie	u of Form CMS-2 Worksheet A	2552-10
				F	rom 01/01/2019 p 12/31/2019	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	8/28/2020 1:2 Recl assi fi ed	7 pm
				+ col. 2)	ions (See A-6)	Trial Balance (col. 3 +-	
					,	col. 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		11, 702, 596	11, 702, 596	0	11, 702, 596	1.00
4.00 5.00	00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL	528, 059 10, 477, 716	7, 085, 768 17, 433, 073	7, 613, 827 27, 910, 789	0 -1, 443, 932	7, 613, 827 26, 466, 857	4.00 5.00
7.00	00700 OPERATION OF PLANT	1, 109, 744	5, 253, 520	6, 363, 264	1, 431	6, 364, 695	7.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 646, 808 1, 471, 746	838, 680 1, 229, 725	2, 485, 488 2, 701, 471	0 -1, 891, 687	2, 485, 488 809, 784	9.00 10.00
11.00	01100 CAFETERI A	0	0	2,701,471	1, 891, 687	1, 891, 687	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 375, 427 179, 191	392, 757 71, 880	1, 768, 184 251, 071	0	1, 768, 184 251, 071	13.00 14.00
14.00 15.00	01500 PHARMACY	1, 982, 590	16, 457, 959	18, 440, 549	-15, 737, 372	2, 703, 177	
16.00	01600 MEDICAL RECORDS & LIBRARY 02300 PARAMED ED PRGM	600, 136	310, 261	910, 397	4,650	915, 047	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	83, 227	14, 345	97, 572	0	97, 572	23.00
30.00	03000 ADULTS & PEDIATRICS	3, 112, 756	912,088		-12, 786	4,012,058	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	3, 380, 314 1, 188, 489	797, 916 243, 773	4, 178, 230 1, 432, 262	23, 791- 692-	4, 154, 439 1, 431, 570	31.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	
50.00	ANCILLARY SERVICE COST CENTERS	3, 460, 274	3, 940, 258	7, 400, 532	-28, 956	7, 371, 576	50.00
51.00	05100 RECOVERY ROOM	294, 667	57, 196	351, 863	-1, 179	350, 684	51.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 3, 400, 130	165, 403 2, 247, 977	165, 403 5, 648, 107	0 -216, 656	165, 403 5, 431, 451	53.00 54.00
60.00	06000 LABORATORY	1, 676, 817	3, 080, 832	4, 757, 649	7, 832	4, 765, 481	60.00
65.00	06500 RESPIRATORY THERAPY	1, 476, 727	275, 042	1, 751, 769	2, 589	1, 754, 358	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 143, 934 328, 056	131, 929 36, 978	1, 275, 863 365, 034	-799 0	1, 275, 064 365, 034	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	169, 616	18, 120	187, 736	0	187, 736	68.00
68. 01 69. 00	06801 OCCUPATI ONAL HEALTH 06900 ELECTROCARDI OLOGY	0 644, 396	0 1, 025, 221	0 1, 669, 617	0 14, 818	0 1, 684, 435	68.01 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	044, 390	3, 235	3, 235	-69	3, 166	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 809, 272	2, 809, 272	0	2, 809, 272	
73.00 76.00	07300 DRUGS CHARGED TO PATI ENTS 03020 CARDI AC	0	0	0	16, 674, 291 0	16, 674, 291 0	73.00 76.00
76. 01	03160 CARDI OPULMONARY	66, 814	13, 951	80, 765	0	80, 765	76.01
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	257, 888	227, 153	485, 041	-32, 161	452, 880	88.00
90.00		0	0	0	0	0	90.00
90. 01 90. 02	09001 WOUND CLINIC 09002 DIABETES CLINIC	517, 725 39, 972	268, 683 7, 308	786, 408 47, 280	-13, 721 0	772, 687 47, 280	90.01 90.02
90.03	09003 ASTHMA CLINIC	0	0	0	0 0	0	90.03
	09004 ANDIS CLINIC 09005 PRIME TIME	101, 746 0	87, 070 91, 129	188, 816 91, 129	-25 0	188, 791 91, 129	
90.05 90.06	09006 SHELBYVILLE WOUND CLINIC	178, 708	101, 540	280, 248	-3, 800	276, 448	
90.07	04951 ONCOLOGY	1,074,668	1,007,191	2,081,859	-12, 317	2,069,542	
90.08 91.00	04950 ANDERSON WOMENS CENTER 09100 EMERGENCY	350, 268 2, 568, 682	82, 379 835, 957	432, 647 3, 404, 639	- 378 - 26, 635	432, 269 3, 378, 004	90.08 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	1, 276, 486 46, 163, 777	915, 391 80, 173, 556	2, 191, 877 126, 337, 333	-118, 738 -968, 396	2, 073, 139 125, 368, 937	
	NONREIMBURSABLE COST CENTERS				,00,070		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PROFESSIONAL BUILDING	0	0 238, 275	0 238, 275	0 -13, 693	0 224, 582	190.00
	19002 PHYSI CI AN BUI LDI NG	0	16, 639	16, 639	-13, 043	16, 639	
		246, 756	628, 214	874, 970	0	874, 970	
	19004 MARKETI NG 19005 SPORTS PHYSI CALS	0 69, 949	0 8, 303	0 78, 252	1, 443, 932 -364	1, 443, 932 77, 888	
190.06	19006 FOUNDATI ON	197, 819	663, 025	860, 844	0	860, 844	190.06
	19007 ASC 19008 OTHER NONREI MBURSABLE	0 855, 615	2, 119 17, 003	2, 119 872, 618	-5 -12, 519	2, 114 860, 099	190.07
	19009 HANCOCK OB	2, 320, 072	3, 231, 908	5, 551, 980	-372, 556	5, 179, 424	
190.10	19010 HANCOCK WELLNESS	790, 135	316, 118	1, 106, 253	0	1, 106, 253	190. 10
	19011 MORRISTOWN CLINIC 19012 O3PUREMED	0	3, 000 0	3, 000 0	0		190. 11 190. 12
190.13	19013 MCCORD WELLNESS	683, 532	336, 734	1, 020, 266	0	1, 020, 266	190. 13
	19014 3 WEST UNIT 19015 NEUROLOGY PHYSICIAN	198, 470 823, 566	214, 187 338, 878	412, 657 1, 162, 444	-3 -73, 891	412, 654 1, 088, 553	
190.16	19016 THORACI	108, 978	35, 402	1, 162, 444 144, 380	-73, 891 0	144, 380	190. 16
190.17	19017 HANCOCK ENDO	115, 609	76, 462	192, 071	0	192, 071	190. 17

Health Financial Systems	HANCOCK REGION	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider C		Period: From 01/01/2019	Worksheet A	
				o 12/31/2019	Date/Time Pre 8/28/2020 1:2	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
190. 18 19018 HANCOCK FOOT & ANKLE	401, 253	219, 886	621, 139	-2, 505	618, 634	190.18
190. 19 19019 HANCOCK RHEUM	58, 284	26, 438	84, 722	0	84, 722	190. 19
200.00 TOTAL (SUM OF LINES 118 through 199)	53, 033, 815	86, 546, 147	139, 579, 962	0	139, 579, 962	200.00

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		Provider CCN: 15-	-0037 Period: From 01/01/20 To 12/31/20	
	Cost Center Description	Adjustments	Net Expenses		8/28/2020 1:27 pm
		(See A-8)	For		
		(00	Allocation		
	GENERAL SERVICE COST CENTERS	6.00	7.00		
. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	-414, 813	11, 287, 783		1.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 598, 957			4.
. 00	00500 ADMI NI STRATI VE & GENERAL	-8, 455, 687			5.
00	00700 OPERATI ON OF PLANT 00900 HOUSEKEEPI NG	-23, 477 -159, 292			7.
	01000 DI ETARY	-494, 857			9.
	01100 CAFETERI A	-736, 136			11.
3.00	01300 NURSI NG ADMI NI STRATI ON	-14,066	1, 754, 118		13.
	01400 CENTRAL SERVICES & SUPPLY	-10, 922			14.
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	-995, 475 -47, 868			15. 16.
	02300 PARAMED ED PRGM	-47,808			23.
5.00	INPATIENT ROUTINE SERVICE COST CENTERS	00,001	20,711		201
	03000 ADULTS & PEDIATRICS	-246, 884	3, 765, 174		30.
	03100 I NTENSI VE CARE UNI T	0			31.
	04000 SUBPROVIDER - IPF	-96, 000			40.
1. 00	04100 SUBPROVI DER – I RF ANCI LLARY SERVI CE COST CENTERS	0	0		41.
0. 00	05000 OPERATING ROOM	-1, 308, 866	6,062,710		50.
1.00	05100 RECOVERY ROOM	0			51.
	05300 ANESTHESI OLOGY	-134, 850			53.
	05400 RADI OLOGY-DI AGNOSTI C	-12, 868			54.
	06000 LABORATORY 06500 RESPI RATORY THERAPY	-313, 687 -59, 451			60. 65.
6.00	06600 PHYSI CAL THERAPY	-37, 431	1 1		66.
	06700 OCCUPATI ONAL THERAPY	0			67.
	06800 SPEECH PATHOLOGY	0			68.
	06801 OCCUPATI ONAL HEALTH	0	-		68.
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	-46, 940 0			69. 71.
	07200 I MPL. DEV. CHARGED TO PATIENT	0			72.
	07300 DRUGS CHARGED TO PATIENTS	0			73.
	03020 CARDI AC	0			76.
6. 01	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	80, 765		76.
3. 00	08800 RURAL HEALTH CLINIC	-5, 163	447, 717		88.
	09000 CLINIC	0	0		90.
	09001 WOUND CLINIC	-7, 521			90.
	09002 DI ABETES CLINIC	-910 0			90. 90.
	09003 ASTHMA CLINIC 09004 ANDIS CLINIC	-1, 125	-		90.
	09005 PRIME TIME	0			90.
0. 06	09006 SHELBYVILLE WOUND CLINIC	-714	275, 734		90.
	04951 ONCOLOGY	-746, 472			90.
	04950 ANDERSON WOMENS CENTER 09100 EMERGENCY	0 -75, 225			90. 91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-75,225	3, 302, 779		92.
	OTHER REIMBURSABLE COST CENTERS				
D1. OC	10100 HOME HEALTH AGENCY	0	0		101.
16 00	SPECIAL PURPOSE COST CENTERS	-149	2,072,990		116.
18. OC		-17, 077, 206			118.
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.
	19001 PROFESSI ONAL BUI LDI NG 19002 PHYSI CI AN BUI LDI NG	0			190. 190.
	19002 PRISICIAN BUILDING	0			190.
	19004 MARKETI NG	0	1, 443, 932		190.
	19005 SPORTS PHYSI CALS	0	77, 888		190.
	19006 FOUNDATI ON	0	860, 844		190.
	19007 ASC 19008 OTHER NONREI MBURSABLE	0	2, 114 860, 099		190. 190.
	19008 OTHER NONRET MEDRSABLE	0			190. 190.
	19010 HANCOCK WELLNESS	0	1, 106, 253		190.
0.11	19011 MORRISTOWN CLINIC	0	3, 000		190.
	19012 O3PUREMED	0	0		190.
	19013 MCCORD WELLNESS	0	1,020,266		190.
	19014 3 WEST UNIT 19015 NEUROLOGY PHYSICIAN	0	412, 654 1, 088, 553		190. 190.
	19016 THORACI	0			190.
	19017 HANCOCK ENDO	0			190.
	19018 HANCOCK FOOT & ANKLE	0			190.

Health Financial Systems	HANCOCK REGION	NAL_HOSPI TAL		In Lieu	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider C	CN: 15-0037	Period:	Worksheet A	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6.00	7.00				
190. 19 19019 HANCOCK RHEUM	0	84, 722				190.19
200.00 TOTAL (SUM OF LINES 118 through 199)	-17, 077, 206	122, 502, 756				200.00

ASSI FI	CATIONS			Provider CCN: 15-	0037 Period: From 01/01/2	Worksheet A-6
					To 12/31/2	
		Increases				072072020 1.27 pm
	Cost Center	Line #	Salary	Other		
Δ -	2.00 • CAFETERI A	3.00	4.00	5.00		
	ETERIA	11.00	1, 030, 494	861, 193		1.00
0			1,030,494	861, 193		
	PLANT	7.00	0	1, 431		1.00
	DICAL RECORDS & LIBRARY	16.00	0	4, 650		2.00
	CTROCARDI OLOGY	69.00	Ō	4, 574		3.00
) <u>RES</u>	SPI RATORY_THERAPY		0_	<u>3,038</u>		4.00
0	• MARKETING		0	13, 693		
	RKETING	190.04	175, 072	1, 268, 860		1.00
0			175, 072	1, 268, 860		
	OUTPATIENT PROCEDURE	60.00	6, 760	1, 846		1.00
	CTROCARDI OLOGY	69.00	33, 620	9, 182		2.00
0			40, 380	11, 028		
	DRUG RECLASS	70.00	ol	14 474 001		
) DRU	JGS CHARGED TO PATIENTS	73.00 0.00	0	16, 674, 291 0		1.00
		0.00	Ő	0		3.00
		0.00	0	0		4.00
)		0.00	0	0		5.00
)		0. 00 0. 00	0	0		6.00 7.00
		0.00	Ő	0		8.00
)		0.00	0	0		9.00
00		0.00 0.00	0	0		10.00
		0.00	0	0		12.00
00		0.00	Ö	0		13.00
0		0.00	0	0		14.00
00		0.00 0.00	0	0		15.00 16.00
		0.00	0	0		17.00
0		0.00	О	0		18.00
00		0.00	0	0		19.00
00		0. 00 0. 00	0	0		20.00
		0.00	0	0		22.00
00		0.00	О	0		23.00
00		0.00	0	0		24.00
00		0. 00 0. 00	0	0		25.00 26.00
		0.00	0	0		27.00
0			0	16, 674, 291		
	TERM ETO BENEFIT RECLASS	5.00	0	60, 100		1.00
	ERATION OF PLANT	7.00	0	8, 881		2.00
	JSEKEEPI NG	9.00	О	1, 513		3.00
		10.00	0	2, 232		4.00
	RSENG ADMENTSTRATION	13.00 15.00	0	17, 702 5, 917		5.00
	OLCAL RECORDS & LIBRARY	16.00	0	11, 014		7.00
	JLTS & PEDIATRICS	30. 00	О	6, 083		8.00
	ENSIVE CARE UNIT	31.00	0	12, 172		9.00
	ERATI NG ROOM DI OLOGY-DI AGNOSTI C	50.00 54.00	0	1, 583 7, 324		10.00
	BORATORY	60.00	0	22		12.00
	SPI RATORY THERAPY	65.00	0	5, 481		13.00
		90.01	0	11,871		14.00
	ELBYVILLE WOUND CLINIC	90.06 91.00	0	3, 218 2, 921		15.00 16.00
	SPI CE	116.00	0	2, 921		17.00
DO PRI	VATE DUTY	190. 03	0	580		18.00
	ICOCK WELLNESS	190.10	0	804		19.00
	CORD_WELLNESS	<u>190.</u> 13	0	<u>259</u> 159, 886		20.00
	and Total: Increases		1, 245, 946	18, 988, 951		500.00

	Financial Systems SIFICATIONS		HANCOCK REGION		CCN: 15-0037	Peri od:	of Form CMS-2552-10 Worksheet A-6
NEULAJ				TTOVIDEL 1	JUN: 10 10007	From 01/01/2019 To 12/31/2019	Date/Time Prepared:
						10 12/31/2019	8/28/2020 1:27 pm
	Cost Center	Decreases	Salary	Other	 Wkst. A-7 Ref	.	
	6.00	7.00	8.00	9.00	10.00	<u> </u>	
	A – CAFETERIA						
1.00	DI ETARY	<u>10.</u> 00	1,030,494	86 <u>1, 1</u> 93		o	1.00
	0 B - PLANT		1, 030, 494	861, 193	i		
1.00	PROFESSI ONAL BUILDING	190. 01	0	13, 693		0	1.00
2.00		0.00	0	C		o	2.00
3.00		0.00	0	C		0	3.00
4.00		0.00	0	<u>13, 693</u>		0	4.00
	C - MARKETING		U	13, 093			
1.00	ADMI NI STRATI VE & GENERAL	5.00	175, 072	1, 268, 860)	0	1.00
	0		175, 072	1, 268, 860)]	
1 00	D - OUTPATIENT PROCEDURE	15 00	40, 200	11 000	,		1.00
1.00 2.00	PHARMACY	15.00 0.00	40, 380	11, 028 C		0	1.00
2.00			40, 380	11, 028			2.00
	E – DRUG RECLASS						
1.00		15.00	0	15, 685, 964		0	1.00
2.00 3.00	ADULTS & PEDIATRICS	30. 00 31. 00	0	12, 786 23, 791		0	2.00 3.00
4.00	SUBPROVIDER - IPF	40.00	0	23, 791		0	4.00
5.00	OPERATI NG ROOM	50.00	0	28, 956		0	5.00
6.00	RECOVERY ROOM	51.00	0	1, 179		0	6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	216, 656		0	7.00
8.00 9.00	LABORATORY RESPI RATORY THERAPY	60. 00 65. 00	0	774 449		0	8.00 9.00
10.00	PHYSI CAL THERAPY	66.00	0	799		0	10.00
11.00	ELECTROCARDI OLOGY	69.00	О	32, 558	8	o	11.00
12.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	69		0	12.00
13.00	PATIENTS RURAL HEALTH CLINIC	88.00	0	32, 161		o	13.00
14.00	WOUND CLINIC	90.01	0	13, 721		0	14.00
15.00	ANDIS CLINIC	90.04	О	25	5	o	15.00
16.00	SHELBYVILLE WOUND CLINIC	90.06	0	3,800		0	16.00
17.00 18.00	ONCOLOGY ANDERSON WOMENS CENTER	90. 07 90. 08	0	12, 317 378		0	17.00 18.00
19.00	EMERGENCY	90.08	0	26, 635		0	19.00
20.00	HOSPICE	116.00	Ō	118, 738		0	20.00
21.00	SPORTS PHYSI CALS	190. 05	0	364		0	21.00
22.00		190.07	0	10 510		0	22.00
23.00 24.00	OTHER NONREIMBURSABLE HANCOCK OB	190. 08 190. 09	0	12, 519 372, 556		0	23.00 24.00
25.00	3 WEST UNIT	190.14	o	3		0	25.00
26.00	HANCOCK FOOT & ANKLE	190. 18	О	2, 505		o	26.00
27.00	NEUROLOGY_PHYSICIAN	1 <u>90.</u> 15	0	73,891		Q	27.00
	F - TERM ETO BENEFIT RECLASS		0	16, 674, 291			
1.00	ADMI NI STRATI VE & GENERAL	5.00	60, 100	C)	0	1.00
2.00	OPERATION OF PLANT	7.00	8, 881	C		0	2.00
3.00	HOUSEKEEPING	9.00	1, 513	C		0	3.00
4.00 5.00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	2, 232 17, 702	C		0	4.00 5.00
5.00 6.00	PHARMACY	13.00	5, 917	C		0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	11, 014	C		0	7.00
8.00	ADULTS & PEDIATRICS	30.00	6, 083	C		0	8.00
9.00	INTENSIVE CARE UNIT	31.00	12, 172	C		0	9.00
10.00 11.00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	1, 583 7, 324	C		0	10.00 11.00
12.00	LABORATORY	60.00	22	C		0	12.00
13.00	RESPI RATORY THERAPY	65.00	5, 481	C		0	13.00
14.00	WOUND CLINIC	90.01	11, 871	C		0	14.00
15.00	SHELBYVILLE WOUND CLINIC	90.06	3, 218	C		0	15.00
16.00 17.00	EMERGENCY HOSPI CE	91.00 116.00	2, 921 209	C		0	16.00 17.00
18.00	PRI VATE DUTY	190.03	580	C		0	18.00
19.00	HANCOCK WELLNESS	190. 10	804	C		o	19.00
20.00	MCCORD_WELLNESS	1 <u>90.</u> 1 <u>3</u>	<u>259</u> 159, 886	0		ō	20.00
			154 886	(1

Heal th	Financial Systems	HANCOCK REGION	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0037		d: 01/01/2019 12/31/2019		pared:
				Acqui si ti on	S			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	1,022,435	0		0	0	0	1.00
2.00	Land Improvements	7, 498, 607	7, 112, 108		0	7, 112, 108	0	2.00
3.00	Buildings and Fixtures	117, 785, 819	12, 930, 599		0	12, 930, 599	0	3.00
4.00	Building Improvements	235, 570	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	79, 660, 653	6, 763, 753		0	6, 763, 753	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	206, 203, 084	26, 806, 460		0	26, 806, 460	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	206, 203, 084	26, 806, 460		0	26, 806, 460	0	10.00
		Endi ng	Fully					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	1,022,435	0					1.00
2.00	Land Improvements	14, 610, 715	0					2.00
3.00	Buildings and Fixtures	130, 716, 418	0					3.00
4.00	Building Improvements	235, 570	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	86, 424, 406	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	233, 009, 544	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00		233, 009, 544	0					10.00

Health Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider (CCN: 15-0037	Period: From 01/01/2019	Worksheet A-7 Part II	
				To 12/31/2019		pared:
		S	SUMMARY OF CAP	ITAL	0/20/2020 1.2	
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMI	N 2, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	10, 465, 716	(0 34	776, 355	460, 126	1.00
3.00 Total (sum of lines 1-2)	10, 465, 716	(0 30	99 776, 355	460, 126	3.00
	SUMMARY OF	CAPI TAL				
Cost Center Description	Other	Total (1)	-			
	Capital - Relat	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	11, 702, 59	6			1.00
3.00 Total (sum of lines 1-2)	0	11, 702, 59	6			3.00

Health Financial Systems	HANCOCK REGION	NAL_HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019	Worksheet A-7 Part III	
				To 12/31/2019		
	COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	2.00	<u>col.2)</u> 3.00	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	130, 716, 418	0	130, 716, 41	8 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	130, 716, 418		130, 716, 41			3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital-Relat ed Costs				
	6, 00	7.00	through 7) 8.00	9,00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 10, 465, 716	-412, 552	1.00
3.00 Total (sum of lines 1-2)	0	0		0 10, 465, 716	-412, 552	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
	11.00	12.00	13.00	instructions) 14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	-1, 862	776, 355	460, 12	6 0	11, 287, 783	1.00
3.00 Total (sum of lines 1-2)	-1,862					3.00
	., 002		1 100,12	-1 0	, 20., 700	0.00

OSPI TAL	REGI ONAL	HANCOCK	

Health Financial Systems ADJUSTMENTS TO EXPENSES

ANCUCK REGIONAL HUSPITAL

In Lieu of Form CMS-2552-10

USTMENTS TO EXPENSES		HANCOCK REGIO	Provider CCN: 15-0037 P	eriod:	Worksheet A-8	
			T	rom 01/01/2019 o 12/31/2019	Date/Time Pre 8/28/2020 1:2	
			Expense Classification on To/From Which the Amount is			
				to be Aujusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
0 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1
2) 00 Investment income - CAP REL			*** Cost Center Deleted ***	2.00	0	
COSTS-MVBLE EQUIP (chapter 2)			Cost center bereted	2.00	0	2
0 Investment income - other (chapter 2)		0		0.00	0	3
0 Trade, quantity, and time		0		0.00	0	4
discounts (chapter 8) Refunds and rebates of		0		0.00	0	5
expenses (chapter 8)				0.00	0	
0 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6
0 Telephone services (pay stations excluded) (chapter		0		0.00	0	7
21)						
0 Television and radio service (chapter 21)		0		0.00	0	8
0 Parking lot (chapter 21)		0		0.00	0	
00 Provider-based physician adjustment	A-8-2	-3, 200, 994			0	10
00 Sale of scrap, waste, etc.		0		0.00	0	11
(chapter 23) 00 Related organization	A-8-1	0			0	12
transactions (chapter 10) 00 Laundry and linen service		0		0.00	0	13
00 Cafeteria-employees and guests	в	-	CAFETERI A	11.00	0	
00 Rental of quarters to employee and others	2	0		0.00	0	15
00 Sale of medical and surgical		0		0.00	0	16
supplies to other than patients						
00 Sale of drugs to other than		0		0.00	0	17
patients 00 Sale of medical records and		0		0.00	0	18
abstracts				0.00	0	10
00 Nursing and allied health education (tuition, fees,		0		0.00	0	19
books, etc.) 00 Vending machines		0		0.00	o	20
00 Income from imposition of		0		0.00	0	
interest, finance or penalty charges (chapter 21)						
00 Interest expense on Medicare		0		0.00	0	22
overpayments and borrowings to repay Medicare overpayments						
00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
limitation (chapter 14)						
00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24
limitation (chapter 14)						
00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25
(chapter 21)		_			_	
00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26
00 Depreciation - CAP REL		0	*** Cost Center Deleted ***	2.00	0	27
COSTS-MVBLE EQUIP 00 Non-physician Anesthetist		о	*** Cost Center Deleted ***	19.00		28
00 Physicians' assistant	A 0 0	0		0.00	0	
00 Adjustment for occupational therapy costs in excess of	A-8-3		OCCUPATI ONAL THERAPY	67.00		30
limitation (chapter 14) 99 Hospice (non-distinct) (see		_	ADULTS & PEDIATRICS	30.00		30
i nstructi ons)				30.00		

th	Fi nanci al	Systems	HA

alth Financial Systems DJUSTMENTS TO EXPENSES	Provider CCN: 15-0037 Period: From 01/01/201		eu of Form CMS-2552-10 Worksheet A-8			
			Expense Classification on To/From Which the Amount is			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
.00 Adjustment for speech	1.00 A-8-3	2.00	3.00 SPEECH PATHOLOGY	4.00	5.00	31.
pathology costs in excess of limitation (chapter 14) 2.00 CAH HIT Adjustment for	A-0-3	0		0.00	0	
Depreciation and Interest 3. 00 HRH MMO RENTAL INCOME	В		NEW CAP REL COSTS-BLDG &	1.00	-	33.
8. 01 HRH HUMAN RESOURCES	B		FIXT EMPLOYEE BENEFITS DEPARTMEN		0	
MI SCELLANEOUS RE 0.02 HRH OTHER REVENUE SALES TAX 0.03 HRH OTHER REVENUE	B	-8, 496	ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5. 00 5. 00	0	33.
MI SCELLANEOUS REVE	В		ADMINI STRATI VE & GENERAL	5.00	0	
APPLICATION FE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
MI SCELLANEOUS REV . 06 HRH MEDICAL DUES MEDICAL STAFF	В		ADMI NI STRATI VE & GENERAL	5.00	0	
DUES . 07 HRH PAT FIN. SERV. BUSINESS	В		ADMINISTRATIVE & GENERAL	5.00	0	
SERV-COP . 08 HRH I NFO SERVI CES	В		ADMI NI STRATI VE & GENERAL	5.00	0	
MI SCELLANEOUS REVE 09 HRH ACCOUNTI NG MI SCELLANEOUS	В	-15, 950	ADMI NI STRATI VE & GENERAL	5.00	0	33
REVENUE 10 HRH ACCOUNTING MANAGEMENT FEES	В	-8, 486	ADMI NI STRATI VE & GENERAL	5.00	0	33
11 HRH EXEC ADMIN MI SCELLANEOUS REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
12 HRH COMMUNICATIONS MISCELLANEOUS REV	В		ADMINI STRATI VE & GENERAL	5.00	0	
 13 HRH COMMUNICATIONS PHONE LEASE REVEN 14 HRH COMM EDUCATION EDUCATION 	B		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00	0	
SERVICE 15 HRH HEALTHY 365 MI SCELLANEOUS	В		ADMI NI STRATI VE & GENERAL	5.00	0	
REVENU 16 HRH GAIN/LOSS GROSS VARIANCE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
I NVENTO 17 HRH PLANT OFFSITE SERVICES	B		OPERATION OF PLANT	7.00	0	
18 HRH HOUSEKEEPING ENVIRONMENTAL SERVI	B		HOUSEKEEPING	9.00	0	
19 HRH NUTRI TI ONAL SER LTACH REVENUE	В	-77, 197	DI ETARY	10.00	0	33
20 HRH NUTRI TI ONAL SER MI SCELLANEOUS RE	В	-200	DI ETARY	10.00	0	33
21 OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33
22 HRH NUTRI TI ONAL SER REBATES/REFUNDS	В	-4, 049	DI ETARY	10.00	0	33
23 HRH CLINICAL EDUCAT AHA COURSE REVEN	В	-14, 066	NURSING ADMINISTRATION	13.00	0	33
24 HRH OTHER REVENUE REBATES/REFUNDS	В		CENTRAL SERVICES & SUPPLY	14.00		
25 HRH OTHER REVENUE DI SCOUNTS EARNED O	В		CENTRAL SERVICES & SUPPLY	14.00	0	33
26 HRH PHARMACY MI SCELLANEOUS REVENUE	В	-2, 495	PHARMACY	15.00	0	33
 27 HRH PHARMACY REBATES/REFUNDS 28 HRH ASSOCIATE PHARM RETAIL PHARMACY- 	B B		PHARMACY PHARMACY	15. 00 15. 00	0	
29 HRH ASSOCIATE PHARM HOSPICE PHARMACY	В	-152, 079	PHARMACY	15.00	0	33
30 HRH ASSOCIATE PHARM PHARMACY MEDS TO	В	-8, 416	PHARMACY	15.00	0	33
. 31 HRH ASSOCIATE PHARM MISCELLANEOUS RE	В	-28, 059	PHARMACY	15.00	0	33
HRH HEALTH I NFO SER MEDI CAL RECORDS-	В	-341	MEDICAL RECORDS & LIBRARY	16.00	0	33.

Health Financial Systems	HANCOCK REGIONAL HOSPI	TAL In Lie	eu of Form CMS-2552-10
ADJUSTMENTS TO EXPENSES	Provi	der CCN: 15-0037 Period: From 01/01/2019	Worksheet A-8
		To 12/31/2019	Date/Time Prepared: 8/28/2020 1:27 pm
		se Classification on Worksheet A	
	lo/From	Which the Amount is to be Adjusted	

	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.33	HRH HEALTH INFO SER	В	-47, 527	MEDICAL RECORDS & LIBRARY	16.00	0	33.33
33. 34	MI SCELLANEOUS RE HRH X-RAY SCHOOL TUI TI ON-X-RAY	В	-68, 831	PARAMED ED PRGM	23.00	0	33. 34
33.35	SCHOO HRH MED/SURG-3 WEST MI SCELLANEOUS RE	В	-133, 034	ADULTS & PEDIATRICS	30.00	0	33. 35
33.36	HRH ANDIS UNIT REBATES/REFUNDS	В	-663	ADULTS & PEDIATRICS	30.00	0	33.36
33.37	HRH SURGERY REBATES/REFUNDS	В		OPERATI NG ROOM	50.00	0	
	HRH LAB WATER TESTING	B		LABORATORY	60.00	0	
	HRH LAB DIRECT TESTS	B		LABORATORY	60.00	0	
33. 39 33. 40		В				0	
	HRH LAB MI SCELLANEOUS REVENUE				60.00	-	
33.41	HRH WATER LAB WATER TESTING	В		LABORATORY	60.00	0	
	HRH SLEEP STUDY CLINIC MANAGMENT	В		RESPI RATORY THERAPY	65.00	0	
33. 43	HRH SLEEP STUDY SLEEP STUDY FEES	В		RESPI RATORY THERAPY	65.00	0	
33.44	HRH CATH LAB REBATES/REFUNDS	В	-46, 940	ELECTROCARDI OLOGY	69.00	0	33.44
33. 45	HRH MED ONCOLOGY MISCELLANEOUS REVEN	В	-60, 606	ONCOLOGY	90.07	0	33.45
33.46	HRH E R REBATES/REFUNDS	В	-225	EMERGENCY	91.00	0	33.46
33.47	MOW	А	-413, 411	DI ETARY	10.00	0	33.47
33. 48	OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33. 48
33.49	PHÝSI CI AN RECRUI TMENT FEES	А	-33, 750	ADMI NI STRATI VE & GENERAL	5.00	0	33.49
	DONATIONS & SPONSORSHIPS	А		ADMI NI STRATI VE & GENERAL	5.00	0	
33.51	ADVERTI SI NG FEE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
	ADVERTI SI NG FEE	A	-635 174	ADMI NI STRATI VE & GENERAL	5.00	0	
	ADVERTI SI NG FEE	A		ADULTS & PEDIATRICS	30.00	0	
33.54	ADVERTI SI NG FEE	A		OPERATI NG ROOM	50.00	0	
33.55	ADVERTISING FEE	A		RADI OLOGY-DI AGNOSTI C	54.00	0	
	ADVERTISING FEE	A		WOUND CLINIC	90.01	0	
						-	
	ADVERTI SI NG FEE	A		SHELBYVILLE WOUND CLINIC	90.06	0	
33.58	I HA LOBBYING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.59	AHA LOBBYING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
	PHY OFFICE BLDG	A		NEW CAP REL COSTS-BLDG & FIXT	1.00		33.60
	PHY OFFICE BLDG	A		RADI OLOGY-DI AGNOSTI C	54.00	0	
33.62	PHY OFFICE BLDG	A		RURAL HEALTH CLINIC	88.00	0	
33.63	INTEREST REVENUE	В		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.63
33.64	RENTAL PROPERTIES EXPENSE	A	-85, 038	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33. 64
33.65	RENTAL PROPERTIES EXPENSE	А	-208, 330	ADMINISTRATIVE & GENERAL	5.00	0	33.65
33.66	RENTAL PROPERTIES EXPENSE	А	-4, 636	OPERATION OF PLANT	7.00	0	33.66
33.67	TELEPHONE SERVICES	А	-50, 774	ADMINISTRATIVE & GENERAL	5.00	0	33.67
	HAF EXPENSE	А		ADMI NI STRATI VE & GENERAL	5.00	0	
33.69	HRH HOSPI CE MI SCELLANEOUS REVENUE	В		HOSPICE	116.00	0	
33.70	SELF INSURANCE CLAIM EXPENSE	А	-2, 449, 411	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.70
	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	~	-17, 077, 206		4.00	0	50.00

(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.

	Financial Syste		HANCOCK REGI	ONAL HOSPITAL	CON. 15 0027	In Lie Period:	eu of Form CMS- Worksheet A-8	
PROVIDE	R BASED PHISIC	TAN ADJUSTMENT		Provider	1	rom 01/01/2019	9	
						Го 12/31/2019	9 Date/Time Pre 8/28/2020 1:2	
	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		ADMI NI STRATI VE & GENERAL	328, 990			-		
2.00		ADMI NI STRATI VE & GENERAL	14, 217					
3.00 4.00		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	190, 135 5, 625					
5.00		ADMI NI STRATI VE & GENERAL	12, 097			-	-	1
6.00	5.00	ADMINISTRATIVE & GENERAL	15,000			0	0	6.00
7.00		ADMI NI STRATI VE & GENERAL	133, 685			0	-	
8.00 9.00		ADULTS & PEDIATRICS SUBPROVIDER - IPF	110, 759 96, 000			0	0	8.00 9.00
9.00 10.00	40.00	SUBFROVIDER - IFI	90,000	90,000	0		0	
11.00		OPERATING ROOM	1, 298, 272	1, 298, 272	0	0	0	11.00
12.00		OPERATING ROOM	6, 295					
13.00		ANESTHESI OLOGY	134, 850			-		
14.00 15.00		LABORATORY WOUND CLINIC	114, 583 5, 625			260, 300		
16.00		DI ABETES CLINIC	910				-	
17.00		ANDIS CLINIC	1, 125			0	0	17.00
18.00		ONCOLOGY	685, 866			0	0	18.00
19.00	91.00	EMERGENCY	75,000			0	0	
200.00	Wkst. A Line #	Cost Center/Physician	3, 229, 034 Unadj usted RCE		28,040 Cost of	Provi der	480 Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE		Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	8.00	9.00	Education 12.00	12 13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	0	0	0			1.00
2.00		ADMINISTRATIVE & GENERAL	0	-				
3.00 4.00		ADMI NI STRATI VE & GENERAL	0	0	0			
4.00 5.00		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL			0		-	1
6.00		ADMI NI STRATI VE & GENERAL	0	Ő	0	0	Ő	
7.00		ADMI NI STRATI VE & GENERAL	0	0	0	0	0	
8.00		ADULTS & PEDIATRICS	0	0	0		-	
9.00 10.00	40.00	SUBPROVIDER - IPF			0	-	-	9.00 10.00
11.00		OPERATING ROOM	0	0	0			11.00
12.00		OPERATING ROOM	0	0	-	0	0	12.00
13.00		ANESTHESI OLOGY	0	0	0	0	0	
14.00 15.00		LABORATORY WOUND CLINIC	60, 820	3, 041	0		0	14.00 15.00
16.00		DI ABETES CLINIC	0	0	0		0	16.00
17.00	90. 04	ANDIS CLINIC	0	0	0	0	0	17.00
18.00		ONCOLOGY	0	0	0	0	0	
19. 00 200. 00	91.00	EMERGENCY	0 60, 820					19.00 200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00	-	
1.00	5.00	ADMI NI STRATI VE & GENERAL	0	0	0	328, 990		1.00
2.00		ADMI NI STRATI VE & GENERAL	0					2.00
3.00 4.00		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	0			190, 135 5, 625		3.00 4.00
4.00 5.00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL			0	12,097		4.00 5.00
6.00		ADMI NI STRATI VE & GENERAL	0	-	0		1	6.00
7.00	5.00	ADMI NI STRATI VE & GENERAL	0	0	0	133, 685		7.00
8.00		ADULTS & PEDIATRICS	0	-				8.00
9. 00 10. 00	40.00 0.00	SUBPROVIDER - IPF		0	-	96,000	1	9.00 10.00
11.00		OPERATING ROOM	0	0	0			11.00
12.00	50.00	OPERATING ROOM	0	0	0	6, 295		12.00
13.00		ANESTHESI OLOGY	0			134,850	1	13.00
14.00			0	60, 820		86, 543		14.00
15.00 16.00		WOUND CLINIC DIABETES CLINIC		0	-			15.00 16.00
17.00		ANDIS CLINIC	0	0	0		1	17.00
18.00		ONCOLOGY	0		0			18.00
19.00 200.00	91.00	EMERGENCY	0		0			19.00 200.00
∠uu. uu			1 0	ου, 820	1 0	J 3, ∠UU, 994	1	∠00. 00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HANCOCK REGIO	NAL HOSPITAL Provider CO	CN: 15-0037 P	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
0001 /	LEGONTION GENERAL SERVICE COSTS				rom 01/01/2019	Part I Date/Time Pre	pared.
						8/28/2020 1:2	27 pm
			CAPI TAL RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
		for Cost	FLXT	BENEFITS		E & GENERAL	
		Allocation (from Wkst A		DEPARTMENT			
		col. 7)					
		0	1.00	4.00	4A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	11, 287, 783	11, 287, 783			[1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 014, 870		5, 095, 355			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	18, 011, 170	848, 863	997,016	19, 857, 049	19, 857, 049	
7.00	00700 OPERATION OF PLANT	6, 341, 218	570, 489	107, 158	7, 018, 865	1, 357, 813	7.00
9.00	00900 HOUSEKEEPI NG	2, 326, 196					
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	314, 927 1, 155, 551	372, 022 0	42, 734 100, 308	729, 683 1, 255, 859		
	01300 NURSI NG ADMI NI STRATI ON	1, 754, 118	0	132, 161	1, 886, 279		
14.00	01400 CENTRAL SERVICES & SUPPLY	240, 149	0	17, 442	257, 591	49, 831	
	01500 PHARMACY	1, 707, 702	192, 046	188, 479	2, 088, 227	403, 972	
	01600 MEDICAL RECORDS & LIBRARY	867, 179		57, 345			
23.00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	28, 741	43, 148	8, 101	79, 990	15, 474	23.00
	03000 ADULTS & PEDIATRICS	3, 765, 174	730, 656				
	03100 I NTENSI VE CARE UNI T	4, 154, 439	765, 682	327, 855			
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 335, 570 0	204, 695 0	115, 688 0			
41.00	ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	41.00
50.00	05000 OPERATING ROOM	6, 062, 710	807, 385	336, 669	7, 206, 764	1, 394, 163	50.00
	05100 RECOVERY ROOM	350, 684	68, 061	28, 683	447, 428		
53.00	05300 ANESTHESI OLOGY	30, 553	0	0	30, 553		
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	5, 418, 583 4, 451, 794	834, 513 187, 616	330, 256 163, 877	6, 583, 352 4, 803, 287	1, 273, 563 929, 205	
	06500 RESPIRATORY THERAPY	1, 694, 907	75, 573	143, 211	1, 913, 691	370, 207	
66.00	06600 PHYSI CAL THERAPY	1, 275, 064	124, 853	111, 351	1, 511, 268		
67.00	06700 OCCUPATI ONAL THERAPY	365, 034	0	31, 933	396, 967	76, 794	
68.00	06800 SPEECH PATHOLOGY	187, 736	0	16, 510	204, 246 0		
	06801 OCCUPATI ONAL HEALTH 06900 ELECTROCARDI OLOGY	1, 637, 495	240, 556	0 65, 998	1, 944, 049	0 376, 080	68.01 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 166	150, 632	0	153, 798		
	07200 IMPL. DEV. CHARGED TO PATIENT	2, 809, 272	0	0	2, 809, 272	543, 459	
	07300 DRUGS CHARGED TO PATI ENTS 03020 CARDI AC	16, 674, 291	0	0	16, 674, 291 0	3, 225, 709 0	1
	03160 CARDI AC	80, 765	73, 165	6, 504	-	-	1
	OUTPATIENT SERVICE COST CENTERS						1
	08800 RURAL HEALTH CLINIC	447, 717	0	25, 103	472, 820		
	09000 CLINIC 09001 WOUND CLINIC	765, 166	93, 134	0 49, 240	0 907, 540		
	09002 DI ABETES CLINIC	46, 370			50, 261	9, 723	
	09003 ASTHMA CLINIC	0	0	0	0	0	
	09004 ANDIS CLINIC	187, 666			281, 169		
	09005 PRIME TIME 09006 SHELBYVILLE WOUND CLINIC	91, 129 275, 734	0	0 17, 082	91, 129 292, 816		
	04951 ONCOLOGY	1, 323, 070	446, 022	104, 608	1, 873, 700		
90.08	04950 ANDERSON WOMENS CENTER	432, 269	0	34, 095	466, 364	90, 219	90.08
91.00	09100 EMERGENCY	3, 302, 779	709, 660	249, 751	4, 262, 190		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	1				1	
	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	2,072,990					
118.00	NONREIMBURSABLE COST CENTERS	108, 291, 731	8, 249, 009	4, 409, 743	104, 567, 345	16, 387, 408	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19001 PROFESSI ONAL BUILDI NG	224, 582	2, 350, 303	0	2, 574, 885		
	19002 PHYSI CI AN BUI LDI NG	16, 639	0	0	16, 639		190.02
	19003 PRI VATE DUTY 19004 MARKETI NG	874, 970 1, 443, 932		23, 963 17, 042	898, 933 1, 460, 974	173, 900 282, 628	
	19005 SPORTS PHYSI CALS	77, 888	0	6, 809		16, 385	
190.06	19006 FOUNDATI ON	860, 844	77, 371	19, 256	957, 471	185, 225	190.06
	19007 ASC	2, 114	0	0	2, 114		190.07
	19008 OTHER NONREI MBURSABLE 19009 HANCOCK OB	860, 099 5, 179, 424	0 208, 002	83, 286 225, 836	943, 385 5, 613, 262		
	19009 HANCOCK OB 19010 HANCOCK WELLNESS	1, 106, 253	208, 002				
	19011 MORRI STOWN CLINIC	3, 000	0	0,033	3, 000		190.11
190.12	19012 O3PUREMED	0	0	0	0		190.12
		1 000 044	0	66, 510	1, 086, 776	210, 239	1100 13
	19013 MCCORD WELLNESS 19014 3 WEST UNIT	1, 020, 266 412, 654					

Health Financial Systems	HANCOCK REGION	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0037	Period: From 01/01/2019	Worksheet B Part I	
				To 12/31/2019		
		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation	NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	
	(from Wkst A col. 7)					
	0	1.00	4.00	4A	5.00	
190. 15 19015 NEUROLOGY PHYSI CI AN	1, 088, 553	0	80, 16	6 1, 168, 719	226, 091	190. 15
190. 16 19016 THORACI	144, 380	0	10, 60	154, 988	29, 983	190. 16
190. 17 19017 HANCOCK ENDO	192, 071	0	11, 25	53 203, 324	39, 333	190. 17
190.18 19018 HANCOCK FOOT & ANKLE	618, 634	0	39, 05	657, 692	127, 232	190. 18
190. 19 19019 HANCOCK RHEUM	84, 722	0	5,67	3 90, 395	17, 487	190. 19
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 through 201)	122, 502, 756	11, 287, 783	5,095,35	55 122, 502, 756	19, 857, 049	202.00

Health Financial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2019	Worksheet B Part I	
				To 12/31/2019		pared: 7 pm
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMI NI STRATI O N	
GENERAL SERVICE COST CENTERS	7.00	9.00	10.00	11.00	13.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL						4.00 5.00
7. 00 00700 OPERATION OF PLANT	8, 376, 678					7.00
9. 00 00900 HOUSEKEEPI NG	109, 164	3, 161, 101	1 440 75	2		9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	572, 911 0	0 52, 514	1, 443, 75	3 0 1, 551, 321		10.00
13.00 01300 NURSI NG ADMI NI STRATI ON	0	86, 536		0 53, 115	2, 390, 834	
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0 295, 750	131, 264 95, 750		0 13, 748 0 74, 790	26, 187 142, 462	
16.00 01600 MEDICAL RECORDS & LIBRARY	196, 475	115, 172		0 40, 063	76, 313	16.00
23. 00 02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	66, 447	132, 669		0 3, 589	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 125, 206	880, 206	740, 15		273, 068	
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	1, 179, 146 315, 230	181, 467 145, 230	480, 40	0 176,043 4 61,355	335, 329 116, 869	
41. 00 04100 SUBPROVI DER - I RF	0	143, 230		0 01, 333	0	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	ol	352, 339		0 96, 833	184, 450	50.00
51.00 05100 RECOVERY ROOM	104, 813	129, 739		0 90, 833	22, 773	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	100.077		0 0 0 170, 477	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	128, 977 123, 078		0 170, 477 0 109, 164	324, 729 207, 938	
65. 00 06500 RESPI RATORY THERAPY	0	94, 265		0 77,650	147, 910	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	192, 272 0	109, 554 0		0 51,847 0 16,866	98, 758 0	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	Ō		0 7, 122	0	68.00
68. 01 06801 OCCUPATI ONAL HEALTH 69. 00 06900 ELECTROCARDI OLOGY	0 370, 454	0 213, 611		0 0 0 28,974	0	68.01 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	231, 973	213, 011		0 20, 774	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 CARDI AC	0	0		0 0	0	73.00 76.00
76. 01 03160 CARDI OPULMONARY	112, 674	0		0 5, 055	0	76.01
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C	0	0	1	0 0	0	88.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 WOUND CLINIC 90. 02 09002 DIABETES CLINIC	0	0		0 27,950 0 2,318	0	90.01 90.02
90. 03 09003 ASTHMA CLINIC	0	Ö		0 0	0	90.03
90. 04 09004 ANDES CLENEC 90. 05 09005 PREME TEME	128, 742	0		0 5, 112	0	90.04 90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	0		0 8, 200	0	
90. 07 04951 ONCOLOGY	686, 871	0		0 57, 762	0	
90. 08 04950 ANDERSON WOMENS CENTER 91. 00 09100 EMERGENCY	1, 092, 872	188, 730 0		0 20, 172 0 125, 350	0 238, 770	90.08 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 0	0	101.00
SPECIAL PURPOSE COST CENTERS	· · · · ·	1				
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	535, 436 7, 316, 436	0 3, 161, 101	223, 19 1, 443, 75			
NONREI MBURSABLE COST CENTERS	1 1				· · ·	[
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 PROFESSI ONAL BUILDING	0	0		0 0 0 0		190. 00 190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	0		0 0	0	190.02
190. 03 19003 PRI VATE DUTY 190. 04 19004 MARKETI NG	0	0		0 40, 379		190.03
190. 05 19005 SPORTS PHYSI CALS	0	0		0 8,464 0 0		190. 04 190. 05
190. 06 19006 FOUNDATI ON	119, 151	0		0 10, 970		190.06
190. 07 19007 ASC 190. 08 19008 OTHER_NONRET MBURSABLE	0	0				190. 07 190. 08
190. 09 19009 HANCOCK OB	320, 322	0		0 25, 108	0	190.09
190. 10 19010 HANCOCK WELLNESS	0	0		0 0		190.10
190. 11 19011 MORRI STOWN CLINIC 190. 12 19012 03PUREMED	0	0		0 0		190. 11 190. 12
190. 13 19013 MCCORD WELLNESS	0	0		0 0	0	190. 13
190. 14 19014 3 WEST UNIT 190. 15 19015 NEUROLOGY PHYSI CLAN	620, 769 0	0		0 8, 245 0 7, 150		190. 14 190. 15
190. 16 19016 THORACI	0	0		0 0	0	190. 16
190. 17 19017 HANCOCK ENDO 190. 18 19018 HANCOCK FOOT & ANKLE	0	0		0 0 0 0		190. 17 190. 18
TTO. TOTT TOTTANICOUN TOUL & ANINE	<u>ا</u> ا	U		U U	0	1170.10

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	1	Period: From 01/01/2019 Fo 12/31/2019		pared.
					8/28/2020 1:2	
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMI NI STRATI O	
					Ν	
	7.00	9.00	10.00	11.00	13.00	
190. 19 19019 HANCOCK RHEUM	0	0	(0 0	0	190.19
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	8, 376, 678	3, 161, 101	1, 443, 753	3 1, 551, 321	2, 390, 834	202.00

	Financial Systems	HANCOCK REGIONAL			In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2019	Worksheet B Part I	
					To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
		SERVI CES & SUPPLY		RECORDS & LI BRARY	PRGM		
		14.00	15.00	16.00	23.00	24.00	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINI STRATI VE & GENERAL						5.00 7.00
	00700 OPERATI ON OF PLANT 00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON						11.00
14.00	01400 CENTRAL SERVICES & SUPPLY	478, 621					14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	15, 492 0	3, 116, 443 0	1, 683, 660	0		15.00 16.00
23.00	02300 PARAMED ED PRGM	1	0		298, 170		23.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	22, 780	0	453, 84	3 0	9, 365, 077	30.00
	03100 INTENSIVE CARE UNIT	26, 105	0	453, 840 56, 66		8, 217, 966	
	04000 SUBPROVIDER - IPF	2, 166	0	46, 72		3, 144, 281	
	04100 SUBPROVI DER – I RF ANCI LLARY SERVI CE COST CENTERS	0	0	(0 0	0	41.00
	05000 OPERATING ROOM	137, 721	0	596, 51		9, 968, 783	1
	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	2,080	0			805, 344 36, 464	
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 988	0	68, 10		8, 864, 358	54.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	122, 930 5, 427	0	151, 11	7 O O O	6, 446, 719 2, 609, 150	
	06600 PHYSI CAL THERAPY	1, 357	0			2, 257, 414	
	06700 OCCUPATI ONAL THERAPY	763	0	(0 0	491, 390	
	06800 SPEECH PATHOLOGY 06801 OCCUPATI ONAL HEALTH	287 0	0			251, 167 0	
	06900 ELECTROCARDI OLOGY	59, 361	0		o c	2, 992, 529	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	77, 54	7 0	493, 071 3, 352, 731	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 116, 443	(0 0	23, 016, 443	73.00
	03020 CARDI AC 03160 CARDI OPULMONARY	0 83	0			0 309, 282	
	DUTPATIENT SERVICE COST CENTERS	03				307, 202	70.01
	08800 RURAL HEALTH CLINIC 09000 CLINIC	1, 619 0	0			565, 907 0	1
	09000 CLINIC	5, 733	0			1, 116, 788	1
	09002 DI ABETES CLI NI C	81	0	(0 0	62, 383	
	09003 ASTHMA CLINIC 09004 ANDIS CLINIC	0 60	0			0 469, 476	
90.05	09005 PRIME TIME	0	0	(0 0	108, 758	90.05
	09006 SHELBYVILLE WOUND CLINIC 04951 ONCOLOGY	1, 328 6, 257	0			358, 990 2, 987, 061	
	04950 ANDERSON WOMENS CENTER	3, 301	0		0 0	768, 786	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	34, 362	0	233, 13	7 0	6, 811, 210	91.00
H	DTHER REIMBURSABLE COST CENTERS						/2.00
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	101.00
	11600 HOSPI CE	6, 158	0	(0 0	3, 982, 522	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	472, 440	3, 116, 443	1, 683, 660	298, 170	99, 854, 050	118.00
E E	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.00
	19001 PROFESSI ONAL BUI LDI NG	0	0		0 0	3, 073, 002	
	19002 PHYSI CI AN BUI LDI NG 19003 PRI VATE DUTY	0 311	0			19, 858 1, 190, 438	190.02
190. 04	19004 MARKETI NG	0	0	(0 0	1, 752, 066	190. 04
	19005 SPORTS PHYSI CALS 19006 FOUNDATI ON	5	0			101, 087 1, 272, 817	
	19007 ASC	11	0		0 0		190.00
	19008 OTHER NONREI MBURSABLE	506	0			1, 126, 391	
	19009 HANCOCK OB 19010 HANCOCK WELLNESS	3, 803 0	0		0 0	7, 048, 392 1, 411, 956	1
190. 11	19011 MORRISTOWN CLINIC	0	0		0	3, 580	190. 11
	19012 03PUREMED 19013 MCCORD WELLNESS	0	0			0 1, 297, 015	190.12 190.13
190. 14	19014 3 WEST UNIT	175	0		0 0	1, 625, 806	190. 14
	19015 NEUROLOGY PHYSI CI AN 19016 THORACI	200 0	0			1, 402, 160 184, 971	
	19018 THORACI 19017 HANCOCK ENDO	63	0			242, 720	
	19018 HANCOCK FOOT & ANKLE	1, 107	0		0 0	786, 031	

Health Financial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period:	Worksheet B Part I	
				From 01/01/2019 To 12/31/2019		
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
	SERVICES &		RECORDS &	PRGM		
	SUPPLY		LI BRARY			
	14.00	15.00	16.00	23.00	24.00	
190. 19 19019 HANCOCK RHEUM	0	0		0 0	107, 882	190.19
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	478, 621	3, 116, 443	1, 683, 66	0 298, 170	122, 502, 756	202.00

Health Financial Systems	HANCOCK REGI ONAI	L HOSPI TAL	In Lieu of Form CMS	5-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-003	7 Period: Worksheet B From 01/01/2019 Part I	
			To 12/31/2019 Date/Time Pr 8/28/2020 1:	
Cost Center Description	Intern &	Total	672672020 1.	. 27 pm
	Residents Cost & Post			
	Stepdown			
	Adjustments			
GENERAL SERVICE COST CENTERS	25.00	26.00		_
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT				5.00
9. 00 00900 HOUSEKEEPING				9.00
10. 00 01000 DI ETARY				10.00
				11.00
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY				13.00
15. 00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
23.00 02300 PARAMED ED PRGM				23.00
30. 00 03000 ADULTS & PEDIATRICS	0	9, 365, 077		30.00
31.00 03100 I NTENSI VE CARE UNI T	0	8, 217, 966		31.00
40.00 04000 SUBPROVIDER - IPF	0	3, 144, 281		40.00
41. 00 04100 SUBPROVI DER – I RF ANCI LLARY SERVI CE COST CENTERS	0	0		41.00
50. 00 05000 OPERATING ROOM	0	9, 968, 783		50.00
51.00 05100 RECOVERY ROOM	0	805, 344		51.00
53. 00 05300 ANESTHESI OLOGY	0	36, 464		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	8, 864, 358 6, 446, 719		54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	0	2, 609, 150		65.00
66.00 06600 PHYSI CAL THERAPY	0	2, 257, 414		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	491, 390		67.00
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 OCCUPATI ONAL HEALTH	0	251, 167 0		68.00 68.01
69. 00 06900 ELECTROCARDI OLOGY	0	2, 992, 529		69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		493,071		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 352, 731 23, 016, 443		72.00
76. 00 03020 CARDI AC	0	0		76.00
76. 01 03160 CARDI OPULMONARY	0	309, 282		76.01
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	565, 907		88.00
90. 00 09000 CLINIC	0	0		90.00
90.01 09001 WOUND CLINIC	0	1, 116, 788		90.01
90. 02 09002 DI ABETES CLI NI C	0	62, 383		90.02
90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC	0	0 469, 476		90.03 90.04
90. 05 09005 PRIME TIME	0	108, 758		90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	358, 990		90.06
90. 07 04951 ONCOLOGY 90. 08 04950 ANDERSON WOMENS CENTER	0	2, 987, 061 768, 786		90.07 90.08
91. 00 09100 EMERGENCY	0	6, 811, 210		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0			92.00
OTHER REIMBURSABLE COST CENTERS	0	0		101.00
SPECIAL PURPOSE COST CENTERS	0	0		101.00
116. 00 11600 HOSPI CE	0	3, 982, 522		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 0	99, 854, 050		118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190. 01 19001 PROFESSI ONAL BUI LDI NG	0	3, 073, 002		190.01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	19, 858		190.02
190. 03 19003 PRI VATE DUTY 190. 04 19004 MARKETI NG	0	1, 190, 438 1, 752, 066		190. 03 190. 04
190. 05 19005 SPORTS PHYSI CALS	0	101, 087		190.04
190. 06 19006 FOUNDATI ON	0	1, 272, 817		190.06
190. 07 19007 ASC	0	2, 534		190.07
190. 08 19008 OTHER NONREI MBURSABLE 190. 09 19009 HANCOCK OB	0	1, 126, 391 7, 048, 392		190. 08 190. 09
190. 10 19010 HANCOCK WELLNESS	0	1, 411, 956		190.10
190. 11 19011 MORRI STOWN CLINIC	0	3, 580		190.11
190. 12 19012 03PUREMED 190. 13 19013 MCCORD WELLNESS	0	0 1, 297, 015		190. 12 190. 13
190. 14 19014 3 WEST UNIT	0	1, 625, 806		190.13
190. 15 19015 NEUROLOGY PHYSI CLAN	0	1, 402, 160		190. 15
190. 16 19016 THORACI	0	184, 971		190.16

Health Financial Systems	HANCOCK REGIONAL	L HOSPI TAL		In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0037	Period: From 01/01/2019 To 12/31/2019	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26.00			
190. 17 19017 HANCOCK ENDO	0	242, 720			190. 17
190. 18 19018 HANCOCK FOOT & ANKLE	0	786, 031			190. 18
190.19 19019 HANCOCK RHEUM	0	107, 882			190. 19
200.00 Cross Foot Adjustments	0	0			200.00
201.00 Negative Cost Centers	0	0			201.00
202.00 TOTAL (sum lines 118 through 201)	0	122, 502, 756			202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	HANCOCK REGIO	Provider CC		Period:	u of Form CMS-2 Worksheet B	2002-1
					rom 01/01/2019 o 12/31/2019	Part II Date/Time Pre 8/28/2020 1:2	pared
	· · · · · · · · · · · · · · · · · · ·		CAPI TAL			8/28/2020 1:2	7 pm
			RELATED COSTS				
	Cost Center Description	Directly Assigned New	NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFI TS	ADMI NI STRATI V E & GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS		1.00	20	4.00	3.00	
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	0	80, 485	80, 485	80, 485		1.0 4.0
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL	0	848, 863	848, 863		864, 593	5.0
7.00	00700 OPERATION OF PLANT	0	570, 489	570, 489		59, 120	7.0
9.00	00900 HOUSEKEEPI NG	0	70, 886	70, 886		21, 540	9.0
10.00 11.00	01000 DI ETARY 01100 CAFETERI A		372, 022	372, 022	2 675 0 1, 585	6, 146 10, 578	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	C		15, 888	
	01400 CENTRAL SERVICES & SUPPLY	0	0	C		2, 170	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	192, 046	192, 046		17, 589	15.0 16.0
23.00	02300 PARAMED ED PRGM		127, 581 43, 148	127, 581 43, 148		8, 862 674	23.0
	INPATIENT ROUTINE SERVICE COST CENTERS	-					
30.00	03000 ADULTS & PEDIATRICS	0		730, 656		40, 416	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	765, 682 204, 695	765, 682 204, 695		44, 204 13, 948	
	04100 SUBPROVI DER – I RF	0		204, 093		13, 740	41.0
	ANCILLARY SERVICE COST CENTERS	1					
	05000 OPERATING ROOM	0	807, 385	807, 385		60, 703	50.0
51.00 53.00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	68, 061 0	68, 061 (3, 769 257	51.0 53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	834, 513	834, 513	-	55, 452	
60.00	06000 LABORATORY	0	187, 616	187, 616		40, 458	60.0
65.00	06500 RESPIRATORY THERAPY	0	75, 573	75, 573		16, 119	65.0
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		124, 853 0	124, 853		12, 729 3, 344	66.0 67.0
68.00	06800 SPEECH PATHOLOGY	0	0	(261	1, 720	68.0
68. 01	06801 OCCUPATI ONAL HEALTH	0	0	C	0 0	0	68.0
69.00	06900 ELECTROCARDI OLOGY	0	240, 556	240, 556		16, 375	69.0
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		150, 632	150, 632 (1, 295 23, 662	
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	o o	140, 456	
76.00	03020 CARDI AC	0	0	0	0	0	76.0
76. 01	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	73, 165	73, 165	103	1, 351	76.0
88.00	08800 RURAL HEALTH CLINIC	0	0	(397	3, 983	88.0
90.00	09000 CLINIC	0	0	C	0	0	90.0
	09001 WOUND CLINIC 09002 DIABETES CLINIC	0	93, 134	93, 134	778 778 61	7,644 423	
	09003 ASTHMA CLINIC		0	0		423	1
90. 04	09004 ANDIS CLINIC	0	83, 599	83, 599	156	2, 368	90.0
90.05	09005 PRIME TIME	0	0	0	-	768	
90.06 90.07	09006 SHELBYVILLE WOUND CLINIC 04951 ONCOLOGY		446, 022	446, 022	270 2 1, 653	2, 466 15, 782	
	04950 ANDERSON WOMENS CENTER	0	0	(539	3, 928	
	09100 EMERGENCY	0	709, 660	709, 660	3, 946	35, 900	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			()		92.0
101.00	10100 HOME HEALTH AGENCY	0	0	(0	0	101.0
	SPECIAL PURPOSE COST CENTERS	1					
	11600 HOSPICE	0		347, 687		21, 436	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	8, 249, 009	8, 249, 009	69, 651	713, 523	118.0
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 0
190. 01	19001 PROFESSI ONAL BUI LDI NG	0	2, 350, 303	2, 350, 303	0	21, 688	190. C
	19002 PHYSI CI AN BUI LDI NG	0	0	C	0		190.0
	19003 PRI VATE DUTY 19004 MARKETI NG			(r) 379) 269	7, 572 12, 306	
	19005 SPORTS PHYSI CALS		0	(108		190. C
190.06	19006 FOUNDATI ON	0	77, 371	77, 371	304	8, 065	190. C
	19007 ASC	0	0	0	0		190.0
	19008 OTHER NONREI MBURSABLE 19009 HANCOCK OB		0 208, 002	(208, 002	1, 316 3, 568	7, 946 47, 281	
	19010 HANCOCK WELLNESS		200,002	200,002	1, 214	9, 965	
190. 11	19011 MORRISTOWN CLINIC	0	0	C	0	25	190. 1
	19012 03PUREMED	0	0	0			190.1
	19013 MCCORD WELLNESS 19014 3 WEST UNIT		0 403, 098	403, 098	0 1, 051 3 305	9, 154 7, 034	
		1	+03,070	403, 090	1, 267	9,844	

Health Financial Systems	HANCOCK REGION	IAL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0037	Period: From 01/01/2019	Worksheet B Part II	
				To 12/31/2019		
		CAPI TAL				
Cost Center Description	Di rectl y	RELATED COSTS	Subtotal	EMPLOYEE	ADMI NI STRATI V	
	Assigned New Capital	FI XT		BENEFI TS DEPARTMENT	E & GENERAL	
	Related Costs					
	0	1.00	2A	4.00	5.00	
190. 16 19016 THORACI	0	0		0 168	1, 305	190. 16
190. 17 19017 HANCOCK ENDO	0	0		0 178	1, 713	190. 17
190. 18 19018 HANCOCK FOOT & ANKLE	0	0		0 617	5, 540	190. 18
190. 19 19019 HANCOCK RHEUM	0	0		0 90	761	190. 19
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 through 201)	0	11, 287, 783	11, 287, 78	80, 485	864, 593	202.00

ALLOCATION OF CAPT ALL RELATED COSTS Provider CAPT 15-0027 Port dot TO 1777217201 Port dot T	Health Financial Systems	HANCOCK REGION	VAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
In Instruction Deleting of HAMI De					eriod:	Worksheet B	
Cost Center Description DESCRIPTION OF PLANT DESCRIPTION PLANT DESCRIPTION PLANT DESCRIPTION PLANT DESCRIPTION PLANT DESCRIPTION PLANT					b 12/31/2019	Date/Time Pre	pared:
T.DO 9.00 10.00 11.00 13.00 1.00 DIOLONER CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00 00000 REP CAP HEL COSTS BLOG A 1 VAT 00	Cost Center Description	OPERATION OF	HOUSEKEEPING	DI ETARY	CAFETERI A		7 pm
7 7 9 10 00 11.00 13.00 12.00 00 DATE DATE 00 DATE DATE </td <td></td> <td>PLANT</td> <td></td> <td></td> <td></td> <td></td> <td></td>		PLANT					
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90.02 9002 D1 ABETES CLINIC 0 0 21 0 90.03 90.03 90003 ASTHMA CLINIC 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
90.03 99003 ASTHMA CLINIC 0 0 0 0 90.03 90.04 99004 ANDIS CLINIC 9,703 0 0 0 90.04 90.05 99005 RIME TIME 0 0 0 0 90.05 90.06 99005 RIME TIME 0 0 0 0 90.06 90.07 04951 NOLOGY 51,765 0 0 517 0 90.07 90.08 04950 ANDERSON WORKIS CENTER 82,363 0 0 1,121 2,125 91.00 91.00 097000 DERGENCY 82,363 0 0 1,121 2,125 91.00 91.00 01000 HOME REALTH AGENCY 0 0 0 0 101.00 1000 91.001 PROFEST CENTERS 0 65,243 556 1.053 116.00 100.00 19000 GIFT, FLOWER, COFTE ES SHOP & CANTEEN 0 0 0 190.04 90.03		0	0	0		-	
90. 04 09004 (ADD S CLINIC 97,703 0 0 46 0 90.04 90. 05 09005 PRIME TIME 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0		-	
90. 66 09006 SHELBYVI LLE WOUND CLINIC 0 0 73 0 90. 67 90. 07 04951 INCOLOGY 51, 765 0 0 517 0 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0 6, 160 180 0 90. 07 92. 00 99252WATI ON BEDS (NON-DISTINCT PART) 82, 363 0 0 1, 121 2, 125 91. 00 92. 00 9052EVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 101. 00 0THER REIMBURSABLE COST CENTERS		9, 703	0	-	-		
90. 07 04951 0NCOLOGY 51,765 0 0 5177 0 90.07 90. 08 04950 ANDERSON WORNS CENTER 0 6,160 0 180 0 90.08 91. 00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 82,363 0 0 1,121 2,125 91.00 0 01000 HER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 92.00 SPECIAL PURPOSE COST CENTERS TOTONE INSTALS (SUM OF LINES 1 through 117) 551,397 103,183 422,020 12,979 20,592 18.00 NONRE IMBURSABLE COST CENTERS 180:00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0		
90.08 04950 ANDERSON WORENS CENTER 0 6, 160 0 180 0 90.08 91.00 09200 DERGENCY 82, 363 0 0 1, 121 2, 125 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 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 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 0 0<			0	0			
92.00 09200 0BSERVATI 0N BEDS_(NON-DI STI NCT PART) 92.00 0THER_REIMBURSABLE_COST_CENTERS 0 0 0 0 101.00 SPECI_AL_PURPOSE_COST_CENTERS 40.353 0 65.243 556 1.053 116.00 SUBTORLS_(SUM_OF_LINES_1_through 117) 551.397 103.183 422.020 12.979 20.592 118.00 NONREI_MBURSABLE_COST_CENTERS 0 0 0 0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.01 1900.01 190.01 190.01 190.01 190.01 190.01 190.01 190.01 0 0 0 0 190.01 190.02 190.02 190.02 190.02 190.02 190.03 190.03 190.03 190.04 ARKETING 0 0 0 190.04 190.04 190.04 190.04 190.04 190.04 190.04 190.05 190.05 190.05 190.05 190.05 190.06 190.07 6 0 0 0 190.07 190.07 190.07 190.07 190.07 190.07<		0	6, 160	0		-	
OTHER RELIMBURSABLE COST CENTERS 101.00 IOTHOR RELIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS 116.00 116.00 IOTOR (MORE) HOSPI CE 101.00 OTHER RELIMBURSABLE COST CENTERS 116.00 116.00 165.243 5566 1.053 116.00 INTERSABLE COST CENTERS 100.00 FORTERS 190.00 GOST CENTERS 190.00 OST CENTERS 190.00 FORTER SIGNAL BUI LDING 0 0 0 0 100.00 190.01 PROFESSI ONAL BUI LDING 0 0 0 0 0 0 0 0 0 0 0 0 0 0 100 0 0 0 <th< td=""><td></td><td>82, 363</td><td>0</td><td>0</td><td>1, 121</td><td>2, 125</td><td></td></th<>		82, 363	0	0	1, 121	2, 125	
101.00 HOME HEALTH AGENCY 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 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 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							92.00
116.00 11600 HOSPI CE 40, 353 0 65, 243 556 1, 053 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 551, 397 103, 183 422, 020 12, 979 20, 592 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 190.00 0 190.00 0 0 0 190.00 0 190.00 0 190.00 0 0 0 0 0 0 0 190.00 0 190.00 0 190.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 551,397 103,183 422,020 12,979 20,592 118.00 NONREI MBURSABLE COST CENTERS		40.252	0	45 242	EE4	1 052	114 00
NORRET MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.01 190.01 19001 PROFESSI ONAL BUI LDI NG 0 0 0 0 190.02 190.02 IPHYSI CI AN BUI LDI NG 0 0 0 0 190.02 190.03 19002 PRIVATE DUTY 0 0 0 361 684 190.02 190.04 19004 MARKETI NG 0 0 0 0 190.04 190.05 19005 SPORTS PHYSI CALS 0 0 0 0 190.05 190.06 FOUNDATI ON 8,980 0 0 98 0 190.07 190.07 19007 ASC 0 0 0 0 190.07 190.08 19008 OTHER NONREI MBURSABLE 0 0 0 190.07 190.09 19009 HANCOCK OB 24, 141 0 0 0					12, 979		
190.01 PROFESSI ONAL BUILDING 0 0 0 190.01 190.02 19002 PHYSI CI AN BUILDING 0 0 0 0 190.02 190.03 PRI VATE DUTY 0 0 0 361 684 190.03 190.04 19004 MARKETING 0 0 0 0 190.04 190.05 19005 SPORTS PHYSI CALS 0 0 0 0 190.05 190.06 19006 FOUNDATI ON 8, 980 0 0 0 190.06 190.07 19007 ASC 0 0 0 0 190.07 190.08 19008 OTHER NONREI MBURSABLE 0 0 0 0 190.09 190.09 19009 HANCOCK WELLNESS 0 0 0 0 190.09 190.10 19010 HANCOCK WELLNESS 0 0 0 0 190.10 190.12 19013 MCCORD WELLNESS 0 0 0 0 190.12 190.13 19013							
190.02 19002 PHYSI CI AN BUI LDI NG 0 0 0 190.02 190.03 19003 PRI VATE DUTY 0 0 361 684 190.03 190.04 19004 MARKETI NG 0 0 0 76 0 190.04 190.05 19005 SPORTS PHYSI CALS 0 0 0 0 190.04 190.06 19006 FOUNDATI ON 8, 980 0 0 98 0 190.06 190.07 19007 ASC 0 0 0 0 190.07 190.09 HANCOCK VBLINESS 0 0 0 0 190.09 190.01 19009 HANCOCK WELLINESS 0 0 0 190.09 190.11 19011 MARCI NOREI MEURASS 0 0 0 190.19 190.12 19012 OSPUREMED 0 0 0 190.19 190.13 19013 MCCORD WELLNESS 0 0 0 190.14 190.14 19014 SURACORD WELLNESS		0			0		
190.04 19004 MARKETI NG 0 0 76 0 190.04 190.05 19005 SPORTS PHYSI CALS 0 0 0 0 190.05 190.06 19006 FOUNDATI ON 8, 980 0 0 98 0 190.06 190.07 19007 ASC 0 0 0 0 190.07 190.08 OTHER NONREI MBURSABLE 0 0 0 190.08 190.09 190.09 19009 HANCOCK OB 24, 141 0 0 225 0 190.09 190.10 19010 HANCOCK WELLNESS 0 0 0 0 190.10 190.12 19010 JORTI STOWN CLINIC 0 0 0 0 190.11 190.12 19013 MCRI STOWN CLINIC 0 0 0 0 190.12 190.13 19013 MCRORD WELLNESS 0 0 0 0 190.14 190.14 19014 SWEST UNI T 46, 784 0 0 74 190.14 </td <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
190.05 SPORTS PHYSI CALS 0 0 0 190.05 190.06 FOUNDATI ON 8, 980 0 0 98 190.06 190.07 19007 ASC 0 0 0 190.07 190.08 19080 OTHER NONREI MBURSABLE 0 0 0 190.08 190.09 HANCOCK OB 24, 141 0 0 225 190.09 190.10 19010 HANCOCK WELLNESS 0 0 0 0 190.10 190.11 19011 MORRI STOWN CLINIC 0 0 0 0 190.12 190.12 19012 OSPUREMED 0 0 0 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 0 0 190.13 190.14 19014 3 WEST UNIT 46, 784 0 0 74 190.14 190.15 19016 THORACI 0 0 0 0 190.16 190.17 19016 THORACI 0 0 0 0 <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td>		0	0	0			
190.06 FOUNDATION 8,980 0 0 98 190.06 190.07 19007 ASC 0 0 0 0 190.07 190.08 19008 OTHER NONREI MBURSABLE 0 0 0 0 190.08 190.09 HANCOCK VB 24,141 0 0 225 190.09 190.10 190.10 HANCOCK WELLNESS 0 0 0 190.10 190.11 19011 MORRI STOWN CLINIC 0 0 0 190.11 190.12 19012 O3PUREMED 0 0 0 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 0 0 190.13 190.14 19014 3 WEST UNIT 46, 784 0 0 74 190.14 190.15 19016 THORACI 0 0 0 0 190.16 190.17 19017 HANCOCK ENDO 0 0 0 0 190.16		0	0	0			
190.08 0THER NONREI MBURSABLE 0 0 0 190.08 190.09 19009 HANCOCK OB 24, 141 0 0 225 0 190.09 190.10 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 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 0 0 190.13 190.14 19014 3 WEST UNI T 46, 784 0 0 74 190.14 190.15 NEUROLOGY PHYSI CLAN 0 0 0 190.15 190.15 190.16 19016 THORACI 0 0 0 190.16 190.16 190.17 19017 HANCOCK ENDO 0 0 0 190.17		8, 980	0	0	-		
190.09 HANCOCK OB 24, 141 0 0 225 0 190.09 190.10 19010 HANCOCK WELLNESS 0 0 0 0 190.10 190.11 19011 MORRI STOWN CLINIC 0 0 0 0 190.10 190.12 19012 03PUREMED 0 0 0 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 0 0 190.13 190.14 19014 SWEST UNIT 46, 784 0 0 74 190.14 190.15 ISULGOY PHYSICIAN 0 0 0 190.14 190.16 190.15 NEUROLOGY PHYSICIAN 0 0 0 190.16 190.16 19016 THORACI 0 0 0 190.16 190.17 19017 HANCOCK ENDO 0 0 0 190.17		0	0	0	0		
190.10 HANCOCK WELLNESS 0 0 0 190.10 190.11 19011 MORRI STOWN CLINIC 0 0 0 190.11 190.12 19012 03PUREMED 0 0 0 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 0 0 190.13 190.14 19014 WEST UNIT 46,784 0 0 74 190.14 190.15 19015 NEUROLOGY PHYSICIAN 0 0 0 190.16 190.16 19016 THORACI 0 0 0 0 190.16 190.17 19017 HANCOCK ENDO 0 0 0 0 190.17		0 24 141	0	0	-		
190.12 19012 03PUREMED 0 0 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 0 0 190.13 190.14 19014 3 WEST UNIT 46, 784 0 0 74 0 190.14 190.15 19015 NEUROLOGY PHYSICIAN 0 0 0 64 0 190.15 190.16 19016 THORACI 0 0 0 0 190.16 190.17 19017 HANCOCK ENDO 0 0 0 0 190.17			0	0			
190.13 MCCORD WELLNESS 0 0 0 190.13 190.14 19014 3 WEST UNIT 46, 784 0 0 74 0 190.14 190.15 19015 NEUROLOGY PHYSICIAN 0 0 0 64 0 190.15 190.16 19016 THORACI 0 0 0 0 190.16 190.17 19017 HANCOCK ENDO 0 0 0 0 190.17		0	0	0	0		
190.14 19014 3 WEST UNIT 46, 784 0 0 74 0 190.14 190.15 19015 NEUROLOGY PHYSICIAN 0 0 0 64 0 190.15 190.16 19016 THORACI 0 0 0 0 190.16 190.17 19017 HANCOCK ENDO 0 0 0 0 190.17			0	0	0		
190.16 19016 THORACI 0 0 0 190.16 190.17 19017 HANCOCK ENDO 0 0 0 0 190.17		•	0	0	74		
190. 17 19017 HANCOCK ENDO 0 0 190. 17		0	0	0	64		
		0	0	0	0		
		0	0	0	0		

Health Financial Systems	HANCOCK REGIO	NAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2019	Worksheet B Part II	
				Fom 01/01/2019 Fo 12/31/2019		
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMI NI STRATI O	
					N	
	7.00	9.00	10.00	11.00	13.00	
190. 19 19019 HANCOCK RHEUM	0	0	(0 0	0	190.19
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	631, 302	103, 183	422, 020	13, 877	21, 276	202.00

Health Financial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2019	Worksheet B Part II	
				To 12/31/2019		epared:
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
	SERVICES &		RECORDS &	PRGM		
	SUPPLY 14.00	15.00	LI BRARY 16.00	23.00	24.00	
GENERAL SERVICE COST CENTERS				1		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7. 00 00700 OPERATION OF PLANT						7.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	7, 087					14.00
	229	240, 193	154 05	2		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY 23.00 02300 PARAMED ED PRGM	0	0	156, 95	2 0 53, 321		16.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS		-				
30. 00 03000 ADULTS & PEDI ATRI CS	337	0	42, 30		1, 152, 089	
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	387 32	0	5, 28 4, 35		920, 084 395, 372	
41. 00 04100 SUBPROVI DER – I RF	0	0		0	0	
ANCI LLARY SERVI CE COST CENTERS				_		
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	2, 039 31	0	55, 60	7 0	945, 061 84, 758	50.00 51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	257	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	252	0	6, 34		910, 409	
	1, 821	0	14, 08		253, 415	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	80 20	0		0	99, 123 158, 770	
67.00 06700 OCCUPATI ONAL THERAPY	11	0		0	4, 011	
68. 00 06800 SPEECH PATHOLOGY	4	0		0	2, 049	1
68. 01 06801 OCCUPATI ONAL HEALTH 69. 00 06900 ELECTROCARDI OLOGY	0 879	0		0	0 294, 004	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0,7	0	7, 22	-	176, 638	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	23, 662	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 CARDI AC	0	240, 193 0		0	380, 649 0	1
76. 01 03160 CARDI OPULMONARY	1	0		0	83, 157	1
OUTPATIENT SERVICE COST CENTERS	I	-		-		
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	24	0		0	4,404	1
90. 01 09001 WOUND CLINIC	85	0		0	101, 891	90.01
90. 02 09002 DI ABETES CLI NI C	1	0		0	506	
90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC	0	0		0	0 95, 873	
90. 05 09005 PRIME_TIME	0	0		0	768	
90. 06 09006 SHELBYVILLE WOUND CLINIC	20	0		0	2, 829	
90.07 04951 ONCOLOGY	93	0		0	515, 832	
90. 08 04950 ANDERSON WOMENS CENTER 91. 00 09100 EMERGENCY	49 509	0	21, 73	3	10, 856 857, 357	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		_	,			92.00
OTHER REI MBURSABLE COST CENTERS	0	0			0	101 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0	0	101.00
116.0011600 HOSPI CE	91	0		0	478, 382	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 996	240, 193	156, 95	2 0	7, 952, 206	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
190. 01 19001 PROFESSI ONAL BUI LDI NG	0	0		0	2, 371, 991	
190. 02 19002 PHYSI CI AN BUI LDI NG	0	0		0		190.02
190. 03 19003 PRI VATE_DUTY 190. 04 19004 MARKETI NG	5	0		0		190. 03 190. 04
190. 05 19005 SPORTS PHYSI CALS	0	0		0		190.04
190. 06 19006 FOUNDATI ON	0	0		0	94, 818	190.06
190. 07 19007 ASC	0	0		0		190. 07 190. 08
190. 08 19008 OTHER NONREI MBURSABLE 190. 09 19009 HANCOCK OB	56	0		0	9, 269 283, 273	
190. 10 19010 HANCOCK WELLNESS	0	0		0		190.10
190. 11 19011 MORRI STOWN CLINIC	0	0		0		190.11
190. 12 19012 03PUREMED 190. 13 19013 MCCORD_WELLNESS	0	0		0		190. 12 190. 13
190. 14 19013 MCCORD WELLINESS 190. 14 19014 3 WEST UNIT	3	0		ŏ	457, 298	
190. 15 19015 NEUROLOGY PHYSI CI AN	3	0		0	11, 178	190. 15
190. 16 19016 THORACI 190. 17 19017 HANCOCK_ENDO	0	0		0		190.16
190. 18 19018 HANCOCK FOOT & ANKLE	16	0		0		190. 17 190. 18

Health Financial Systems	HANCOCK REGION	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2019 To 12/31/2019		nared
					8/28/2020 1:2	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
	SERVICES &		RECORDS &	PRGM		
	SUPPLY		LI BRARY			
	14.00	15.00	16.00	23.00	24.00	
190. 19 19019 HANCOCK RHEUM	0	0		0	851	190. 19
200.00 Cross Foot Adjustments				53, 321	53, 321	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	7, 087	240, 193	156, 95	2 53, 321	11, 287, 783	202.00

Health Financial Systems	HANCOCK REGIONAL	L HOSPI TAL	In Lieu of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-003	37 Period: Worksheet B From 01/01/2019 Part II	
			To 12/31/2019 Date/Time Pr 8/28/2020 1:	
Cost Center Description	Intern &	Total	0/20/2020 1.	
	Residents Cost & Post			
	Stepdown			
	Adjustments	24.00		
GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT				5.00
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				11.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
15.00 01500 PHARMACY				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 23. 00 02300 PARAMED ED PRGM				16.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS				23.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	1, 152, 089		30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0	920, 084		31.00
41. 00 04100 SUBPROVIDER - IPF	0	395, 372 0		40.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0	945, 061		50.00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	0	84, 758 257		51.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	910, 409		54.00
60. 00 06000 LABORATORY	0	253, 415		60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	99, 123 158, 770		65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	4, 011		67.00
68.00 06800 SPEECH PATHOLOGY	0	2, 049		68.00
68. 01 06801 0CCUPATI ONAL HEALTH 69. 00 06900 ELECTROCARDI OLOGY	0	0 294, 004		68.01 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	TS 0	176, 638		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	23, 662		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CARDIAC	0	380, 649 0		73.00
76. 01 03160 CARDI AC	0	83, 157		76.00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0	4, 404 0		88.00 90.00
90. 01 09001 WOUND CLINIC	0	101, 891		90.00
90. 02 09002 DI ABETES CLI NI C	0	506		90.02
90. 03 09003 ASTHMA CLINIC	0	0		90.03
90. 04 09004 ANDES CLENIC 90. 05 09005 PRIME TIME	0	95, 873 768		90.04 90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	2, 829		90.06
90.07 04951 ONCOLOGY	0	515, 832		90.07
90. 08 04950 ANDERSON WOMENS CENTER 91. 00 09100 EMERGENCY	0	10, 856 857, 357		90.08
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T) 0	007,007		92.00
OTHER REIMBURSABLE COST CENTERS				101 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		101.00
116. 00 11600 HOSPI CE	0	478, 382		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	117) 0	7, 952, 206		118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEI		0		190.00
190. 00 19000 GFFT, FLOWER, COFFEE SHOP & CANTEEL 190. 01 19001 PROFESSI ONAL BUILDING	0	2, 371, 991		190.00
190. 02 19002 PHYSI CI AN BUI LDI NG	0	140		190. 02
190. 03 19003 PRI VATE DUTY	0	9,001		190.03
190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS	0	12, 651 821		190.04 190.05
190. 06 19006 FOUNDATI ON	Ő	94, 818		190.06
190. 07 19007 ASC	0	18		190.07
190. 08 19008 OTHER NONREI MBURSABLE 190. 09 19009 HANCOCK OB	0	9, 269 283, 273		190.08 190.09
190. 10 19010 HANCOCK WELLNESS	0	11, 179		190.10
190. 11 19011 MORRI STOWN CLINIC	0	25		190. 11
190. 12 19012 03PUREMED 190. 13 19013 MCCORD_WELLNESS	0	0		190. 12 190. 13
190. 14 19013 MCCORD WELLNESS 190. 14 19014 3 WEST UNIT	0	10, 205 457, 298		190. 13
190. 15 19015 NEUROLOGY PHYSICIAN	0	11, 178		190. 15
190. 16 19016 THORACI	0	1, 473		190.16

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0037	Period: From 01/01/2019 To 12/31/2019	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	25.00	26.00			
190. 17 19017 HANCOCK_ENDO	0	1, 892			190. 17
190.18 19018 HANCOCK FOOT & ANKLE	0	6, 173			190. 18
190. 19 19019 HANCOCK RHEUM	0	851			190. 19
200.00 Cross Foot Adjustments	0	53, 321			200.00
201.00 Negative Cost Centers	0	o			201.00
202.00 TOTAL (sum lines 118 through 201)	0	11, 287, 783			202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	HANCOCK REGION	IAL HOSPITAL Provider C	CN: 15-0037 P	In Lie Period:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2019 0 12/31/2019		
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)		ADMI NI STRATI V E & GENERAL (ACCUM. COST)	0PERATI ON OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
1 00	GENERAL SERVICE COST CENTERS	251 400		1	1	[1 1 00
13.00 14.00 15.00 16.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02300 PARAMED ED PRGM	351, 600 2, 507 26, 441 17, 770 2, 208 11, 588 0 0 0 5, 982 3, 974 1, 344	52, 345, 870 10, 242, 544 1, 100, 863 1, 645, 295 439, 020 1, 030, 494 1, 357, 725 179, 191 1, 936, 293 589, 122 83, 227	-19, 857, 049 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7, 018, 865 2, 557, 235 729, 683 1, 255, 859 1, 886, 279 257, 591 2, 088, 227 1, 052, 105	169, 431 2, 208 11, 588 0 0 0 5, 982 3, 974	9.00 10.00 11.00 13.00 14.00 15.00 16.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	22, 759	3, 106, 673	0	4, 798, 234	22, 759	30.00
31. 00 40. 00	03100 INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF ANCI LLARY SERVI CE COST CENTERS	22, 739 23, 850 6, 376 0	3, 108, 873 3, 368, 142 1, 188, 489 0	0	5, 247, 976 1, 655, 953	23, 850 6, 376	31.00 40.00
50.00	05000 OPERATING ROOM	25, 149	3, 458, 691	0	7, 206, 764	0	50.00
51.00 53.00 54.00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	2, 120 0 25, 994 5, 844	294, 667 0 3, 392, 806 1, 683, 555		447, 428 30, 553 6, 583, 352	2, 120 0	1
65.00	06500 RESPIRATORY THERAPY	2, 354	1, 471, 246		1, 913, 691	0	65.00
	06600 PHYSI CAL THERAPY	3, 889	1, 143, 934		1, 511, 268	3, 889	•
67.00	06700 OCCUPATI ONAL THERAPY	0	328, 056			0	67.00
	06800 SPEECH PATHOLOGY 06801 OCCUPATI ONAL HEALTH	0	169, 616 0			0	68.00 68.01
69.00 71.00 72.00 73.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 03020 CARDI AC	7, 493 4, 692 0 0	0 678, 016 0 0 0	0	1, 944, 049 153, 798 2, 809, 272 16, 674, 291	7, 493	69.00 71.00 72.00
	03160 CARDI OPULMONARY	2, 279	66, 814	-	-	-	
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	257, 888				
90. 01 90. 02	09000 CLINIC 09001 WOUND CLINIC 09002 DIABETES CLINIC 09003 ASTHMA CLINIC	0 2, 901 0 0	0 505, 854 39, 972 0	0	907, 540		90.01
	09004 ANDIS CLINIC	2, 604	101, 746	0	281, 169		
	09005 PRIME TIME 09006 SHELBYVILLE WOUND CLINIC	0	0 175, 490		91, 129 292, 816		90.05 90.06
	04951 ONCOLOGY	13, 893	1, 074, 668		1, 873, 700		
	04950 ANDERSON WOMENS CENTER	0	350, 268				90.08
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	22, 105	2, 565, 761	0	4, 262, 190	22, 105	91.00 92.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	10, 830	1, 276, 277	' O	2, 544, 910	10.830	116.00
118.00		256, 946	45, 302, 403				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190.00
	19001 PROFESSI ONAL BUI LDI NG 19002 PHYSI CI AN BUI LDI NG	73, 209	0	0	2, 574, 885 16, 639		190. 01 190. 02
190.03	19003 PRI VATE DUTY	0	246, 176	0	898, 933		190.03
	19004 MARKETI NG	0	175, 072		1, 460, 974		190.04
	19005 SPORTS PHYSI CALS 19006 FOUNDATI ON	0 2, 410	69, 949 197, 819		84, 697 957, 471		190. 05 190. 06
	19007 ASC	2,410	177, 019	0	2, 114		190.08
190.08	19008 OTHER NONREI MBURSABLE	0	855, 615		943, 385	0	190. 08
	19009 HANCOCK OB	6, 479	2, 320, 072		-,,		190.09
	19010 HANCOCK WELLNESS 19011 MORRISTOWN CLINIC	0	789, 331 0		1, 183, 086 3, 000		190. 10 190. 11
190.12	19012 03PUREMED	0	0	0	0	0	190. 12
	19013 MCCORD WELLNESS 19014 3 WEST UNI T	0 12, 556	683, 273 198, 470				190. 13 190. 14

Heal th Financial	I Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION	I - STATISTICAL BASIS		Provi der C		eri od:	Worksheet B-1	
					rom 01/01/2019 o 12/31/2019	Date/Time Pre 8/28/2020 1:2	
		CAPI TAL					
		RELATED COSTS					
Cos	st Center Description	NEW BLDG &			ADMI NI STRATI V	OPERATION OF	
		FI XT	BENEFITS	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		1.00	SALARI ES)	F A	5 00	7.00	
		1.00	4.00	5A	5.00	7.00	100.15
	JROLOGY PHYSI CI AN	0	823, 566		1, 168, 719		190.15
190.16 19016 THO		0	108, 978		154, 988		190.16
190. 17 19017 HAN		0	115, 609		203, 324		190.17
	NCOCK FOOT & ANKLE	0	401, 253		657, 692		190.18
190. 19 19019 HAN		0	58, 284	(90, 395	0	190.19
	oss Foot Adjustments						200.00
	gative Cost Centers						201.00
	st to be allocated (per Wkst. B,	11, 287, 783	5,095,355		19, 857, 049	8, 376, 678	202.00
	rt I)	00 101017	0 007040		0 100450	40 440055	000 00
	t cost multiplier (Wkst. B, Part I)	32. 104047	0.097340		0. 193452	49.440055	
	st to be allocated (per Wkst. B,		80, 485		864, 593	631, 302	204.00
	rt II)		0. 001538		0. 008423	2 70/010	205 00
205.00 Uni	t cost multiplier (Wkst. B, Part		0.001538		0.008423	3. 726012	205.00
	HE adjustment amount to be allocated						206.00
	er Wkst. B-2)						200.00
	HE unit cost multiplier (Wkst. D,						207.00
	rts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	HANCOCK REGIONA	AL HOSPITAL Provider CO	N· 15-0037 P	In Lie	u of Form CMS-2 Worksheet B-1	
COST ALLOCATION - STATISTICAL DASIS			F	rom 01/01/2019 o 12/31/2019	Date/Time Pre	
					8/28/2020 1:2	
Cost Center Description	HOUSEKEEPI NG (HOURS OF	DI ETARY (PATI ENT	CAFETERIA (MANHOURS)	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	
	SERVI CE)	DAYS)	(N	SUPPLY	
				(MANHOURS)	(COSTED	
	9.00	10.00	11.00	13.00	REQUIS.) 14.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7. 00 00700 OPERATION OF PLANT						7.00
9.00 00900 HOUSEKEEPI NG	393, 860					9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	7, 387	044 570			10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	6, 543 10, 782	0	864, 579 29, 602			11.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	16, 355	0	7, 662		6, 023, 204	14.00
15. 00 01500 PHARMACY	11, 930	0	41, 682		194, 962	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY 23.00 02300 PARAMED ED PRGM	14, 350 16, 530	0	22, 328 2, 000		0	16.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS	10, 550	0	2,000	0	1	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	109, 670	3, 787	79, 895	79, 895	286, 669	30.00
31.00 03100 I NTENSI VE CARE UNI T	22, 610	0	98, 111	98, 111	328, 514	
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	18, 095 0	2, 458 0	34, 194 0	34, 194 0	27, 257 0	40.00
ANCI LLARY SERVICE COST CENTERS		0	0	<u> </u>	0	41.00
50. 00 05000 OPERATI NG ROOM	43, 900	0	53, 967	53, 967	1, 733, 144	50.00
51.00 05100 RECOVERY ROOM	16, 165	0	6, 663		26, 174	51.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 16, 070	0	0 95, 010	0 95, 010	0 213, 779	53.00 54.00
60. 00 06000 LABORATORY	15, 335	0	60, 839		1, 547, 006	
65. 00 06500 RESPI RATORY THERAPY	11, 745	0	43, 276		68, 300	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	13, 650 0	0	28, 895		17,079	
68. 00 06800 SPEECH PATHOLOGY	0	0	9, 400 3, 969		9, 604 3, 617	68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0	0	0	68.01
69. 00 06900 ELECTROCARDI OLOGY	26, 615	0	16, 148	0	747, 032	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 03020 CARDI AC	0	0	0		0	76.00
76. 01 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0	2, 817	0	1, 048	76.01
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	20, 373	88.00
90. 00 09000 CLINIC	0	0	0		0	90.00
90. 01 09001 WOUND CLINIC	0	0	15, 577	0	72, 151	90.01
90. 02 09002 DI ABETES CLI NI C 90. 03 09003 ASTHMA CLI NI C	0	0	1, 292 0		1,025	90.02 90.03
90. 04 09004 ANDIS CLINIC	0	0	2, 849	Ű	761	
90. 05 09005 PRIME TIME	0	0	0	0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC 90. 07 04951 ONCOLOGY	0	0	4, 570		16, 715	
90.07 04951 ONCOLOGY 90.08 04950 ANDERSON WOMENS CENTER	23, 515	0	32, 192 11, 242		78, 740 41, 545	
91.00 09100 EMERGENCY	0	0	69, 860		432, 423	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
OTHER REI MBURSABLE COST CENTERS	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>				Ŭ	101.00
116.00 11600 HOSPI CE	0	1, 142	34, 631			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	393, 860	7, 387	808, 671	677, 013	5, 945, 425	118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190. 01 19001 PROFESSI ONAL BUI LDI NG	0	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 190. 04 19004 MARKETI NG	0	0	22, 504 4, 717	22, 504 0		190. 03 190. 04
190. 05 19005 SPORTS PHYSI CALS	0	0	0	-	68	190.05
190. 06 19006 FOUNDATI ON	0	0	6, 114			190.06
190. 07 19007 ASC 190. 08 19008 0THER_NONRELIMBURSABLE	0	0	0	0		190. 07 190. 08
190. 09 19009 HANCOCK OB	0	0	13, 993	0	47,857	
190. 10 19010 HANCOCK WELLNESS	0	0	0	0	0	190. 10
190. 11 19011 MORRI STOWN CLINIC	0	0	0	0		190.11
190. 12 19012 03PUREMED 190. 13 19013 MCCORD WELLNESS	0	0	0	0		190. 12 190. 13
190. 14 19014 3 WEST UNI T	0	0	4, 595	0	2, 196	190.14
190. 15 19015 NEUROLOGY PHYSI CI AN	0	0	3, 985	0	2, 522	190. 15
190. 16 19016 THORACI	0	0	0	0	0	190. 16

Health Fir	ancial Systems	HANCOCK REGIONA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C	CN: 15-0037	Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI O	SERVICES &	
		SERVI CE)	DAYS)		N	SUPPLY	
					(MANHOURS)	(COSTED	
						REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
190. 17 190	17 HANCOCK ENDO	0	0		0 0	792	190. 17
190. 18 190	18 HANCOCK FOOT & ANKLE	0	0		0 0	13, 929	190. 18
190. 19 190	19 HANCOCK RHEUM	0	0		0 0	0	190. 19
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	3, 161, 101	1, 443, 753	1, 551, 32	2, 390, 834	478, 621	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	8. 025951	195. 445106	1. 79430	3. 417835	0. 079463	203.00
204.00	Cost to be allocated (per Wkst. B,	103, 183	422, 020	13, 87	21, 276	7, 087	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 261979	57. 130093	0. 01605	0. 030415	0. 001177	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						
			·	•			•

The information and the set of t	Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	HANCOCK REGION	IAL HOSPITAL Provider CO	CN: 15-0037	In Lieu of Form C Period: Worksheet	
Cost Center Description PHONENCY (COSTUL PSQUES.) VEX.DDS (CONTEX PSQUES.) PPOLATION (CONTEX PSQUES.) PPOLATION (CONTEX PSQUES.) 1.00 COSTULATOR (CONTEX) 15.00 16.00 72.00 1.00 COSTULATOR (CONTEX) 10.00 72.00 1.00 1.00 COSTULATOR (CONTEX) 10.00 72.00 1.00 1.00 COSTULATOR (CONTEX) 10.00 72.00 1.00 1.00 COSTULATOR (CONTEX) FERENCIAL STRUCT ON TACLOSIS- (CONTEX) 1.00 1.00 0.00000 COSTEX/CENTRATION 10.00 1.00 1.00 1.00 1.00 COSTEX/CENTRATION 10.00 3.387 1.00 1.00 1.00 COSTEX/CENTRATION 10.00 1.00 3.00 1.00 1.00 1.00 COSTEX/CENTRATION 10.00 3.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 <td></td> <td></td> <td></td> <td></td> <td>From 01/01/2019 To 12/31/2019 Date/Time</td> <td>Prepared:</td>					From 01/01/2019 To 12/31/2019 Date/Time	Prepared:
Internal 15.00 16.00 24.00 1000000000000000000000000000000000000	Cost Center Description	(COSTED	RECORDS & LI BRARY (TI ME	PRGM (ASSI GNED	8/28/2020	<u>1:27 pm</u>
1.00 00000 MEW CAP NEE COST S-BLOG & FLYI 1.00 4.00 1.00 00000 MEW CAP NEE COST S-BLOG & FLYI 5.00 4.00 1.00 00000 MEW CAP NEE COST S-BLOG & FLYI 5.00 5.00 1.00 00000 MEW CAP NEE COST S-BLOG & FLYI 5.00 5.00 5.00 1.00 01000 METAW NETW TAY 0 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.		15.00		23.00		
4.00 0400 DREALWEE BAREET IS DEPARTMENT 4.00 5.00 DRESOLUTION OF INATION OF IF ANT 7.00 5.00 DRESOLUTION OF ICAL RECORDS A SUPPLY 100 11.00 5.00 DRESOLUTION CARE TRUNT 0 0 3.00 5.00 DRESOLUTION CARE TRUNT 0 0 5.00 5.00 DRESOLUTION CARE TRUNT 0 0 5.00 <						1 00
00.00 03000 ADULTS & PEDIATRICS 0 913 0 30.00 01.00 03000 INTENSIVE CARE UNIT 0 114 0 31.00 01.00 04000 SUBPRAVIDER - IPF 0 94 0 41.00 01.00 04000 SUBPRAVIDER - IPF 0 0 0 41.00 01.00 00000 SUBPRAVIDER - IPF 0 0 0 41.00 01.000 CONDERSTIN (R CONT 0 0 0 53.00 53.00 01.000 CONDERSTIN (R CONT 0 0 0 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00	4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 23. 00 02300 PARAMED ED PRGM	0		10	0	$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
13.100 03100 [NITERSINE CARE UNIT 0 11.4 0 31.00 14.00 04100 SUPPROVIDER - IFF 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td>0</td> <td>913</td> <td></td> <td>0</td> <td>30.00</td>		0	913		0	30.00
D0.00 DCCOOL OPERATING REDUX 0 1.200 0 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 77.00 67.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00	31.00 03100 I NTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF	0 0	114 94		0 0	31.00 40.00
53.00 OS300 AVESTIESI OLDGY 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	1, 200		0	50.00
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73.00 073.00 073.00 73.00 73.00 73.00 76.00 0320 CARDIAC 0 0 76.00 0.01 03160 CARDI OPULMONARY 0 0 76.00 0.01 DITPATLENT SERVICE COST CENTERS 0 0 0 76.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 90.00 90.01 90001 WOND CLINIC 0 0 0 90.00 90.02 90003 ASTHMA CLINIC 0 0 0 90.02 90.03 90003 ASTHMA CLINIC 0 0 0 90.03 90.04 90003 ASTHMA CLINIC 0 0 0 90.04 90.05 99005 PRIOSO RANDERSON WOMENS CENTER 0 0 0 90.05 90.06 990.05 990.06 990.07 990.07 990.07 990.07 90.00 0 0 0 0 0 0 <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>0</td> <td></td> <td></td> <td>0</td> <td>71.00</td>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	71.00
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OUTPATIENT SERVICE COST CENTERS Image: Cost C			-			
88. 00 OBSON RURAL HEALTH CLINIC O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O <tho< th=""> O O O O O O O O O O O O O O O O O O O O O O O O O O <tho< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>76. 01</td></tho<></tho<>		0	0		0	76. 01
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92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 116.00 116.00 116.00 116.00 118.00 NONREI MBURSABLE COST CENTERS 118.00 NONREI MBURSABLE COST CENTERS 118.00 0 0 0 0 0 0 190.01 190.02 190.01 190.02 190.02 190.02 190.02 190.02 190.02 190.02 190.03 190.04 190.04 190.04 190.04 190.04 190.04 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td>		0	0		0	
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SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 3, 387 100 118.00 NORREI MBURSABLE COST CENTERS NOMREI MBURSABLE COST CENTERS 0 0 0 190.00 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.01 190.02 19002 PHYSI CI AN BUI LDI NG 0 0 0 190.02 190.03 19003 PRI VATE DUTY 0 0 0 190.03 190.04 19004 MARKETI NG 0 0 0 190.04 190.05 SPORTS PHYSI CALS 0 0 190.05 190.06 19006 FOUNDATI ON 0 0 190.06 190.07 19007 ASC 0 0 0 190.07 190.08 19008 OTHER NONREI MBURSABLE 0 0 0 190.09 190.01 190101 MARCOCK OB 0 0 0 190.09						92.00
116.00 11600 HOSPICE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 3, 387 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.01 190.01 19001 PROFESSI ONAL BUI LDI NG 0 0 190.01 190.02 19002 PHYSI CI AN BUI LDI NG 0 0 0 190.02 190.03 19004 MARKETI NG 0 0 0 190.03 190.04 190.04 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.06 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.08 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 190.09 19	101.00 10100 HOME HEALTH AGENCY	0	0		0	101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 3,387 100 118.00 NONREL MEURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 190.00 190.00 190.00 190.00 190.00 190.01 190.00 190.01 190.00 190.01 190.00 190.01 190.02 190.02 190.02 190.02 190.02 190.02 190.03 190.04 0 0 0 190.02 190.03 190.04 190.05 190.05 SPORTS PHYSI CALS 0 0 0 190.05 190.04 190.05 190.05 190.05 190.05 190.05 190.05 190.04 190.05 190.04 190.05 190.05 190.05 190.04 190.05 190.05 190.05 190.06 190.05 190.06 190.05 190.06 190.05 190.07 190.06 190.07 190.07 190.07 190.07 190.08 190.09 190.09 190.09 190.09 190.0		0	0		ol	116 00
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190.02 19002 PHYSI CI AN BUI LDI NG 0 0 190.02 190.03 19003 PRI VATE DUTY 0 0 0 190.03 190.04 19004 MARKETI NG 0 0 0 190.04 190.05 19005 SPORTS PHYSI CALS 0 0 0 190.05 190.06 FOUNDATI ON 0 0 0 190.06 190.07 190.07 ASC 0 0 0 190.08 190.09 190.09 HANCOCK OB 0 0 0 190.09 190.10 HANCOCK KUELLNESS 0 0 0 190.09 190.11 19011 MORRI STOWN CLI NI C 0 0 190.12 190.12 19013 MCCORD WELLNESS 0 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 190.13 190.14 19015 NEUROLOGY PHYSI CI AN 0 0 190.14		0	0		0	
190.03 19003 PRI VATE DUTY 0 0 190.03 190.04 19004 MARKETI NG 0 0 0 190.04 190.05 19005 SPORTS PHYSI CALS 0 0 0 190.05 190.06 19006 FOUNDATI ON 0 0 0 190.06 190.07 ASC 0 0 0 190.07 190.08 19009 KARCK OB 0 0 190.08 190.09 19009 HANCOCK OB 0 0 190.09 190.10 19010 HANCOCK WELLNESS 0 0 0 190.10 190.12 19011 MORRI STOWN CLINIC 0 0 0 190.12 190.12 19013 MCCORD WELLNESS 0 0 190.12 190.12 190.13 19013 MCCORD WELLNESS 0 0 190.13 190.14 190.14 190.15		0	0		0	
190.04 19004 MARKETING 0 0 190.04 190.05 SPORTS PHYSI CALS 0 0 0 190.05 190.06 FOUNDATI ON 0 0 0 190.06 190.06 190.07 ISOC 0 0 0 0 190.06 190.07 ISOC 0 0 0 190.07 190.08 OTHER NONREI MBURSABLE 0 0 0 190.08 190.09 HANCOCK VBLLNESS 0 0 0 190.09 190.10 IPOROK WELLNESS 0 0 190.10 190.12 IPORUMED 0 0 0 190.11 190.12 IPORUMED 0 0 190.12 190.12 190.13 IPORUMED 0 0 190.13 190.13 190.14 IPORUMELLNESS 0 0 0 190.14 190.15 NEUROLOGY PHYSI CI AN 0 0 0 190.15		0	0		0	
190.06 19006 FOUNDATION 0 0 0 190.06 190.07 19007 ASC 0 0 0 190.07 190.08 19008 OTHER NONREI MBURSABLE 0 0 0 190.08 190.09 HANCOCK OB 0 0 0 0 190.09 190.10 19010 HANCOCK WELLNESS 0 0 0 190.10 190.11 19011 MORRI STOWN CLINIC 0 0 0 190.12 190.12 03PUREMED 0 0 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 190.13 190.13 19014 3 WEST UNIT 0 0 190.14 190.15 NEUROLOGY PHYSICIAN 0 0 0 190.15	190. 04 19004 MARKETI NG	0	0		0	190.04
190.07 19007 ASC 0 0 190.07 190.08 19008 OTHER NONREI MBURSABLE 0 0 190.08 190.09 19009 HANCOCK OB 0 0 190.09 190.10 19009 HANCOCK WELLNESS 0 0 0 190.10 190.11 19010 HANCOCK WELLNESS 0 0 0 190.11 190.12 03PUREMED 0 0 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 190.13 190.13 19014 3 WEST UNI T 0 0 190.13 190.14 19015 NEUROLOGY PHYSI CI AN 0 0 190.15		0	0		0	
190.08 19008 OTHER NONREI MBURSABLE 0 0 0 190.08 190.09 19009 HANCOCK OB 0 0 0 190.09 190.10 19010 HANCOCK WELLNESS 0 0 0 190.10 190.11 19011 MORRI STOWN CLINIC 0 0 0 190.11 190.12 19012 OSPUREMED 0 0 0 190.12 190.13 IPOCOW WELLNESS 0 0 0 190.13 190.14 19014 3 WEST UNIT 0 0 190.14 190.15 NEUROLOGY PHYSICIAN 0 0 0 190.15		0	0		0	
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190.11 190.11 MORRI STOWN CLINIC 0 0 0 190.11 190.12 19012 03PUREMED 0 0 0 190.12 190.13 19013 MCCORD WELLNESS 0 0 0 190.13 190.14 19014 3 WEST UNIT 0 0 0 190.14 190.15 NEUROLOGY PHYSICIAN 0 0 0 190.15		0	0		0	
190. 12 19012 03PUREMED 0 0 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 190. 13 190. 14 19014 3 WEST UNIT 0 0 0 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 190. 15		0	0			
190.13 MCCORD WELLNESS 0 0 0 190.13 190.14 19014 3 WEST UNIT 0 0 0 190.14 190.15 19015 NEUROLOGY PHYSICIAN 0 0 0 190.15		0	0		0	
190.15 19015 NEUROLOGY PHYSICIAN 0 0 190.15	190. 13 19013 MCCORD WELLNESS	0	0		0	190. 13
		0	0		0	
		0	0			

Health Financial Systems	3	HANCOCK REGION	AL HOSPI TAL		In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATI	STICAL BASIS		Provider C		Period:	Worksheet B-1
					From 01/01/2019 To 12/31/2019	Date/Time Prepared: 8/28/2020 1:27 pm
Cost Center	Description	PHARMACY	MEDI CAL	PARAMED ED		
		(COSTED	RECORDS &	PRGM		
		REQUIS.)	LI BRARY	(ASSI GNED		
			(TIME SPENT)	TIME)		
		15.00		23.00		
190. 17 19017 HANCOCK END	0	13.00	10.00	23.00	0	190, 17
190. 18 19018 HANCOCK FOO		0	0		0	190.18
190. 19 19019 HANCOCK RHE		0	0		0	190.19
200.00 Cross Foot		Ű	0		0	200.00
201.00 Negative Co						201.00
5	allocated (per Wkst. B,	3, 116, 443	1, 683, 660	298, 17	0	202.00
Part I)		-, -,				
	ultiplier (Wkst. B, Part I)	31, 164. 430000	497.094774	2, 981. 70000	00	203.00
204.00 Cost to be	allocated (per Wkst. B,	240, 193	156, 952	53, 32	21	204.00
Part II)						
	ultiplier (Wkst. B, Part	2, 401. 930000	46. 339534	533. 21000	00	205.00
1)						
	ment amount to be allocated				0	206.00
(per Wkst.						
	ost multiplier (Wkst. D,			0.00000	00	207.00
Parts III a	nd IV)				1	

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	HANCOCK REGIO		CN. 1E 0027		u of Form CMS-	2332-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0037	Period: From 01/01/2019	Worksheet C Part I	
				To 12/31/2019	Date/Time Pre	pared:
			xviii	llooni tol	8/28/2020 1: 2 PPS	27 pm
				<u>Hospi tal</u> Costs	PPS	
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
oust center bescription	(from Wkst.	Adj.		Di sal I owance	10101 00313	
	B, Part I,			bi our i olianoo		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	9, 365, 077		9, 365, 07	7 0	9, 365, 077	30.0
31.00 03100 INTENSIVE CARE UNIT	8, 217, 966		8, 217, 96			
40. 00 04000 SUBPROVI DER – I PF	3, 144, 281		3, 144, 28		3, 144, 281	
41.00 04100 SUBPROVI DER – I RF	0			0 0	0	41.0
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	9, 968, 783		9, 968, 78			
51.00 05100 RECOVERY ROOM	805, 344		805, 34			
53. 00 05300 ANESTHESI OLOGY	36, 464		36, 46		,	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 864, 358		8, 864, 35		8, 864, 358	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	6, 446, 719		6, 446, 71		6, 446, 719	
66. 00 06600 PHYSI CAL THERAPY	2, 609, 150 2, 257, 414				2, 609, 150 2, 257, 414	
67. 00 06700 OCCUPATI ONAL THERAPY	491, 390				491, 390	
58.00 06800 SPEECH PATHOLOGY	251, 167		,		251, 167	
68. 01 06801 0CCUPATI ONAL HEALTH	231, 107		231, 10	0 0	231, 107	
69. 00 06900 ELECTROCARDI OLOGY	2, 992, 529	-	2, 992, 52			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	493, 071		493, 07		493, 071	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 352, 731		3, 352, 73		3, 352, 731	
73.00 07300 DRUGS CHARGED TO PATIENTS	23, 016, 443		23, 016, 44			
76. 00 03020 CARDI AC	0			0 0		
76. 01 03160 CARDI OPULMONARY	309, 282		309, 28	32 0	309, 282	76.0
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	565, 907		565, 90)7 0	565, 907	88.0
90. 00 09000 CLINIC	0			0 0		90.0
90. 01 09001 WOUND CLINIC	1, 116, 788		1, 116, 78		.,	
90. 02 09002 DI ABETES CLINIC	62, 383		62, 38	33 0	62, 383	
90. 03 09003 ASTHMA CLINIC	0			0 0	0	1
90. 04 09004 ANDIS CLINIC	469, 476		469, 47		469, 476	
90. 05 09005 PRIME TIME	108, 758		108, 75		108, 758	
90. 06 09006 SHELBYVILLE WOUND CLINIC	358, 990		358, 99		358, 990	
90.07 04951 ONCOLOGY	2, 987, 061		2, 987, 06		2, 987, 061	
90. 08 04950 ANDERSON WOMENS CENTER	768, 786		768, 78		768, 786	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 811, 210		6, 811, 21		6, 811, 210	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	4, 193, 150		4, 193, 15		4, 193, 150	92.0
101.00 10100 HOME HEALTH AGENCY	0		1	0	0	101.0
SPECIAL PURPOSE COST CENTERS	0	l	I		0	1.01.0
116. 00 11600 HOSPI CE	3, 982, 522		3, 982, 52	2	3, 982, 522	1116 0
200.00 Subtotal (see instructions)	104, 047, 200					
201.00 Less Observation Beds	4, 193, 150		4, 193, 15		4, 193, 150	
202.00 Total (see instructions)	99, 854, 050					

OMPOTATION	N OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/28/2020 1:2	epared: 27 pm
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Charges Outpati ent	Total (col. (+ col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	TIENT ROUTINE SERVICE COST CENTERS	II		1			
	0 ADULTS & PEDIATRICS	6, 600, 788		6, 600, 78		1	30.00
	O INTENSIVE CARE UNIT	10, 677, 393		10, 677, 39		1	31.00
	0 SUBPROVI DER – I PF	3, 234, 962		3, 234, 96		1	40.00
	0 SUBPROVI DER – I RF	0			0		41.00
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	9, 611, 004	15, 793, 557			0.00000	
	O RECOVERY ROOM	886, 485	1, 489, 909			0.000000	
	O ANESTHESI OLOGY	1, 118, 247	2,043,145			0.000000	
	0 RADI OLOGY-DI AGNOSTI C	2, 606, 758	73, 027, 065			0.000000	
	O LABORATORY	4, 858, 122	42, 694, 002			0.000000	
	0 RESPI RATORY THERAPY	2, 855, 759	8, 128, 036			0.000000	
	0 PHYSI CAL THERAPY	714, 876	4, 371, 964			0.000000	
	O OCCUPATI ONAL THERAPY	560, 247	798, 348			0.00000	
	O SPEECH PATHOLOGY	118, 327	538, 793			0. 000000	
	1 OCCUPATIONAL HEALTH	0	0		0 0. 000000	0.00000	
	0 ELECTROCARDI OLOGY	3, 424, 468	14, 009, 543			0.000000	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	405, 816	421, 354			0.00000	
	O IMPL. DEV. CHARGED TO PATIENT	5, 567, 061	4, 146, 717			0. 000000	
	O DRUGS CHARGED TO PATIENTS	6, 980, 166	90, 419, 860			0.00000	
	O CARDI AC	0	0		0 0. 000000	0. 000000	
	O CARDI OPULMONARY	0	457, 488	457, 48	8 0. 676044	0.00000	76.0
	ATIENT SERVICE COST CENTERS			1	-		
	O RURAL HEALTH CLINIC	0	0		0		88.0
		0	0		0 0.000000	0.000000	
	1 WOUND CLINIC	5, 370	4, 179, 804			0.000000	
	2 DI ABETES CLI NI C	0	63, 998			0.000000	
	3 ASTHMA CLINIC	0	0		0 0.000000	0.000000	
	4 ANDIS CLINIC	0	56, 729			0.000000	
	D5 PRIME TIME	0	472, 877			0.000000	
	6 SHELBYVILLE WOUND CLINIC	0	1, 196, 910			0.000000	
	1 ONCOLOGY	20, 391	6, 863, 197			0.000000	
	O ANDERSON WOMENS CENTER	29, 798	3, 963, 067			0.000000	
	O EMERGENCY	4, 170, 350	51, 800, 682			0.000000	
	0 OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS	7, 892	8, 684, 241	8, 692, 13	3 0. 482407	0. 000000	92.00
	0 HOME HEALTH AGENCY	0	0		0		101.00
	IAL PURPOSE COST CENTERS	U	0	1			
16. 00 1160		1, 249, 523	1, 568, 571	2, 818, 09	4		116.0
00.00	Subtotal (see instructions)	65, 703, 803	337, 189, 857			1	200.0
00.00		00, 703, 803	331, 189, 857	402, 893, 66	U		200.0
01.00	Less Observation Beds						

ealth Financial Systems	HANCOCK REGIONAL			u of Form CMS-2552
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepare 8/28/2020 1:27 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
0. 00 03000 ADULTS & PEDIATRICS				30
1.00 03100 INTENSIVE CARE UNIT				31
0. 00 04000 SUBPROVIDER - IPF				40
1. 00 04100 SUBPROVIDER - IRF				41
ANCILLARY SERVICE COST CENTERS				
0.00 05000 OPERATING ROOM	0. 392401			50
1.00 05100 RECOVERY ROOM	0. 338893			51
3. 00 05300 ANESTHESI OLOGY	0. 011534			53
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 117201			54
0. 00 06000 LABORATORY	0. 135572			60
5. 00 06500 RESPI RATORY THERAPY	0. 237545			65
6. 00 06600 PHYSI CAL THERAPY	0. 443775			66
7. 00 06700 OCCUPATI ONAL THERAPY	0.361690			67.
3. 00 06800 SPEECH PATHOLOGY	0. 382224			68
3. 01 06801 0CCUPATI ONAL HEALTH	0.000000			68
9. 00 06900 ELECTROCARDI OLOGY	0. 171649			69
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 596094			71
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 345152			72
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 236308			73
6. 00 03020 CARDI AC	0. 000000			76
6. 01 03160 CARDI OPULMONARY	0. 676044			76
OUTPATIENT SERVICE COST CENTERS	0.070044			70
3. 00 08800 RURAL HEALTH CLINIC				88
2. 00 09000 CLINIC	0, 000000			90
D. 01 09001 WOUND CLINIC				90.
	0. 266844			
D. 02 09002 DI ABETES CLI NI C	0. 974765			90
D. 03 09003 ASTHMA CLINIC	0.000000			90.
D. 04 09004 ANDIS CLINIC	8. 275767			90.
0.05 09005 PRIME TIME	0. 229992			90
D. 06 09006 SHELBYVILLE WOUND CLINIC	0. 299931			90
D. 07 04951 ONCOLOGY	0. 433940			90
D. 08 04950 ANDERSON WOMENS CENTER	0. 192540			90.
1.00 09100 EMERGENCY	0. 121692			91
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 482407			92
OTHER REIMBURSABLE COST CENTERS				
D1.0010100 HOME HEALTH AGENCY				101
SPECIAL PURPOSE COST CENTERS				
16. 00 11600 HOSPI CE				116
00.00 Subtotal (see instructions)				200
01.00 Less Observation Beds				201
02.00 Total (see instructions)				202

ealth Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	HANCOCK REGION		CNI 15 0027	Peri od:	u of Form CMS-: Worksheet C	
COMPUTATION OF RAILO OF COSIS TO CHARGES		Provider C		From 01/01/2019 Part I		
				To 12/31/2019	Date/Time Pre	pared
					8/28/2020 1:2	7 pm
			e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col. 26)	0.00	0.00	4.00	F 00	
INDATIENT POUTINE CEDULAE AACT AENTERS	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.0/5.077		0.0/5.07	7 0	0.2/5.077	200.0
30. 00 03000 ADULTS & PEDIATRICS	9, 365, 077		9, 365, 07			
81. 00 03100 I NTENSI VE CARE UNI T 10. 00 04000 SUBPROVI DER - I PF	8, 217, 966		8, 217, 96			
	3, 144, 281		3, 144, 28		-, , =	40.0
11.00 04100 SUBPROVIDER - IRF	0			0 0	0	41.0
ANCI LLARY SERVI CE COST CENTERS	0.0(0.70)		0.0(0.70	2 0	0.0(0.70)	
0.00 05000 OPERATING ROOM	9, 968, 783		9, 968, 78			
1.00 O5100 RECOVERY ROOM	805, 344		805, 34			51.0
3. 00 05300 ANESTHESI OLOGY	36, 464		36, 46			
4. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 864, 358		8, 864, 35		-, ,	
	6, 446, 719		6, 446, 71		-,,	
5. 00 06500 RESPI RATORY THERAPY	2, 609, 150				_/	
6.00 06600 PHYSI CAL THERAPY	2, 257, 414	0			=/==./	
7.00 06700 OCCUPATI ONAL THERAPY	491, 390	0				
8.00 06800 SPEECH PATHOLOGY	251, 167	0	251, 16		2017107	68.0
8. 01 06801 0CCUPATI ONAL HEALTH	0	0		0 0	-	
9.00 06900 ELECTROCARDI OLOGY	2, 992, 529		2, 992, 52			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	493, 071		493, 07		170/0/1	
2.00 07200 I MPL. DEV. CHARGED TO PATIENT	3, 352, 731		3, 352, 73		-,,	
3. 00 07300 DRUGS CHARGED TO PATIENTS	23, 016, 443		23, 016, 44		20/010/110	
6.00 03020 CARDI AC	0			0 0		76.0
6. 01 03160 CARDI OPULMONARY	309, 282		309, 28	2 0	309, 282	76.0
OUTPATIENT SERVICE COST CENTERS	F(F 007		F(F 00	7 0	F/F 007	
8. 00 08800 RURAL HEALTH CLINIC	565, 907		565, 90			88.0
0. 00 09000 CLINIC	0			0 0		90.0
	1, 116, 788		1, 116, 78		.,	
0. 02 09002 DI ABETES CLI NI C	62, 383		62, 38		62, 383	
0. 03 09003 ASTHMA CLINIC	0			0 0	0	
0. 04 09004 ANDIS CLINIC	469, 476		469, 47		1077170	
0. 05 09005 PRIME TIME	108, 758		108, 75		108, 758	
0. 06 09006 SHELBYVILLE WOUND CLINIC 0. 07 04951 ONCOLOGY	358, 990		358, 99		000///0	
	2, 987, 061		2, 987, 06		2, 987, 061	
0.08 04950 ANDERSON WOMENS CENTER	768, 786		768, 78		768, 786	
1.00 09100 EMERGENCY	6, 811, 210		6, 811, 21		6, 811, 210	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 193, 150		4, 193, 15	U	4, 193, 150	92.0
OTHER REIMBURSABLE COST CENTERS	0		1	0	0	101 /
01. 00 10100 HOME HEALTH AGENCY	0		l	0	0	101.0
SPECIAL PURPOSE COST CENTERS	2 002 522		2 002 52	2	2 002 522	114
16.00 11600 HOSPI CE	3, 982, 522		3, 982, 52		3, 982, 522	
00.00 Subtotal (see instructions)	104, 047, 200					
201.00 Less Observation Beds	4, 193, 150		4, 193, 15		4, 193, 150	
02.00 Total (see instructions)	99, 854, 050	0	99, 854, 05	0 0	99, 854, 050	1202. I

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/28/2020 1:2	epared: 27 pm
			e XIX	Hospi tal	Cost	
Cost Center Description	Inpati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	II					
0. 00 03000 ADULTS & PEDIATRICS	6, 600, 788		6, 600, 78			30.0
1.00 03100 INTENSIVE CARE UNIT	10, 677, 393		10, 677, 39			31.0
0. 00 04000 SUBPROVIDER - IPF	3, 234, 962		3, 234, 96			40.0
1.00 04100 SUBPROVI DER – I RF	0			0		41.0
ANCI LLARY SERVI CE COST CENTERS	0 (11 00)	15 300 553	05 101 51	1 0 000 101		1
0. 00 05000 OPERATING ROOM	9, 611, 004	15, 793, 557			0.000000	
1.00 05100 RECOVERY ROOM	886, 485	1, 489, 909			0.00000	
3. 00 05300 ANESTHESI OLOGY	1, 118, 247	2,043,145			0.00000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2,606,758	73, 027, 065			0.00000	
0. 00 06000 LABORATORY 5. 00 06500 RESPI RATORY_THERAPY	4,858,122	42, 694, 002			0.00000	
	2,855,759	8, 128, 036			0. 000000	
6. 00 06600 PHYSI CAL THERAPY 7. 00 06700 0CCUPATI ONAL THERAPY	714, 876	4, 371, 964			0.00000	
	560, 247	798, 348			0. 000000 0. 000000	
8. 00 06800 SPEECH PATHOLOGY 8. 01 06801 0CCUPATI ONAL HEALTH	118, 327 0	538, 793 0				
9. 00 06900 ELECTROCARDI OLOGY	3, 424, 468	14,009,543		0.000000	0. 000000 0. 000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	405, 816	421, 354			0. 000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 567, 061	4, 146, 717			0. 000000	
3. 00 07300 DRUGS CHARGED TO PATIENTS	6, 980, 166	90, 419, 860			0.000000	
6. 00 03020 CARDI AC	0, 980, 100	90, 419, 800 0		0. 000000	0. 000000	
6. 01 03160 CARDI OPULMONARY	0	457, 488			0. 000000	
OUTPATIENT SERVICE COST CENTERS	U U	437,400	437,40	0.070044	0.000000	/ /0.0
8. 00 08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0. 000000	88.0
0. 00 09000 CLINIC	0	0		0 0.000000	0. 000000	
0. 01 09001 WOUND CLINIC	5, 370	4, 179, 804	4, 185, 17		0.000000	
0. 02 09002 DI ABETES CLINIC	0	63, 998			0.000000	
0. 03 09003 ASTHMA CLINIC	0	0		0 0.000000	0.000000	
0.04 09004 ANDIS CLINIC	0	56, 729	56, 72	9 8. 275767	0.000000	90.0
0. 05 09005 PRIME TIME	0	472, 877	472, 87	0. 229992	0.000000	90.0
0.06 09006 SHELBYVILLE WOUND CLINIC	0	1, 196, 910			0.000000	90.0
0. 07 04951 ONCOLOGY	20, 391	6, 863, 197	6, 883, 58	0. 433940	0.000000	90.0
0.08 04950 ANDERSON WOMENS CENTER	29, 798	3, 963, 067	3, 992, 86	0. 192540	0.000000	90.0
1.00 09100 EMERGENCY	4, 170, 350	51, 800, 682	55, 971, 03	0. 121692	0.000000	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 892	8, 684, 241	8, 692, 13	0. 482407	0.00000	92.0
OTHER REIMBURSABLE COST CENTERS						
01.0010100 HOME HEALTH AGENCY	0	0		0]101. 0
SPECIAL PURPOSE COST CENTERS						_
16. 00 11600 HOSPI CE	1, 249, 523	1, 568, 571				116.0
00.00 Subtotal (see instructions)	65, 703, 803	337, 189, 857	402, 893, 66	0		200.0
01.00 Less Observation Beds						201.0
02.00 Total (see instructions)	65, 703, 803	337, 189, 857	402, 893, 66	0		202.0

OMPUTATION OF RATIO OF COSTS TO CHARGES	HANCOCK REGIONAL	Provider CCN: 15-0037	In Lieu Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepar 8/28/2020 1:27 p
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
0. 00 03000 ADULTS & PEDIATRICS				30
1.00 03100 INTENSIVE CARE UNIT				31
0. 00 04000 SUBPROVIDER - IPF				40
1.00 04100 SUBPROVIDER - IRF				41
ANCI LLARY SERVICE COST CENTERS	- I			
0.00 05000 OPERATING ROOM	0. 000000			50
1.00 05100 RECOVERY ROOM	0. 000000			51
3. 00 05300 ANESTHESI OLOGY	0. 000000			53
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
D. 00 06000 LABORATORY	0. 000000			60
5. 00 06500 RESPIRATORY THERAPY	0. 000000			65
5. 00 06600 PHYSI CAL THERAPY	0. 000000			66
7. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67
8. 00 06800 SPEECH PATHOLOGY	0. 000000			68
B. 01 06801 OCCUPATI ONAL HEALTH	0. 000000			68
9. 00 06900 ELECTROCARDI OLOGY	0. 000000			69
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73
6. 00 03020 CARDI AC	0. 000000			76
6. 01 03160 CARDI OPULMONARY	0. 000000			76
OUTPATIENT SERVICE COST CENTERS				
3. 00 08800 RURAL HEALTH CLINIC	0. 000000			88
D. 00 09000 CLINIC	0. 000000			90
D. 01 09001 WOUND CLINIC	0. 000000			90
D. 02 09002 DI ABETES CLI NI C	0. 000000			90
D. 03 09003 ASTHMA CLINIC	0. 000000			90
D. 04 09004 ANDIS CLINIC	0. 000000			90
0. 05 09005 PRIME TIME	0. 000000			90
0. 06 09006 SHELBYVILLE WOUND CLINIC	0. 000000			90
D. 07 04951 ONCOLOGY	0. 000000			90
D. 08 04950 ANDERSON WOMENS CENTER	0. 000000			90
1.00 09100 EMERGENCY	0. 000000			91
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 000000			92
D1.00 10100 HOME HEALTH AGENCY				101
SPECIAL PURPOSE COST CENTERS				
16. 00 11600 HOSPI CE				116
00.00 Subtotal (see instructions)				200
01.00 Less Observation Beds				201
02.00 Total (see instructions)				202

Health Financial Systems	HANCOCK REGIO	NAL_HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
	-		XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 152, 089	0	1, 152, 08	9 6, 669	172.75	30.00
31.00 INTENSIVE CARE UNIT	920, 084		920, 08	4 4, 992	184.31	31.00
40.00 SUBPROVIDER - IPF	395, 372	0	395, 37	2 2, 458	160.85	40.00
41.00 SUBPROVIDER - IRF	0	0		0 0	0.00	41.00
200.00 Total (lines 30 through 199)	2, 467, 545		2, 467, 54	5 14, 119		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 404	242, 541				30.00
31.00 INTENSIVE CARE UNIT	1, 973	363, 644				31.00
40. 00 SUBPROVI DER – I PF	1, 683					40.00
41. 00 SUBPROVI DER – I RF	0	0				41.00
200.00 Total (lines 30 through 199)	5, 060	876, 896				200.00

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C	CN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	-		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	945, 061				139, 825	50.00
51.00 05100 RECOVERY ROOM	84, 758				12, 076	
53. 00 05300 ANESTHESI OLOGY	257				37	
54.00 05400 RADI OLOGY-DI AGNOSTI C	910, 409	75, 633, 823			29, 736	54.00
60. 00 06000 LABORATORY	253, 415	47, 552, 124	0. 00532	3, 493, 325	18, 616	60.00
65. 00 06500 RESPI RATORY THERAPY	99, 123	10, 983, 795	0. 00902	1, 459, 468	13, 170	65.00
66. 00 06600 PHYSI CAL THERAPY	158, 770	5, 086, 840			10, 130	66.00
67.00 06700 OCCUPATI ONAL THERAPY	4, 011	1, 358, 595			625	
68.00 06800 SPEECH PATHOLOGY	2,049	657, 120			177	
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0.00000	0 0	0	68.01
69. 00 06900 ELECTROCARDI OLOGY	294, 004	17, 434, 011	0. 01686	1, 775, 237	29, 938	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	176, 638				56, 238	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	23, 662	9, 713, 778	0. 00243	6 2, 485, 888	6, 056	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	380, 649	97, 400, 026	0.00390	3, 639, 027	14, 221	73.00
76. 00 03020 CARDI AC	0	0	0.00000	0 0	0	76.00
76. 01 03160 CARDI OPULMONARY	83, 157	457, 488	0. 18176	09 0	0	76.01
OUTPATIENT SERVICE COST CENTERS				_		
88.00 08800 RURAL HEALTH CLINIC	4, 404	0	0.00000	0 0	0	88.00
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90.01 09001 WOUND CLINIC	101, 891	4, 185, 174	0. 02434	6 3, 590	87	90.01
90. 02 09002 DI ABETES CLINIC	506	63, 998	0.00790	06 0	0	90.02
90. 03 09003 ASTHMA CLINIC	0	0	0.00000	0 0	0	90.03
90. 04 09004 ANDIS CLINIC	95, 873	56, 729	1. 69001	7 0	0	90.04
90. 05 09005 PRIME TIME	768	472, 877	0. 00162	.4 0	0	90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	2, 829	1, 196, 910			0	90.06
90. 07 04951 ONCOLOGY	515, 832	6, 883, 588	0. 07493	20, 299	1, 521	90.07
90.08 04950 ANDERSON WOMENS CENTER	10, 856			9 29, 798	81	90.08
91.00 09100 EMERGENCY	857, 357	55, 971, 032			60, 819	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	515, 841				12	
200.00 Total (lines 50 through 199)	5, 522, 120	379, 562, 423		24, 757, 734	393, 365	200.00

Health Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-3	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE (OTHER PASS THROUGH COST		-	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	School	School	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0 0	0	1 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	•
41. 00 04100 SUBPROVI DER – I RF	0	0		0	0	
200.00 Total (lines 30 through 199)	0	0			0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	I npati ent	200.00
oost conter beschiption		(sum of cols.	Days	(col. 5 ÷	Program Days	
		1 through 3,	buys	col. 6)	rrogram bays	
	i nstructi ons) I			001.0)		
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTER		0100	0.00	1100	0100	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	6, 66	0.00	1, 404	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	4, 992		1, 973	
40. 00 04000 SUBPROVIDER - IPF	0	0	2, 458		1, 683	
41. 00 04100 SUBPROVIDER - IRF	0	0	2, 100		0	•
200.00 Total (lines 30 through 199)	Ŭ	0			-	200.00
Cost Center Description	I npati ent	0	1,	, I	0,000	200.00
obst conter beschiption	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTER						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T						31.00
40. 00 04000 SUBPROVI DER - I PF	0					40.00
41. 00 04100 SUBPROVIDER - I RF	0					40.00
200.00 Total (lines 30 through 199)						200.00
	I OI					l≥00.00

Heal th	Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	FLONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA SH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0037	Period: From 01/01/2019 To 12/31/2019		
			Title	XVIII	Hospi tal	PPS	- p
	Cost Center Description	Non Physician	Nursing	Nursing		Allied Health	
	•	Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments		-		
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 0	0 0	
51.00	05100 RECOVERY ROOM	0	0		0 0	0 0	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	298, 170	54.00
60.00	06000 LABORATORY	0	0		0 0	0 0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0 0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0 0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0 0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0 0	68.00
68.01	06801 OCCUPATI ONAL HEALTH	0	0		0 0	0 0	68.01
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0 0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0 0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0 0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.00
76.00	03020 CARDI AC	0	0		0 0	0 0	76.00
76.01	03160 CARDI OPULMONARY	0	0		0 0	0 0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0 0	88.00
90.00	09000 CLINIC	0	0		0 0	0 0	90.00
90.01	09001 WOUND CLINIC	0	0		0 0	0 0	90.01
90.02	09002 DI ABETES CLINIC	0	0		0 0	0 0	90.02
90.03	09003 ASTHMA CLINIC	0	0		0 0	0 0	90.03
90.04	09004 ANDIS CLINIC	0	0		0 0	0 0	90.04
90.05	09005 PRIME TIME	0	0		0 0	0 0	90.05
90.06	09006 SHELBYVILLE WOUND CLINIC	0	0		0 0	0 0	90.06
90.07	04951 ONCOLOGY	0	0		0 0	0 0	90.07
90.08	04950 ANDERSON WOMENS CENTER	0	0		0 0	0 0	90.08
91.00	09100 EMERGENCY	0	0		0 0	0 0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00) Total (lines 50 through 199)	0	0		0 0	298, 170	200.00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PAS	S Provider C	CN: 15-0037	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	8/28/2020 1:2	7 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
	1.00	5.00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	0		1	0 25, 404, 561	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	-		0 25, 404, 561 0 2, 376, 394		50.00
53. 00 05300 ANESTHESI OLOGY	0			0 2, 378, 394		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	298, 170				54.00
60. 00 06000 LABORATORY		2,0,1/0		0 47, 552, 124		60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 10, 983, 795		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 086, 840		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	o o		0 1, 358, 595		
68.00 06800 SPEECH PATHOLOGY	0	0		0 657, 120		
68.01 06801 OCCUPATI ONAL HEALTH	0	0		0 0	0.000000	68.01
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 17, 434, 011	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 827, 170	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 9, 713, 778	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 97, 400, 026	0.00000	73.00
76. 00 03020 CARDI AC	0			0 0		
76.01 03160 CARDI OPULMONARY	0	0		0 457, 488	0.00000	76.01
OUTPATIENT SERVICE COST CENTERS	1		1	-		
88.00 08800 RURAL HEALTH CLINIC	0	-		0 0		88.00
90. 00 09000 CLINIC	0	-		0 0	0.000000	90.00
90. 01 09001 WOUND CLINIC	0	0		0 4, 185, 174		90.01
90. 02 09002 DI ABETES CLI NI C	0	0		0 63, 998		90.02 90.03
90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC	0			0 0 0 56,729	0. 000000 0. 000000	90.03
90. 05 09005 PRIME TIME	0	0		0 472, 877	0.000000	90.04
90. 06 09006 SHELBYVILLE WOUND CLINIC	0			0 1, 196, 910		90.05
90. 07 04951 0NCOLOGY				0 6, 883, 588		1
90. 08 04950 ANDERSON WOMENS CENTER	0	0		0 3, 992, 865		
91. 00 09100 EMERGENCY	0	0		0 55, 971, 032		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		0 8, 692, 133		
200.00 Total (lines 50 through 199)	0	298, 170	298, 1			200.00
	•	•	•		•	

Health Financial Systems	HANCOCK REGIONA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0037	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2019		
				To 12/31/2019		
		Title	XVIII	Hospi tal	8/28/2020 1:2 PPS	7 pm
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpatient	Outpati ent	
cost center bescription	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷	charges	Costs (col.		Costs (col. 9	
	col. 7)		x col. 10)	0	x col. 12)	
	9.00	10, 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	15.00	
50. 00 05000 OPERATING ROOM	0.000000	3, 758, 747		0 3, 438, 950	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	338, 577		0 274, 903		51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	456, 220		0 363, 365		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 003942	2, 470, 400				54.00
60. 00 06000 LABORATORY	0. 000000	3, 493, 325		0 5, 311, 626		60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 459, 468		0 1, 975, 835		65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	324, 565		0 16,063		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	211, 719		0 7, 980		67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	56, 879		0 60, 184		68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0. 000000	00,0,7		0 0		68.01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 775, 237		0 4, 504, 214	-	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	263, 356		0 133, 861	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	2, 485, 888		0 772, 991	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 639, 027		0 30, 836, 056	0	73.00
76. 00 03020 CARDI AC	0. 000000	0,007,027		0 0		76.00
76. 01 03160 CARDI OPULMONARY	0. 000000	0		0 180, 783		76.01
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 WOUND CLINIC	0. 000000	3, 590		0 1, 306, 329	0	90.01
90. 02 09002 DI ABETES CLINIC	0. 000000	0		0 0	0	90.02
90. 03 09003 ASTHMA CLINIC	0. 000000	0		0 0	0	90.03
90. 04 09004 ANDIS CLINIC	0. 000000	0		0 18,834	0	90.04
90. 05 09005 PRI ME TI ME	0. 000000	0		0 0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0. 000000	0		0 356, 837	0	90.06
90. 07 04951 ONCOLOGY	0. 000000	20, 299		0 1, 953, 180	0	90.07
90.08 04950 ANDERSON WOMENS CENTER	0. 000000	29, 798		0 389, 823	0	90.08
91.00 09100 EMERGENCY	0. 000000	3, 970, 440		0 8, 963, 498	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	199		0 2, 338, 836	0	92.00
200.00 Total (lines 50 through 199)		24, 757, 734	9, 73			200.00
				·		

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0037	Peri od:	Worksheet D	
				From 01/01/2019	Part V	
				To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
		Ti +L c	e XVIII	Hospi tal	PPS	pili
			Charges	nospi tai	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
cost center bescription	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Servi ces (see		Services Not		
	Worksheet C,	i nst.)	Subject To	Subject To		
	Part I, col.	11130.7	Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		2100	0.00		0.00	
50. 00 05000 OPERATING ROOM	0. 392401	3, 438, 950		0 0	1, 349, 447	50.00
51.00 05100 RECOVERY ROOM	0. 338893			0 0		
53. 00 05300 ANESTHESI OLOGY	0. 011534			0 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 117201			0 0		
60. 00 06000 LABORATORY	0. 135572			0 0		1
65. 00 06500 RESPIRATORY THERAPY	0. 237545			0 0	469, 350	
66. 00 06600 PHYSI CAL THERAPY	0. 443775			0 0	7, 128	1
67. 00 06700 OCCUPATI ONAL THERAPY	0. 361690			0 0	2,886	1
68. 00 06800 SPEECH PATHOLOGY	0. 382224		1	0 0		1
68. 01 06801 OCCUPATI ONAL HEALTH	0. 000000			0 0	0	1
69. 00 06900 ELECTROCARDI OLOGY	0. 171649			0 0		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 596094			0 0		
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 345152			0 0		1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 236308			0 13, 200		
76. 00 03020 CARDI AC	0. 000000		1	0 0		1
76. 01 03160 CARDI OPULMONARY	0. 676044			0 0		
OUTPATIENT SERVICE COST CENTERS	01070011	100,700		<u> </u>	122/21/	/ 0/ 0/
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
90. 00 09000 CLINIC	0. 000000			0 0		
90. 01 09001 WOUND CLINIC	0. 266844			0 0		
90. 02 09002 DI ABETES CLI NI C	0. 974765			0 0	0	1
90. 03 09003 ASTHMA CLINIC	0. 000000			0 0		
90. 04 09004 ANDIS CLINIC	8. 275767			0 0	155, 866	
90. 05 09005 PRIME TIME	0. 229992			0 0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0. 299931	356, 837		0 0	107, 026	
90. 07 04951 ONCOLOGY	0. 433940			0 0	847, 563	1
90.08 04950 ANDERSON WOMENS CENTER	0. 192540			0 0		
91. 00 09100 EMERGENCY	0. 121692			0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 482407			0 0		1
200.00 Subtotal (see instructions)		82, 325, 279		0 13, 200		
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		82, 325, 279		0 13, 200	17, 192, 209	202.00

	Financial Systems	HANCOCK REGION	IAL_HOSPI TAL		In Lieu	of Form CMS	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0037	Period: From 01/01/2019	Worksheet D Part V	
					To 12/31/2019	Date/Time Pr 8/28/2020 1:	epared:
			Title	XVIII	Hospi tal	PPS	27 pili
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To Ded. & Coins.	Subject To Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS	0.00	7.00				
	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60.00	06000 LABORATORY	0	0				60.00
65.00	06500 RESPI RATORY THERAPY	0	0				65.00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
	06801 OCCUPATI ONAL HEALTH	0	0				68.01
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0 3, 119				72.00
	03020 CARDI AC	0	3, 119				76.00
	03160 CARDI OPULMONARY	0	0				76.01
	OUTPATIENT SERVICE COST CENTERS		0				/0.01
	08800 RURAL HEALTH CLINIC	0	0				88. 00
90.00	09000 CLINIC	0	0				90.00
90. 01	09001 WOUND CLINIC	0	0				90.01
90.02	09002 DI ABETES CLINIC	0	0				90.02
90.03	09003 ASTHMA CLINIC	0	0				90.03
90.04	09004 ANDIS CLINIC	0	0				90.04
90.05	09005 PRIME TIME	0	0				90.05
	09006 SHELBYVILLE WOUND CLINIC	0	0				90.06
90. 07	04951 ONCOLOGY	0	0				90.07
90.08	04950 ANDERSON WOMENS CENTER	0	0				90.08
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00		0	3, 119				200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
	Net Charges (line 200 - line 201)	0	3, 119				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0037 Period: To 01/01/2019 To 12/31/2019 Period: Period: To 01/01/2019 To 12/31/2019 Period: Period: To 01/01/2019 To 12/31/2019 Period: Period: To 01/01/2019 Period: Period: Period: To 01/01/2019 Period: Period: To 01/01/2019 Period: Period: To 01/01/2019 Period: Period: Period: To 01/01/2019 Period: Period: To 01/01/2019
Component CCN: 15-S037 To 12/31/2019 Date/Time Prepared: B/28/2020 1: 27 pm VILLARY SERVICE Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Total Charges (col. 1 + col. 28) Ratio of Cost (col. 1 + col. 2) Inpatient Program Capital Costs (col um 3 x col um 4) Capital Costs (col um 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05100 (PECATI NG ROOM 945,061 25,404,561 0.037200 0 0 50.00 51.00 05100 (RECOVERY ROOM 84,758 2,376,394 0.035667 0 0 53.00 53.00 05300 ANESTHESI OLOGY 257,3,161,392 0.000081 0 0 53.00 66.00 06600 [LABORATORY 293,415 47,552,124 0.005329 293,970 1,567 60.00 66.00 06600 [LABORATORY 20,971 50,6840 0.031212 13,354 417 66.00 66.00 06600 [LABORATORY 2,049 657,120 0.003118 6,760 21 68.00 68.00 <td< td=""></td<>
ANCI LLARY SERVICE COST CENTERS Capital Related Cost (from Wkst. Col. 26) Total Charges (a. 0. 8) Ratio of Cost (col. 1 + col. 2) Inpatient Cost (column 3 x column 4) Capital Column 4) Capital Column 4) Capital Column 4) MACI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 DPERATING ROOM 945,061 25,404,561 0.037200 0 0 50.00 51.00 05000 ANESTHESI OLOGY 257 3,161,392 0.000081 0 0 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 910,409 75,633,823 0.012037 55,835 672 54.00 66.00 06500 DESPI RATORY THERAPY 99,123 10,983,795 0.00924 85,229 769 65.00 66.00 06600 PHYSI CAL THERAPY 1,358,595 0.00252 23,917 66.00 0 0 68.00 68.01 OCCUPATI IONAL THERAPY 2,4604 4,011 1,358,595 0.00252 61,303 181 67.00 66.00 06500 OCUPATI IONAL HEALTH 0 0
ANCI LLARY SERVICE COST CENTERS Cost Conter Description Capital Related Cost (from Wkst. b, Part II, col. 26) Total Charges (col. 8) Ratio of Cost (col. 1) Inpatient Program (Capital Costs (col. m3 x colum 4) Capital Costs (colum 3 x colum 4) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATINC ROOM 945,061 25,404,561 0.037200 0 0 50.00 51.00 05100 RECOVERY ROOM 84,758 2,376,394 0.035667 0 0 51.00 53.00 05300 ARESTHESI OLOGY 257 73,161,392 0.000081 0 0 53.00 60.00 66000 LABORATORY 253,415 47,552,124 0.005329 293,970 1,567 60.00 67.00 06000 PERSI RATORY THERAPY 99,123 10,983,755 0.002952 61.303 181 67.00 68.00 068000 SPEECH PATHOLOGY 2,049 657.120 0.003118 6,760 21 68.00 68.00 068001 0CUPATI ONAL THERAPY 4,011 1,358,595
Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Total Charges (col. 1 + col. 2) Ratio of Cost to Charges Inpatient Program Charges Capital Costs (col umn 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 945,061 25,404,561 0.037200 0 0 50.00 51.00 05000 OPERATING ROOM 84,758 2.376,394 0.035667 0 0 51.00 53.00 05300 ANESTHESI OLOGY 257 3,161,392 0.000081 0 53.00 54.00 06500 RESPI RATORY THERAPY 99,123 10,983,795 0.009024 85,229 769 65.00 66.00 06600 PASTIONAL HERAPY 158,770 5.086,840 0.03112 13,354 417 66.00 68.00 06800 SPECH PATHOLOGY 2,049 657,120 0.003118 6,760 21 68.00 68.00 06800 SPECH PATHOLOGY 2,049 657,120
Rel ated Cost (from Wkst. (from Wkst. c) to Charges (col. 1 + col. 26) Program (col. 1 + col. 2) Column 3 x (column 4) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (DPERATI NC ROOM 945, 061 25, 404, 561 0.037200 0 0 50.00 51.00 05000 (DPERATI NC ROOM 84, 758 2, 376, 394 0.035667 0 0 51.00 54.00 05400 (RADI OLGGY-DI AGNOSTI C 910, 409 75, 633, 823 0.012037 55, 835 672 54.00 66.00 06500 [RESPI RATORY THERAPY 253, 415 47, 552, 124 0.005329 293, 970 1, 567 60.00 66.00 06500 [RESPI RATORY THERAPY 158, 770 5, 086, 840 0.031212 13, 354 4117 66.00 67.00 0600 CUPATI ONAL THERAPY 2, 049 657, 120 0.003118 6, 760 21 68.00 68.00 06800 SPECH PATHOLOGY 2, 049 657, 120 0.003118 6, 760 21 68.01 69.00
ANCI LLARY SERVICE COST CENTERS (from Wkst. B, Part II, col. 26) C, Part I, col. 8) (col. 1 + col. 2) Charges col umn 4) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 945,061 25,404,561 0.037200 0 50.00 51.00 05100 RECOVERY ROOM 84,758 2,376,394 0.035667 0 0 51.00 54.00 05300 ANESTHESI OLOGY 257 3,161,392 0.000081 0 53.00 54.00 06500 RESPI RATORY THERAPY 253,415 47,552,124 0.005329 293,970 1,567 60.00 66.00 06600 PHYSI CAL THERAPY 99,123 10,983,795 0.009024 85,229 769 65.00 66.00 06600 SPEECH PATHORAL THERAPY 4,011 1,358,595 0.002952 61,303 181 67.00 67.00 06801 OCCUPATI ONAL THERAPY 2,049 657,120 0.003118 6,760 21 68.00 68.00
B, Part II, col. 26) col. 8) col. 2) Image: col. 8 col. 2) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATI NG ROOM 945,061 25,404,561 0.037200 0 0 50.00 51.00 05100 RECOVERY ROOM 84,758 2,376,394 0.035667 0 0 51.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 910,409 75,633,823 0.012037 55,835 672 54.00 60.00 066000 LABORATORY 1168,770 5,086,840 0.031212 13,354 411 66.00 65.00 065000 OCUPATI ONAL THERAPY 99,123 10,983,795 0.00024 85,229 769 65.00 68.00 066000 CUPATI ONAL THERAPY 158,770 5.086,840 0.031212 13,354 411 66.00 68.01 06800 SPEECH PATHONGY 2,049 657,120 0.000186 8,00 0 68.01 <td< td=""></td<>
ANCI LLARY SERVI CE COST CENTERS Image: col and
Image: 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS
ANCI LLARY SERVICE COST CENTERS 50.00 050000 OPERATI NG ROOM 945,061 25,404,561 0.037200 0 0 50.00 51.00 05100 RECOVERY ROOM 84,758 2,376,394 0.035667 0 0 51.00 53.00 05300 ANESTHESI OLOGY 257 3,161,392 0.000081 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 910,409 75,633,823 0.012037 55,835 672 54.00 60.00 06000 LABORATORY 253,415 47,552,124 0.005329 293,970 1,567 60.00 65.00 06500 RESPI RATORY THERAPY 99,123 10,983,795 0.009024 85,229 769 65.00 66.00 06600 PHYSI CAL THERAPY 4,011 1,358,595 0.002952 61,303 181 67.00 67.00 06700 OCCUPATI ONAL THERAPY 2,049 657,120 0.003118 6,760 21 68.00 68.01 06801 OCCUPATI ONAL HEALTH 0 0 0.000000 0 68
50.00 05000 0PERATI NG ROOM 945, 061 25, 404, 561 0.037200 0 0 50.00 51.00 05100 RECOVERY ROOM 84, 758 2, 376, 394 0.035667 0 0 51.00 53.00 05300 ANESTHESI OLOGY 257 3, 161, 392 0.000081 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 910, 409 75, 633, 823 0.012037 55, 835 672 54.00 60.00 06000 LABORATORY 253, 415 47, 552, 124 0.005329 293, 970 1, 567 60.00 65.00 06500 RESPI RATORY THERAPY 99, 123 10, 983, 795 0.009024 85, 229 769 65.00 66.00 06600 PHYSI CAL THERAPY 4,011 1, 358, 595 0.002952 61, 303 181 67.00 67.00 06200 CCUPATI ONAL THERAPY 2,049 657, 120 0.003118 6,760 21 68.00 68.01 06801 0CCUPATI ONAL HEALTH 0 0 0.000000 0 68.01 69.0
51.00 05100 RECOVERY ROOM 84,758 2,376,394 0.035667 0 0 51.00 53.00 05300 ANESTHESI OLOGY 257 3,161,392 0.000081 0 0 53.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 910,409 75,633,823 0.012037 55,835 672 54.00 60.00 06000 LABORATORY 253,415 47,552,124 0.005329 293,970 1,567 60.00 65.00 06500 RESPI RATORY THERAPY 99,123 10,983,795 0.009024 85,229 769 65.00 66.00 06600 PHYSI CAL THERAPY 158,770 5,086,840 0.031212 13,354 417 66.00 67.00 06700 0CCUPATI ONAL THERAPY 4,011 1,358,595 0.002952 61,303 181 67.00 68.01 06801 0CCUPATI ONAL HEALTH 0 0 0.000000 0 68.01 69.00 ELECTROCARDI OLOGY 294,004 17,434,011 0.016864 8,556 144 69.00 71.00 OT100
53.00 05300 ANESTHESI OLOGY 257 3, 161, 392 0.000081 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 910, 409 75, 633, 823 0.012037 55, 835 672 54.00 60.00 06000 LABORATORY 253, 415 47, 552, 124 0.005329 293, 970 1, 567 60.00 65.00 06500 RESPI RATORY THERAPY 99, 123 10, 983, 795 0.009024 85, 229 76 65.00 66.00 06600 PHYSI CAL THERAPY 158, 770 5.086, 840 0.031212 13, 354 417 66.00 67.00 06700 OCUPATI ONAL THERAPY 4, 011 1, 358, 595 0.002952 61, 303 181 67.00 68.00 06800 SPEECH PATHOLOGY 2, 049 657, 120 0.003118 6, 760 21 68.01 69.00 06900 ELCTROCARDI OLOGY 294, 004 17, 434, 011 0.016864 8, 556 144 69.00 71.00 07100 MEL SUPLI ES CHARGED TO PATI ENT 23, 662 9, 713, 778 0.002436 <t< td=""></t<>
54.00 05400 RADI OLOGY-DI AGNOSTI C 910, 409 75, 633, 823 0.012037 55, 835 672 54.00 60.00 06000 LABORATORY 253, 415 47, 552, 124 0.005329 293, 970 1, 567 60.00 65.00 06500 RESPI RATORY THERAPY 99, 123 10, 983, 795 0.009024 85, 229 769 65.00 66.00 06600 PHYSI CAL THERAPY 158, 770 5, 086, 840 0.031212 13, 354 417 66.00 67.00 06700 0CCUPATI ONAL THERAPY 4, 011 1, 358, 595 0.002952 61, 303 181 67.00 68.00 06801 DCEUPATI ONAL HEALTH 0 0.000000 0 0 68.01 69.00 CLECTROCARDI OLOGY 294, 004 17, 434, 011 0.016864 8, 556 144 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 176, 638 827, 170 0.213545 15, 234 3, 253 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 23, 662 9, 713, 778 0.002436 0
60.00 06000 LABORATORY 253, 415 47, 552, 124 0.005329 293, 970 1, 567 60.00 65.00 06500 RESPI RATORY THERAPY 99, 123 10, 983, 795 0.009024 85, 229 769 65.00 66.00 06600 PHYSI CAL THERAPY 158, 770 5, 086, 840 0.031212 13, 354 417 66.00 67.00 0C000 CCUPATI ONAL THERAPY 4, 011 1, 358, 595 0.002952 61, 303 181 67.00 68.00 06800 SPEECH PATHOLOGY 2, 049 657, 120 0.003118 6, 760 21 68.01 69.00 06900 ELECTROCARDI OLOGY 294, 004 17, 434, 011 0.016864 8, 556 144 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 176, 638 827, 170 0.213545 15, 234 3, 253 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 23, 662 9, 713, 778 0.002436 0 0 72.00 <t< td=""></t<>
65.00 06500 RESPI RATORY THERAPY 99, 123 10, 983, 795 0.009024 85, 229 769 65.00 66.00 06600 PHYSI CAL THERAPY 158, 770 5, 086, 840 0.031212 13, 354 417 66.00 67.00 0CCUPATI ONAL THERAPY 4, 011 1, 358, 595 0.002952 61, 303 181 67.00 68.00 06800 SPEECH PATHOLOGY 2, 049 657, 120 0.03118 6, 760 21 68.00 68.01 06000 CUPATI ONAL HEALTH 0 0 0.000000 0 68.01 69.00 06900 ELCTROCARDI OLOGY 294, 004 17, 434, 011 0.016864 8, 556 144 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 176, 638 827, 170 0.213545 15, 234 3, 253 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 380, 649 97, 400, 026 0.003908 235, 681 921 73.00 73.00 03020 CARDI AC 0 0 0 0 0 76.00 76.
66.00 06600 PHYSI CAL THERAPY 158, 770 5, 086, 840 0.031212 13, 354 417 66.00 67.00 06700 OCCUPATI ONAL THERAPY 4, 011 1, 358, 595 0.002952 61, 303 181 67.00 68.00 06800 SPECH PATHOLOGY 2, 049 657, 120 0.003118 6, 760 21 68.00 68.01 06801 OCUPATI ONAL HEALTH 0 0 0.000000 0 68.01 69.00 OPO00 ELECTROCARDI OLOGY 294, 004 17, 434, 011 0.016864 8, 556 144 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 176, 638 827, 170 0.213545 15, 234 3, 253 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 23, 662 9, 713, 778 0.02436 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 380, 649 97, 400, 026 0.0030908 235, 681 921 73.00 76.01
67.00 06700 OCCUPATI ONAL THERAPY 4,011 1,358,595 0.002952 61,303 181 67.00 68.00 06800 SPEECH PATHOLOGY 2,049 657,120 0.003118 6,760 21 68.00 68.01 06801 OCUPATI ONAL HEALTH 0 0 0.000000 0 68.01 69.00 06900 ELECTROCARDI OLOGY 294,004 17,434,011 0.016864 8,556 144 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 176,638 827,170 0.213545 15,234 3,253 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 23,662 9,713,778 0.002436 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 380,649 97,400,026 0.003908 235,681 921 73.00 76.00 03020 CARDI AC 0 0 0.000000 0 0 76.00 0 03160 CARDI AC 0 0 0.000000 0 0 76.00 0 0
68.00 06800 SPECH PATHOLOGY 2,049 657,120 0.003118 6,760 21 68.00 68.01 06801 0CUPATI ONAL HEALTH 0 0 0.000000 0 0 68.01 69.00 06900 ELECTROCARDI OLOGY 294,004 17,434,011 0.016864 8,556 144 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 176,638 827,170 0.213545 15,234 3,253 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 23,662 9,713,778 0.002436 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 380,649 97,400,026 0.003908 235,681 921 73.00 76.00 03020 CARDI AC 0 0 0.000000 0 0 76.00 0.110 03160 CARDI AC 0 0 0 0 0 0 0 76.00 0 08800
68. 01 06801 0CCUPATI ONAL HEALTH 0 0 0.000000 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 294, 004 17, 434, 011 0.016864 8, 556 144 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 176, 638 827, 170 0.213545 15, 234 3, 253 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 23, 662 9, 713, 778 0.002436 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 380, 649 97, 400, 026 0.003908 235, 681 921 73. 00 76. 00 03020 CARDI AC 0 0 0.000000 0 0 76. 00 0.3160 CARDI OPULMONARY 83, 157 457, 488 0.181769 0 0 76. 01 0UTPATI ENT SERVICE COST CENTERS 4, 404 0 0.000000 0 0 88. 00
69.00 06900 ELECTROCARDI OLOGY 294,004 17,434,011 0.016864 8,556 144 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 176,638 827,170 0.213545 15,234 3,253 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 23,662 9,713,778 0.002436 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 380,649 97,400,026 0.003908 235,681 921 73.00 76.00 03020 CARDI AC 0 0 0.000000 0 0 76.00 03160 CARDI OPULMONARY 83,157 457,488 0.181769 0 0 0 76.01 0 0 0.8800 RURAL HEALTH CLINIC 4,404 0 0.000000 0 0 88.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 176, 638 827, 170 0.213545 15, 234 3, 253 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 23, 662 9, 713, 778 0.002436 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 380, 649 97, 400, 026 0.003908 235, 681 921 73.00 76.00 03020 CARDI AC 0 0 0 0 76.00 76.01 03160 CARDI OPULMONARY 83, 157 457, 488 0.181769 0 0 76.01 0 08800 RURAL HEALTH CLINIC 4, 404 0 0.000000 0 0 88.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 23, 662 9, 713, 778 0.002436 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 380, 649 97, 400, 026 0.003908 235, 681 921 73.00 76.00 03020 CARDI AC 0 0 0.000000 0 0 76.00 03160 CARDI OPULMONARY 83, 157 457, 488 0.181769 0 0 76.01 0UTPATI ENT SERVI CE COST CENTERS 4, 404 0 0.000000 0 0 88.00
73.00 07300 DRUGS CHARGED TO PATI ENTS 380, 649 97, 400, 026 0.003908 235, 681 921 73.00 76.00 03020 CARDI AC 0 0 0 0 76.00 76.00 76.01 03160 CARDI OPULMONARY 83, 157 457, 488 0.181769 0 76.00 0UTPATI ENT SERVICE COST CENTERS 4, 404 0 0.000000 0 0 88.00
76. 00 03020 CARDI AC 0 0 0.000000 0 76. 00 76. 01 03160 CARDI OPULMONARY 83, 157 457, 488 0. 181769 0 76. 00 0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 4, 404 0 0. 000000 0 0 88. 00
76. 01 03160 CARDI OPULMONARY 83, 157 457, 488 0. 181769 0 0 76. 01 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 4, 404 0 0. 000000 0 0 88. 00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 4,404 0 0.000000 0 0 88.00
88.00 08800 RURAL HEALTH CLINIC 4,404 0 0.00000 0 0 88.00
90. 00 09000 CLINIC 0 0 0 0.000000 0 0 90. 00
90. 01 09001 WOUND CLINIC 101, 891 4, 185, 174 0. 024346 277 7 90. 01
90. 02 09002 DI ABETES CLINIC 506 63, 998 0. 007906 0 0 90. 02
90. 03 09003 ASTHMA CLINIC 0 0 0 0 0 0 0 90. 03
90. 04 09004 ANDIS CLINIC 95, 873 56, 729 1. 690017 0 0 90. 04
90. 05 09005 PRIME TIME 768 472, 877 0. 001624 0 0 90. 05
90. 06 09006 SHELBYVILLE WOUND CLINIC 2, 829 1, 196, 910 0. 002364 0 0 90. 06
90. 07 04951 ONCOLOGY 515, 832 6, 883, 588 0. 074937 47 4 90. 07
90. 08 04950 ANDERSON WOMENS CENTER 10, 856 3, 992, 865 0. 002719 0 0 90. 08
91. 00 09100 EMERGENCY 857, 357 55, 971, 032 0. 015318 68, 814 1, 054 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 8, 692, 133 0. 000000 0 92. 00
200. 00 Total (lines 50 through 199) 5, 006, 279 379, 562, 423 845, 060 9, 010 200. 00

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0037	Period		Worksheet D	
THROUGH COSTS			001 45 0007		01/01/2019		
		Component	CCN: 15-S037	To 1	2/31/2019	Date/Time Pre 8/28/2020 1:2	
		Title	e XVIII	Subpr	ovider -	PPS	7 piii
					I PF	110	
Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
	Anesthetist	School	School	Post	-Stepdown		
	Cost	Post-Stepdown		Adj	ustments		
		Adjustments		-			
	1.00	2A	2.00		ЗA	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00 O5000 OPERATING ROOM	0	0		0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	298, 170	54.00
60. 00 06000 LABORATORY	0	0		0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
68.01 06801 OCCUPATI ONAL HEALTH	0	0		0	0	0	68.01
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	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	0	0	76.00
76. 01 03160 CARDI OPULMONARY	0	0		0	0	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	0	0		0	0	0	90.01
90. 02 09002 DI ABETES CLI NI C	0	0		0	0	0	90.02
90. 03 09003 ASTHMA CLINIC	0	0		0	0	0	90.03
90. 04 09004 ANDIS CLINIC	0	0		0	0	0	90.04
90. 05 09005 PRIME TIME	0	0		0	0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	0		0	0	0	90.06
90. 07 04951 ONCOLOGY	0	0		0	0	0	90.07
90.08 04950 ANDERSON WOMENS CENTER	0	0		0	0	0	90.08
91.00 09100 EMERGENCY	0	0		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
200.00 Total (lines 50 through 199)	0	0	1	0	0	298, 170	200.00

Health Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2019	Part IV	
		Component	CCN: 15-S037	To 12/31/2019	Date/Time Pre 8/28/2020 1:2	epared:
		Title	XVIII	Subprovider -	PPS	
		in the	XVIII	IPF	115	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
		.,	and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				1		
50. 00 05000 OPERATI NG ROOM	0	0		0 25, 404, 561	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 2, 376, 394	0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 3, 161, 392	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	298, 170	298, 17		0.003942	
60. 00 06000 LABORATORY	0	0		0 47, 552, 124		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 10, 983, 795	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 086, 840	0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 358, 595	0.000000	
68. 00 06800 SPEECH PATHOLOGY	0	0		0 657, 120	0.000000	
68. 01 06800 SFEECH FAMILEOUT	0	0		0 0 0	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 17, 434, 011	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0.000000	
	0	0		0211110		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 9, 713, 778	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 97, 400, 026	0.000000	
76.00 03020 CARDI AC	0	0		0 0	0.000000	
76. 01 03160 CARDI OPULMONARY	0	0		0 457, 488	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS		0			0.00000	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	•
90.00 09000 CLINIC	0	0		0 0	0.000000	
90.01 09001 WOUND CLINIC	0	0		0 4, 185, 174	0.000000	
90. 02 09002 DI ABETES CLINIC	0	0		0 63, 998	0.000000	
90. 03 09003 ASTHMA CLINIC	0	0		0 0	0.000000	•
90. 04 09004 ANDIS CLINIC	0	0		0 56, 729	0.00000	
90. 05 09005 PRIME TIME	0	0		0 472, 877	0. 000000	
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	0		0 1, 196, 910	0. 000000	
90. 07 04951 ONCOLOGY	0	0		0 6, 883, 588	0. 000000	
90.08 04950 ANDERSON WOMENS CENTER	0	0		0 3, 992, 865		
91. 00 09100 EMERGENCY	0	0		0 55, 971, 032		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 8, 692, 133		
200.00 Total (lines 50 through 199)	0	298, 170	298, 17	379, 562, 423		200.00

Health Financial Systems	HANCOCK REGIONA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0037	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S037	From 01/01/2019 To 12/31/2019	Part IV Date/Time Pre	norod.
		component	CCN. 15-3037	10 12/31/2019	8/28/2020 1:2	pareu. 7 pm
		Title	× XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)	10.00	x col. 10)	10.00	x col. 12)	
ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0.000000	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0.000000	0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0.000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.003942	55, 835		20 0	0	54.00
60. 00 06000 LABORATORY	0.000000	293, 970		0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0.000000	85, 229		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	13, 354		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	61, 303		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000	6, 760		0 0	0	68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0. 000000	0		0 0	0	68.01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	8, 556		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	15, 234		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	235, 681		0 0	0	73.00
76. 00 03020 CARDI AC	0. 000000	0		0 0	0	76.00
76. 01 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 WOUND CLINIC	0. 000000	277		0 0	0	90.01
90. 02 09002 DI ABETES CLI NI C	0. 000000	0		0 0	0	90.02
90. 03 09003 ASTHMA CLINIC	0. 000000	0		0 0	0	90.03
90. 04 09004 ANDIS CLINIC	0. 000000	0		0 0	0	90.04
90. 05 09005 PRIME TIME	0. 000000	0		0 0	0	90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	0. 000000	0		0 0	0	90.06
90. 07 04951 ONCOLOGY	0.000000	47		0 0	0	90.07
90. 08 04950 ANDERSON WOMENS CENTER	0.000000	0		0 0	0	90.08
91.00 09100 EMERGENCY	0.000000	68, 814		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (lines 50 through 199)	0. 000000	0 845, 060		0 0 20 0	0	92.00 200.00
200.00 TOTAL (THES SO THEOUGH 199)	1	640,000	1 2.		0	∠UU. UU

)MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 8/28/2020 1:2	parec
	Cost Center Description	Title XVIII	Hospi tal	PPS	
			-	1.00	
	PART I - ALL PROVIDER COMPONENTS				1
00	Inpatient days (including private room days and swing-bed day			6, 669	1.0
00	Inpatient days (including private room days, excluding swing-			6, 669	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	lys). If you have only p	rivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation b			3, 683	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through Decemb	er 31 of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				_
00	Total swing-bed NF type inpatient days (including private roc reporting period	m days) through Decembe	r 31 of the cost	0	7.
00	Total swing-bed NF type inpatient days (including private roc	m days) after December	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)			1 404	
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excludin	y swing-bed and	1, 404	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII c		room days)	0	10.
I. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room dave) after	0	11.
1.00	December 31 of the cost reporting period (if calendar year, e		room days) arter	0	' ' '
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.
3.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13.
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this li	ne)	0	13.
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				1 10.
7.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17.
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 o	f the cost	0.00	19.
0. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20.
	reporting period	``		0.0/5.077	
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	9, 365, 077 0	
. 00	5 x line 17)		ting period (init	0	22.
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23.
1.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24.
	7 x line 19)		0.1		
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25.
5.00	x line 20) Total swing-bed cost (see instructions)			0	26.
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		9, 365, 077	27.
3. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and obsorvation had a	bargos)	0	28.
	Private room charges (excluding swing-bed charges)		lai yes)	0	
0. 00	Semi-private room charges (excluding swing-bed charges)			0	30.
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus lino 22) (soo instru	ctions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x li	, ,		0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			-
3. 00	Adjusted general inpatient routine service cost per diem (see			1, 404. 27	38.
9.00	Program general inpatient routine service cost (line 9 x line	: 38)		1, 971, 595	39.
	Medically necessary private room cost applicable to the Progr	, , ,		0	
. 00	Total Program general inpatient routine service cost (line 39	+ IINE 40)		1, 971, 595	41.

	Financial Systems	HANCOCK REGIO				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	F	veriod: rom 01/01/2019 o 12/31/2019		epared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
10.00		1.00	2.00	3.00	4.00	5.00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00 44.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	8, 217, 966	4, 992	1, 646. 23	1, 973	3, 248, 012	44.00
45.00 46.00 47.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						45.00 46.00 47.00
	Cost Center Description						
48.00	Program inpatient ancillary service cost (Wk	st D_3 col	3 line 200)			1.00 5,625,524	48.00
49.00	PASS THROUGH COST ADJUSTMENTS			ons)		10, 845, 131	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	n Wkst. D, sum	of Parts I and	606, 185	50.00
51.00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	atient ancilla	ry services (f	rom Wkst. D, s	um of Parts II	403, 103	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	1, 009, 288 9, 835, 843	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)	ing agat and t	anget employet (line E(minue	line E2)	0	
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and t	arget amount (TTTE 50 millius	The 55)	0	
59.00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and co	mpounded by the	-	
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see	s 55, 59 or 60 n expected cos	enter the les	ser of 50% of		0. 00 0	
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym		uctions)			0	
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	a cost reporti	na period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	-				0	
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs throug	h December 31	of the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after	December 31 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil	2		• •			70.00
71.00 72.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /u ÷ line	∠)			71.00
73.00	Medically necessary private room cost applic		m (line 14 x l	ine 35)			73.00
74.00 75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•			art II, column		74.00 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	,					78.00
79.00	Aggregate charges to beneficiaries for exces	•		· ·			79.00
80.00	Total Program routine service costs for comp		cost limitatio	n (line 78 min	us 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 cost (83.00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85.00	Utilization review - physician compensation	•					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:						86.00
87.00	Total observation bed days (see instructions)				2, 986	
88.00	Adjusted general inpatient routine cost per	•				1, 404. 27	
07.UU	Observation bed cost (line 87 x line 88) (se	e matructions	7			4, 193, 150	1 07.00

Health Financial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 8/28/2020 1:2	pared: 7 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 152, 089	9, 365, 077	0. 12302	0 4, 193, 150	515, 841	90.00
91.00 Nursing School cost	0	9, 365, 077	0.00000	0 4, 193, 150	0	91.00
92.00 Allied health cost	0	9, 365, 077	0. 00000	0 4, 193, 150	0	92.00
93.00 All other Medical Education	0	9, 365, 077	0. 00000	0 4, 193, 150	0	93.00

	Financial Systems HANCOCK REGIONAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037 Component CCN: 15-S037	Period: From 01/01/2019 To 12/31/2019	u of Form CMS-2 Worksheet D-1 Date/Time Pre 8/28/2020 1:2	pare
		Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	excluding newborn)		2, 458	1 1.
00	Inpatient days (including private room days, excluding swing-			2, 458	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	nys). If you have only p	rivate room days,	0	3.
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		ar 31 of the cost	2, 458 0	
	reporting period			-	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December :	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	1, 683	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this li	ne)	0	
	Total nursery days (title V or XIX only)	an (exer during swring-bed	uays)	0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction)		3, 144, 281	21
00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-10} cm 17		ting period (line		
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 144, 281	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed o	narges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)	~		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li		/	0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0.00	
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	fferential (line	-	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see		1	1, 279. 20	38
$\cap \cap$	Inglasted general inpatrent routine service cost per diell (See				
	Program general innatient routine service cost (line 9 x line	281	1	2 152 QOA	1.50
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			2, 152, 894 0	

						Worksheet D-1	1
			Component	CCN: 15-S037	From 01/01/2019 To 12/31/2019	Date/Time Pre	
			Title	e XVIII	Subprovider -	8/28/2020 1:2 PPS	27 pm
	Cost Center Description	Total Inpatient	Total I npati ent	Average Per Diem (col.	5 5	Program Cost (col. 3 x	
		Cost 1.00	Days 2.00	÷ col . 2) 3.00	4.00	col. 4) 5.00	-
. 00 NI	URSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
	ntensive Care Type Inpatient Hospital Units						
	NTENSI VE CARE UNI T ORONARY CARE UNI T	0		0.	00 0	0	43
	URN INTENSIVE CARE UNIT						45
	URGI CAL I NTENSI VE CARE UNI T						46
. 00 01	THER SPECIAL CARE (SPECIFY) Cost Center Description						47
00 0	· · · · · · · · · · · · · · · · · · ·		0.000			1.00	
	rogram inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines /			ons)		172, 038	
PA	ASS THROUGH COST ADJUSTMENTS						
	ass through costs applicable to Program inpa II)	atient routine	services (Tro	OM WKST. D, SI	um of Parts I and	d 270, 711	1 50
. 00 Pa	ass through costs applicable to Program inpa	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	9, 230	51
	nd IV) otal Program excludable cost (sum of lines !	50 and 51)				279, 941	1 52
	otal Program inpatient operating cost exclu		elated, non-ph	iysi ci an anes [.]	thetist, and	2, 044, 991	1 53
	edical education costs (line 49 minus line ! ARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00 Pr	rogram di scharges					0	
	arget amount per discharge					0.00	
	arget amount (line 54 x line 55) ifference between adjusted inpatient operati	ing cost and t	arget amount (line 56 minus	s line 53)		
	onus payment (see instructions)					0	
	esser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and o	compounded by the	e 0.00	59
	arket basket esser of lines 53/54 or 55 from prior year (cost report u	ndated by the	market baske	ŀ	0.00	0 60
	f line 53/54 is less than the lower of line					0.00	
	hich operating costs (line 53) are less than		ts (lines 54 >	: 60), or 1% (of the target		
	mount (line 56), otherwise enter zero (see i elief payment (see instructions)	instructions)				0) 62
	llowable Inpatient cost plus incentive payme	ent (see instr	uctions)				
	ROGRAM INPATIENT ROUTINE SWING BED COST edicare swing-bed SNF inpatient routine cos	ts through Doc	ombor 21 of th	o cost ropor	ting pariod (Saa	0	0 64
	nstructions) (title XVIII only)	ts through bec		le cost repor	ting period (see		04
	edicare swing-bed SNF inpatient routine cos nstructions)(title XVIII only)	ts after Decem	ber 31 of the	cost reporti	ng period (See	0) 65
	otal Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XV	II only). For	0	66
	AH (see instructions) itle V or XIX swing-bed NF inpatient routing	o costs throug	h Docombor 21	of the cost	conarting pariod	0) 67
	line 12 x line 19)	e costs throug	TI December 31	of the cost i	eportring perrou		
	itle V or XIX swing-bed NF inpatient routing line 13 x line 20)	e costs after	December 31 of	the cost re	porting period	0	68 (
	otal title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lir	ie 68)		0) 69
	ART III - SKILLED NURSING FACILITY, OTHER NU killed nursing facility/other nursing facili				7\	1	70
	djusted general inpatient routine service of	5		•	()		71
. 00 Pr	rogram routine service cost (line 9 x line	71)		ŗ			72
	edically necessary private room cost applica	0	•				73
	otal Program general inpatient routine servi apital-related cost allocated to inpatient i				Part II column		74
26	6, line 45)						
	er diem capital-related costs (line 75 ÷ lin rogram capital-related costs (line 9 x line						76
1	npatient routine service cost (line 74 minu:						78
. 00 Ag	ggregate charges to beneficiaries for exces	s costs (from	•				79
	otal Program routine service costs for compariant routine service cost per diam limit		cost limitatio	on (line 78 mi	nus line 79)		80
	npatient routine service cost per diem limi npatient routine service cost limitation (li		1)				81
	easonable inpatient routine service costs (83
1	rogram inpatient ancillary services (see ins		>				84
	tilization review – physician compensation otal Program inpatient operating costs (sum	•	· · · ·				85
	ART IV - COMPUTATION OF OBSERVATION BED PASS					I	
	otal observation bed days (see instructions)					0	
	djusted general inpatient routine cost per o	11	1 1			0.00	

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2019	Worksheet D-1	
		Component (CCN: 15-S037	To 12/31/2019		pared: 7 pm
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				. 89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	395, 372	3, 144, 281	0. 12574	13 0	0	90.00
91.00 Nursing School cost	0	3, 144, 281	0.0000	0 00	0	91.00
92.00 Allied health cost	0	3, 144, 281	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	3, 144, 281	0.0000	0 00	J 0	93.00

	Financial Systems HANCOCK REGIONA ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
		Title XIX	Hospi tal	Cost	. / piii
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days			6, 669	
00	Inpatient days (including private room days, excluding swing		volucita noom davia	6, 669 0	
00	Private room days (excluding swing-bed and observation bed c do not complete this line.	ays). Ti you nave only p	nivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation	bed days)		3, 683	4
00	Total swing-bed SNF type inpatient days (including private r	room days) through Decemb	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private r	coom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	ter becenber	ST OF THE COST	0	0
00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	7
~~	reporting period		01 - C + b +	0	
00	Total swing-bed NF type inpatient days (including private ror reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable	to the Program (excludin	ng swing-bed and	107	9
	newborn days) (see instructions)	0	0 0		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10
. 00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
	December 31 of the cost reporting period (if calendar year,		room aajo) artor	Ū	· ·
. 00	Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including prival)	ite room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including priva	to room dave)	0	13
. 00	after December 31 of the cost reporting period (if calendar			0	13
. 00	Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	1 17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	ces through December 31 c	of the cost	0.00	19
. 00	reporting period	as after December 21 of	the cost	0.00	20
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	Les alter December 31 01	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ons)		9, 365, 077	21
. 00	Swing-bed cost applicable to SNF type services through Decem	nber 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	or 21 of the cost reporti	ng ported (line 4	0	23
. 00	x line 18)	a si di the cost reporti	ng period (inne o	0	23
. 00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	- 31 of the cost reportin	na period (line 8	0	25
. 50	x line 20)	at an the cost reporting	a bounda (inte o	0	20
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		9, 365, 077	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation bed o	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room per diem charge (ifferential (line 32 m		uctions)	0.00	
	Average per diem private room cost differential (line 34 x l		,	0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	lifferential (line	9, 365, 077	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			1
				1 404 27	38
. 00	Adjusted general inpatient routine service cost per diem (se			1, 404. 27	
. 00 . 00	Program general inpatient routine service cost per diem (se Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Proc	ne 38)		1, 404. 27 150, 257 0	39

	Financial Systems	HANCOCK REGIO		01 45 0007		u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	F	Period: From 01/01/2019 To 12/31/2019		epared:
		-		e XIX	Hospi tal	Cost	., p
	Cost Center Description	Total Inpatient Cost	Total I npati ent Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00		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	I NTENSI VE CARE UNI T	8, 217, 966	4, 992	1, 646. 23	3 19	31, 278	
44.00 45.00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T						44.00 45.00
45.00	SURGICAL INTENSIVE CARE UNIT						45.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)			168, 902	48.00
49.00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		350, 437	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D sum	of Parts L and	0	50.00
00100	111)						
51.00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, s	um of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu	ding capital r	elated, non-ph	ysician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
	Program di scharges					0	54.00
	Target amount per discharge					0.00	1
56.00 57.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and t	arget amount (line 56 minus	line 53)	0	1
58.00	Bonus payment (see instructions)	ing cost and th			Trific 33)	0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report u	pdated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line				the amount by	0.00	1
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	ombor 31 of th	e cost reporti	ng period (See	0	64.00
04.00	instructions)(title XVIII only)	ts through bee		e cost reporti	ng period (see	0	04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I onlv). For	0	66.00
	CAH (see instructions)			, ,	5.		
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs throug	h December 31	of the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 of	the cost repo	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino coste	(ling 67 , lin	o 49)		o	69.00
09.00	PART III - SKILLED NURSING FACILITY, OTHER N					0	09.00
70.00	Skilled nursing facility/other nursing facil	2		• • •			70.00
71.00 72.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		line /0 ÷ line	2)			71.00 72.00
73.00	Medically necessary private room cost applic		m (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv				art II adumn		74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine servic	e costs (from	WORKSneet B, P	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	,					77.00 78.00
79.00	Aggregate charges to beneficiaries for exces		provi der recor	ds)			79.00
80.00	Total Program routine service costs for comp		cost limitatio	n (line 78 min	us 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 cost (83.00
84.00	Program inpatient ancillary services (see in						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					
87.00 88.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		÷ line 2)			2, 986 1, 404. 27	1
	Observation bed cost (line 87 x line 88) (se		,			4, 193, 150	
						-	

Health Financial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		pared: 7 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 152, 089	9, 365, 077	0. 12302	0 4, 193, 150	515, 841	90.00
91.00 Nursing School cost	0	9, 365, 077	0.00000	0 4, 193, 150	0	91.00
92.00 Allied health cost	0	9, 365, 077	0. 00000	0 4, 193, 150	0	92.00
93.00 All other Medical Education	0	9, 365, 077	0. 00000	0 4, 193, 150	0	93.00

Health Financial Systems HANCOCK REGIC	NAL_HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0037	Peri od:	Worksheet D-3	3
			From 01/01/2019		
			To 12/31/2019		
				8/28/2020 1:2	27 pm
	Title	XVIII	Hospi tal	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		•			
30. 00 03000 ADULTS & PEDIATRICS			1, 293, 161		30.00
31. 00 03100 INTENSIVE CARE UNIT			5, 099, 779		31.00
40. 00 04000 SUBPROVI DER – I PF			20, 856		40.00
41. 00 04100 SUBPROVI DER – I RF			20,030		41.00
ANCI LLARY SERVICE COST CENTERS			0	<u> </u>	41.00
		0.2024		1 474 026	
		0. 39240		1, 474, 936	1
51.00 05100 RECOVERY ROOM		0. 33889		114, 741	
53.00 05300 ANESTHESI OLOGY		0. 01153			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11720			
60. 00 06000 LABORATORY		0. 1355	72 3, 493, 325	473, 597	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 23754	1, 459, 468	346, 689	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4437	75 324, 565	144, 034	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 36169	211, 719	76, 577	67.00
68.00 06800 SPEECH PATHOLOGY		0. 38222	56, 879	21, 741	68.00
68. 01 06801 OCCUPATI ONAL HEALTH		0.0000			1
69. 00 06900 ELECTROCARDI OLOGY		0. 17164		304, 718	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5960			1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 3451		858,009	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 23630		859,931	1
		0. 23030			1
76. 01 03160 CARDI OPULMONARY		0.67604	14 0	0	76.01
OUTPATIENT SERVICE COST CENTERS		0.0000			
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
90. 00 09000 CLINIC		0.0000		-	
90. 01 09001 WOUND CLINIC		0. 26684		958	90.01
90. 02 09002 DI ABETES CLI NI C		0. 97476	55 0	0	90.02
90. 03 09003 ASTHMA CLINIC		0.0000	0 0	0	90.03
90. 04 09004 ANDES CLENEC		8. 27576	57 0	0	90.04
90. 05 09005 PRI ME TI ME		0. 22999	92 0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC		0. 29993	31 0	0	90.06
90. 07 04951 ONCOLOGY		0. 43394		8,809	
90. 08 04950 ANDERSON WOMENS CENTER		0. 19254			1
91. 00 09100 EMERGENCY		0. 1216			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 48240			
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.40240	24, 757, 734		
201.00 Less PBP Clinic Laboratory Services-Program only cha	race (line (1)		24, 757, 734		200.00
202.00 Net charges (line 200 minus line 201)	iyes (iine ol)		-		201.00
202.00 met charges (The 200 minus the 201)		I	24, 757, 734	l	202.00

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0037	Period:	Worksheet D-3	3
	Component	CCN: 15-S037	From 01/01/2019 To 12/31/2019		epare
				8/28/2020 1:2	
	Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			1
0. 00 03000 ADULTS & PEDIATRICS			0		30.
			0		31.
0. 00 04000 SUBPROVI DER - I PF			2, 235, 191		40.
. 00 04100 SUBPROVIDER - IRF			0		41.
ANCI LLARY SERVI CE COST CENTERS		0. 39240	01 0	0	50.
. 00 05100 RECOVERY ROOM		0. 33889		0	
B. 00 05300 ANESTHESI OLOGY		0. 01153		0	
1. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11720		6, 544	
0. 00 06000 LABORATORY		0. 13557		39, 854	
5. 00 06500 RESPIRATORY THERAPY		0. 23754		20, 246	
0. 00 06600 PHYSI CAL THERAPY		0. 44377		5, 926	
2. 00 06700 OCCUPATI ONAL THERAPY		0. 36169		22, 173	
B. 00 06800 SPEECH PATHOLOGY		0. 38222		2, 584	
B. 01 06801 OCCUPATI ONAL HEALTH		0.00000		0	
0. 00 06900 ELECTROCARDI OLOGY		0. 17164			
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 59609		9, 081	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 34515		0	
8. 00 07300 DRUGS CHARGED TO PATIENTS		0. 23630		55, 693	
0. 00 03020 CARDI AC		0.00000		0	
0. 01 03160 CARDI OPULMONARY		0.67604	14 0	0	76.
OUTPATIENT SERVICE COST CENTERS					
B. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.
0. 00 09000 CLINIC		0.00000	0 0	0	
0. 01 09001 WOUND CLINIC		0. 26684		74	
0. 02 09002 DIABETES CLINIC		0. 97476		0	
0. 03 09003 ASTHMA CLINIC		0.0000		0	
0. 04 09004 ANDIS CLINIC		8. 27576		0	
0. 05 09005 PRIME TIME		0. 22999		0	
0. 06 09006 SHELBYVILLE WOUND CLINIC		0. 29993		0	
		0. 43394		20	
0. 08 04950 ANDERSON WOMENS CENTER		0. 19254		0	
. 00 09100 EMERGENCY		0. 12169		8, 374	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	through (Q)	0. 48240		172 020	
00.00 Total (sum of lines 50 through 94 and 96 01.00 Less PBP Clinic Laboratory Services-Progr			845, 060	172, 038	
1.00 Less PBP Clinic Laboratory Services-Progr	am oniv charges (TTNe 61)	1	0		201.

Heal th Finar	ncial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0037	Peri od:	Worksheet D-3	
					From 01/01/2019 To 12/31/2019		nored.
					To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
			Ti †I	e XIX	Hospi tal	Cost	
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges	Program	Program Costs	
				J	Charges	(col. 1 x	
					J	col. 2)	
				1.00	2.00	3.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS					•	
30.00 03000	ADULTS & PEDIATRICS				276, 204		30.00
31.00 03100	INTENSIVE CARE UNIT				132, 637		31.00
40.00 04000	SUBPROVIDER - IPF				0		40.00
41.00 04100	SUBPROVI DER – I RF				0		41.00
ANCI L	LARY SERVICE COST CENTERS					•	1
50.00 05000	OPERATING ROOM			0. 3924	01 199, 960	78, 465	50.00
51.00 05100	RECOVERY ROOM			0. 3388	93 17, 924	6,074	51.00
53.00 05300	ANESTHESI OLOGY			0.0115	34 17,666	204	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C			0. 1172	01 44, 664	5, 235	54.00
60.00 06000	LABORATORY			0. 1355			60.00
65.00 06500	RESPI RATORY THERAPY			0. 2375			65.00
	PHYSI CAL THERAPY			0. 4437			•
	OCCUPATIONAL THERAPY			0.3616			•
	SPEECH PATHOLOGY			0. 3822			•
	OCCUPATIONAL HEALTH			0.0000			68.01
	ELECTROCARDI OLOGY			0. 1716		8, 344	•
	MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 5960		3, 977	71.00
	IMPL. DEV. CHARGED TO PATIENT			0.3451			72.00
	DRUGS CHARGED TO PATIENTS			0. 2363		30, 128	73.00
	CARDI AC			0.0000			76.00
	CARDI OPULMONARY			0.6760		0	76.01
	TIENT SERVICE COST CENTERS					. · · ·	
	RURAL HEALTH CLINIC			0.0000	0 00	0	88.00
				0.0000	0 00	0	90.00
90.01 09001	WOUND CLINIC			0. 2668	44 13	3	90.01
90.02 09002	DIABETES CLINIC			0. 9747	65 0	0	90.02
	ASTHMA CLINIC			0.0000		0	90.03
90.04 09004	ANDIS CLINIC			8. 2757	67 0	0	90.04
	PRIME TIME			0. 2299		0	90.05
	SHELBYVILLE WOUND CLINIC			0. 2999		0	90.06
	ONCOLOGY			0. 4339		20	90.07
	ANDERSON WOMENS CENTER			0. 1925			•
	EMERGENCY			0. 1216			
	OBSERVATION BEDS (NON-DISTINCT PART)			0. 4824		0	•
200.00	Total (sum of lines 50 through 94 and	96 through 98)			689, 173		
201.00	Less PBP Clinic Laboratory Services-Pr		6 (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)	5 5 5	. ,		689, 173		202.00
1				1			

	Financial Systems HANCOCK REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0037	Period: From 01/01/2019	u of Form CMS-2 Worksheet E Part A	
			To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.0
1.00	DRG amounts other than outlier payments for discharges occurr instructions)	ring prior to October 1	(see	6, 285, 074	
1.02	DRG amounts other than outlier payments for discharges occurr instructions)	ring on or after October	1 (see	2, 049, 278	1.0
1.03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	for di scharges occurri ng	prior to October	0	1.0
1.04	DRG for federal specific operating payment for Model 4 BPCl f October 1 (see instructions)	for di scharges occurri ng	on or after	0	1.0
2.00	Outlier payments for discharges. (see instructions)			0	2.0
2.01 2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0	2.0 2.0
2.02	Outlier payments for discharges occurring prior to October 1	-		40, 116	
2.04	Outlier payments for discharges occurring on or after October			3, 323	
3.00	Managed Care Simulated Payments	(0	
4.00	Bed days available divided by number of days in the cost repo	orting period (see instr	uctions)	52.82	4.0
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	st recent cost reporting	period ending or	0.00	5.0
5.00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet t	the criteria for an add-	on to the cap for	0.00	6.0
7.00	new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f	r) (1) (i v) (B) (1)	0.00	7.0
7.01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	42 CFR §412.105(f)(1)(iv)(B)(2) If the	0.00	7.0
3. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.0
3. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8.0
3. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	nes (8, 8,01 and 8,02)	(see	0.00	9.0
	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	rent year from your reco	rds	0.00 0.00	
	Current year allowable FTE (see instructions)			0.00	
	Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Se	ptember 30, 1997,	0.00	
	Sum of lines 12 through 14 divided by 3.			0.00	
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clo			0.00	
	Adjusted rolling average FTE count	JSule			18.0
	Current year resident to bed ratio (line 18 divided by line 4	4).		0.000000	1
	Prior year resident to bed ratio (see instructions)			0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.0
	IME payment adjustment (see instructions)			0	
	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42		055 410 405	0	
	Number of additional allopathic and osteopathic IME FTE resic (f)(1)(iv)(C).	dent cap slots under 42	CFR 412.105	0.00	
	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or lin	e 24 (see	0.00 0.00	
6.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.0
	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	
	IME add-on adjustment amount - Managed Care (see instructions	5)		0	
9. 00 9. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		0	
0 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	patient dave (soo instru	ctions)) E0	30 0
	Percentage of Medicaid patient days (see instructions)	Satient days (See InStru		2.58 14.24	
	Sum of Lines 30 and 31			14. 24	
	Allowable disproportionate share percentage (see instructions	5)		3.68	
	Disproportionate share adjustment (see instructions)	*		76, 676	

	Financial Systems HANCOCK REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2019		
		Title XVIII	Hospi tal	PPS	, bu
			Prior to 10/1		
	Uncompanyated Caro Adjustment		1.00	2.00	
35.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.00000000	0. 00000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se		1, 131, 355	35.02
	instructions)		(70.007		
35.03 36.00	Pro rata share of the hospital uncompensated care payment amo Total uncompensated care (sum of columns 1 and 2 on line 35.0		670, 097 954, 481	284, 384	35.03 36.00
50.00	Additional payment for high percentage of ESRD beneficiary di				30.00
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.00
	652, 682, 683, 684 and 685 (see instructions)		0		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)		41.00		
41.01	Total ESRD Medicare covered and paid discharges excluding MS-	-DRGs 652, 682, 683, 684	0		41.01
	an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	3 3 ,	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)	32, 683, 684 an 685. (See	. 0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
	days)				
45.00	Average weekly cost for dialysis treatments (see instructions		0.00		45.00
46.00 47.00	Total additional payment (line 45 times line 44 times line 41 Subtotal (see instructions)	1.01)	9, 408, 948		46.00
48.00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48.00
	only. (see instructions)	· · · · · · · · · · · · · · · · · · ·			
				Amount 1.00	
49.00	Total payment for inpatient operating costs (see instructions	5)		9, 408, 948	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar	nd Pt. II, as applicable)		679, 728	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52.00 53.00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment	ne 49 see instructions).		0 5, 015	52.00 53.00
54.00	Special add-on payments for new technologies			0,019	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6			0	55.00
56.00 57.00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I		brough 25)	0	56.00 57.00
57.00	Ancillary service other pass through costs from Wkst. D, Pt.		ni ougir 55).	9, 738	
59.00	Total (sum of amounts on lines 49 through 58)			10, 103, 429	
60.00	Primary payer payments			0	60.00
61.00 62.00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	s line 60)		10, 103, 429 1, 070, 200	
63.00	Coinsurance billed to program beneficiaries			6, 479	
64.00	Allowable bad debts (see instructions)			44, 470	
65.00	Adjusted reimbursable bad debts (see instructions)			28, 906	
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		15, 124	
67.00 68.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	9, 055, 656 0	67.00 68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0 0	70.87 70.88
	Pioneer ACO demonstration payment adjustment amount (see inst	tructions)		0	70.88
70. 88 70. 89	HSP bonus payment HVBP adjustment amount (see instructions)	/		0	1
70. 88 70. 89 70. 90	nor bonds payment nybr adjustment amount (see riistraetrons)			0	70.91
70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	
70. 89 70. 90 70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70.92
70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			-	70. 92 70. 93

CALCUL	Financial Systems HANCOCK REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0037	Peri od:	u of Form CMS-2 Worksheet E	
				From 01/01/2019 To 12/31/2019	Part A Date/Time Pre	pared
		Title	e XVIII	Hospi tal	8/28/2020 1:2 PPS	/pm
		1 1110		Y (yyyy)	Amount	
				0	1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		2019	658, 250	70.9
	the corresponding federal year for the period prior to 10/1)					
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			2020	269, 559	70.9
0 00	the corresponding federal year for the period ending on or af	ter 10/1)			0	70.0
0. 98 0. 99	Low Volume Payment-3				0 28, 020	
1.00	HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines	60 8 70)			9, 970, 328	
1.01	Sequestration adjustment (see instructions)	07 & 70)			199, 407	
1.02	Demonstration payment adjustment amount after sequestration				0	
1.03	Sequestration adjustment-PARHM pass-throughs					71.0
2.00	Interim payments				9, 657, 884	72.0
2.01	Interim payments-PARHM					72.0
3.00	Tentative settlement (for contractor use only)				0	73.0
3. 01	Tentative settlement-PARHM (for contractor use only)					73.0
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			113, 037	74.(
4 04						
4.01 5.00	Balance due provider/program-PARHM (see instructions)	noo with			126, 509	74.0
5.00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ince with			120, 509	/5.0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
D. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.
	plus 2.04 (see instructions)					
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
2.00	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	
3.00	Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instr	uctions)			0.00	94.
					0	
	Time value of money for operating expenses (see instructions)				0	
5.00 6.00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruc			Prior to 10/1	0	
				Prior to 10/1 1.00	0	
					0 0n/After 10/1	
6. 00	Time value of money for capital related expenses (see instruc HSP Bonus Payment Amount HSP bonus amount (see instructions)				0 0n/After 10/1 2.00	
<u>5. 00</u> 00. 00	Time value of money for capital related expenses (see instruc HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	0 0n/After 10/1 2.00 0	96.
<u>6.00</u> 00.00 01.00	Time value of money for capital related expenses (see instruc HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	ti ons)		1.00 0 0.000000000	0 0n/After 10/1 2.00 0 0.0000000000	96. 100.
<u>6.00</u> 00.00 01.00	Time value of money for capital related expenses (see instruc HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	ti ons)		1.00	0 0n/After 10/1 2.00 0 0.0000000000	96. (
<u>5.00</u> 00.00 01.00 02.00	Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ti ons)		1.00 0 0.0000000000 0	0 0n/After 10/1 2.00 0 0.0000000000 0	96. 100. 101. 102.
00.00 00.00 01.00 02.00 03.00	Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	s)		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.0000000000 0 0.00000000000000	96. 100. 101. 102. 103.
00.00 00.00 01.00 02.00 03.00	Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	is)	ustment	1.00 0 0.0000000000 0	0 0n/After 10/1 2.00 0 0.0000000000 0 0.00000000000000	96. 100. 101. 102. 103.
00.00 01.00 02.00 03.00 04.00	Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	s) nation) Adju		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.0000000000 0 0.00000000000000	96. 100. 101. 102. 103. 104.
00.00 01.00 02.00 03.00 04.00	Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	s) nation) Adju		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.0000000000 0 0.00000000000000	96. 100. 101. 102. 103. 104.
5. 00 00. 00 01. 00 02. 00 03. 00 04. 00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HVRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s)) ration) Adji riod under		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.0000000000 0 0.00000000000000	96. 100. 101. 102. 103. 104. 200.
00.00 01.00 02.00 03.00 04.00 00.00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin	s)) ration) Adji riod under		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0	96. 100. 101. 102. 103. 104. 200. 201.
00.00 00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00	Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)	s)) ration) Adji riod under		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.0000000000 0 0.0000 0	96. 100. 101. 102. 103. 104. 200. 201. 202.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00	Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) ration) Adju ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202.
5. 00 00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	s) ration) Adju ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202.
5. 00 00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	s) ration) Adju ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000	96. 100. 101. 102. 103. 104. 200. 201. 202. 203.
3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	s) ration) Adju ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202.
0. 00 0. 00 1. 00 2. 00 1. 00 1. 00 0. 00 1.	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	s) ration) Adji riod under e 49) first year	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205.
00.00 00.00 01.00 02.00 03.00 04.00 02.00 02.00 02.00 03.00 04.00 05.00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	s) ration) Adji riod under e 49) first year	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204.
00 000 100 200 300 400 000 100 200 300 400 500 600 700	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	s) ration) Adju ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207.
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) Kural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) ration) Adju ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208.
5. 00 00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 00. 00 01. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus Payment (see instructions) HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	s) ration) Adju ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
0, 00 0,	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medi care di scharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	s) ration) Adju ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 209. 210.
0.00 0.00 11.00 12.00 13.00 14.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 0.00 19.00 10.00 10.00 10.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 16.00 15.00 16.00 17.00 16.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00	Time value of money for capital related expenses (see instruct HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	s) ration) Adju ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 207. 208. 209. 209. 210.
5. 00 00. 00 01. 00 02. 00 03. 00 04. 00 02. 00 01. 00 02. 00 03. 00 04. 00 05. 00 05. 00 06. 00 07. 00 08. 00 09. 00 11. 00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment for HSP Bonus Payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	tions) tions) s) ration) Adju rriod under re 49) first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 206. 207. 208. 209. 210. 210.
5. 00 00. 00 01. 00 02. 00 03. 00 04. 00 02. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 05. 00 06. 00 07. 00 08. 00 07. 00 08. 00 09. 00 11. 00 12. 00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (see instructions)	tions) tions) s) ration) Adju rriod under re 49) first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 211. 221.
b) 00 00 00 01 00 02 00 03 00 04 00 05 00 06 00 07 00 08 00 09 00 00 00 01 00 02 00 03 00 04 00 05 00 06 00 07 00 08 00 09 00 01 00 02 00 03 00	Time value of money for capital related expenses (see instructions) HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment for HSP Bonus Payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ructions) ructions) ructions) line 59) 211)	of the curr	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 210. 210.

	Financial Systems LUME CALCULATION EXHIBIT 4		HANCOCK REGIO	Provi der C	1	Period: From 01/01/2019 To 12/31/2019		t 4 pared
		W/S E, Part A line	Amounts (from E, Part A)	Title Pre/Post Entitlement	XVIII Period Prior to 10/01	Hospital Period On/After 10/01	Total (Col 2 through 4)	
20		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0		0 0	0	1.
01	DRG amounts other than outlier payments for discharges	1.01	6, 285, 074	0	6, 285, 07	4	6, 285, 074	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1.02	2, 049, 278	0		2, 049, 278	2, 049, 278	1.
)3	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1.03	0	0		0	0	1.
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.
00	Outlier payments for	2.00						2.
)1	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	2.
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	40, 116	0	40, 11	6	40, 116	2.
03	Outlier payments for discharges occurring on or after October 1 (see	2.04	3, 323	0		3, 323	3, 323	2.
00	instructions) Operating outlier reconciliation	2. 01	0	0		o o	0	3.
00	Managed care simulated payments	3.00	0	0		0 0	0	4.
	Indirect Medical Education Adju	ustment			1			
00	Amount from Worksheet E, Part	21.00	0. 000000	0.00000	0.00000	0 0.000000		5.
0	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	0	0		0 0	0	6.
)1	IME payment adjustment for managed care (see instructions)	22.01	0	0		0 0	0	6
	Indirect Medical Education Adju	ustment for th	e Add-on for Se	ection 422 of	the MMA			
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.000000		_		7
0	IME adjustment (see instructions)	28.00	0	0		0 0	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
0	Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9.
	Disproportionate Share Adjustme							
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0368	0. 0368	0. 036	8 0. 0368		10
	Disproportionate share adjustment (see instructions)	34.00	76, 676				76, 676	
01	Uncompensated care payments Additional payment for high per	36.00	954,481 RD beneficiary	di scharges	670, 09	7 284, 384	954, 481	11.
00	Total ESRD additional payment	46.00		ui scharges 0		0 0	0	12.
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	9, 408, 948 0	0 0	7, 053, 11	0 2, 355, 838 0 0	9, 408, 948 0	13
00	(see instructions) Total payment for inpatient operating costs (see	49.00	9, 408, 948	0	7, 053, 11	0 2, 355, 838	9, 408, 948	15.

	Financial Systems		HANCOCK REGION	Provi der C	CN: 15-0037	Period:	u of Form CMS-2 Worksheet E	
						From 01/01/2019 To 12/31/2019		pared
				Title	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
	1	0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	679, 728	0	515, 59	97 164, 131	679, 728	16.0
17.00	Special add-on payments for new technologies	54.00	0	0		0 0	0	17.0
17.01	Net organ aquisition cost							17.0
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see		0	0		0 0	0	18.0
19.00	instructions) SUBTOTAL			0	7, 568, 70	2, 519, 969	10, 088, 676	19.0
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1.00 1.01	674, 815 0	0		74 163, 441 0 0	674, 815 0	
21.00	Capital DRG outlier payments	2.00	4, 913	0	4, 22	23 690	4, 913	21.0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0		0 0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0.000	0.0000		22.0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0. 000	0. 0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.0
26.00	Total prospective capital payments (see instructions)	12.00	679, 728	0	515, 59	97 164, 131	679, 728	26.0
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 08697 658, 25		658, 250	27.0 28.0
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				269, 559	269, 559	29.0
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

	Financial Systems	HANCOCK REGION				u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2019	Worksheet E Part A Exhibi	+ 5
					To 12/31/2019		
						8/28/2020 1:2	7 pm
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	1.00	2.00	3.00	4.00	1.00
1.00	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.00	6, 285, 074	6, 285, 074	4	6, 285, 074	1.00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 049, 278		2, 049, 278	2, 049, 278	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	(כ	0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	(0 0	0	2.01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	40, 116	40, 110	6	40, 116	2. 02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	3, 323		3, 323	3, 323	2.03
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0	(0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	(0 0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)		0	(0	6. 01
	Indirect Medical Education Adjustment for the	e Add-on for Se	ection 422 of 1	the MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0. 000000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0		0 0	0	8.01
9.00 9.01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0			0	9.00 9.01
9.01	lines 6.01 and 8.01)	29.01	0	(0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 0368	0. 0368	0. 0368		10.00
	(see instructions)						
11.00	Disproportionate share adjustment (see instructions)	34.00	76, 676	57, 823	3 18, 853	76, 676	11.00
11.01	Uncompensated care payments Additional payment for high percentage of ESA	36.00	954, 481	670, 09	7 284, 384	954, 481	11.01
12.00	Total ESRD additional payment (see instructions)	46. 00	ui scharges 0	(0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	9, 408, 948	7, 053, 110	2, 355, 838	9, 408, 948	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0	(0 0	0	14.00
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	9, 408, 948	7, 053, 110	2, 355, 838	9, 408, 948	15.00
		50.00	679, 728	515, 59	7 164, 131	679, 728	16.00
16.00	Payment for inpatient program capital (from Wkst Pt if applicable)	I					
16.00 17.00 17.01	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	54.00	0	(o o	0	17.00 17.01
	Wkst. L, Pt. I, if applicable)	54.00 68.00	0		o o o o	0 0	17.01
17. 00 17. 01	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for			(17. 01 17. 02

	Financial Systems	HANCOCK REGIO			In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCUL	ATION EXHIBIT 5			Period: From 01/01/2019 To 12/31/2019		pared:
				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	674, 815	511, 37	4 163, 441	674, 815	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	4, 913	4, 22	3 690	4, 913	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	0.000	0 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	0.000	0 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	679, 728	515, 59	7 164, 131	679, 728	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00 28.00 29.00 30.00 30.01	Low volume adjustment prior to October 1 Low volume adjustment on or after October 1 HVBP payment adjustment (see instructions) HVBP payment adjustment for HSP bonus	70. 96 70. 97 70. 93 70. 90	658, 250 269, 559 34, 270 0		269, 559	658, 250 269, 559 34, 270 0	29.00
31. 00 31. 01	payment (see instructions) HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-19, 387 0	-15, 08	4 -4, 303 0 0	-19, 387 0	
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 28, 020	28, 020	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.	1	Y				100.00

	Financial Systems HANCOCK REGIONAL	- HOSPI TAL Provi der CCN: 15-0037	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
CALCOL			From 01/01/2019 To 12/31/2019	Part B Date/Time Pre	
		Title XVIII	Hospi tal	8/28/2020 1:2 PPS	7 pm
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			3, 119	
	Medical and other services reimbursed under OPPS (see instruc OPPS payments	ctions)		17, 116, 834 13, 873, 024	
	Outlier payment (see instructions)			62, 083	
4.01	Outlier reconciliation amount (see instructions)			0	
	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	uctions)		0.000	1
	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)			0	
	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		75, 375	9.00 10.00
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			3, 119	1
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			12 200	12.00
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		13, 200 0	
	Total reasonable charges (sum of lines 12 and 13)			13, 200	
15 00	Customary charges			0	15 00
	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for		0	0	
	had such payment been made in accordance with 42 CFR §413.13(on a onargobaci o		10100
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or	nlvifline 18 exceeds l	ine 11) (see	13, 200 10, 081	•
17.00	instructions)			10,001	
20.00	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds l	ine 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			3, 119	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			14, 010, 482	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	าร)		0	25.00
	Deductibles and Coinsurance amounts relating to amount on lin	•		2, 587, 153	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2	2 and 23] (see	11, 426, 448	27.00
	Direct graduate medical education payments (from Wkst. E-4, I			0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36))		0	
	Subtotal (sum of lines 27 through 29) Primary payer payments			11, 426, 448 1, 929	
32.00	Subtotal (line 30 minus line 31)			11, 424, 519	
-	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		0	22.00
	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0 202, 018	
	Adjusted reimbursable bad debts (see instructions)			131, 312	
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		137, 503	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			11, 555, 831 -139	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
	Pioneer ACO demonstration payment adjustment (see instruction	าร)		0	39.50
	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	aced devices (see instru	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
	Subtotal (see instructions)			11, 555, 970	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			231, 119	1
	Sequestration adjustment-PARHM pass-throughs				40.03
	Interim payments			11, 254, 036	
	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01
	Tentative settlement-PARHM (for contractor use only)				42.01
	Balance due provider/program (see instructions)			70, 815	
	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2	chapter 1	0	43.01 44.00
	§115. 2			0	17.00
	TO BE COMPLETED BY CONTRACTOR			-	00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Pre 8/28/2020 1:2	pared
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		9, 617, 7(0	11, 119, 464 0	1. 2. 3.
	payment. If none, write "NONE" or enter a zero. (1)					
~ .	Program to Provider	40 (04 (0040	10.11		101 570	
. 01 . 02	ADJUSTMENTS TO PROVIDER	12/31/2019	40, 18	32 12/31/2019 0	134, 572 0	3. 3.
. 02				0	0	
. 04				0	0	
05				0	0	
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	
51 52				0	0	
5∠ 53				0	0	
54				0	0	3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		40, 18		134, 572	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9, 657, 88	34	11, 254, 036	4.
	TO BE COMPLETED BY CONTRACTOR					1
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01 02	TENTATI VE TO PROVIDER			0	0	
02				0	0	
	Provider to Program					1
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
99	5. 50-5. 98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		113, 03	37	70, 815	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		9, 770, 92		11, 324, 851	7
				Contractor	NPR Date	
		()	Number 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor	, i	,	1.00	2.00	8

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0037 CCN: 15-S037	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Pre 8/28/2020 1:2	epared
		Title	e XVIII	Subprovider - IPF	PPS	F
		I npati er	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Total interim payments paid to provider	1.00	2.00	3.00	4.00	1.0
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 377, 1	0	0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	3.
04				0	0	
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	3
53				0	0	
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	-
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 599, 1	96	0	4.
	appropriate) TO BE COMPLETED BY CONTRACTOR					-
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER		1	0	0	5
02				0	0	
03				0	0	5.
50	Provider to Program		1		-	۱.
50 51	TENTATI VE TO PROGRAM			0	0	
52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		2,8	11	0	
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 602, 0		0	
50			1,002,0	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Name of Contractor		C	1.00	2.00	8

Heal th	Financial Systems HANCOCK REGION	AL HOSPITAL	In Lie	u of Form CMS-	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0037	Period:	Worksheet E-1	i		
			From 01/01/2019 To 12/31/2019	Date/Time Pre	epared.		
				8/28/2020 1:2			
		Title XVIII	Hospi tal	PPS			
	TO DE CONDUETED DV CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				-		
1.00							
2.00							
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00		
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HII technology	Wkst. S-2, Pt. I		7.00		
8.00	Calculation of the HIT incentive payment (see instructions)				8.00		
9.00	Sequestration adjustment amount (see instructions)				9.00		
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				-		
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00		
31.00	Other Adjustment (specify)	Line 21) (coo instruction			31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	(see Instructio	ins)		32.00		

	Financial Systems HANCOCK REGIONAL		In Lie	u of Form CMS-2	2552-1
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Peri od:	Worksheet E-3	
		Component CCN: 15-SO37	From 01/01/2019 To 12/31/2019	Date/Time Pre	
		Title XVIII	Subprovi der -	8/28/2020 1:2 PPS	7 pm
			I PF		
				1.00	
1.00	PART II - MEDICARE PART A SERVICES - IPF PPS Net Federal IPF PPS Payments (excluding outlier, ECT, and me	dical education navments		1, 759, 226	1.00
2.00	Net IPF PPS Outlier Payments	arear education payments)	6, 207	2.0
3.00	Net IPF PPS ECT Payments			0	3.0
4.00	Unweighted intern and resident FTE count in the most recent of 15, 2004. (see instructions)	cost report filed on or	before November	0.00	4.0
4.01	Cap increases for the unweighted intern and resident FTE cour program or hospital closure, that would not be counted without			0.00	4. O´
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
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 teaching program" (see instuctions)	the new program growth	period of a "new	0.00	6.0
7.00	Current year's unweighted L&R FTE count for residents within teaching program" (see instructions)	the new program growth	period of a "new	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjust	stment (see instructions)	0.00	8.0
9.00	Average Daily Census (see instructions)	-	, 	6.734247	9.0
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0.000000	
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0	11.0
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1, 765, 433	12.0
13.00 14.00	Nursing and Allied Health Managed Care payment (see instruction Organ acquisition (DO NOT USE THIS LINE)	ion)		0	13.0 14.0
	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	14.0
16.00	Subtotal (see instructions)			1, 765, 433	
	Primary payer payments			0	17.0
	Subtotal (line 16 less line 17).			1, 765, 433	18.0
	Deducti bl es			133, 600	19.0
	Subtotal (line 18 minus line 19)			1, 631, 833	
21.00	Coinsurance			0	21.0
	Subtotal (line 20 minus line 21)			1, 631, 833	
	Allowable bad debts (exclude bad debts for professional servi Adjusted reimbursable bad debts (see instructions)	ices) (see instructions)		4, 074 2, 648	23.0 24.0
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		2,040	24.0
	Subtotal (sum of lines 22 and 24)			1, 634, 481	26.0
	Direct graduate medical education payments (see instructions))		0	27. C
28.00	Other pass through costs (see instructions)			220	28. C
	Outlier payments reconciliation			0	29.0
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.0
30.50	Pioneer ACO demonstration payment adjustment (see instruction			0	30.5
30.99	Demonstration payment adjustment amount before sequestration			0	30.9
31.00 31.01	Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions)			1, 634, 701 32, 694	
31. 01 31. 02	Demonstration payment adjustment amount after sequestration			52, 094	31.0
	Interim payments			1, 599, 196	
	Tentative settlement (for contractor use only)			0	33.0
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.0			2, 811	34.0
35.00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	35.0
	TO BE COMPLETED BY CONTRACTOR			(007	E0 0
	Original outlier amount from Worksheet E-3, Part II, line 2 Outlier recordination adjustment amount (see instructions)			6, 207	50.0
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	51.0 52.0
	Time Value of Money (see instructions)				52.0

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII	
			To 12/31/2019	Date/Time Pre 8/28/2020 1:2	pare 7 pm
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR	XIX SERVICES		
~~	COMPUTATION OF NET COST OF COVERED SERVICES		250 427		1
00 00	Inpatient hospital/SNF/NF services Medical and other services		350, 437	0	1.
00	Organ acquisition (certified transplant centers only)		0	0	3.
00	Subtotal (sum of lines 1, 2 and 3)		350, 437	0	
00		tient primary payer payments			
00	Outpatient primary payer payments		0	5.	
00	Subtotal (line 4 less sum of lines 5 and 6)		350, 437	0	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges		r		
00	Routine service charges		408, 842		8.
00	Ancillary service charges	689, 173	0		
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0	0	11
00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		1, 098, 015	0	12
.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
. 00	basis	0	0	15	
. 00	Amounts that would have been realized from patients liable for	payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with 4			-	
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15
. 00	Total customary charges (see instructions)		1, 098, 015	0	16
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	747, 578	0	17
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds li	ne 0	0	18
00	16) (see instructions)			0	10
. 00	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see instr	-	0 350, 437	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21
. 00	Other than outlier payments	compreted for FFS prov	0	0	22
	Outlier payments		0	0	
	Program capital payments		0	0	24
.00	Capital exception payments (see instructions)		0		25
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	27
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		350, 437	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1	350, 437	0	31
. 00	Deductibles		0	0	
	Coinsurance		0	0	1 00
	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review	1 22)		~	35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	350, 437	0		
. 00 . 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	350, 437	0	37	
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)	350, 437	0	38	
. 00	Total amount payable to the provider (sum of lines 38 and 39)		350, 437	0	
. 00	Interim payments		350, 437 550, 228	0	
. 00	Balance due provider/program (line 40 minus line 41)		-199, 791	0	
. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2	- 199, 791	0	
	chapter 1, §115.2		U U	0	1 '

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column		Fi		Worksheet G Date/Time Pre 8/28/2020 1:2	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	18, 659, 717	0	0	0	1.00
00	Temporary investments	0	0	0	0	2.00
00	Notes receivable	0	0	0	0	3.00
00	Accounts receivable Other receivable	14, 505, 535	0	0	0	4.00
00	Allowances for uncollectible notes and accounts receivable		0	0	0	6.00
00	Inventory	31, 719, 734	0	0	0	7.00
00	Prepai d expenses	0	0	0	0	8.00
00	Other current assets	96, 639, 538	0	0	0	
	Due from other funds Total current assets (sum of lines 1-10)	161, 524, 524		0	0	10.0
	FIXED ASSETS	101, 021, 021				1 11.0
2. 00	Land	15, 633, 150		0	0	12.00
	Land improvements	0	0	0	0	13.00
	Accumulated depreciation		0	0	0	
	Buildings Accumulated depreciation	130, 951, 989 -152, 976, 407	0	0	0	15.0 16.0
	Leasehold improvements	0	0	0	0	17.0
3. 00	Accumulated depreciation	0	0	0	0	18.0
	Fixed equipment	0	0	0	0	19.0
	Accumulated depreciation	0	0	0	0	20.0
	Automobiles and trucks Accumulated depreciation		0	0	0	21.0
	Major movable equipment	89, 637, 381	0	0	0	23.0
	Accumulated depreciation	0	0	0	0	24.0
	Minor equipment depreciable	0	0	0	0	25.0
	Accumulated depreciation	0	0	0	0	26.0
	HIT designated Assets Accumulated depreciation		0	0	0	27.0
	Mi nor equi pment-nondepreci abl e		0	0	0	29.0
	Total fixed assets (sum of lines 12-29)	83, 246, 113		0	0	
	OTHER ASSETS					
	Investments	0	0	0	0	31.0
	Deposits on leases Due from owners/officers		0	0	0	32.0 33.0
	Other assets	38, 923, 945	-	0	0	34.0
	Total other assets (sum of lines 31-34)	38, 923, 945		0	0	35.0
	Total assets (sum of lines 11, 30, and 35)	283, 694, 582	0	0	0	36.0
	CURRENT LIABILITIES	7 050 104		0	0	1 27 0
	Accounts payable Salaries, wages, and fees payable	7, 852, 134 5, 416, 964		0	0	37.0
	Payroll taxes payable	0,410,704		0	0	
	Notes and Loans payable (short term)	0	0	0	0	40.0
	Deferred income	0	0	0	0	
	Accelerated payments	0		0	0	42.0
	Due to other funds Other current liabilities	5, 930, 728	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	19, 199, 826		0	0	
	LONG TERM LIABILITIES					
	Mortgage payable	0		0	0	
	Notes payable	0	0	0	0	
	Unsecured Loans Other Long term liabilities		0	0	0	48.0
	Total long term liabilities (sum of lines 46 thru 49)		0	0	0	50.0
	Total liabilities (sum of lines 45 and 50)	19, 199, 826		0	0	51.0
	CAPI TAL ACCOUNTS	1				
	General fund balance	264, 494, 756				52.0
	Specific purpose fund Donor created - endowment fund balance - restricted		0	o		53.0 54.0
	Donor created - endowment fund balance - restricted			0		55.0
	Governing body created - endowment fund balance			0		56.0
7.00	Plant fund balance - invested in plant				0	57.C
3.00	Plant fund balance - reserve for plant improvement,				0	58.0
9.00	replacement, and expansion	264 404 754			0	E0 0
	Total fund balances (sum of lines 52 thru 58)	264, 494, 756	0	0	0	59.0

Health Financial Systems STATEMENT OF CHANGES IN FUND BALANCES	HANCOCK REGIONA	Provider CC	CN: 15-0037	Peri od:	u of Form CMS Worksheet G-	
				From 01/01/2019 To 12/31/2019	Date/Time Pr 8/28/2020 1:	
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.00Additions (credit adjustments) (specify)6.007.008.009.0010.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00ROUNDING/MISC13.0014.0015.0016.0017.00Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	238, 325, 478 26, 169, 410 264, 494, 888 0 264, 494, 888 132 264, 494, 756				$ \begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 0.4.00\\ 0.5.00\\ 0.6.00\\ 0.6.00\\ 0.7.00\\ 0.8.00\\ 0.7.00\\ 10.00\\ 11.00\\ 0.13.00\\ 0.13.00\\ 0.13.00\\ 0.14.00\\ 0.15.00\\ 0.14.00\\ 0.15.00\\ 0.14.00\\ 0.15.00\\ 0.14.00\\ 19.00\\ \end{array} $
	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.006.007.008.009.009.00	0			0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 ROUNDING/MISC 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17)	00	0 0 0 0 0 0		000		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			Ő		19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 15-0037	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	epared:
	Cost Center Description		I npati ent	Outpati ent	8/28/2020 1:2 Total	<u>2/pm</u>
	cost center bescription		1.00	2.00	3.00	
	PART I - PATIENT REVENUES			2100	0100	
	General Inpatient Routine Services					1
. 00	Hospi tal		6, 594, 2	.79	6, 594, 279	1.0
2.00	SUBPROVIDER - IPF		3, 234, 9	62	3, 234, 962	2.0
3.00	SUBPROVIDER - IRF			0	0	3.0
1.00	SUBPROVIDER					4.0
5.00	Swing bed - SNF			0	0	
b. 00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.0
3.00	NURSI NG FACI LI TY					8.0
9.00	OTHER LONG TERM CARE		0 000 0	41	0 000 041	9.0
0.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		9, 829, 2	.41	9, 829, 241	10.0
1.00	INTENSIVE CARE UNIT		10, 677, 3	03	10, 677, 393	11.0
2.00	CORONARY CARE UNIT		10,077,3	173	10,077,393	12.0
3.00	BURN I NTENSI VE CARE UNI T					13.0
4.00						14.0
5.00	OTHER SPECIAL CARE (SPECIFY)					15.0
6.00	Total intensive care type inpatient hospital services (sum o	oflines	10, 677, 3	93	10, 677, 393	
	11-15)				.,.,.,	
7.00	Total inpatient routine care services (sum of lines 10 and	16)	20, 506, 6	34	20, 506, 634	17.0
8.00	Ancillary services		39, 715, 5	88 258, 382, 166	298, 097, 754	18.0
9.00	Outpatient services		4, 189, 2	66 77, 281, 909	81, 471, 175	19.0
20.00	RURAL HEALTH CLINIC			0 0	0	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		
	HOME HEALTH AGENCY			0	0	
23.00	AMBULANCE SERVICES					23.0
24.00	СМНС					24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.0
26.00	HOSPICE		1, 249, 6			
27.00			274 (0 1, 470, 954		
27.01 27.02	SELF-INSURANCE		374,6			
27.02	DI ETARY SERVI CES PRO FEES		11 4	0 27, 353 22 1, 791, 388		
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst	66, 047, 3			
0.00	G-3, line 1)	J LU WKSL.	00,047,3	342, 903, 550	400, 930, 933	20.0
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			139, 579, 962		29.0
30.00	ADD (SPECI FY)			0		30.0
1.00				0		31.0
2.00				0		32.0
3.00				0		33.0
4.00				0		34.0
5.00				0		35.0
6.00	Total additions (sum of lines 30-35)			0		36.0
7.00	DEDUCT (SPECIFY)			0		37.0
8.00				0		38.0
9.00				0		39.0
0.00				0		40.0
1.00				0		41.0
2.00	Total deductions (sum of lines 37-41)			0		42.0
3.00	Total operating expenses (sum of lines 29 and 36 minus line	1))(trancfo	ri	139, 579, 962	1	43.0

STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0037 Period: From 01/01/2019 To 12/31/2019 Worksheet G-3 bate/Time Prepared: B/28/2020 1: 27 pm 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 1.00 1.00 1.00 2.00 Less contractual allowances and discounts on patients' accounts 273, 210, 239 2.00 3.00 Net patient revenues (line 1 minus line 2) 1.00 135, 740, 714 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 138, 579, 962 4.00 5.00 Net income from service to patients (line 3 minus line 4) -3, 839, 248 5.00 0 Income from investments 0 6.00 7.00 8.00 0.00 Revenues from tilelephone and other miscell aneous communication services 0 9.00 8.00 0.00 Revenues from laudry and linen service 0 10.00 10.00 11.00 Rebates and refunds of expenses 0 11.00 11.00 0.00 Revenues from meals sold to employees and guests 0 12.00 13.00 12.00 Revenue from sale of medical a	Heal th	Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
1.00Total patient revenues (from Wkst. G-2, Part I, column 3, Line 28)408, 950, 9531.002.00Less contractual al lowances and discounts on patients' accounts273, 210, 2392.003.00Net patient revenues (line 1 minus line 2)135, 740, 7143.004.00Less total operating expenses (from Wkst. G-2, Part II, Line 43)139, 579, 9624.005.00Net income from service to patients (line 3 minus line 4)-3, 839, 2485.006.00Contributions, donations, bequests, etc06.007.00Income from investments07.008.00Revenues from television and radio service09.009.00Purchase discounts011.0010.00Purchase discounts011.0011.00Rebates and refunds of expenses011.0012.00Revenue from neals ol to employees and guests013.0013.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical records and abstracts018.0010.00Revenue from sale of medical records and abstracts018.0010.00Revenue from sale of meding expenses019.0010.00Revenue from sale of medical actives, etc.)019.0010.00Revenue from sale of medical records and abstracts018.0010.00Revenue from sale of medical records and abstracts019.0010.00Revenue from sale of medical ecords, and canteen<	STATEN	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-0037	From 01/01/2019	Date/Time Pre	pared:
1.00Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)408, 950, 9531.002.00Less contractual al lowances and discounts on patients' accounts273, 210, 2392.003.00Net patient revenues (line 1 minus line 2)135, 740, 7143.004.00Less total operating expenses (from Wkst. G-2, Part II, line 43)139, 579, 9624.005.00Net income from service to patients (line 3 minus line 4)-3, 839, 2485.006.00Contributions, donations, bequests, etc06.007.00Income from investments07.008.00Revenues from television and radio service09.009.00Purchase discounts011.0010.00Purchase discounts011.0011.00Rebates and refunds of expenses011.0012.00Revenue from neals old to employees and guests012.0013.00Revenue from sale of medical and surgical supplies to other than patients014.0010.00Revenue from sale of medical records and abstracts018.0010.00Revenue from sale of medical records and abstracts019.0010.00Revenue from gifts, flowers, coffee shops, and canteen022.0010.00Revenue from gifts, flowers, coffee shops, and canteen022.0010.00Revenue from sale of medical records and bastracts018.0010.00Revenue from sale of medical apporpriations023.0010.01Revenue from sale of medic						1 00	
2.00Less contractual allowances and discounts on patients' accounts273,210,2392.003.00Net patient revenues (line 1 minus line 2)135,740,7143.004.00Less total operating expenses (from Wkst. G-2, Part II, line 43)139,579,9624.005.00Net income from service to patients (line 3 minus line 4)-3,839,2485.006.00Contributions, donations, bequests, etc06.007.00Income from investments07.008.00Revenues from telephone and other miscel aneous communication services08.009.00Revenues from telephone and other miscel aneous communication services09.0010.00Purchase discounts011.0010.00Rebates and refunds of expenses011.0011.00Revenue from meals sold to employees and guests012.0012.00Revenue from sale of medical and surgical supplies to other than patients014.0013.00Revenue from sale of medical and surgical supplies to other than patients019.0010.00Revenue from sale of textbooks, uniforms, etc.)019.0010.00Revenue from gilts, flowers, coffee shops, and canteen021.0010.00Revenue from gilts, flowers, coffee shops, and canteen022.0010.00Revenue from gilts, flowers, coffee shops, and canteen022.0010.00Revenue from gilts, flowers, coffee shops, and canteen022.0010.00Revenue from gilts, flowers, coffee shops, and cante	1 00	Total patient revenues (from Wkst G-2 Par	t l column 3 lin	ne 28)			1 00
3.00Net patient revenues (line 1 minus line 2)135,740,7143.004.00Less total operating expenses (from Wkst. G-2, Part II, line 43)139,579,9624.005.00Net income from service to patients (line 3 minus line 4)-3,839,2485.006.00Contributions, donations, bequests, etc06.007.00Income from investments07.008.00Revenues from tel ephone and other miscel laneous communication services08.009.00Revenue from tel evision and radio service09.0010.00Purchase di scounts011.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from rental of living quarters014.0015.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical and surgical supplies to other than patients018.0019.00Revenue from sale of medical and surgical supplies to other than patients018.0019.00Revenue from sale of medical metrics019.0010.00Revenue from sale of medical metrics019.0010.00Revenue from sale of medical records and abstracts019.0010.00Revenue from sale of textbooks, uniforms, etc.)021.0020.00Rental of hospital space022.0020.00Rental of hospital space020.0020.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
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OTHER INCOME06.00Contributions, donations, bequests, etc07.00Income from investments08.00Revenue from telephone and other miscellaneous communication services09.00Revenue from television and radio service010.00Purchase discounts011.00Rebates and refunds of expenses012.00Parking lot receipts013.00Revenue from meals sold to employees and guests014.00Revenue from sale of medical and surgical supplies to other than patients015.00Revenue from sale of medical records and abstracts019.00Tuition (fees, sale of textbooks, uniforms, etc.)010.00Rental of vending machines020.00Revenue from gifts, flowers, coffee shops, and canteen021.00Retal of vending machines022.00Rental of hoxpital space023.00Governmental appropriations024.00OTHER INCOME/TRAMSFER9, 983, 47024.00OTHER NON-OPERATING INCOME20, 847, 41824.01OTHER NON-OPERATING INCOME20, 847, 41825.00Total other income (sum of line 27 and subscripts)822, 23027.00Rescuese (sum of line 27 and subscripts)822, 230				,			
7.00Income from investments07.008.00Revenues from telephone and other miscellaneous communication services08.009.00Revenue from television and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from laundry and linen service013.0014.00Revenue from meals sold to employees and guests014.0015.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of drugs to other than patients017.0018.00Revenue from sale of drugs to other than patients019.0010.00Retail of vending machines019.0020.00Rental of hospital space021.0021.00Rental of hospital space021.0022.00Rental of hospital space022.0023.00Total other income (sum of lines 6-24)00.837,47024.00Total (line 5 plus line 25)26.0026.0027.00LOSS ON SALE OF EQUIPMENT822,23028.0028.00Total other expenses (sum of line 27 and subscripts)822,23028.00						0,001,210	
8.00Revenues from telephone and other miscellaneous communication services08.009.00Revenue from television and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from meals sold to employees and guests013.0014.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revalue from grantal space021.0021.00Revenue from soll a propriations021.0022.00Rental of hospital space021.0023.00Governmental appropriations021.0024.00OTHER NON-OPERATI NG INCOME20.847,41824.0125.00Total other income (sum of lines 6-24)30,830,88825.0026.00Total (line 5 plus line 25)27.00822,23027.0028.00Total other expenses (sum of line 27 and subscripts)822,23082.00	6.00	Contributions, donations, bequests, etc				0	6.00
9.00Revenue from television and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from laundry and linen service013.0014.00Revenue from meals sold to employees and guests013.0015.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)018.0020.00Revenue from igifts, flowers, coffee shops, and canteen020.0021.00Rental of hospital space021.0022.00Rental of hospital space022.0023.00Governmental appropriations022.0024.00OTHER NON-OPERATIN GI INCOME9,983,47024.0025.00Total other income (sum of lines 6-24)30,830,88825.0026.00Total (line 5 plus line 25)822,23027.0028.00Total other expenses (sum of line 27 and subscripts)822,230820.00	7.00	Income from investments				0	7.00
10.00Purchase di scounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from landry and linen service013.0014.00Revenue from nental sold to employees and guests014.0015.00Revenue from sale of medical and surgical supplies to other than patients015.0016.00Revenue from sale of medical records and abstracts017.0018.00Revenue from gifts, flowers, coffee shops, and canteen019.0020.00Rental of hospital space021.0022.00Rental of hospital space021.0023.00Governmental appropriations021.0024.00OTHER INCOME/TRANSFER9, 983, 47024.0024.01OTHER NON-OPERATING INCOME20, 847, 41824.0125.00Total other income (sum of lines 6-24)30, 830, 88825.0026.00Total (line 5 plus line 25)26, 991, 64026, 0027.00Total other expenses (sum of line 27 and subscripts)822, 23027.00	8.00	Revenues from telephone and other miscellan	eous communication	i servi ces		0	8.00
11.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from laundry and linen service013.0014.00Revenue from meals sold to employees and guests014.0015.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of drugs to other than patients017.0018.00Revenue from sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0023.00Governmental appropriations022.0024.01OTHER INCOME/TRANSFER9,983,47024.0024.01OTHER NON-OPERATING INCOME20,847,41824.0125.00Total other income (sum of lines 6-24)30,830,88825.0026.00Total (line 5 plus line 25)26,991,640822,23027.0028.00Total other expenses (sum of line 27 and subscripts)822,23028.00	9.00	Revenue from television and radio service				0	9.00
12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 12.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 22.00 21.00 Rental of vending machines 0 22.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.01 OTHER NON-OPERATING INCOME 20,847,418 24.01 25.00 Total other income (sum of lines 6-24) 30,830,888 25.00 26,00 Total (line 5 plus line 25) 26,091,640 26.00<	10.00	Purchase di scounts				0	10.00
13.00Revenue from laundry and linen service013.0014.00Revenue from meals sold to employees and guests014.0015.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients015.0017.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0022.00Rental of hospital space022.0023.00Governmental appropriations023.0024.01OTHER INCOME/TRANSFER9, 983, 47024.0024.01OTHER NON-OPERATING INCOME20, 847, 41824.0125.00Total other income (sum of lines 6-24)30, 830, 88825.0026.00Total (line 5 plus line 25)26, 091, 64026, 0027.0028.00Total other expenses (sum of line 27 and subscripts)822, 23028.00	11.00	Rebates and refunds of expenses				0	11.00
14.00Revenue from meals sold to employees and guests014.0015.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical records and abstracts017.0018.00Revenue from gifts, flowers, coffee shops, and canteen019.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0022.00Rental of hospital space023.0023.00Governmental appropriations023.0024.00OTHER INCOME/TRANSFER9, 983, 47024.0025.00Total other income (sum of lines 6-24)30, 830, 88825.0026.00Total (line 5 plus line 25)26, 091, 64026, 0027.0028.00Total other expenses (sum of line 27 and subscripts)822, 23027.00						0	
15.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of drugs to other than patients017.0018.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0022.00Rental of hospital space022.0023.00Governmental appropriations023.0024.00OTHER INCOME/TRANSFER9,983,47024.0024.01OTHER NON-OPERATING INCOME20,847,41824.0125.00Total other income (sum of lines 6-24)30,830,88825.0026.00Total other expenses (sum of line 27 and subscripts)822,23027.0028.00Total other expenses (sum of line 27 and subscripts)822,23028.00	13.00					0	13.00
16.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of drugs to other than patients017.0018.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0022.00Rental of hospital space022.0023.00Governmental appropriations023.0024.00OTHER INCOME/TRANSFER9, 983, 47024.0024.01OTHER NON-OPERATING INCOME20, 847, 41824.0125.00Total other income (sum of lines 6-24)30, 830, 88825.0026.00Total (line 5 plus line 25)26, 991, 64026, 90127.00LOSS ON SALE OF EQUIPMENT822, 23027.0028.00Total other expenses (sum of line 27 and subscripts)822, 23028.00			ests			0	
17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME/TRANSFER 9, 983, 470 24.00 24.01 OTHER NON-OPERATING INCOME 20, 847, 418 24.01 25.00 Total other income (sum of lines 6-24) 30, 830, 888 25.00 26.00 Total other expenses (sum of line 27 and subscripts) 822, 230 27.00						0	15.00
18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.01 OTHER INCOME/TRANSFER 9,983,470 24.00 24.01 OTHER INCOME/TRANSFER 9,983,470 24.00 25.00 Total other income (sum of lines 6-24) 30,830,888 25.00 26.00 Total other splus line 25) 26.00 26.00 27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00				han patients		0	
19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME/TRANSFER 9,983,470 24.00 24.01 OTHER NON-OPERATING INCOME 20,847,418 24.01 25.00 Total other income (sum of lines 6-24) 30,830,888 25.00 26.00 Total other splus line 25) 26,991,640 26.00 27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00						0	
20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME/TRANSFER 9,983,470 24.00 24.01 OTHER NON-OPERATING INCOME 20,847,418 24.01 25.00 Total other income (sum of lines 6-24) 30,830,888 25.00 26.00 Total other splus line 25) 26,991,640 26.00 27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00						0	
21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME/TRANSFER 9,983,470 24.00 24.01 OTHER NON-OPERATING INCOME 20,847,418 24.01 25.00 Total other income (sum of lines 6-24) 30,830,888 25.00 26.00 Total (line 5 plus line 25) 26,991,640 26,091,640 26.00 27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00	19.00					0	
22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME/TRANSFER 9,983,470 24.00 24.01 OTHER NON-OPERATING INCOME 20,847,418 24.01 25.00 Total other income (sum of lines 6-24) 30,830,888 25.00 26.00 Total (line 5 plus line 25) 26,991,640 26,991,640 26.00 27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00			and canteen			-	
23.00 Governmental appropriations 0 23.00 24.00 OTHER INCOME/TRANSFER 9,983,470 24.00 24.01 OTHER NON-OPERATING INCOME 20,847,418 24.01 25.00 Total other income (sum of lines 6-24) 30,830,888 25.00 26.00 Total (line 5 plus line 25) 26,991,640 26,991,640 26,091 27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00						0	
24.00 OTHER INCOME/TRANSFER 9,983,470 24.00 24.01 OTHER NON-OPERATING INCOME 20,847,418 24.01 25.00 Total other income (sum of lines 6-24) 30,830,888 25.00 26.00 Total (line 5 plus line 25) 26,991,640 26.00 27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00							
24. 01 0THER NON-OPERATING INCOME 20, 847, 418 24. 01 25. 00 Total other income (sum of lines 6-24) 30, 830, 888 25. 00 26. 00 Total (line 5 plus line 25) 26, 991, 640 26. 00 27. 00 LOSS ON SALE OF EQUIPMENT 822, 230 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 822, 230 28. 00							
25.00 Total other income (sum of lines 6-24) 30,830,888 25.00 26.00 Total (line 5 plus line 25) 26,991,640 26.00 27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00							
26.00 Total (line 5 plus line 25) 26,991,640 26.00 27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00							
27.00 LOSS ON SALE OF EQUIPMENT 822,230 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00							
28.00 Total other expenses (sum of line 27 and subscripts) 822,230 28.00							
29.00 Net income (or loss) for the period (line 26 minus line 28) 26,169,410 29.00							
	29.00	Net income (or loss) for the period (line 2	6 minus line 28)			26, 169, 410	29.00

ANALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider C		Period:	Worksheet O	
			Hospi ce CC		rom 01/01/2019 o 12/31/2019	Date/Time Pre 8/28/2020 1:2	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS				1		
. 00	CAP REL COSTS-BLDG & FIXT*		0	0	0 0	0	1 1.
. 00	CAP REL COSTS-MVBLE EQUIP*		0	(c	0 0	0	2.
. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	(c	0 0	0	3.
. 00	ADMI NI STRATI VE & GENERAL*	179, 937	443, 700	623, 637	-118, 738	504, 899	4.
. 00	PLANT OPERATION & MAINTENANCE*	0	113, 611	113, 611	0	113, 611	5.
. 00	LAUNDRY & LINEN SERVICE*	0	0	0	0 0	0	6.
. 00	HOUSEKEEPI NG*	0	277	277	0	277	7.
. 00	DI ETARY*	0	5, 333	5, 333	3 0	5, 333	
. 00	NURSI NG ADMI NI STRATI ON*	0	0	0	0 0	0	
0.00	ROUTINE MEDICAL SUPPLIES*	0	77, 500	77, 500	0 0	77, 500	
1.00	MEDI CAL RECORDS*	0	0	0	0	0	11.
2.00	STAFF TRANSPORTATION*	0	12, 268	12, 268	3 0	12, 268	
3.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.
4.00	PHARMACY*	0	119, 867	119, 867	0	119, 867	
5.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0		0	0	
5.00	OTHER GENERAL SERVICE*	0	0		0	0	
7.00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.
- 00	DI RECT PATI ENT CARE SERVI CE COST CENTERS		10 105	10.105	i ol	10 105	1 25
00 0.00	PHYSICIAN SERVICES**	1 742	12, 125			12, 125	
. 00	NURSE PRACTITIONER**	1, 743	6, 775	8, 518		8, 518 0	
. 00	REGI STERED NURSE**	782, 094	79, 715	861, 809		861, 809	1
9.00	LPN/LVN**	/02, 094	/ 4, / 13	001,005		0 0 0	
). 00	PHYSICAL THERAPY**	0	0			0	
. 00	OCCUPATIONAL THERAPY**	0	0			0	
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0			0	
3.00	MEDI CAL SOCI AL SERVI CES**	0	0			0	
4.00	SPIRITUAL COUNSELING**	0	0		0	0	
5.00	DI ETARY COUNSELI NG**	0	0		0	0	
5.00	COUNSELING - OTHER**	0	0		0	0	36.
7.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0		o o	0	
3. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		0	0	
9.00	PATIENT TRANSPORTATION**	0	28, 320	28, 320	0 0	28, 320	39
0. 00	I MAGI NG SERVI CES**	0	0	0	0 0	0	40
. 00	LABS & DI AGNOSTI CS**	0	0	0	0 0	0	41
2.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0 0	0	42
2.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0 0	0	42
3.00	OUTPATI ENT SERVI CES**	0	0	0	0 0	0	43
1.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0 0	0	44.
5.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0 0	0	
b. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	143, 679	3, 636	147, 315	0	147, 315	46.
	NONREI MBURSABLE COST CENTERS						
	BEREAVEMENT PROGRAM *	0	0	0	0	0	
. 00	VOLUNTEER PROGRAM *	0	0	0	0	0	
2.00	FUNDRAI SI NG*	0	0	0	0	0	
. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0	0	
. 00	PALLIATIVE CARE PROGRAM*	169, 033	12, 264	181, 297	0	181, 297	
. 00	OTHER PHYSI CI AN SERVI CES*	0	0			0	
. 00	RESIDENTIAL CARE*	0	0			0	
	ADVERTI SI NG*	0	0			0	
. 00	TELEHEALTH/TELEMONI TORI NG*	0	0			0	
00	THRIFT STORE*	0	0			0	
0. 00		0	0			0	
	OTHER NONREI MBURSABLE (SPECI FY)*	1 274 404	015 201			0 2 072 120	
U. UL	TOTAL	1, 276, 486	915, 391	2, 191, 877	-118, 738	2, 073, 139	1100

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

IALYS	Financial Systems SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	: 15-0037	Peri od:	Worksheet O	
			Hospi ce CCN:	15-1547	From 01/01/2019 To 12/31/2019	Date/Time Prepar 8/28/2020 1:27 p	
					Hospi ce I	0/20/2020 1.27	pili
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		· · · ·		
		6.00	7.00				
	GENERAL SERVICE COST CENTERS		-				
00 00	CAP REL COSTS-BLDG & FIXT*	0	0				1.0 2.0
00	CAP REL COSTS-MVBLE EQUIP* EMPLOYEE BENEFITS DEPARTMENT*	0	0				3.0
00	ADMI NI STRATI VE & GENERAL*	-149	504, 750				4.0
00	PLANT OPERATION & MAINTENANCE*	0	113, 611				5.0
00	LAUNDRY & LINEN SERVICE*	0	0				6.0
00	HOUSEKEEPI NG*	0	277				7.0
00		0	5, 333				8.0
00	NURSING ADMINISTRATION*	0	0				9. (10. (
0.00	ROUTI NE MEDI CAL SUPPLI ES* MEDI CAL RECORDS*	0	77, 500 0				10. (11. (
2.00	STAFF TRANSPORTATION*	0	12, 268				12. (
. 00	VOLUNTEER SERVICE COORDINATION*	0	0				13. (
. 00	PHARMACY*	0	119, 867				14. (
5.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0			15	15. (
. 00	OTHER GENERAL SERVICE*	0	0				16. (
. 00	PATIENT/RESIDENTIAL CARE SERVICES					1	17.(
	DI RECT PATI ENT CARE SERVI CE COST CENTERS	0	10 105			21	<u>م</u> ا
5.00 5.00	PHYSICIAN SERVICES**	0	12, 125 8, 518				25. 26.
. 00	NURSE PRACTITIONER**	0	0, 510				20. 27.
. 00	REGI STERED NURSE**	0	861, 809				28.
. 00	LPN/LVN**	0	0				29.
0. 00	PHYSI CAL THERAPY**	0	0			30	30. (
. 00	OCCUPATIONAL THERAPY**	0	0				31.
. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32.
3.00	MEDICAL SOCIAL SERVICES**	0	0				33.
1.00 5.00	SPI RI TUAL COUNSELI NG** DI ETARY COUNSELI NG**	0	0				34. 35.
5.00 5.00	COUNSELING - OTHER**	0	0				36. I
. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0				37. I
. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0				38.
. 00	PATI ENT TRANSPORTATI ON**	0	28, 320			39	39.
0. 00	I MAGI NG SERVI CES**	0	0			40	40.
. 00	LABS & DI AGNOSTI CS**	0	0				41.
. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0				42.
. 50 . 00	DRUGS CHARGED TO PATIENTS** OUTPATIENT SERVICES**	0	0				42. 43.
. 00	PALLIATIVE RADIATION THERAPY**	0	0				43. 44.
5.00	PALLIATIVE CHEMOTHERAPY**	0	0				45.
b. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	147, 315				46.
	NONREI MBURSABLE COST CENTERS		· · ·				
. 00	BEREAVEMENT PROGRAM *	0	0			60	60.
. 00	VOLUNTEER PROGRAM *	0	0				61.
2.00	FUNDRAI SI NG*	0	0				52. I
. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	101 207				63.
. 00	PALLIATIVE CARE PROGRAM* OTHER PHYSICIAN SERVICES*	0	181, 297				64. 65.
. 00	RESIDENTIAL CARE*	0	0				55. 56.
. 00	ADVERTI SI NG*	0	0				50. 57.
	TELEHEALTH/TELEMONI TORI NG*	0	o				57. 58.
	THRI FT STORE*	0	0				59.
. 00	NURSING FACILITY ROOM & BOARD*	0	0			70	70.
	OTHER NONREI MBURSABLE (SPECIFY)*	0	0				71. (
0 00	TOTAL	-149	2,072,990			100	DO.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Health Financial Systems	HANCOCK REGION				u of Form CMS-2	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE ROUTINE HOME	Provider CO		Peri od:	Worksheet 0-2	
CARE				From 01/01/2019		
		Hospi ce CCI	N: 15-1547	To 12/31/2019		
					8/28/2020 1:2	/pm
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS			-			
25.00 INPATIENT CARE-CONTRACTED						25.00
26.00 PHYSI CLAN SERVI CES	625	6, 775	7,40	0 0	7,400	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	280, 379	28, 578	308, 95	7 0	308, 957	28.00
29.00 LPN/LVN	0	0		0 0	0	29.00
		0				20 00

30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	10, 153	10, 153	0	10, 153	39.00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	0	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	51, 509	1, 303	52, 812	0	52, 812	46.00
100.00	TOTAL *	332, 513	46, 809	379, 322	0	379, 322	100.00
*	-for the encount is calling 7 to What O F and						

 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	<u>± cor. 8)</u> 7.00	-	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	1.00		
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSI CI AN SERVI CES	0	7,400		26.00
27.00	NURSE PRACTI TI ONER	0	0		27.00
28.00	REGI STERED NURSE	0	308, 957	,	28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	10, 153		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
	PALLIATIVE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	52, 812		46.00
100.00	TOTAL *	0	379, 322		100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51			

Health Financ	ial Systems	HANCOCK REGIONAL	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	IOSPI TAL-BASED HOSPI CE COSTS FOR HOSP	ICE INPATIENT	Provider CC		Period:	Worksheet 0-3	
RESPITE CARE			Hospi ce CCN		From 01/01/2019 To 12/31/2019		
						8/28/2020 1:2	7 pm
			OTHER	SUBTOTAL	Hospi ce I RECLASSI FI -	SUBTOTAL	
		SALARI ES	UTHER	(col. 1 +	CATIONS	SUBIUTAL	
				(COI. 1 + col. 2)	CATTONS		
		1.00	2.00	3.00	4,00	5.00	
DIRECT	PATIENT CARE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	ENT CARE-CONTRACTED		2, 503	2, 50	3 0	2, 503	25.00
	I AN SERVICES	231	2,000	23		231	26.00
	PRACTITIONER	0	0	20	0 0	0	27.00
	ERED NURSE	103, 565	10, 556	114, 12	1 0	114, 121	28.00
29.00 LPN/LV	N	0	0		0 0	0	29.00
30.00 PHYSIC	AL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPA	TI ONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH	/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33. 00 MEDI CA	L SOCIAL SERVICES	0	0		0 0	0	33.00
34.00 SPI RI T	UAL COUNSELING	0	0		0 0	0	34.00
35.00 DI ETAR	Y COUNSELING	0	0		0 0	0	35.00
36.00 COUNSE	LING - OTHER	0	0		0 0	0	36.00
37.00 HOSPIC	E AIDE & HOMEMAKER SERVICES	0	0		0 0	0	37.00
38.00 DURABL	E MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00 PATI EN	T TRANSPORTATI ON	0	3, 750	3, 75	0 0	3, 750	39.00
40.00 I MAGI N	G SERVICES	0	0		0 0	0	40.00
41.00 LABS &	DI AGNOSTI CS	0	0		0 0	0	41.00
42.00 MEDI CA	L SUPPLIES-NON-ROUTINE	0	0		0 0	0	42.00
42.50 DRUGS	CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 OUTPAT	I ENT SERVI CES	0	0		0 0	0	43.00
44.00 PALLIA	TIVE RADIATION THERAPY	0	О		0 0	0	44.00
45.00 PALLIA	TI VE CHEMOTHERAPY	0	О		0 0	0	45.00
	PATIENT CARE SERVICES (SPECIFY)	19, 026	481	19, 50	7 0	19, 507	46.00
100.00 T0TAL	*	122, 822	17, 290	140, 11	2 0	140, 112	100.00

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 19,026

 100.00
 TOTAL *
 122,822

 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5					
		6, 00	± col. 6) 7.00					
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00					
25.00	INPATIENT CARE-CONTRACTED	0	2, 503		25.00			
26.00	PHYSI CI AN SERVI CES	0	231		26.00			
27.00	NURSE PRACTI TI ONER	0	0		27.00			
28.00	REGI STERED NURSE	0	114, 121		28.00			
29.00	LPN/LVN	0	0		29.00			
30.00	PHYSI CAL THERAPY	0	0		30.00			
31.00	OCCUPATI ONAL THERAPY	0	0		31.00			
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00			
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00			
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00			
35.00	DI ETARY COUNSELI NG	0	0		35.00			
36.00	COUNSELING - OTHER	0	0		36.00			
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00			
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00			
39.00	PATI ENT TRANSPORTATI ON	0	3, 750		39.00			
40.00	I MAGI NG SERVI CES	0	0		40.00			
41.00	LABS & DI AGNOSTI CS	0	0		41.00			
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00			
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50			
43.00	OUTPATI ENT SERVI CES	0	0		43.00			
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00			
45.00		0	0		45.00			
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	19, 507		46.00			
100.00	TOTAL *	0	140, 112		100.00			
* Tran	* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.							

Health Financial Systems	HANCOCK REGIC				u of Form CMS-2	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS	FOR HOSPICE GENERAL	Provider C		Period: From 01/01/2019	Worksheet 0-4	
INPATIENT CARE		Hospi ce CCI		To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 + col. 2)	CATIONS		
	1.00	2.00	3,00	4,00	5.00	
DIRECT PATIENT CARE SERVICE COST C		2.00	0.00	1.00	0.00	
25.00 INPATIENT CARE-CONTRACTED		9, 622	9, 62	2 0	9, 622	25.00
26.00 PHYSICIAN SERVICES	887	0	88	7 0	887	26.00
27.00 NURSE PRACTITIONER	0	0 0		0 0	0	27.0
28.00 REGI STERED NURSE	398, 150	40, 581	438, 73	1 0	438, 731	28.0
29.00 LPN/LVN	(0 0		0 0	0	29.0
30. 00 PHYSI CAL THERAPY	(0 0		0 0	0	30.0
31. 00 OCCUPATI ONAL THERAPY	(0 0		0 0	0	31.0
32.00 SPEECH/LANGUAGE PATHOLOGY	(0 0		0 0	0	32.0
33.00 MEDICAL SOCIAL SERVICES	0	0 0		0 0	0	33.0
34. 00 SPI RI TUAL COUNSELI NG	0	0 0		0 0	0	34.0
35.00 DIETARY COUNSELING	0	0 0		0 0	0	35.0
36.00 COUNSELING - OTHER	0	0 0		0 0	0	36.0
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	(0 0		0 0	0	37.0
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN		0 0		0 0	0	38.0
39. 00 PATIENT TRANSPORTATION		14, 417	14, 41	7 0	14, 417	39.0
I MAGING SERVICES	0	0 0		0 0	0	40.0
1.00 LABS & DIAGNOSTICS	0	0 0		0 0	0	41.0
12.00 MEDI CAL SUPPLI ES-NON-ROUTI NE		0 0		0 0	0	42.0
2.50 DRUGS CHARGED TO PATIENTS	0	0 0		0 0	0	42.5
3. 00 OUTPATIENT SERVICES	(0 0		0 0	0	43.0
4.00 PALLIATIVE RADIATION THERAPY	(0 0		0 0	0	44.0
15.00 PALLIATIVE CHEMOTHERAPY	(0 0		0 0	0	
16.00 OTHER PATIENT CARE SERVICES (SPECI					74, 996	
100.00 TOTAL *	472, 181	66, 472	538, 65	3 0	538, 653	100. (

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 73, 144

 100.00
 TOTAL *
 472, 181

 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.
 472, 181

		ADJUSTMENTS	TOTAL (col. 5					
		6.00	± col. 6) 7.00	-				
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	1.00					
25.00	I NPATI ENT CARE-CONTRACTED	0	9, 622		25.00			
26.00	PHYSI CI AN SERVI CES	0	887		26.00			
27.00	NURSE PRACTITIONER	0	0		27.00			
28.00	REGI STERED NURSE	0	438, 731		28.00			
29.00	LPN/LVN	0	0		29.00			
30.00	PHYSI CAL THERAPY	0	0		30.00			
31.00	OCCUPATIONAL THERAPY	0	0		31.00			
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00			
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00			
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00			
35.00	DI ETARY COUNSELI NG	0	0		35.00			
36.00	COUNSELING - OTHER	0	0		36.00			
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00			
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00			
39.00	PATI ENT TRANSPORTATI ON	0	14, 417		39.00			
40.00	I MAGI NG SERVI CES	0	0		40.00			
41.00	LABS & DI AGNOSTI CS	0	0		41.00			
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00			
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50			
43.00	OUTPATI ENT SERVI CES	0	0		43.00			
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00			
45.00		0	0		45.00			
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	74, 996		46.00			
100.00	TOTAL *	0	538, 653		100.00			
* Tran	* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.							

Heal th	Financial Systems HANCOCK REGIONAL	L HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0037	Period:	Worksheet 0-5	5
EXPENS	SES FOR ALLOCATION	Hospi ce CC		From 01/01/2019 To 12/31/2019		nared
		nospi ce ce	N. 13 1347	10 12/31/2017	8/28/2020 1:2	
				Hospi ce I		
	Descriptions		HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
				EXPENSES FROM		
			Instructions) WKST B PART I	2)	
				(see		
			1.00	i nstructi ons) 2.00	3.00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	3.00	
1.00	CAP REL COSTS-BLDG & FIXT			0 347, 687	347, 687	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 124, 233	124, 233	3.00
4.00	ADMI NI STRATI VE & GENERAL		504, 75	0 554, 457	1, 059, 207	4.00
5.00	PLANT OPERATION & MAINTENANCE		113, 61	1 535, 436	649, 047	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	-	
7.00	HOUSEKEEPING		27		=	
8.00	DI ETARY		5, 33			
9.00	NURSING ADMINISTRATION			0 118, 363		
10.00	ROUTINE MEDICAL SUPPLIES		77, 50			
11.00	MEDI CAL RECORDS			0 0	-	
12.00	STAFF TRANSPORTATION		12, 26	8	12, 268	1
13.00	VOLUNTEER SERVICE COORDINATION		110.0/	0	0	
14.00			119, 86			
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0 0	0	
16.00 17.00	OTHER GENERAL SERVICE PATI ENT/RESI DENTI AL CARE SERVICES			0 0		
17.00	LEVEL OF CARE			0	0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		379, 32		379, 322	
52.00	HOSPI CE I NPATI ENT RESPI TE CARE		140, 11		140, 112	1
53.00	HOSPI CE GENERAL I NPATI ENT CARE		538, 65		538, 653	
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	
64.00	PALLIATIVE CARE PROGRAM		181, 29	7	181, 297	
65.00	OTHER PHYSI CI AN SERVI CES			0	0	
66.00	RESIDENTIAL CARE			0	0	
67.00	ADVERTI SI NG			U	0	
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	
69.00	THRIFT STORE			0	0	
70.00 71.00	NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY)			0		
	NEGATIVE COST CENTER			0		
	TOTAL		2, 072, 99	0 1, 909, 532		
100.00			1 2,012,77	1, 707, 332	I 5, 702, JZZ	1.00.00

Heal th	n Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE		Provider C Hospice CC		Period: From 01/01/2019 To 12/31/2019	Worksheet 0-6 Part I	pared:
					Hospi ce I	0/20/2020 1.2	<u>/ piii</u>
	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBL EQUI P		SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS	1		-		T	
1.00	CAP REL COSTS-BLDG & FIXT	347, 687	347, 687				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	124, 233	0		0 124, 233		3.00
4.00	ADMI NI STRATI VE & GENERAL	1, 059, 207	0		0 0	1,007,207	•
5.00	PLANT OPERATION & MAINTENANCE	649, 047	0		0 0	017,017	•
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0 0	
7.00	HOUSEKEEPING	277	0		0 0	277	
8.00	DI ETARY	228, 531	0		0 0	228, 531	
9.00	NURSI NG ADMI NI STRATI ON	118, 363	0		0 0	118, 363	
10.00	ROUTINE MEDICAL SUPPLIES	83, 658	0		0 0	83, 658	
11.00	MEDI CAL RECORDS	0	0		0 0	0	
12.00	STAFF TRANSPORTATION	12, 268	0		0 0	12, 268	
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0 0	
14.00	PHARMACY	119, 867	0		0 0	119, 867	•
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	0		0 0	0	
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		0	1	0	0	17.00
F0 00	LEVEL OF CARE			1			
50.00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE	0			(-	
51.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	379, 322	0		44, 537		
52.00 53.00	HOSPICE INPATIENT RESPICE CARE	140, 112 538, 653	347, 687		0 16, 451 0 63, 245		
55.00	NONREIMBURSABLE COST CENTERS	536, 653	347,007		0 03, 243	949, 585	53.00
60,00	BEREAVEMENT PROGRAM	0	0	1	0 (0 10	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0		
62.00	FUNDRAI SI NG	0	0				
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0				
64.00	PALLIATI VE CARE PROGRAM	181, 297	0			181, 297	
65.00	OTHER PHYSI CI AN SERVICES	01,2,7	0		0 0	0 0	
66.00	RESI DENTI AL CARE	0	0		0 0		
67.00	ADVERTI SI NG	0	0		0 0		
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0		
69.00	THRI FT_STORE	0	n		0		
70.00	NURSING FACILITY ROOM & BOARD	0	J J				
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	ol o	
99.00		0	0		0 0		99.00
	TOTAL	3, 982, 522	347,687		0 124, 233	3, 982, 522	
				•		1	

Heal th	n Financial Systems	HANCOCK REGIO	NAL HOSPITAL			In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-0037 N: 15-1547		eriod: rom 01/01/2019 o 12/31/2019	Worksheet 0-6 Part I Date/Time Pre 8/28/2020 1:2	pared:
						Hospi ce I		
	Descriptions	ADMI NI STRATI V E & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY &		HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00		7.00	8.00	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT							1 1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINI STRATI VE & GENERAL	1, 059, 207						4.00
5.00	PLANT OPERATION & MAINTENANCE	235, 170	884, 217					5.00
6.00	LAUNDRY & LINEN SERVICE	0	001,217		0			6.00
7.00	HOUSEKEEPING	100	0		0	377		7.00
8.00	DI ETARY	82, 804				0	311, 335	
9.00	NURSI NG ADMI NI STRATI ON	42, 887	0			0	511, 555	9.00
10.00	ROUTINE MEDICAL SUPPLIES	30, 312	0			0		10.00
11.00	MEDICAL SUPPLIES	30, 312	0			0		11.00
		•	0			0		
12.00	STAFF TRANSPORTATION	4, 445	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0			0		13.00
14.00		43, 432	0			0		14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	0			0		15.00
16.00		0	0			0		16.00
17.00		0	0			0		17.00
50.00	LEVEL OF CARE			1				50.00
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00		153, 577				100	404 574	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	56, 728			0	188	131, 576	•
53.00		344, 062	884, 217		0	189	179, 759	53.00
	NONREI MBURSABLE COST CENTERS			1				1 / 2 . 2 .
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00		0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00		65, 690	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00		0	0		0	0	0	00.00
67.00	ADVERTI SI NG	0	0			0		67.00
68.00		0	0			0		68.00
69.00	THRI FT STORE	0	0			0		69.00
70.00								70.00
71.00	. ,	0	0		0	0	0	
99.00		0	0		0	0	0	99.00
100.00	D TOTAL	1, 059, 207	884, 217		0	377	311, 335	100.00

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of For	
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Hospice CCN: 15-0037 Hospice CCN: 15-1547 From 01/01/2019 Part I Hospice CCN: 15-1547 To 12/31/2019 Date/Ti	
Hospi ce 1	<u>0 1.27 piir</u>
Descriptions NURSING ROUTINE MEDICAL STAFF VOLUN ADMINISTRATIO MEDICAL RECORDS TRANSPORTATIO SERVI	E
N SUPPLIES N COORDIN	
9.00 10.00 11.00 12.00 13.0)
GENERAL SERVICE COST CENTERS	1 00
1. 00 CAP REL COSTS-BLDG & FIXT	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	2.00
3. 00 EMPLOYEE BENEFITS DEPARTMENT	3.00
4. 00 ADMI NI STRATI VE & GENERAL	4.00
5. 00 PLANT OPERATION & MAINTENANCE	5.00
6. 00 LAUNDRY & LI NEN SERVI CE	6.00
7. 00 HOUSEKEEPING 8. 00 DI ETARY	7.00 8.00
	9.00
	10.00
10. 00 ROUTINE MEDICAL SUPPLIES 0 113, 970 11. 00 MEDICAL RECORDS 0 0	11.00
12. 00 STAFF TRANSPORTATION 0 16, 713	12.00
13. 00 VOLUNTEER SERVICE COORDINATION 0 0	0 13.00
14. 00 PHARMACY 0 0	0 13.00
15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0	0 15.00
16. 00 OTHER GENERAL SERVICE 0 0	0 16.00
17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES	17.00
LEVEL OF CARE	
50. 00 HOSPICE CONTINUOUS HOME CARE 0 0 0 0	0 50.00
51.00 HOSPICE ROUTINE HOME CARE 145, 436 102, 792 0 5, 571	0 51.00
52.00 HOSPICE INPATIENT RESPITE CARE 6, 683 4, 724 0 5, 571	0 52.00
53. 00 HOSPICE GENERAL INPATIENT CARE 9, 131 6, 454 0 5, 571	0 53.00
NONREI MBURSABLE COST CENTERS	
60. 00 BEREAVEMENT PROGRAM 0 0	0 60.00
61.00 VOLUNTEER PROGRAM 0 0	0 61.00
62. 00 FUNDRAI SI NG 0 0	0 62.00
63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0	0 63.00
64. 00 PALLIATIVE CARE PROGRAM 0 0	0 64.00
65. 00 OTHER PHYSI CI AN SERVI CES 0 0	0 65.00
66. 00 RESIDENTIAL CARE 0 0	0 66.00
67. 00 ADVERTISING 0 0	0 67.00
68. 00 TELEHEALTH/TELEMONI TORI NG 0 0	0 68.00
69. 00 THRIFT STORE 0 0	0 69.00
70.00 NURSING FACILITY ROOM & BOARD	70.00
71.00 OTHER NONREI MBURSABLE (SPECI FY) 0 0	0 71.00
99. 00 NEGATI VE COST CENTER 0 0 0 0	0 99.00
100. 00 T0TAL 161, 250 113, 970 0 16, 713	0 100. 00

Heal th	Financial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVI CE COSTS	Provider C Hospice CC	CN: 15-0037 N: 15-1547	Period: From 01/01/2019 To 12/31/2019	Worksheet 0-6 Part I Date/Time Pre 8/28/2020 1:2	epared:
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI V E SERVI CES	OTHER GENERA SERVI CE	L PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4,00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	163, 299					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	00,277	0				15.00
16.00		0	0		0		16.00
17.00		Ŭ			0		17.00
17.00	LEVEL OF CARE			1			17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	54, 433	0		0	885, 668	
52.00	HOSPICE INPATIENT RESPITE CARE	54, 433	0		0 0	416, 466	
53.00		54, 433	0		0 0	2, 433, 401	
00.00	NONREI MBURSABLE COST CENTERS	01,100			0	2/ 100/ 101	
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	
62.00	FUNDRAI SI NG	0			0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	
64.00	PALLIATIVE CARE PROGRAM	0			0	246, 987	
65.00	OTHER PHYSICIAN SERVICES	0			0	210,707	
66,00	RESI DENTI AL CARE	0	0		0 0	0	
67.00	ADVERTI SI NG	0	0		0	0	
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	1
69.00	THRI FT STORE	0			õ	0	
70.00	NURSING FACILITY ROOM & BOARD				Ŭ	0	
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	0	
99.00	· · ·	0	0		0 0	0	
	TOTAL	163, 299	0		0 0	3, 982, 522	
	-1	1	Ū	1	-1 0	0, 702, 022	1.50.00

	Financial Systems	HANCOCK REGION		NI. 15 0027		u of Form CMS-	
	LOCATION - HOSPITAL-BASED HOSPICE GENER	AL SERVICE CUSIS	Provider C	JN: 15-0037	Period: From 01/01/2019	Worksheet 0-6 Part II)
STATIST			Hospi ce CCI	N: 15-1547	To 12/31/2019	Date/Time Pre	
					lloopi.co.l	8/28/2020 1:2	27 pm
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	Hospi ce I RECONCI LI ATI O		
	cost center bescriptions	& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT	i v	(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
			111202)	SALARI ES)		00010)	
		1.00	2.00	3.00	4A	4.00	
C	GENERAL SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FIXT	317					1.0
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.0
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	927, 5 ⁻	16		3.0
4.00	ADMI NI STRATI VE & GENERAL	0	0		0 -1, 059, 207	2, 923, 315	4.0
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	649, 047	5.0
5.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.0
7.00	HOUSEKEEPING	0	0		0 0	277	7.0
8.00	DI ETARY	0	0		0 0	228, 531	8.0
9.00	NURSI NG ADMI NI STRATI ON	0	0		0 0	118, 363	9.0
0.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	83, 658	10.0
1.00	MEDI CAL RECORDS	0	0		0 0	0	11. (
2.00	STAFF TRANSPORTATI ON	0	0		0 0	12, 268	12.0
3.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.0
14.00	PHARMACY	0	0		0 0	119, 867	14.0
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.0
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.0
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.0
-	_EVEL OF CARE						
	HOSPICE CONTINUOUS HOME CARE				0 0	0	
	HOSPICE ROUTINE HOME CARE			332, 51		423, 859	
	HOSPICE INPATIENT RESPITE CARE	0	0			156, 563	
-	HOSPICE GENERAL INPATIENT CARE	317	0	472, 18	31 0	949, 585	53.0
	VONREI MBURSABLE COST CENTERS						1
	BEREAVEMENT PROGRAM	0	0		0 0	0	
	VOLUNTEER PROGRAM	0	0		0 0	0	
	FUNDRALSING	0	0		0 0	0	
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	
	PALLIATIVE CARE PROGRAM	0	0		0 0	181, 297	
	OTHER PHYSICIAN SERVICES	0	0		0 0	0	
	RESIDENTIAL CARE	0	0		0 0	0	
	ADVERTI SI NG	0	0		0 0	0	
	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	
	THRIFT STORE	0	0		0 0	0	
	NURSING FACILITY ROOM & BOARD		~		0	~	70.
	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	0	
	NEGATIVE COST CENTER	nt 1) 047 (07	~	104 0	22	1 050 007	99.
	COST TO BE ALLOCATED (per Wkst. 0-6, Pa		0	124, 23		1, 059, 207	
IUT. UU	UNIT COST MULTIPLIER	1, 096. 804416	0. 000000	0. 13394	+∠	0. 362331	JIUT.

Heal th Fi	nancial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	OCATION - HOSPITAL-BASED HOSPICE GEN CAL BASIS	IERAL SERVI CE COSTS	Provider C Hospice CC		Period: From 01/01/2019 To 12/31/2019		pared:
					Hospi ce I	0/20/2020 1.2	
	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET	DI ETARY	NURSI NG ADMI NI STRATI O N (DI RECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GE	NERAL SERVICE COST CENTERS	0.00	2.00		2,00		
1.00 CA 2.00 CA 3.00 EM 4.00 AE 5.00 PL 6.00 LA 7.00 HC 8.00 DI 9.00 NL 10.00 RC 11.00 ME 12.00 ST 13.00 VC 14.00 PH 15.00 PH 16.00 OT	AP REL COSTS-BLOG & FIXT AP REL COSTS-BLOG & FIXT AP REL COSTS-MVBLE EQUIP MPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL ANT OPERATION & MAINTENANCE AUNDRY & LINEN SERVICE DUSEKEEPING ETARY JRSING ADMINISTRATION DUTINE MEDICAL SUPPLIES EDICAL RECORDS TAFF TRANSPORTATION DULINEER SERVICE COORDINATION HARMACY HYSICIAN ADMINISTRATIVE SERVICES THER GENERAL SERVICE ATIENT/RESIDENTIAL CARE SERVICES	317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	10	00 0 336 0 0 0 0 0 0 0 0 0 0 0	3, 426 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
	VEL OF CARE			1			
51.00 HC 52.00 HC 53.00 HC	DSPICE CONTINUOUS HOME CARE DSPICE ROUTINE HOME CARE DSPICE INPATIENT RESPITE CARE DSPICE GENERAL INPATIENT CARE NREIMBURSABLE COST CENTERS	0 317	0		i0 142 i0 194	0 3, 090 142 194	50.00 51.00 52.00 53.00
60.00 BE 61.00 VC 62.00 FL 63.00 HC 64.00 PA 65.00 01 66.00 RE 67.00 AL 68.00 TE 69.00 TH 70.00 NL 71.00 OI 99.00 NE 100.00 CO	REAVEMENT PROGRAM JUNTEER PROGRAM JUNTEER PROGRAM JNDRAISING DSPICE/PALLIATIVE MEDICINE FELLOWS ALLIATIVE CARE PROGRAM THER PHYSICIAN SERVICES ESIDENTIAL CARE DVERTISING ELEHEALTH/TELEMONITORING HRIFT STORE JRSING FACILITY ROOM & BOARD THER NONREIMBURSABLE (SPECIFY) EGATIVE COST CENTER DST TO BE ALLOCATED (per Wkst. 0-6, 1) NIT COST MULTIPLIER	Part I) 884,217 2,789.328076	0 0 0 0.000000	37			

Heal th	Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0037	Peri od:	Worksheet 0-6	วั
STATI S	TI CAL BASI S		Hospi ce CC	N: 15-1547	From 01/01/2019 To 12/31/2019		
					Hospice I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI		(CHARGES)	
		SUPPLI ES	(PATI ENT	N (III L EAGE)	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS) 10.00	11.00	12.00	SERVICE) 13.00	14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES	3, 426					10.00
11.00	MEDI CAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION				99		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 0		13.00
14.00	PHARMACY				0 0	99	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	0	15.00
16.00	OTHER GENERAL SERVICE				0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE			1	-		
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0		
51.00	HOSPICE ROUTINE HOME CARE	3, 090	0		33 0		
52.00	HOSPICE INPATIENT RESPITE CARE	142	0		33 0		
53.00	HOSPICE GENERAL INPATIENT CARE	194	0		33 0	33	53.00
(0.00	NONREI MBURSABLE COST CENTERS						1 (0.00
60.00	BEREAVEMENT PROGRAM				0 0		
61.00	VOLUNTEER PROGRAM				0 0	-	
62.00 63.00	FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0		
63.00 64.00	PALLIATIVE CARE PROGRAM				0 0		
65.00	OTHER PHYSICIAN SERVICES				0 0		
66.00	RESIDENTIAL CARE					-	
67.00	ADVERTI SI NG					0	
68.00	TELEHEALTH/TELEMONI TORI NG					0	
69.00	THRI FT STORE				0 0	0	
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)				0 0	l o	1
	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	113, 970	0	16, 7	13 0	163, 299	
	UNIT COST MULTIPLIER	33. 266200	0. 000000				

Heal th	Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lieu	u of Form CMS	-2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provider C	CN: 15-0037	Period:	Worksheet 0-	6
STATI S	TI CAL BASI S		Hospi ce CC	N: 15-1547	From 01/01/2019 To 12/31/2019	Part II Date/Time Pr	epared:
						8/28/2020 1:	
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATIENT/			
		ADMI NI STRATI V E SERVI CES	SERVI CE (SPECI FY	RESIDENTIAL			
		(PATI ENT	BASIS)	(IN-FACILIT			
		DAYS)	Brist 6)	DAYS)	•		
		15.00	16.00	17.00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00 8.00	HOUSEKEEPI NG DI ETARY						7.00 8.00
8.00 9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15.00
16.00	OTHER GENERAL SERVICE		0				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE	-	-	1			
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 52.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	0	-		0		51.00 52.00
52.00 53.00	HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	0			0		52.00
55.00	NONREI MBURSABLE COST CENTERS	0		′	0		- 55.00
60,00	BEREAVEMENT PROGRAM		C				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00	FUNDRAI SI NG		0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00	OTHER PHYSICIAN SERVICES		0				65.00
66.00	RESI DENTI AL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRIFT STORE		0)			69.00
70.00 71.00	NURSING FACILITY ROOM & BOARD				0		70.00 71.00
71.00 99.00	OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER	0			U		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0			0		100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	oo		101.00
					1		

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE Provider CON: 15-0037 Hospice CCN: 15-1547 Period: From U/01/2019 Workset 0-7 bat/Time Prepare For 12/31/2019 Cost Center Descriptions From Wkst. C, Part 1, Col. 9 in e Cost to 0 HCHC HRHC HIRC 0 1.00 2.00 3.00 4.00 0 1.00 2.00 3.00 4.00 0 1.00 2.00 3.00 4.00 0 1.00 2.00 3.00 4.00 0 0 0.361690 0 0 0 1.00 SPEECH PATHOLOCY 66.00 0.3226308 0 0 3.00 DURABLE MEDICAL EQUIP RENTED 66.00 0.3236308 0 0 0 0.00 DURABLE MEDICAL EQUIP RENTED 66.00 0.326308 0 0 0 0 1.00 DURABLE MEDICAL EQUIP RENTED 66.00 0.326308 0 0 0 0 0 0 0 0 0 0 0 0 <th>Heal th</th> <th>Financial Systems</th> <th>HANCOCK REGION</th> <th>VAL HOSPI TAL</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems	HANCOCK REGION	VAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Line Hospice CCN: 15-1547 To 12/3/2019 Date/Time Preparate P/28/2020 1:27 p Date/Time Preparate P/28/2020 1:27 p Hospice I Cost Center Descriptions From Wkst. C Part I, Col. Charges by LOC (from Provider Records) HIRC HIRC </td <td></td> <td></td> <td>VICE COSTS BY</td> <td>Provider C</td> <td>CN: 15-0037</td> <td></td> <td>Worksheet 0-7</td> <td></td>			VICE COSTS BY	Provider C	CN: 15-0037		Worksheet 0-7	
Cost Center Descriptions From Wkst. C, Part I, Col. 9 line Cost Cost Cost Co Charges by LOC (from Provider Records) ANCILLARY SERVICE COST CENTERS 0 1.00 2.00 3.00 4.00 0 0 1.00 2.00 3.00 4.00 0 0 0.433775 0 0 0 0 1.00 PHYSICAL THERAPY 66.00 0.4343775 0 0 0 0 0 2.00 3.00 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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	LEVEL	UF CARE		Hospi ce CC	N: 15-1547		Date/Time Pre 8/28/2020 1:2	pared: 7 pm
Cost Center Descriptions From Wkst. C, Part I, Col. 9 Line Cost to Charge Ratio HCHC HRHC HIRC 0 1.00 2.00 3.00 4.00 1.00 PHYSICAL THERAPY 66.00 0.443775 0 0 0 2.00 0CCUPATIONAL THERAPY 67.00 0.361690 0 0 0 2 3.01 OCCUPATIONAL THERAPY 67.00 0.361690 0 0 0 2 3.01 OCCUPATIONAL THERAPY 67.00 0.382224 0 0 0 0 3 3.01 DCCUPATIONAL HEALTH 68.01 0.00236308 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 0 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>·</td></td<>								·
ANCI LLARY SERVICE COST CENTERS Part I, Col. 9 line Charge Ratio Anci LLARY Service Cost centers 1.00 PHYSI CAL THERAPY 66.00 0.443775 0 0 0 1 2.00 OCCUPATIONAL THERAPY 66.00 0.443775 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 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 0 0 0 0 0					Charges by	LOC (from Provi	der Records)	
Image: Note of the second se		Cost Center Descriptions			НСНС	HRHC	HI RC	
ANCILLARY SERVICE COST CENTERS Image: Control of the con			9 line					
1.00 PHYSICAL THERAPY 66.00 0.443775 0 0 0 0 2.00 OCCUPATIONAL THERAPY 67.00 0.361690 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	1.00	2.00	3.00	4.00	
2.00 OCCUPATIONAL THERAPY 67.00 0.361690 0 0 0 2 3.00 SPEECH PATHOLOGY 68.00 0.382224 0 0 0 3 3.01 OCUPATIONAL HEALTH 68.01 0.000000 0 0 3 4.00 DRUGS CHARGED TO PATIENTS 73.00 0.236308 0 0 0 4 5.00 DURABLE MEDICAL EQUIP-RENTED 96.00 0 1.35572 0 0 0 6 6.00 LABORATORY 60.00 0.35572 0 0 0 7 7.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 71.00 0.596094 0 0 0 7 8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0.440775				1
3.00 SPEECH PATHOLOGY 68.00 0.382224 0 0 0 3 3.01 OCCUPATIONAL HEALTH 68.01 0.000000 0 0 0 3 4.00 DRUGS CHARGED TO PATIENTS 73.00 0.236308 0 0 0 3 5.00 DURABLE MEDI CAL EQUI P-RENTED 96.00 0 135572 0 0 0 6 6.00 LABORATORY 60.00 0.135572 0 0 0 7 7.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 71.00 0.596094 0 0 0 7 8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00 0 0 0 0 0 7 9.00 RADIOLOGY-THERAPEUTIC 55.00 0 0 0 0 0 0 0 10 1 11.00 Total s (sum of lines 1-11) Total s (sum of lines 1-11) Total s (sum of lines 1-11) 11 x col. 2) x col. 3) x col. 4) x col. 5) x col. 5) 1.00 PHYSI CAL THERAPY 0 0						-	-	
3.01 OCCUPATIONAL HEALTH 68.01 0.000000 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 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 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								
4.00 DRUGS CHARGED TO PATIENTS 73.00 0.236308 0 0 0 4 5.00 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0.35572 0 0 0 6 7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.596094 0 0 0 6 8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00 0 0 0 0 0 6 9.00 RADIOLOGY-THERAPEUTIC 55.00 0 0.000000 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 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<						-	-	
5.00 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 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 0 0 0 0 0 0 0 0 0 0 0 0						-		•
6.00 LABORATORY 60.00 0.135572 0 0 0 6 7.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 71.00 0.596094 0 0 0 7 8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00 0 55.00 0 0 6 6 9.00 RADI OLOGY-THERAPEUTIC 55.00 0 0 0 0 10 0 6.00 0.000000 0 0 0 10 0 10 0 6.00 0.000000 0 0 0 10 10 0 6.00 0.000000 0 0 0 10 10 10 0 6.00 0 0 0 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 <t< td=""><td></td><td></td><td></td><td>0. 230306</td><td></td><td>0 0</td><td>0</td><td>5.00</td></t<>				0. 230306		0 0	0	5.00
7.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 71.00 0.596094 0 0 0 76 8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00 55.00 0 0 0 0 6 9.00 RADI OLOGY-THERAPEUTIC 55.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 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 <td< td=""><td></td><td></td><td></td><td>0 125572</td><td></td><td>0</td><td>0</td><td>•</td></td<>				0 125572		0	0	•
8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00 55.00 - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - <						-	-	
9.00 RADI OLOGY-THERAPEUTI C 55.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 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 0 0 0 0 0 0 0 0 0 0 0 0 <				0. 590094		0 0	0	8.00
10.00 CARDI AC 76.00 0.000000 0 0 0 10.01 10.01 CARDI OPULMONARY 76.01 0.676044 0 0 0 10 11.00 Totals (sum of lines 1-11)								9,00
10.01 CARDI OPULMONARY 76.01 0.676044 0 0 0 11 11.00 Totals (sum of lines 1-11) Charges by LOC (from Provider Records) Shared Service Costs by LOC 11 Cost Center Descriptions HGI P HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGI P (col. 1 K col. 2) x col. 3) x col. 4) x col. 5) 5.00 6.00 7.00 8.00 9.00 ANCI LLARY SERVICE COST CENTERS 5.00 0 0 0 0 0 2 1.00 PHYSI CAL THERAPY 0 0 0 0 0 2 3 2 3 2 3 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3				0 00000		0	0	
11.00 Totals (sum of lines 1-11) Charges by LOC (from Provider Records) Shared Service Costs by LOC Costs by LOC Interface						-	-	
ANCI LLARY SERVICE COST CENTERS Cost Center Descriptions Charges by LOC (from Provider Records) HCHC (col. 1 x col. 2) HRHC (col. 1 x col. 3) HIRC (col. 1 x col. 4) HGI P (col. 1 x col. 5) ANCI LLARY SERVICE COST CENTERS 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 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 0 0 0 0 0 0 0 0 0 0 0			70.01	0. 070044		0 0	0	11.00
LOC (from Provider Records) LOC (from Provider Records) HRHC (col. 1 HIRC (col. 1 HGIP (col. 1 K col. 2) X col. 3) X col. 4) X col. 5) X col. 5) ANCI LLARY SERVICE COST CENTERS 5.00 6.00 7.00 8.00 9.00 1.00 PHYSI CAL THERAPY 0 0 0 0 0 0 2.00 2.00 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 2.00 3.00 SPEECH PATHOLOGY 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00		Charges by		Shared Servi	ce Costs by LOC		11.00
Provider Records Provider Records Image: Cost Center Descriptions HGIP HCHC (col. 1 x col. 2) HIRC (col. 1 x col. 3) HGIP (col. 1 x col. 4) HGIP (col. 1 x col. 5) HGIP (col. 1 x col. 4) HGIP (col. 1 x col. 5) HGIP (col. 1 x col. 4) HGIP (col. 1 x col. 4) HGIP (col. 1 x col. 4) HGIP (col. 1 x col. 5) HGIP (col. 1 x col. 4) HGIP (col. 1 x col. 4) HGIP (col. 1 x col. 5) HGIP (col. 1 x col. 4) HGIP					Sharea Servi	CC 00313 by 200		
Records Records Image: Normal State Sta								
Cost Center Descriptions HGI P HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGI P (col. 1 x col. 2) x col. 3) x col. 4) x col. 5) 5.00 6.00 7.00 8.00 9.00 ANCI LLARY SERVICE COST CENTERS 1.00 PHYSI CAL THERAPY 0 0 0 0 0 2.00 OCCUPATI ONAL THERAPY 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 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								
S. 00 6. 00 7. 00 8. 00 9. 00 ANCI LLARY SERVICE COST CENTERS		Cost Center Descriptions		HCHC (col. 1	HRHC (col.	1 HIRC (col. 1	HGIP (col. 1	
ANCI LLARY SERVICE COST CENTERS 1.00 PHYSI CAL THERAPY 0 0 0 0 1 2.00 OCCUPATI ONAL THERAPY 0 0 0 0 0 2 3.00 SPEECH PATHOLOGY 0 0 0 0 0 0 2 3.01 OCCUPATI ONAL HEALTH 0 0 0 0 0 3 3 0 0 0 0 0 3 3 0 0 0 0 0 3 3 0 0 0 0 0 3 3 0 0 0 0 0 3 3 0 0 0 0 0 3 3 0 0 0 0 0 3 3 0 0 0 0 0 3 3 0 0 0 0 0 0 4 3 3 0 0 0 0 4		·						
1.00 PHYSI CAL THERAPY 0 0 0 0 1 2.00 OCCUPATI ONAL THERAPY 0 0 0 0 2 3.00 SPEECH PATHOLOGY 0 0 0 0 0 2 3.01 OCCUPATI ONAL HEALTH 0 0 0 0 0 3 4.00 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 4 5.00 DURABLE MEDI CAL EQUI P-RENTED			5.00	6.00	7.00	8.00	9.00	
2.00OCCUPATIONAL THERAPY000023.00SPEECH PATHOLOGY0000033.01OCCUPATIONAL HEALTH0000034.00DRUGS CHARGED TO PATIENTS0000045.00DURABLE MEDICAL EQUIP-RENTED000006			1					
3.00SPEECH PATHOLOGY000033.01OCCUPATI ONAL HEALTH0000034.00DRUGS CHARGED TO PATI ENTS0000045.00DURABLE MEDI CAL EQUI P-RENTED0000066.00LABORATORY000006				-				
3. 01OCCUPATIONAL HEALTH000034. 00DRUGS CHARGED TO PATIENTS0000045. 00DURABLE MEDI CAL EQUIP-RENTED0000066. 00LABORATORY000006			0	0		-		
4. 00DRUGS CHARGED TO PATIENTS000045. 00DURABLE MEDI CAL EQUI P-RENTED0000066. 00LABORATORY0000006			0	0		°	-	
5.00 DURABLE MEDI CAL EQUI P-RENTED 5.00 LABORATORY 0 0 0 0 0			0	0		°	-	
6.00 LABORATORY 0 0 0 0 6			0	0		0 0	0	
								5.00
			0	0		-	-	
	7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	1 1.00
								8.00
								9.00
			0	-			-	
			0	, o			-	
11.00 Totals (sum of lines 1-11) 0 0 0 11	11.00	Totals (sum of lines 1-11)		0		0 0	0	11.00

CALCULA	TION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider C	CN: 15-0037	Peri od:	Worksheet 0-8	
		Hospi ce CCI	N: 15-1547	From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
				Hospi ce I		•
			TITLE XVII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2.00	3.00	
	IOSPI CE CONTI NUOUS HOME CARE		r			
	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			0	1.0
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.0
	Total average cost per diem (line 1 divided by line 2)				0.00	3.0
	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	e 10)		0 0		4.0
	Program cost (line 3 times line 4) HOSPICE ROUTINE HOME CARE			0 0		5.
	HOSPICE ROUTINE HOME CARE Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7 apl 7			885, 668	6.0
	line 11)	7, COL. 7,			880, 008	0.
	Total unduplicated days (Wkst. S-9, col. 4, line 11)				3, 090	7.
	Total average cost per diem (line 6 divided by line 7)				286.62	8.
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	3.0	90	200. 02	9.
	Program cost (line 8 times line 9)	ne rry	885,6			10.
	IOSPICE INPATIENT RESPITE CARE		000,0			1 10.
	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7. col. 8.			416, 466	1 11.
	line 11)	, ,				
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				142	12.
	Total average cost per diem (line 11 divided by line 12)				2, 932. 86	13.
4.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)	1	42 0		14.
	Program cost (line 13 times line 14)		416, 4	66 0		15.
	HOSPI CE GENERAL I NPATI ENT CARE					
	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7, col. 9,			2, 433, 401	16.
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17.
	Total average cost per diem (line 16 divided by line 17)	40)			12, 543. 30	
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		94 0		19.
	Program cost (line 18 times line 19) TOTAL HOSPICE CARE		2, 433, 4	00 0		20.
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 735, 535	21
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				3, 735, 535	
	Average cost per diem (line 21 divided by line 22)				1, 090. 35	
J. 00	Average cost per drem (rifle zi drvided by rifle zz)		I	I I	1,070.33	ZJ.

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0037 Period: Worksheet L From 01/01/2019 Parts I-III To 12/31/2019 Date/Time Pro	epared
	8/28/2020 1:	
	Title XVIII Hospital PPS	
	1.00	_
PART I - FULLY PROSPECTIVE METHOD		
CAPITAL FEDERAL AMOUNT		
00 Capital DRG other than outlier	674, 815	5 1.0
01 Model 4 BPCI Capital DRG other than outlier		0 1.0
00 Capital DRG outlier payments	4, 913	3 2.0
01 Model 4 BPCI Capital DRG outlier payments	(0 2.
00 Total inpatient days divided by number of days i		
00 Number of interns & residents (see instructions)		
00 Indirect medical education percentage (see inst	ructions) 0.00	0 5.
1.01) (see instructions)	/line 5 by the sum of lines 1 and 1.01, columns 1 and (0 6.
30) (see instructions)	licare Part A patient days (Worksheet E, part A line 0.00	
00 Percentage of Medicaid patient days to total day		
DO Sum of lines 7 and 8	0.00	
00 Allowable disproportionate share percentage (see		
.00 Disproportionate share adjustment (see instructi		0 11.
.00 Total prospective capital payments (see instruc	tions) 679, 728	8 12.
	1.00	_
PART II - PAYMENT UNDER REASONABLE COST		
00 Program inpatient routine capital cost (see ins	tructions) (0 1.
00 Program inpatient ancillary capital cost (see in	nstructions) (0 2.
00 Total inpatient program capital cost (line 1 plu	us line 2) (D 3.
00 Capital cost payment factor (see instructions)		0 4.
00 Total inpatient program capital cost (line 3 x l	Line 4) (0 5.
	1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS		
00 Program inpatient capital costs (see instruction		
00 Program inpatient capital costs for extraordinal	,	
00 Net program inpatient capital costs (line 1 minu		
00 Applicable exception percentage (see instruction		
Capital cost for comparison to payments (line 3		0 5.
Percentage adjustment for extraordinary circums		
00 Adjustment to capital minimum payment level for 00 Capital minimum payment level (line 5 plus line		0 7. 0 8.
00 Current year capital payments (from Part I, line		0 8.
		0 9. 0 10.
00 Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)		0 11.
.00 Net comparison of capital minimum payment level	to capital payments (line 10 plus line 11)	0 12.
00 Current year exception payment (if line 12 is po		0 13.
	it level over capital payment for the following period (0 14.
(if line 12 is negative, enter the amount on thi		
(if line 12 is negative, enter the amount on the	·	0 15.
(if line 12 is negative, enter the amount on the	yment (see instructions)	0 15. 0 16.

	Financial Systems	HANCOCK REGION				u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0037	Peri od:	Worksheet M-1	
			Component	CCN: 15-3987	From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 1:2	
					RHC I	Cost	
		Compensati on	Other Costs	Total (col.	1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1 00	FACILITY HEALTH CARE STAFF COSTS	00.004		00.0		00.004	1 1 00
1.00	Physi ci an	20, 024	0			20, 024	1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	144, 399	0			144, 399	
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	82, 183	0	02/11		82, 183	
6.00	Clinical Psychologist	0	0		0 0	0	
7.00	Clinical Social Worker	0	0		0 0	0	
8.00	Laboratory Techni ci an	0	0		0 0	0	
9.00	Other Facility Health Care Staff Costs	11, 282	0			11, 282	
10.00	Subtotal (sum of lines 1 through 9)	257, 888	0	207,00		257, 888	•
11.00	Physician Services Under Agreement	0	0		0 0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15.00	Medical Supplies	0	20, 373	20, 3	73 0	20, 373	
16.00	Transportation (Health Care Staff)	0	0		0 0	0	
17.00	Depreciation-Medical Equipment	0	0		0 0	0	
	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	
	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20, 373			20, 373	•
22.00	Total Cost of Health Care Services (sum of	257, 888	20, 373	278, 20	61 0	278, 261	22.00
	Lines 10, 14, and 21)						
22.00	COSTS OTHER THAN RHC/FQHC SERVICES		22.1/1	22.1	(1)) 1(1	0	1 22 20
23.00	Pharmacy	0	32, 161			0	
24.00	Dental	0	0		0 0	0	
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 0	0	25.01
25.02	Chronic Care Management	0	0		0 0	0	
26.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs					_	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	32, 161	32, 10	-32, 161	0	28.00
	through 27) FACILITY OVERHEAD						-
29.00	FACILITY OVERHEAD Facility Costs	0	0		0 0	0	29.00
29.00	Administrative Costs	0	0 174, 619		-	174, 619	
		0					•
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	174, 619	174, 6	17 0	174, 619	31.00
32.00	Total facility costs (sum of lines 22, 28	257, 888	227, 153	485, 04	41 -32, 161	452, 880	32.00
		201,000	227, 100	400,04	-32,101	402,000	1 02.00

	Financial Systems	HANCOCK REGION		01 45 0007		u of Form CMS	
IALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0037	Period: From 01/01/2019	Worksheet M-	1
			Component	CCN: 15-3987	To 12/31/2019	Date/Time Pr 8/28/2020 1:	
					RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6. 00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
00	Physician	0	20, 024				1.0
00	Physician Assistant	0	/	1			2.0
00	Nurse Practitioner	0					3.0
00	Visiting Nurse	0	C)			4. (
00	Other Nurse	0	82, 183				5.
00	Clinical Psychologist	0	C	1			6.
00	Clinical Social Worker	0	C)			7.
00	Laboratory Techni ci an	0	C				8.
00	Other Facility Health Care Staff Costs	0	11, 282				9.
. 00	Subtotal (sum of lines 1 through 9)	0					10.
. 00	Physician Services Under Agreement	0	C				11.
. 00	Physician Supervision Under Agreement	0	C				12.
. 00	Other Costs Under Agreement	0	C				13.
. 00	Subtotal (sum of lines 11 through 13)	0	C				14.
. 00	Medical Supplies	0	20, 373				15.
	Transportation (Health Care Staff)	0	C				16.
	Depreciation-Medical Equipment	0					17.
	Professional Liability Insurance	0	C				18.
	Other Health Care Costs	0	C				19.
	Allowable GME Costs						20.
	Subtotal (sum of lines 15 through 20)	0	/	1			21.
. 00	Total Cost of Health Care Services (sum of	0	278, 261				22.
	Lines 10, 14, and 21)						_
00	COSTS OTHER THAN RHC/FQHC SERVICES						-
	Pharmacy	0					23.
00	Dental	0					
	Optometry Telehealth	0					25.
	Chronic Care Management	0					25.
	All other nonreimbursable costs	0	-	1			25.
. 00	Nonallowable GME costs	0					20.
. 00	Total Nonreimbursable Costs (sum of lines 23	0	C				27.
. 00	through 27)	0		'			20.
	FACILITY OVERHEAD		L	1			1
. 00	Facility Costs	0	C				29.
. 00	Administrative Costs	-5, 163	-	1			30.
. 00	Total Facility Overhead (sum of lines 29 and	-5, 163		1			31.
	30)	2, .00	, 100				
. 00	Total facility costs (sum of lines 22, 28	-5, 163	447, 717				32.
	and 31)						

Health Financial Systems	HANCOCK REGIO	NAL_HOSPITAL		In Lie	u of Form CMS-2	2552-1
ALLOCATION OF OVERHEAD TO HOSPITAL-BASE	RHC/FQHC SERVICES	Provider C		Period:	Worksheet M-2	
		Component		From 01/01/2019 To 12/31/2019		narod
		component	CON. 13-3707	10 12/31/2019	8/28/2020 1:2	
		_		RHC I	Cost	
	Number of FTE	Total Visits	Producti vi ty		Greater of	
	Personnel		Standard (1)	Visits (col.	col. 2 or	
				1 x col. 3)	col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						-
Positions		1				
. 00 Physi ci an	0.08					1.0
. 00 Physician Assistant	0.00			5		2.0
.00 Nurse Practitioner	0.98					3.0
.00 Subtotal (sum of lines 1 through				2, 394		4.0
.00 Visiting Nurse	0.00				0	5.0
.00 Clinical Psychologist	0.00				0	6.0
.00 Clinical Social Worker	0.00)		0	7.0
.01 Medical Nutrition Therapist (FQHC)		0	1
. 02 Diabetes Self Management Training	(FQHC 0.00)		0	7.0
only)	1 1.00	2.244			2 244	
.00 Total FTEs and Visits (sum of lin	es 4 1.06	3, 244	-		3, 244	8.0
through 7) 00 Physician Services Under Agreemer	to	0			0	9.0
.00 Physician Services Under Agreemer	15		<u>'</u>		0	9.0
					1.00	
DETERMINATION OF ALLOWABLE COST A	PPLICABLE TO HOSPITAL-BAS	ED RHC/FQHC SE	RVI CES			
0.00 Total costs of health care servic	es (from Wkst. M-1, col.	7, line 22)			278, 261	10.0
1.00 Total nonreimbursable costs (from	Wkst. M-1, col. 7, line	28)			0	11.0
2.00 Cost of all services (excluding o	verhead) (sum of lines 10) and 11)			278, 261	12.0
3.00 Ratio of hospital-based RHC/FQHC	services (line 10 divided	by line 12)			1.000000	13.0
4.00 Total hospital-based RHC/FQHC ove	rhead - (from Worksheet.	M-1, col. 7, I	ine 31)		169, 456	14.0
5.00 Parent provider overhead allocate	d to facility (see instru	ictions)			118, 190	15.0
5.00 Total overhead (sum of lines 14 a					287, 646	16.0
7.00 Allowable GME overhead (see instr	uctions)				0	17.
8.00 Enter the amount from line 16					287, 646	18.0
9.00 Overhead applicable to hospital-b	ased RHC/FQHC services (I	ine 13 x line	18)		287, 646	19.0
0 00 Total allowable cost of bosnital.	based RUC/EOUC services	sum of lines 1	0 and 10		545 007	20 0

20.00 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19) 565, 907 20.00

	Financial Systems HANCOCK REGIONAL			J OF Form CMS-2	
SERVI CE	TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0037	Period: From 01/01/2019	Worksheet M-3	
DERVICE	5	Component CCN: 15-3987	To 12/31/2019	Date/Time Pre	pared
				8/28/2020 1:2	
		Title XVIII	RHC I	Cost	
			-	1.00	
L.				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M 2 Lino 20)		565, 907	1.0
	Cost of vaccines and their administration (from Wkst. M-4, li	· · · · ·		19, 168	
	Total allowable cost excluding vaccine (line 1 minus line 2)	ne is)		546, 739	
1	Total Visits (from Wkst. M-2, column 5, line 8)			3, 244	4.
1	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0,211	5.
1	Total adjusted visits (line 4 plus line 5)			3, 244	6.
	Adjusted cost per visit (line 3 divided by line 6)			168.54	7.
			Cal cul ati on		
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	
			1.00	2.00	
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	84.70	
	Rate for Program covered visits (see instructions)		0.00	84.70	9.
	CALCULATION OF SETTLEMENT			207	1 10
	Program covered visits excluding mental health services (from	-	0	297	
	Program cost excluding costs for mental health services (line		0	25, 156	
1	Program covered visits for mental health services (from contr		0	0	
	Program covered cost from mental health services (line 9 x li		0	0	
	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction	-	0	0	14.
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	25, 156	
	Total program charges (see instructions)(from contractor's re	·	0	38, 175	
1	Total program preventive charges (see instructions)(from contractor s re			5, 275	
1	Total program preventive costs ((line 16.02/line 16.01) times			3, 476	
1	Total Program non-preventive costs ((line 16 minus lines 16.0			11, 491	16.
	(Titles V and XIX see instructions.)			, .,	
	Total program cost (see instructions)		0	14, 967	16.
	Primary payer amounts			0	
	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		7, 316	18.
1	records)				
19.00 E	Beneficiary coinsurance for RHC/FQHC services (see instructio	ns) (from contractor		5, 117	19.
1	records)				
	Net Medicare cost excluding vaccines (see instructions)			14, 967	
1	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		10, 008	
1	Total reimbursable Program cost (line 20 plus line 21)			24, 975	
	Allowable bad debts (see instructions)			326	
1	Adjusted reimbursable bad debts (see instructions)			212	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction			0	
	Demonstration payment adjustment amount before sequestration	13)		0	
	Net reimbursable amount (see instructions)			25, 187	
	Sequestration adjustment (see instructions)			25, 187	
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			14, 101	
	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		10, 582	
	Protested amounts (nonallowable cost report items) in accorda		,	0	
	chapter I, §115.2				1

Heal th	Financial Systems HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0037	Peri od:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-3987	From 01/01/2019 To 12/31/2019		
		Title XVIII	RHC I	Cost	
			Pneumococcal	l nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	257, 888			
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				
3.00	Pneumococcal and influenza vaccine health care staff cost (li		267	2, 430	
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	5 7	4, 112		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	4, 379			
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh			6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	287, 646			
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	0. 015737	0. 018134	8.00	
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	4, 527	5, 216	9.00	
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	8, 906	10, 262	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	28	166	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	318.07	61.82	12.00
13.00	Number of pneumococcal and influenza vaccine injections admir beneficiaries	istered to Program	20	59	13.00
14.00		heir) administration	6, 361	3, 647	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3		19, 168	15.00	
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)		10, 008	16.00	

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2					
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR		Provider CCN: 15-0037	Period:	d: Worksheet M-5	
SERVI	CES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-3987	From 01/01/2019 To 12/31/2019		
			RHC I	Cost	/ piii
				t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00 2.00	Total interim payments paid to hospital-based RHC/FQHC 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			14, 101 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
	Program to Provider				
3.01				0	3.01
3. 02 3. 03				0	3. 02 3. 03
3.03				0	3.03
3.04				0	3.04
5.05	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99					3.99
4.00					4.00
	27) TO BE COMPLETED BY CONTRACTOR				
F 00					
5.00	each payment. If none, write "NONE" or enter a zero. (1)				5.00
5.01	Program to Provider			0	5.01
5.01				0	5.01
5.02				0	5.02
0.00	Provider to Program				0.00
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	5.99
6.00					6.00
6.01	SETTLEMENT TO PROVIDER			10, 582	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			24, 683	7.00
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
8.00	Name of Contractor	0	1.00	2.00	8.00
o. UU	Name of Contractor				0.00