Health Financial	Systems	HANCOCK REGIONAL			u of Form CMS-2552-10
This report is a	required by law (42 USC 139	5g; 42 CFR 413.20(b)). Fail	ure to report can resu	lt in all interim	FORM APPROVED
	ince the beginning of the c				OMB NO. 0938-0050
HOSPITAL AND HOS AND SETTLEMENT S	SPITAL HEALTH CARE COMPLEX (SUMMARY	COST REPORT CERTIFICATION	Provider CCN: 150037	Period: From 01/01/2014 To 12/31/2014	
PART I - COST RE	EPORT STATUS				
Provider 1	.[X]Electronically filed	cost report		Date: 5/27/20	15 Time: 12:05 pm
	<pre>!.[]Manually submitted or</pre>				
	I. [0] If this is an amendeI. [F] Medicare Utilization			esubmitted this co	ost report
Contractor 5 use only	 [1] Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 	6. Date Received: 7. Contractor No. 8. [N] Initial Report for 9. [N] Final Report for t	11. this Provider CCN 12.	NPR Date: Contractor's Vendo [O]If line 5, co number of tim	or Code: 4 Plumn 1 is 4: Enter nes reopened = 0-9.
PART II - CERTI	FICATION				
ADMINISTRATIVE A	ON OR FALSIFICATION OF ANY ACTION, FINE AND/OR IMPRISO CURED THROUGH THE PAYMENT D ACTION, FINES AND/OR IMPRIS	NMENT UNDER FEDERAL LAW. FIRECTLY OF A	URTHERMORE, IF SERVICE	S IDENTIFIED IN TH	IIS REPORT WERE
	CERTIFICATION BY OFFICER	OR ADMINISTRATOR OF PROVIDE	R(S)		

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANCOCK REGIONAL HOSPITAL (150037) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)

Encryption Information
ECR: Date: 5/27/2015 Time: 12:05 pm
z2N7aAqTEQdfXse:WiPU09wkAksng0
ejpz:OwOLhXtIRZpjpHz6Akn8y7Ztz
iyvW1Tq7KA06oPXY
PI: Date: 5/27/2015 Time: 12:05 pm
7XPVeCJ11o7AifqDSI.us831r:yGu0
nNrkH02FvSAe4:wi7SJHfv9kFi9GOX
PhD70i5n620r:khG

Officer or Administrator of Provider(s)

Title

5-28-15

Date

7770 3 3 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		Title XVIII			
	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 Hospital	0	45,318	37,179	-47,067	-434,873 1.00
2.00 Subprovider - IPF	0	440	0		0 2.00
3.00 Subprovider - IRF	o	35	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		2,635		0 10.00
200.00 Total	0	45,793	39,814	-47,067	-434,873 200.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150037 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 11:52 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: . 10 NORTH STATE STREET 1.00 PO Box: 1.00 State: IN 2.00 City: GREENFIELD Zip Code: 46140-County: HANCOCK 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal HANCOCK REGIONAL 150037 26900 07/01/1966 Ν Р 0 3.00 1 HOSPI TAI Р 4.00 Subprovider - IPF HANCOCK REGIONAL GERO 15S037 26900 12/01/1996 N 4 Ν 4.00 PSYCH UNIT 5.00 Subprovider - IRF HANCOCK REGIONAL 15T037 26900 5 01/01/2005 Ν Ρ Ν 5.00 HOSPITAL REHAB 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF 7.00 7.00 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10 00 11.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA HANCOCK REGIONAL HHA 157092 26900 10/14/1983 Р Ν 12.00 12.00 Separately Certified ASC 13.00 13.00 HANCOCK REGIONAL 151547 26900 14.00 Hospi tal -Based Hospi ce 02/02/1996 14.00 HOSPI CE KNI GHTSTOWN RURAL 15.00 15.00 Hospital-Based Health Clinic - RHC 153987 26900 09/22/1998 N 0 N HEALTH Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2 00 1 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22 00 N 22 00 Υ share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be N Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 Ν 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 4. 00 1.00 2.00 3.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 430 453 0 484 0 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

		HOSPI TAL		1	In Lieu	of For		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der	CCN: 150037	Period: From 01/0 To 12/3	01/2014 31/2014	Workshe Part I Date/Ti 5/27/20	me Pre	pared:
	In-State Medicaio paid day	d Medicaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	id 0 [.] ys Med	ther li cai d lays	
	1.00	2. 00	3. 00	4. 00	5. 00		. 00	
25.00 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, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0 0	0	O Usban //	Rural S	O Data of	Coogs	25. 00
				1.	00	2.0		
26.00 Enter your standard geographic classification (not was cost reporting period. Enter "1" for urban or "2" for		us at the beg	ginning of t	he	1			26. 00
27.00 Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassification.	age) statı r "2" for	rural. If ap		t	1			27. 00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0	F., 41		35. 00
					ini ng: 00	Endi 2. 0		
36.00 Enter applicable beginning and ending dates of SCH's of periods in excess of one and enter subsequent date		bscript line	36 for numb	er				36. 00
37.00 If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.		ber of period	ds MDH statu	s	0			37. 00
38.00 Enter applicable beginning and ending dates of MDH soft periods in excess of one and enter subsequent date		bscript line	38 for numb					38. 00
					/N 00	Y/ 2.0		
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage recCFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	i)? Enter quirement:	in column 1 s in accordar	"Y" for yes nce with 42	me '	Y	Y		39. 00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	n adjustmo ber 1. En	ent? Enter "Y ter "Y" for y	" for yes o	r 1	N V	N XVIII	XI X	40. 00
					1.00		3.00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymen	nt for di	sproporti onat	te share in	accordance	N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300 PPS capi 48.00 Is the facility electing full federal capital paymen					N N	N N	N N	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in	approved	GME programs	s? Enter "Y	" for yes	N			56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon	r yes or '	"N" for no ir	n column 1.	If column				57. 00
for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	l, if appl	l i cabl e.						
58.00 If line 56 is yes, did this facility elect cost reimled defined in CMS Pub. 15-1, § 2148? If yes, complete WI	kst. D-5.	. 3		s as	N			58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes 60.00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	costs for	r a program t	that meets t		N Y			59. 00 60. 00
	Y/N	IME	Direct GM	E IN	ME	Di rect	GME	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00	2. 00	3. 00	4.	0. 00	5. (61.00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00		0. 00				61. 01
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00))). 00				61. 02

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der		Period: From 01/01/2014 Fo 12/31/2014	Worksheet S-2 Part I Date/Time Pre	pared:
	Y/N	IME	Direct GME	IME	5/27/2015 11: Direct GME	52 am
	1. 00	2. 00	3. 00	4.00	5.00	-
Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00				61. 0
enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	00		61.0
current cost reporting period (see instructions). 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		0.00	0.0	00		61. 0
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0. 0	00		61. 0
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
51.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3.00	4.00	61. 10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 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.				0. 00	0. 00	61. 20
					1.00	-
ACA Provisions Affecting the Health Resources and Ser	vi ces	Administration	(HRSA)		1.00	
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructions). 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	ti ons) Teachi	ng Health Cent	er (THC) into			62.00
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N	63.00
TO THE THE COLUMN TO THE COLUMN TO THE YES, COMPLETE	11110	33 54 67. (366	Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No						
period that begins on or after July 1, 2009 and befor 54.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	y trair -primar all nor	ned residents ry care nprovider	0.0	0. 00	0. 000000	64.00

2.00

Unwei ghted FTEs

Nonprovi der Si te

3. 00

Unweighted FTEs in Hospital

4.00

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

5.00

resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

Program Name Program Code

1.00

i				0.00	0.00	0 00000	/ F 00
	enter in column 1, if line 63 s yes, or your facility			0.00	0.00	0. 000000	65.00
	rained residents in the base						
	vear period, the program name						
	associated with primary care						
	TEs for each primary care						
	program in which you trained						
	residents. Enter in column 2,						
	the program code, enter in						
	column 3, the number of						
	inweighted primary care FTE						
	residents attributable to						
	rotations occurring in all						
	non-provider settings. Enter in						
	column 4, the number of						
u	inweighted primary care						
r	resident FTEs that trained in						
У	our hospital. Enter in column						
5	5, the ratio of (column 3						
d	livided by (column 3 + column						
4	!)). (see instructions)						
				Unwei ghted	Unwei ghted	Ratio (col. 1/	
				FTEs	FTEs in	(col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te			
				1. 00	2.00	3.00	
	Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	or cost reporti	ng peri ods	
	<u>beginning on or after July 1, 20</u> Enter in column 1 the number of		sy caro rosi dont	0.00	0. 00	0. 000000	66 00
	TES attributable to rotations of			0.00	0.00	0.00000	00.00
	Enter in column 2 the number of						
	TEs that trained in your hospit						
	[column 1 divided by (column 1 +						
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
		ŭ		FTĔs	FTEsin	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
				Si te			
		1.00	2. 00	3. 00	4. 00	5. 00	
67. 00 E	Enter in column 1, the program			0.00	0.00	0. 000000	67. 00
	name associated with each of						
У	our primary care programs in						
	which you trained residents.						
E	Enter in column 2, the program						
E c	code. Enter in column 3, the						
E c n	code. Enter in column 3, the number of unweighted primary						
E C n c	code. Enter in column 3, the number of unweighted primary care FTE residents attributable						
E c n c t	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all						
E c n c t	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in						
E c n c t n c	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						
E c n c t n c	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						
E c n c t n c u r	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						
E c n c t n c u r	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						
E c n c t n c u r y 5	code. Enter in column 3, the number of unweighted primary care FTE residents attributable contations 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						
E c n c t n c u r y 5 d	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column						
E c n c t n c u r y 5 d	code. Enter in column 3, the number of unweighted primary care FTE residents attributable contations 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						
E c n c t n c u r y 5 d	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column				1.0	0 2.00 3.00	
E c n n c t n c u r y y 5 d 4	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 livided by (column 3 + column 4)). (see instructions)				<u>'</u>	0 2.00 3.00	
E C n n c t n n c u r r y y 5 d 4	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column b)). (see instructions) Inpatient Psychiatric Facility F s this facility an Inpatient Ps	ychiatric Facility (I	PF), or does it conta	ain an IPF subp	<u>'</u>	0 2.00 3.00	70.00
E C n n C t t n n C u u r r y y 5 5 d 4	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in rour hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 1)). (see instructions) Inpatient Psychiatric Facility F s this facility an Inpatient Psychiatric Facility F s this facility an Inpatient Psychiatric For yes or "N" for no	ychiatric Facility (I	,,	·	rovi der? Y		
70. 00 F	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 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F s this facility an Inpatient Psychiatric Facility F inter "Y" for yes or "N" for no fline 70 yes: Column 1: Did the	ychiatric Facility (I e facility have an ap	oproved GME teaching p	orogram in the	rovider? Y	0 2.00 3.00 N 0	70. 00
70. 00 T	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 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F s this facility an Inpatient Psychiatric Facility F inter "Y" for yes or "N" for no fline 70 yes: Column 1: Did the recent cost report filed on or between the state of the stat	ychiatric Facility (I e facility have an ap efore November 15, 20	oproved GME teaching p 004? Enter "Y" for ye	orogram in the es or "N" for n	rovider? Y most N o. (see		
70. 00 I E 71. 00 I F 4	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 6, the ratio of (column 3 + column b)). (see instructions) Inpatient Psychiatric Facility F s this facility an Inpatient Ps center "Y" for yes or "N" for no fline 70 yes: Column 1: Did the recent cost report filed on or biz CFR 412.424(d)(1)(iii)(c)) Co	ychiatric Facility (I e facility have an ap efore November 15, 20 lumn 2: Did this faci	oproved GME teaching p 004? Enter "Y" for ye lity train residents	orogram in the es or "N" for n in a new teach	rovider? Y most N o. (see ing		
70. 00 The state of the state	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column b)). (see instructions) Inpatient Psychiatric Facility F s this facility an Inpatient Psychiatric Tyr for yes or "N" for no file 70 yes: Column 1: Did the cecent cost report filed on or become cost of the column of the cost of the column of the cost of	ychiatric Facility (I e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii)	oproved GME teaching p 004? Enter "Y" for yo lity train residents (D)? Enter "Y" for yo	orogram in the es or "N" for n in a new teach es or "N" for n	rovider? Y most N o. (see ing o.		
70. 00 F 71. 00 F 74 75 75 75 75 75 75 75	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in cour hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 1)). (see instructions) Inpatient Psychiatric Facility F is this facility an Inpatient Psinter "Y" for yes or "N" for no fline 70 yes: Column 1: Did the recent cost report filed on or be 12 CFR 412.424(d)(1)(iii)(c)) Coorogram in accordance with 42 CF column 3: If column 2 is Y, enter	ychiatric Facility (I e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu	oproved GME teaching p 004? Enter "Y" for ye lity train residents (D)? Enter "Y" for ye umn 3. (see instruction	orogram in the es or "N" for n in a new teach es or "N" for n ons) If this co	rovider? Y most N o. (see ing o. st		
70. 00 I F F C C C C C C C C C C C C C C C C C	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in cour hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 1)). (see instructions) Inpatient Psychiatric Facility F is this facility an Inpatient Psychiatric Facility F in the ratio of the recent cost report filed on or be 12 CFR 412.424(d)(1)(iii)(c)) Coorogram in accordance with 42 CF column 3: If column 2 is Y, enter reporting period covers the beginners.	ychiatric Facility (I e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y	oproved GME teaching p 004? Enter "Y" for ye lity train residents o(D)? Enter "Y" for ye umn 3. (see instructic year, enter 4 in colum	orogram in the es or "N" for n in a new teach es or "N" for n ons) If this co	rovider? Y most N o. (see ing o. st		
70. 00 F 71. 00 F F F F F F F F F	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in cour hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 3). (see instructions) Inpatient Psychiatric Facility F is this facility an Inpatient Psychiatric Ty" for yes or "N" for no fline 70 yes: Column 1: Did the recent cost report filed on or be column 3: If column 2 is Y, enter reporting period covers the begin subsequent academic years of	ychiatric Facility (I . e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y the new teaching prog	oproved GME teaching p 004? Enter "Y" for you lity train residents (D)? Enter "Y" for you umn 3. (see instruction year, enter 4 in colum gram in existence, enter	orogram in the es or "N" for n in a new teach es or "N" for n ons) If this comn 3, or if the ter 5. (see	rovider? Y most N o. (see ing o. st		
70. 00 I F 71. 00 I P C C r o i	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 6, the ratio of (column 3 + column 6)). (see instructions) Inpatient Psychiatric Facility F is this facility an Inpatient Ps inter "Y" for yes or "N" for no fline 70 yes: Column 1: Did the recent cost report filed on or but the column 3: If column 2 is Y, enter reporting period covers the beging resubsequent academic years of instructions) For cost reporting period cover teporting period covers the sum of the column 3: If column 2 is Y, enter reporting period covers the beging resubsequent academic years of instructions) For cost reporting	ychiatric Facility (I . e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y the new teaching properiods beginning of	oproved GME teaching pood? Enter "Y" for year ity train residents of (D)? Enter "Y" for yearn see instruction of the column 3. (see instruction of the column see in the column see in column see in column see in column see in column or after October 1,	program in the es or "N" for n in a new teach es or "N" for n ons) If this comn 3, or if the ter 5. (see 2012, if this	rovider? Y most N o. (see ing o. st fifth cost		
70. 00 I F 71. 00 I F C C C C C C C C C C C C C C C C C C	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column b)). (see instructions) Inpatient Psychiatric Facility F is this facility an Inpatient Psychiatric Tyr for yes or "N" for no file To yes: Column 1: Did the cecent cost report filed on or be column 3: If column 2 is Y, enter the control of the column 3: If column 2 is Y, enter the control of the column 3 is period covers the begins or subsequent academic years of instructions).	ychiatric Facility (I . e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y the new teaching properiods beginning or nning of the sixth or	oproved GME teaching pood? Enter "Y" for year lity train residents of (D)? Enter "Y" for yearn 3. (see instruction of the column 3. (see instruction of the column of the	program in the es or "N" for n in a new teach es or "N" for n ons) If this comn 3, or if the ter 5. (see 2012, if this	rovider? Y most N o. (see ing o. st fifth cost		
70.00 The state of the state	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in column hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F is this facility an Inpatient Psychiatric Facility F is this facility and Inpatient Psychiatric Facility F in the Type of Type or Typ	ychiatric Facility (I . e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colunning of the fourth y the new teaching properiods beginning or nning of the sixth or nter 6 in column 3.	oproved GME teaching pood? Enter "Y" for year lity train residents of (D)? Enter "Y" for yearn 3. (see instruction of the column 3. (see instruction of the column of the	program in the es or "N" for n in a new teach es or "N" for n ons) If this comn 3, or if the ter 5. (see 2012, if this	rovider? Y most N o. (see ing o. st fifth cost		
70. 00 T T T T T T T T T	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in cour hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 3)). (see instructions) Inpatient Psychiatric Facility F is this facility an Inpatient Psychiatric Facility F in the ratio of the column 1: Did the column 3: If column 1: Did the column 3: If column 2 is Y, enter the column 3: If co	ychiatric Facility (I . e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y the new teaching prog periods beginning or nning of the sixth or nter 6 in column 3. (y PPS	oproved GME teaching p 004? Enter "Y" for ye lity train residents (D)? Enter "Y" for ye umn 3. (see instructio year, enter 4 in colum gram in existence, ent n or after October 1, r any subsequent acade (see instructions)	orogram in the es or "N" for n in a new teach es or "N" for n ons) If this comn 3, or if the ter 5. (see 2012, if this emic year of the	rovider? Y most N o. (see ing o. st fifth cost e new		71.00
75. 00 E C C C C C C C C C	code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all con-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in column hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F is this facility an Inpatient Psychiatric Facility F is this facility and Inpatient Psychiatric Facility F in the Type of Type or Typ	ychiatric Facility (I . e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y the new teaching prog periods beginning or nning of the sixth or nter 6 in column 3. (y PPS habilitation Facility	oproved GME teaching p 004? Enter "Y" for ye lity train residents (D)? Enter "Y" for ye umn 3. (see instructio year, enter 4 in colum gram in existence, ent n or after October 1, r any subsequent acade (see instructions)	orogram in the es or "N" for n in a new teach es or "N" for n ons) If this comn 3, or if the ter 5. (see 2012, if this emic year of the	rovider? Y most N o. (see ing o. st fifth cost		

claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems HANCOCK REGION				u of Form CMS		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet S- Part I Date/Time Pr 5/27/2015 11	repared:	
		Premi ums	Losses	Insurance	1. 32 aiii	
		1. 00	2.00	3. 00	\perp	
118.01 List amounts of malpractice premiums and paid losses:		747, 560			0 118. 01	
			1.00	2.00	+	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			N		118. 02	
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.						
121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.	antable device	s charged to	Y		121. 00	
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f	or ves and "N"	for no lf	N		125. 00	
yes, enter certification date(s) (mm/dd/yyyy) below.	-					
126.00 f this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column	2.				126. 00	
127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column		ication date			127. 00	
128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column		ication date			128. 00	
129.00 If this is a Medicare certified lung transplant center, ent		cation date in			129. 00	
column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center,	enter the cer	tification			130. 00	
date in column 1 and termination date, if applicable, in co 131.00 of this is a Medicare certified intestinal transplant cente		erti fi cati on			131. 00	
date in column 1 and termination date, if applicable, in co 132.00 of this is a Medicare certified islet transplant center, en	lumn 2.				132. 00	
in column 1 and termination date, if applicable, in column	2.					
133.00 f this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column		cation date			133. 00	
134.00 If this is an organ procurement organization (0P0), enter t and termination date, if applicable, in column 2.	he OPO number	in column 1			134. 00	
All Providers 140.00Are there any related organization or home office costs as	dofined in CMS	Dub 1E 1	l N		140. 00	
chapter 10? Enter "Y" for yes or "N" for no in column 1. If	yes, and home	office costs	IV.		140.00	
are claimed, enter in column 2 the home office chain number 1.00 2.0		tions)	3. 00			
If this facility is part of a chain organization, enter on home office and enter the home office contractor name and c			me and address	of the		
141.00 Name: Contractor's Name:	JOHET ACTOL HAIID		r's Number:		141. 00	
142.00 Street: PO Box: 143.00 Ci ty: State:		Zi p Code:			142. 00 143. 00	
				1.00		
144.00 Are provider based physicians' costs included in Worksheet				Y	144. 00	
145.00 f costs for renal services are claimed on Worksheet A, lin only? Enter "Y" for yes or "N" for no.	e /4, are the (costs for inpa	tient services	N	145. 00	
			1. 00	2.00		
146.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub.			N		146. 00	
the approval date (mm/dd/yyyy) in column 2. 147.00Was there a change in the statistical basis? Enter "Y" for	yes or "N" for	no.	N		147. 00	
148.00 Was there a change in the order of allocation? Enter "Y" fo 149.00 Was there a change to the simplified cost finding method? E			N N		148. 00 149. 00	
no.				T1.11 V1.V	147.00	
	Part A 1.00	Part B 2.00	7i tle V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon						
155. 00 Hospi tal	N	N	N	N	155. 00	
156.00 Subprovider - IPF 157.00 Subprovider - IRF	N N	N N	N N	N N	156. 00 157. 00	
158. 00 SUBPROVI DER 159. 00 SNF	N	N	N	N	158. 00 159. 00	
160.00 HOME HEALTH AGENCY	N	N N	N N	N	160. 00	
161. 00 CMHC	I	Į N	IN	N N	161. 00	

Health Financial Systems	HANCOCK RI	EGIONAL HOSPITAL			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der (CCN: 15003	From O	1/01/2014 2/31/2014	Worksheet S-2 Part I Date/Time Pre	
						5/27/2015 11:	52 am
						1.00	
Mul ti campus						N	
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	0 166. 00
U 111 1 C 11 T 1 1 (111)	T) ' ' ' ' ' A		l D '			1.00	
Health Information Technology (HI 167.00 st this provider a meaningful use						Υ	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the	05 is "Y") and is a me	aningful user (line			the	l .	0168. 00
169.00 If this provider is a meaningful transition factor. (see instruction		and is not a CAH (line 105	is "N"), e	enter the	0. 5	0169. 00
				Ве	gi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and end	ing date for the re	porting	10,	/01/2013	09/30/2014	170. 00
						1.00	
171.00 If line 167 is "Y", does this pro Medicare cost plans reported on W (see instructions)						N	171. 00

OSDI TA	Financial Systems L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	HANCOCK REGIONAL HOSPITAL	CCN: 150037 F	Peri od:	Worksheet S-2	-2552- 2
JSPI IA	IL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUE	STIONNAIRE Provider	F	eriod: From 01/01/2014 To 12/31/2014	Part II	epare
				Y/N	Date	. 52 ai
-	General Instruction: Enter Y for all YES resp	annon Enton N for all NO m	onences Enter	1.00	2.00	
m C	nm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	onses. Effer N 101 all NO 10	esponses. Enter	dir udtes iii	the	
00 F	Provider Organization and Operation Has the provider changed ownership immediatel	ly prior to the heginning of	the cost	N		1.
00	reporting period? If yes, enter the date of t	the change in column 2. (see	instructions)	14		'.
			Y/N	Date	V/I	
00 H	Has the provider terminated participation in	the Medicare Program? If	1.00 N	2. 00	3. 00	2.
	yes, enter in column 2 the date of termination					
	voluntary or "l" for involuntary.	tions including management	N			1,
	Is the provider involved in business transact contracts, with individuals or entities (e.g.		IN IN			3.
(or medical supply companies) that are related	d to the provider or its				
	officers, medical staff, management personnel of directors through ownership, control, or 1					
	relationships? (see instructions)	raili i y and other Silli i a				
			Y/N	Туре	Date	
F	Financial Data and Reports		1.00	2. 00	3. 00	
	Column 1: Were the financial statements prep	pared by a Certified Public	Υ	А		4.
	Accountant? Column 2: If yes, enter "A" for					
	or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr					
	Are the cost report total expenses and total		N			5.
	those on the filed financial statements? If y	yes, submit reconciliation.		V//N	1 1 0	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
	Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes, is t	ne provider is	N		6
	the legal operator of the program? Are costs claimed for Allied Health Programs'	? If "Y" see instructions.		Υ		7.
00 N	Were nursing school and/or allied health prog	grams approved and/or renewe	d during the	N		8
	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		st roport2 lf	N		9.
	yes, see instructions.	is craffiled on the current co.	st report: II	IN		7.
	Was an Intern-Resident program been initiated	d or renewed in the current	cost reporting	N		10.
. 00	period? If yes, see instructions. Are GME cost directly assigned to cost cente	rs other than I & R in an An	aroved	N		11.
	Teaching Program on Worksheet A? If yes, see					
					Y/N 1.00	
E	Bad Debts				1.00	
	Is the provider seeking reimbursement for bac				Y	12.
	If line 12 is yes, did the provider's bad del period? If yes, submit copy.	ot collection policy change	during this cos	st reporting	N	13
1.	lf line 12 is yes, were patient deductibles a	and/or co-payments waived? I	f yes, see inst	ructi ons.	N	14.
Е	Bed Complement					
. 00 [[Did total beds available change from the price	or cost reporting period? If	1	ructions. rt A	N Part B	15.
		Description	Y/N	Date	Y/N	
		0	1.00	2. 00	3. 00	
	PS&R Data		1	03/10/2015	Y	
			I V			٦ 16
00 1	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,		Y	037 107 2013		16
00 1	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R		Y	037 107 2013		16
00 N	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see		Y	037 107 2013		16
00 1	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R		Y N	03/10/2013	N	
00 N	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records			03/10/2013	N	
00 V F F F F F F F F F	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			03/10/2013	N	
00 1	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records			03/10/2013	N	
00 N	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments			03/10/2013	N N	17
00 1	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		N	03/10/2013		17
. 00 N	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments		N	03/10/2013		17
00 1	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N N	03/10/2013	N	17.
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments		N	03/10/2013		16. 17. 18.
.00 1	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N N	03/10/2013	N	17.
.00 1	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N N	03/10/2013	N N	17. 18.
. 00 1	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N N	03/10/2013	N	17.

Health Financial Systems	HANCOCK REGIONAL I	HOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provi der CCN: 150037	From 01/01/2014	Worksheet S-2 Part II Date/Time Prepared

Bescription Y/N Both Pert B P						From 01/01/2014 To 12/31/2014		
21.00 Was the cost report prepared only using the provider's records? If yes, see Instructions. COMPLETED BY COST RELIBERSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost		·			Pa	rt A		
21.00 Nas the cost report propered only using the provider's records? If yes, see 1.00			Desci	ri pti on	Y/N	Date	Y/N	
provider's records? If yes, see Instructions				0	1.00	2. 00	3. 00	
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	43. 00	Enter the telephone number and email address		317-713-7946		TSEVERS@BLUEAN	DCO. COM	43. 00

				From 01/01/2014 To 12/31/2014	Part II Date/Time Prep 5/27/2015 11:5	
		Part B				
		Date				
		4. 00				
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	03/10/2015				16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					17. 00
18. 00						18. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					20. 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.					21. 00
			3.00			
	Cost Report Preparer Contact Information		5. 55			
	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		MANAGER			41. 00
42. 00	Enter the employer/company name of the cost r	report				42. 00
43. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					43. 00

 Heal th Financial
 Systems
 HANCOCK

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA

				-	Го 12/31/2014	Date/Time Prep 5/27/2015 11:	
						I/P Days / 0/P	JZ (IIII
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	3	7 13, 50	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3. 00	HMO I PF Subprovi der						3. 00
4.00	HMO I RF Subprovi der						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	40.50	- 0.00	0	6. 00
7. 00	Total Adults and Peds. (exclude observation		3	7 13, 50!	0.00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00	າ	4 8, 760	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	31.00	2	0, 700	0.00	U	9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)		6	1 22, 26!	0.00	o	14. 00
15. 00	CAH visits		0	22, 20.	0.00		15. 00
16. 00	SUBPROVI DER - I PF	40. 00	1	0 3, 650			16. 00
17. 00	SUBPROVI DER - I RF	41. 00		5 1, 82!		0	17. 00
18. 00	SUBPROVI DER	11.00		1, 02		ı .	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	116. 00		7 2, 55!	5		24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)		8	3			27.00
28. 00	Observation Bed Days					0	28.00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00							31. 00
32. 00	Labor & delivery days (see instructions)			0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			I	1	l l	33. 00

				'		5/27/2015 11:	52 am
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 269	426	3, 598			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)		0.10				
2.00	HMO and other (see instructions)	834	918				2.00
3.00	HMO I PF Subprovi der	32	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	1 2/0	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 269	426	3, 598			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	2, 309	0	5, 037			8. 00
9. 00	CORONARY CARE UNIT	2, 309	U	5,037			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	·						12.00
13. 00	· · · · · · · · · · · · · · · · · · ·						13. 00
14. 00	1	3, 578	426	8, 635	0.00	536. 46	1
15. 00	CAH visits	3,370	420	0, 033	0.00	330.40	15.00
16. 00		2, 434	0	2, 643	0.00	18. 09	
17. 00		186	0	2, 043			•
18. 00		100	J	270	0.00	3.10	18.00
19. 00							19.00
20. 00	•						20.00
21. 00	•						21.00
22. 00	HOME HEALTH AGENCY	11, 264	0	18, 440	0.00	29. 27	22. 00
23. 00		1.720.	J	10, 110	0.00		23. 00
24. 00		0	0	0	0.00	16. 79	
24. 10		0	0	694			24. 10
25. 00	1						25. 00
26. 00	RURAL HEALTH CLINIC	269	0	1, 569	0.00	2. 88	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER			,			26. 25
27. 00	Total (sum of lines 14-26)				0.00	606. 59	27. 00
28. 00			0	2, 060			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			118			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	1 . 3	0	26	50			32.00
32. 01				0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
					•	•	

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150037

				To	12/31/2014	Date/Time Prep 5/27/2015 11:	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14. 00	15. 00 2, 579	1, 00
1.00	8 exclude Swing Bed, Observation Bed and			1, 121	90	2, 379	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			252	236		2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO I RF Subprovi der						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						6. 00 7. 00
7. 00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	C	1, 121	96	2, 579	
15. 00	CAH visits		_		_		15. 00
16.00	SUBPROVI DER - I PF	0. 00	C		0	218	
17. 00	SUBPROVIDER - I RF	0. 00	C	17	0	27	17. 00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY						18. 00 19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0. 00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days	0. 00					27. 00 28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'histraction)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days				l		33. 00

Provider CCN: 150037

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | 11/2014 | Part II | P

					To	12/31/2014	Date/Time Pre 5/27/2015 11:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col . 4	COI . 3)	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							-
1.00	Total salaries (see	200. 00	36, 574, 339	0	36, 574, 339	1, 178, 041. 91	31. 05	1.00
0.00	instructions)					0.00		
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0.00	2. 00
3.00	Non-physician anesthetist Part		0	О	0	0.00	0.00	3. 00
4. 00	B Physician-Part A -		0	0	0	0.00	0.00	4. 00
1. 00	Admi ni strati ve		0		Ĭ			
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0	0	0	0. 00 0. 00		
6. 00	Non-physician-Part B		171, 059		171, 059	5, 620. 46	•	1
7.00	Interns & residents (in an	21. 00	0	0	0	0.00		
7. 01	approved program) Contracted interns and		0	0	0	0.00	0.00	7. 01
7.01	residents (in an approved		O			0.00	0.00	7.01
8. 00	programs) Home office personnel		0	_		0.00	0.00	8. 00
9. 00	SNF	44. 00	0	Ö	0	0.00	1	
10.00	Excluded area salaries (see		5, 746, 072	91, 001	5, 837, 073	210, 128. 00	27. 78	10.00
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract Labor: Direct Patient		283, 759	0	283, 759	5, 148. 00	55. 12	11. 00
12. 00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12. 00
12.00	management and other		0		Ĭ	0.00	0.00	12.00
	management and administrative services							
13. 00	Contract Labor: Physician-Part		258, 788	О	258, 788	2, 054. 00	125. 99	13. 00
14. 00	A - Administrative Home office salaries &		0		0	0.00	0. 00	14. 00
14.00	wage-related costs		U			0.00	0.00	14.00
15. 00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15. 00
16. 00	Home office and Contract		0	О	0	0.00	0.00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							1
17. 00	Wage-related costs (core) (see		8, 417, 606	0	8, 417, 606			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
10.00	(see instructions)		O	Ĭ				10.00
19.00	Excluded areas		1, 771, 883	0	1, 771, 883			19.00
20. 00	Non-physician anesthetist Part A		0	0	U			20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	0	0			22. 00
	Admi ni strati ve		_	_				
22. 01 23. 00	Physician Part A - Teaching Physician Part B		48, 061	0	0 48, 061			22. 01 23. 00
24.00	Wage-related costs (RHC/FQHC)		0	Ö	0			24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
	OVERHEAD COSTS - DIRECT SALARIE	S						
26.00	Employee Benefits Department	4. 00	236, 024		236, 024	8, 771. 00		
27. 00 28. 00	Administrative & General Administrative & General under	5. 00	6, 030, 175 1, 039, 087		5, 939, 174 1, 039, 087	168, 137. 00 6, 204. 00	1	•
	contract (see inst.)		_	_	_			
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	0 810, 917	0	0 810, 917	0. 00 27, 573. 00		
31. 00	Laundry & Linen Service	8. 00	010, 717	Ö	010, 717	0.00		
32.00	Housekeepi ng	9. 00	818, 608	0	818, 608	57, 506. 00		
33. 00	Housekeeping under contract (see instructions)		0	"		0. 00	0.00	33. 00
34.00	Di etary	10. 00	1, 080, 269	-708, 906	371, 363	22, 091. 00	1	
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0.00	35. 00
36. 00	Cafeteri a	11. 00	0	708, 906	708, 906	43, 017. 00		
37. 00 38. 00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	0 1, 261, 447	0	0 1, 261, 447	0. 00 31, 461. 00	1	37. 00 38. 00
39.00	Central Services and Supply	14. 00	1, 261, 447 64, 059		64, 059	31, 461.00		
40. 00	Pharmacy	15. 00	1, 385, 223			33, 340. 00		40. 00

Health Financial Systems			HANCOCK REGIO	NAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI	TAL WAGE INDEX INFORMATION			Provi der	CCN: 150037	Peri od:	Worksheet S-3		
						From 01/01/2014	Part II		
						To 12/31/2014			
							5/27/2015 11:		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from	(col.2 ± col.	Salaries in	col. 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00		
41.00	Medical Records & Medical	16. 00	579, 917	0	579, 91	7 24, 328. 00	23. 84	41. 00	
	Records Library								
42.00	Social Service	17. 00	0	0		0.00	0. 00	42.00	
43.00	Other General Service	18. 00	0	0		0.00	0. 00	43.00	

Provider CCN: 150037

Worksheet A Amount Reclassificati Adjusted Paid Hours Average Hourl	,
Worksheet A Allount Neer assists catt Adjusted Fara hours Average hours	
Line Number Reported on of Salaries Salaries Related to Wage (col. 4	
(from (col.2 ± col. Salaries in col.5)	
1.00 2.00 3.00 4.00 5.00 6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY	
1.00 Net salaries (see 37, 442, 367 0 37, 442, 367 1, 178, 625. 45 31.	7 1.00
instructions)	
2.00 Excluded area salaries (see 5,746,072 91,001 5,837,073 210,128.00 27.3	2.00
instructions)	
3.00 Subtotal salaries (line 1 31,696,295 -91,001 31,605,294 968,497.45 32.6	3.00
minus line 2)	
4.00 Subtotal other wages & related 542,547 0 542,547 7,202.00 75.3	4.00
costs (see inst.)	
5.00 Subtotal wage-related costs 8,417,606 0 8,417,606 0.00 26.0	5.00
(see inst.)	
6.00 Total (sum of lines 3 thru 5) 40,656,448 -91,001 40,565,447 975,699.45 41.5	6.00
7. 00 Total overhead cost (see 13, 305, 726 -107, 068 13, 198, 658 426, 077. 00 30. 9	7.00
instructions)	

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form	CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150037	Peri od: Workshee From 01/01/2014 Part IV	t S-3
		To 12/31/2014 Date/Time	e Prepared:

2.00		To 12/31/2014	Date/Time Pre 5/27/2015 11:	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST RETIREMENT COST Separation Company Contribution Contribu			Amount	
PART IV - WAGE RELATED COSTS			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 1,284,370 Qualified Defined Benefit Plan Cost (see instructions) 0 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 401K/TSA Plan Administration fees 0 Legal /Accounting/Management Fees-Pension Plan 10,328 7.00 Employee Managed Care Program Administration Fees 0 PEALTH AND INSURANCE COST Health Insurance (Purchased or Self Funded) 0 0 Prescription Drug Plan 0 0 0 0 0 0 0 0 0	1.00	401K Employer Contributions	0	1.00
Qualified Defined Benefit Plan Cost (see instructions) PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees 0 0 0 0 0 0 0 0 0	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 284, 370	3. 00
	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
10, 328		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
The color of the	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST 8. 00 Heal th Insurance (Purchased or Self Funded) 9. 00 Prescription Drug Plan 10. 00 Dental, Hearing and Vision Plan 11. 00 Life Insurance (If employee is owner or beneficiary) 12. 00 Accident Insurance (If employee is owner or beneficiary) 13. 00 Disability Insurance (If employee is owner or beneficiary) 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance 16. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 736 1 20. 00 State or Federal Unemployment Taxes 0 Day Care Cost and Allowances 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 8, 821 2 24. 00 Total Wage Related cost (Sum of Lines 1 -23) 1. 948, 711 2	6.00	Legal /Accounting/Management Fees-Pension Plan	10, 328	6. 00
Heal th Insurance (Purchased or Self Funded) 9.00 Prescription Drug Plan 0 0 0 0 0 0 0 0 0	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00 Prescription Drug Plan 0 10.00 Dental Hearing and Vision Plan 239, 204 1 11.00 Life Insurance (If employee is owner or beneficiary) 132, 766 1 12.00 Accident Insurance (If employee is owner or beneficiary) 0 1 13.00 Disability Insurance (If employee is owner or beneficiary) 0 1 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 1 15.00 Workers' Compensation Insurance 202, 544 1 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 1 Non cumulative portion) 1 17.00 Insurance 1 1 1 1 1 1 1 1 1		HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan 11.00 Life Insurance (If employee is owner or beneficiary) 12.00 Accident Insurance (If employee is owner or beneficiary) 13.00 Disability Insurance (If employee is owner or beneficiary) 13.00 Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20,736 1 20,736 1 20.00 State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 3,821 2 30 Tuition Reimbursement 49,942 2 40 Total Wage Related cost (Sum of Lines 1 -23)	8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
11. 00 Life Insurance (If employee is owner or beneficiary) 12. 00 Accident Insurance (If employee is owner or beneficiary) 13. 00 Disability Insurance (If employee is owner or beneficiary) 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 736 1 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 30. 0 Tuition Reimbursement 49, 942 2 24. 00 Total Wage Related cost (Sum of Lines 1 -23)	9.00	Prescription Drug Plan	0	9. 00
11. 00 Life Insurance (If employee is owner or beneficiary) 12. 00 Accident Insurance (If employee is owner or beneficiary) 13. 00 Disability Insurance (If employee is owner or beneficiary) 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 736 1 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 30. 0 Tuition Reimbursement 49, 942 2 24. 00 Total Wage Related cost (Sum of Lines 1 -23)	10.00	Dental, Hearing and Vision Plan	239, 204	10. 00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20,736 1 20,736 1 20,00 State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 49,942 2 21.00 Total Wage Related cost (Sum of Lines 1 -23)	11.00		132, 766	11. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20,736 1 20,736 1 20,00 State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 49,942 2 24.00 Total Wage Related cost (Sum of Lines 1 -23)	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
15.00 'Workers' Compensation Insurance 202,544 1 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 1 Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 0 0 1 18.00 Medicare Taxes - Employers Portion Only 0 0 1 19.00 Unemployment Insurance 20,736 1 20.00 State or Federal Unemployment Taxes 0 2 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 8,821 2 23.00 Tuition Reimbursement 49,942 2 24.00 Total Wage Related cost (Sum of Lines 1 -23) 1,948,711 2	13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FI CA-Empl oyers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unempl oyment Insurance 20. 00 State or Federal Unemployment Taxes O THER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 38. 821 2 39. 00 Tuition Reimbursement 49, 942 2 400 Total Wage Related cost (Sum of Lines 1 -23)	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 0 DTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 3. 00 Tuition Reimbursement 49, 942 2 24. 00 Total Wage Related cost (Sum of Lines 1 -23) 17. 00 In the mount of the	15.00	'Workers' Compensation Insurance	202, 544	15. 00
TAXES	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17.00 FI CA-Employers Portion Only 0 18.00 Medicare Taxes - Employers Portion Only 0 19.00 Unemployment Insurance 20,736 1 20.00 State or Federal Unemployment Taxes 0 2 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions) 22.00 Day Care Cost and Allowances 8,821 2 2 2 2 2 2 2 2 2		Non cumulative portion)		
18.00 Medicare Taxes - Employers Portion Only 0 1 19.00 Unemployment Insurance 20,736 1 20.00 State or Federal Unemployment Taxes 0 2 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 2 22.00 Day Care Cost and Allowances 8,821 2 23.00 Tuition Reimbursement 49,942 2 24.00 Total Wage Related cost (Sum of Lines 1 -23) 1,948,711 2		TAXES		
19.00 Unempl oyment Insurance 20,736 1 20.00 State or Federal Unempl oyment Taxes 0 2 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 8,821 2 23.00 Tuition Reimbursement 49,942 2 24.00 Total Wage Related cost (Sum of Lines 1 -23) 1,948,711 2	17.00	FICA-Employers Portion Only	0	17. 00
20.00 State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 3.00 Tuition Reimbursement 49,942 2 24.00 Total Wage Related cost (Sum of Lines 1 -23)	18.00	Medicare Taxes - Employers Portion Only	0	18. 00
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 3.00 Tuition Reimbursement 49,942 2 24.00 Total Wage Related cost (Sum of Lines 1 -23)	19.00	Unempl oyment Insurance	20, 736	19. 00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 49,942 2 24.00 Total Wage Related cost (Sum of Lines 1 -23)	20.00	State or Federal Unemployment Taxes	0	20. 00
instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) 8,821 2 49,942 2 41,948,711 2		OTHER		
22.00 Day Care Cost and Allowances 8,821 2 23.00 Tuition Reimbursement 49,942 2 24.00 Total Wage Related cost (Sum of lines 1 -23) 1,948,711 2	21. 00		0	21. 00
23.00 Tuition Reimbursement 49,942 2 24.00 Total Wage Related cost (Sum of lines 1 -23) 1,948,711 2	22.02		0.004	22.00
24.00 Total Wage Related cost (Sum of lines 1 -23) 1,948,711 2				
Part B - Uther than Lore Related Cost	24. 00		1, 948, 711	24. 00
	05.00			05.00
25. 00 OTHER WAGE RELATED COSTS (SPECIFY)	25. 00	UTHER WAGE RELATED CUSTS (SPECIFY)	0	25. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Pre 5/27/2015 11:	pared:
Cost Center Description		Contract Labor		32 aiii
		1. 00	2. 00	

			5/27/2015 11:	52 am_
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - IPF	0	0	3.00
4.00	Subprovi der - 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	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17.00
18. 00	Other	0	0	18. 00

	Financial Systems	HANCOCK REGION				eu of Form CMS-2	
HOME I	HEALTH AGENCY STATISTICAL DATA			F	eriod: rom 01/01/2014 o 12/31/2014		
			Component	1 CON. 137072 1	Home Health	5/27/2015 11: PPS	52 am
					Agency I		
	To a second	-			1.	00	
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2. 00	3. 00	4. 00	5. 00	
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0 0. 00	0 521. 00				
2.00	Undupi Cated Census Count (See First detrons)	0.00	521.00		oyees (Full Ti		2.00
		Enter the number	er of hours in	Staff	Contract	Total	
		your normal	work week				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		0.00				3. 00
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.00			4. 00 5. 00
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			0. 00 0. 00			•
8. 00	Physical Therapy Service			0.00			1
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0.00			ł
11. 00	Occupational Therapy Supervisor			0.00	0.00	0.00	11. 00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.00			1
14.00	Medical Social Service			0.00	0. 00	0.00	14. 00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0.00			l
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. 00 0. 00			•
	HOME HEALTH AGENCY CBSA CODES					0.00	
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost			5			19. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			99915			20. 00
	during this cost reporting period (line 20 contains the first code).						
20. 01	Solitaring the invest edge).			26900			20. 01
20. 02 20. 03				11300 34620			20. 02 20. 03
20. 04		Full Ep	i sodes	29020			20. 04
				LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
	DDC ACTIVITY DATA	1.00	2. 00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	4, 003	88	1			21. 00
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	659, 572 3, 584	15, 406 4	11, 419 67			1
24.00	Physical Therapy Visit Charges	653, 960	773	9, 663	5, 991	670, 387	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	1, 653 316, 350	0	-			ł
27. 00	Speech Pathology Visits	150	0	C	0	150	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	28, 601 102	0	-		28, 601 103	28. 00 29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	22, 069 1, 234	0 13	-			30. 00 31. 00
32. 00	Home Health Aide Visit Charges	95, 639	1, 034	318	5, 247	102, 238	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	10, 726	105	188	245	11, 264	33. 00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 1, 776, 191	0 17, 213	-		_	34. 00 35. 00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	599		48	13		
37. 00	outlier) Total Number of Outlier Episodes		3		1	4	37. 00
38. 00	Total Non-Routine Medical Supply Charges	71, 719	209	370	7, 095	79, 393	38. 00

	Financial Systems	HANCOCK REGIO				u of Form CN		552-1
	AL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	IED HEALTH CEN	TER Provi der	CCN: 150037	Peri od:	Worksheet :	S-8	
STATIS	STICAL DATA		Componer	t CCN: 153987	From 01/01/2014 To 12/31/2014	Date/Time 5/27/2015		
					Rural Health Clinic (RHC) I	Cos	t	
					1.	00		
	Clinic Address and Identification							
. 00	Street				224 WEST MAIN	STREET		1. 0
			С	i ty	State	Zip Code		
			1	. 00	2. 00	3. 00		
2. 00	City, State, Zip Code, County		KNI GHTSTOWN		IN			2. 0
						1. 00		
3. 00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for ur	ban				0	3.0
					Grant Award	Date		
					1. 00	2. 00		
	Source of Federal Funds							
4. 00	Community Health Center (Section 330(d), PHS				148, 632	01/01/2014	4	4. 0
5.00	Migrant Health Center (Section 329(d), PHS Ad				0			5. 0
5. 00	Health Services for the Homeless (Section 340	O(d), PHS Act)			0			6. 0
7.00	Appal achi an Regi onal Commissi on				0			7. 0
3. 00	Look-Alikes				0			8. 0
9. 00	OTHER (SPECIFY)				0			9. 0
					1 00	2.00		
10. 00	Does this facility operate as other than an F	DUC or EOUC2 Er	stor "V" for v	oc or "N" for	1. 00 N	2. 00	0	10. 0
10.00	no in column 1. If yes, indicate number of or subscripts of line 11 the type of other opera	ther operations	s in column 2.	(Enter in	IN.			10. 0
	Subscripts of Time II the type of other opera		iday	- 	londay	Tuesday		
		from	to	from	to	from		
		1.00	2.00	3.00	4. 00	5. 00		
	Facility hours of operations (1)							
11. 00	Clinic							11. 0
					1.00	2.00		
12. 00	Have you received an approval for an exception	on to the produ	ictivity stand	ard?	1.00	2. 00		12. 0
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N		0	13. 0
	numbers below.	Erst the names	or arr provi	der 5 drid				
				Provi	ider name	CCN number	r	
					1. 00	2. 00		
14. 00	Provider name, CCN number							14. 0
		Y/N	V	XVIII	XIX	Total Visi	ts	
		1. 00	2.00	3. 00	4. 00	5. 00		
15. 00	Have you provided all or substantially all			0	0 0		0	15. 0
	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)							
	(See Tristi deti Olis)		Co	_L unty				
				. 00				
2. 00	City, State, Zip Code, County		HANCOCK 4	. 00				2. C
. 00	Jointy, State, Zip Code, County	Tuesday		nesday	Thur	sday		2. 0
		to	from	to	from	to		
		6. 00	7.00	8. 00	9. 00	10. 00		
	Facility hours of operations (1)	0.00	7.00	0.00	7. 00	10.00		
11 00	Clinic		1	1				11. 0
	10	(I .	1	1	l	- 1	

Health Financial Systems	HANCOCK REGIO	NAL H	OSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH CEN	TER	Provi der	CCN: 150037	Peri od: From 01/01/2014	Worksheet S-8	
STATISTICAL DATA			Componen ⁻	t CCN: 153987	To 12/31/2014	Date/Time Pre 5/27/2015 11:	
					Rural Health	Cost	
					Clinic (RHC) I		
	Fri	day		Sa	turday		
	from		to	from	to		
	11. 00		12.00	13. 00	14. 00		
Facility hours of operations (1)							
11. 00 Clinic							11. 00

Health Financial Systems		HANCOCK REGIO	NAL HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL IDENTIFICATION DATA				Provi der	CCN: 150037	Peri od:	Worksheet S-9	
						From 01/01/2014		
				Component	t CCN: 151547	To 12/31/2014		
							5/27/2015 11:	52 am_
						Hospi ce I		
	Unduplicated							
	Days							
	Title XVIII	Title XIX	Ti tl	le XVIII	Title XIX	All Other	Total (sum of	
			SI	killed	Nursi ng		cols. 1, 2 &	
			N.		Foo! Li ±v		E.)	

		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility	,		, , , , , , , , , , , , , , , , , , ,	
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	3, 636	13	0	0	268	3, 917	2.00
3.00	Inpatient Respite Care	184	0	0	0	12	196	3.00
4.00	General Inpatient Care	355	18	0	0	9	382	4.00
5.00	Total Hospice Days	4, 175	31	0	0	289	4, 495	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	0	0	0	0	0	0	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0. 00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	0. 00	0.00	0.00	0.00	0.00	0. 00	8.00
	5/line 6)							
9.00	Unduplicated Census Count	154	0	0	0	0	154	9. 00

Heal th	Financial Systems HANCOCK REGIONAL HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150037	Peri od:	Worksheet S-10	0
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/27/2015 11:	
					1.00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi Medicaid (see instructions for each line)	ded by li	ne 202 columi	n 8)	0. 332391	1. 00
2. 00	Net revenue from Medicaid				11, 194, 352	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				11, 174, 332	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments	from Medicaio	1?		4.00
5. 00	If line 4 is "no", then enter DSH or supplemental payments from		o mour our		o	5.00
6.00	Medi cai d charges				16, 511, 402	6. 00
7.00	Medicaid cost (line 1 times line 6)				5, 488, 241	7. 00
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of li	nes 2 and 5; if	0	8. 00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructi	ons for e	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	
10.00	Stand-allone SCHIP charges				0	
11.00	Stand-alone SCHIP cost (line 1 times line 10)	1: 11	:	: e +	0	
12. 00	Difference between net revenue and costs for stand-alone SCHIP (enter zero)	iine ii m	inus iine 9;	ir < zero then	U	12. 00
	Other state or local government indigent care program (see instr	uctions f	or each line)		
13. 00	Net revenue from state or local indigent care program (Not inclu				0	13.00
14. 00	Charges for patients covered under state or local indigent care				Ö	
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)				0	15. 00
16. 00	Difference between net revenue and costs for state or local indi	gent care	program (li	ne 15 minus line	0	16. 00
	13; if < zero then enter zero)					
17 00	Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fun	di na char	i ty coro		0	17. 00
17. 00 18. 00	Government grants, appropriations or transfers for support of ho					•
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local			ms (sum of lines		19.00
17.00	8, 12 and 16)	rnar gerre	care program	iis (suii or rriics		17.00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	T		1.00	2.00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (charges excluding non-reimbursable cost centers) for the entire		4, 686, 2	11 0	4, 686, 211	20.00
21. 00	Cost of initial obligation of patients approved for charity care		1, 557, 6	54 0	1, 557, 654	21 00
21.00	times line 20)	(11110-1	1,007,0		1,007,001	21.00
22. 00	· · · · · · · · · · · · · · · · · · ·			0 0	0	22. 00
23.00			1, 557, 6	54 0	1, 557, 654	23. 00
24. 00	Does the amount in line 20 column 2 include charges for patient	days bays	nd a Langth	of stay limit	1. 00	24. 00
24.00	imposed on patients covered by Medicaid or other indigent care p		ilu a religili (or Stay Trillet		24.00
25. 00			ogram's Leng	th of stav limit	0	25. 00
26. 00				or oray rimit	10, 891, 326	
27. 00					104, 852	1
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (lin		s line 27)		10, 786, 474	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe			e 28)	3, 585, 327	
30.00		,			5, 142, 981	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	e 30)			5, 142, 981	31. 00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (HANCOCK REGIONAL		CCN: 150037 P	<u> </u>	u of Form CMS-: Worksheet A	2552-10
RECEAS.	STITEATION AND ADJUSTMENTS OF TRIAL BALANCE (JI EAFENSES	Frovider	F	rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	5/27/2015 11: Recl assi fi ed	52 am
	cost center bescription	Sararres	other	+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		6, 042, 435			6, 042, 435	1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	236, 024	8, 016, 567			8, 252, 591	4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 030, 175 810, 917	12, 346, 952 4, 264, 895			17, 708, 053 5, 079, 295	
	00900 HOUSEKEEPI NG	818, 608	662, 700			1, 481, 308	
	01000 DI ETARY	1, 080, 269	917, 609			686, 809	
	01100 CAFETERI A	0	0	1 (47 005	., ,	1, 311, 069	
	01300 NURSI NG ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1, 261, 447 64, 059	386, 438 62, 249			1, 647, 885 126, 308	
	01500 PHARMACY	1, 385, 223	6, 360, 355			7, 726, 967	
	01600 MEDICAL RECORDS & LIBRARY	579, 917	267, 991			859, 226	
23. 00	02300 PARAMED ED PRGM	68, 188	12, 508	80, 696	0	80, 696	23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 522, 427	654, 753	3, 177, 180	O	3, 177, 180	30.00
	03100 INTENSIVE CARE UNIT	2, 960, 513	748, 832			3, 709, 345	
	04000 SUBPROVI DER - I PF	1, 107, 800	258, 265			1, 366, 065	
41. 00	04100 SUBPROVI DER - I RF	156, 648	60, 790	217, 438	0	217, 438	41.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	2, 389, 797	2, 234, 659	4, 624, 456	O	4, 624, 456	50.00
	05100 RECOVERY ROOM	198, 149	54, 419			252, 568	
	05300 ANESTHESI OLOGY	0	139, 038			139, 038	
	05400 RADI OLOGY-DI AGNOSTI C	2, 280, 541	2, 014, 263			4, 294, 804	
	06000 LABORATORY	1, 466, 165	2, 539, 388			4, 013, 463	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 108, 772 904, 370	296, 926 224, 383			1, 413, 093 1, 128, 753	
	06700 OCCUPATI ONAL THERAPY	251, 541	25, 310			276, 851	1
	06800 SPEECH PATHOLOGY	173, 388	26, 555	199, 943	0	199, 943	
	06801 OCCUPATI ONAL HEALTH	0	0	050.047	0	072.400	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	443, 679	507, 168 3, 189, 177			972, 680 3, 189, 177	
	07200 I MPL. DEV. CHARGED TO PATIENT		1, 649, 055			1, 649, 055	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	1
	03020 CARDI AC	0	0	0	0	0	
76. 01	03160 CARDIOPULMONARY OUTPATIENT SERVICE COST CENTERS	50, 114	43, 883	93, 997	0	93, 997	76. 01
88. 00	08800 RURAL HEALTH CLINIC	171, 059	93, 356	264, 415	0	264, 415	88. 00
	09000 CLI NI C	0	0	C	-	0	
	09001 WOUND CLINIC	591, 241	273, 414			864, 655	
	O9002 DIABETES CLINIC O9003 ASTHMA CLINIC	33, 598	7, 751 0	41, 349	0	41, 349 0	ı
	09004 ANDIS CLINIC	43, 753	61, 857	105, 610	Ö	105, 610	
	09005 PRIME TIME	0	108, 748			108, 748	1
	09006 SHELBYVILLE WOUND CLINIC	127, 238	135, 538			262, 776	
	04951 ONCOLOGY 04950 ANDERSON WOMENS CENTER	452, 144 221, 923	1, 004, 251 67, 000			1, 456, 395 288, 923	
	09100 EMERGENCY	2, 171, 216	536, 626			2, 707, 842	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	70/ 204	222.040	4/2 425		4/2 425	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	796, 304	-333, 869	462, 435	0	462, 435	1101.00
116. 00	11600 HOSPI CE	1, 038, 801	1, 140, 921	2, 179, 722	0	2, 179, 722	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	33, 996, 008	57, 103, 156			90, 463, 418	
	NONREI MBURSABLE COST CENTERS						1400 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PROFESSIONAL BUILDING	0	538, 872	538, 872	-33, 328	0 505, 544	190.00
	19002 PHYSI CLAN BUI LDI NG	6	103, 400			103, 406	
190. 03	19003 PRI VATE DUTY	406, 663	224, 655			631, 318	
190 0/1	19004 MARKETI NG	0	0	C		669, 074	
	1 · · · · · · · · · · · · · · · · · · ·		()	0	-	0 181, 914	190. 05
190. 05	19005 WATER LAB	121 650	40 254	101 01/			
190. 05 190. 06	19005 WATER LAB 19006 FOUNDATION	121, 658	60, 256 720				
190. 05 190. 06 190. 07 190. 08	19005 WATER LAB 19006 FOUNDATION 19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	121, 658 0 0	60, 256 720 0	720 0	0	720	190. 07
190. 05 190. 06 190. 07 190. 08 190. 09	19005 WATER LAB 19006 FOUNDATION 19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19009 HANCOCK OB	0 0 1, 067, 887	720 0 2, 486, 476	720 0 3, 554, 363	O O O	720 0 3, 554, 363	190. 07 190. 08 190. 09
190. 05 190. 06 190. 07 190. 08 190. 09 190. 10	19005 WATER LAB 19006 FOUNDATION 19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19009 HANCOCK OB 19010 HANCOCK WELLNESS	0 0	720 0	720 0 3, 554, 363	O O O	720 0 3, 554, 363 1, 981, 841	190. 03 190. 08 190. 09 190. 10
190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11	19005 WATER LAB 19006 FOUNDATION 19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19009 HANCOCK OB 19010 HANCOCK WELLNESS 19011 MORRISTOWN CLINIC	0 0 1, 067, 887 841, 127 0	720 0 2, 486, 476 1, 140, 714 0	720 C 3, 554, 363 1, 981, 841	0 0 0 0	720 0 3, 554, 363 1, 981, 841 0	190. 00 190. 00 190. 00 190. 10 190. 10
190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11 190. 12	19005 WATER LAB 19006 FOUNDATION 19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19009 HANCOCK OB 19010 HANCOCK WELLNESS	0 0 1, 067, 887	720 0 2, 486, 476	720 C 3, 554, 363 1, 981, 841 C 1, 700	0 0 0 0 0	720 0 3, 554, 363 1, 981, 841 0 1, 700	190. 07 190. 08 190. 09 190. 10 190. 11
190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11 190. 12 190. 13 190. 14	19005 WATER LAB 19006 FOUNDATION 19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19009 HANCOCK OB 19010 HANCOCK WELLNESS 19011 MORRISTOWN CLINIC 19012 03PUREMED 19013 MCCORD WELLNESS 19014 3 WEST UNIT	0 0 1, 067, 887 841, 127 0 95, 508 0 45, 482	720 0 2, 486, 476 1, 140, 714 0 -93, 808 7, 736 82, 564	720 3, 554, 363 1, 981, 841 C 1, 700 7, 736 128, 046	0 0 0	720 0 3, 554, 363 1, 981, 841 0 1, 700 7, 736 128, 046	190. 07 190. 08 190. 09 190. 10 190. 11 190. 13 190. 14
190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11 190. 12 190. 13 190. 14	19005 WATER LAB 19006 FOUNDATION 19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19009 HANCOCK OB 19010 HANCOCK WELLNESS 19011 MORRISTOWN CLINIC 19012 03PUREMED 19013 MCCORD WELLNESS 19014 3 WEST UNIT 19015 NEUROLOGY PHYSICIAN	0 0 1, 067, 887 841, 127 0 95, 508	720 0 2, 486, 476 1, 140, 714 0 -93, 808 7, 736	720 3, 554, 363 1, 981, 841 0 1, 700 7, 736 128, 046 36, 000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	720 0 3, 554, 363 1, 981, 841 0 1, 700 7, 736 128, 046 36, 000	190. 07 190. 08 190. 09 190. 10 190. 11 190. 12 190. 14 190. 15

Provider CCN: 150037

Peri od: From 01/01/2014 To 12/31/2014 Worksheet A Date/Time Prepared: 5/27/2015 11:52 am

			5/27/2015 11:	52 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT	-1, 149, 700	4, 892, 735		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 904, 301	5, 348, 290		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-5, 172, 065			5. 00
7. 00 00700 OPERATION OF PLANT	-57, 080			7. 00
9. 00 00900 HOUSEKEEPI NG	-11, 700			9. 00
10. 00 01000 DI ETARY	-356, 300	330, 509		10.00
11. 00 01100 CAFETERIA	-47, 853	1, 263, 216		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-22, 805			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	-37, 149			14. 00
15. 00 01500 PHARMACY	-680, 530	7, 046, 437		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	-66, 513	792, 713		16. 00
23.00 02300 PARAMED ED PRGM	-60, 105	20, 591		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-1, 747	3, 175, 433		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	3, 709, 345		31.00
40. 00 04000 SUBPROVI DER - PF	-96, 000			40.00
				41.00
	-36, 000	181, 438		41.00
ANCILLARY SERVICE COST CENTERS	200 000	4 007 450		
50. 00 05000 OPERATI NG ROOM	-388, 298			50.00
51.00 05100 RECOVERY ROOM	0			51. 00
53. 00 05300 ANESTHESI OLOGY	-130, 587	8, 451		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-355, 446	3, 939, 358		54.00
60. 00 06000 LABORATORY	-213, 202	3, 800, 261		60.00
65. 00 06500 RESPIRATORY THERAPY	-130, 313	1, 282, 780		65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 128, 753		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	276, 851		67. 00
68. 00 06800 SPEECH PATHOLOGY	-1, 250			68. 00
i i	-1, 230	170, 073		68. 01
68. 01 06801 OCCUPATI ONAL HEALTH		- 1		
69. 00 06900 ELECTROCARDI OLOGY	-290			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 189, 177		71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENT	0	1, 649, 055		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
76. 00 03020 CARDI AC	0	0		76. 00
76. 01 03160 CARDI OPULMONARY	0	93, 997		76. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	-6, 670	257, 745		88. 00
90. 00 09000 CLI NI C	0,070	207,710		90.00
	_			90.00
90. 01 09001 WOUND CLINIC	-7, 248			
90. 02 09002 DI ABETES CLI NI C	-350	40, 999		90. 02
90. 03 09003 ASTHMA CLINIC	0	0		90. 03
90. 04 09004 ANDIS CLINIC	-4, 875			90. 04
90. 05 09005 PRI ME TI ME	0	108, 748		90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	-324	262, 452		90. 06
90. 07 04951 ONCOLOGY	-520, 077	936, 318		90. 07
90.08 04950 ANDERSON WOMENS CENTER	-3, 065	285, 858		90. 08
91. 00 09100 EMERGENCY	-61, 104	2, 646, 738		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	01,101	2,010,700		92.00
OTHER REIMBURSABLE COST CENTERS				72.00
101.00 10100 HOME HEALTH AGENCY	2 021 144	2 202 570		101.00
	2, 821, 144	3, 283, 579		1101.00
SPECIAL PURPOSE COST CENTERS	44.010	0.404.000		11/ 00
116. 00 11600 HOSPI CE	-44, 840			116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-9, 746, 643	80, 716, 775		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190. 01 19001 PROFESSI ONAL BUILDING	0	505, 544		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	103, 406		190. 02
190. 03 19003 PRI VATE DUTY	0	631, 318		190. 03
190. 04 19004 MARKETI NG	0	669, 074		190. 04
190. 05 19005 WATER LAB	0	0		190. 05
190. 06 19006 FOUNDATION	0	181, 914		190.06
190. 07 19007 ASC		720		190. 07
190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 08
190. 09 19009 HANCOCK OB	0	3, 554, 363		190. 09
190. 10 19010 HANCOCK WELLNESS	0	1, 981, 841		190. 10
190.11 19011 MORRISTOWN CLINIC	0	0		190. 11
190. 12 19012 03PUREMED	0	1, 700		190. 12
190. 13 19013 MCCORD WELLNESS	0	7, 736		190. 13
190. 14 19014 3 WEST UNIT	l n	128, 046		190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	0	36, 000		190. 15
200. 00 TOTAL (SUM OF LINES 118-199)	-9, 746, 643			200.00
200.00 TOTAL (30M OF LINES 110-177)	1 7, 740, 043	00,010,407	I	1200.00

Heal th Financial Systems

HANCOCK REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 150037

Period: From 01/01/2014 To 12/31/2014

Propagation of Form CMS-2552-10

Provider CCN: 150037

Period: From 01/01/2014 To 12/31/2014

Propagation of Form CMS-2552-10

Date/Time Prepared:

					10	12/31/2014	5/27/2015 11	epared: :52 am
		Increases			' '			
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	A - CAFETERIA RECLASS							
1.00	CAFETERI A	11. 00	70 <u>8, 9</u> 06	602, 163				1. 00
	TOTALS		708, 906	602, 163				
	B - PLANT RECLASS							
1.00	OPERATION OF PLANT	7. 00	0	3, 483				1. 00
2.00	MEDICAL RECORDS & LIBRARY	16. 00	0	11, 318				2. 00
3.00	ELECTROCARDI OLOGY	69.00	0	11, 132				3. 00
4.00	RESPI RATORY THERAPY	65.00						4. 00
	TOTALS		0	33, 328				
	C - MARKETING RECLASS							
1.00	MARKETI NG	1 <u>90.</u> 04	9 <u>1, 0</u> 01	57 <u>8, 0</u> 73				1. 00
	TOTALS		91, 001	578, 073				_
	D - OUTPATIENT PROCEDURE RECL	.ASS						
1.00	LABORATORY	60.00	6, 829	1, 081				1. 00
2.00	ELECTROCARDI OLOGY	<u>69.</u> 00	9, 238	<u>1, 4</u> 63				2. 00
	TOTALS		16, 067	2, 544				
500.00	Grand Total: Increases		815, 974	1, 216, 108				500.00

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 150037 Period: From 01/01/2014 To 12/31/2014 Date/Time Prepared:

					То	12/31/2014 Date/Time Pr 5/27/2015 11	epared: :52 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	1000	708, 906	602, 163	0		1. 00
	TOTALS		708, 906	602, 163			
	B - PLANT RECLASS						
1.00	PROFESSI ONAL BUILDING	190. 01	0	33, 328	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0		4. 00
	TOTALS		0	33, 328			
	C - MARKETING RECLASS						
1.00	ADMI NI STRATI VE & GENERAL	5. 00	91, 001	57 <u>8, 0</u> 73	0		1. 00
	TOTALS		91, 001	578, 073			
	D - OUTPATIENT PROCEDURE RECL	.ASS					
1.00	PHARMACY	15. 00	16, 067	2, 544	0		1. 00
2.00		0.00	0	0	0		2. 00
	TOTALS		16, 067	2, 544			
500.00	Grand Total: Decreases		815, 974	1, 216, 108			500.00

Provi der CCN: 150037

					To 12/31/2014		pared:
				Acqui si ti ons		3/2//2013 11.	JZ (IIII
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	270, 285	970, 909		0 970, 909	0	1. 00
2.00	Land Improvements	5, 505, 951	0		0	0	2. 00
3.00	Buildings and Fixtures	43, 186, 865	0		0	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equi pment	53, 707, 886	2, 798, 103		0 2, 798, 103		5. 00
6.00	Movable Equipment	58, 064, 889	4, 229, 131		0 4, 229, 131	60, 610	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	160, 735, 876	7, 998, 143		0 7, 998, 143	289, 430	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	160, 735, 876	7, 998, 143		0 7, 998, 143	289, 430	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1. 00	Land	1, 241, 194	0				1. 00
2.00	Land Improvements	5, 505, 951	0				2. 00
3.00	Buildings and Fixtures	43, 186, 865	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	56, 277, 169	0				5. 00
6. 00	Movable Equipment	62, 233, 410	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	168, 444, 589	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	168, 444, 589	0				10. 00

Heal th	Financial Systems	HANCOCK REGION	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150037	Peri od: From 01/01/2014 To 12/31/2014		pared:
			SU	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	6, 042, 435	0		0	0	1. 00
3.00	Total (sum of lines 1-2)	6, 042, 435	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	6, 042, 435				1. 00
3.00	Total (sum of lines 1-2)	0	6, 042, 435				3. 00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
				From 01/01/2014 To 12/31/2014		ared:
				10 12/31/2014	5/27/2015 11:5	
	COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col 2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				1		
1.00 NEW CAP REL COSTS-BLDG & FLXT	43, 186, 865	0	43, 186, 86	5 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	43, 186, 865	0	43, 186, 86	5 1.000000	0	3.00
	ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	/ 00	d Costs	through 7)	0.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	6. 00	7. 00	8. 00	9. 00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	INTERS 0	0		0 5, 555, 560	-660, 452	1. 00
3.00 Total (sum of lines 1-2)	0			0 5, 555, 560		3. 00
3. 00 10 tai (30iii 01 111ie3 1-2)	0		JMMARY OF CAPI		-000, 432	3.00
		30	JIMINATE OF CALL	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		_		_		
1.00 NEW CAP REL COSTS-BLDG & FIXT	-2, 373			0	.,,	1. 00
3.00 Total (sum of lines 1-2)	-2, 373	0	1	0 0	4, 892, 735	3. 00

OSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 150037 | Period: | Worksheet A-8 | From 01/01/2014 | Pata/Time Propagation

				t	o 12/31/2014		
				Expense Classification on To/From Which the Amount is		5/27/2015 11:	52 am
					,		
	Cook Cookin Doorsinkiiss	D: - (0-d- (2)	A	Cook Cooker	1: "	MI+ A 7 D-6	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		O	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1. 00
2. 00	2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8.00	21) Tellevision and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 832, 521		0. 00	0	
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13. 00 14. 00	Laundry and Linen service Cafeteria-employees and guests		0		0. 00 0. 00	0	
15. 00	Rental of quarters to employee and others		0		0.00		1
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	
22. 00	interest, finance or penalty charges (chapter 21) Interest expense on Medicare		0		0.00		
22.00	overpayments and borrowings to repay Medicare overpayments		O		0.00	0	22.00
23. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP		0	FIXT *** Cost Center Deleted ***	2.00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00		28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00

| Peri od: | Worksheet A-8 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

				T	o 12/31/2014	Date/Time Prep 5/27/2015 11:5	
				Expense Classification on To/From Which the Amount is		0,2,,,2010	<u> </u>
				10711 oill will cit the Allount 13	to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
33. 00	HRH MMO RENTAL INCOME	1. 00 B	2. 00 -652, 294	3.00 NEW CAP REL COSTS-BLDG &	4. 00 1. 00	5. 00 10	33. 00
33. 01	HRH HUMAN RESOURCES	В	-15, 604	FIXT EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 01
33. 02	MI SCELLANEOUS RE HRH OTHER REVENUE SALES TAX	В		ADMI NI STRATI VE & GENERAL	5. 00	0	33. 02
33. 03	HRH OTHER REVENUE MI SCELLANEOUS REVE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	HRH OTHER REVENUE HEARTBEATS	В	-435	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	REVENUE HRH OTHER REVENUE CHARGE	В	-90	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33. 06	CARD-OTHER HRH GREENFIELD PAR EDUCATION	В	78	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	SERVICE HRH MED STAFF SERV QA	В	-18, 000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	APPLICATION FE HRH MEDICAL DUES MEDICAL STAFF	В	-21, 450	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	DUES HRH PAT FIN. SERV. BUSINESS	В	-2, 012	ADMINISTRATIVE & GENERAL	5.00	0	33. 09
33. 10	SERV-COP HRH PAT FIN. SERV. EXPENSE	В	-49, 398	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11	REIMBURSE HRH INFO SERVICES	В	-91, 716	ADMI NI STRATI VE & GENERAL	5. 00	0	33. 11
33. 12	MI SCELLANEOUS REVE HRH ACCOUNTING MI SCELLANEOUS	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 13	REVENUE HRH ACCOUNTING MANAGEMENT FEES			ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	HRH EXEC ADMIN MISCELLANEOUS REVENUE	В		ADMI NI STRATI VE & GENERAL	5. 00	0	33. 14
33. 15	HRH PURCHASING REBATES/REFUNDS			ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	HRH COMMUNICATIONS MISCELLANEOUS REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
33. 17	HRH COMMUNICATIONS PHONE LEASE REVEN	В	-184, 349	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	HRH COMM EDUCATION MISCELLANEOUS REV	В	-100	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	HRH COMM EDUCATION EDUCATION SERVICE	В	-9, 176	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20	HRH TOBACCO AWARENE MI SCELLANEOUS RE	В	-200	ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 22 33. 23	HRH GAIN/LOSS INVENTORY HRH GAIN/LOSS GROSS VARIANCE	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 22 33. 23
33. 24	I NVENTO HRH SECURITY MI SCELLANEOUS	В		ADMINISTRATIVE & GENERAL	5. 00	0	
	REVENUE				7. 00	0	
33. 25 33. 28	HRH PLANT OFFSITE SERVICES HRH HOUSEKEEPING ENVIRONMENTAL	B B		OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	33. 25 33. 28
33. 29	HRH NUTRITIONAL SER	В	-2, 066	DI ETARY	10.00	0	33. 29
33. 30	REBATES/REFUNDS HRH NUTRITIONAL SER LTACH	В	-16, 462	DI ETARY	10.00	0	33. 30
33. 31	REVENUE HRH NUTRITIONAL SER	В	-528	DI ETARY	10. 00	0	33. 31
33. 32	MI SCELLANEOUS RE HRH CLINICAL EDUCAT AHA COURSE	В	-14, 781	NURSING ADMINISTRATION	13. 00	0	33. 32
33. 33	REVEN HRH CLINICAL EDUCAT EDUCATION	В	-195	NURSING ADMINISTRATION	13. 00	0	33. 33
33. 34	SERVIC HRH OTHER REVENUE	В		CENTRAL SERVICES & SUPPLY	14. 00	0	
33. 35	REBATES/REFUNDS HRH OTHER REVENUE DISCOUNTS	В		CENTRAL SERVICES & SUPPLY	14. 00	0	33. 35
33. 36	EARNED O HRH PHARMACY MI SCELLANEOUS	В		PHARMACY	15. 00	0	
33. 37	REVENUE HRH PHARMACY REBATES/REFUNDS	В		PHARMACY	15. 00		33. 37
33. 38	HRH ASSOCIATE PHARM RETAIL	В		PHARMACY	15. 00	0	33. 38
33. 39	PHARMACY- HRH ASSOCIATE PHARM HOSPICE	В	-72, 107	PHARMACY	15. 00	0	33. 39
33. 40	PHARMACY HRH ASSOCIATE PHARM	В	-5, 459	PHARMACY	15. 00	0	33. 40
	MI SCELLANEOUS RE			I			

| Peri od: | Worksheet A-8 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150037

							Date/Time Prepared: 5/27/2015 11:52 am	
		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			3/2//2015 11.	oz alli		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 Ref. 5.00		
33. 41	HRH HEALTH INFO SER MEDICAL	В		MEDICAL RECORDS & LIBRARY	16. 00	0	33. 41	
33. 42	RECORDS- HRH HEALTH INFO SER MISCELLANEOUS RE	В	-65, 424	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 42	
33. 43 33. 44	HRH ANDIS UNIT REBATES/REFUNDS	В	-1, 747	ADULTS & PEDIATRICS	30.00	0	33. 43	
33. 45 33. 46	HRH DIAG IMAGING MISCELLANEOUS	В	0	RADI OLOGY-DI AGNOSTI C	0. 00 0. 00 54. 00	0	33. 44 33. 45 33. 46	
	REVEN					0		
33. 47	HRH DIAG IMAGING HEARTBEATS REVENUE	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 47	
33. 48	HRH PIC - AHN EXPENSE REIMBURSEMENT	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 48	
33. 50	HRH MMO-RAD HEARTBEATS REVENUE	В		RADI OLOGY DI AGNOSTI C	54.00	0	33. 50	
33. 51 33. 52	HRH MMO EXPENSE REIMBURSEMENT HRH LAB WATER TESTING	B B		RADI OLOGY-DI AGNOSTI C LABORATORY	54. 00 60. 00	0	33. 51 33. 52	
33. 52	HRH LAB HEARTBEATS REVENUE	В		LABORATORY	60.00	0	33. 52	
33. 54	HRH LAB MISCELLANEOUS REVENUE	В		LABORATORY	60.00	0	33. 54	
33. 55	HRH SLEEP STUDY CLINIC MANAGMENT	В		RESPIRATORY THERAPY	65. 00	0	33. 55	
33. 56	HRH SLEEP STUDY SLEEP STUDY FEES	В	-60, 171	RESPIRATORY THERAPY	65. 00	0	33. 56	
33. 58	HRH CARDIO SERV HEARTBEATS REVENUE	В	-290	ELECTROCARDI OLOGY	69. 00	0	33. 58	
33. 59	THE VEHICLE		0		0.00	0	33. 59	
33.60			0		0.00	0	33. 60	
33. 62			0		0.00	0	33. 62	
33. 63			0		0.00	0	33. 63	
33. 64	HRH AWC GENERAL BOUTIQUE SERVICES	В	-3, 065	ANDERSON WOMENS CENTER	90. 08	0	33. 64	
33. 65 33. 66	HRH E R REBATES/REFUNDS HRH HOME HEALTH MISCELLANEOUS	B B		EMERGENCY HOME HEALTH AGENCY	91. 00 101. 00	0 0	33. 65 33. 66	
33. 67 33. 68 33. 69	REVENU		0		0.00	0	33. 67	
	HRH HOSPICE MISCELLANEOUS	В	0 -44, 840	HOSPI CE	0. 00 116. 00	0	33. 68 33. 69	
33. 70	REVENUE MOW	А	-337, 244	DI ETARY	10. 00	0	33. 70	
33. 71	CAFETERIA GUEST MEALS	Α		CAFETERI A	11. 00	0	33. 71	
33. 72	PHYSICIAN RECRUITMENT FEES	Α	-58, 968	ADMINISTRATIVE & GENERAL	5. 00	0	33. 72	
33. 73	DONATIONS & SPONSORSHIPS	Α	-5, 690	ADMINISTRATIVE & GENERAL	5. 00	0	33. 73	
33.74	ADVERTISING FEE	A	-352, 033	ADMINISTRATIVE & GENERAL	5. 00	0	33. 74	
33. 77	ADVERTISING FEE	A	-2, 903	WOUND CLINIC	90. 01	0	33. 77	
33. 78	ADVERTISING FEE	A		SHELBYVILLE WOUND CLINIC	90. 06	0		
33. 79	THA LOBBYING EXPENSE	Α	·	ADMINISTRATIVE & GENERAL	5. 00	0		
33. 80	AHA LOBBYING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5. 00	0	33. 80	
33. 81	PHY OFFI CE BLDG	A		NEW CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 81	
33. 82	PHY OFFICE BLDG	Α	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 82	
33. 83	PHY OFFICE BLDG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 83	
33. 84	PHY OFFICE BLDG	Α	·	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 84	
33. 85	PHY OFFI CE BLDG	A	·	RURAL HEALTH CLINIC	88.00	0	33. 85	
33. 86	I NTEREST REVENUE	В	·	NEW CAP REL COSTS-BLDG & FLXT	1. 00	11	33. 86	
33. 87	RENTAL PROPERTIES EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0		
33. 88	RENTAL PROPERTIES EXPENSE	A		NEW CAP REL COSTS-BLDG & FLXT	1. 00	10		
33. 89	RENTAL PROPERTIES EXPENSE	A		OPERATION OF PLANT	7. 00	0	33. 89	
33. 90	TELEPHONE SERVICES	A		ADMINISTRATIVE & GENERAL	5.00	0	33. 90	
33. 91 33. 92	XRAY SCHOOL TUITION REVENUE HAF EXPENSE	B A		PARAMED ED PRGM ADMINISTRATIVE & GENERAL	23. 00 5. 00	0	33. 91 33. 92	
33. 92	SELF INSURANCE CLAIM EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 92	
34. 00	SUBURBAN EXPENSE	A		HOME HEALTH AGENCY	101. 00	0	34. 00	
34. 01	SALE OF USED EQUIPMENT	B		RADI OLOGY-DI AGNOSTI C	54.00	0	34. 01	
34. 02	OTHER ADJUSTMENTS (SPECIFY)	-	0		0. 00	Ö	34. 02	
34. 03	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34. 03	
34. 04	(3) OTHER ADJUSTMENTS (SPECIFY)		Ω		0.00	0	34. 04	
	(3)				0.00			

Health Financial Systems			HANCOCK REGIO	NAL HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES				Provi der CCN: 150037	Peri od:	Worksheet A-8		
					From 01/01/2014			
					To 12/31/2014			
						5/27/2015 11:	52 am	
				Expense Classification				
				To/From Which the Amount i				
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
		1.00	2. 00	3. 00	4. 00	5. 00		
34. 05	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34. 05	
	(3)							
50.00	TOTAL (sum of lines 1 thru 49)		-9, 746, 643				50.00	
	(Transfer to Worksheet A,							
	column 6, line 200.)							

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

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

 B. Amount Received if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provider CCN: 150037

					1	Го 12/31/2014	Date/Time Pre 5/27/2015 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	mrst. A Line "	I denti fi er	Remuneration	Component	Component	ROL AMOUNT	ider Component	
							Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	362, 327	362, 327	0	0	-	1. 00
2.00		NURSING ADMINISTRATION	7, 829			l		2. 00
3.00		SUBPROVIDER - IPF	96, 000			0	1	3. 00
4.00		SUBPROVI DER - I RF	36, 000			0		4. 00
5.00		OPERATING ROOM	388, 298			0	1	5. 00
6.00		ANESTHESI OLOGY	130, 587	130, 587		0	-	6. 00
7. 00		RADI OLOGY-DI AGNOSTI C	87, 500			0	0	7. 00
8.00		LABORATORY	114, 583			0	0	8. 00
9.00		RESPI RATORY THERAPY	18, 500			0	1	9. 00
10.00		SPEECH PATHOLOGY	1, 250			0	-	10.00
12.00		WOUND CLINIC	4, 345			0		12.00
13.00		DIABETES CLINIC	350	•		0	l "I	13.00
14. 00 15. 00		ANDIS CLINIC ONCOLOGY	4, 875 520, 077	4, 875 520, 077	0	0	0	14. 00 15. 00
16. 00		EMERGENCY	60, 000		0	0	0	16. 00
200.00	91.00	EWERGENCT	1, 832, 521	1, 832, 521	0	U	0	200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	WKSt. A LITTE #	I denti fi er	Li mi t	Unadjusted RCE		Component	of Malpractice	
		racittifici	Li iiii C	Li mi t	Continuing	Share of col.	Insurance	
					Education	12	Trisul direc	
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	0	0		0		1. 00
2.00		NURSING ADMINISTRATION	0	0	0	0	o	2.00
3.00	40. 00	SUBPROVIDER - IPF	0	0	0	0	o	3.00
4.00	41. 00	SUBPROVIDER - IRF	0	0	0	0	o	4.00
5.00	50. 00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	6. 00
7.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	7. 00
8.00		LABORATORY	0	0	0	0	0	8. 00
9.00		RESPI RATORY THERAPY	0	0	0	0	-	9. 00
10.00	68. 00	SPEECH PATHOLOGY	0	0	0	0	0	10. 00
12.00		WOUND CLINIC	0	0	0	0	-	12.00
13. 00		DIABETES CLINIC	0	0	0	0	1	13. 00
14. 00		ANDIS CLINIC	0	0		0	0	14. 00
15. 00		ONCOLOGY	0	0		0	0	15. 00
16. 00	91. 00	EMERGENCY	0	0	0	0	-	16. 00
200.00	14/1 1 4 1 1 //	0 1 0 1 (8)	0	0	0	0	0	200. 00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		ADMINISTRATIVE & GENERAL	10.00	10.00		362, 327		1. 00
2. 00		NURSI NG ADMINI STRATI ON	l n	Ö		7, 829		2. 00
3. 00		SUBPROVI DER - I PF	0	Ō	0	96, 000		3. 00
4.00		SUBPROVI DER - I RF	0	0	0	l		4. 00
5.00	50. 00	OPERATING ROOM	0	0	0	388, 298		5. 00
6.00		ANESTHESI OLOGY	0	0	0			6. 00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	0			87, 500	1	7. 00
8.00		LABORATORY	0	1		114, 583		8. 00
9.00		RESPI RATORY THERAPY	0	0	0	18, 500		9. 00
10.00		SPEECH PATHOLOGY	0	0	0	1, 250		10.00
12.00	90. 01	WOUND CLINIC	0	0	0	4, 345		12.00
13.00		DIABETES CLINIC	0	0	0	350		13.00
14. 00		ANDIS CLINIC	0			4, 875		14.00
15. 00		ONCOLOGY	0			520, 077		15.00
16.00	91. 00	EMERGENCY	0			60, 000		16.00
200.00			0	0	0	1, 832, 521		200.00

| Peri od: | Worksheet B | From 01/01/2014 | Part | To | 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150037

Cost Center Description					o 12/31/2014	Date/Time Pre	
Ref Company			CAPI TAI			5/2//2015 11:	52 am
A							
Company Comp	Cost Center Description	Net Expenses		EMPLOYEE	Subtotal	ADMI NI STRATI VE	
ERINESIA SERVICE COST CENTERS 0			FLXT			& GENERAL	
CHILD 1.00				DEPARTMENT			
FIRSTALL SPENUTC FORT CENTERS 1.00		7					
1.00			1.00	4.00	4A	5. 00	
0.000 DOMPO DEPLOYEE BEREFITS DEPARTWENT 1, 345, 598 336, 409 77.72 13, 765, 749 1, 765, 749 7, 70							
5.00 0.0000 CORNIN ISTRATIVE & CENERAL 12,055, '988 303,049 876,712 13,765,749 10,000		The state of the s					
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000						40 7/5 740	
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.00000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000		1					
10.00 1000 DETARY 330.509 49, 104 54.820 434, 433 80, 001 10.00 1010 DETARY 12.03, 216 13.208 186, 212 1, 824, 509 336, 000 13.008 13.208 186, 212 1, 824, 509 336, 000 13.008 13.208 186, 212 1, 824, 509 336, 000 13.008 13.208 186, 212 1, 824, 509 336, 000 13.008 13.208							
11.00 01100 CAFETERIA 1.203.216 93.731 104.447 1, 461.594 2269.156 11.00 13.00							
14.00 01400 CENTRAL SERVICES & SUPPLY 89, 169 0 9, 460 98, 615 18, 160 14, 00 16.00 01400 WIRICAL RECORDS & LIBRARY 792, 713 42, 698 85, 608 421, 071 166, 606 16.00 16.00 16.00 WIRICAL RECORDS & LIBRARY 792, 713 42, 698 85, 608 421, 071 166, 606 16.00 16	11. 00 01100 CAFETERI A	1, 263, 216		104, 647			11. 00
15.00 01500 PHARMACY 7, 044, 437 71, 685 202, 112 7, 320, 234 1, 347, 994 15.00 2300 PHARMACY 10.00		1					
16.00 1600 REDICAL RECORDS & LIBRARY 702, 713 42, 608 85, 606 921, 017 109, 606 16. 00			1		1		
0.300 PARAMED ED PROM 20,501 16,307 10,066 46,964 8,648 23,00		1					
IMPATT ENT ROUTINE SERVICE COST CENTERS 3, 175, 433 343, 658 372, 356 3, 891, 447 716, 614 30, 00 03000 (AURITS & PERD TRIC SS 3, 175, 433 343, 658 372, 356 3, 891, 447 716, 614 31, 00 04000 (JURTENS) 20, 1435, 755 816, 849 31, 00 04000 (JURTENS) 20, 1435, 755 816, 849 31, 00 04100 (JURTENS) 20, 1435, 755 21, 1435, 755 816, 849 31, 00 04100 (JURTENS) 22, 143 22, 23, 31 40, 939 41, 00 04100 (JURTENS) 22, 143 22, 23, 31 40, 939 41, 00 04100 (JURTENS) 22, 143 22, 23, 31 40, 939 41, 00 05, 00		1					
30.00		20,371	10, 307	10,000	, +0, 70+	0,040	25.00
40.00 04000 SUBPROVIDER - FF 1,270,065 77,363 163,531 1,510,959 278,245 40,000		3, 175, 433	343, 658	372, 356	3, 891, 447	716, 614	30. 00
14.00 04100 SUBPROVIDER - IRF 181 438 17, 751 23, 124 222, 313 40, 93 41, 00		1					
MICH LARY SERVICE COST CENTERS 280,036 352,777 4,874,971 897,731 50.00 51.00 05100 0	· · · · · · · · · · · · · · · · · · ·						
50.00		181, 438	17, 751	23, 124	222, 313	40, 939	41.00
51.00		4 236 158	286 036	352 777	4 874 971	897 731	50.00
1.5							
60.00 06000 ABDRATORY 3,800,261 77,996 217,440 4,04,797 754,661 60.00 66.00 06600 RESPIRATORY THERAPY 1,282,780 28,003 163,751 1,474,508 271,532 65.00 66.00 06600 RESPIRATORY THERAPY 1,282,780 28,003 163,7132 313,891 57,820 67.00 67.00 6700 000		1	1				
65.00 06500 RESPIRATORY THERAPY 1, 282, 780 28, 053 163, 675 1, 474, 508 271, 532 65.00 67.00 06700 OCUPATIONAL THERAPY 1, 128, 783 52, 744 133, 501 1, 314, 998 242, 158 66.00 68.00 06800 OSEGO PREVIDUATIONAL THERAPY 1, 282, 786 52, 744 133, 501 1, 314, 998 242, 158 66.00 68.00 06800 OSEGO OSEGO	54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 939, 358	179, 212	336, 649	4, 455, 219	820, 433	54.00
66.00 06c00 PhYSICAL THERAPY 1, 128, 753 52, 744 133, 501 1, 314, 998 242, 188 66.00 67.00 06c70 00c000 00c00 00c000 00c0000 00c000 00c000 00c000 00c000 00c000 00c000 00c0000 00c000 00c000 00c000 00c000 00c000 00c000 00c0000 00c0000 00c0000 00c0000 00c00000 00c00000 00c00000 00c00000 00c000000 00c0000000 00c00000000		The state of the s		· ·			
67. 00 06/700 06/700 06/700 07/							
68.00 06800 SPEECH PATHOLOGY 198, 693 6,091 25,595 230, 379 42, 425 68. 00 69. 00 06900 CELETROCARDI OLOGY 972, 390 84, 352 66, 899 1, 123, 601 206, 912 69. 00 72. 00 70.00 7		The state of the s					
68.01 0.0801 0.0020 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000			l ~				
17.00 07100 MDID CAL SUPPLIES CHARGED TO PATIENTS 3, 189, 177 0 0 3, 189, 177 587, 290 71, 00 72, 00 7200 MPL. DEV. CHARGED TO PATIENTS 1, 649, 055 0 0 0 0 0 0 0 0 0			0,071	20, 070	0		
17.0 07200 IMPL. DEV. CHARGED TO PATIENT 1, 649, 055 0 0 1, 649, 055 303, 675 22 00 73. 00 073	69. 00 06900 ELECTROCARDI OLOGY	972, 390	84, 352	66, 859	1, 123, 601	206, 912	69. 00
173.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		1	0	C			
76. 00			0	C	1, 649, 055		
10 03160 CARDI OPULIMONARY 93, 997 0 7,398 101,395 18,672 76,01		0	0				
OUTPATLENT SERVICE COST CENTERS		93, 997	Ö	7, 398	101, 395		
99. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0							
90. 01 090.01 090.01 090.01 090.02 DIABETES CLINI C 40,999 2,342 4,960 48,301 8,895 90. 02 90. 03 090.03 ASTHMA CLINI C 0 0 0 0 0 0 0 0 0	1 I	1	1		1		
90. 02 09002 DI ABETES CLINIC							
90. 03 09003 ASTHMA CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
90. 04 990.04 990.05 990		0	0	., , , ,	0		
90. 06 09006 SHELBYVILLE WOUND CLINIC 262, 452 0 18, 783 281, 235 51, 790 90. 07 90. 07 04951 0NCOLOGY 936, 318 0 66, 745 1, 003, 063 184, 715 90. 07 90. 08		100, 735	3, 992	6, 459	111, 186	20, 475	
90. 07	· ·	1	1	C			
90. 08 0.4950 ANDERSON WOMENS CENTER 285, 858 20, 748 32, 760 339, 366 62, 495 90. 08 91. 00 0.920							
91. 00 09100 EMERGENCY 2, 646, 738 328, 539 320, 511 3, 295, 788 606, 923 91. 00 92. 00 085ERVATI ON BEDS (NON-DISTINCT PART) 92. 00 117, 549 3, 401, 128 626, 321 101. 00 1				· ·			
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		1					
OTHER REIMBURSABLE COST CENTERS 101.00 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 1		2,010,700	020,007	020, 01.	0,275,755	000,720	
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 2, 134, 882 112, 114 153, 346 2, 400, 342 442, 025 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 80, 716, 775 3, 853, 110 4, 970, 132 79, 283, 109 12, 065, 053 118.00 NONRE! MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 1, 192, 981 219, 689 190.01 190.01 19001 PROFESSI ONAL BUI LDI NG 505, 544 687, 437 0 1, 192, 981 219, 689 190.01 190.02 19002 PHYSI CI AN BUI LDI NG 103, 406 0 1 103, 407 19, 043 190.02 190.02 19002 PHYSI CI AN BUI LDI NG 669, 074 5, 351 13, 433 687, 858 126, 670 190.04 190.04 190.04 19004 MARKETI NG 669, 074 5, 351 13, 433 687, 858 126, 670 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.05 190.06 190.0	OTHER REIMBURSABLE COST CENTERS						
116. 00 116. 00 116. 00 116. 00 118. 00		3, 283, 579	0	117, 549	3, 401, 128	626, 321	101. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 80, 716, 775 3, 853, 110 4, 970, 132 79, 283, 109 12, 065, 053 118. 00		2 124 002	112 114	152 244	2 400 242	442 025	116 00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 1, 192, 981 219, 689 190. 01 190. 01 190. 02 19002 19002 19002 19002 19002 19002 19003 1900				· ·			
190. 01 19001 PROFESSI ONAL BUI LDI NG 190. 02 19002 PHYSI CI AN BUI LDI NG 190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 631, 318 0 60, 031 691, 349 127, 313 190. 03 190. 04 19004 MARKETI NG 190. 05 19005 WATER LAB 0 0 0 0 0 0 190.05 190. 06 19006 FOUNDATI ON 181, 914 0 17, 959 199, 873 36, 807 190. 07 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS 1, 981, 981 219, 689 190. 01 103, 406 0 0 1 103, 407 19, 043 190. 02 181, 914 0 0 17, 959 199, 873 36, 807 190. 07 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 10 19010 HANCOCK WELLNESS 1, 981, 841 0 124, 165 2, 106, 006 387, 823 190. 10 190. 11 19011 MORRI STOWN CLINI C 0 0 0 14, 099 15, 799 2, 909 190. 12 190. 13 19013 MCCORD WELLNESS 7, 736 0 0 7, 736 1, 425 190. 13		337373	5, 555, 115	., ,		,,	
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 631, 318 0 600, 031 691, 349 127, 313 190. 03 190. 04 19004 MARKETI NG 669, 074 5, 351 13, 433 687, 858 126, 670 190. 05 190. 05 190. 05 190. 06 190. 06 190. 06 190. 06 190. 07 190. 08 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 09 190. 10 190.				C			
190. 03 19003 PRI VATE DUTY 631, 318		1		C			
190. 04 19004 MARKETI NG 669, 074 5, 351 13, 433 687, 858 126, 670 190. 04 190. 05 19005 WATER LAB 0 0 0 0 0 190. 05 190. 06 19006 FOUNDATI ON 181, 914 0 17, 959 199, 873 36, 807 190. 06 190. 07 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB 3, 554, 363 0 157, 639 3, 712, 002 683, 569 190. 09 190. 10 19010 HANCOCK WELLNESS 1, 981, 841 0 124, 165 2, 106, 006 387, 823 190. 10 190. 11 19011 MORRI STOWN CLINI C 0 0 0 0 0 190. 11 190. 11 19012 190. 12 190. 12 190. 13 19013 MCCORD WELLNESS 7, 736 0 0 7, 736 1, 425 190. 13		1	1	I 60 021			
190. 05 19005 WATER LAB							
190. 07 19007 ASC 720 281, 947 0 282, 667 52, 053 190. 07 190. 08 1908 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 190. 08 190. 09 19009 HANCOCK 0B 3, 554, 363 0 157, 639 3, 712, 002 683, 569 190. 09 190. 10 19010 HANCOCK WELLNESS 1, 981, 841 0 124, 165 2, 106, 006 387, 823 190. 10 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 190. 11 190. 11 19012 19012 03PUREMED 1, 700 0 14, 099 15, 799 2, 909 190. 12 190. 13 19013 MCCORD WELLNESS 7, 736 0 0 7, 736 1, 425 190. 13			1	,, C	0		
190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 190. 08 190. 09 19009 HANCOCK 0B 3, 554, 363 0 157, 639 3, 712, 002 683, 569 190. 09 190. 10 190. 10 190. 10 MORRI STOWN CLINI C 0 0 0 0 190. 12 19012 03PUREMED 1, 700 0 14, 099 15, 799 2, 909 190. 12 190. 13 19013 MCCORD WELLNESS 7, 736 0 0 7, 736 1, 425 190. 13	190. 06 19006 FOUNDATI ON	181, 914	0	17, 959	199, 873		
190. 09 19009 HANCOCK OB 3, 554, 363 0 157, 639 3, 712, 002 683, 569 190. 09 190. 10 19010 HANCOCK WELLNESS 1, 981, 841 0 124, 165 2, 106, 006 387, 823 190. 10 190. 11 19011 MORRI STOWN CLI NI C 0 0 0 0 190. 11 190. 12 19012 03PUREMED 1, 700 0 14, 099 15, 799 2, 909 190. 12 190. 13 19013 MCCORD WELLNESS 7, 736 0 0 7, 736 1, 425 190. 13		1		_			
190. 10 19010 HANCOCK WELLNESS 1, 981, 841 0 124, 165 2, 106, 006 387, 823 190. 10 190. 11 19011 MORRI STOWN CLI NI C 0 0 0 0 190. 11 190. 12 19012 03PUREMED 1, 700 0 14, 099 15, 799 2, 909 190. 12 190. 13 19013 MCCORD WELLNESS 7, 736 0 0 7, 736 1, 425 190. 13		-	1	_	_		
190. 11 19011 MORRI STOWN CLINI C 0 0 0 0 190. 11 190. 12 19012 03PUREMED 1, 700 0 14, 099 15, 799 2, 909 190. 12 190. 13 19013 MCCORD WELLNESS 7, 736 0 0 7, 736 1, 425 190. 13		1					
190. 12 19012 03PUREMED 1, 700 0 14, 099 15, 799 2, 909 190. 12 190. 13 19013 MCCORD WELLNESS 7, 736 0 0 7, 736 1, 425 190. 13		1, 701, 041	ا	124, 100	, 2, 100, 000 0		
190. 13 19013 MCCORD WELLNESS 7, 736 0 0 7, 736 1, 425 190. 13		1, 700	Ö	14, 099	15, 799		
190. 14 19014 3 WEST UNIT 128, 046 64, 890 6, 714 199, 650 36, 766 190. 14		1	1	C		1, 425	190. 13
	190. 14 19014 3 WEST UNIT	128, 046	[64, 890	6, 714	199, 650	36, 766	190. 14

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150037	Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014		nared·
				10 12/01/2011	5/27/2015 11:	
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	for Cost	FLXT	BENEFITS		& GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1. 00	4. 00	4A	5. 00	
190. 15 19015 NEUROLOGY PHYSI CI AN	36, 000	0		0 36,000	6, 629	190. 15
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	88, 518, 437	4, 892, 735	5, 364, 17	88, 518, 437	13, 765, 749	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/27/2015	11:52 am

				12/31/2014	5/27/2015 11:	
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT	0.00	10.00		ADMI NI STRATI ON	
GENERAL SERVICE COST CENTERS	7. 00	9. 00	10.00	11. 00	13. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT	7, 504, 787					7. 00
9. 00 00900 HOUSEKEEPI NG	70, 483	1, 990, 827				9. 00
10. 00 01000 DI ETARY	110, 731	31, 591	656, 756			10. 00
11. 00 01100 CAFETERI A	211, 367	52, 058		1, 994, 173		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	29, 988	70.045	0	74, 364	2, 264, 942	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	161, 651	78, 965 57, 600		8, 625 78, 910	12, 578 115, 078	14. 00 15. 00
16. 00 01600 PHARWACT 16. 00 01600 MEDI CAL RECORDS & LI BRARY	96, 285	69, 285		57, 769	115, 078	16.00
23. 00 02300 PARAMED ED PRGM	36, 774	79, 810	1	4, 432	6, 463	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	00/111	7,7,010	1 0	.,	0, 100	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	774, 956	529, 507	207, 320	171, 056	249, 459	30.00
31.00 03100 INTENSIVE CARE UNIT	652, 569	109, 165	284, 489	233, 062	339, 887	31.00
40. 00 04000 SUBPROVI DER - I PF	174, 456		148, 334	83, 389	121, 610	40. 00
41. 00 04100 SUBPROVI DER - I RF	40, 030	30, 244	16, 613	14, 274	20, 817	41.00
ANCILLARY SERVICE COST CENTERS	/ 45 047	044 050	l al	07.074	F0.000	
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM	645, 017	211, 958	1	36, 961	53, 902	50. 00 51. 00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	58, 006	78, 048 0		11, 376	16, 591 0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	404, 127	77, 589	1	172, 051	248, 900	54.00
60. 00 06000 LABORATORY	173, 854	74, 040		140, 091	204, 302	60.00
65. 00 06500 RESPI RATORY THERAPY	63, 259	56, 707	1	153, 893	224, 429	65. 00
66. 00 06600 PHYSI CAL THERAPY	118, 940	65, 905	0	57, 601	84, 002	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	19, 141	0	67. 00
68.00 06800 SPEECH PATHOLOGY	13, 735	0	0	9, 091	0	68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	190, 216	128, 502	0	32, 917	0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	U	0	72. 00 73. 00
75. 00 07300 DRUGS CHARGED TO PATTENTS 76. 00 03020 CARDI AC	0	0	0	0	0	76.00
76. 01 03160 CARDI OPULMONARY	o o	Ö	_	5, 850	0	76. 01
OUTPATIENT SERVICE COST CENTERS			-	2, 222		
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	79, 211	0	0	29, 757	0	90. 01
90. 02 09002 DI ABETES CLI NI C	5, 281	0	0	3, 174	0	90. 02
90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC	0 000	0	0	2 002	0	90. 03
90. 04 09004 ANDIS CLINIC 90. 05 09005 PRIME TIME	9, 002	0	0	3, 803	0	90. 04 90. 05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	0		0	0	90.06
90. 07 04951 ONCOLOGY	o o	Ö	Ö	31, 007	0	90. 07
90.08 04950 ANDERSON WOMENS CENTER	46, 788	0	o	17, 730	0	90. 08
91. 00 09100 EMERGENCY	740, 864	113, 535	0	143, 304	208, 986	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS			1			
101. 00 10100 HOME HEALTH AGENCY	0	58, 952	0	134, 931	196, 777	101. 00
SPECIAL PURPOSE COST CENTERS	252, 819		O	77 205	104 270	1114 00
116. 00 11600 HOSPICE 118. 00 SUBTOTALS (SUM OF LINES 1-117)	5, 160, 409			77, 385 1, 805, 944	106, 370 2, 210, 151	
NONREI MBURSABLE COST CENTERS	3, 100, 407	1, 770, 027	030, 730	1,003,744	2, 210, 131	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	0	190. 00
190. 01 19001 PROFESSI ONAL BUILDING	1, 550, 187	0	0	0		190. 01
190.02 19002 PHYSICIAN BUILDING	0	0	0	o	0	190. 02
190. 03 19003 PRI VATE DUTY	0	0	0	37, 571	54, 791	190. 03
190. 04 19004 MARKETI NG	12, 066	0	0	6, 521		190. 04
190. 05 19005 WATER LAB	0	0	0	0		190. 05
190. 06 19006 FOUNDATI ON	0	0	0	8, 864		190. 06
190. 07 19007 ASC	635, 796	0	0	0		190. 07
190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB	0	0	0	21 051		190. 08 190. 09
190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS	0	0	0	21, 051 107, 402		190. 09
190. 11 19011 MORRI STOWN CLINI C		0		107, 402		190. 10
190. 12 19012 03PUREMED	0	0		4, 262		190. 11
190. 13 19013 MCCORD WELLNESS		Ö	l ől	0		190. 12
190. 14 19014 3 WEST UNIT	146, 329	0	o	2, 558		190. 14
190. 15 19015 NEUROLOGY PHYSICIAN	0	0	o	O	0	190. 15
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	7, 504, 787	1, 990, 827	656, 756	1, 994, 173	2, 264, 942	J202. 00

Provi der CCN: 150037

| Period: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 | 11: 52 am

					12/31/2014	5/27/2015 11:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
		SERVICES &		RECORDS &	PRGM		
		SUPPLY	45.00	LI BRARY	00.00	04.00	
	CENEDAL CEDVICE COST CENTEDS	14. 00	15. 00	16. 00	23. 00	24. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	216, 943					14. 00
15. 00	01500 PHARMACY	3, 022	9, 084, 489				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3,022	9, 084, 489	1, 313, 962			16. 00
23. 00	02300 PARAMED ED PRGM	0	0	1, 313, 702	183, 091		23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	۷.		<u></u> σ _l	103, 071		25.00
30. 00	03000 ADULTS & PEDI ATRI CS	4, 028	0	303, 401	ol	6, 847, 788	30.00
31. 00	03100 NTENSI VE CARE UNI T	8, 775	o	37, 884	o	6, 918, 435	
40. 00	04000 SUBPROVI DER - I PF	520	o	31, 237	o	2, 436, 116	
41. 00	04100 SUBPROVI DER - I RF	70	o	185, 762	0	571, 062	
11.00	ANCI LLARY SERVI CE COST CENTERS	, ,		100, 702		071,002	11.00
50. 00	05000 OPERATING ROOM	6, 779	0	398, 775	0	7, 126, 094	50.00
51. 00	05100 RECOVERY ROOM	251	0	0	0	528, 447	
53. 00	05300 ANESTHESI OLOGY	3	o	0	o o	10, 010	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 901	0	45, 527	183, 091	6, 408, 838	
60. 00	06000 LABORATORY	48, 573	o	101, 023	0	5, 590, 741	
65. 00	06500 RESPI RATORY THERAPY	536	0	0.017.020	0	2, 244, 864	1
66. 00	06600 PHYSI CAL THERAPY	53	0	0	0	1, 883, 657	
67. 00	06700 OCCUPATI ONAL THERAPY	24	0	0	0	390, 968	
68. 00	06800 SPEECH PATHOLOGY	155	0	0	0	295, 785	
68. 01	06801 OCCUPATI ONAL HEALTH	0	0	0	0	0	1
69. 00	06900 ELECTROCARDI OLOGY	1, 371	0	51, 841	0	1, 735, 360	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	128, 208	0	01,011	o o	3, 904, 675	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	o o	1, 952, 730	
73. 00	07300 DRUGS CHARGED TO PATIENTS	O	9, 084, 489	2, 326	o o	9, 086, 815	
76. 00	03020 CARDI AC	0	0	0	0	0.000	1
76. 01	03160 CARDI OPULMONARY	27	o	0	0	125, 944	1
, 0. 0 .	OUTPATIENT SERVICE COST CENTERS			<u> </u>		120, 711	1
88. 00	08800 RURAL HEALTH CLINIC	105	0	0	0	335, 215	88. 00
90.00	09000 CLI NI C	0	0	0	0	0	1
90. 01	09001 WOUND CLINIC	662	0	0	0	1, 269, 875	1
90. 02	09002 DI ABETES CLINIC	0	o	0	o	65, 651	1
90. 03	09003 ASTHMA CLINIC	O	0	0	0	0	1
90. 04	09004 ANDIS CLINIC	2	0	0	0	144, 468	90. 04
90. 05	09005 PRIME TIME	0	0	0	0	128, 774	90. 05
90.06	09006 SHELBYVILLE WOUND CLINIC	513	0	0	0	333, 538	90.06
90. 07	04951 ONCOLOGY	791	0	0	0	1, 219, 576	90. 07
90. 08	04950 ANDERSON WOMENS CENTER	169	0	0	0	466, 548	90. 08
91.00	09100 EMERGENCY	6, 813	0	155, 854	0	5, 272, 067	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	72	0	332	0	4, 418, 513	101. 00
	SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPI CE	3, 288	0	0	0	3, 282, 229	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	216, 711	9, 084, 489	1, 313, 962	183, 091	74, 994, 783	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190. 01	19001 PROFESSI ONAL BUILDING	0	0	0	0	2, 962, 857	190. 01
190. 02	19002 PHYSICIAN BUILDING	0	0	0	0	122, 450	190. 02
190. 03	19003 PRI VATE DUTY	71	0	0	0	911, 095	190. 03
	19004 MARKETI NG	0	0	0	0	833, 115	190. 04
190. 05	19005 WATER LAB	0	0	0	0		190. 05
190.06	19006 FOUNDATI ON	0	0	0	0	245, 544	190. 06
190. 07	19007 ASC	0	0	0	0	970, 516	190. 07
	19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	o	0	190. 08
	19009 HANCOCK OB	161	0	0	0	4, 416, 783	
	19010 HANCOCK WELLNESS	0	0	0	0	2, 601, 231	190. 10
190. 11	19011 MORRI STOWN CLINIC	0	0	0	o		190. 11
190. 12	19012 03PUREMED	0	O	0	o	22, 970	190. 12
190. 13	19013 MCCORD WELLNESS	0	o	0	О	9, 161	190. 13
190. 14	19014 3 WEST UNIT	0	О	0	О	385, 303	190. 14
	19015 NEUROLOGY PHYSI CI AN	0	o	0	o		190. 15
200.00	1 1				o		200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	216, 943	9, 084, 489	1, 313, 962	183, 091	88, 518, 437	202. 00
-							

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/27/2015	11:52 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150037

			5/27/2015	
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS	20.00	20.00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT				1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00 00700 OPERATION OF PLANT				7. 00
9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	+			10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00 01500 PHARMACY				15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY				16. 00
23. 00 02300 PARAMED ED PRGM				23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	6, 847, 788		30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	6, 918, 435		31.00
40. 00 04000 SUBPROVI DER - PF	0	2, 436, 116		40.00
41. 00 O4100 SUBPROVI DER - I RF ANCI LLARY SERVI CE COST CENTERS	0	571, 062		41. 00
50. 00 O5000 OPERATING ROOM	0	7, 126, 094		50.00
51. 00 05100 RECOVERY ROOM		528, 447		51.00
53. 00 05300 ANESTHESI OLOGY	o	10, 010		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	6, 408, 838		54.00
60. 00 06000 LABORATORY	0	5, 590, 741		60.00
65. 00 06500 RESPI RATORY THERAPY	0	2, 244, 864		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 883, 657		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	390, 968		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	295, 785		68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	1 725 240		68. 01
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	1, 735, 360		69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		3, 904, 675 1, 952, 730		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		9, 086, 815		73. 00
76. 00 03020 CARDI AC	o o	0		76. 00
76. 01 03160 CARDI OPULMONARY	0	125, 944		76. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0	335, 215		88. 00
90. 00 09000 CLI NI C	0	0		90.00
90. 01 09001 WOUND CLINIC	0	1, 269, 875		90. 01
90. 02 09002 DI ABETES CLINIC 90. 03 09003 ASTHMA CLINIC	0	65, 651 0		90. 02
90. 04 09004 ANDIS CLINIC	0	144, 468		90.03
90. 05 09005 PRIME TIME	0	128, 774		90. 05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	333, 538		90.06
90. 07 04951 ONCOLOGY	0	1, 219, 576		90. 07
90.08 04950 ANDERSON WOMENS CENTER	0	466, 548		90. 08
91. 00 09100 EMERGENCY	0	5, 272, 067		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92. 00
OTHER REIMBURSABLE COST CENTERS		4 440 540		101 00
101. 00 10100 HOME HEALTH AGENCY	0	4, 418, 513		101. 00
SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE	0	3, 282, 229		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	74, 994, 783		118.00
NONREI MBURSABLE COST CENTERS	·	, 1, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190. 01 19001 PROFESSI ONAL BUILDING	Ö	2, 962, 857		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	122, 450		190. 02
190. 03 19003 PRI VATE DUTY	0	911, 095		190. 03
190. 04 19004 MARKETI NG	0	833, 115		190. 04
190. 05 19005 WATER LAB	0	0		190. 05
190. 06 19006 FOUNDATI ON	0	245, 544		190.06
190. 07 19007 ASC	0	970, 516		190. 07
190.08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0 4 416 783		190. 08 190. 09
190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS	0	4, 416, 783 2, 601, 231		190. 09
190. 10 19010 HANCOCK WELLINESS 190. 11 19011 MORRI STOWN CLINIC		2,601,231		190. 10
190. 12 19012 03PUREMED		22, 970		190. 11
190. 13 19013 MCCORD WELLNESS	l ő	9, 161		190. 13
190. 14 19014 3 WEST UNIT	o	385, 303		190. 14
190. 15 19015 NEUROLOGY PHYSICIAN	O	42, 629		190. 15
200.00 Cross Foot Adjustments	o	O		200. 00
	•	·		

Heal th Financi	al Systems	HANCOCK REGIONAL	HOSPI TAL		In Lieu	u of Form CMS	-2552-10
COST ALLOCATIO	ON - GENERAL SERVICE COSTS		Provi der	CCN: 150037	Peri od: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Pr 5/27/2015 11	
Cc	ost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
		25. 00	26. 00				
201. 00 Ne	egative Cost Centers	0	0				201. 00
202. 00 TO	OTAL (sum lines 118-201)	o	88, 518, 437				202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | 14 Form: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150037

Cost Center Description				'	o 12/31/2014	Date/lime Pre 5/27/2015 11:	
Chemistry Stanffler Cost Centress	Cost Center Description	Assigned New Capital	RELATED COSTS NEW BLDG &	Subtotal	BENEFITS	ADMI NI STRATI VE	
1.00 DOUGO MARE CAP REL COSTS-SHEEG & IT NT 1.5 883 15 10 10 10 10 10 10 10		0	1.00	2A	4. 00	5. 00	
4.00 000000 000000 000000							1 00
16.00 01-000 PEDICAL RECORDS & LIBRARY 0 42,698 42,698 23, 34,302 30 2323 23.	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION	000000000000000000000000000000000000000	353, 049 1, 195, 773 31, 256 49, 104 93, 731 13, 298	353, 049 3 1, 195, 773 31, 256 49, 104 93, 731 13, 298	2, 596 354 358 162 310 551	30, 155 7, 716 2, 067 6, 954 8, 681	4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00
123 00 02300 PRAMILED ED PRIOR 0 16, 307 16, 307 30 223 23 00		1		1			
IMPART ENT ROUTINE SERVICE COST CENTERS 3 a 343, 668 1, 102 18, 516 3 o 0 30.00 30.00 0.0000 0.0000 0.0000 0.0000 0.00				1		1	
30.00		0	16, 307	16, 307	30		23.00
31.00		0	343, 658	343, 658	1, 102	18, 516	30.00
A1.00 A100 SUBPROVIDER - IRF		1					
MICLILARY SERVICE COST CENTERS		1		1		l	
50.00		0	17, 751	17, 751	68	1, 058	41. 00
51.00 05100 RECOVERY ROOM 0 25,723 25,723 87 1,463 51.00 63.00 05300 MESTHESI OLOGY 0 0 0 0 45.50 0 53.00 05300 MESTHESI OLOGY 0 0 0 0 0 45.50 0 53.00 05300 MESTHESI OLOGY 0 0 0 0 77,066 644 19,463 60.00 60.00 06600 RESPIRATORY THERAPY 0 28,053 28,053 485 7,016 65.00 06600 RESPIRATORY THERAPY 0 52,744 395 6,257 66.00 66.00 06600 RESPIRATORY THERAPY 0 6,091 6,091 76 100 110 1,494 67.00 68.01 68.00 08000 SEPECH PATHOLOGY 0 6,091 6,091 76 100		Ι ο	286 036	286 036	1 044	22 105	50.00
53.00 0300 ANESTHESS OLOGY 0 0 0 0 0 40 53.00				1			
60.00 60000 LABORATORY 0 77, 096 77, 096 644 19, 483 60.00 650.00 66500 RESPIRATORY THERAPY 0 28, 653 28, 653 485 7, 106 65.00 66500 PHYSICAL THERAPY 0 52, 744 52, 744 395 6, 257 66.00 67.00 6700 0 101 11, 494 67.00 67.00 6700 0 0 0 0 0 0 0 0 0	53. 00 05300 ANESTHESI OLOGY	0	0			40	53. 00
65.00 06500 RESPIRATORY THERAPY 0 28,053 28,053 28,053 485 7,016 65.00 66.00 06600 PHYSI CAL THERAPY 0 52,744 395 6,527 66.00 66.00 06700 0CCUPATIONAL THERAPY 0 0,0 0 0 0 110 1,494 67.00 68.01 06800 0SCEPCIA PATHOLOGY 0 0,691 6.091 76 1,096 68.00 06800 OSCEPTIONAL HEALTH 0 0 0 0 0 0 0 0 0	l l			1		1	
66.00 06-600 PHYSI CAL THERAPY 0 52, 744 52, 744 395 6, 257 66.00		1		1		l	
67.00 06/700 06/700 06/700 06/700 07.00 07.00 07.00 08.00 08.00 06.00 08.00 06.00 08.00 06.00 06.00 08.00 06.00 08.00 06.00 08.00 06.00 08.00 06.00 08.00 06.00 08.00 08.00 08.00 08.00 08.00 08.00 08.00 08.00 08.00 08.00 08.00 08.00 08.00 07.00		1		1			
68.01		1	02,711	1		1	
69 00 06900 0640		0	6, 091	6, 091		1	68. 00
17.00		0	0) .	0		
12 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0 73. 40 073. 00 073. 00 0 0300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	84, 352		198		
173.00 07300 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 75.00		0	1 0	ή	0	l	
10 03160 CARDI OPULMONARY 0 0 0 0 0 22 482 76. 01		1	Ö		0		
OUTPATE HST SERVICE COST CENTERS	76. 00 03020 CARDI AC	0	0) c	0	0	76. 00
88.00 08800 RURAL HEALTH CLINIC 0 0 0 75 1,346 88.00 09.00 09000 CLINIC 0 0 0 0 0 0 09.00 090.00		0	0) <u> </u>	22	482	76. 01
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0		0	0		75	1 2/6	00 00
90. 02 09002 DI ABETES CLINIC 0 2,342 2,342 15 230 90. 02 90. 03 90003 ASTHMA CLINIC 0 0 0 0 0 0 0 0 0			0			1	
90. 03 09003 ASTHMA CLINIC 0 0 0 0 0 90. 03 90. 04 09004 ANDIS CLINIC 0 3,992 3,992 19 529 90. 04 90. 05 09005 PRI IME TIME 0 0 0 0 0 517 90. 06 09006 SHELBYYI LLE WOUND CLINIC 0 0 0 0 56 1,338 90. 06 90. 07 04951 ONCOLOGY 0 0 0 0 0 198 4,773 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0 20,748 20,748 97 1,615 90. 08 91. 00 09100 EMERGENCY 0 328,539 328,539 949 15,681 91. 00 92. 00 90200 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 348 16,183 101. 00 92. 00 90200 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 348 16,183 101. 00 93. 00 0000 0000 0 0 0 0 0	90. 01 09001 WOUND CLINIC	0	35, 127	35, 127	258	4, 662	90. 01
90. 04 99.04 ANDI S CLINIC 0 3,992 3,992 19 529 90. 04 90. 05 9005 PRIME TIME 0 0 0 0 0 0 517 90. 05 90. 06 9006 SHELBYVI LLE WOUND CLINIC 0 0 0 0 0 56 1,338 90. 06 90. 07 04951 0NICOLOGY 0 0 0 0 0 198 4,773 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0 328,539 328,539 949 15,681 91. 00 9100 EMERGENCY 0 328,539 328,539 328,539 949 15,681 91. 00 92. 0		0	2, 342	1		l e	
90. 05 09005 PRI ME TIME		0	0	ή	_	l e	
90. 06 0906 SHELBYVILLE WOUND CLINIC 0 0 0 56 1, 338 90. 06 90. 07 04951 0NCOLOGY 0 0 0 198 4, 773 90. 07 90. 80 04950 ANDERSON WOMENS CENTER 0 20, 748 20, 748 97 1, 615 90. 08 91. 00 9100 EMERGENCY 0 328, 539 328, 539 949 15, 681 91. 00 92. 00 90. 00		0	· ·	1			
90. 08 04950 ANDERSON WOMENS CENTER 0 20, 748 20, 748 97 1, 615 90. 08 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 328, 539 328, 539 949 15, 681 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0100 O 0 348 16, 183 101. 00 0100 O O O O O O O O O			_	1		l e	
91. 00 09100 EMERGENCY 0 328, 539 328, 539 949 15, 681 91. 00 92. 00 00 00 00 00 00 00 00			0) c			
92. 00 OTHER REI MBURSABLE COST CENTERS 101. 00 FIGURE 10 FIGUR 1		1					
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O		0	328, 539			15,081	
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE							72.00
116. 00		0	0) C	348	16, 183	101. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 3,853,110 3,853,110 14,715 311,704 118. 00 190.00			110 114	110 114	454	11 401	11/ 00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00 190. 00 190. 01 19001 PROFESSI ONAL BUI LDI NG 0 687, 437 687, 437 0 5,676 190. 01 190. 02 19002 PHYSI CI AN BUI LDI NG 0 0 0 0 0 492 190. 02 190. 02 19002 PRI VATE DUTY 0 0 0 0 178 3,289 190. 03 190. 04 19004 MARKETI NG 0 5,351 5,351 40 3,273 190. 04 190. 05 19005 WATER LAB 0 0 0 0 0 0 190. 05 190. 06 190.06 FOUNDATI ON 0 0 0 0 0 190. 05 190. 06 190. 0				1			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 190. 01 19001 PROFESSI ONAL BUILDING 0 687, 437 687, 437 0 5, 676 190. 01 190. 02 19002 PHYSI CI AN BUILDING 0 0 0 0 0 492 190. 02 190. 03 19003 PRI VATE DUTY 0 0 0 178 3, 289 190. 03 19003 PRI VATE DUTY 0 0 0 178 3, 289 190. 03 190. 05 19005 WATER LAB 0 0 5, 351 5, 351 40 3, 273 190. 04 190. 06 190. 06 190.06 FOUNDATION 0 0 0 0 53 951 190. 06 190. 06 190.06 FOUNDATION 0 0 0 0 53 951 190. 06 190. 06 190.08 190.08 190.08 190.08 190.09 HANCOCK OB 0 0 0 0 0 0 0 0 0 190. 05 190. 190. 19010 HANCOCK OB 0 0 0 0 0 0 0 0 0 0 0 190. 190. 190. 19			3,000,110	7 3,033,110	14,713	311,704	110.00
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 0 0 0 0 0 178 3, 289 190. 03 190. 04 19004 MARKETI NG 0 5, 351 5, 351 40 3, 273 190. 04 190. 05 19005 WATER LAB 0 0 0 0 0 0 0 0 0 190. 05 190. 06 19006 FOUNDATI ON 190. 07 19007 ASC 0 281, 947 281, 947 0 1, 345 190. 07 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0			0	190. 00
190. 03 19003 PRI VATE DUTY 0 0 0 5, 351 5, 351 40 3, 289 190. 04 190. 04 190. 05 19005 WATER LAB 0 0 0 0 0 0 0 0 190. 05 190. 05 190. 06 190. 06 190. 06 190. 06 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 08 190. 08 190. 08 190. 08 190. 08 190. 08 190. 09 190. 190.			687, 437	687, 437	0	l	
190. 04 19004 MARKETING 0 5, 351 5, 351 40 3, 273 190. 04 190. 05 19005 WATER LAB 0 0 0 0 0 0 190. 05 190. 06 190. 06 190. 06 190. 06 190. 07 190. 07 190. 07 190. 07 190. 08 190. 08 190. 08 190. 08 190. 09 190. 10 190. 11 190. 11 190. 11 190. 12 190. 12 190. 12 190. 12 190. 12 190. 13 190. 13 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 15			0		0		
190. 05 19005 WATER LAB 0 0 0 0 0 0 190. 05 19006 FOUNDATION 0 0 0 53 951 190. 06 190. 07 19007 ASC 0 281, 947 281, 947 0 1, 345 190. 07 1900 19009 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 0 190. 08 190.08 190.09 19009 HANCOCK OB 0 0 0 0 467 17, 662 190. 09 190. 1900 HANCOCK WELLNESS 0 0 0 0 368 10, 020 190. 10 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 368 10, 020 190. 11 190. 12 190. 12 190. 13 190. 13 190. 13 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 15 1		1	5 251	5 351			
190. 06 19006 FOUNDATION 0 0 0 53 951 190. 06 190. 07 19007 ASC 0 281, 947 281, 947 0 1, 345 190. 07 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 0 190. 08 19009 HANCOCK 0B 0 0 0 0 467 17, 662 190. 09 190. 10 1901 HANCOCK WELLINESS 0 0 0 0 368 10, 020 190. 10 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 368 10, 020 190. 11 190. 12 19012 03PUREMED 0 0 0 0 42 75 190. 12 190. 13 190. 13 19013 MCCORD WELLINESS 0 0 0 0 0 0 37 190. 13 190. 14 19014 3 WEST UNIT 0 64, 890 64, 890 20 950 190. 14		0	0, 331	3, 331			
190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 190. 08 190. 09 19009 HANCOCK 0B 0 0 0 0 467 17, 662 190. 09 190. 10 190. 10 190. 10 190. 10 HANCOCK WELLNESS 0 0 0 0 0 368 10, 020 190. 10 190. 11 19011 MORRI STOWN CLINI C 0 0 0 0 0 190. 11 190. 12 190. 12 190. 12 190. 12 190. 12 190. 12 190. 13 190. 13 190. 13 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 15 1	190. 06 19006 FOUNDATI ON	0	0	o	53		
190. 09 19009 HANCOCK 0B 0 0 0 467 17, 662 190. 09 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 11 190. 11 190. 11 190. 11 190. 12 190. 12 190. 12 190. 12 190. 12 190. 12 190. 13 190. 13 190. 13 190. 13 190. 14 190. 16 190. 16 190. 16 190. 190. 190. 190. 190. 190. 190. 190.		0	281, 947	281, 947	0		
190. 10 19010 HANCOCK WELLNESS 0 0 0 0 368 10, 020 190. 10 190. 11 19011 MORRI STOWN CLI NI C 0 0 0 0 0 190. 11 190. 12 19012 03PUREMED 0 0 0 0 42 75 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 0 37 190. 13 190. 14 19014 3 WEST UNI T 0 64, 890 64, 890 20 950 190. 14		0	0		_	l e	
190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 0 190. 11 190. 12 19012 03PUREMED 0 0 0 42 75 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 42 950 190. 13 190. 14 19014 3 WEST UNIT 0 64, 890 64, 890 20 950 190. 14		0	0)			
190. 12 19012 03PUREMED 0 0 0 42 75 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 0 37 190. 13 190. 14 19014 3 WEST UNIT 0 64, 890 64, 890 20 950 190. 14						l	
190. 14 19014 3 WEST UNI T 0 64, 890 64, 890 20 950 190. 14	190. 12 19012 03PUREMED	0	0) c	42	75	190. 12
		1	0	0	0		
170. 19 17019 NEUNOLOUT 11113101 NN 0 0 0 1/1 190. 15		1		64, 890			
	176. TO TO TO THE ONO EQUATION OF AIM	1 0	· · · · · · · · · · · · · · · · · · ·	, ₁		171	1.70. 10

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014		pared: 52 am
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
	0	1.00	2A	4. 00	5. 00	
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	0	0 4, 892, 735	4, 892, 73	0 0 0 5 15, 883	0	200. 00 201. 00 202. 00

Provider CCN: 150037

				7 12/31/2014	5/27/2015 11:	
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMI NI STRATI ON	
OFNEDAL CERVILOR COCT OFNITERS	7. 00	9. 00	10.00	11. 00	13. 00	
GENERAL SERVICE COST CENTERS	I I				I	1 00
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT					•	1. 00 4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 OO700 OPERATION OF PLANT	1 224 202				•	7.00
9. 00 00900 HOUSEKEEPI NG	1, 226, 282 11, 517	50, 847				9.00
10. 00 01000 DI ETARY	18, 094	807	70, 234			10.00
11. 00 01100 CAFETERI A	34, 537	1, 330		136, 862		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	4, 900	1, 330	0	5, 104		1
14. 00 01400 CENTRAL SERVICES & SUPPLY	4, 700	2, 017	0	5, 104		1
15. 00 01500 PHARMACY	26, 414	1, 471	0	5, 416		
16. 00 01600 MEDI CAL RECORDS & LI BRARY	15, 733		0	3, 965		16.00
23. 00 02300 PARAMED ED PRGM	6, 009	1, 770 2, 038	0	3, 965		
INPATIENT ROUTINE SERVICE COST CENTERS	0,009	2, 030	U U	304	93	23.00
30. 00 03000 ADULTS & PEDIATRICS	126, 628	13, 524	22, 171	11, 740	3, 583	30.00
31. 00 03100 NTENSI VE CARE UNI T	106, 630	2, 788		15, 992		31.00
40. 00 04000 SUBPROVI DER - 1 PF	28, 506	2, 788 2, 231	15, 863	5, 723		40.00
41. 00 04100 SUBPROVI DER - 1 FF	6, 541	772	1, 777	980		
ANCILLARY SERVICE COST CENTERS	0, 541	112	1,777	700	277	41.00
50. 00 05000 OPERATING ROOM	105, 396	5, 414	n	2, 537	774	50.00
51. 00 05100 RECOVERY ROOM	9, 478	1, 993	0	781	238	
53. 00 05300 ANESTHESI OLOGY	0,470	1, 773	0	701	l e	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	66, 034	1, 982	0	11, 808		
60. 00 06000 LABORATORY	28, 408	1, 902	0	9, 615		
65. 00 06500 RESPI RATORY THERAPY	10, 337	1, 448	0	10, 562		
66. 00 06600 PHYSI CAL THERAPY	19, 435	1, 448		3, 953		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	17, 435	1, 003	0	1, 314		67.00
68. 00 06800 SPEECH PATHOLOGY	2, 244	0	0	624	l .	68. 00
68. 00 00800 SFEECH FATHOLOGY 68. 01 06801 OCCUPATI ONAL HEALTH	2, 244	0	0	024	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	31, 081	3, 282	0	2, 259		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31,001	3, 202	0	2, 237	0	71.00
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
75. 00 07300 DROGS CHARGED TO PATTENTS 76. 00 03020 CARDI AC	0	0		0	0	76.00
76. 00 03020 CARDI AC 76. 01 03160 CARDI OPULMONARY	0	0		403		76. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	U	U U	402		76.01
	O	0			1 0	00 00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0	0	0	0	0	88. 00 90. 00
	1	0	0	2.042		1
	12, 943	0	0	2, 042	l .	90. 01
90. 02 09002 DI ABETES CLI NI C 90. 03 09003 ASTHMA CLI NI C	863	0	0	218	0	90. 02
	1, 471	0	0	· ·	0	90.03
90. 04 09004 ANDLS CLINIC 90. 05 09005 PRIME TIME	1	0	0	261	0	90.04
	0	0	0	0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC 90. 07 04951 ONCOLOGY	0	0	0	2, 128	_	90. 06 90. 07
90. 07 04931 ONCOLOGY 90. 08 04950 ANDERSON WOMENS CENTER	7, 645	0	0	·		90.07
91. 00 09100 EMERGENCY	121, 057	2, 900	0	1, 217 9, 835	l .	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	121,037	2, 900	U	9, 033	3,002	91.00
OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	0	1, 506	0	9, 260	2 927	101. 00
SPECIAL PURPOSE COST CENTERS	l o	1, 500	ı	7, 200	2,021	101.00
116. 00 11600 HOSPI CE	41, 311	0	O	5, 311	1 529	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	843, 212	50, 847		123, 943		118. 00
NONREI MBURSABLE COST CENTERS	043, 212	50, 647	70, 234	123, 743	31,747	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	O	0		190. 00
190. 01 19001 PROFESSI ONAL BUILDING	253, 299	0	0	0		190. 00
190. 02 19002 PHYSI CI AN BUI LDI NG	253, 244	0	0	0		190. 01
190. 03 19003 PRI VATE DUTY	0	0	0	2, 579		190. 02
190. 04 19004 MARKETI NG	1, 972	0	0			190. 03
190. 05 19005 WATER LAB	1, 9/2	0	0	448		190. 04
190. 06 19006 FOUNDATION	0	0	0	608		190. 05
190. 07 19007 ASC	103, 889	0	0	000		190. 00
	103, 889	0	0	0		
190.08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0	0	1 445		190. 08
190. 09 19009 HANCOCK OB		0	0	1, 445 7, 271		190. 09 190. 10
190. 10 19010 HANCOCK WELLNESS		٥	0	7, 371		
190. 11 19011 MORRI STOWN CLINI C	0	0	0	0		190. 11
190. 12 19012 03PUREMED	0	0	0	292		190. 12
190. 13 19013 MCCORD WELLNESS	0	0	0	17.		190. 13
190. 14 19014 3 WEST UNIT	23, 910	0	0	176		190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	0	이	0	0	'l 0	190. 15
200.00 Cross Foot Adjustments	_	_ ا		_	_	200.00
201.00 Negative Cost Centers	1 22/ 202	E0 047	70 224	127 070		201.00
202.00 TOTAL (sum lines 118-201)	1, 226, 282	50, 847	70, 234	136, 862	32, 534	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150037

			T	0 12/31/2014	Date/Time Pre 5/27/2015 11:	
Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	PARAMED ED PRGM	Subtotal	JZ dili
	14.00	15. 00	16. 00	23. 00	24. 00	
GENERAL SERVICE COST CENTERS						4 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
9. 00 00900 HOUSEKEEPI NG						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 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	3, 287					14. 00
15. 00 01500 PHARMACY	46	142, 087				15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	68, 801			16. 00
23. 00 O2300 PARAMED ED PRGM	0	0	0	25, 004		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	61	ol	15, 887		556, 870	30.00
31. 00 03100 NTENSIVE CARE UNIT	133	o	1, 984		474, 615	1
40. 00 04000 SUBPROVI DER - PF	8	Ö	1, 636		140, 750	1
41. 00 04100 SUBPROVI DER - I RF	1	0	9, 727		38, 974	41. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	103	0	20, 879		445, 378	1
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	4 0	0	0		39, 767 40	51. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	29	0	2, 384		287, 219	
60. 00 06000 LABORATORY	736	O	5, 290		146, 098	
65. 00 06500 RESPI RATORY THERAPY	8	0	0		61, 133	
66. 00 06600 PHYSI CAL THERAPY	1	0	0		85, 675	1
67. 00 06700 OCCUPATIONAL THERAPY	0	0	0		2, 918	
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 OCCUPATI ONAL HEALTH	2 0	0	0		10, 133 0	68. 00 68. 01
69. 00 06900 ELECTROCARDI OLOGY	21	0	2, 714		129, 253	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 942	Ö	0		17, 116	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		7, 846	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	142, 087	122		142, 209	
76. 00 03020 CARDI AC 76. 01 03160 CARDI OPULMONARY	0 0	0	0		0 906	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	0		900	76.01
88. 00 08800 RURAL HEALTH CLINIC	2	0	0		1, 423	88. 00
90. 00 09000 CLI NI C	0	O	0		0	90.00
90. 01 09001 WOUND CLINIC	10	0	0		55, 042	1
90. 02 09002 DI ABETES CLI NI C 90. 03 09003 ASTHMA CLI NI C	0	O	0		3, 668 0	90. 02
90. 04 09004 ANDIS CLINIC		0	0		6, 272	90.03
90. 05 09005 PRI ME TI ME	o	Ö	0		517	90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	8	0	0		1, 402	90. 06
90. 07 04951 0NC0L0GY	12	0	0		7, 111	
90. 08 04950 ANDERSON WOMENS CENTER	3	0	0 1/1		31, 325	1
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	103	0	8, 161		490, 227	91.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					, ,2.00
101.00 10100 HOME HEALTH AGENCY	1	0	17		30, 142	101. 00
SPECIAL PURPOSE COST CENTERS	50				470 400	144 (00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	50 3, 284	142, 087	0 68, 801		172, 189 3, 386, 218	
NONREI MBURSABLE COST CENTERS	3, 204	142, 067	00, 001	<u> </u>	3, 300, 210	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190. 00
190. 01 19001 PROFESSI ONAL BUILDING	0	0	0		946, 412	190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	0	0			190. 02
190. 03 19003 PRI VATE DUTY	1	0	0			190. 03
190. 04 19004 MARKETI NG 190. 05 19005 WATER_LAB		0	0			190. 04 190. 05
190. 06 19006 FOUNDATION		o	0			190.06
190. 07 19007 ASC	O	O	0		387, 181	
190.08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		0	190. 08
190. 09 19009 HANCOCK OB	2	0	0			190. 09
190. 10 19010 HANCOCK WELLNESS	0	0	0			190. 10 190. 11
190. 11 19011 MORRISTOWN CLINIC 190. 12 19012 03PUREMED		0	0			190. 11
190. 13 19013 MCCORD WELLNESS		ol	0			190. 12
190. 14 19014 3 WEST UNIT	0	o	0		89, 946	190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN		o	0			190. 15
200.00 Cross Foot Adjustments			^	25, 004		200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	3, 287	142, 087	68, 801	25, 004		201.00
	3,207	1 12, 007	30, 001	25, 004	1, 5,2, 155	1=02.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part II
To 12/31/2014	Date/Time Prepared:
5/27/2015	11:52 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150037

				5/27/2015 11:	
	Cost Center Description	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments	27, 00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	T			1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
9. 00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11. 00
13.00	01300 NURSING ADMINISTRATION				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15.00	01500 PHARMACY				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY				16. 00
23. 00	02300 PARAMED ED PRGM				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS	0	556, 870		30. 00
	03100 INTENSIVE CARE UNIT	0	474, 615		31. 00
	04000 SUBPROVI DER - I PF	0	140, 750		40. 00
41. 00	04100 SUBPROVI DER - I RF	0	38, 974		41. 00
EO 00	ANCILLARY SERVICE COST CENTERS		44E 270		E0 00
50. 00 51. 00	05000 OPERATING ROOM	0	445, 378		50. 00 51. 00
51.00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	39, 767		1
	05400 RADI OLOGY-DI AGNOSTI C		40 287, 219		53. 00 54. 00
60. 00	06000 LABORATORY	0	146, 098		60.00
65. 00	06500 RESPIRATORY THERAPY	0	61, 133		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	85, 675		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	2, 918		67. 00
	06800 SPEECH PATHOLOGY	0	10, 133		68. 00
	06801 OCCUPATI ONAL HEALTH	0	0		68. 01
	06900 ELECTROCARDI OLOGY	0	129, 253		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17, 116		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	7, 846		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	142, 209		73. 00
76.00	03020 CARDI AC	0	0		76. 00
76. 01	03160 CARDI OPULMONARY	0	906		76. 01
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0	1, 423		88. 00
90.00	09000 CLINIC	0	0		90.00
	09001 WOUND CLINIC	0	55, 042		90. 01
	09002 DI ABETES CLI NI C	0	3, 668		90. 02
	09003 ASTHMA CLINIC	0	0		90. 03
90. 04 90. 05	09004 ANDIS CLINIC 09005 PRIME TIME	0	6, 272 517		90. 04 90. 05
	09006 SHELBYVILLE WOUND CLINIC	0	1, 402		90.03
	04951 ONCOLOGY	0	7, 111		90.07
	04950 ANDERSON WOMENS CENTER	o	31, 325		90. 08
	09100 EMERGENCY	0	490, 227		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	, == .		92.00
	OTHER REIMBURSABLE COST CENTERS		·		
101.00	10100 HOME HEALTH AGENCY	0	30, 142		101. 00
	SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPI CE	0	172, 189		116. 00
118. 00		0	3, 386, 218		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19001 PROFESSI ONAL BUILDING	0	946, 412		190. 01
	19002 PHYSI CI AN BUI LDI NG	0	492		190. 02
	19003 PRI VATE DUTY	0	6, 834		190. 03
	19004 MARKETI NG	0	11, 084		190. 04
	19005 WATER LAB 19006 FOUNDATION		1 612		190. 05 190. 06
	19006 FOUNDATION 19007 ASC		1, 612 387, 181		190. 06
	19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		387, 181		190. 07
	19009 HANCOCK OB		19, 576		190. 08
	19010 HANCOCK WELLNESS	0	17, 759		190. 09
	19011 MORRI STOWN CLINIC		0		190. 11
	19012 03PUREMED	o	409		190. 12
	19013 MCCORD WELLNESS	l ol	37		190. 13
	19014 3 WEST UNIT	Ö	89, 946		190. 14
	19015 NEUROLOGY PHYSICIAN	0	171		190. 15
200.00		0	25, 004		200. 00
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Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150037	Peri od: From 01/01/2014	Worksheet B	
					Date/Time Pre 5/27/2015 11:	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	25. 00	26. 00				
201.00 Negative Cost Centers	0	0				201. 00
202.00 TOTAL (sum lines 118-201)	o	4, 892, 735				202.00

	LLOCATION - STATISTICAL BASIS	HANCOCK REGION		CCN: 150037 F	Peri od:	Worksheet B-1	
				F	From 01/01/2014 To 12/31/2014	Date/Time Pre	
					12/31/2014	5/27/2015 11:	52 am
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	NADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00	OO100 NEW CAP REL COSTS-BLDG & FIXT OO400 EMPLOYEE BENEFITS DEPARTMENT	403, 241 1, 309	36, 338, 315				1. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	29, 097	5, 939, 174		74, 752, 688		5.00
7. 00	00700 OPERATION OF PLANT	98, 551	810, 917				1
9. 00	00900 HOUSEKEEPI NG	2, 576	818, 608		.,		1
10.00	01000 DI ETARY	4, 047	371, 363				1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	7, 725 1, 096	708, 906 1, 261, 447	1	1, 461, 594 1, 824, 590	7, 725 1, 096	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	64, 059			0	1
	01500 PHARMACY	5, 908	1, 369, 156	1	.,,	5, 908	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 519	579, 917	1		3, 519	1
23. 00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 344	68, 188	3 (46, 964	1, 344	23. 00
30. 00	03000 ADULTS & PEDIATRICS	28, 323	2, 522, 427	' (3, 891, 447	28, 323	30.00
31. 00	03100 INTENSIVE CARE UNIT	23, 850	2, 960, 513	1		· ·	31.00
40.00	04000 SUBPROVI DER – I PF	6, 376	1, 107, 800				1
41. 00	04100 SUBPROVIDER - IRF ANCILLARY SERVICE COST CENTERS	1, 463	156, 648	3 (222, 313	1, 463	41. 00
50.00	05000 OPERATING ROOM	23, 574	2, 389, 797	' (4, 874, 971	23, 574	50.00
51. 00	05100 RECOVERY ROOM	2, 120	198, 149			2, 120	
53.00	05300 ANESTHESI OLOGY	14 770	2 200 541	1		14 770	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	14, 770 6, 354	2, 280, 541 1, 472, 994			6, 354	54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	2, 312	1, 108, 772		.,		1
66. 00	06600 PHYSI CAL THERAPY	4, 347	904, 370		., ,	4, 347	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	251, 541			0	
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 OCCUPATI ONAL HEALTH	502	173, 388			502 0	1
69. 00	06900 ELECTROCARDI OLOGY	6, 952	452, 917			_	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	. 0) (3, 189, 177	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0			0	
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC	0	0		-	0	
76. 01	03160 CARDI OPULMONARY	0	50, 114	1		0	1
	OUTPATIENT SERVICE COST CENTERS						
88. 00 90. 00	08800 RURAL HEALTH CLINIC 09000 CLINIC	0	171, 059	1		0	
90. 00	09000	2, 895	591, 241			_	90.00
90. 02	09002 DI ABETES CLINIC	193	33, 598				90. 02
	09003 ASTHMA CLINIC	0	0	(0	0	
90. 04 90. 05	09004 ANDIS CLINIC 09005 PRIME TIME	329	43, 753		111, 186 108, 748	329 0	90. 04 90. 05
90.05	09006 SHELBYVILLE WOUND CLINIC	0	127, 238		281, 235	0	1
	04951 ONCOLOGY	0	452, 144		1, 003, 063	0	1
90. 08	04950 ANDERSON WOMENS CENTER	1, 710	221, 923		339, 366	1, 710	
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	27, 077	2, 171, 216		3, 295, 788	27, 077	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	0	796, 304	. (3, 401, 128	0	101. 00
11/ 00	SPECIAL PURPOSE COST CENTERS	0.240	1 020 001	1 /	2 400 242	0.240	11/ 00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	9, 240 317, 559	1, 038, 801 33, 668, 983		2, 400, 342 65, 517, 360		116.00
110.00	NONREI MBURSABLE COST CENTERS	317, 339	33, 000, 703	13, 705, 745	7 03, 317, 300	100, 002	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C) (0	0	190. 00
	19001 PROFESSI ONAL BUILDI NG	56, 656	0)			190. 01
	19002 PHYSI CI AN BUI LDI NG 19003 PRI VATE DUTY	0	406, 663				190. 02 190. 03
	19004 MARKETI NG	441	91, 001		687, 858		190. 04
	19005 WATER LAB	0	0) (0		190. 05
	19006 FOUNDATION	0	121, 658		199, 873		190.06
	19007 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	23, 237	0		282, 667		190. 07 190. 08
190. 09	19009 HANCOCK OB	0	1, 067, 887		3, 712, 002		190. 09
	19010 HANCOCK WELLNESS	0	841, 127	1			190. 10
	19011 MORRISTOWN CLINIC 19012 O3PUREMED	0	95, 508	1	0		190. 11 190. 12
	19012 03PUREMED 19013 MCCORD WELLNESS		95, 508 N		15, 799 7, 736		190. 12
	19014 3 WEST UNIT	5, 348	45, 482		199, 650		190. 14
-					·		

Health Fin	ancial Systems	HANCOCK REGION	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014		
		CAPITAL RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	n ADMI NI STRATI VE	OPERATION OF	
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		·	SALARI ES)				
		1.00	4. 00	5A	5. 00	7. 00	
190. 15 190	15 NEUROLOGY PHYSICIAN	0	0)	0 36, 000	0	190. 15
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 892, 735	5, 364, 173	3	13, 765, 749	7, 504, 787	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 133526	0. 147618	8	0. 184151	27. 361374	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)		15, 883		355, 645	1, 226, 282	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000437		0. 004758	4. 470848	205. 00

	Financial Systems	HANCOCK REGIONA			In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: from 01/01/2014 to 12/31/2014	Worksheet B-1 Date/Time Pre	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	5/27/2015 11: CENTRAL	52 am
		(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI ON	SERVICES &	
		SERVICE)	DAYS)		(MANHOURS)	SUPPLY (COSTED	
			10.00		, ,	REQUIS.)	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	13. 00	14. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1					4. 00 5. 00
7.00	00700 OPERATION OF PLANT						7. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	412, 334 6, 543	11, 702				9. 00 10. 00
11. 00	01100 CAFETERI A	10, 782	0	843, 668			11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 16, 355	0	31, 461 3, 649		5, 380, 020	13. 00 14. 00
15. 00	01500 PHARMACY	11, 930	Ö	33, 384		74, 931	15. 00
16. 00 23. 00	01600 MEDICAL RECORDS & LIBRARY 02300 PARAMED ED PRGM	14, 350 16, 530	0	24, 440 1, 875	l l	0	16. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	10, 550	<u> </u>	1,073	1,075	<u> </u>	25.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	109, 670 22, 610	3, 694 5, 069	72, 368 98, 601		99, 888 217, 615	30. 00 31. 00
40. 00	04000 SUBPROVI DER - I PF	18, 095	2, 643	35, 279		12, 889	40.00
41. 00	04100 SUBPROVI DER - I RF	6, 264	296	6, 039	6, 039	1, 736	41. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	43, 900	O	15, 637	15, 637	168, 104	50.00
51.00	05100 RECOVERY ROOM	16, 165	0	4, 813	I	6, 217	51.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 16, 070	0	72, 789	-	70 47, 147	53. 00 54. 00
60.00	06000 LABORATORY	15, 335	0	59, 268	59, 268	1, 204, 579	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	11, 745 13, 650	0	65, 107 24, 369		13, 294 1, 312	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	8, 098	0	606	67. 00
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 OCCUPATI ONAL HEALTH	0	0	3, 846 0		3, 845 0	68. 00 68. 01
69. 00	06900 ELECTROCARDI OLOGY	26, 615	O	13, 926	Ö	33, 991	69. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	0	3, 179, 458 0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	o	C	Ö	0	73. 00
76. 00 76. 01	03020 CARDI AC 03160 CARDI OPULMONARY	0	0	2, 475	1	0 678	76. 00 76. 01
70.01	OUTPATIENT SERVICE COST CENTERS			2, 470		070	70.01
88. 00 90. 00	08800 RURAL HEALTH CLINIC 09000 CLINIC	0	0	C	- 1	2, 612 0	88. 00 90. 00
90. 01	09001 WOUND CLINIC	0	Ö	12, 589	-	16, 417	90. 01
90. 02 90. 03	09002 DI ABETES CLINIC 09003 ASTHMA CLINIC	0	0	1, 343 0		0	90. 02 90. 03
90. 03	09004 ANDIS CLINIC	0	0	1, 609	- 1	50	90.03
90. 05 90. 06	09005 PRIME TIME	0	0	0	0	12.725	90.05
90.06	09006 SHELBYVILLE WOUND CLINIC 04951 ONCOLOGY	0	0	13, 118	0	12, 725 19, 623	90. 06 90. 07
90.08	04950 ANDERSON WOMENS CENTER	0	0	7, 501		4, 197	90.08
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	23, 515	O I	60, 627	60, 627	168, 950	91. 00 92. 00
101 00	OTHER REIMBURSABLE COST CENTERS	12 210	ما	F7. 00F	F7 00F	1 705	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	12, 210	0	57, 085	57, 085	1, 785	101. 00
	11600 HOSPI CE	0	0	32, 739		81, 547	
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	412, 334	11, 702	764, 035	641, 165	5, 374, 272	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
	19001 PROFESSI ONAL BUILDING 19002 PHYSI CI AN BUILDING	0	0	C			190. 01 190. 02
190. 03	19003 PRI VATE DUTY	O	O	15, 895		1, 755	190. 03
	19004 MARKETI NG 19005 WATER LAB	0	0	2, 759 0	I I		190. 04 190. 05
190.06	19006 FOUNDATI ON	0	Ö	3, 750	-	0	190. 06
	1907 ASC	0	0	C	0		190. 07 190. 08
	3 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 9 19009 HANCOCK OB		0	8, 906			190. 08
	19010 HANCOCK WELLNESS	0	o	45, 438	0		190. 10
	19011 MORRI STOWN CLINIC 19012 O3PUREMED		0	0 1, 803			190. 11 190. 12
190. 13	19013 MCCORD WELLNESS	0	Ö	C	0	0	190. 13
	19014 3 WEST UNIT 19015 NEUROLOGY PHYSICIAN	0	0 0	1, 082 0	0 0		190. 14 190. 15
200.00							200. 00

Health Fin	ancial Systems	HANCOCK REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLO	CATION - STATISTICAL BASIS				Peri od:	Worksheet B-1	
					From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/27/2015 11:	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI ON		
		SERVI CE)	DAYS)			SUPPLY	
					(MANHOURS)	(COSTED	
						REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 990, 827	656, 756	1, 994, 173	2, 264, 942	216, 943	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	4. 828190	56. 123398	2. 363694	3. 447086	0.040324	203. 00
204. 00	Cost to be allocated (per Wkst. B,	50, 847	70, 234	136, 862	32, 534	3, 287	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 123315	6. 001880	0. 162223	0. 049515	0.000611	205. 00
	11)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

| Peri od: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

					To 12/31/2014 Date/Time Pr 5/27/2015 1	
	Cost Center Description	PHARMACY	MEDI CAL	PARAMED ED	372772013	1. 52 diii
		(COSTED REQUIS.)	RECORDS & LI BRARY	PRGM (ASSI GNED		
		REGOLO.	(TIME	TI ME)		
		15. 00	SPENT) 16. 00	23. 00	-	
	GENERAL SERVICE COST CENTERS	13.00	10.00	25.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
4. 00 5. 00	OO400					4. 00 5. 00
7.00	00700 OPERATION OF PLANT					7. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00
11. 00	01100 CAFETERI A					11.00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	100				14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	3, 954			16. 00
23. 00	02300 PARAMED ED PRGM	0	0	100	<u>)</u>	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	l	913		0	30.00
31. 00	03100 NTENSI VE CARE UNI T	o o	114			31. 00
40.00	04000 SUBPROVI DER - I PF	0	94		0	40.00
41. 00	O4100 SUBPROVI DER - I RF ANCI LLARY SERVI CE COST CENTERS	0	559		0	41. 00
50.00	05000 OPERATI NG ROOM	0	1, 200	(ol .	50. 00
51.00	05100 RECOVERY ROOM	0	0			51.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 137	100))	53. 00 54. 00
60.00	06000 LABORATORY	o	304	i e		60.00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	(65.00
66. 00 67. 00	06700 OCCUPATIONAL THERAPY		0		اد	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0	(68. 00
68. 01 69. 00	O6801 OCCUPATI ONAL HEALTH O6900 ELECTROCARDI OLOGY	0	0 156	()	68. 01 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	(ס	72. 00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 CARDI AC	100	7	1))	73. 00 76. 00
76. 01	03160 CARDI OPULMONARY	O	0			76. 00
00.00	OUTPATIENT SERVICE COST CENTERS		0			00.00
88. 00 90. 00	08800 RURAL HEALTH CLINIC 09000 CLINIC	0	0))	88. 00 90. 00
90. 01	09001 WOUND CLINIC	o	0		٥	90. 01
90. 02	09002 DI ABETES CLINIC	0	0	(90. 02
90. 03 90. 04	09003 ASTHMA CLINIC 09004 ANDIS CLINIC		0) 	90. 03 90. 04
90. 05	09005 PRIME TIME	o	0	(90. 05
90. 06	O9006 SHELBYVILLE WOUND CLINIC O4951 ONCOLOGY	0 0	0	1))	90. 06 90. 07
	04950 ANDERSON WOMENS CENTER		0			90.07
	09100 EMERGENCY	0	469	(0	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					92. 00
101.00	10100 HOME HEALTH AGENCY	0	1	(ס	101. 00
11/ 00	SPECIAL PURPOSE COST CENTERS	1 0	0	· .		11/ 00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0 100	0 3, 954		0 0	116. 00 118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PROFESSIONAL BUILDING	0	0))	190. 00 190. 01
	19001 PROFESSIONAL BUILDING		0		5	190. 01
	19003 PRI VATE DUTY	0	0	(ס	190. 03
	19004 MARKETING 19005 WATER_LAB	0	0	())	190. 04 190. 05
	19006 FOUNDATION	l o	0		o	190.06
	19007 ASC	0	0	()	190. 07
	19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19009 HANCOCK OB	0	0 0		כן כו	190. 08 190. 09
190. 10	19010 HANCOCK WELLNESS	O	0))	190. 10
	19011 MORRI STOWN CLINIC	0	0)	190. 11
	19012 03PUREMED 19013 MCCORD WELLNESS		0	() 	190. 12 190. 13
190. 14	19014 3 WEST UNIT	0	Ö		ס	190. 14
190. 15 200. 00	19015 NEUROLOGY PHYSICIAN Cross Foot Adjustments	0	0	()	190. 15 200. 00
200.00	Toross root Aujustillerits	<u> </u>		I	<u> </u>	1200.00

Heal th Fi	nancial Systems	HANCOCK REGION	AL HOSPITAL	In Lieu of Form CMS-2552-10			
COST ALLO	OCATION - STATISTICAL BASIS		Provi der		Peri od: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Pre 5/27/2015 11:	
	Cost Center Description	PHARMACY	MEDI CAL	PARAMED ED			
		(COSTED	RECORDS &	PRGM			
		REQUIS.)	LI BRARY	(ASSI GNED			
			(TIME	TIME)			
			SPENT)				
		15. 00	16. 00	23.00			
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	9, 084, 489	1, 313, 962	183, 09	1		202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	90. 844. 890000	332. 312089	1, 830. 91000	0		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	142, 087	68, 801	25, 00	4		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1, 420. 870000	17. 400354	250. 04000	0		205. 00

					o 12/31/2014	Date/Time Pre 5/27/2015 11:	pared:
			Ti +I	e XVIII	Hospi tal	PPS	JZ alli
			11 (1	C XVIII	Costs	113	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00	03000 ADULTS & PEDI ATRI CS	6, 847, 788		6, 847, 788	0	6, 847, 788	30.00
31. 00	03100 I NTENSI VE CARE UNI T	6, 918, 435	ł .	6, 918, 435		6, 918, 435	1
40. 00	04000 SUBPROVI DER - I PF	2, 436, 116		2, 436, 116		2, 436, 116	
41. 00	04100 SUBPROVI DER - I RF	571, 062		571, 062			
41.00	ANCI LLARY SERVI CE COST CENTERS	371,002	l	371,002		371,002	1 11.00
50. 00	05000 OPERATI NG ROOM	7, 126, 094		7, 126, 094	0	7, 126, 094	50.00
51. 00	05100 RECOVERY ROOM	528, 447		528, 447		528, 447	51.00
53. 00	05300 ANESTHESI OLOGY	10, 010		10, 010		10, 010	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 408, 838	ł .	6, 408, 838		6, 408, 838	1
60.00	06000 LABORATORY	5, 590, 741		5, 590, 741		5, 590, 741	1
65. 00	06500 RESPI RATORY THERAPY	2, 244, 864	0			2, 244, 864	1
66. 00	06600 PHYSI CAL THERAPY	1, 883, 657		_, _, ,		1, 883, 657	1
67. 00	06700 OCCUPATI ONAL THERAPY	390, 968		.,,		390, 968	
68. 00	06800 SPEECH PATHOLOGY	295, 785		1		295, 785	
68. 01	06801 OCCUPATI ONAL HEALTH	275, 765			0	275, 705	1
69. 00	06900 ELECTROCARDI OLOGY	1, 735, 360	,	1, 735, 360	1	1, 735, 360	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 904, 675		3, 904, 675		3, 904, 675	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 952, 730		1, 952, 730		1, 952, 730	
73. 00	07300 DRUGS CHARGED TO PATIENTS	9, 086, 815		9, 086, 815		9, 086, 815	
76. 00	03020 CARDI AC	9,080,813		9,000,010		9, 080, 813	1
76. 00 76. 01	03160 CARDI OPULMONARY	125, 944		125, 944		125, 944	
70.01	OUTPATIENT SERVICE COST CENTERS	125, 744		125, 744		125, 744	70.01
88. 00	08800 RURAL HEALTH CLINIC	335, 215		335, 215	0	335, 215	88. 00
90.00	09000 CLINIC	333, 213		333, 213		0 333, 213	1
90. 00	09001 WOUND CLINIC	1, 269, 875		1, 269, 875		1, 269, 875	
90. 01	09002 DI ABETES CLINIC	65, 651		65, 651		65, 651	90. 02
90. 03	09003 ASTHMA CLINIC	05,051		05,051	0	03,031	1
90. 04	09004 ANDIS CLINIC	144, 468	1	144, 468	_	144, 468	1
90. 05	09005 PRIME TIME	128, 774		128, 774		128, 774	1
90. 06	09006 SHELBYVILLE WOUND CLINIC	333, 538		333, 538		333, 538	1
90. 07	04951 ONCOLOGY	1, 219, 576		1, 219, 576		1, 219, 576	1
90. 07	04950 ANDERSON WOMENS CENTER	466, 548		466, 548		466, 548	1
91. 00	09100 EMERGENCY	5, 272, 067		5, 272, 067		5, 272, 067	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 493, 177		2, 493, 177		2, 493, 177	1
72.00	OTHER REIMBURSABLE COST CENTERS	2,473,177		2, 473, 177		2, 475, 177	72.00
101 00	10100 HOME HEALTH AGENCY	4, 418, 513		4, 418, 513		4, 418, 513	101 00
101.00	SPECIAL PURPOSE COST CENTERS	4, 410, 515		7, 410, 510	1	4, 410, 515	101.00
116 00	11600 HOSPI CE	3, 282, 229		3, 282, 229)	3, 282, 229	116 00
200.00	1	77, 487, 960					1
200.00		2, 493, 177		2, 493, 177		2, 493, 177	1
202.00		74, 994, 783					1
202.00	1.56. (500 11151 4011 6115)	1 , 1, , , 1, 703	1	1 , 1, , , 1, , 00	.1	, ,, ,, ,, ,00	1-32. 00

					0 12/31/2014	5/27/2015 11:	
			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
			Charges	<i>y</i> ,,,,,,,	1.0001 tu	110	
	Cost Center Description	I npati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	cost contor boson per on	patront	output. o	+ col . 7)	Ratio	Inpati ent	
				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	1.4.1.0	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	6, 317, 566		6, 317, 566			30.00
31. 00	03100 INTENSIVE CARE UNIT	7, 802, 674		7, 802, 674			31. 00
40. 00	04000 SUBPROVI DER - I PF	3, 071, 585		3, 071, 585			40.00
41. 00	04100 SUBPROVI DER - I RF	363, 156		363, 156			41. 00
	ANCILLARY SERVICE COST CENTERS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
50.00	05000 OPERATING ROOM	5, 701, 063	9, 034, 522	14, 735, 585	0. 483598	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	846, 533	1, 077, 119			0. 000000	
53. 00	05300 ANESTHESI OLOGY	14, 202	753			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 596, 027	39, 627, 790			0. 000000	
60.00	06000 LABORATORY	5, 750, 655	27, 851, 253			0. 000000	
65. 00	06500 RESPIRATORY THERAPY	2, 743, 609	4, 440, 658			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	862, 792	3, 261, 781			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	582, 873	540, 662			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	169, 896	417, 821			0. 000000	
68. 01	06801 OCCUPATI ONAL HEALTH	107,070	0			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	3, 441, 942	7, 909, 248			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 331, 591	3, 104, 441			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	5, 248, 643	1, 095, 588			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	10, 136, 668	29, 243, 756			0. 000000	
76. 00	03020 CARDI AC	0	27, 243, 730			0. 000000	
76. 00	03160 CARDI OPULMONARY		283, 291			0. 000000	
70.01	OUTPATIENT SERVICE COST CENTERS	<u> </u>	205, 271	203, 271	0. 444373	0.000000	70.01
88. 00	08800 RURAL HEALTH CLINIC	0	347, 836	347, 836			88. 00
90.00	09000 CLINIC		0-7,030			0. 000000	
90. 01	09001 WOUND CLINIC	8, 171	3, 814, 002	`		0. 000000	
90. 02	09002 DI ABETES CLINI C	0, 1, 1	55, 080			0. 000000	
90. 02	09003 ASTHMA CLINIC		33,000			0.000000	
90.03	09004 ANDIS CLINIC		56, 227			0. 000000	
90.04	09005 PRIME TIME	53	265, 476			0. 000000	
90.05	09006 SHELBYVILLE WOUND CLINIC	0	1, 610, 003			0. 000000	
90.08	04951 ONCOLOGY	19, 601	2, 496, 663			0. 000000	
90.07	04950 ANDERSON WOMENS CENTER	6, 334	2, 490, 663			0. 000000	
90.08	09100 EMERGENCY		2, 910, 155 18, 590, 777			0. 000000	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 897, 473					
92.00		203, 117	1, 946, 264	2, 149, 381	1. 159951	0. 000000	92.00
101 00	OTHER REIMBURSABLE COST CENTERS		(72 (14	(72 (1)	1		101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	672, 614	672, 614	·		101. 00
114 00	11600 HOSPI CE	421 427	1 220 507	1 052 027			114 00
		621, 437	1, 230, 587				116. 00
200.00		63, 737, 661	161, 884, 367	225, 622, 028			200. 00
201. 00 202. 00		42 727 4/1	141 004 277	225 422 020	,		201. 00 202. 00
202.00	p Total (See Histructions)	63, 737, 661	161, 884, 367	225, 622, 028	P[1202.00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037 | Period: From 01/01/2014 | To 12/31/2014 | To 12/31/2014 | To 12/31/2015 | 11:52 am

				5/27/2015 11:52 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVI DER - 1 PF				40.00
41. 00 04100 SUBPROVI DER - 1 RF				41.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 483598			50.00
51.00 05100 RECOVERY ROOM	0. 274710			51.00
53. 00 05300 ANESTHESI OLOGY	0. 669341			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 144918			54.00
60. 00 06000 LABORATORY	0. 166382			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 312469			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 456691			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 347980			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 503278			68. 00
68. 01 06801 0CCUPATI ONAL HEALTH	0. 000000			68. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 152879			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 718295			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 307796			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 230744			73.00
76. 00 03020 CARDI AC	0. 000000			76. 00
76. 01 03160 CARDI OPULMONARY	0. 444575			76. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 WOUND CLINIC	0. 332239			90. 01
90. 02 09002 DI ABETES CLINIC	1. 191921			90. 02
90. 03 09003 ASTHMA CLINIC	0. 000000			90. 03
90. 04 09004 ANDIS CLINIC	2. 569371			90.04
90. 05 09005 PRI ME TI ME	0. 484972			90. 05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0. 207166			90.06
90. 07 04951 0NCOLOGY	0. 484677			90. 07
90. 08 04950 ANDERSON WOMENS CENTER	0. 159969			90. 08
91. 00 09100 EMERGENCY	0. 245347			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 159951			92.00
OTHER REIMBURSABLE COST CENTERS	11.107701			72.00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				101.00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202. 00 Total (see instructions)				202. 00
202. 001 110101 (000 111011 0011 0110)	1 1			1202.00

					10 12/31/2014	5/27/2015 11:	
			Ti t	le XIX	Hospi tal	Cost	
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
	03000 ADULTS & PEDIATRICS	6, 847, 788		6, 847, 78			
	03100 INTENSIVE CARE UNIT	6, 918, 435		6, 918, 43			
40.00	04000 SUBPROVI DER - I PF	2, 436, 116		2, 436, 11		_,,	
41.00	04100 SUBPROVI DER - I RF	571, 062		571, 06	2 0	571, 062	41. 00
	ANCILLARY SERVICE COST CENTERS	T	T				
	05000 OPERATING ROOM	7, 126, 094		7, 126, 09			1
51.00	05100 RECOVERY ROOM	528, 447		528, 44			
53. 00	05300 ANESTHESI OLOGY	10, 010		10, 01		10,010	
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 408, 838		6, 408, 83		-,,	
60.00	06000 LABORATORY	5, 590, 741	_	5, 590, 74		5, 590, 741	
65. 00	06500 RESPI RATORY THERAPY	2, 244, 864		, , , , , ,		_, ,	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 883, 657		1, 883, 65		1, 883, 657	1
67. 00	06700 OCCUPATI ONAL THERAPY	390, 968		390, 96		,	
68. 00	06800 SPEECH PATHOLOGY	295, 785	0	295, 78		,	
	06801 OCCUPATI ONAL HEALTH	0	0		0	_	68. 01
69. 00	06900 ELECTROCARDI OLOGY	1, 735, 360		1, 735, 36		1, 735, 360	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	3, 904, 675		3, 904, 67		3, 904, 675	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 952, 730		1, 952, 73		1, 952, 730	
	07300 DRUGS CHARGED TO PATIENTS	9, 086, 815		9, 086, 81		9, 086, 815	
76. 00	03020 CARDI AC	0			0	0	76.00
76. 01	03160 CARDI OPULMONARY	125, 944		125, 94	4 0	125, 944	76. 01
	OUTPATIENT SERVICE COST CENTERS	225 245	I	225 24	- 0	225 245	00.00
	08800 RURAL HEALTH CLINIC 09000 CLINIC	335, 215		335, 21			
	09000 CLINIC 09001 WOUND CLINIC	1 2/0 075			-	_	90. 00 90. 01
	09002 DI ABETES CLI NI C	1, 269, 875		1, 269, 87		1, 269, 875	90.01
	09003 ASTHMA CLINIC	65, 651		65, 65	0 0	65, 651 0	90.02
90. 03	09004 ANDIS CLINIC	_			-	_	
	09005 PRIME TIME	144, 468 128, 774		144, 46 128, 77		144, 468 128, 774	
90.05	09006 SHELBYVILLE WOUND CLINIC	333, 538		333, 53			
90.00	04951 ONCOLOGY	1, 219, 576		1, 219, 57		1, 219, 576	
	04950 ANDERSON WOMENS CENTER	466, 548		466, 54			1
	09100 EMERGENCY	5, 272, 067		5, 272, 06		5, 272, 067	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 493, 177		2, 493, 17		2, 493, 177	
92.00	OTHER REIMBURSABLE COST CENTERS	2,473,177		2,473,17	1	2,473,177	72.00
101 00	10100 HOME HEALTH AGENCY	4, 418, 513		4, 418, 51	2	4, 418, 513	101 00
101.00	SPECIAL PURPOSE COST CENTERS	4,410,513		4,410,51	J ₁	4, 410, 513	1101.00
116 00	11600 HOSPI CE	3, 282, 229		3, 282, 22	9	3, 282, 229	116 00
200.00		77, 487, 960					
201.00		2, 493, 177		2, 493, 17		2, 493, 177	
202.00		74, 994, 783					
202.00	1.0441 (300 111341 4041 0113)	, , , , , , , , , , , , , , , , , ,	1	1 , 1, 7,7, 70	٥	, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,	1-02.00

| Period: | Worksheet C | From 01/01/2014 | Part I | Date/Time Prepared: | 5/27/2015 | 11:52 am

						5/27/2015 11:	52 am
			Ti t	le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
				,		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30.00	03000 ADULTS & PEDIATRICS	6, 317, 566		6, 317, 56	6		30.00
31. 00	03100 INTENSIVE CARE UNIT	7, 802, 674		7, 802, 67			31. 00
40. 00	04000 SUBPROVI DER - I PF	3, 071, 585		3, 071, 58			40. 00
41. 00	04100 SUBPROVI DER – I RF	363, 156		363, 15			41. 00
41.00	ANCILLARY SERVICE COST CENTERS	303, 130		303, 13	0		1 41.00
50. 00	05000 OPERATING ROOM	5, 701, 063	9, 034, 522	14, 735, 58	5 0. 483598	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	846, 533	1, 077, 119				
53. 00	05300 ANESTHESI OLOGY	14, 202	753			0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 596, 027	39, 627, 790				1
		1					1
60.00	06000 LABORATORY	5, 750, 655	27, 851, 253			0.000000	
65.00	06500 RESPI RATORY THERAPY	2, 743, 609	4, 440, 658			0.000000	1
66. 00	06600 PHYSI CAL THERAPY	862, 792	3, 261, 781			0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	582, 873	540, 662				1
68. 00	06800 SPEECH PATHOLOGY	169, 896	417, 821	1			1
68. 01	06801 OCCUPATI ONAL HEALTH	0	0		0. 000000		
69. 00	06900 ELECTROCARDI OLOGY	3, 441, 942	7, 909, 248	11, 351, 19	0. 152879	0. 000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 331, 591	3, 104, 441	5, 436, 03	2 0. 718295	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5, 248, 643	1, 095, 588	6, 344, 23	1 0. 307796	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 136, 668	29, 243, 756	39, 380, 42	4 0. 230744	0.000000	73. 00
76.00	03020 CARDI AC	o	0		0.000000	0.000000	76. 00
76. 01	03160 CARDI OPULMONARY	o	283, 291	283, 29	1 0. 444575	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS				·		1
88. 00	08800 RURAL HEALTH CLINIC	0	347, 836	347, 83	6 0. 963716	0.000000	88. 00
90.00	09000 CLI NI C	l ol	. 0		0. 000000	0. 000000	90.00
90. 01	09001 WOUND CLINIC	8, 171	3, 814, 002	3, 822, 17		0. 000000	
90. 02	09002 DI ABETES CLINIC	0	55, 080			0. 000000	1
90. 03	09003 ASTHMA CLINIC	0	0		0.000000	0. 000000	1
90. 04	09004 ANDIS CLINIC		56, 227			0. 000000	
90. 05	09005 PRIME TIME	53	265, 476			0. 000000	1
90. 06	09006 SHELBYVILLE WOUND CLINIC	0	1, 610, 003				1
90. 00	04951 ONCOLOGY	19, 601	2, 496, 663			0. 000000	
90.07	04950 ANDERSON WOMENS CENTER	1					1
		6, 334	2, 910, 155				
91.00	09100 EMERGENCY	2, 897, 473	18, 590, 777			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	203, 117	1, 946, 264	2, 149, 38	1. 159951	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS				.1		
101.00	10100 HOME HEALTH AGENCY	0	672, 614	672, 61	4		101. 00
	SPECIAL PURPOSE COST CENTERS			1	-1		4
	11600 H0SPI CE	621, 437	1, 230, 587				116. 00
200.00		63, 737, 661	161, 884, 367	225, 622, 02	8		200. 00
201.00							201. 00
202.00	Total (see instructions)	63, 737, 661	161, 884, 367	225, 622, 02	8		202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037
Period: Worksheet C
From 01/01/2014
To 12/31/2014
Date/Time Prepared: 5/27/2015 11: 52 am

INPATIENT ROUTINE SERVICE COST CENTERS 11.00					5/27/2015 11:52 am
INPATEENT ROUTINE SERVICE COST CENTERS 30,00 330,00			Title XIX	Hospi tal	Cost
INPATI ENT ROUTINE SERVICE COST CENTERS 11.00	Cost Center Description	PPS Inpatient		<u> </u>	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30000 ADULTS & PEDIATRIC S 31.00 31.00 31.00 10.00 11.00	· ·				
IMPATI ENT ROUTINE SERVICE COST CENTERS 30,00 310,0					
30.00 03000 ADULTS & PEDIATRICS 31.00 40.00 04000 SUBPROVIDER - I PF 41.00 41.00 41.00 41.00 41.00 51.00 SUBPROVIDER - I PF 41.00 41.00 41.00 41.00 51.00 SUBPROVIDER - I RF 41.00 51.00 51.00 SUBPROVIDER - I RF 41.00 51	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			
31.00 03100 INTENSIVE CARE UNIT					30.00
40. 00 0.0000 0.0000 0.000000 0.000000 0.000000 0.000000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000 0.000000 0.00000 0.00000 0.0000					31.00
ALCO OATOO SUBPROVIDER - IRF					
ANCILLARY SERVICE COST CENTERS 50.00					
50.00 05000 05000 05000 05000 051.00 051.00 051.00 051.00 051.00 051.00 051.00 051.00 051.00 053.00 050000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 0500000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 05000000 050000000 05000000 050000000 050000000 050000000 050000000 050000000 050000000 050000000 050000000 050000000 050000000 0500000000					99
51.00 05100 RECOVERY ROOM 0.000000 51.00 53.00 53.00 0.55100 53.00 53.00 0.55100 53.00 0.55100 53.00 0.55100 53.00 0.55100 53.00 0.55100 0.550000 0.550000 0.550000 0.550000 0.550000 0.550000 0.550000 0.5500000 0.5500000 0.5500000 0.5500000 0.5500000 0.5500000 0.55000000 0.55000000 0.55000000 0.55000000 0.55000000 0.55000000 0.550000000 0.550000000 0.550000000 0.550000000 0.550000000 0.550000000 0.550000000 0.550000000 0.550000000 0.5500000000 0.550000000 0.5500000000 0.5500000000 0.5500000000 0.550000000000		0.000000			50.00
53.00 05300 ABSTHESI OLOGY 0.00000 54.00 0.00000 54.00 0.00000 0.00000 54.00 0.00000 0.00000 54.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1			
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 06000 06000 LABORATORY 0.000000 06000 06000 LABORATORY 0.000000 06500 RESPI RATORY THERAPY 0.000000 06500 RESPI RATORY THERAPY 0.000000 06500 06500 RESPI RATORY THERAPY 0.000000 06500 06500 RESPI RATORY THERAPY 0.000000 06500 06500 RESPI RATORY THERAPY 0.000000 06800 06800 06800 SPEECH PATHOLOGY 0.000000 06800 06800 06800 DELECTROCARDI OLOGY 0.000000 06800 06800 DELECTROCARDI OLOGY 0.000000 06900 ELECTROCARDI OLOGY 0.000000 06900 ELECTROCARDI OLOGY 0.000000 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 072.00					
60. 00 06000 LABORATORY 0. 000000 065. 00 06500 RESPIRATORY THERAPY 0. 0000000 066. 00 06600 PHYSI CAL THERAPY 0. 0000000 066. 00 06600 PHYSI CAL THERAPY 0. 0000000 067. 00 06600 PHYSI CAL THERAPY 0. 0000000 067. 00 06600 PHYSI CAL THERAPY 0. 0000000 067. 00 06600 SPECIA PATHOLOGY 0. 0000000 068. 00 06600 SPECIA PATHOLOGY 0. 0000000 068. 01 06801 0CCUPATI ONAL HEALTH 0. 0000000 069. 00 071000 07100 07100 07100 071000 07100 071000 07100 0710		1			
65. 00 06500 RESPI RATORY THERAPY 0.000000 66. 00 066000 PHYSI CAL THERAPY 0.000000 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 06800 0CCUPATI ONAL THERAPY 0.000000 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 06801 0CCUPATI ONAL THERAPY 0.000000 68. 00 06801 0CCUPATI ONAL THEALTH 0.000000 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 76. 00 03020 CARDI AC 0.000000 76. 00 030900 RURAL HEALTH CLINI C 0.000000 76. 01 0.000000 76. 01 0.000000 0.000000 0.00000 0.0000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1			
66. 00 06600 PHYSICAL THERAPY 0. 000000 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 68. 00 68. 01 06801 0CCUPATI ONAL HEALTH 0. 000000 68. 00 68. 01 06801 0CCUPATI ONAL HEALTH 0. 000000 69. 00 69. 01 06700 0CCUPATI ONAL HEALTH 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 72. 00 73. 00 07300 BRUSS CHARGED TO PATI ENTS 0. 000000 73. 00 74. 00 03300 CARDI AC 0. 000000 73. 00 75. 00 03300 CARDI AC 0. 000000 75. 00 76. 01 03160 CARDI OPULMONARY 0. 000000 76. 01 001PATI ENT SERVICE COST CENTERS 76. 01 001PATI ENT SERVICE COST CENTERS 76. 01 001 09001 WOUND CLI NI C 0. 000000 90. 01 090. 00 09000 CLI NI C 0. 000000 90. 01 090. 01 09001 MOUND CLI NI C 0. 000000 90. 01 090. 03 09003 ASTHMA CLI NI C 0. 000000 90. 03 090. 04 09004 ANDI S CLI NI C 0. 000000 90. 05 090. 05 09005 PRI ME TI ME 0. 000000 90. 05 090. 06 09005 PRI ME TI ME 0. 000000 90. 05 090. 07 04951 MOCLOCY 0. 000000 90. 05 090. 08 04950 ANDERSON WOMENS CENTER 0. 000000 90. 05 090. 08 04950 ANDERSON WOMENS CENTER 0. 000000 90. 05 090. 09 09000 ERROENCY 0. 000000 90. 05 090. 08 04950 ANDERSON WOMENS CENTER 0. 000000 90. 05 090. 08 04950 ANDERSON WOMENS CENTER 0. 000000 90. 07 091. 00 09100 EMERGENCY 0. 000000 90. 07 091. 00 09100 EMERGENCY 0. 000000 90. 07 092. 00 09200 DIBER REALTH AGENCY 0. 000000 90. 07 011600 HOSPICE Subtractions 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 0000000					
67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 68. 00 06800 SPECH PATHOLOGY 0.000000 68. 00 68. 01 06801 OCCUPATI ONAL HEALTH 0.000000 68. 01 06801 OCCUPATI ONAL HEALTH 0.000000 69. 00 06900 ELECTROCARDI OLOGY 0.000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72. 00 1MPL. DEV. CHARGED TO PATI ENT 0.000000 72. 00 07200 1MPL. DEV. CHARGED TO PATI ENT 0.000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 76. 00 03020 CARDI AC 0.000000 76. 00 030800 RURAL HEALTH CLINI C 0.000000 09. 01 09000 CLI NI C 0.000000 09. 01 09000 CLI NI C 0.000000 09. 01 09000 DI ABETES CLI NI C 0.000000 09. 01 09000 DI ABETES CLI NI C 0.000000 09. 01 09000 DI ABETES CLI NI C 0.000000 09. 02 09002 DI ABETES CLI NI C 0.000000 09. 02 09002 DI ABETES CLI NI C 0.000000 09. 02 09002 DI ABETES CLI NI C 0.000000 09. 03 09003 ASTHMA CLI NI C 0.000000 09. 04 09004 ANDIS CLI NI C 0.000000 09. 05 09. 05 09005 PRI ME TI ME 0.000000 09. 05 09. 05 09005 PRI ME TI ME 0.000000 09. 05 090					
68. 00 06800 O68001 OCCUPATIONAL HEALTH					
68.01 06801 OCCUPATIONAL HEALTH 0.000000 69.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.00 03020 CARDIAC 0.000000 76.00 76.01 03160 CARDI OPULMONARY 0.000000 76.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 90.00 90.00 09000 CLINIC 0.000000 90.00 90.01 09011 WOUND CLINIC 0.000000 90.01 90.02 09002 DIABETES CLINIC 0.000000 90.01 90.03 09003 ASTHMA CLINIC 0.000000 90.01 90.04 09004 ANDIS CLINIC 0.000000 90.01 90.05 09005 PRIME TIME 0.000000 90.01 90.06 09006 SHELBYVI LLE WOUND CLINIC 0.000000 90.05 90.07 04951 NOCLOGY 0.000000 90.05 90.08 04950 ANDERSON WOMENS CENTER 0.000000 90.08 91.00 0910 O910 WERREENCY 0.000000 90.08 91.00 09200 DERROSENCY 0.000000 90.08 92.00 09200 DERROSENCY 0.000000 90.07 92.00 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200					
69. 00 66900 ELECTROCARDI OLOGY	· · · · · · · · · · · · · · · · · · ·	1			
71. 00					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 73.00 DRUGS CHARGED TO PATIENTS 0. 000000 75.00 03000 DRUGS CHARGED TO PATIENTS 0. 0000000 76.00 03020 CARDI AC 0. 0000000 76.00 03160 CARDI AC 0. 0000000 76.00 03160 CARDI OPULMONARY 0. 0000000 76.01 0000000 TRIAL HEALTH CLINI C 0. 000000 90.00 090.00 CLINI C 0. 0000000 90.00 090.00					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73000 DRUGS CHARGED TO PATIENTS 0.000000 756. 00 03020 CARDI AC 0.000000 76. 00 03020 CARDI OPULMONARY 0.000000 76. 01 076. 01					
76. 00 03020 CARDI AC 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1			
76. 01 03160 CARDI OPULMONARY 0.000000 76. 01					
SECOND S					
88. 00 08800 RURAL HEALTH CLINIC		0. 000000			/6. 01
90. 00					
90. 01					
90. 02					
90. 03					
90. 04 09004 ANDIS CLINIC 0.000000 90. 04 90. 05 09005 PRIME TIME 0.000000 90. 05 90. 06 09006 SHELBYVILLE WOUND CLINIC 0.000000 90. 06 90. 06 90. 07 04951 0NCOLOGY 0.000000 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0.000000 91. 00 91. 00 09100 EMERGENCY 0.000000 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 OTHER REIMBURSABLE COST CENTERS 101. 00 1000 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 0.000000 201. 00					
90. 05 09005 PRI ME TI ME 0. 000000 90. 05 90. 06 09006 SHELBYVI LLE WOUND CLINI C 0. 000000 90. 06 90. 07 04951 0NCOLOGY 0. 000000 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0. 000000 90. 08 91. 00 09100 EMERGENCY 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000 92. 00 0THER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 Less Observation Beds 201. 00	l				
90. 06 09006 SHELBYVI LLE WOUND CLINI C 0. 000000 90. 06 90. 07 04951 0NCOLOGY 0. 000000 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 0. 000000 91. 00 09100 EMERGENCY 0. 000000 91. 00 092. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000 07HER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 0					
90. 07					
90. 08 04950 ANDERSON WOMENS CENTER 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000 92. 00 OTHER REI MBURSABLE COST CENTERS 101. 00 SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 Cost of the					
91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 0000000 92. 00 OTHER REIMBURSABLE COST CENTERS 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000 0THER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 200. 00 Subtotal (see instructions) Less Observation Beds 116. 00 201. 00					
101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00		0. 000000			92. 00
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
116. 00 116.00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					101. 00
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
201.00 Less Observation Beds 201.00					116. 00
	200.00 Subtotal (see instructions)				200. 00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				
	202.00 Total (see instructions)				202. 00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I Date/Time Pre 5/27/2015 11:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col	•		
	26)	2.00	2)	4.00	Г 00	
INDATI ENT DOUTINE CEDVICE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	FF/ 070	1 0	J FF (07	0 5 (50	00.42	1 20 00
30. 00 ADULTS & PEDIATRICS	556, 870		556, 87			
31. 00 INTENSIVE CARE UNIT	474, 615		474, 61			
40. 00 SUBPROVIDER - I PF	140, 750		140, 75			
41. 00 SUBPROVI DER - I RF	38, 974		38, 97		131. 67	41.00
200.00 Total (lines 30-199)	1, 211, 209		1, 211, 20	9 13, 634		200. 00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost (col. 5 x col.				
		(COI. 5 x COI.				
	6. 00	7.00	+			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	1, 269	124, 895				30.00
31. 00 INTENSIVE CARE UNIT	2, 309					31.00
40. 00 SUBPROVI DER - I PF	2, 434		1			40.00
41. 00 SUBPROVIDER - IRF	186					41. 00
200. 00 Total (lines 30-199)	6, 198					200.00
200.00 10141 (111103 30 177)	0, 170	1 70,574	T			1200.00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 11:	pared: 52 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T	T	T	T		
50. 00 05000 OPERATI NG ROOM	445, 378					
51. 00 05100 RECOVERY ROOM	39, 767				6, 414	
53. 00 05300 ANESTHESI OLOGY	40					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	287, 219					
60. 00 06000 LABORATORY	146, 098					
65. 00 06500 RESPI RATORY THERAPY	61, 133					
66. 00 06600 PHYSI CAL THERAPY	85, 675					
67. 00 06700 OCCUPATI ONAL THERAPY	2, 918					
68. 00 06800 SPEECH PATHOLOGY	10, 133	•				
68. 01 06801 OCCUPATI ONAL HEALTH	0	1	0.0000		0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	129, 253					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 116					
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 846	1	l .			
73.00 07300 DRUGS CHARGED TO PATIENTS	142, 209					
76. 00 03020 CARDI AC	0	1	0.0000		0	76. 00
76. 01 03160 CARDI OPULMONARY	906	283, 291	0. 00319	8 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	1, 423				·	88. 00
90. 00 09000 CLI NI C	0				0	90. 00
90. 01 09001 WOUND CLINIC	55, 042				47	90. 01
90. 02 09002 DI ABETES CLINIC	3, 668	1	1		0	90. 02
90. 03 09003 ASTHMA CLINIC	0	٦ -	0.00000		0	90. 03
90. 04 09004 ANDIS CLINIC	6, 272				0	90. 04
90. 05 09005 PRIME TIME	517				0	90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	1, 402				0	90. 06
90. 07 04951 ONCOLOGY	7, 111					90. 07
90.08 04950 ANDERSON WOMENS CENTER	31, 325				57	90. 08
91. 00 09100 EMERGENCY	490, 227				38, 730	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	202, 748		1		27	92. 00
200.00 Total (lines 50-199)	2, 175, 426	205, 542, 409	1	21, 011, 830	208, 049	200. 00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2014		narodi
				To 12/31/2014	Date/Time Pre 5/27/2015 11:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	1	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
40. 00 04000 SUBPROVI DER - I PF	0	0)	0 0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0)	0 0	0	41.00
200.00 Total (lines 30-199)	0	0)	0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 658	0.00	1, 26	9 0		30. 00
31.00 03100 INTENSIVE CARE UNIT	5, 037	0.00	2, 30	9 0		31. 00
40. 00 04000 SUBPROVI DER - I PF	2, 643	0.00	2, 43	4 0		40. 00
41. 00 04100 SUBPROVI DER - I RF	296	0.00	18	6 0		41.00
200.00 Total (lines 30-199)	13, 634		6, 19	0 8		200. 00

j	Health Financial Systems	HANCOCK REGIONAL HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150037	From 01/01/2014	Worksheet D Part IV Date/Time Prepared:

				1	0 12/31/2014	5/27/2015 11:	pared: 52 am
			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	J .	
						4)	
	ANOLI LABO OFFICE OF SERVICE	1.00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			1	0		
	05100 RECOVERY ROOM	0	0	0	0	0	50.00
51.00	05300 ANESTHESI OLOGY	0	0		0	0	51. 00 53. 00
54. 00	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0	183, 091	0	183, 091	54.00
60.00	06000 LABORATORY	0	0	103,091	0	163, 091	60.00
65. 00	06500 RESPIRATORY THERAPY		0		0	1 0	65. 00
66. 00	06600 PHYSI CAL THERAPY		0		0	1 0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0		0	1 0	67. 00
	06800 SPEECH PATHOLOGY		0		0	1 0	68.00
	06801 OCCUPATI ONAL HEALTH		0		0	1 0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	o	0	Ö	0	اً م	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	O	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						1
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01	09001 WOUND CLINIC	0	0	0	0	0	90. 01
	09002 DI ABETES CLINIC	0	0	0	0	0	90. 02
	09003 ASTHMA CLINIC	0	0	0	0	0	90. 03
	09004 ANDIS CLINIC	0	0	0	0	0	90. 04
	09005 PRIME TIME	0	0	0	0	0	90. 05
90. 06	09006 SHELBYVILLE WOUND CLINIC	0	0	0	0	01	90. 06
	04951 ONCOLOGY	0	0	0	0	01	90. 07
	04950 ANDERSON WOMENS CENTER	0	0	0	0	01	90. 08
	09100 EMERGENCY	0	0	0	0	01	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	100 001	0	100 001	92.00
200.00	Total (lines 50-199)	0	0	183, 091	0	183, 091	J∠UU. UU

Health Financial Systems	HANCOCK REGIONAL H	OSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150037	From 01/01/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:52 am

THROUG	H COSTS					o 12/31/2014	Date/Time Pre 5/27/2015 11:	
				Ti tl	e XVIII	Hospi tal	PPS	32 dili
	Cost Center Description	Total	Total Ch		Ratio of Cost		Inpati ent	
	, , , , , , , , , , , , , , , , , , ,	Outpati ent	(from Wks			Ratio of Cost	Program	
		Cost (sum of	Part I,	col .	(col. 5 ÷ col.	to Charges	Charges	
		col. 2, 3 and	8)		7)	(col. 6 ÷ col.	Ü	
		4)				7)		
		6.00	7.00	0	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0		35, 585			2, 389, 376	
51. 00	05100 RECOVERY ROOM	0		23, 652			310, 243	
53.00	05300 ANESTHESI OLOGY	0	l	14, 955			1, 470	
54.00	05400 RADI OLOGY-DI AGNOSTI C	183, 091		23, 817			2, 399, 655	
60.00	06000 LABORATORY	0	33, 60	01, 908			2, 860, 458	60. 00
65. 00	06500 RESPI RATORY THERAPY	0	7, 18	84, 267			1, 455, 808	
66. 00	06600 PHYSI CAL THERAPY	0	4, 1:	24, 573			377, 279	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		23, 535			212, 680	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	58	87, 717	0.000000	0.000000	92, 999	68. 00
68. 01	06801 OCCUPATI ONAL HEALTH	0	1	0	0.000000	0.000000	0	68. 01
	06900 ELECTROCARDI OLOGY	0	11, 3!	51, 190			1, 628, 585	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 4:	36, 032			966, 398	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	6, 3	44, 231	0. 000000	0. 000000	2, 235, 426	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	39, 38	80, 424			4, 372, 578	73. 00
76.00	03020 CARDI AC	0	· I	0	0.000000	0. 000000	0	76. 00
76. 01	03160 CARDI OPULMONARY	0	28	83, 291	0.000000	0.000000	0	76. 01
	OUTPATIENT SERVICE COST CENTERS							
	08800 RURAL HEALTH CLINIC	0	34	47, 836			0	88. 00
	09000 CLI NI C	0	1	0	0.00000		0	90. 00
90. 01	09001 WOUND CLINIC	0		22, 173			3, 268	90. 01
90. 02	09002 DI ABETES CLINIC	0	· !	55, 080			0	90. 02
90. 03	09003 ASTHMA CLINIC	0	1	0	0.00000		0	90. 03
90. 04	09004 ANDIS CLINIC	0	l .	56, 227			0	90. 04
90. 05	09005 PRIME TIME	0		65, 529			47	90. 05
90. 06	09006 SHELBYVILLE WOUND CLINIC	0	1, 6	10, 003			0	90. 06
	04951 ONCOLOGY	0	2, 5	16, 264			2, 306	90. 07
	04950 ANDERSON WOMENS CENTER	0		16, 489			5, 343	
91. 00	09100 EMERGENCY	0		88, 250				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		49, 381		0. 000000	287	92.00
200.00	Total (lines 50-199)	183, 091	205, 5	42, 409			21, 011, 830	200. 00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 150037 From 01/01/2014 To 12/31/2014 Date/Time Prepared:

			'		5/27/2015 11:	52 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	2, 129, 281	0			50.00
51.00 05100 RECOVERY ROOM	0	286, 663	0			51.00
53. 00 05300 ANESTHESI OLOGY	0	753	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 935	11, 414, 026	47, 254			54.00
60. 00 06000 LABORATORY	0	3, 823, 726	0			60.00
65. 00 06500 RESPIRATORY THERAPY	0	1, 263, 881	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	6, 218	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 814	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	52, 642	0			68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0			68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	3, 064, 386	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	844, 570	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	379, 796	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	10, 670, 236	o			73. 00
76. 00 03020 CARDI AC	O	0	О			76. 00
76. 01 03160 CARDI OPULMONARY	O	109, 804	O			76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0			88. 00
90. 00 09000 CLI NI C	0	0	0			90.00
90. 01 09001 WOUND CLINIC	0	2, 389, 649	0			90. 01
90. 02 09002 DIABETES CLINIC	0	39	0			90. 02
90.03 09003 ASTHMA CLINIC	0	0	0			90. 03
90. 04 09004 ANDIS CLINIC	0	2, 944	0			90. 04
90.05 09005 PRIME TIME	0	17, 004	0			90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	0	294, 048	0			90.06
90. 07 04951 ONCOLOGY	0	354, 464	0			90. 07
90.08 04950 ANDERSON WOMENS CENTER	0	617	0			90. 08
91. 00 09100 EMERGENCY	0	4, 127, 173	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 164, 082	0			92.00
200.00 Total (lines 50-199)	9, 935	42, 399, 816	47, 254			200. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2014 | Part V | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 | 11:52 am

				201111		3/2//2013 11.	<u> </u>
		1	liti	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	,	
		Part I, col. 9		Subject To	Subject To		
		, ,		Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
ANCI	LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	OO OPERATING ROOM	0. 483598	2, 129, 281	Ιο	O	1, 029, 716	50.00
	OO RECOVERY ROOM	0. 274710				78, 749	
	OO ANESTHESI OLOGY	0. 669341			-	504	
	OO RADI OLOGY-DI AGNOSTI C	0. 144918				1, 654, 098	
	OO LABORATORY	0. 166382	3, 823, 726	365	0	636, 199	60.00
65.00 0650	00 RESPI RATORY THERAPY	0. 312469	1, 263, 881	0	0	394, 924	65.00
66.00 0660	OO PHYSI CAL THERAPY	0. 456691	6, 218	0	0	2, 840	66. 00
67. 00 0670	OO OCCUPATIONAL THERAPY	0. 347980	3, 814	l o	0	1, 327	67. 00
	OO SPEECH PATHOLOGY	0. 503278			0	26, 494	68. 00
	01 OCCUPATIONAL HEALTH	0. 000000		1	0	0	1
	00 ELECTROCARDI OLOGY	0. 152879		-	0	468, 480	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 718295			0	606, 650	
					0		
	OO IMPL. DEV. CHARGED TO PATIENT	0. 307796		•	47.040	116, 900	
	DO DRUGS CHARGED TO PATIENTS	0. 230744		1	17, 043	2, 462, 093	
	20 CARDI AC	0. 000000				0	76. 00
	O CARDI OPULMONARY	0. 444575	109, 804	0	0	48, 816	76. 01
OUTF	PATIENT SERVICE COST CENTERS						1
	OO RURAL HEALTH CLINIC	0. 000000				0	88. 00
90.00 0900	OO CLI NI C	0. 000000	0	0	0	0	90.00
90. 01 0900	01 WOUND CLINIC	0. 332239	2, 389, 649	0	o	793, 935	90. 01
	DI ABETES CLINIC	1. 191921	39		o	46	90. 02
	O3 ASTHMA CLINIC	0. 000000	0	0	0	0	90. 03
	04 ANDIS CLINIC	2. 569371				7, 564	
	DS PRIME TIME	0. 484972			0	8, 246	
	06 SHELBYVILLE WOUND CLINIC	0. 404772			0	60, 917	
					0	· ·	
	ONCOLOGY	0. 484677			0	171, 801	90. 07
	O ANDERSON WOMENS CENTER	0. 159969			0	99	
	OO EMERGENCY	0. 245347				1, 012, 590	
	OO OBSERVATION BEDS (NON-DISTINCT PART)	1. 159951				1, 350, 278	
200.00	Subtotal (see instructions)		42, 399, 816	365	17, 043	10, 933, 266	200. 00
201.00	Less PBP Clinic Lab. Services-Program			0	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		42, 399, 816	365	17, 043	10, 933, 266	202.00
	,	•	•	•			

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 150037 Period: Worksheet D From 01/01/2014 Part V

12/31/2014 Date/Time Prepared: 5/27/2015 11:52 am Titl<u>e XVIII</u> Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 51.00 53. 00 05300 ANESTHESI OLOGY 0 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 60. 00 | 06000 | LABORATORY 61 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 0000000000 06600 PHYSI CAL THERAPY 0 66.00 66.00 67. 00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06801 OCCUPATIONAL HEALTH 0 68 01 68 01 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 933 73.00 73.00 76.00 03020 CARDI AC C 76.00 03160 CARDI OPULMONARY 76.01 76.01 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 0 0 0 0 0 0 0 88.00 0 90.00 09000 CLI NI C 0 90.00 90. 01 09001 WOUND CLINIC 0 90.01 0 09002 DIABETES CLINIC 90.02 90.02 09003 ASTHMA CLINIC 90.03 90.03 90.04 09004 ANDIS CLINIC 0 90.04 09005 PRIME TIME 90. 05 90.05 09006 SHELBYVILLE WOUND CLINIC 0 90.06 90.06 90.07 04951 ONCOLOGY 0 90.07 90.08 04950 ANDERSON WOMENS CENTER 90.08 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 200.00 Subtotal (see instructions) 3, 933 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 0 Only Charges 202.00 Net Charges (line 200 +/- line 201) 202. 00 61 3, 933

					6.5	
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	HANCOCK REGION L COSTS	Provi der	CCN: 150037 t CCN: 15S037	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 11:	pared:
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26) 1.00	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 60.00 06000 LABORATORY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 68.01 06801 OCCUPATI ONAL HEALTH 69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENT 76.00 03020 CARDI AC	445, 378 39, 767 40 287, 219 146, 098 61, 133 85, 675 2, 918 10, 133 0 129, 253 17, 166 7, 846 142, 209	1, 923, 652 14, 955 44, 223, 817 33, 601, 908 7, 184, 267 4, 124, 573 1, 123, 535 587, 717 0 11, 351, 190 5, 436, 032 6, 344, 231 39, 380, 424	0. 0206 0. 0026 0. 0064 0. 0043 0. 0085 0. 0207 0. 0025 0. 0172 0. 0000 0. 0113 0. 0031 0. 0012 0. 0036 0. 0036	73 1, 119 75 18 75 108, 489 48 355, 057 79 100, 720 72 54, 854 77 75, 074 41 9, 112 00 0 37 10, 842 49 52, 874 37 0 11 317, 639	705 1, 544 857 1, 139 195 157 0 123 167 0 1, 147	53. 00 54. 00 60. 00 65. 00 66. 00 67. 00 68. 00 68. 01 69. 00 71. 00 72. 00 73. 00 76. 00
76. 01 03160 CARDI OPULMONARY	906	283, 291	0. 00319	98 0	0	76. 01
SECTION SERVICE COST CENTERS	1, 423 0 55, 042 3, 668 0 6, 272 517 1, 402 7, 111 31, 325 490, 227 0	3, 822, 173 55, 080 0 56, 227 265, 529 1, 610, 003 2, 516, 264 2, 916, 489 21, 488, 250 2, 149, 381	0. 00000 0. 01440 0. 06650 0. 00000 0. 11150 0. 00190 0. 00080 0. 00280 0. 01070 0. 02280 0. 00000	00 0 01 534 94 0 00 0 48 0 47 6 71 0 26 0 41 991	0 8 0 0 0 0 0 11 1,439	90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 91. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY FIROUGH COSTS	SERVICE OTHER PASS		CCN: 150037 CCN: 15S037	Peri od: From 01/01/2014 To 12/31/2014		pared: 52 am
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	ŭ		h All Other Medical Education Cost	4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			1			4
50. 00 05000 OPERATING ROOM	0	0	•	0 0	1	
51.00 05100 RECOVERY ROOM 53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C	0		183, 0	0 0	0 183, 091	54.00
50. 00 06000 LABORATORY	0		103, 0	0 0	103, 091	
55. 00 06500 RESPIRATORY THERAPY	0	0			0	
66. 00 06600 PHYSI CAL THERAPY	0				0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ö		0	0	
68. 00 06800 SPEECH PATHOLOGY	0	Ö		0 0	0	
68. 01 06801 OCCUPATI ONAL HEALTH	0	Ö		o o	Ō	
69. 00 06900 ELECTROCARDI OLOGY	0	o		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03020 CARDI AC	0	0		0	0	76. 00
76. 01 03160 CARDI OPULMONARY	0	0		0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS			T		Г	
38. 00 08800 RURAL HEALTH CLINIC	0	0	•	0 0	1	
90. 00 09000 CLI NI C	0	0		0 0	0	1
90. 01 09001 WOUND CLINIC 90. 02 09002 DIABETES CLINIC	0			0	0	
90. 02 09002 DI ABETES CLINIC 90. 03 09003 ASTHMA CLINIC	0			0 0	0	
90. 04 09004 ANDIS CLINIC	0			0	0	
90. 05 09005 PRI ME TI ME	0				0	
90.06 09006 SHELBYVILLE WOUND CLINIC	0				0	
90. 07 04951 ONCOLOGY	0	Ö		0 0	Ö	1
90. 08 04950 ANDERSON WOMENS CENTER	0	Ö		0 0	0	
91. 00 09100 EMERGENCY		ĺ		o o	Ö	1 ,0.0.
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 0	Ö	
200.00 Total (lines 50-199)	1 0	Ö	183, 0	91 0	183, 091	

Haal th	Financial Systems	HANCOCK REGIO	NAI HOSDITAI		Inlie	u of Form CMS-2	2552_10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS		S Provi der	CCN: 150037 t CCN: 15S037	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/27/2015 11:	
			Ti tl	e XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4) 6.00	Total Charges (from Wkst. C, Part I, col. 8)		t Outpatient Ratio of Cost	Inpatient Program Charges	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	14, 735, 585	0.00000	0. 000000	11, 137	50.00
51.00	05100 RECOVERY ROOM	0	1, 923, 652	0. 00000	0. 000000	1, 119	51.00
53.00	05300 ANESTHESI OLOGY	0			0. 000000	18	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	183, 091	44, 223, 817	0. 00414	0. 004140	108, 489	54.00
60.00	06000 LABORATORY	0	33, 601, 908	0. 00000	0. 000000	355, 057	60.00
65.00	06500 RESPI RATORY THERAPY	0			0. 000000	100, 720	65. 00
66.00	06600 PHYSI CAL THERAPY	0			0. 000000	54, 854	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 123, 535	0. 00000	0. 000000	75, 074	67.00
68.00	06800 SPEECH PATHOLOGY	0	587, 717	0. 00000	0. 000000	9, 112	68. 00
68. 01	06801 OCCUPATI ONAL HEALTH	0	C	0. 00000	0. 000000	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	0	11, 351, 190	0. 00000	0. 000000	10, 842	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 436, 032	0. 00000	0. 000000	52, 874	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6, 344, 231	0.00000	0. 000000	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	39, 380, 424	0. 00000	0. 000000	317, 639	73. 00
76.00	03020 CARDI AC	0	C	0. 00000	0. 000000	0	76. 00
76. 01	03160 CARDI OPULMONARY	0	283, 291	0.00000	0. 000000	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0		1		0	
90.00	09000 CLI NI C	0				0	90.00
90. 01	09001 WOUND CLINIC	0	-,,	1		534	90. 01
90. 02	09002 DIABETES CLINIC	0	55, 080			0	90. 02
90. 03	09003 ASTHMA CLINIC	0	C			0	90. 03
90. 04	09004 ANDIS CLINIC	0	56, 227			0	90. 04
90. 05	09005 PRIME TIME	0	,			6	90. 05
90. 06	09006 SHELBYVILLE WOUND CLINIC	0	1,0.0,000	1		0	90. 06
90. 07	04951 ONCOLOGY	0	2,0.0,20			0	90. 07
90. 08	04950 ANDERSON WOMENS CENTER	0	_, ,			991	90. 08
91. 00	09100 EMERGENCY	0				63, 089	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_, ,	1	0. 000000	0	92.00
200.00	Total (lines 50-199)	183, 091	205, 542, 409	'I		1, 161, 555	J200. 00

Health Financial Systems	HANCOCK REGIONAL H	OSPI TAL	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150037	Peri od: From 01/01/2014	Worksheet D		
I I I I I I I I I I I I I I I I I I I		Component CCN: 15SO37	To 12/31/2014			
		Title XVIII	Subprovi der -	PPS		

			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent	IPF		
	cost center bescription	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	onal goo	Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C)	0		50. 00
51.00	05100 RECOVERY ROOM	0	C		0		51.00
53.00	05300 ANESTHESI OLOGY	0	C		0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	449	C		0		54. 00
60.00	06000 LABORATORY	0	C		0		60. 00
65. 00	06500 RESPI RATORY THERAPY	0	C		0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C		0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	C		0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C		0		68. 00
	06801 OCCUPATI ONAL HEALTH	0	C)	0		68. 01
	06900 ELECTROCARDI OLOGY	0	C)	0		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)	0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	C)	0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	C)	0		73. 00
76.00	03020 CARDI AC	0	C)	0		76. 00
76. 01	03160 CARDI OPULMONARY	0)	0		76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	C	1	0		88. 00
90. 00	09000 CLI NI C	0	C)	0		90. 00
	09001 WOUND CLINIC	0	()	0		90. 01
	09002 DI ABETES CLINI C	0	()	0		90. 02
	09003 ASTHMA CLINIC	0	()	0		90. 03
	09004 ANDIS CLINIC	0	()	0		90. 04
	09005 PRIME TIME	0	()	0		90. 05
	09006 SHELBYVILLE WOUND CLINIC	0	(2	O		90.06
	04951 ONCOLOGY	0	(<u>'</u>	U		90. 07
	04950 ANDERSON WOMENS CENTER	0	(2	O		90. 08
91.00	09100 EMERGENCY	0	(<u>'</u>	U		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(<u>'</u>	U		92.00
200.00	Total (lines 50-199)	449	C	기	이		200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	HANCOCK REGIO L COSTS	Provi der	CCN: 150037 t CCN: 15T037	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
			e XVIII	Subprovi der - I RF	5/27/2015 11: PPS	52 am _
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	445, 378	14, 735, 585	0. 03022	25 4, 354	132	50.00
51. 00 05100 RECOVERY ROOM	39, 767		1		0	1
53. 00 05300 ANESTHESI OLOGY	40	1			Ö	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	287, 219				54	1
60. 00 06000 LABORATORY	146, 098		1			1
65. 00 06500 RESPI RATORY THERAPY	61, 133		1			
66. 00 06600 PHYSI CAL THERAPY	85, 675	4, 124, 573	0. 0207	72 83, 373	1, 732	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 918	1, 123, 535	0. 0025	97 87, 071	226	67. 00
68. 00 06800 SPEECH PATHOLOGY	10, 133	587, 717	0.0172	16, 586	286	68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0. 00000	00	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	129, 253	11, 351, 190	0. 0113	183	2	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 116	5, 436, 032	0. 00314	49 5, 376	17	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 846	6, 344, 231	0. 0012	37 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	142, 209	39, 380, 424	0.0036	11 32, 748	118	73.00
76. 00 03020 CARDI AC	0	0	0. 00000	00	0	76. 00
76. 01 03160 CARDI OPULMONARY	906	283, 291	0. 00319	98 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS	_					
88.00 08800 RURAL HEALTH CLINIC	1, 423					
90. 00 09000 CLI NI C	0	1				
90. 01 09001 WOUND CLI NI C	55, 042					
90. 02 09002 DI ABETES CLI NI C	3, 668					90. 02
90. 03 09003 ASTHMA CLINIC	0	1			0	
90. 04 09004 ANDIS CLINIC	6, 272				0	90. 04
90. 05 09005 PRIME TIME	517				0	
90. 06 09006 SHELBYVILLE WOUND CLINIC	1, 402				0	
90. 07 04951 ONCOLOGY	7, 111				0	90. 07
90. 08 04950 ANDERSON WOMENS CENTER 91. 00 09100 EMERGENCY	31, 325 490, 227				0 27	90. 08 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	490, 227		1		0	
200.00 Total (lines 50-199)	1, 972, 678		1	265, 395	_	200. 00

APPORTIONMEN THROUGH COST	NT OF INPATIENT/OUTPATIENT ANCILLARY SE IS	ERVICE OTHER PASS		CCN: 150037 t CCN: 15T037	Peri od: From 01/01/2014 To 12/31/2014		pared: 52 am
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	J		All Other Medical Education Cost	4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	LARY SERVICE COST CENTERS			-1	_1	1	
	OPERATI NG ROOM	0	(0 0	1	
	RECOVERY ROOM ANESTHESI OLOGY	0	(0 0	1	
	RADI OLOGY - DI AGNOSTI C	0) 183, C	0 0	0 183, 091	54.00
1	LABORATORY	0	}	103, 0	0 0	0 103, 091	
	RESPI RATORY THERAPY	0)		0	
	PHYSI CAL THERAPY	0	ì	5	0 0		
- 1	OCCUPATIONAL THERAPY	0	ì	o l	0 0	o o	
	SPEECH PATHOLOGY	0	ì	ก	0 0	o o	
	OCCUPATI ONAL HEALTH	0	(0 0	o o	
	ELECTROCARDI OLOGY	0	(0 0	0	69.00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0 0	0	71.00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENT	0	(o	0 0	0	72.00
73. 00 07300	DRUGS CHARGED TO PATIENTS	0	(o l	0 0	0	73.00
76. 00 03020	CARDI AC	0	(o	0 0	0	76.00
	CARDI OPULMONARY	0	()	0 0	0	76. 01
	TIENT SERVICE COST CENTERS			,		,	
	RURAL HEALTH CLINIC	0			0 0	1	
	CLINIC	0	(0 0	1	1
	WOUND CLINIC	0	()	0	0	
	DI ABETES CLINIC	0	(0 0	0	
	ASTHMA CLINIC ANDIS CLINIC	0			0 0	0	
	PRIME TIME	0			0 0	0	
	SHELBYVILLE WOUND CLINIC	0	}		0 0		
	ONCOLOGY	0					1
	ANDERSON WOMENS CENTER	0	ì	5	0 0		
91. 00 09100		0		ol .			1 ,0.0.
	OBSERVATION BEDS (NON-DISTINCT PART)	0	ì	ől	0 0		
200. 00	Total (lines 50-199))	183, 0	-	1	1

Health Financial Systems	HANCOCK REGIO	NAI HOSPITAI		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CCN: 150037	Peri od:	Worksheet D	2002 10
THROUGH COSTS		Componen	t CCN: 15T037	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/27/2015 11:	pared: 52 am
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	,			4, 354	
51. 00 05100 RECOVERY ROOM	0				0	
53. 00 05300 ANESTHESI OLOGY	0	,			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	183, 091				8, 367	54. 00
60. 00 06000 LABORATORY	0	,,			21, 988	1
65. 00 06500 RESPI RATORY THERAPY	0	1, 101, 201			4, 144	
66. 00 06600 PHYSI CAL THERAPY	0	4, 124, 573			83, 373	
67.00 06700 OCCUPATIONAL THERAPY	0	1, 123, 535			87, 071	
68. 00 06800 SPEECH PATHOLOGY	0	,			16, 586	
68. 01 06801 OCCUPATI ONAL HEALTH	0				0	
69. 00 06900 ELECTROCARDI OLOGY	0	,			183	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 436, 032			5, 376	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	-,,			0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	39, 380, 424			32, 748	
76. 00 03020 CARDI AC	0				0	
76. 01 03160 CARDI OPULMONARY	0	283, 291	0.00000	0. 000000	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0				0	
90. 00 09000 CLI NI C	0				0	
90. 01 09001 WOUND CLINIC	0	-,,			0	
90. 02 09002 DI ABETES CLINI C	0	55, 080			0	
90.03 09003 ASTHMA CLINIC	0	C			0	
90. 04 09004 ANDIS CLINIC	0	56, 227			0	90. 04
90. 05 09005 PRI ME TI ME	0	265, 529	1		0	
90.06 09006 SHELBYVILLE WOUND CLINIC	0	1, 610, 003	1		0	
90. 07 04951 0NC0L0GY	0	2, 516, 264			0	90. 07
90.08 04950 ANDERSON WOMENS CENTER	0	2, 916, 489			0	
91. 00 09100 EMERGENCY	0	21, 488, 250			1, 205	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_, ,	•	0. 000000	0	92.00
200.00 Total (lines 50-199)	183, 091	205, 542, 409	·[265, 395	200.00

Health Financial Systems	HANCOCK REGIONAL H	OSPI TAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150037	Peri od: From 01/01/2014	Worksheet D	
THOUGH COSTS		Component CCN: 15T037	To 12/31/2014		
		Title XVIII	Subprovi der -	PPS	

			Ti tl	e XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent	IKF		
	oost outtor boscii pittori	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	3	Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0		50.00
51.00	05100 RECOVERY ROOM	0	C		0		51. 00
53.00	05300 ANESTHESI OLOGY	0	C		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	35	C		0		54. 00
60.00	06000 LABORATORY	0	C		0		60.00
65. 00	06500 RESPI RATORY THERAPY	0	C		0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C		0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	C		0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C		0		68. 00
	06801 OCCUPATI ONAL HEALTH	0	C		0		68. 01
69. 00	06900 ELECTROCARDI OLOGY	0	C		0		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	C		0		73. 00
76. 00	03020 CARDI AC	0	C		0		76. 00
76. 01	03160 CARDI OPULMONARY	0	C		0		76. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	C	1	0		88. 00
	09000 CLI NI C	0	C		0		90. 00
	09001 WOUND CLINIC	0	C		0		90. 01
	09002 DI ABETES CLINIC	0	C		0		90. 02
90. 03	09003 ASTHMA CLINIC	0	C		0		90. 03
	09004 ANDIS CLINIC	0	C		0		90. 04
90. 05	09005 PRIME TIME	0	(0		90. 05
90. 06	09006 SHELBYVILLE WOUND CLINIC	0	(0		90.06
90. 07	04951 ONCOLOGY	0	C)	U		90. 07
90. 08	04950 ANDERSON WOMENS CENTER	0	C)	0		90. 08
91. 00	09100 EMERGENCY	0	(0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	1	U		92.00
200.00	Total (lines 50-199)	35	C	ון	0		200. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150037	From 01/01/2014	Worksheet D-1 Date/Time Prep 5/27/2015 11:	
	Title XVIII	Hospi tal	PPS	
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ANTI - ALL PROVIDER CONCINENTS NAME NAM			Title XVIII	Hospi tal	5/27/2015 11: PPS	52 am_
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	39. 00	Program general inpatient routine service cost (line 9 x line 3	8)		1, 535, 845	39. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,535,845 41.00					_	
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 535, 845	41.00

<u>Heal</u> th	Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	<u>2552-</u> 10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150037	Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014		pared:
			T: +1	o VVIII	Hooni tol	5/27/2015 11:	52 am
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	oost denter bescription		Inpatient Days			(col. 3 x col.	
				col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1. 00	2. 00	3. 00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT	6, 918, 435	5, 037	1, 373. 5	2, 309	3, 171, 458	43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
40.00	Dragram innetient encillery complex eact (WK	a+ D 2 aal 1	2 Line 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ins)		5, 873, 455 10, 580, 758	1
47.00	PASS THROUGH COST ADJUSTMENTS	+1 through +0)	(See Thistruction	113)		10, 300, 730	77.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	342, 472	50. 00
51. 00	<pre> </pre>	ationt anailla	av comileos (fr	om Wko+ D. o	um of Dorsto II	217 004	51.00
31.00	and IV)	atrent anciria	y services (ii	OIII WKSt. D, S	uiii 01 Parts 11	217, 984	31.00
52.00	Total Program excludable cost (sum of lines					560, 456	ł
53. 00	Total Program inpatient operating cost exclu		elated, non-phy	sician anesth	etist, and	10, 020, 302	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	•
56. 00 57. 00	Target amount (line 54 x line 55)	ing coot and to	anget emount (1	ino E/ minuo	Line E2)	0	
58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (i	The 56 minus	11 ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	pdated and co	mpounded by the		1
(0.00	market basket	0.00	,,,,,,,				
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	ı
01.00	which operating costs (line 53) are less than						01.00
	amount (line 56), otherwise enter zero (see instructions)						
	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64. 00
45 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	to after Decemb	oor 21 of the c	oct roportino	pariod (Saa	0	65. 00
65. 00	instructions)(title XVIII only)	ts arter becenii	ber 31 of the C	ost reporting	perrou (see		65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66. 00
/7.00	CAH (see instructions)		- Db 21 -	£ 11			/7.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	i becember 31 c	ii 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
(0.00	(line 13 x line 20)		/I: /7 I:	(0)			,,,,,,,
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil		•				70.00
71. 00	Adjusted general inpatient routine service c	,	ine 70 ÷ line	2)			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		m (lina 14 v li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient	•			art II, column		75. 00
74 00	26, line 45)	no 2)					76 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
	Inpatient routine service cost (line 74 minu	,					78. 00
79. 00	Aggregate charges to beneficiaries for exces				753		79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitation	ı (line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem from		1)				82.00
83. 00	Reasonable inpatient routine service costs (see instruction	* .				83. 00
84.00	Program inpatient ancillary services (see in		-ma)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PASS		Jugir 00)				. 55. 60
87. 00	Total observation bed days (see instructions)				2, 060	
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	,			1, 210. 28 2, 493, 177	
07.00	lopser ration per cost (line of x line oo) (se	c matructions,	,			2,473,1//	J 07.00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	556, 870	6, 847, 788	0. 08132	1 2, 493, 177	202, 748	90.00
91.00 Nursing School cost	0	6, 847, 788	0.00000	2, 493, 177	0	91.00
92.00 Allied health cost	0	6, 847, 788	0.00000	2, 493, 177	0	92.00
93.00 All other Medical Education	0	6, 847, 788	0.00000	2, 493, 177	0	93.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150037		Worksheet D-1
	Component CCN: 15SO37	From 01/01/2014 To 12/31/2014	
	Title XVIII	Subprovi der -	PPS

1.00			litie XVIII	Subprovider -	PPS	
NSMITHER DAYS NSMITHER DAY		Cost Center Description			1.00	
Name		PART I - ALL PROVIDER COMPONENTS			1.00	
1.00 Impatient days (including private room days, excluding swing-bed and newborn days) 2,643 2,00 3,00 Private room days (cutual ng swing-bed and observation bed days) 1.7 you have only private room days (cutual ng swing-bed and observation bed days) 2,643 4,00 5.00 1.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do a do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days). 5.00 Iprata sain gabed SMT type inpatient days. (including private room days) after December 31 of the cost reporting period (in calendar year, enter 0 on this line). 7.00 Total sain gabed SMT type inpatient days. (including private room days) after December 31 of the cost reporting period (in calendar year, enter 0 on this line). 7.00 Total sain gabed MF type inpatient days. (including private room days) after December 31 of the cost reporting period (in calendar year, enter 0 on this line). 7.00 Total sain gabed MF type inpatient days. (including private room days) after December 31 of the cost reporting period. 7.00 Total sain gabed MF type inpatient days upplicable to the Program (excluding swing-bed and newton days). 8.00 Total sain gabed MF type inpatient days upplicable to the Itle XVIII only (including private room days). 8.00 Total sain gabed MF type inpatient days upplicable to the Itle XVIII only (including private room days). 8.00 Swing-bed SMF type inpatient days applicable to tile tile XVIII only (including private room days). 8.00 Swing-bed SMF type inpatient days applicable to tile tile XVIII only (including private room days). 8.00 Total sain gabed SMF type inpatient days applicable to tile tile XVIII only (including private room days). 8.00 Total sain gabed SMF type inpatient days applicable to tile XVIII only (including private room days). 8.01 Total sain gabed SMF type inpatient days applicable to tile XVIII only (including private room days). 8.01 Total sain gabed SMF type inpatient days applicable to tile XVIII only (including private room days). 9.00 Total sain gabed SMF type inpatient days applicable to tile XVIII only (including private room days). 9.01 Total sain gabed SMF type inpatient days applicable to tile XVIII only (including private room days). 9.01 Total						
do not complete this line						
2,643 4.00 5.00 7.00	3.00). If you have only pr	ivate room days,	0	3.00
10 10 10 10 10 10 10 10	4.00		days)		2, 643	4. 00
10 10 10 10 13 13 13 13				r 31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) through becember 31 of the cost 8. 00 Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost 9. 00 Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Medical ly necessary private room days applicable to titles V or XIX only (including private room days) 15. 00 Ming-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 16. 00 Medical ly necessary private room days applicable to the Program (excluding swing-bed days) 17. 00 Ming-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 18. 00 Medicare rate for swing-bed SNF services applicable to services after becember 31 of the cost 18. 00 Medicare rate for swing-bed SNF services applicable to services after becember 31 of the cost 18. 00 Medicare rate for swing-bed SNF services applicable to services after becember 31 of the cost 18. 00 Medicare rate for swing-bed SNF services applicable to services after becember 31 of the cost 18. 00 Medicare rate for swing-bed SNF services applicable to services after becember 31 of the cost 18. 00 Medicare rate for swing-bed SNF services after becember 31 of the cost reporting period (line 6 x x line 12) 28. 00 Medicare rate for swing-bed SNF services after becember 31 of the cost reporting period (line 6 x x line 12) 29. 00 Medicare ra					_	
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reporting period 8 .00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10 .00 Swing-bed SW year inpatient days applicable to title XVIII only (including private room days) 11 .00 Swing-bed SW year inpatient days applicable to title XVIII only (including private room days) 12 .00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after becomes 31 of the cost reporting period (if calendar year, enter 0 on this line) 12 .00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after becomes 31 of the cost reporting period (if calendar year, enter 0 on this line) 13 .00 Swing-bed SW type inpatient days applicable to titles V or XIX only (including private room days) 12 .00 through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14 .00 Swing-bed SW type inpatient days applicable to titles V or XIX only (including private room days) 15 .00 Total nursery days (title V or XIX only (including private room days) 16 .00 Total nursery days (title V or XIX only (including private room days) 17 .00 Total nursery days (title V or XIX only (including private room days) 18 .00 Total nursery days (title V or XIX only (including private room days) 18 .00 Total nursery days (title V or XIX only (including private room days) 18 .00 Total nursery days (title V or XIX only (including private room days) 18 .00 Total nursery days (title V or XIX only (including private room days) 18 .00 Total nursery days (title V or XIX only (including private room days) 18 .00 Total nursery days (title V or XIX only (including private room days) 18 .00 Total nursery days (title V or XIX only (including private room days) 18 .00 Total nursery days (title V or XIX only (including private room days) 18 .00 Total nursery days (title V or XIX only (including private room days (including vincluding vincluding vincluding vinclud	7. 00		davs) through December	31 of the cost	0	7. 00
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38.00 Adjusted general inpatient routine service cost per diem (see instructions) 921.72 38.00 921.72 38.00 Program general inpatient routine service cost (line 9 x line 38) 2, 243, 466 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			TMENTS			
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	•			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,243,466 41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)	ļ	2, 243, 466	41. 00

Heal th	Financial Systems	HANCOCK REGIONA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	Fi	eriod: com 01/01/2014	Worksheet D-1		
			·	CCN: 15S037 To		5/27/2015 11:		
			Title	XVIII	Subprovider - IPF	PPS		
	Cost Center Description	Total Inpatient Costli		Average Per iem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NUDCEDY (4:41 - V 0 VIV1.)	1.00	2.00	3.00	4. 00	5. 00	42.00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00	
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00	
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Line 200)			1. 00 296, 483	48. 00	
	Total Program inpatient costs (sum of lines			s)		2, 539, 949		
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine s	ervices (from \	Wkst. D, sum o	of Parts I and	129, 611	50. 00	
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (from	m Wkst. D, sur	n of Parts II	8, 301	51. 00	
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				137, 912	52. 00	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-physi	ician anesthet	tist, and	2, 402, 037	53. 00	
54 OO	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00	
55.00	Target amount per discharge					0.00		
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tare	net amount (liu	ne 56 minus li	ne 53)	0	56. 00 57. 00	
58. 00	Bonus payment (see instructions)				,	0	58. 00	
59. 00								
60.00	Lesser of lines 53/54 or 55 from prior year					0. 00 0	60. 00 61. 00	
61. 00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
62. 00	amount (line 56), otherwise enter zero (see instructions) .00 Relief payment (see instructions)							
63. 00	3.00 Allowable Inpatient cost plus incentive payment (see instructions)							
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	ber 31 of the o	cost reportino	g period (See	0	64. 00	
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the co	st reporting p	period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 65)	(title XVIII	only). For	0	66. 00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through I	December 31 of	the cost repo	orting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of t	he cost report	ting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70. 00	
71.00	Adjusted general inpatient routine service c		ne 70 ÷ line 2))			71.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(line 14 x line	e 35)			72. 00 73. 00	
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,	rkshoot P. Day	st II column		74. 00 75. 00	
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li		COSTS (TI OIII WOI	rksileet b, Fai	t II, Cordiiii		76. 00	
77. 00	Program capital -related costs (line 9 x line	•					77. 00	
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider records)			78. 00 79. 00	
80. 00	Total Program routine service costs for comp	arison to the co			s line 79)		80. 00	
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00	
83. 00	Reasonable inpatient routine service costs (see instructions)				83. 00	
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)			-	84. 00 85. 00	
	Total Program inpatient operating costs (sum	of lines 83 thre					86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instructions					0	87. 00	
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	diem (line 27 ÷ 1	line 2)				88. 00 89. 00	
U7. UU	Topservation bed cost (Time of X Time 88) (Se	e mstructions)			ı	ı o	07.00	

Provider CCN: 150037
Component CCN: 15S037 To 12/31/2014 Date/Time Prepared: 5/27/2015 11: 52 am Title XVIII Subprovider - PPS PF PF
IPF
Cost Center Description Cost Routine Cost column 1 ÷ Total Observation
(from line 27) column 2 Observation Bed Pass
Bed Cost (from Through Cost
line 89) (col. 3 x col.
4) (see
i nstructions)
1.00 2.00 3.00 4.00 5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST
90. 00 Capi tal -rel ated cost 140, 750 2, 436, 116 0. 057776 0 0 90. 00
91. 00 Nursing School cost 0 2, 436, 116 0. 000000 0 0 91. 00
92. 00 Allied health cost 0 2, 436, 116 0.000000 0 92. 00
93. 00 All other Medical Education 0 2,436,116 0.000000 0 93.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150037		Worksheet D-1
	Component CCN: 15TO37	From 01/01/2014 To 12/31/2014	
	Title XVIII	Subprovi der -	PPS

Note			TI LIE AVIII	I RF	FF3	
		Cost Center Description			1.00	
INVAILEBIT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (including private room days, excluding saing-bed and nebborn days) 276 20 3.00 20 20 20 20 20 20 20						
Private room days (excluding swing-bed and observation bed days). If you have only private room days 3.0						
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28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 571,062) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	27.00		ne 21 minus iine 26)		5/1,062	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 ÷ line 3) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 571,062) 37.00 FROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 Volume of the private room charges (excluding swing-bed charges) 0 30.00 30.00	28. 00		and observation bed cha	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 571,062) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 358,842 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.0000000000000000000000000000000000	29. 00	Private room charges (excluding swing-bed charges)				
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 571,062 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 358,842 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ino 20)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 571,062 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 70 Program general inpatient routine service cost (line 9 x line 38) 80 Medically necessary private room cost applicable to the Program (line 14 x line 35) 90 0 Value of the program (line 14 x line 35) 90 0 Value of the program (line 14 x line 35) 90 0 Value of the program (line 14 x line 35) 90 0 Value of the program (line 14 x line 35) 90 0 Value of the program (line 14 x line 35) 90 0 Value of the program (line 14 x line 35) 90 0 Value of the program (line 14 x line 35)		,	The 28)			
35. 00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 00 36. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 571, 062 37. 00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 929. 26 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 358, 842 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 571,062 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 358,842 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				tions)		
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 358, 842 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00		9 ' '	31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 929.26 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 358,842 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			d private room cost dif	ferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,929.26 38.00 Program general inpatient routine service cost (line 9 x line 38) 358,842 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)	,		37.1,002	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,929.26 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,929.26 38.00 358,842 39.00			MENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 358,842 39.00 40.00	38 00			I	1 020 24	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					· ·	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 358,842 41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)	ļ	358, 842	41. 00

Heal th	Financial Systems	HANCOCK REGIONA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	Fi	eriod: com 01/01/2014	Worksheet D-1	
			'	CCN: 15T037 To		5/27/2015 11:	
					Subprovider - IRF	PPS	
	Cost Center Description	Total Inpatient Costli		Average Per iem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+: +Lo V 0 VIV only)	1.00	2. 00	3.00	4. 00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0. 00	0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1. 00 96, 736	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			s)		455, 578	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sum o	of Parts I and	24, 491	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (fro	m Wkst. D, sur	n of Parts II	2, 760	51. 00
52. 00	Total Program excludable cost (sum of lines					27, 251	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phys	ician anesthet	tist, and	428, 327	53. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55.00	Target amount per discharge					0. 00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	get amount (li	ne 56 minus li	ne 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)				,	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period e	nding 1996, up	dated and comp	bounded by the	0. 00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				no amount by	0. 00 0	60. 00 61. 00
01.00	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see	n expected costs				O	01.00
62. 00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decemb	ber 31 of the	cost reportino	g period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after December	r 31 of the co	st reporting p	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	4 plus line 65)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through I	December 31 of	the cost repo	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	cember 31 of t	he cost report	ting 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						70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne 70 ÷ line 2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	abĺe to Program	•	e 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,	rksheet B, Par	t II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der records)			78. 00 79. 00
80. 00 81. 00	Total Program routine service costs for comp	arison to the co			s line 79)		80. 00 81. 00
81.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in)				83. 00 84. 00
85. 00			s)				85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 85)				86. 00
87. 00	Total observation bed days (see instructions)				0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		iine 2)				88. 00 89. 00
						'	

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15T037	From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	38, 974	571, 062	0. 06824	18 0	0	90. 00
91.00 Nursing School cost	0	571, 062	0.00000	00	0	91.00
92.00 Allied health cost	0	571, 062	0.00000	00	0	92. 00
93.00 All other Medical Education	0	571, 062	0. 00000	00	0	93. 00

Health Financial Systems	HANCOCK REGIONAL H	IOSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037	Peri od: From 01/01/2014	Worksheet D-1	
				Date/Time Pre 5/27/2015 11:	
		Title XIX	Hospi tal	Cost	<u> </u>
Cost Center Description					

		Title XIX	Hospi tal	5/27/2015 11: Cost	52 am
	Cost Center Description	THE XIX	поэрг саг		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			5, 658	
2.00	Inpatient days (including private room days, excluding swing-be			5, 658	
3.00	Private room days (excluding swing-bed and observation bed days do not complete this line.). IT you have only pr	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		3, 598	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber	or or the cost		0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber 5	i or the cost		0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	426	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruction)		Join days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	only (Therauting private	e i ooni days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(excluding swing-bed	uays)	0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT	+h	6 414	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
10.00	reporting period		464	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through becember 31 or	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			6, 847, 788	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0, 047, 700	22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
05 00	7 x line 19)	6.11			05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 \times line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		6, 847, 788	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3,	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	Tine 28)		0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34. 00	Average per diem private room charge differential (line 32 minu		tions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x line	31)		0.00	ł
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	0 6, 847, 788	36. 00 37. 00
37.00	27 minus line 36)			3,317,700] 55
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	FUENTO			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST Adjusted general inpatient routine service cost per diem (see i			1, 210. 28	38. 00
39. 00	Program general inpatient routine service cost per diem (see i			515, 579	
40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		515, 579	41.00

	Financial Systems	HANCOCK REGION		OON 450007		u of Form CMS-	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der	CCN: 150037	Peri od: From 01/01/2014	Worksheet D-1	
					To 12/31/2014	Date/Time Pre 5/27/2015 11:	
	Coat Contan Decemintion	Total		le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units					_	
43. 00 44. 00	INTENSIVE CARE UNIT	6, 918, 435	5, 037	1, 373.	52 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	1						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			nns)		413, 872 929, 451	1
17.00	PASS THROUGH COST ADJUSTMENTS	TT thi bugit 10) (300 111311 4011	7137		727, 101	17.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sui	m of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	0	51.00
50.00	and IV)	50 (54)					
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-phy	vsician anestl	hetist and	0	
00.00	medical education costs (line 49 minus line]
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55. 00
56.00	,				50)		56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (i	ine 56 minus	11 ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, เ	updated and c	ompounded by the		59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost renort un	dated by the m	narket hasket		0.00	60.00
61. 00						0.00	1
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost report	ing period (See	0	64. 00
	instructions)(title XVIII only)		04 6 11				45.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after Decemb	er 31 or the c	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost r	eporting period	0	67. 00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil		•				70.00
71. 00	Adjusted general inpatient routine service c					-	71. 00
72.00	,		. (1: 14 1:	25)			72. 00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00	,		rovi don rocore	46)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on		•	•		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84.00	Program inpatient ancillary services (see in		/				84. 00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ii ougri 85)				86. 00
87.00	Total observation bed days (see instructions)	11 03				87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 210. 28 2, 493, 177	1
57.00	(30)					2, 170, 177	, 57. 55

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		pared:
					5/27/2015 11:	52 am
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	556, 870	6, 847, 788	0. 08132	1 2, 493, 177	202, 748	90.00
91.00 Nursing School cost	0	6, 847, 788	0.00000	0 2, 493, 177	0	91.00
92.00 Allied health cost	0	6, 847, 788	0.00000	0 2, 493, 177	0	92.00
93.00 All other Medical Education	0	6, 847, 788	0.00000	0 2, 493, 177	0	93. 00

HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 INPATIENT ANCILLARY SERVICE COST APPORTIONMENT								
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Heal th	Financial Systems	HANCOCK REGIONAL HOSPI	I TAL		In Lie	u of Form CMS-2	2552-10
NPATI_ENT_ROUTINE_SERVICE_COST_CENTERS Title_XVIII Hospit lat Program Costs (col 1 x col 2) NO No No No No No No No						Peri od:		
Title XVIII							D-+- /T: D	
Name						10 12/31/2014		
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3				Ti tl e	e XVIII	Hospi tal		<u> </u>
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00		Cost Center Description			Ratio of Cos			
INPATIENT ROUTI NE SERVI CE COST CENTERS 3.0 0 3.00					To Charges			
INPATIENT ROUTINE SERVICE COST CENTERS						Charges		
INPATIENT ROUTINE SERVICE COST CENTERS 923, 479 31. 00					1.00			
30. 00 03000 ADULTS & PEDIATRICS 3, 708, 289 31. 00 03100 NTENSI VE CARE UNIT 3,708, 289 31. 00 04000 SUBPROVIDER - IPF 14, 203 40. 00 04000 SUBPROVIDER - IRF 4,298 41. 00 04100 SUBPROVIDER - IRF 4,298 41. 00 04100 SUBPROVIDER - IRF 4,298 41. 00 05000 OPERATI NG ROOM 0,483598 2,389,376 1,155,497 50. 00 05000 OPERATI NG ROOM 0,274710 310,243 85,227 51. 00 05100 RECOVERY ROOM 0,274710 310,243 85,227 51. 00 05300 ANESTHESI OLOGY 0,669341 1,470 984 53. 00 05300 ANESTHESI OLOGY 0,144918 2,399,655 347,753 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0,144918 2,399,655 347,753 54. 00 05600 RADI OLOGY-DI AGNOSTI C 0,144918 2,399,655 347,753 54. 00 05600 RADIRATORY 0,166382 2,860,458 475,929 60. 00 06000 LABORATORY 0,312469 1,455,808 454,895 65. 00 06500 RESPIRATORY THERAPY 0,312469 1,455,808 454,895 65. 00 06600 PHYSI CAL THERAPY 0,456691 377,279 172,300 66. 00 06700 OCCUPATI ONAL THERAPY 0,347980 212,680 74,008 67. 00 06700 OCCUPATI ONAL THERAPY 0,503278 92,999 46,804 68. 00 68. 00 6800 SPEECH PATHOLOGY 0,503278 92,999 46,804 68. 00 68. 00 6800 SPEECH PATHOLOGY 0,503278 92,999 46,804 69. 00 69. 00 ELECTROCARDI OLOGY 0,503278 92,999 46,804 69. 00 69. 00 00 00 00 00 00 00 00		INDATION DOUTING CODY OF COCT CENTERS			1.00	2.00	3.00	
31.00 03100 INTENSIVE CARE UNIT	20.00					022 470		20.00
40. 00 04000 SUBPROVI DER - I PF 14, 203 4, 298 41. 00 41. 00 41. 00 04100 SUBPROVI DER - I RF 1. 01 04. 00 42.								1
41. 00 04100 SUBPROVI DER - IRF ANCI LLARY SERVI CE COST CENTERS								
NACI LLARY SERVI CE COST CENTERS								
50.00	41.00					4, 290		41.00
51.00 05100 RECOVERY ROOM 0. 274710 310, 243 85, 227 51.00 53.00 05300 ANESTHESI OLOGY 0. 669341 1, 470 984 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 144918 2, 399, 655 347, 753 54.00 60.00 06000 LABORATORY 0. 166382 2, 860, 458 475, 929 60.00 65.00 06500 RESPI RATORY THERAPY 0. 312469 1, 455, 808 454, 895 65.00 66.00 06600 PHYSI CAL THERAPY 0. 456691 377, 279 172, 300 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 347980 212, 680 74, 008 67.00 68.01 06800 SPEECH PATHOLOGY 0. 347980 212, 680 74, 008 67.00 68.01 06801 OCCUPATI ONAL HERAPY 0. 503278 92, 999 46, 80 68.00 68.01 06801 OCCUPATI ONAL HERAPT 0. 000000 0 0 68.01 69.00 TILLIA GARRIA G	50 00			I	0 48350	2 389 376	1 155 497	50.00
53.00 05300 ANESTHESI OLOGY 0.669341 1,470 984 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.144918 2,399,655 347,753 54.00 60.00 06000 LABORATORY 0.166382 2,860,458 475,929 60.00 65.00 06500 RESPI RATORY THERAPY 0.312469 1,455,808 454,895 65.00 66.00 06600 PHYSI CAL THERAPY 0.456691 377,279 172,300 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.347980 212,680 74,008 67.00 68.01 06800 SPEECH PATHOLOGY 0.503278 92,999 46,804 68.00 68.01 06801 OCCUPATI ONAL HEALTH 0.000000 0 0 68.01 69.00 06900 ELECTROCARDI OLOGY 0.152879 1,628,585 248,976 69,00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.718295 966,398 694,159 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.230744 4,372,578 1,008,946 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 144918 2, 399, 655 347, 753 54. 00 60. 00 06000 LABORATORY 0. 166382 2, 860, 458 475, 929 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 312469 1, 455, 808 454, 895 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 456691 377, 279 172, 300 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 347980 212, 680 74, 008 67. 00 68. 01 06801 OCCUPATI ONAL HEALTH 0. 503278 92, 999 46, 804 68. 00 68. 01 06900 ELECTROCARDI OLOGY 0. 152879 1, 628, 585 248, 976 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 718295 966, 398 694, 159 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 230744 4, 372, 578 1, 008, 946 73. 00 76. 01 03160 CARDI AC 0. 000000 0 0 0 76. 01 09. 01 09000 CLI NI C 0. 000000 0 0 0 76. 01 00. 000000 CLI NI C 0. 00								1
60. 00 06000 LABORATORY 0. 166382 2, 860, 458 475, 929 60. 00 65. 00 06500 RESPIRATORY THERAPY 0. 312469 1, 455, 808 454, 895 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 456691 377, 279 172, 300 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 347980 212, 680 74, 008 67. 00 68. 01 06801 OCCUPATI ONAL HEALTH 0. 000000 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 0. 152879 1, 628, 585 248, 976 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 718295 966, 398 694, 159 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 307796 2, 235, 426 688, 055 72. 00 76. 00 03020 CARDI AC 0. 000000 0 0 76. 00 76. 01 03160 CARDI OPULMONARY 0. 444575 0 0 76. 01 70. 00 09000 CLI NI C 0. 000000 0 0 90. 00 90. 01 09000 UND CLI NI C 0. 000000 0 0								
65. 00 06500 RESPIRATORY THERAPY 0. 312469 1, 455, 808 454, 895 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 456691 377, 279 172, 300 66. 00 06700 0CCUPATI ONAL THERAPY 0. 347980 212, 680 74, 008 67. 00 06800 SPEECH PATHOLOGY 0. 503278 92, 999 46, 804 68. 00 06801 0CCUPATI ONAL HEALTH 0. 000000 0 0 0 68. 01 06900 ELECTROCARDI OLOGY 0. 152879 1, 628, 585 248, 976 69. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 718295 966, 398 694, 159 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 307796 2, 235, 426 688, 055 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 230744 4, 372, 578 1, 008, 946 73. 00 76. 00 03020 CARDI AC 0. 000000 0 0 76. 00 0 0 76. 00 0 0 0 0 0 0 0 0 0							•	
66. 00 06600 PHYSI CAL THERAPY 0. 456691 377, 279 172, 300 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 347980 212, 680 74, 008 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 503278 92, 999 46, 804 68. 00 68. 01 06801 0CCUPATI ONAL HEALTH 0. 000000 0 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 0. 152879 1, 628, 585 248, 976 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 307796 2, 235, 426 688, 055 72. 00 72. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 230744 4, 372, 578 1, 008, 946 73. 00 76. 00 03020 CARDI AC 0. 000000 0 0 0 76. 00 76. 01 03160 CARDI OPULMONARY 0. 444575 0 0 0 0 0 0 0 0 0							•	
67. 00 06700 0CCUPATI ONAL THERAPY 0.347980 212, 680 74, 008 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.503278 92, 999 46, 804 68. 00 68. 01 0CCUPATI ONAL HEALTH 0.000000 0 0 68. 01 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.152879 1, 628, 585 248, 976 69. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.307796 2, 235, 426 688, 055 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.230744 4, 372, 578 1, 008, 946 73. 00 76. 00 03020 CARDI AC 0.000000 0 0 0 76. 00 076. 01 03160 CARDI OPULMONARY 0.444575 0 0 0 0 76. 01 03160 CARDI OPULMONARY 0.000000 0 0 0 76. 01 030800 RURAL HEALTH CLINIC 0.000000 0 0 0 00 09. 00 090. 01 090.01 090.01 000000 0 0 0 00.00000 0 0							•	1
68. 01 06801 0CCUPATI ONAL HEALTH 0.000000 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 0.152879 1,628,585 248,976 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.718295 966,398 694,159 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.307796 2,235,426 688,055 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.230744 4,372,578 1,008,946 73. 00 76. 00 03020 CARDI AC 0.000000 0 0 76. 00 76. 01 0100 0100 0100 0100 76. 01 0100 0100 0100 76. 01 0100 0100 0100 76. 01 0100 0100 0100 76. 01 0100 0100 76. 01 0100 0100 76. 01 0100 0100 76. 01 0100 0100 76. 01 0100 0100 76. 01 0100 0100 76. 01 0100 76. 01 0100 0100 76. 01 0100 76. 01 0100 0100 76. 01 76. 01 0100 76. 01	67.00	06700 OCCUPATI ONAL THERAPY			0. 34798	212, 680	74, 008	67. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 152879 1, 628, 585 248, 976 69. 00 71. 00 771. 00 771. 00 771. 00 771. 00 772. 00 772. 00 772. 00 773. 00 774	68.00	06800 SPEECH PATHOLOGY			0. 50327	8 92, 999	46, 804	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 718295 966, 398 694, 159 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 307796 2, 235, 426 688, 055 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 230744 4, 372, 578 1, 008, 946 73. 00 76. 00 0. 000000 0 0 0 0 0 0	68. 01	06801 OCCUPATI ONAL HEALTH			0. 00000	0 0	0	68. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 307796 2, 235, 426 688, 055 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 230744 4, 372, 578 1, 008, 946 73. 00 76. 00 03020 CARDI AC 0. 000000 0 0 0 0 76. 00 00000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69.00	06900 ELECTROCARDI OLOGY			0. 15287	1, 628, 585	248, 976	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 230744 4, 372, 578 1, 008, 946 73. 00 76. 00 03020 CARDI AC 0. 000000 0 0 0 76. 00 0 0 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 71829	966, 398	694, 159	71. 00
76. 00 03020 CARDI AC 0.000000 0 0 76. 00 76. 01 03160 CARDI OPULMONARY 0.444575 0 0 76. 01	72.00				0. 30779	2, 235, 426	688, 055	
76. 01 03160 CARDI OPULMONARY 0.444575 0 0 76. 01							1, 008, 946	73. 00
SERVICE COST CENTERS	76.00	03020 CARDI AC			0.00000	00	0	76. 00
88. 00 08800 RURAL HEALTH CLINIC 0.000000 0 90.00	76. 01				0. 44457	'5 0	0	76. 01
90. 00 09000 CLI NI C 0. 000000 0 0 90. 00 90. 00 90. 01 90. 01 90. 02 09002 DI ABETES CLI NI C 0. 000000 0 0 90. 02 90. 02 09002 DI ABETES CLI NI C 0. 000000 0 0 90. 02 0. 332239 3, 268 1, 086 90. 01 90. 02 0. 000000 0 0 0 0 0 0 0								
90. 01 09001 WOUND CLINIC 0. 332239 3, 268 1, 086 90. 01 90. 02 09002 DI ABETES CLINIC 1. 191921 0 0 90. 02							_	
90. 02 09002 DI ABETES CLINIC 1. 191921 0 0 90. 02							_	
90. 03 09003 ASTHMA CLINIC 0.000000 0 90. 03								
0. 04 00004 4400 0 0 0 0 0							_	
90. 04 09004 ANDIS CLINIC 2. 569371 0 0 90. 04								

0.484972

0. 207166

0. 484677

0. 159969

0. 245347

1. 159951

2, 306

5, 343

287

1, 697, 624

21, 011, 830

21, 011, 830

90.05 90.06

90.07

90.08

91.00

92.00

201. 00

202. 00

23

1, 118

416, 507

855

333

5, 873, 455 200. 00

0

90.05

90.06

90.07

201.00

202.00

09005 PRIME TIME

90. 08 04950 ANDERSON WOMENS CENTER

04951 ONCOLOGY

91. 00 09100 EMERGENCY

09006 SHELBYVILLE WOUND CLINIC

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

Net Charges (line 200 minus line 201)

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

	Financial Systems INT ANCILLARY SERVICE COST APPORTIONMENT	HANCOCK REGIONAL HOSPITAL	CCN: 150037	Peri od:	u of Form CMS-3 Worksheet D-3	
INFAIL	IN ANCIELARI SERVICE COSI AFFORTIONMENT	Frovider	CCN. 150057	From 01/01/2014	WOLKSHEET D-3	'
		·	t CCN: 15SO37	To 12/31/2014	Date/Time Pre 5/27/2015 11:	
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
Ti-	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDIATRICS			0		30.00
	03100 NTENSI VE CARE UNI T			0		31.00
	04000 SUBPROVI DER - I PF			2, 852, 565		40. 00
	04100 SUBPROVI DER - I RF			0		41.00
_	ANCILLARY SERVICE COST CENTERS					1
	05000 OPERATI NG ROOM		0. 4835	98 11, 137	5, 386	50.00
51.00	05100 RECOVERY ROOM		0. 2747	10 1, 119	307	51.00
53.00	05300 ANESTHESI OLOGY		0. 6693	41 18	12	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1449	18 108, 489	15, 722	54.00
60.00	06000 LABORATORY		0. 1663	82 355, 057	59, 075	60.00
65.00	06500 RESPIRATORY THERAPY		0. 3124	69 100, 720	31, 472	65.00
66.00	06600 PHYSI CAL THERAPY		0. 4566	91 54, 854	25, 051	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 3479	80 75, 074	26, 124	67.00
	06800 SPEECH PATHOLOGY		0. 5032	· ·	4, 586	
	06801 OCCUPATI ONAL HEALTH		0.0000		0	1
- 1	06900 ELECTROCARDI OLOGY		0. 1528	· ·	1, 658	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7182		37, 979	
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 3077		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 2307	· ·	73, 293	
	03020 CARDI AC		0.0000		0	
	03160 CARDI OPULMONARY		0. 4445	75 0	0	76. 0°
	DUTPATIENT SERVICE COST CENTERS D8800 RURAL HEALTH CLINIC		0.0000	00	0	88. 00
	09000 CLINIC		0.0000		0	
	09001 WOUND CLINIC		0. 3322		177	
	09002 DI ABETES CLINIC		1. 1919		0	
	09003 ASTHMA CLINIC		0.0000		0	
	09004 ANDIS CLINIC		2. 5693		0	1
	09005 PRIME TIME		0. 4849		3	
	09006 SHELBYVILLE WOUND CLINIC		0. 2071		0	
	04951 ONCOLOGY		0. 4846		Ō	
	04950 ANDERSON WOMENS CENTER		0. 1599		159	
	09100 EMERGENCY		0. 2453		15, 479	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1599	51 0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)			1, 161, 555	296, 483	200.00
201.00	Less PBP Clinic Laboratory Services-Pr	ogram only charges (line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)			1, 161, 555		202.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150037	Peri od:	Worksheet D-3	
	Component	t CCN: 15T037	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 11:	
	Ti tI	e XVIII	Subprovi der -	PPS	JZ dili
Cost Center Description		Ratio of Cos To Charges	•	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31. 00
40. 00 04000 SUBPROVI DER - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER - RF			226, 917		41. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 4835	1	2, 106	
51. 00 05100 RECOVERY ROOM		0. 2747		0	1
53. 00 05300 ANESTHESI OLOGY		0. 6693		0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1449		1, 213	1
60. 00 06000 LABORATORY		0. 1663		3, 658	
65. 00 06500 RESPIRATORY THERAPY		0. 3124		1, 295	
66. 00 06600 PHYSI CAL THERAPY		0. 4566		38, 076	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3479	· ·	30, 299	
68. 00 06800 SPEECH PATHOLOGY		0. 5032		8, 347	1
68. 01 06801 0CCUPATI ONAL HEALTH		0.0000		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 1528		28	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 7182	· ·	3, 862	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3077		0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 2307		7, 556	
76. 00 03020 CARDI AC 76. 01 03160 CARDI OPULMONARY		0.0000		0	
76. 01 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS		0. 4445	75 0	0	76. 01
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 00
90. 00 09000 CLI NI C		0.0000		0	
90. 01 09001 WOUND CLINIC		0. 3322		0	
90. 02 09002 DI ABETES CLI NI C		1. 1919		0	1
90. 03 09003 ASTHMA CLINIC		0.0000	- '	0	
90. 04 09004 ANDI S CLI NI C		2. 5693		0	1
90. 05 09005 PRI ME TI ME		0. 4849		0	1
90. 06 09006 SHELBYVILLE WOUND CLINIC		0. 2071		0	1
90. 07 04951 0NCOLOGY		0. 4846		0	
90. 08 04950 ANDERSON WOMENS CENTER		0. 1599		0	1
91. 00 09100 EMERGENCY		0. 2453		296	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1599		0	1
200.00 Total (sum of lines 50-94 and 96-98)		,/	265, 395		200.00
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (line 61)		0,0	12,700	201. 00
202.00 Net Charges (line 200 minus line 201)	- 5	1	265, 395		202. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi dei	CCN: 150037	Peri od:	Worksheet D-3	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre 5/27/2015 11:	
	Ti	tle XIX	Hospi tal	Cost	oz alli
Cost Center Description		Ratio of Cos		Inpati ent	
oost ochter beschiptron		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			632, 802		30. 00
31.00 03100 INTENSIVE CARE UNIT			199, 286		31. 00
40. 00 04000 SUBPROVI DER - I PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 48359	· ·		50.00
51. 00 05100 RECOVERY ROOM		0. 2747	· ·		
53. 00 05300 ANESTHESI OLOGY		0. 66934			
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1449	· ·		
60. 00 06000 LABORATORY		0. 16638	· ·		
65. 00 06500 RESPIRATORY THERAPY		0. 31246			
66. 00 06600 PHYSI CAL THERAPY		0. 45669			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 34798	· ·		
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 OCCUPATI ONAL HEALTH		0. 5032 0. 00000	· ·	1, 648 0	
69. 00 06900 ELECTROCARDI OLOGY		0. 00000			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7182			
72. 00 07100 MEDICAL SUFFEILS CHARGED TO PATTENTS		0. 7182		04,001	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 23074			
76. 00 03020 CARDI AC		0. 00000		03, 012	
76. 01 03160 CARDI OPULMONARY		0. 4445		0	
OUTPATIENT SERVICE COST CENTERS		0.1110	0		70.01
88. 00 08800 RURAL HEALTH CLINIC		0. 9637	16 0	0	88. 00
90. 00 09000 CLI NI C		0.00000		l	1
90. 01 09001 WOUND CLI NI C		0. 33223		0	90. 01
90. 02 09002 DI ABETES CLINI C		1. 19192		Ō	1
90.03 09003 ASTHMA CLINIC		0.00000		0	90. 03
90. 04 09004 ANDIS CLINIC		2. 5693	71 0	0	90. 04
90.05 09005 PRIME TIME		0. 4849	72 0	0	90. 05
00 04 00004 SHELDWALLE WOUND CLINIC		0 2071		۸ .	00.04

0. 207166

0. 484677

0. 159969

0. 245347

1. 159951

1, 365, 146

1, 365, 146

90.05 90.06

90.07

90.08

91.00

92.00 0 413, 872 200. 00

201. 00

202. 00

0

578

23, 051

09006 SHELBYVILLE WOUND CLINIC

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

Net Charges (line 200 minus line 201)

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

04950 ANDERSON WOMENS CENTER

04951 ONCOLOGY

91. 00 09100 EMERGENCY

90.06

90.07

90.08

201.00

202.00

			To 12/31/2014		Date/Time Prepared:	
		Title	e XVIII	Hospi tal	5/27/2015 11: PPS	52 am
		11 (10	7,7711	nospi tui	113	
	DART A LINDATIONT HOCKITAL CORVINCE UNDER LIND		0	1. 00	2. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments					1.00
1. 01	DRG amounts other than outlier payments for discharges occurrin	g prior		6, 117, 662		1. 01
	to October 1 (see instructions)	·				
1. 02	DRG amounts other than outlier payments for discharges occurring	g on or		2, 039, 220		1. 02
1. 03	after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
00	discharges occurring prior to October 1 (see instructions)					
1. 04	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
2. 00	discharges occurring on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)			53, 369		2.00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0		2. 02
3.00	Managed Care Simulated Payments			0		3. 00
4. 00	Bed days available divided by number of days in the cost report period (see instructions)	i ng		53. 45		4. 00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most			0.00		5. 00
6. 00	cost reporting period ending on or before 12/31/1996. (see instr FTE count for allopathic and osteopathic programs which meet th	/		0.00		6. 00
0.00	criteria for an add-on to the cap for new programs in accordanc			0.00		0.00
	CFR 413.79(e)					
7. 00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7. 00
7. 01	CFR $\S412.105(f)(1)(iv)(B)(1)$	nder 42		0.00		7. 01
7.01	CFR §412. 105(f)(1)(iv)(B)(2) If the cost report straddles July			0.00		7.01
	then see instructions.					
8. 00	Adjustment (increase or decrease) to the FTE count for allopath	I		0.00		8. 00
	osteopathic programs for affiliated programs in accordance with $413.75(b)$, $413.79(c)(2)(iv)$, 64 FR 26340 (May 12 , 1998), and 67					
	(August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap slot	I		0.00		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 2 instructions.	UII, see				
8. 02	The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8. 02
	closed teaching hospital under section 5506 of ACA. (see instru					
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8, 01		0.00		9. 00
10. 00	FTE count for allopathic and osteopathic programs in the curren	t year		0.00		10.00
	from your records	,				
11.00	FTE count for residents in dental and podiatric programs.			0.00		11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0. 00 0. 00		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
	or after September 30, 1997, otherwise enter zero.					
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00		15. 00
	Adjusment for residents in Initial years of the program Adjusment for residents displaced by program or hospital closur	e		0. 00 0. 00		16. 00 17. 00
18. 00	Adjusted rolling average FTE count			0.00		18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000		19. 00
20.00	Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000		20.00
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0.000000		21. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0		22. 01
	Indirect Medical Education Adjustment for the Add-on for Section		ne MMA			
23. 00	Number of additional allopathic and osteopathic IME FTE residen slots under 42 Sec. $412.105 (f)(1)(iv)(C)$.	t cap		0.00		23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0.00		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lo	wer of		0.00		25. 00
0/ 00	line 23 or line 24 (see instructions)			0.000000		0, 00
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26. 00 27. 00
28. 00	IME add-on adjustment amount (see instructions)			0.00000		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0		28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0		29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days		1. 61		30.00
	(see instructions)	, ,				
31.00	Percentage of Medicaid patient days (see instructions)			15. 56		31.00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			17. 17 3. 91		32. 00 33. 00
	Disproportionate share adjustment (see instructions)			79, 734		34. 00
		'				

Numerorans ted Care Adjustment PS Prior 16 October Octob		ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150037	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prep 5/27/2015 11:	pared:
Imagenesisted Cirrl Adjustment 0 0 0 0 0 0 0 0 0			Title XVIII	Hospi tal		JZ (IIII
Discompensated Care Adjustment 9 1.00 2.00 1.00 2.00 1.00 2.00 1.00 1.00 2.00 1.00						
				October 1		
3.5.0 Total unsupperstated care amount (see instructions)			0	1. 00	2. 00	
35.01 Section 3 Gene instructions 0.000046688 0.000039112 35.01 35.00 Respital uncompensated carer payment (I Films 34 is zero, in this limb) (seet instructions) 31.847 75.393 35.03		Uncompensated Care Adjustment				
	35.00	Total uncompensated care amount (see instructions)		9, 046, 380, 143	7, 647, 644, 855	35.00
### Interference on this Lines (see instructions) ### Analysis of the Company of	35. 01	Factor 3 (see instructions)		0. 000046089	0. 000039112	35. 01
3.0 3.0	35. 02	Hospital uncompensated care payment (If line 34 is zero,		416, 939	299, 115	35. 02
amount (see Instructions) 36,00 70 10 10 10 10 10 10		enter zero on this line) (see instructions)				
35.00 Total uncompensated care (sum of column 1 and 2 on line 38.00 38	35. 03	Pro rata share of the hospital uncompensated care payment		311, 847	75, 393	35. 03
85.03 Additional payment for high percentage of ESR0 beneficiary discharges (lines 40 through 46) Additional payment for high percentage of ESR0 beneficiary discharges (lines 40 through 46) 40.00 Additional payment for high percentage of ESR0 beneficiary discharges (lines 40 through 46) 40.00 Additional payment for high percentage of ESR0 beneficiary (line 41 by line 40 for lines the lines 42 by lines 40 for lines 42 by lines 40 for lines 40 by lines 40 by lines 40 for lines 40 by lines 40 by lines 40 for lines 40 by l						
### Additional payment for high percentage of ESSD Deneficiary of scharges (times 40 through 49) ### Additional payment for high percentage of ESSD Deneficiary of scharges (times 40 through 49) ### Additional payment for high percentage of ESSD Deneficiary of scharges (times 40 through 49) ### Additional payment for high percentage of ESSD Deneficiary of Scharges (times 40 through 49) ### Additional payment for high percentage of ESSD Deneficiary of Scharges (times 40 through 49) ### Additional payment for high percentage of ESSD Deneficiary of Scharges (times 40 through 49) ### Additional payment for high percentage of ESSD Deneficiary of Scharges (times 40 through 49) ### Additional payment for high percentage of ESSD Deneficiary of Scharges (times 40 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 41 through 49) ### Additional payment for high percentage (times 49) ### Additional payment for high payment for high percentage (times 49) ### Addi	36. 00			387, 240		36. 00
10.00 Cital Medicare discharges on Worksheet S-3, Part						
excluding discharges for MS-DRGs 652, 683, 684 and 685 (685 instructions) 41.00 101at LSR0 Medicare discharges excluding MS-DRGs 652, 101at LSR0 Medicare discharges excluding ms-DRGs 652, 101at LSR0 Medicare discharges excluding ms-DRGs 652, 101at LSR0 Medicare SR0 mistractions) 41.01 101at LSR0 Medicare SR0 mistractions 41.01 101at LSR0 Medicare SR0 mistractions 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustemit, 9 43.00 101at Medicare SR0 inpatient days excluding MS-DRGs 652, 101at			ischarges (lines 40 throug	jh 46)		
A65 (see instructions)	40.00			0		40.00
1.00 107a1 FSR0 Medicare discharges excluding MS-DRGs 652, 652, 662 662, 663, 664 an 665, (see instructions) 674, 663, 664 an 665, (see instructions) 675, 663, 664 an 665, (see instructions) 675, 660 672, 673, 674, 674, 674, 674, 674, 674, 674, 674						
682, 683, 684 an 685. (see instructions)	41 00					41 00
1.01 Total ESKD Medi care covered and paid discharges excluding MS-DRS 602, 692, 693, 694 and 695, 69e Instructions) MS-DRS 602, 692, 693, 694 and 695, 69e Instructions) MS-DRS 602, 692, 693, 694 and 695, 692, 692, 693, 694 and 695, 692, 692, 693, 694 and 695, 692, 692, 693, 694, 694, 694, 694, 694, 694, 694, 694	41.00			U		41.00
MS-DRGS 652, 682, 683, 684 an 685. (see Instructions) 42.00 24.0	/1 O1			0		41 O1
42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 43.00 43.00 43.00 43.00 43.00 682.682, 684 and 685, 696 instructions) 44.00 682.682, 684 and 685, 696 instructions) 44.00 682.682, 684 and 685, 696 instructions) 44.00 682.682, 684 and 685, 696 instructions) 45.00 682.682, 682.682, 684 and 685, 696 instructions) 45.00 682.682, 682	41.01			0		41.01
qualify for a glustment	42 00			0.00		42 00
1.00	.2.00			0.00		.2.00
622, 683, 684 an 685. (see instructions) 44.00 4	43.00			o		43. 00
44.00 Ratio of average length of stay to one week (line 43 divided by 1 ne 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see nstructions) 46.00 10tal additional payment (line 45 times line 44 times line 47.00 10tal additional payment (line 45 times line 44 times line 47.00 10tal additional payment (line 45 times line 44 times line 47.00 10tal additional payment (line 45 times line 44 times line 47.00 10tal additional payment (line 45 times line 44 times line 47.00 10tal additional payment (line 45 times line 44 times line 47.00 10tal additional payment (line 45 times line 44 times line 47.00 10tal additional payment (line 45 times line 44 times line 47.00 10tal payment for inpatient program capital (line 45 times line 45 time						
divided by Irina 11 divided by 7 days) 45.00 Nergap weekly cost for dialysis treatments (see 0.00 45.00	44.00			0. 000000		44.00
instructions		divided by line 41 divided by 7 days)				
46.00 Total additional payment (line 45 times line 44 times line 47.00 46.00 47.00 Subtotal (see instructions) 8,677,225 47.00 48.00	45.00	Average weekly cost for dialysis treatments (see		0.00		45.00
41.01		instructions)				
47.00 Subtotal (see instructions) 8.677.225 47.00 48.00 Mospital specific payments (to be completed by SCH and MOH, small rural hospitals only (see instructions) 0 48.00 49.00 Total payment for inpatient operating costs (see instructions) 50.00 Payment for inpatient operating costs (see instructions) 653.126 653.126 650.00 Payment for inpatient program capital (from Wkst. L., Pt. II and Pt. III, as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L., Pt. III, see instructions) 0 51.00 Exception payment for inpatient program capital (Wkst. L., Pt. III, see instructions) 52.00 Direct graduate medical education payment (from Wkst. E-4, III, 40 50.00 51.00 52.00 52.00 53.00	46.00	Total additional payment (line 45 times line 44 times line		0		46.00
WDM, small Furnal hospitals only. (see instructions) 49.00 70.00				8, 677, 225		
49.00 Total payment for inpatient operating costs (see instructions) 50.00 Payment for inpatient program capital (from Wkst. L. Pt. I and Pt. II., as applicable) 50.00 Payment for inpatient program capital (Wkst. L. Pt. II.) 653,126 50.00 51.00 51.00 52.00	48. 00			0		48. 00
instructions) 50.00 Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L, Pt. III) and Pt. III, as applicable) 52.00 Direct graduate medical education payment (from Wkst. E-4, III, see instructions). 53.00 Nursing and Alliad Heal th Managed Care payment 55.549 53.00 Nursing and Alliad Heal th Managed Care payment 55.500 Not organ acquisition cost (Wkst. D-4 Pt. III), col. 1, III of 1. III of 1. 1, III of 1. II						
50.00 Payment for inpatient program capital (From Wkst. L, Pt. I and Pt. II. as a applicable) 50.00 51.00 52	49. 00			8, 677, 225		49. 00
and Pt. II, as applicable 51.00				(50.40)		
51.00 Exception payment for inpatient program capital (Wkst. L, P. Pt. III, see instructions) 51.00 51.00 51.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 53.00 54.00 55	50.00			653, 126		50.00
Pt. 111, see instructions 52.00 52.00 55.20 5	E1 00			0		E1 00
52.00 Direct graduate medical education payment (from Wkst. E-4 1 49 see instructions) 53.00 55.00 Nursing and Allied Heal th Managed Care payment 5,549 53.00 54.00 59.	51.00			U		51.00
Iline 49'see instructions).	52 00			0		52 00
53.00 Nursing and Allied Health Managed Care payment 5,549 53.00 54.00 Special add-on payments for new technologies 0 54.00 55.00 Net organ acquisition cost (Wkst. D. 4Pt. III., col. 1, line 69) 0 55.00 56.00 Cost of physicians' services in a teaching hospital (see intructions) 0 0 56.00 57.00 Routine service other pass through costs (from Wkst. D, Pt. III., col. unn 9, lines 30 through 35). 0 0 9,935 58.00 Alliary service other pass through costs from Wkst. D, Pt. IV., col. 11 line 200) 9,935 58.00 59.00 Total smounts on lines 49 through 58) 9,345,835 59.00 60.00 Primary payer payments 4,289 60.00 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 1,075,680 62.00 62.00 Deductible sibilled to program beneficiaries 1,075,680 62.00 63.00 Coinsurance billed to program beneficiaries 6,384 63.00 64.00 Allowable bad debts (see instructions) 0 65.00 65.00 Aljowable bad debts for dual eligible beneficiaries (see instructions) 0 65.00	32.00					32.00
54.00 Special add-on payments for new technologies 0 55.00 5	53. 00			5, 549		53. 00
55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, III ne 69) 55.00 1 ne 69) 56.00 1 ne 69) 56.00 1 ne 69) 56.00 56.00 56.00 57.00 69.00 57.00 69.00 57.00 69.00 57.00 69.00 57.00 69.00 57.00 69.00				0		54.00
1 in 6 69 Cost of physicians' services in a teaching hospital (see intructions) 56.00 56.00 57.00 77.00				0		55. 00
Intructions						
Intructions	56.00	Cost of physicians' services in a teaching hospital (see		0		56.00
Pt. III, column 9, lines 30 through 35).		intructions)				
58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) Pt. IV, col. 11 line 200 Primary payer payments 9, 345, 835 59.00 Adjustent amount son lines 49 through 58) 9, 345, 835 59.00 Primary payer payments 4, 289 60.00 Primary payer payments 60.00 Primary payer payments 61.00 Primary payer payments 61.00 Primary payer payments 61.00 Primary payer payments 62.00 Primary payer payments 62.00 Primary payer payments 63.00 Primary payer payments 64.00 Primary payer payments 70.00 Primary payer payments 70.00 Primary payer payment 70.00 Primary payment 70.00 Primary payer 70.00 Primary p	57.00			0		57.00
Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) 9, 345, 835 59.00 Finary payer payments 4, 289 60.00 Total amount payable for program beneficiaries (line 59 minus line 60) 9, 341, 546 61.00 Finary payer payments 1, 075, 680 62.00 Deductibles billed to program beneficiaries 1, 075, 680 62.00 Beductibles billed to program beneficiaries 6, 384 63.00 Goinsurance billed to program beneficiaries 6, 384 63.00 Allowable bad debts (see instructions) 0 65.00 Adjusted reimbursable bad debts (see instructions) 0 65.00 Adjusted reimbursable bad debts (see instructions) 0 65.00 Go. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 66.00 Instructions 8, 259, 482 67.00 Go. 00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 0 68.00 Go. 00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 0 69.00 Go. 00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 0 70.00 Total amount payable for program beneficiaries (see instructions) 0 70.90 RURAL DEMONSTRATION PROJECT 0 70.50 Total amount payable for program beneficiaries (line 59 90.00 HSP bonus payment HVBP adjustment amount (see instructions) 0 70.90 HSP bonus payment HRR adjustment amount (see instructions) 0 70.92 HSP bonus payment HRR adjustment amount (see instructions) 0 70.93 HSP bonus payment did ustment amount (see instructions) 0 70.94 HRR adjustment amount (see instructions)		Pt. III, column 9, lines 30 through 35).				
59.00 Total (sum of amounts on lines 49 through 58) 9, 345, 835 59.00 60.00 Primary payer payments 4, 289 60.00 10.00 Total amount payable for program beneficiaries (line 59 minus line 60) 9, 341, 546 61.00 62.00 Deductibles billed to program beneficiaries 6, 384 63.00 63.00 Coinsurance billed to program beneficiaries 6, 384 63.00 64.00 Allowable bad debts (see instructions) 0 64.00 65.00 Adjusted reimbursable bad debts (see instructions) 0 65.00 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 65.00 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 8, 259, 482 67.00 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 0 68.00 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 90. (For SCH see instructions) 0 69.00 70.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 70.00 70.89 IPoneer ACO demonstration payment adjustment amount (see instructions) 0 70.90 70.91	58. 00			9, 935		58. 00
60.00 Primary payer payments 4,289 60.00 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 7.01 7.05 7.00 62.00 Deductibles billed to program beneficiaries 7.075 680 62.00 63.00 Coinsurance billed to program beneficiaries 7.075 680 63.00 64.00 Allowable bad debts (see instructions) 0 64.00 65.00 Adjusted reimbursable bad debts (see instructions) 0 65.00 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 65.00 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 8, 259, 482 67.00 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGS (see instructions) 0 69.00 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 0 69.00 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 70.50 70.50 RURAL DEMONSTRATION PROJECT 0 70.50 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 0 70.90 70.91 HSP bonus payment HRR adjustment amount (see instructions) 0 70.91 70.92 Bundled Model 1 discount amount (see instructions) 0 70.92 70.93 HVBP payment adjustment amount (see instructions) 0 70.93 70.94 HRR adjustment amount (see instructions) 0 70.94 70.94 RRR adjustment amount (see instructions) 0 70.94 70.95 70.96 70.96 70.96 70.97 70.97 70.97 70.97 70.98 70.99 70.99 70.99 70.90 70.90 70.90 70.90 70.91 70.90 70.91 70.90 70.92 70.90 70.91 70.90 70.91 70.90 70.91 70.90 70.91 70.90 70.91 70.90 70.91		Pt. IV, col. 11 line 200)				
61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductible so billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 63.00 Adjusted reimbursable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 RURAL DEMONSTRATION PROJECT 70.89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.93 HWPP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94						
minus line 60) 1,075,680 62.00 62.00 Deductibles billed to program beneficiaries 63.00 60.00 insurance billed to program beneficiaries 63.00 63.00 Allowable bad debts (see instructions) 0 64.00 65.00 Adjusted reimbursable bad debts (see instructions) 0 65.00 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 65.00 66.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 8, 259, 482 67.00 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 0 68.00 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 0 69.00 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 70.50 70.89 Pioneer ACO demonstration payment adjustment amount (see instructions) 0 70.50 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 0 70.90 70.91 HSP bonus payment HRR adjustment amount (see instructions) 0 70.91 70.92 HRR adjustment amount (see instructions) 0 70.93 70.94 HRR adjustment amount (see instructions) 0 70.94 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
62.00 Deductibles billed to program beneficiaries 1,075,680 62.00 63.00 Coinsurance billed to program beneficiaries 6,384 63.00 64.00 64.00 65.00 Adjusted reimbursable bad debts (see instructions) 0 64.00 65.00 Adjusted reimbursable bad debts (see instructions) 0 65.00 66.00 Adjusted reimbursable bad debts (see instructions) 0 66.00 66.00 Counties and the program beneficiaries (see instructions) 0 66.00 Counties and the program beneficiaries (see instructions) 0 66.00 Counties and the program beneficiaries (see instructions) 0 66.00 Counties and the program beneficiaries (see instructions) 0 66.00 Counties and the program beneficiaries (see instructions) 0 66.00 Counties and the program beneficiaries (see instructions) 0 66.00 Counties and the program beneficiaries (see instructions) 0 Counties an	61.00			9, 341, 546		61.00
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				15, 006		
70. 95 Recovery of accelerated depreciation 0 70. 95						
	70. 95	necovery or accererated deprecration		ı o		10. 95

Heal th	Financial Systems HANCOCK REGIO	NAL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/27/2015 11:	
			Ti tl	e XVIII	Hospi tal	PPS	
					Prior to	On/After	
					October 1	October 1	
			C)	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)			201	4 191, 771		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)				0 0		70. 97
70. 98	Low Volume Payment-3				0		70. 98
70. 99	HAC adjustment amount (see instructions)				0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)				8, 466, 259		71. 00
71. 01	Sequestration adjustment (see instructions)				169, 325		71. 01
							l

	lines 69 & 70)			1	
71. 01	Sequestration adjustment (see instructions)		169, 325		71. 01
72.00	Interim payments		8, 251, 616		72. 00
73.00	Tentative settlement (for contractor use only)		l ol		73. 00
74.00	Balance due provider (Program) (line 71 minus lines 71.01,		45, 318		74. 00
	72, and 73)				
75.00	Protested amounts (nonallowable cost report items) in		526, 292		75. 00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90. 00
	instructions)				
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0		91. 00
92. 00			0		92.00
	instructions)				
93. 00	Capital outlier reconciliation adjustment amount (see		0		93. 00
	instructions)				
94. 00			0.00		94. 00
	instructions)				
95. 00			0		95. 00
	instructions)		_		
96. 00			0		96. 00
	instructions)			2 44 24	
			Prior to 10/1		
			1. 00	2. 00	
400.00	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment		_1	_	
	HVBP adjustment factor (see instructions)		0		101. 00
102. 00	HVBP adjustment amount for HSP bonus payment (see instruct	i ons)	0	0	102. 00
	HRR Adjustment for HSP Bonus Payment				
	HRR adjustment factor (see instructions)		0.0000		
104. 00	HRR adjustment amount for HSP bonus payment (see instructi	ons)	0	0	104. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2014 | Part A Exhibit 4 | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 11:52 am Provi der CCN: 150037

1.00					Ti +I	e XVIII	Hospi tal	5/27/2015 11: PPS	52 am
1.00 Bits amounts other than outlier 0.0 1.00 2.00 3.00 4.00 5.00 0.0			W/S E, Part A	Amounts (from					
1.00 OKC anounts other than outlier 1.00 0 0 0 0 0 0 0 0 0									
1. Display	1 00	DRG amounts other than outlier				3.00	4.00		1 00
Experience Control C	1.00		1.00			0			1.00
1.02 BRC amounts other than out i.er 1.02 2.039,220 0 0 2.039,220 2.039,220 1.02	1. 01		1. 01	6, 117, 662	0	6, 117, 662	0	6, 117, 662	1. 01
Dec Payments Pay	1 00		1 00	2 020 220	0	0	2 020 220	2 020 220	1 00
Coccurring on or affect October 1.03 0.0	1.02		1.02	2, 039, 220	0	U	2, 039, 220	2,039,220	1.02
1.04 SPICE OCCUPYING PRIVATE NOVEL 4 SPICE OCCUPYING PRIVATE NOVEL 1.04 SPICE OCCUPY									
1.04 SPICE OCCUPYING PRIVATE NOVEL 4 SPICE OCCUPYING PRIVATE NOVEL 1.04 SPICE OCCUPY	1 03	DRG for Federal specific	1 03	0	0	0	0	0	1 03
Cotober 1	1.00		1.00	J	J	9	J		1.00
1,04 0 0 0 0 0 0 0 0 0									
Operating payment for Model 4 RPCI occurring on after Cartober RPCI occurring outside RPCI RPC	1. 04	N .	1. 04	0	0	0	0	0	1. 04
October Octo		operating payment for Model 4				_		_	
2.00 Outlier payments for 2.00 53,369 0 40,027 13,342 53,369 2.00 discharges (see instructions) 2.02 0 0 0 0 0 0 0 2.01 0 0 0 0 0 0 0 0 0									
discharges (see Instructions) 2.01 0 0 0 0 0 0 0 0 0	2.00	d .	2. 00	53, 369	0	40, 027	13, 342	53, 369	2. 00
discharges for loadel 4 BPC 2.01 0 0 0 0 0 0 0 3.00					_	_		_	
3.00 Operating outlier 2.01 O O O O O O O O O	2. 01		2. 02	O	O	0	O	0	2.01
Managed care slimulated 3.00 0 0 0 0 0 0 0 4.00	3.00	Operating outlier	2. 01	0	0	0	0	0	3. 00
payments	4 00		2 00	0	0	0	0	0	4 00
Anount from Worksheet E, Part 21.00	4.00		3.00	U	U	U	U	0	4.00
A, I Ine 21 (see instructions) 6. 01 IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0 0 0 6.00 instructions) 7. 00 IME payment adjustment for 22.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
Mile payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	5.00		21.00	0.000000	0.000000	0.000000	0.000000		5.00
MMC payment adjustment for managed care (see instructions) Moreore (se	6.00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
managed care (See Instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	4 01		22.01	0	0	0	0	0	4 01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 Mapyment adjustment factor 27.00 0.000000 0.000000 0.00000000	0.01		22.01	0	O	0	J		0.01
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Instructions	8. 01		28. 01	0	0	0	0	0	8. 01
9.00 Total IME payment (sum of lines 6 and 8) 9.01 Total IME payment for managed care (sum of lines 6 and 8) 9.01 Total IME payment for managed care (sum of lines 6 and 8) 9.01 0 0 0 0 0 0 0 0 9.01									
1	9. 00		29. 00	0	0	0	0	0	9. 00
Care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Share Percentage (see instructions) Disproportionate share percentage (see instructions) Disproportionate share percentage (see instructions) Disproportionate share adjustment Disproportionate share adjust									
8.01) Disproportionate Share Adjustment	9.01		29.01	0	O	0	0	0	9.01
10.00		8. 01)							
Share percentage (see Instructions) 11.00 15 proportionate share 34.00 79,734 0 59,800 19,934 79,734 11.00 15 proportionate share 34.00 387,240 0 311,847 75,393 387,240 11.01 10 10 10 10 10 10	10.00			0.0301	0.0301	0.0301	0.0301		 10 00
11.00 Disproportionate share adjustment (see instructions) 34.00 79,734 0 59,800 19,934 79,734 11.00 11.01 Uncompensated care payments 36.00 387,240 0 311,847 75,393 387,240 12.00 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Cose instructions 46.00 0 0 0 0 0 13.00 Subtotal (see instructions) 47.00 8,677,225 0 6,529,336 2,147,889 8,677,225 13.00 14.00 Hospital specific payments (see instructions) 48.00 0 0 0 0 0 15.00 Total payment for inpatient operating costs (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program 50.00 653,126 0 489,845 163,281 653,126 16.00 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 0 17.01 Capital received from manufacturers for replaced devices for applicable MS-DRGS Capital outlier reconciliation 93.00 0 0 0 0 0 18.00 18.00 Capital outlier reconciliation 93.00 0 0 0 0 0 0 18.00 10.01 Total payment amount (see	10.00	1	33.00	0.0371	0.0371	0.0371	0.0371		10.00
11. 01 Uncompensated care payments 36. 00 387, 240 0 311, 847 75, 393 387, 240 11. 01	11 00		24.00	70 724	0	E0 000	10.024	70 724	11 00
Additional payment for high percentage of ESRD beneficiary discharges	11.00		34.00	19, 134	U	59, 800	19, 934	19, 134	11.00
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Capital	16 00		50.00	652 126	0	400 O4E	162 201	452 12 4	16 00
new technologies	10.00		30.00	000, 120	U	407, 043	103, 201	055, 120	10.00
17. 01 Net organ aquisition cost 55. 00 0 0 0 0 0 0 17. 01 17. 02 Capital received from manufacturers for replaced devices for applicable MS-DRGs 68. 00 0 0 0 0 0 0 0 0 17. 02 18. 00 Capital outlier reconciliation adjustment amount (see 93. 00 0 0 0 0 0 0 0 18. 00	17. 00		54.00	0	0	0	0	0	17. 00
17.02 Capital received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see	17. 01		55. 00	n	O	n	n	n	17. 01
devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see		Capital received from			Ö	0	o		1
18.00 Capital outlier reconciliation 93.00 0 0 0 0 18.00 adjustment amount (see									
adjustment amount (see	18. 00			O	0	0	O	О	18. 00
[TITSTITUCTIONS)		,							
		ITHSTRUCTIONS)	I					l	l

					Ţ	o 12/31/2014	Date/Time Pre 5/27/2015 11:	
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3.00	4. 00	5. 00	
19.00	SUBTOTAL			0	7, 019, 181	2, 311, 170	9, 330, 351	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2. 00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	652, 113	0	489, 085	163, 028	652, 113	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0) c	0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	1, 013	0	760	253	1, 013	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	ol c	0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0.0000	0.0000	0.0000	0.0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0) c	0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0.0000	0.0000	0.0000	0.0000		24. 00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11.00	0	0) c	0	0	25. 00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	653, 126	0	489, 845	163, 281	653, 126	26. 00
	payments (see instructions)							
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27.00	Low volume adjustment factor				0. 027321	0.000000		27. 00
28. 00	Low volume adjustment	70. 96			191, 771		191, 771	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29.00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Y					100.00
	adjustments to Wkst. E, Pt. A.							

	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ITON EXHIBIT 5		F	rom 01/01/2014 o 12/31/2014	Part A Exhibited Temperature Prepared Time Prepared 5/27/2015 11:1	pared:
			Title	e 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. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	6, 117, 662	0		0	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 039, 220		8, 156, 882	8, 156, 882	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00	53, 369	0	53, 369	53, 369	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
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
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	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) Indirect Medical Education Adjustment for the	22.01	oction 422 of t	bo MMA		0	6. 01
7. 00	IME payment adjustment factor (see	27.00	0. 000000	0.00000	0. 000000		7. 00
8. 00	instructions) IME adjustment (see instructions)	28. 00	0.00000	0. 000000	0.00000	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01		0	0	0	8. 01
9. 00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29. 00		0	0	0	
9. 00 9. 01	Total IME payment for managed care (sum of	29. 00	0	0	0	0	
7. 01	lines 6.01 and 8.01)	27.01		0			7.01
	Disproportionate Share Adjustment	I.			L		
10.00	Allowable disproportionate share percentage	33.00	0. 0391	0. 0391	0. 0391		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	79, 734	0	79, 734	79, 734	11. 00
	instructions)						
11. 01		36.00	387, 240	311, 847	75, 393	387, 240	11. 01
40.00	Additional payment for high percentage of ESF						
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	_	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	8, 677, 225	311, 847	8, 365, 378		
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	0	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	8, 677, 225	311, 847	8, 365, 378	8, 677, 225	15. 00
16.00	Payment for inpatient program capital	50.00	653, 126	0	653, 126	653, 126	16. 00
17. 00	Special add-on payments for new technologies	54.00	0	0	0	0	17. 00
17. 01	Net organ aquisition cost	55. 00	0	0	0	0	
17. 02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
10 00	SUBTOTAL		1	311 9/17	0 010 504	0 330 351	10 00

311, 847

9, 018, 504

9, 330, 351 19. 00

19. 00 | SUBTOTAL

	Financial Systems	HANCOCK REGIO				u of Form CMS-	2552-10
HOSPI TA	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der	F	eriod: rom 01/01/2014 o 12/31/2014		pared:
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
	Capital DRG other than outlier	1.00	652, 113	0	652, 113	652, 113	20. 00
	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
	Capital DRG outlier payments	2.00	1, 013	0	1, 013	1, 013	21. 00
	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0. 0000		22. 00
	Indirect medical education adjustment (see instructions)	6. 00	0	0	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24. 00
	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25. 00
	Total prospective capital payments (see	12.00	653, 126	0	653, 126	653, 126	26. 00
	instructions)						
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	191, 771	191, 771		191, 771	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
	HVBP payment adjustment (see instructions)	70. 93	15, 006	0	15, 006	15, 006	30. 00
	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31 00	HRR adjustment (see instructions)	70 94	l n	l	0	۸ ا	31 00

70.94

70. 91

0

70. 99

31.00 HRR adjustment (see instructions)
31.01 HRR adjustment for HSP bonus payment (see

32.00 HAC Reduction Program adjustment (see

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

instructions)

instructions)

31.01

100. 00

0 31.00

0 32. 00

(Amt. to Wkst. E, Pt. A) 4.00

0 0

3. 00

2.00

1.00

Ν

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:	150037 Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 11:52 am
	T1 + 1 > 0 #		222

			10 12/31/2014	5/27/2015 11:	
		Title XVIII	Hospi tal	PPS	oz am
		THE WITT	nospi tui	110	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			3, 994	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		10, 886, 012	1
3.00	PPS payments	0113)		7, 899, 574	1
4. 00	Outlier payment (see instructions)			41, 992	1
5. 00	, , , , , , , , , , , , , , , , , , , ,	i ons)			1
	Enter the hospital specific payment to cost ratio (see instructi	10115)		0.000	•
6.00	Line 2 times line 5			0	
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	•
8.00	Transitional corridor payment (see instructions)			0	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	, col. 13, line 200		47, 254	1
10.00	Organ acquisitions			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 994	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12. 00	Ancillary service charges			17, 408	1
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col	I. 4)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			17, 408	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pay	•	9	0	
16. 00	Amounts that would have been realized from patients liable for pat	payment for services or	n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			17, 408	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lir	ne 11) (see	13, 414	19. 00
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lir	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see i	instructions)		3, 994	1
22. 00	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			7, 988, 820	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for (CAH, see instructions)		1, 761, 027	26. 00
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plu	us the sum of lines 22	and 23} (for	6, 231, 787	27. 00
	CAH, see instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			6, 231, 787	30. 00
31. 00	Primary payer payments			589	31.00
32. 00	Subtotal (line 30 minus line 31)			6, 231, 198	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			161, 311	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			104, 852	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		161, 311	36. 00
37.00	Subtotal (see instructions)			6, 336, 050	37. 00
38.00	MSP-LCC reconciliation amount from PS&R			39	38. 00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruct	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39. 99
40.00	Subtotal (see instructions)			6, 336, 011	40. 00
40. 01	Sequestration adjustment (see instructions)			126, 720	1
41.00	Interim payments			6, 172, 112	41.00
42.00	Tentative settlement (for contractors use only)			0	1
43. 00	Balance due provider/program (see instructions)			37, 179	1
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2 o	chapter 1	0,,.,,	1
11.00	§115. 2	0 WI TH 0M0 1 db. 10 2,	shapter 1,	Ŭ	11.00
	TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money			0.00	l
93. 00	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94. 00
, 00	1.11. (1.1 or 1.1 or		1	·	, , 00

Peri od: Worksheet E-1
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/27/2015 11:52 am Provi der CCN: 150037

			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		8, 196, 816		6, 057, 742	1.00
2.00	Interim payments payable on individual bills, either		C)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2014	27, 300	12/31/2014	114, 370	3. 01
3. 02	ADSOSTMENTS TO TROVIDER	07/18/2014	27, 500		0	3. 02
3. 03		077 107 2011	27,000		0	3. 03
3. 04			C		0	3. 04
3. 05			C		0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		C)	0	3. 50
3. 51			C)	0	3. 51
3. 52			C)	0	3. 52
3.53			C)	0	3. 53
3.54			C)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		54, 800)	114, 370	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 251, 616		6, 172, 112	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C)	0	5. 01
5.02			C)	0	5. 02
5. 03			C)	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		45, 318	3	37, 179	6. 01
6. 02	SETTLEMENT TO PROGRAM		45, 510		37, 177	6. 02
7.00	Total Medicare program liability (see instructions)		8, 296, 934		6, 209, 291	7. 00
	(======================================		2, 2, 2, 7, 0	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8.00	Name of Contractor					8. 00

		ΠΤΙ	e XVIII	Subprovider - IPF	PPS	
		Innatier	t Part A		rt B	
		Tripatroi		rui		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 020, 818		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Drawit days to Drawnson		0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM					3. 50
3. 52						3. 52
3. 53			0		l o	3. 53
3. 54			Ö		Ö	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 020, 818		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5. 03			0		0	5. 03
F F0	Provi der to Program					
5. 50 5. 51	TENTATI VE TO PROGRAM		0		0	5. 50 5. 51
5. 51						5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
3. 77	5. 50-5. 98)		٥			3. //
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		440		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 021, 258		0	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 00	name of softi dotor	1		I	ı	1 0.00

Inpatient Part A			Titl	e XVIII	Subprovi der - I RF	PPS	
1.00 Total Interim payments paid to provider 2.00 3.00 4.00 1.00			I npati en	t Part A	Par	t B	
1.00							
Interim payments payable on individual bills, either submitted or to be submitted for the cost reporting period. If none, write "NONE" or enter a zero. 3.00		I 	1. 00				
amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER O	2. 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		· ·			2. 00
3.02 3.03 3.04 0 0 0 3.03 3.04 3.05 3.	3. 00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
3.04 0	3.01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 04 0 0 0 3. 04 3. 05	3.02			C)	0	3. 02
3.05	3.03			C)	0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM O O 3.50	3.04						3. 04
3. 50 ADJUSTMENTS TO PROGRAM	3.05			C		0	3. 05
3.51 3.52 3.53 0 0 0 3.51 3.52 3.53 3.53 0 0 0 3.53 3.53 3.54 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 0 0 0 0 0 0							
3.52 3.53 3.54 3.99 3.50-3.98		ADJUSTMENTS TO PROGRAM		_		- 1	
3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.57 3.59 3.50-3.98							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 268,688 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Contractor Number							
3. 50-3. 98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E-07 Wkst. E-3, line and column as appropriate) To Be COMPLETED BY CONTRACTOR				_		-	
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 99	3. 50-3. 98)		C			
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	4. 00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		268, 688		0	4. 00
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	E 00						E 00
TENTATIVE TO PROVIDER	5.00	desk review. Also show date of each payment. If none,					5.00
Solition Settlement amount (balance due) based on the cost report. (1) Settlement To PROGRAM S		Program to Provider					
Description	5. 01	TENTATI VE TO PROVI DER					5. 01
Provider to Program	5.02						5. 02
TENTATI VE TO PROGRAM	5.03			C		0	5. 03
5.51 0				_	1		
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0		TENTATIVE TO PROGRAM					
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 5.99 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 6.01 6.01 SETTLEMENT TO PROVIDER 35 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 268,723 0 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00				_			
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99			(0	5. 99
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 268,723 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00	Determined net settlement amount (balance due) based on					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 01			35		0	6. 01
7.00 Total Medicare program liability (see instructions) 268,723 0 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00						l	
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00		l l		268, 723		o	
0 1.00 2.00				·	Contractor		
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8. 00	Name of Contractor					8. 00

Heal th	Financial Systems HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150037 Period:			Worksheet E-1	
			From 01/01/2014 To 12/31/2014		nared:
			10 12/31/2014	5/27/2015 11:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst. S	· ·	14	2, 579	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		3, 578	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			834	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-7	12		8, 635	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			225, 622, 028	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	ne 20		4, 686, 211	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			596, 418	8. 00
9.00	Seguestration adjustment amount (see instructions)				
10.00	00 Calculation of the HIT incentive payment after sequestration (see instructions)				
	I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH				
30.00	On Initial/interim HIT payment adjustment (see instructions) 631,557				
31.00	Other Adjustment (specify)			0	31. 00
22 00	20 Palance due provider (line 9 (or line 10) minus line 20 and line 21) (see instructions)				

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

631, 557 30. 00 0 31. 00 -47, 067 32. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150037	From 01/01/2014	
	Component CCN: 15S037	To 12/31/2014	Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Subprovi der - I PF	PPS

DART 11 - MEDICANE PART A SERVICES - IPF PPS		IFF		
SART II - MEDICARE PART A SERVICES - IPF PPS PPS PROPATOR (sex uding outlier, ECT, and medical education payments) 2, 21, 884 1.00 1.00 Net IPF PPS Dayments (sex uding outlier, ECT, and medical education payments) 2, 479 2.00 1.00 Net IPF PPS CUT Payments 2, 479 2.00 1.01 Outlier PPS CUT Payments 2, 479 2.00 1.02 Unwel ghted Intern and resident FTE count in the most recent cost report filed on or before November 1.00 1.01 Outlier PPS CUT Payments 0.00 4.00 1.02 Outlier PPS CUT Payments 0.00 4.00 1.03 Outlier PPS CUT Payments 0.00 4.00 1.05 Outlier PPS CUT Payments 0.00 4.00 1.06 Outlier PPS CUT Payments 0.00 4.00 1.07 Outlier PPS CUT Payments 0.00 4.00 1.08 Outlier PPS CUT Payments 0.00 6.00 1.09 Outlier PPS CUT Payments 0.00 6.00 1.00 Outlier PPS CUT Payments 0.00 6.00 1.00 Outlier PPS CUT Payments 0.00 6.00 1.00 Outlier PPS CUT PAYMENT 0.00 0.00 1.00 Outlier PPS CUT PPS 0.00 0.00 0.00 1.00 Outlier PPS CUT PPS 0.00 0.00 0.00 1.00 Outlier PPS CUT PPS 0.00 0.00 0.00 0.00 1.00 Outlier PPS CUT PPS 0.00			1, 00	
1.00 Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		PART II - MEDICARE PART A SERVICES - IPF PPS	11.00	
Net IPF PPS ECT Payments	1.00		2, 221, 884	1.00
Unwelghted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions) Cap increases for the unwelghted intern and resident FTE count for residents that were displaced by program or hospital closure. That would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(III)(F)(1) or (2) (see instructions) 0.00 5.00	2.00	Net IPF PPS Outlier Payments	2, 479	2. 00
15. 2004 (see instructions) 4.01 Cap Increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 (FR \$412.424(a))(i)(iii)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)	3.00	Net IPF PPS ECT Payments	0	3.00
4.01 Cap Increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412, 424(a)(1)(iii)(F)(1) or (2) (see instructions) 0.00 5.00	4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4.00
program or hospital closure, that would not be counted without a temporary cap adjustment under 42′ CFR \$412.424(6)(i)(iii)(iii)(i)(i)(i)(i)(i)(i)(i)(i)(i		15, 2004. (see instructions)		
5.00 New Teaching program adjustment. (see instructions) 0.00 5.00 6.00 Corrent year's unwelghted FTE count of 1&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 0.00 6.00 1.	4. 01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	4. 01
Current year's unwelghted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	5.00		0.00	5. 00
2.00 Current 'year's unweighted 1&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 7.00	6.00		0.00	6. 00
teaching program" (see instructions) 8.00 9.00 Average Daily Census (see instructions) 10.00 Teaching Adjustment Factor (((1 + (line 8/line 9)) raised to the power of .5150 -1). 10.00 Teaching Adjustment (line 1 multiplied by line 10). 11.00 Teaching Adjustment (line 1 multiplied by line 10). 12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 12.00 14.00 Organ acquisition (D0 NOT USE THIS LINE) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 16.00 Teach of physicians' services in a teaching hospital (see instructions) 17.00 Teach of physicians' services in a teaching hospital (see instructions) 18.00 Teach of physicians' services in a teaching hospital (see instructions) 18.00 Teach of physicians' services in a teaching hospital (see instructions) 18.00 Teach of physicians' services in a teaching hospital (see instructions) 18.00 Teach of physicians' services in a teaching hospital (see instructions) 18.00 Teach of physicians' services in a teaching hospital (see instructions) 18.00 Teach of physicians' services in a teaching hospital (see instructions) 18.00 Teach of physicians' services in a teaching hospital (see instructions) 18.00 Teach of physicians' services in a teaching hospital (see instructions) 18.00 T		teaching program" (see instuctions)		
1.	7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
9.00				
10. 00 Teaching Adj ustment Factor {((1 + (line 8/line 9)) ralsed to the power of .5150 -1}. 0.000000 10.00 Teaching Adj ustment (line 1 multiplied by line 10). 0 11.00 11.00 12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 2, 224, 363 12.00 13.00 Nursing and Allied Heal th Managed Care payment (see instruction) 0 13.00 14.00 15.00 1				
11.00				
12.00			1	
13. 00 Nursing and Allied Health Managed Care payment (see instruction) 0 14. 00 0 14. 00 0 0 14. 00 0 0 0 0 0 0 0 0 0			1	
14.00 Organ acquisition (DO NOT USE THIS LINE) 14.00 15.00 Cost of physicians' services in a teaching hospital (see instructions) 0 15.0		1 3		
15.00 Cost of physicians' services in a teaching hospital (see instructions) 2, 224, 363 16.00 17.00		1	0	
16. 00 Subtotal (see instructions) 2, 224, 363 16. 00 17. 00 Primary payer payments 2, 224, 363 18. 00 18. 00 19. 00				
17. 00				
18.00 Subtotal (line 16 less line 17). 2, 224, 363 18.00 19.00 Deductibles 161, 696 19.00 2.000 Subtotal (line 18 minus line 19) 2, 062, 667 20.00 20.00 Subtotal (line 20 minus line 21) 2, 062, 667 20.00 23.00 24.00 23.00 24.00 25.00 24.00 25.00				
19.00 Deductibles 161,696 19.00 20.00 Subtotal (line 18 minus line 19) 2,062,667 20.00			1	
20. 00 Subtotal (line 18 minus line 19) 2,062,667 20. 00 21. 00 Coinsurance 608 21. 00 22. 00 22. 00 23. 00 All owable bad debts (exclude bad debts for professional services) (see instructions) 0 24. 00 25. 00 All owable bad debts (exclude bad debts for professional services) (see instructions) 0 24. 00 25. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 24. 00 25. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 24. 00 25. 00 26. 00 Subtotal (sum of lines 22 and 24) 2,062,059 26. 00 27. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 27. 00 27. 00 28. 00 Other pass through costs (see instructions) 449 28. 00 29. 00 Outlier payments reconciliation 0 29. 00 29. 00 Outlier payments reconciliation 0 29. 00 03. 00 03. 00 05. 00				
21.00 Coinsurance 608 21.00 22.00 Subtotal (line 20 minus line 21) 2,062,059 22.00 23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 0.24.00 24.00 Adjusted reimbursable bad debts (see instructions) 0.24.00 25.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0.24.00 25.00 26.00 Subtotal (sum of lines 22 and 24) 2,062,059 26.00 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0.27.00 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0.27.00			1	
22.00 Subtotal (line 20 minus line 21) 2,062,059 22.00 23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 0 23.00 23.00 25.00 Adjusted reimbursable bad debts (see instructions) 0 24.00 25.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 25.00 25.00 Subtotal (sum of lines 22 and 24) 2,062,059 26.00 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 27.00 2				
23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 0 23.00 24.00 Adjusted reimbursable bad debts (see instructions) 0 24.00 25.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 2,062,059 25.00 25.00 Subtotal (sum of lines 22 and 24) 2,062,059 26.00 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 27.00 28.00 Other pass through costs (see instructions) 449 28.00 29.00 Outlier payments reconciliation 0 29.00 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.50 30.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.50 31.00 Total amount payable to the provider (see instructions) 2,062,508 31.00 31.01 Sequestration adjustment (see instructions) 2,062,508 31.00 32.00 Interim payments 2,020,818 32.00 33.00 Fortative settlement (for contractor use only) 33.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 440 <				
24.00 Adj usted reimbursable bad debts (see instructions) 0 24.00 25.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 0 25.00 26.00 Subtotal (sum of lines 22 and 24) 2,062,059 26.00 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 27.00 28.00 Other pass through costs (see instructions) 449 28.00 29.00 Outlier payments reconciliation 0 29.00 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.00 30.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.50 30.99 Recovery of Accelerated Depreciation 0 30.99 31.00 Total amount payable to the provider (see instructions) 2,062,508 31.00 31.01 Sequestration adjustment (see instructions) 2,062,508 31.01 32.00 Interim payments 2,002,818 32.00 33.00 Tentative settlement (for contractor use only) 34.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 440 34.00 35.00				
25. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 26. 00 Subtotal (sum of lines 22 and 24) 27. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 28. 00 Other pass through costs (see instructions) 29. 00 Outlier payments reconciliation 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 50 Pioneer ACO demonstration payment adjustment (see instructions) 30. 99 Recovery of Accelerated Depreciation 31. 01 Sequestration adjustment (see instructions) 32. 00 Sequestration adjustment (see instructions) 33. 00 Total amount payable to the provider (see instructions) 31. 01 Sequestration adjustment (see instructions) 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Bal ance due provider/program (line 31 minus lines 31.01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35. 00 Original outlier amount from Worksheet E-3, Part II, line 2 36. 00 Outlier reconciliation adjustment amount (see instructions) 37. 00 Outlier reconciliation adjustment amount (see instructions) 38. 00 Outlier reconciliation adjustment amount (see instructions) 39. 00 Outlier reconciliation adjustment amount (see instructions)				
26. 00 Subtotal (sum of lines 22 and 24) 27. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 28. 00 Other pass through costs (see instructions) 29. 00 Other pass through costs (see instructions) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 50 Pioneer ACO demonstration payment adjustment (see instructions) 30. 99 Recovery of Accelerated Depreciation 31. 01 Sequestration adjustment (see instructions) 31. 01 Sequestration adjustment (see instructions) 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 50. 00 Original outlier amount from Worksheet E-3, Part II, line 2 20. 00 Outlier reconciliation adjustment amount (see instructions) 20. 00 Outlier reconciliation adjustment amount (see instructions) 20. 00 Outlier reconciliation adjustment amount (see instructions) 21. 00 Outlier reconciliation adjustment amount (see instructions) 22. 00 Outlier reconciliation adjustment amount (see instructions)				
27. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 27. 00 28. 00 Other pass through costs (see instructions) 449 28. 00 29. 00 Outlier payments reconciliation 0 29. 00 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30. 00 30. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30. 99 30. 99 Recovery of Accelerated Depreciation 0 30. 99 31. 00 Total amount payable to the provider (see instructions) 2, 062, 508 31. 00 31. 01 Sequestration adjustment (see instructions) 41, 250 31. 01 32. 00 Interim payments 2, 020, 818 32. 00 33. 00 Tentative settlement (for contractor use only) 0 33. 00 34. 00 Bal ance due provider/program (line 31 minus lines 31. 01, 32 and 33) 440 34. 00 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35. 00 50. 00 Original outlier amount from Worksheet E-3, Part II, line 2 2, 479 50. 00 51. 00 Outlier reconciliation adjustment amount (see instructi		,	2, 062, 059	
28. 00 Other pass through costs (see instructions) 29. 00 Outlier payments reconciliation 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 00 Pioneer ACO demonstration payment adjustment (see instructions) 30. 99 Recovery of Accelerated Depreciation 31. 00 Total amount payable to the provider (see instructions) 31. 01 Sequestration adjustment (see instructions) 32. 00 Interim payments 33. 00 Interim payments 34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 TO BE COMPLETED BY CONTRACTOR 50. 00 Original outlier amount from Worksheet E-3, Part II, line 2 50. 00 Outlier reconciliation adjustment amount (see instructions)			1 ' '	
29. 00			449	
30. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 30. 99 Recovery of Accelerated Depreciation 31. 00 Total amount payable to the provider (see instructions) 31. 01 Sequestration adjustment (see instructions) 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115. 2 TO BE COMPLETED BY CONTRACTOR 50. 00 Original outlier amount from Worksheet E-3, Part II, line 2 0 Untlier reconciliation adjustment amount (see instructions) 0 30. 50 0 30. 50 2, 062, 508 31. 00 2, 062, 508 31. 00 31. 01 32. 00 31. 01 32. 00 33. 00 34. 00 35. 00 0 Original outlier amount (line 31 minus lines 31.01, 32 and 33) 35. 00 0 Outlier reconciliation adjustment amount (see instructions)	29. 00		0	29. 00
30. 99 Recovery of Accelerated Depreciation 30. 99 31. 00 Total amount payable to the provider (see instructions) 31. 01 Sequestration adjustment (see instructions) 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115. 2 TO BE COMPLETED BY CONTRACTOR 50. 00 Original outlier amount from Worksheet E-3, Part II, line 2 0 Untlier reconciliation adjustment amount (see instructions) 0 30. 99 2, 062, 508 31. 00 41, 250 31. 01 2, 020, 818 32. 00 33. 00 35. 00 0 Original outlier amount (line 31 minus lines 31.01, 32 and 33) 440 35. 00 0 Outlier reconciliation adjustment amount (see instructions)	30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
31. 00 Total amount payable to the provider (see instructions) 31. 01 Sequestration adjustment (see instructions) 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35. 00 35. 00 Original outlier amount from Worksheet E-3, Part II, line 2 31. 00 Outlier reconciliation adjustment amount (see instructions) 2, 062, 508 31. 00 41, 250 31. 01 2, 020, 818 32. 00 33. 00 440 34. 00 35. 00 Original outlier amount from Worksheet E-3, Part II, line 2 2, 479 50. 00 51. 00 Outlier reconciliation adjustment amount (see instructions)	30. 5C	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
31. 01 Sequestration adjustment (see instructions) 32. 00 Interim payments 32. 00 Interim payments Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2 Outlier reconciliation adjustment amount (see instructions) 31. 01 2, 020, 818 32. 00 33. 00 440 34. 00 35. 00 50. 00 Original outlier amount from Worksheet E-3, Part II, line 2 2, 479 50. 00 51. 00	30. 99	Recovery of Accelerated Depreciation	0	30. 99
32.00 Interim payments 2,020,818 32.00 33.00 Tentative settlement (for contractor use only) 0 33.00 34.00 34.00 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 To BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 2,479 50.00 0 Outlier reconciliation adjustment amount (see instructions) 0 51.00	31.00	Total amount payable to the provider (see instructions)	2, 062, 508	31.00
33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 440 34.00 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 50.00 Outlier reconciliation adjustment amount (see instructions) 33.00 33.00 34.00 35.00 50.00 Silver in the settlement (for contractor use only) 50.00 Outlier reconciliation adjustment amount (see instructions)	31. 01	Sequestration adjustment (see instructions)	41, 250	31. 01
34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 10 Be Completed By Contractor 10 Diginal outlier amount from Worksheet E-3, Part II, line 2 2,479 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00	32.00	Interim payments	2, 020, 818	
35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 15.2 10.8E COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 2,479 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00				
\$115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 50.00 Outlier reconciliation adjustment amount (see instructions)			1	
50.00 Original outlier amount from Worksheet E-3, Part II, line 2 2,479 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00	35. 00	<u>§115. 2</u>	0	35. 00
51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00				
			1	
52.00 The rate used to carculate the rime value of money 0.00 52.00		· · · · · · · · · · · · · · · · · · ·		
E2 00 Time Value of Manay (see instructions)			1	
53.00 Time Value of Money (see instructions) 0 53.00	os. 00	Time value of money (see firstructions)	١	აა. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15003	7 Period: From 01/01/2014	Worksheet E-3
	Component CCN: 15TC		Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Subprovi der -	PPS
		IRF	

	IRF		
	DADT LLL MEDICADE DADT A CEDIU OFC. LDE DDG	1. 00	
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS	280, 220	1. 00
2. 00	Net Federal PPS Payment (see instructions)	0.0000	2. 00
3. 00	Medicare SSI ratio (IRF PPS only) (see instructions) Inpatient Rehabilitation LIP Payments (see instructions)	0.0000	3. 00
4. 00	Outlier Payments	0	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5. 00
5.00	to November 15, 2004 (see instructions)	0.00	5.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
3.01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	5. 01
	CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7. 00
	teaching program" (see instructions)		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8.00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	0. 810959	10.00
11. 00	Teaching Adjustment Factor (see instructions)	0.000000	11. 00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	280, 220	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	280, 220	17.00
18. 00	Primary payer payments	0	18.00
19. 00	Subtotal (line 17 less line 18).	280, 220	19.00
20. 00	Deducti bl es	6, 048	20.00
21. 00	Subtotal (line 19 minus line 20)	274, 172	21.00
22. 00	Coi nsurance	0	
23. 00	Subtotal (line 21 minus line 22)	274, 172	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25. 00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	
27. 00	Subtotal (sum of lines 23 and 25)	274, 172	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	
29. 00	Other pass through costs (see instructions)	35	
30. 00	Outlier payments reconciliation	0	
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
31. 99	Recovery of Accelerated Depreciation	0	
32. 00	Total amount payable to the provider (see instructions)	274, 207	
32. 01	Sequestration adjustment (see instructions)	5, 484	
33. 00	Interim payments	268, 688	
34. 00	Tentative settlement (for contractor use only)	0	
35. 00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	35	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
	§115. 2		
F0 60	TO BE COMPLETED BY CONTRACTOR		F0 00
50.00		0	
51.00	Outlier reconciliation adjustment amount (see instructions)	0	
52.00	The rate used to calculate the Time Value of Money		52.00
ეკ. 00	Time Value of Money (see instructions)	ΟĮ	53. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15003	From 01/01/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2015 11:52 am

			lo 12/31/2014	Date/lime Pre 5/27/2015 11:	
		Title XIX	Hospi tal	Cost	oz am
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		929, 451		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		929, 451	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		929, 451	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		832, 088		8. 00
9.00	Ancillary service charges		1, 365, 146	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		2, 197, 234	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
16.00	Total customary charges (see instructions)		2, 197, 234	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	IT line 16 exceeds	1, 267, 783	0	17. 00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	if line 4 avecede line	0	0	18. 00
18.00	16) (see instructions)	IT TIME 4 exceeds Time	U	U	18.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		929, 451	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c			0	21.00
22. 00	Other than outlier payments	ompreted for 113 provide	0	0	22.00
	Outlier payments		0	0	
24. 00	Program capital payments		0	· ·	24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		929, 451	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		929, 451	0	31.00
32.00	Deducti bl es		0	0	32. 00
33.00	Coi nsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		929, 451	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		929, 451	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		929, 451	0	40. 00
41.00	Interim payments		1, 364, 324	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-434, 873	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

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

Peri od: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared:

			'	0 12/31/2014	5/27/2015 11:	
	<u> </u>	General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	OUDDENT ACCETO	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	19, 243, 114			0	1.00
2. 00	Temporary investments	19, 243, 114		0	0	2.00
3. 00	Notes receivable			-	0	3.00
4. 00	Accounts recei vabl e	10, 854, 003	1	O	ő	4. 00
5.00	Other recei vable	C	o c	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0) c	0	0	6. 00
7.00	Inventory	4, 497, 605	5 C	0	0	7. 00
8.00	Prepai d expenses	0	0	0	0	8. 00
9. 00	Other current assets	0	0	0	0	9. 00
10. 00	Due from other funds	0	0		0	10. 00
11. 00	Total current assets (sum of lines 1-10)	34, 594, 722	2 C	0	0	11. 00
12 00	FI XED ASSETS	4 747 145	i c	0	0	12.00
12. 00 13. 00	Land Land improvements	6, 747, 145		-		12. 00 13. 00
14. 00	Accumulated depreciation			0	0	14.00
15. 00	Buildings	102, 565, 981	ή "	0	Ö	15. 00
16. 00	Accumulated depreciation	-112, 513, 047	1	0	Ō	16.00
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumul ated depreciation	0) c	0	0	18. 00
19. 00	Fi xed equi pment	0) c	0	0	19. 00
20. 00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation	0 000 410	0	0	0	22. 00
23. 00	Maj or movable equipment	62, 233, 410		0	0	23. 00
24. 00 25. 00	Accumulated depreciation			0	0	24. 00 25. 00
26. 00	Minor equipment depreciable Accumulated depreciation			0	0	26.00
27. 00	HIT designated Assets			0	0	27.00
28. 00	Accumulated depreciation		ol o	0	Ö	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	Ö		0	Ō	29. 00
30.00	Total fixed assets (sum of lines 12-29)	59, 033, 489	o c	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	C	0	0	-	31. 00
32. 00	Deposits on Leases	0	0	-	0	32. 00
33. 00	Due from owners/officers	0	0		0	33. 00
34. 00	Other assets	55, 014, 784		-	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34)	55, 014, 784	1		0	35. 00 36. 00
30.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	148, 642, 995	0	U U	U	30.00
37. 00	Accounts payable	21, 051, 221		0	0	37. 00
38. 00	Salaries, wages, and fees payable	5, 500, 843	1	0	0	38. 00
39. 00	Payroll taxes payable	0		0	Ö	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	40. 00
41.00	Deferred income	0) c	0	0	41. 00
42.00	Accel erated payments	0)			42. 00
43. 00	Due to other funds	0	0	0	0	43. 00
44. 00	Other current liabilities	2, 845, 168			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	29, 397, 232	2 C	0	0	45. 00
46. 00	LONG TERM LIABILITIES	1 0		O	0	46. 00
47. 00	Mortgage payable Notes payable			-		47.00
48. 00	Unsecured Loans				0	48. 00
49. 00	Other long term liabilities			-	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49				0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	29, 397, 232	2 0	0		51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	119, 245, 763	3			52. 00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	119, 245, 763	3	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	148, 642, 995	1	o o	0	60.00
	59)					
		•	•	. '	-	

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 150037 Perio

Peri od: Worksheet G-1 From 01/01/2014 To 12/31/2014 Date/Time Pre

Date/Time Prepared: 5/27/2015 11:52 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 110, 054, 293 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 9, 191, 470 2.00 3.00 Total (sum of line 1 and line 2) 119, 245, 763 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 119, 245, 763 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 119, 245, 763 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 19.00 Fund balance at end of period per balance 19.00

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

			10 12/31/2014	5/27/2015 11:	
	Cost Center Description	Inpatient	Outpati ent	Total	02 diii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	7, 330, 8	59	7, 330, 859	1. 00
2.00	SUBPROVI DER - I PF	3, 071, 5	35	3, 071, 585	2. 00
3.00	SUBPROVI DER - I RF	363, 1	56	363, 156	3. 00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	10, 765, 6	00	10, 765, 600	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9, 133, 7	55	9, 133, 755	11. 00
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	9, 133, 7	55	9, 133, 755	16. 00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	19, 899, 3	55	19, 899, 355	17. 00
18.00	Ancillary services	43, 393, 9	97 129, 888, 211	173, 282, 208	18. 00
19.00	Outpatient services	2, 945, 3			
20.00	RURAL HEALTH CLINIC		0 349, 787	349, 787	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22. 00	HOME HEALTH AGENCY		672, 614	672, 614	22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE	623, 2	22 1, 249, 942	1, 873, 164	26. 00
27.00	DI ETARY/PRI VATE DUTY		0 270, 038		27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	66, 861, 9	21 162, 550, 057	229, 411, 978	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		98, 265, 080		29. 00
30.00	ADD (SPECIFY)		0		30. 00
31.00			0		31. 00
32.00			0		32. 00
33.00			0		33. 00
34.00			0		34.00
35.00			0		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		0		37. 00
38.00			0		38. 00
39.00			0		39. 00
40.00			0		40. 00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	98, 265, 080		43. 00
	to Wkst. G-3, line 4)				

	Financial Systems HANCOCK REGIONAL			u of Form CMS-2	
STATE	ENT OF REVENUES AND EXPENSES	Provi der CCN: 150037	Peri od:	Worksheet G-3	
			From 01/01/2014 To 12/31/2014	Date/Time Pre	nared:
			10 12/31/2014	5/27/2015 11:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		229, 411, 978	1. 00
2.00	Less contractual allowances and discounts on patients' account	S		137, 638, 346	2. 00
3.00	Net patient revenues (line 1 minus line 2)			91, 773, 632	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	3)		98, 265, 080	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-6, 491, 448	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	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
	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other th	an patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 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/NONOPER			15, 606, 835	
	Total other income (sum of lines 6-24)			15, 606, 835	
	Total (line 5 plus line 25)			9, 115, 387	
	GAIN/LOSS INVENTORY			-76, 083	
28 00	Total other expenses (sum of line 27 and subscripts)			-76 083	1 28 00

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

-76, 083 27. 00 -76, 083 28. 00 9, 191, 470 29. 00

						Home Health	PPS	
		Sal ari es	Employee	 Transportati on	Contracted/Dur	Agency I Other Costs	Total (sum of	
		Sai ai i es	Benefits	(see	chased	Other costs	cols. 1 thru	
				instructions)	Servi ces		5)	
		1.00	2.00	3.00	4.00	5. 00	6. 00	
	GENERAL SERVICE COST CENTERS	T			ı			
1. 00	Capital Related - Bldg. &			0		0	0	1. 00
2. 00	Fixtures Capital Related - Movable			0		0	0	2. 00
2.00	Equi pment			U		U	0	2.00
3.00	Plant Operation & Maintenance	l o	0	0	0	0	0	3. 00
4.00	Transportati on	o	0	0	0	0	0	4. 00
5.00	Administrative and General	527, 253	602, 704	205, 169	0	3, 036	1, 338, 162	5. 00
	HHA REIMBURSABLE SERVICES							
6. 00	Skilled Nursing Care	673, 782	0	0	0	0	673, 782	6. 00
7.00	Physical Therapy	418, 964	0	0	0	0	418, 964	7. 00
8.00	Occupational Therapy	543, 450	0	0	0	0	543, 450	
9. 00 10. 00	Speech Pathology Medical Social Services	20, 623 33, 018	0	0	0	0	20, 623 33, 018	
11. 00	Home Heal th Aide	111, 301	0	0	0	0	111, 301	11.00
12. 00	Supplies (see instructions)	0	0	Ö	Ö	45, 935	45, 935	
13. 00	Drugs	0	0	0	0	0	0	13. 00
14.00	DME	o	0	0	0	0	0	14. 00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0	0	0	0	0	15. 00
16. 00	Respiratory Therapy	0	0	0	0	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	0	0	0	17. 00
18.00	Clinic Health Promotion Activities	0	0	0	0	0	0	18.00
19. 00 20. 00	Day Care Program	0	0	0	0	0	0	19. 00 20. 00
21. 00	Home Delivered Meals Program		0	0	0	0	0	21.00
22. 00	Homemaker Service	l ő	0	Ö	Ö	0	0	22. 00
23. 00	All Others (specify)	0	0	0	0	0	0	23. 00
24.00	Total (sum of lines 1-23)	2, 328, 391	602, 704	205, 169	0	48, 971	3, 185, 235	24. 00
		-,,	002,701	200, 107	Ŭ	40, 771	0, 100, 200	24.00
		Recl assi fi cati	Recl assi fi ed	Adjustments	Net Expenses	40, 771	0, 100, 200	24.00
			Reclassified Trial Balance		for Allocation	40, 771	3, 160, 260	24.00
		Recl assi fi cati	Reclassified Trial Balance (col. 6 +		for Allocation (col. 8 + col.	40, 771	6, 166, 256	24.00
		Reclassificati on	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	for Allocation (col. 8 + col. 9)	40, 771	0, 100, 200	24.00
	GENERAL SERVICE COST CENTERS	Recl assi fi cati	Reclassified Trial Balance (col. 6 +		for Allocation (col. 8 + col.	40, 771	5, 100, 200	24.00
1.00	Capital Related - Bldg. &	Reclassificati on	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	for Allocation (col. 8 + col. 9)	40, 7/1	3, 160, 260	1. 00
1.00	Capital Related - Bldg. & Fixtures	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	for Allocation (col. 8 + col. 9)	40, 7/1	5, 166, 266	1.00
	Capital Related - Bldg. & Fixtures Capital Related - Movable	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	for Allocation (col. 8 + col. 9)	40, 7/1	3, 160, 280	
1.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	for Allocation (col. 8 + col. 9)	40, 7/1	3, 160, 280	1.00
1. 00 2. 00 3. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	for Allocation (col. 8 + col. 9)	40, 7/1	3, 160, 280	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col.7) 8.00	9.00 0 0	for Allocation (col. 8 + col. 9) 10.00 0	40, 7/1	3, 180, 280	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	Recl assi fi cati on 7.00 0 0	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	for Allocation (col. 8 + col. 9)	40, 7/1	3, 180, 280	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General	Recl assi fi cati on 7.00 0 0	Reclassified Trial Balance (col. 6 + col.7) 8.00	9.00 0 0	for Allocation (col. 8 + col. 9) 10.00 0	40, 7/1	3, 160, 280	1. 00 2. 00 3. 00 4. 00 5. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	Recl assi fi cati on 7.00	Reclassi fied Trial Balance (col. 6 + col.7) 8.00 0 0 1,338,162 673,782 418,964	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964	40, 7/1	3, 180, 280	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy	Recl assi fi cati on 7.00	Reclassi fied Trial Balance (col. 6 + col. 7) 8.00 0 0 0 1,338,162 673,782 418,964 543,450	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450	40, 7/1	3, 160, 280	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623	40, 7/1	3,100,200	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018	40, 7/1	3, 100, 200	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301	70, 771	3, 100, 200	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935	70, 771	3, 100, 200	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col.7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	70, 771	3, 100, 200	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
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935	9.00 0 0 0 98,344 0 0 0 0 0 0 0 0 0 0 0 0 0	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935	40, 7/1	3, 100, 200	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col.7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 0 0 0 98,344 0 0 0 0 0 0 0 0 0 0 0 0 0	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	40, 7/1	3, 100, 200	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
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 0 0 0 98,344 0 0 0 0 0 0 0 0 0 0 0 0 0	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	40, 7/1	3, 180, 280	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 0 0 0 98,344 0 0 0 0 0 0 0 0 0 0 0 0 0	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	40, 7/1	3, 160, 280	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
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 0 0 0 98,344 0 0 0 0 0 0 0 0 0 0 0 0 0	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	40, 7/1	3, 160, 280	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 0 0 0 98,344 0 0 0 0 0 0 0 0 0 0 0 0 0	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	40, 7/1	3,100,200	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	40, 7/1	3, 160, 280	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	40, 7/1	3, 160, 280	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 0 0 0 98,344	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	70, 7/1	3, 100, 200	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	Recl assi fi cati on 7.00	Reclassified Trial Balance (col. 6 + col. 7) 8.00 0 0 1,338,162 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0	9.00 9.00 0 0 98,344 0 0 0 0 0 0 0 0 0 0 0 0	for Allocation (col. 8 + col. 9) 10.00 0 0 1,436,506 673,782 418,964 543,450 20,623 33,018 111,301 45,935 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	70, 7/1	3, 100, 200	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00

	Equi pment							l
3.00	Plant Operation & Maintenance	0	0	0	0		0	3. 00
4.00	Transportation	0	0	0	0	0		4. 00
5.00	Administrative and General	1, 436, 506	0	0	0	0	1, 436, 506	5. 00
	HHA REIMBURSABLE SERVICES							l
6.00	Skilled Nursing Care	673, 782	0	0	0	0	673, 782	6. 00
7.00	Physical Therapy	418, 964	0	0	0	0	418, 964	7. 00
8.00	Occupational Therapy	543, 450	o	o	0	o	543, 450	8. 00
9.00	Speech Pathology	20, 623	o	o	0	o	20, 623	9. 00
10.00	Medical Social Services	33, 018	0	0	0	0	33, 018	
11. 00	Home Heal th Aide	111, 301	o	o	Ō	0	111, 301	11. 00
12. 00	Supplies (see instructions)	45, 935	o	o	0	0	45, 935	
13. 00	Drugs	45, 755	0	0	0	o o	45, 435	13. 00
14. 00	DME		0	0	0	0	0	14.00
14.00	HHA NONREI MBURSABLE SERVI CES		U _I	<u> </u>	<u> </u>	U _I	0	14.00
15 00			٥	0		o	0	15 00
15.00	Home Dialysis Aide Services	0	0		0		0	15. 00
16. 00	Respiratory Therapy	0	0	0	0	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	0	O	0	17. 00
18. 00	CI i ni c	0	0	0	0	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0	0	0	0	19. 00
20. 00	Day Care Program	0	0	0	0	0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	0	0	0	0	21. 00
22.00	Homemaker Service	0	0	0	0	0	0	22. 00
23.00	All Others (specify)	0	0	0	0	0	0	23. 00
24.00	Total (sum of lines 1-23)	3, 283, 579	o	o	0	O	3, 283, 579	24. 00
		Admi ni strati ve	Total (cols.					
		& General	4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &							1.00
	Fixtures							l
2.00	Capital Related - Movable							2. 00
	Equi pment							l
3.00	Plant Operation & Maintenance							3. 00
4.00	Transportation							4. 00
5. 00	Administrative and General	1, 436, 506						5. 00
	HHA REIMBURSABLE SERVICES	.,,						
6.00	Skilled Nursing Care	524, 013	1, 197, 795					6. 00
7. 00	Physical Therapy	325, 837	744, 801					7. 00
8. 00	Occupational Therapy	422, 652	966, 102					8. 00
9. 00	Speech Pathology	16, 039	36, 662					9. 00
10. 00	Medical Social Services	25, 679	58, 697					10.00
	1							
11.00	Home Heal th Ai de	86, 561	197, 862					11.00
12.00	Supplies (see instructions)	35, 725	81, 660					12.00
13.00	Drugs	0	0					13.00
14. 00	DME	0	0					14. 00
45.00	HHA NONREI MBURSABLE SERVI CES							45.00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16. 00	Respi ratory Therapy	0	0					16. 00
17. 00	Private Duty Nursing	0	0					17. 00
18. 00	Clinic	0	0					18. 00
19.00	Health Promotion Activities	0	0					19. 00
20.00	Day Care Program	0	0					20.00
	Home Delivered Meals Program	0	0					21. 00
22.00	Homemaker Service	0	0					22. 00
	All Others (specify)	0	0					23. 00
24.00	Total (sum of lines 1-23)		3, 283, 579					24. 00
		'	,					

Health Financial S	Systems	HANCOCK REGIONAL H	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION -	HHA STATISTICAL BASIS		Provi der	CCN: 150037	Peri od: From 01/01/2014	Worksheet H-1
			HHA CCN:	157092		Date/Time Prepared: 5/27/2015 11:52 am
					Home Health	PPS
					Agency I	

							5/27/2015 11:	52 am_
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		Bl dgs &	Movabl e	PI ant	Transportati or	nReconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance	, ,		(ACCUM. COST)	
		(· ·	(SQUARE FEET)			,	
		1.00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures	_				_		
2.00	Capital Related - Movable		0			0		2.00
	Equipment					_		
3.00	Plant Operation & Maintenance	1 0	0	C		0		3. 00
4. 00	Transportation (see	1 0	0	Ċ)		4. 00
00	instructions)	Ĭ	, and the second		1			
5.00	Administrative and General	1 0	0	C		-1, 436, 506	1, 847, 073	5. 00
0.00	HHA REIMBURSABLE SERVICES				Ί	1, 100, 000	1,017,070	0.00
6. 00	Skilled Nursing Care	0	0	(0	673, 782	6.00
7. 00	Physical Therapy		0				418, 964	
8. 00	Occupational Therapy		0		3) 0	543, 450	
9. 00	Speech Pathology		0					
	Medical Social Services	0	0				20, 623	
10.00		0	0				33, 018	
11.00	Home Heal th Ai de	0	0	C			111, 301	
12. 00	Supplies (see instructions)	0	0	C)	0	45, 935	
13. 00	Drugs	0	0	C)	0	0	
14. 00	DME] 0	0	C) (0 0	0	14. 00
	HHA NONREIMBURSABLE SERVICES	,			1			
15.00	Home Dialysis Aide Services	0	0	C	1	0	Ŭ	
16. 00	Respiratory Therapy	0	0	C) (0	0	
17. 00	Private Duty Nursing	0	0	C)	0	0	17. 00
18. 00	Clinic	0	0	C) (0	0	18. 00
19. 00	Health Promotion Activities	0	0	C		0	0	19.00
20.00	Day Care Program	l 0	0	C		0	0	20.00
21. 00	Home Delivered Meals Program	l 0	0	C		0	0	21.00
22. 00	Homemaker Service	0	0	C		0	0	22. 00
23. 00	All Others (specify)	1 0	0	Ċ		0	0	23. 00
24. 00	Total (sum of lines 1-23)	1 0	0	Č		-1, 436, 506	1, 847, 073	
25. 00	Cost To Be Allocated (per				\mathcal{I}	1, 430, 300	1, 436, 506	
23.00	Worksheet H-1, Part I)				Ί '		1,430,300	25.00
26 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000		0. 777720	26 00
20.00	Tour cost martipiner	1 0.000000	0.000000	0.000000	η υ. υυυυυι	7	0.777720	I 20.00

Peri od: Worksheet H-2
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/27/2015 11:52 am HHA CCN: 157092

Home Health

PPS

						Agency I		
			CAPI TAL					
	Cost Center Description	HHA Trial	RELATED COSTS NEW BLDG &	EMPLOYEE	Subtotal	ADMINI STRATI VE	OPERATION OF	
	cost center bescription	Balance (1)	FLXT	BENEFITS	Subtotal	& GENERAL	PLANT	
				DEPARTMENT				
		0	1.00	4. 00	4A	5. 00	7. 00	
1.00	Administrative and General	0	0	117, 549	117, 549		0	1.00
2. 00 3. 00	Skilled Nursing Care	1, 197, 795 744, 801	0	0	1, 197, 795 744, 801	220, 575 137, 156	0	2. 00 3. 00
4. 00	Physical Therapy Occupational Therapy	966, 102	0	0	966, 102		0	4. 00
5. 00	Speech Pathology	36, 662	0	0	36, 662		0	5. 00
6.00	Medical Social Services	58, 697	0	0	58, 697		0	6. 00
7.00	Home Health Aide	197, 862	0	0	197, 862		0	7. 00
8.00	Supplies (see instructions)	81, 660	0	0	81, 660	15, 038	0	8. 00
9. 00 10. 00	Drugs DME	0	0	0	0	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	0	0	0	, and the second	0	11. 00
12. 00	Respiratory Therapy	0	0	0	Ō	0	0	12. 00
13.00	Private Duty Nursing	0	O	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0	0	0	0	15. 00 16. 00
17. 00	Home Delivered Meals Program		0	0	0	0	0	17. 00
18. 00	Homemaker Service	Ö	O	Ö	Ö	Ö	0	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	3, 283, 579	0	117, 549		· ·	0	20.00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum				0. 000000			21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.	HOUGEVEENING	DI STADY	0.1557501.4	NUIDOL NO	OFNITD AL	BUA BUA OV	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSING ADMINISTRATION	CENTRAL SERVI CES &	PHARMACY	
					7.0	SUPPLY		
		9. 00	10.00	11. 00	13. 00	14. 00		
1. 00	Administrative and General						15. 00	
	Children Normalina Cara	58, 952	0	134, 931	196, 777	72	0	1. 00
2.00	Skilled Nursing Care	58, 952	0	134, 931 0	0	72 0	0	2. 00
3.00	Physi cal Therapy	1		134, 931 0 0 0		72 0	0 0 0	2. 00 3. 00
		1	0 0	134, 931 0 0 0 0	0	72 0	0	2. 00
3. 00 4. 00 5. 00 6. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	1	0 0 0 0	134, 931 0 0 0 0 0 0	0	72 0	0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
3. 00 4. 00 5. 00 6. 00 7. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	1	0 0 0 0 0	134, 931 0 0 0 0 0 0	0 0 0 0 0	72 0 0 0 0 0 0	0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	1	0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0	0 0 0 0 0 0	72 0 0 0 0 0 0	0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	1	0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0	0 0 0 0 0	72 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	1	0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0 0	0 0 0 0 0 0	72 0 0 0 0 0 0 0 0	0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	1	0 0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	72 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	1	0 0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	72 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	1	0 0 0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	72 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 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	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	1	0 0 0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	72 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 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	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	1	0 0 0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	72 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	1	0 0 0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	72 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	72 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	1	0 0 0 0 0 0 0 0 0	134, 931 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	72 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 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 17.00 18.00 19.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	72 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	72 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	72 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

						Home Health Agency I	PPS	<u> </u>
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16. 00	23. 00	24. 00	25. 00	26. 00	27. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	332 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	530, 260 1, 418, 370 881, 957 1, 144, 011 43, 413 69, 506 234, 298 96, 698 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		530, 260 1, 418, 370 881, 957 1, 144, 011 43, 413 69, 506 234, 298 96, 698 0 0 0 0 0 0 0 0 4, 418, 513	193, 430 120, 277 156, 015 5, 920 9, 479 31, 952 13, 187 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 17. 00 19. 00 20. 00 21. 00
	6 decimal places. Cost Center Description	Total HHA Costs						
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	28. 00 1, 611, 800 1, 002, 234 1, 300, 026 49, 333 78, 985 266, 250 109, 885 0 0 0 0 0 0 0 4, 418, 513						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	HANCOCK REGIONAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COST BASIS	O HHA COST CENTERS STATISTICAL	Provi der CCN: 150037 HHA CCN: 157092	Peri od: From 01/01/2014 To 12/31/2014	Worksheet H-2 Part II Date/Time Prepared: 5/27/2015 11:52 am

Home Health Agency I CAPI TAL RELATED COSTS Reconciliation ADMINISTRATIVE **EMPLOYEE** OPERATION OF HOUSEKEEPI NG Cost Center Description NEW BLDG & & GENERAL **PLANT** FIXT **BENEFITS** (HOURS OF (SQUARE DEPARTMENT (ACCUM. (SQUARE SERVICE) FEET) (GROSS COST) FEET) SALARI ES) 1.00 5A 5.00 7. 00 9.00 4.00 117, 549 0 796, 304 1.00 Administrative and General C 12, 210 1.00 0 0 0 0 0 0 0 0 0 0 0 2.00 Skilled Nursing Care 1, 197, 795 2.00 3.00 Physical Therapy 0 744, 801 3.00 0 0 0 000000000000000 Occupational Therapy 966, 102 4.00 0 4.00 0 01 5.00 Speech Pathology 36, 662 5.00 6.00 Medical Social Services 0 58, 697 6.00 7.00 Home Health Aide 0 0 0 197, 862 7.00 8.00 0 8.00 Supplies (see instructions) 81, 660 9.00 Drugs 0 0 9.00 10.00 DMF 10.00 0 0 11.00 Home Dialysis Aide Services 000 11.00 0 0 12.00 Respiratory Therapy 12.00 0 13.00 Private Duty Nursing 13.00 0 0 14.00 Clinic 0 0 0 0 0 0 0 0 14.00 Health Promotion Activities 15.00 0 0 15.00 0 16.00 Day Care Program 16.00 0 17.00 Home Delivered Meals Program 0 0 17.00 0 0 Homemaker Service 18.00 18.00 0 All Others (specify) 0 19.00 19.00 0 20.00 Total (sum of lines 1-19) 796, 304 3, 401, 128 0 12, 210 20.00 Total cost to be allocated 117, 549 58, 952 21.00 626, 321 21.00 22.00 Unit cost multiplier 0.000000 0.147618 0.184151 0.000000 4. 828174 22.00 DI ETARY CENTRAL PHARMACY MEDI CAL NURSI NG Cost Center Description CAFETERI A (PATI ENT (MANHOURS) ADMI NI STRATI ON SERVICES & (COSTED RECORDS & DAYS) **SUPPLY** REQUIS.) LI BRARY (MANHOURS) (COSTED (TIME REQUIS.) SPENT) 10. 00 11 00 13.00 15. 00 16.00 14 00 1.00 Administrative and General 57,085 57, 085 1,785 1.00 0 2.00 Skilled Nursing Care 0 0 2.00 3.00 Physical Therapy 0 0 0 0 3.00 0000000000000000 0 0 4 00 Occupational Therapy 4 00 5.00 Speech Pathology 0 5.00 6.00 Medical Social Services 6.00 0 7.00 Home Heal th Aide 0 0 O 7.00 0 8.00 Supplies (see instructions) 0 8.00 9.00 9.00 Drugs 0 10.00 DME 0 0 0 0 10.00 0 Home Dialysis Aide Services 0 11 00 11 00 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 0 13.00 0 0 14.00 Clinic 0 14.00 0 15.00 Health Promotion Activities 0 15.00 0 16.00 Day Care Program 0 16.00 Home Delivered Meals Program 17.00 17.00 0 0 0 0 18.00 18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 19.00 20.00 Total (sum of lines 1-19) 0 57,085 57, 085 1, 785 0 20.00 21.00 Total cost to be allocated 0 134, 931 196, 777 72 0 332 21.00 Unit cost multiplier 0.000000 2. 363686 3.447088 0.040336 0.000000 332.000000 22.00 22.00

Heal th	Financial Systems		HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CENT	TERS STATISTICAL	Provi der CO	CN: 150037	Peri od: From 01/01/2014	Worksheet H-2 Part II	
BASIS				HHA CCN:	157092	To 12/31/2014	Date/Time Pre	
							5/27/2015 11:	52 am
						Home Health	PPS	
		D.D.U.ED ED				Agency I		
	Cost Center Description	PARAMED ED PRGM						
		(ASSI GNED						
		TIME)						
		23. 00						1
1. 00	Administrative and General	0						1.00
2.00	Skilled Nursing Care	o						2.00
3.00	Physi cal Therapy	o						3. 00
4.00	Occupational Therapy	0						4. 00
5.00	Speech Pathology	0						5. 00
6.00	Medical Social Services	0						6. 00
7.00	Home Health Aide	0						7. 00
8.00	Supplies (see instructions)	0						8. 00
9.00	Drugs	0						9. 00
10.00	DME	0						10.00
11. 00	Home Dialysis Aide Services	0						11. 00
12. 00	Respi ratory Therapy	0						12. 00
13.00	Private Duty Nursing	0						13. 00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17. 00	Home Delivered Meals Program	0						17. 00
18.00	Homemaker Service	0						18. 00 19. 00
19. 00 20. 00	All Others (specify) Total (sum of lines 1-19)	0						20.00
21. 00	Total (Sum of Times 1-19)							21. 00
21.00	Unit cost multiplier	0. 000000						22.00
22.00	Join C Cost multiplier	0.000000						1 22.00

Heal th	Financial Systems		HANCOCK REGION	IAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	TS .			CCN: 150037	Peri od: From 01/01/2014		
				HHA CCN:	157092	To 12/31/2014	Date/Time Prep 5/27/2015 11:5	
					e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst.	Ancillary Costs (from	Costs (cols. + 2)	1	Per Visit (col. 3 ÷ col.	
		COI. 20, 1111e	п-2, Pait I)	Part II)	+ 2)		4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM LIN	MITATION COST, O	?	
1. 00	Cost Per Visit Computation Skilled Nursing Care	2. 00	1, 611, 800		1, 611, 80	00 6, 922	232. 85	1. 00
2. 00	Physical Therapy	3.00		(1	· ·	l .	2.00
3.00	Occupational Therapy	4. 00		(1	· ·		
4.00	Speech Pathology	5. 00		Ć				4.00
5. 00	Medical Social Services	6. 00	78, 985		78, 98	35 156	506. 31	5. 00
6. 00	Home Health Aide	7. 00	266, 250		266, 25		113. 25	6. 00
7. 00	Total (sum of lines 1-6)		4, 308, 628	(.,			7. 00
			1		Program Visi			
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	art B to Subject to		
	cost center bescription	COST LIMITS	CBSA NO. (1)	rait A	Deducti bl es Coi nsurance	& Deductibles		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation	1	lagar I					
8.00	Skilled Nursing Care		99915	(93		8.00
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care		26900 11300	(1	55		8. 01 8. 02
8. 03	Skilled Nursing Care		34620	(0		8.03
8. 04	Skilled Nursing Care		29020	(36		8. 04
9. 00	Physical Therapy		99915	(72		9. 00
9. 01	Physi cal Therapy		26900	(2, 7	78		9. 01
9. 02	Physi cal Therapy		11300	(18	39		9. 02
9. 03	Physi cal Therapy		34620	(0		9. 03
9. 04	Physi cal Therapy		29020	(50		9. 04
10. 00	Occupational Therapy		99915	(20		10.00
10. 01	Occupational Therapy		26900	(10. 01
10. 02	Occupational Therapy		11300	(87		10. 02
10. 03 10. 04	Occupational Therapy		34620 29020	(0 2		10. 03 10. 04
11. 00	Occupational Therapy Speech Pathology		99915	(11		11.00
11. 00	Speech Pathology		26900	(1	33		11. 00
11. 02	Speech Pathology		11300	(6		11. 02
11. 03	Speech Pathology	1	34620	(0		11. 03
11. 04	Speech Pathology		29020	(0		11. 04
12. 00	Medical Social Services		99915	(15		12.00
12. 01	Medical Social Services		26900	()	87		12. 01
	Medical Social Services	1	11300	(P	1		12. 02
12. 03	Medical Social Services		34620	(0		12. 03
12. 04	Medical Social Services	1	29020	(]	0		12. 04
13.00	Home Health Aide		99915	(1	01		13.00
13. 01 13. 02	Home Health Aide Home Health Aide		26900 11300	(1, 0	41		13. 01 13. 02
13. 02	Home Health Aide	1	34620	(íl '	0		13. 02
13. 03	Home Heal th Aide		29020	(ól	0		13. 03
14. 00				(64		14. 00
	Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HHA	Total Charges	Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)		÷ col. 4)	
			<u> </u>	Dont III				
			1 00	Part II) 2 00	3 00	4 00	5 00	
	Supplies and Drugs Cost Comput	0	1.00	Part II) 2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs	0	109, 885		109, 88		0. 000000	

	FIONMENT OF PATIENT SERVICE COSTS			Provi der	CCN: 150037	Peri od:	Worksheet H-3	3
11 010	TOWNENT OF PATTERN SERVICE GOSTE	,		HHA CCN:	157092	From 01/01/2014 To 12/31/2014	Part I	parec
				Ti tl	e XVIII	Home Health	PPS	02 (
			Program Visits		Cost of	Agency I		
					Servi ces			
	Cost Center Description	Part A	Not Subject to	t B	Part A	Part B Not Subject to	Subject to	
	cost center bescription	rait A		Deductibles &		Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	DADT I COMPUTATION OF LECCED	6. 00	7. 00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER (BENEFICIARY COST LIMITATION	JF AGGREGATE I	PRUGRAM CUSI, A	IGGREGATE OF TH	IE PROGRAM LII	WITATION COST, O	К	
	Cost Per Visit Computation							1
00	Skilled Nursing Care	0	.,			0 1, 002, 419	1	1.
00	Physical Therapy	0	3, 689			0 611, 526	l .	2.
00	Occupational Therapy Speech Pathology	0	1, 698 150			0 825, 211 0 25, 517	1	3.
00	Medical Social Services	0	103	l e		0 52, 150	1	5.
00	Home Health Aide	0	1, 319			0 149, 377	1	6.
00	Total (sum of lines 1-6)	0	11, 264			0 2, 666, 200)	7.
	Cost Center Description	6. 00	7 00	8. 00	9.00	10.00	11 00	-
	Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03 04	Skilled Nursing Care Skilled Nursing Care							8. 8.
00	Physical Therapy							9.
01	Physical Therapy							9.
02	Physical Therapy							9.
03	Physical Therapy							9.
04	Physical Therapy Occupational Therapy							9. 10.
0. 01	Occupational Therapy							10.
0. 02	Occupational Therapy							10.
0. 03	Occupational Therapy							10.
0. 04	Occupational Therapy							10.
1. 00 1. 01	Speech Pathology Speech Pathology							11.
1. 02								11.
1. 03	Speech Pathology							11.
1. 04	1							11.
2. 00	Medical Social Services							12.
2. 01 2. 02	Medical Social Services Medical Social Services							12. 12.
2. 03	Medical Social Services							12.
2. 04	Medical Social Services							12.
3. 00	Home Health Aide							13.
3. 01	Home Heal th Ai de							13.
3. 02 3. 03	Home Health Aide Home Health Aide							13. 13.
3. 04	Home Health Aide							13.
4. 00								14.
		Prog	ram Covered Cha	arges	Cost of			
					Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to		
				Deductibles &		Deductibles &		
		6. 00	Coi nsurance 7.00	Coi nsurance 8. 00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	Supplies and Drugs Cost Computa		7.00	0.00	7.00	10.00	11.00	
								-

i i Oit i	IONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150037	Peri od:	Worksheet H-3
				HHA CCN:	157092	From 01/01/2014 To 12/31/2014	Part Date/Time Prepar 5/27/2015 11:52
				Title	e XVIII	Home Health Agency I	PPS
	Cost Center Description	Total Program	· · · · · · · · · · · · · · · · · · ·			Agency 1	
	•	Cost (sum of					
		cols. 9-10)					
		12. 00					
	PART I - COMPUTATION OF LESSER	OF AGGREGATE P	ROGRAM COST, AGGRE	GATE OF THE	E PROGRAM LI	MITATION COST, OR	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation						
00	Skilled Nursing Care	1, 002, 419					
00	Physical Therapy	611, 526					
00	Occupati onal Therapy	825, 211					
00	Speech Pathology	25, 517					
00	Medical Social Services	52, 150					
00	Home Health Aide	149, 377					
00	Total (sum of lines 1-6)	2, 666, 200					
	Cost Center Description						
		12. 00					
00	Limitation Cost Computation	I					
00 01	Skilled Nursing Care Skilled Nursing Care						
02	Skilled Nursing Care						
03	Skilled Nursing Care						
04	Skilled Nursing Care						
00	Physical Therapy						
01	Physical Therapy						
02	Physi cal Therapy						
03	Physi cal Therapy						
04	Physical Therapy						
. 00	Occupational Therapy						1
. 01	Occupational Therapy						1
. 02	Occupational Therapy						1
. 03	Occupational Therapy						1
. 04	Occupational Therapy Speech Pathology						1
. 00	Speech Pathology						
. 02	Speech Pathology						'1
. 03	Speech Pathology						1
. 04	Speech Pathology						1
. 00	Medical Social Services						1
. 01	Medical Social Services						1
. 02	Medical Social Services						1
. 03	Medical Social Services						1
. 04	Medical Social Services						1
3. 00	Home Health Aide						1
. 01	Home Health Aide						1
. 02	Home Health Aide						1
	Home Health Aide	1					1
3. 03 3. 04	Home Health Aide						1 1

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-255							2552-10			
APPORTIONMENT OF PATIENT SERVICE COSTS					Provi der	CCN: 150037		i od:	Worksheet H-3	
					HHA CCN:	157092		om 01/01/2014 12/31/2014		
					Ti tl	e XVIII	ŀ	Home Health	PPS	
								Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Tot	al HHA	HHA Shared		Transfer to		
		Part I, col.	Ratio	Char	ge (from	Ancillary		Part I as		
		9, line		pr	ovi der	Costs (col.	1	Indi cated		
				re	cords)	x col. 2)				
		0	1.00		2. 00	3. 00		4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHA	RED HOSPI	TAL DEPARTMEN	NTS			
1.00	Physi cal Therapy	66. 00	0. 456691		0		0 c	ol. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67. 00	0. 347980		0		0 c	ol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68. 00	0. 503278		0		0 c	ol. 2, line 4	. 00	3.00
3.01	Speech Pathology 1	68. 01	0. 000000		0		0 c	ol. 2, line 4	. 01	3. 01
4.00	Cost of Medical Supplies	71. 00	0. 718295		0		0 c	ol. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73. 00	0. 230744		0		0 c	ol. 2, line 1	6. 00	5. 00

th Financial Systems HANCOCK REGIONAL CULATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 150037	Peri od:	u of Form CMS-2 Worksheet H-4	
	HHA CCN:	157092	From 01/01/2014 To 12/31/2014	Part I-II Date/Time Pre 5/27/2015 11:	
	Ti tl	e XVIII	Home Health Agency I	PPS	
		Part A	Not Subject to Deductibles & Coinsurance		
		1.00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	MARY CHARGE	S			
Reasonable Cost of Part A & Part B Services					
Reasonable cost of services (see instructions) Total charges			0 0	0	
Customary Charges			0 0	U	1
Amount actually collected from patients liable for payment for on a charge basis (from your records)	servi ces		0 0	0	
Amount that would have been realized from patients liable for processing for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0 0	0	
Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	
Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (complete		0 0	0	
only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	yifline		0 0	0	
Primary payer amounts			0 1, 233	0	
The state of the s			Part A	Part B	\top
			Servi ces 1.00	Servi ces 2. 00	+
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	+
Total reasonable cost (see instructions)			0	-1, 233	1
Total PPS Reimbursement - Full Episodes without Outliers			0	1, 949, 560	
10 Total PPS Reimbursement - Full Episodes with Outliers			0	6, 406	
10 Total PPS Reimbursement - LUPA Episodes			0	20, 231	
70 Total PPS Reimbursement - PEP Episodes			0	20, 427	
10 Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	853	
10 Total PPS Outlier Reimbursement - PEP Episodes 10 Total Other Payments			0	207 0	
DME Payments			0	0	
0 Oxygen Payments			0	0	
0 Prosthetic and Orthotic Payments			0	0	
Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	
O Subtotal (sum of lines 10 thru 20 minus line 21)	•		0	1, 996, 451	2
00 Excess reasonable cost (from line 8)			0	0	
O Subtotal (line 22 minus line 23)			0	1, 996, 451	2
O Coinsurance billed to program patients (from your records)				0) 2
Net cost (line 24 minus line 25)			0	1, 996, 451	
O Reimbursable bad debts (from your records)					2
Reimbursable bad debts for dual eligible beneficiaries (see ins			_	1 00/ 454	2
Total costs - current cost reporting period (line 26 plus line	21)		0		
O OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	0	
O Pioneer ACO demonstration payment adjustment (see instructions))		0	0 1, 996, 451	
Subtotal (see instructions)			0		
Sequestration adjustment (see instructions)			0	39, 929 1 956 522	
			1	1, 956, 522	
O Interim payments (see instructions)			^		
Tentative settlement (for contractor use only)	nd 33)		0	0	
, , , , , , , , , , , , , , , , , , , ,	,	Pub. 15-2	0 0	0) 3

Health Financial Systems HANCOCK REGIONAL HOSPITAL ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO Provide In Lieu of Form CMS-2552-10 Peri od: From 01/01/2014 To 12/31/2014 Date/Ti me Prepared: 5/27/2015 11:52 am PPS Provi der CCN: 150037

PROGRAM BENEFICIARIES

HHA CCN: 157092

				Home Health Agency I	PPS	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	1, 956, 522 0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	11 ogi alli to 11 ovi dei			0	0	3. 01
3. 02				Ö		3. 02
3.03				o	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program			-T	1	
3. 50 3. 51				0	0	3. 50 3. 51
3. 52				0		3. 52
3. 53				0	0	3. 53
3. 54				Ö	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	1, 956, 522	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider			_	_	
5. 01				0	0	5. 01
5. 02 5. 03				0		5. 02 5. 03
5.05	Provider to Program			<u> </u>	0	3.03
5.50	Troving to Trogram			0	0	5. 50
5. 51				o	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6.02	SETTLEMENT TO PROGRAM			o	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	1, 956, 522	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	Name of Contractor	()	1. 00	2. 00	0.00
8. 00	Name of Contractor	I		1	1 1	8. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 15003	
		From 01/01/2014
	Local co CCN, 1E1E	17 To 12/21/2014 Data/Time Drapared

			Hospi ce (CCN: 151547 T	o 12/31/2014	Date/Time Pre 5/27/2015 11:	
					Hospi ce I	072772010 11.	02 am
		Salaries (from	Employee	Transportation		Other	
			Benefits (from		Services (from		
		'	Wkst. K-2)	(Wkst. K-3)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1. 00
2.00	Capital Related Costs-Movable Equip.			0		0	2. 00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3. 00
4.00	Transportation - Staff	0	0	0	0	0	4. 00
5.00	Volunteer Service Coordination	0	0	0	0	0	5. 00
6.00	Administrative and General	158, 190	0	0	0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7. 00
8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	194, 230	0	0	0	0	9. 00
10.00	Nursing Care	514, 647	0	0	0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0	0	0	0	11. 00
12.00	Physi cal Therapy	0	0	0	0	0	12. 00
13.00	Occupational Therapy	0	0	0	0	0	13. 00
14.00	Speech/ Language Pathology	0	0	0	0	0	14. 00
15. 00	Medical Social Services	68, 637	0	0	0	0	15. 00
16. 00	Spiritual Counseling	0	0	0	0	0	16. 00
17. 00	Dietary Counseling	0	0	0	0	0	17. 00
18. 00	Counseling - Other	0	0	0	0	0	18. 00
19. 00	Home Health Aide and Homemaker	103, 097	0	0	0	0	19. 00
	HH Aide & Homemaker - Cont. Home Care	0	0	1	0	0	
21. 00		0	0	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
	Drugs, Biological and Infusion Therapy	0	0		0	0	
	Anal gesi cs	0	0	1	0	0	
	Sedatives / Hypnotics	0	0	1	0	0	
25. 00		0	0	1	0	0	20.00
26. 00	Durable Medical Equipment/Oxygen	0	0	1	0	0	
27. 00	Pati ent Transportati on	0	0	1	0	0	
28. 00	I maging Services	0	0	1	0	0	
29. 00	Labs and Diagnostics	0	0	1	0	0	
30.00	Medical Supplies	0	0	0	0	0	
31. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	000
32. 00	Radiation Therapy	0	0	1	0	0	
33. 00	Chemotherapy	0	0	1	0	0	33. 00
34. 00	Other	0	0	0	0	1, 140, 921	34. 00
	HOSPI CE NONREI MBURSABLE SERVI CE	1		1			ļ
	Bereavement Program Costs	0	0	1	0	0	35. 00
36. 00	Volunteer Program Costs	0	0	0	0	0	36. 00
37. 00	Fundrai si ng	0	0	0	0	0	37. 00
38. 00	Other Program Costs	0	0	0	0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	1, 038, 801	0	0	0	1, 140, 921	39.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150037	Period: Worksheet K From 01/01/2014			
	Hospi ce CCN: 151547	To 12/31/2014 Date/Time Prepared:			

			Hospi ce	CCN:	151547 T	o 12/31/2014		
						Hospi ce I	5/27/2015 11:	52 am_
		Total (cols.	Reclassi fi ca	ti Sub	total (col	Adjustments	Total (col. 8	
		1-5)	on		± col . 7)	Auj us tillerits	± col. 9)	
		6.00	7.00		8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00		0.00	7. 00	10.00	
1.00	Capital Related Costs-Bldg and Fixt.			O	C	0	0	1.00
2.00	Capital Related Costs-Movable Equip.			ol	C	0	0	2. 00
3.00	Plant Operation and Maintenance			o	C	0	0	3.00
4.00	Transportation - Staff			o	C	0	0	4. 00
5.00	Volunteer Service Coordination			o	C	0	0	5. 00
6.00	Administrative and General	158, 190		0	158, 190	0	158, 190	6. 00
	I NPATI ENT CARE SERVI CE							
7.00	Inpatient - General Care		1	0	C	0	0	7. 00
8.00	Inpatient - Respite Care			0		0	0	8. 00
	VISITING SERVICES							
9. 00	Physi ci an Servi ces	194, 230	l .	0	194, 230		,	9. 00
10. 00	Nursing Care	514, 647	7	0	514, 647	0	514, 647	10. 00
11. 00	Nursing Care-Continuous Home Care			0	C	0	0	11. 00
12. 00	Physical Therapy			o	C	0	0	12. 00
	Occupational Therapy)	0	(0	0	13. 00
	Speech/ Language Pathol ogy	()	2	0	(0	0	14.00
	Medical Social Services	68, 637		0	68, 637	0	68, 637	15. 00
	Spiritual Counseling			0	(0	0	16.00
	Dietary Counseling			0	(0	0	17.00
18.00	Counseling - Other	102.00)	0	102.00	0	102 007	18.00
19. 00 20. 00	Home Health Aide and Homemaker HH Aide & Homemaker - Cont. Home Care	103, 097	ı		103, 097		103, 097	19.00
21. 00	Other		1	0	(0	0	20. 00 21. 00
21.00	OTHER HOSPICE SERVICE COSTS		<u>′</u>	<u> </u>) 0	0	21.00
22 00	Drugs, Biological and Infusion Therapy		7	0	(0	0	22. 00
23. 00	Anal gesi cs		1	0	(_	_	23. 00
24. 00	Sedatives / Hypnotics		á	ol	(o o	24.00
25. 00	Other - Specify			ol	Č	0	ő	25. 00
26. 00	Durable Medical Equipment/Oxygen			o	(0	Ō	26. 00
27. 00	Pati ent Transportation			ol	Ċ	Ö	ō	27. 00
28. 00	Imaging Services			ol	C	0	0	28. 00
29. 00	Labs and Diagnostics			0	C	0	0	29. 00
30.00	Medical Supplies			0	C	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)			o	C	0	0	31. 00
32.00	Radi ati on Therapy			o	C	0	0	32. 00
33.00	Chemotherapy			o	C	0	0	33. 00
34.00	Other	1, 140, 921		0	1, 140, 921	-44, 840	1, 096, 081	34.00
	HOSPICE NONREIMBURSABLE SERVICE							
35. 00	Bereavement Program Costs	(0		0	0	35. 00
36. 00	Volunteer Program Costs			0	C	0	0	36. 00
37. 00	Fundrai si ng			0	C	0	0	37. 00
38. 00	Other Program Costs	(0		0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	2, 179, 722	2	0	2, 179, 722	-44, 840	2, 134, 882	39.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Provi der CCN: 150037	Period: Worksheet K-1 From 01/01/2014

Hospi ce CCN: 151547 To 12/31/2014 Date/Time Prepared:

			nospi ce (JON. 151547	10 12/31/2014	5/27/2015 11:	
					Hospi ce I		
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance	0	0		0	0	3. 00
4.00	Transportation - Staff	0	0)	0 0	0	4. 00
5.00	Volunteer Service Coordination	0	0)	0	0	5. 00
6.00	Administrative and General	158, 190	0		0 0	0	6. 00
	I NPATI ENT CARE SERVI CE						
7. 00	Inpatient - General Care	0	0	1	0		
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	194, 230	0	1	0		
10. 00	Nursing Care	0	0	1	0		10. 00
11. 00	Nursing Care-Continuous Home Care	0	0	1	0	-	11. 00
12. 00	Physi cal Therapy	0	0	1	0	0	12. 00
13. 00	Occupational Therapy	0	0	1	0	0	13. 00
14. 00	Speech/ Language Pathology	0	0	١	0	0	14. 00
15. 00	Medical Social Services	0	0	68, 63		0	15. 00
16. 00	Spiritual Counseling	0	0	1	0	0	16. 00
17. 00	Di etary Counseling	0	0	1	0	0	
18. 00	Counseling - Other	0	Ü		0	0	18.00
19. 00	Home Health Aide and Homemaker	0	Ü		0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	1	0 0	-	20.00
21. 00	Other OTHER HOSPICE SERVICE COSTS	l o		1	0 0	U	21. 00
22. 00	Drugs, Biological and Infusion Therapy			I			22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26.00
27. 00	Patient Transportation		0		0	0	
28. 00	I maging Services		0		0 0	0	
29. 00	Labs and Diagnostics		0		0 0	0	
30.00	Medical Supplies		0		0 0	ő	
31. 00	Outpatient Services (including E/R Dept.)		0		0 0	ő	
32. 00	Radi ati on Therapy		0	,	0 0	Ō	
33. 00	Chemotherapy	0	0		0 0		33. 00
34. 00	Other	l ol	0	,	0 0	Ō	
	HOSPICE NONREIMBURSABLE SERVICE	· · · · · · · · · · · · · · · · · · ·		•			
35.00	Bereavement Program Costs	0	C		0 0	0	35. 00
36.00	Volunteer Program Costs	0	0		0 0	0	36. 00
37.00	Fundrai si ng		0		0 0	0	37. 00
38. 00	Other Program Costs		0		0 0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	352, 420	0	68, 63	7 0	514, 647	39. 00

Health Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der CCN: 15	50037 Period: From 01/0		Worksheet K-1	
		Hospi ce CCN: 1		31/2014		
			Hospi o			

						5/27/2015 11:52 am	
					Hospi ce I		
		Total	Ai des	All-Other	Total (1)		
		Therapi sts					
		6. 00	7.00	8. 00	9. 00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00	
2.00	Capital Related Costs-Movable Equip.					2. 00	
3.00	Plant Operation and Maintenance		0		0		
4.00	Transportation - Staff		0		0	4.00	
5.00	Volunteer Service Coordination		0		0	5. 00	
6.00	Administrative and General		0		0 158, 190	6. 00	
	I NPATI ENT CARE SERVI CE						
7. 00	Inpatient - General Care		0		0		
8.00	Inpatient - Respite Care		0		0 0	8. 00	
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces		0		0 194, 230		
10. 00	Nursing Care		0		0 514, 647	10. 00	
11. 00	Nursing Care-Continuous Home Care	_	0		0 0	11. 00	
12. 00	Physi cal Therapy	0	0		0 0	12. 00	
13.00	Occupational Therapy	0	0		0	13.00	
14.00	Speech/ Language Pathology	0	0		0 0	14.00	
15. 00	Medical Social Services		0		0 68, 637	15. 00	
16.00	Spiritual Counseling		0		0 0	16.00	
17. 00	Di etary Counsel i ng		0		0 0	17. 00	
18.00	Counseling - Other		0		0 0	18.00	
19. 00	Home Health Aide and Homemaker		103, 097		0 103, 097	19.00	
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0		
21. 00	Other OTHER HOSPICE SERVICE COSTS		0		0 0	21. 00	
22.00						22.00	
22. 00 23. 00	Drugs, Biological and Infusion Therapy Analgesics					22. 00 23. 00	
24. 00	Sedatives / Hypnotics					24.00	
25. 00	Other - Specify					25. 00	
26. 00	Durable Medical Equipment/Oxygen					26.00	
27. 00	Patient Transportation		0		0		
28. 00	Imaging Services		0		0 0	28.00	
29. 00	Labs and Diagnostics		0		0 0	29.00	
30.00	Medical Supplies		0		0 0	30.00	
31. 00	Outpatient Services (including E/R Dept.)		0		0 0		
32. 00	Radi ati on Therapy		0		0 0		
33. 00	Chemotherapy		0		0 0		
34. 00	Other		0		0 0		
34.00	HOSPI CE NONREI MBURSABLE SERVI CE		<u> </u>		0	34.00	
35. 00	Bereavement Program Costs		0		0 0	35. 00	
36. 00	Volunteer Program Costs		n		0 0		
37. 00	Fundrai si ng		n		0 0		
38. 00	Other Program Costs		n		0 0	38.00	
	Total (sum of lines 1 thru 38)	0	103, 097		0 1, 038, 801		
200	1 (22 2	۱ ۹		ı	., ., ., ., ., .,	1 57.00	

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150037
 Peri od: From 01/01/2014
 Worksheet K-4 Part I

 Hospice CCN: 151547
 To 12/31/2014
 Date/Time Prepared: 5/27/2015 11: 52 am

			·			5/27/2015 11:	52 am_
					Hospi ce I		
			CAPITAL RE	LATED COST			
		NET EXPENSES	BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON	1.00	0.00	MAI NT.	4.00	
	CENEDAL CEDIU CE COCT CENTEDO	0	1. 00	2. 00	3. 00	4. 00	
1 00	GENERAL SERVICE COST CENTERS		0				1 00
1.00	Capital Related Costs-Bldg and Fixt.	0	Ü	0			1. 00 2. 00
2.00	Capital Related Costs-Movable Equip.	0	0				
3. 00 4. 00	Plant Operation and Maintenance	0	0				3. 00 4. 00
	Transportation - Staff	0	0				
5.00	Volunteer Service Coordination	150 100	0			1	
6. 00	Administrative and General INPATIENT CARE SERVICE	158, 190	0	C	C)l O	6. 00
7. 00	Inpatient - General Care	O	0			0	7. 00
8. 00	'		0				8. 00
6.00	Inpatient - Respite Care VISITING SERVICES	l d	0)	0.00
9. 00	Physi ci an Servi ces	194, 230	0			0	9. 00
	Nursing Care	514, 647	0			1	10.00
11. 00	Nursing Care-Continuous Home Care	314,047	0		_		11.00
12. 00	Physical Therapy		0	· ·			12.00
13. 00	Occupational Therapy		0				13. 00
14. 00	Speech/ Language Pathology		0				14. 00
	Medical Social Services	68, 637	0				15. 00
	Spiritual Counseling	00,037	0				16. 00
	Di etary Counsel i ng		0				17. 00
18. 00	Counseling - Other		0				18.00
19. 00	Home Health Aide and Homemaker	103, 097	0	1			19.00
20. 00	HH Aide & Homemaker - Cont. Home Care	103, 077	0	l ~		1	20.00
21. 00	Other	0	0	1	_	1	21. 00
21.00	OTHER HOSPICE SERVICE COSTS	٩				,, ,	21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0	C	C	0	22. 00
	Anal gesi cs	0	0			1	23. 00
	Sedatives / Hypnotics	0	0	i o		ol o	24. 00
		0	0	i o		o o	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		C	o o	26. 00
27. 00	Patient Transportation	0	0		C	o o	27. 00
28. 00	Imaging Services	0	0	C	C	0	28. 00
	Labs and Diagnostics	0	0	l c	C	0	29. 00
	Medical Supplies	0	0	l c	C	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	l c	C	0	31.00
32.00	Radiation Therapy	0	0	l c	C	0	32. 00
33.00	Chemotherapy	0	0	l c	C	0	33. 00
34.00	Other	1, 096, 081	0	l c	C	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE						
35.00	Bereavement Program Costs	0	0	C	C	0	35. 00
36.00	Volunteer Program Costs	0	0	C	C	0	36. 00
37.00	Fundrai si ng	0	0	C	C	0	37. 00
38.00	Other Program Costs	0	0	C	C	0	38. 00
39.00	Total (sum of lines 1 thru 38)	2, 134, 882	0	C	C	0	39. 00
		•					

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPICE GENERAL SERVICE COST	Provi der CCN: 150037	Period: Worksheet K-4 From 01/01/2014 Part I
		To 12/31/2014 Date/Time Prepared:

			Hospi ce	CCN: 151547	To 12/31/2014	
					Hospi ce I	5/27/2015 11:52 am
		VOLUNTEER	SUBTOTAL	ADMINI STRATI VE	TOTAL (col. 5A	
		SERVI CES COORDI NATOR	(col s. 0 - 5)	& GENERAL	± col. 6)	
		5. 00	5A	6.00	7. 00	
	GENERAL SERVICE COST CENTERS				<u>'</u>	
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4. 00
5.00	Volunteer Service Coordination	0				5. 00
6.00	Administrative and General	0	158, 190	158, 190		6. 00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	() (0	7. 00
8.00	Inpatient - Respite Care	0	(ol ol	8. 00
	VISITING SERVICES					
9.00	Physi ci an Servi ces	0	194, 230	15, 544	209, 774	9. 00
10.00	Nursi ng Care	0	514, 647	41, 186	555, 833	10.00
11. 00	Nursing Care-Continuous Home Care	0	(0	11. 00
12.00	Physi cal Therapy	0	(0	12. 00
13.00	Occupational Therapy	0	(0	13. 00
14.00	Speech/ Language Pathology	0	() (0	14. 00
15. 00	Medical Social Services	0	68, 637	5, 493	74, 130	15. 00
16.00	Spiritual Counseling	0	() (0	16. 00
17. 00	Di etary Counseling	0	() (0	17. 00
18. 00	Counseling - Other	0	() (0	18. 00
19. 00	Home Health Aide and Homemaker	0	103, 097	8, 251	111, 348	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	() (0	20. 00
21. 00	Other	0	() (0	21. 00
	OTHER HOSPICE SERVICE COSTS	_				
	Drugs, Biological and Infusion Therapy	0				22. 00
23. 00	Anal gesi cs	0	() (0	23. 00
24. 00	J 1	0	() (0	24. 00
25. 00	Other - Specify	0	() (0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	() (0	26. 00
27. 00	Patient Transportation	0	() (0	27. 00
28. 00	I maging Services	0	() (0	28. 00
29. 00	Labs and Diagnostics	0	(0	29. 00
30. 00	Medical Supplies	0	(0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	() (0	31. 00
32. 00	Radiation Therapy	0	(0	32. 00
33. 00	Chemotherapy	0	(0	33. 00
34. 00	Other	0	1, 096, 081	87, 716	1, 183, 797	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE		1			_
35. 00	Bereavement Program Costs	0	() (0	35. 00
36. 00	Volunteer Program Costs	0	() (이	36. 00
37. 00	Fundrai si ng	0	() (이	37. 00
38. 00	Other Program Costs	0)		0	38.00
39. 00	Total (sum of lines 1 thru 38)	0	2, 134, 882	<u>'</u>	2, 134, 882	39.00

			·			5/27/2015 11:	52 am
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON		
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
				FT.)		(HOURS)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2. 00
3.00	Plant Operation and Maintenance	0	0				3. 00
4.00	Transportation - Staff	0	0	(0		4. 00
5.00	Volunteer Service Coordination	0	0	(0	0	5. 00
6.00	Administrative and General	0	0	(0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	(0	0	7. 00
8.00	Inpatient - Respite Care	0	0	(0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0	(0	0	9. 00
10.00	Nursing Care	0	0		ol ol	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		ol ol	0	11. 00
12.00	Physical Therapy	0	0		ol ol	0	12.00
13.00	Occupational Therapy	0	0		ol ol	0	13. 00
14.00	Speech/ Language Pathology	0	0		ol ol	0	14.00
15. 00	Medical Social Services	0	0		ol	0	15. 00
16. 00	Spiritual Counseling	0	0		ol	0	16.00
17. 00	Di etary Counseling	0	0		ol	0	17. 00
18. 00	Counseling - Other	0	0		ol	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0		ol	0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	Ö		ol	0	20.00
21. 00	Other	0	Ö		o	0	21. 00
21.00	OTHER HOSPICE SERVICE COSTS				٥,	J	200
22. 00	Drugs, Biological and Infusion Therapy	0	0	(ol	0	22. 00
23. 00	Anal gesi cs	0	0		ol ol	0	23. 00
24. 00	Sedatives / Hypnotics	0	Ö		ol ol	0	24. 00
25. 00	Other - Specify	0	0		ol ol	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		ol ol	0	26. 00
27. 00	Patient Transportation	0	0		ol ol	0	27. 00
28. 00	Imaging Services	0	0		ol ol	0	28. 00
29. 00	Labs and Diagnostics	0	0		ol o	0	29. 00
30. 00	Medical Supplies	0	0			0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0			0	31.00
32. 00	Radi ati on Therapy	0	0			0	32.00
33. 00	Chemotherapy		0	•		0	33.00
34. 00	Other	0	0			0	34.00
34.00	HOSPI CE NONREI MBURSABLE SERVI CE	0	0		<u> </u>	U	34.00
35. 00	Bereavement Program Costs	1	0		0	0	35. 00
36. 00	Volunteer Program Costs		0	1		0	36.00
37. 00	Fundrai si ng		0		1	0	37.00
38. 00	Other Program Costs			1		0	38.00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		0] /		0	39.00
	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000		
40.00	John Coost Martipiner	1 0.000000	0.00000	1 0.00000) J. 000000	0.000000	1 40.00

						5/27/2015	11:52 am_
					Hospi ce I		
		RECONCI LI ATI ON					
			& GENERAL				
			(ACC. COST)				
	T	6A	6. 00				
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1. 00
2.00	Capital Related Costs-Movable Equip.	0					2. 00
3.00	Plant Operation and Maintenance	0					3. 00
4.00	Transportation - Staff	0					4. 00
5.00	Volunteer Service Coordination						5. 00
6.00	Administrative and General	-158, 190	1, 976, 692				6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0				7. 00
8.00	Inpatient - Respite Care	0	0				8. 00
	VISITING SERVICES						
9.00	Physician Services	0	194, 230				9. 00
10.00	Nursi ng Care	0	514, 647				10. 00
11. 00	Nursing Care-Continuous Home Care	0	0				11. 00
12.00	Physi cal Therapy	0	0				12. 00
13.00	Occupational Therapy	0	0				13. 00
14.00	Speech/ Language Pathology	0	0				14. 00
15.00	Medical Social Services	0	68, 637				15. 00
16.00	Spiritual Counseling	0	0				16. 00
17.00	Di etary Counsel i ng	0	0				17. 00
18.00	Counseling - Other	0	0				18. 00
19.00	Home Health Aide and Homemaker	0	103, 097				19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0				20. 00
21.00	Other	0	0				21. 00
	OTHER HOSPICE SERVICE COSTS	·					
22.00	Drugs, Biological and Infusion Therapy	0	0				22. 00
23.00	Anal gesi cs	0	0				23. 00
24.00	Sedatives / Hypnotics	0	0				24. 00
25.00	Other - Specify	o	0				25. 00
26.00	Durable Medical Equipment/Oxygen	o	0				26. 00
27.00	Pati ent Transportation	o	0				27. 00
28.00	I maging Services	o	0				28. 00
29.00	Labs and Diagnostics	O	0				29. 00
30.00		o	0				30.00
31.00	Outpatient Services (including E/R Dept.)	o	0				31.00
32.00	Radiation Therapy	0	0				32. 00
33.00	Chemotherapy	0	0				33. 00
34.00	Other	0	1, 096, 081				34.00
	HOSPI CE NONREI MBURSABLE SERVI CE						
35.00	Bereavement Program Costs	0	0				35. 00
36.00		0	0				36.00
	Fundrai si ng	O	0				37. 00
38. 00		O	0				38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		158, 190				39. 00
40.00	Unit Cost Multiplier		0. 080028				40.00
	•		'	'			'

 Heal th Financial
 Systems
 HANCOCK

 ALLOCATION OF GENERAL SERVICE
 COSTS TO HOSPICE COST CENTERS

Peri od: Worksheet K-5
From 01/01/2014
To 12/31/2014 Date/Time Prepared: 5/27/2015 11: 52 am Provi der CCN: 150037 Hospi ce CCN: 151547

						072772010 11.	0 <u>2</u> uiii
					Hospi ce I		
			CAPI TAL				
			RELATED COSTS				
	Cost Center Description	Hospi ce Tri al	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		Bal ance (1)	FLXT	BENEFITS		& GENERAL	
				DEPARTMENT			
		0	1.00	4. 00	4A	5. 00	
1.00	Administrative and General		112, 114	153, 346	265, 460	48, 885	1. 00
2.00	Inpatient - General Care	0	0	C	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	C	0	0	3. 00
4.00	Physi ci an Servi ces	209, 774	0	C	209, 774	38, 630	4. 00
5.00	Nursing Care	555, 833	0	C	555, 833	102, 357	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	C	0	0	6. 00
7.00	Physi cal Therapy	0	0	C	0	0	7. 00
8.00	Occupational Therapy	0	0	C	0	0	8. 00
9.00	Speech/ Language Pathology	0	o	C	0	0	9. 00
10.00	Medical Social Services	74, 130	o	C	74, 130	13, 651	10.00
11.00	Spiritual Counseling	0	O	C	0	0	11. 00
12.00	Di etary Counseling	0	0	C	0	0	12. 00
13.00	Counseling - Other	0	0	C	0	0	13. 00
14.00	Home Health Aide and Homemaker	111, 348	0	C	111, 348	20, 505	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	C	0	0	15. 00
16. 00	Other	0	0	C	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	o	C	0	o	17. 00
18. 00	Anal gesi cs	0	o	C	0	o	18. 00
19. 00	Sedatives / Hypnotics	0	o	C	0	o	19. 00
20.00	Other - Specify	0	o	C	0	o	20.00
21. 00	Durable Medical Equipment/Oxygen	0	o	C	0	o	21. 00
22. 00	Patient Transportation	0	o	C	0	o	22. 00
23. 00	I maging Services	0	o	C	0	o	23. 00
24. 00	Labs and Diagnostics	0	o	C	0	o	24. 00
25. 00	Medical Supplies	0	o	C	0	o	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	C	0	ō	26. 00
27. 00	Radiation Therapy	0	0	C	0	Ö	27. 00
28. 00	Chemotherapy	0	0	Ċ	0	Ō	28. 00
29. 00	Other	1, 183, 797	0	Ċ	1, 183, 797	217, 997	29. 00
30. 00	Bereavement Program Costs	0	0	Č	1, 100, 7, 7	2.7,777	30.00
31. 00	Volunteer Program Costs	0	l o		0	0	31. 00
32. 00	Fundrai si ng	1			0	0	32. 00
33. 00	Other Program Costs		ا		0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	2, 134, 882	112, 114	153, 346	2, 400, 342		34. 00
	Unit Cost Multiplier (see instructions)	2, 101, 002	112, 117	100, 040	0. 000000		35. 00
55.50	Total Cook and Cription (See This Creek total)	I	1		0.00000	1	30.00

Heal th Financial SystemsHANCOCKALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Peri od: Worksheet K-5
From 01/01/2014 Part I
To 12/31/2014 Date/Ti me Prepared: 5/27/2015 11: 52 am Provi der CCN: 150037 Hospi ce CCN: 151547

						3/2//2013 11.	JZ alli
					Hospi ce I		
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		PLANT				ADMI NI STRATI ON	
	T	7. 00	9. 00	10.00	11. 00	13. 00	
1.00	Administrative and General	252, 819	()	0 77, 385		
2.00	Inpatient - General Care	0	()	0 0	0	
3.00	Inpatient - Respite Care	0	()	0 0	0	3. 00
4.00	Physi ci an Servi ces	0	()	0 0	0	4. 00
5.00	Nursing Care	0	()	0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	C		0 0	0	6. 00
7.00	Physi cal Therapy	0	C		0 0	0	7. 00
8.00	Occupational Therapy	0	(0 0	0	8. 00
9.00	Speech/ Language Pathology	0	(0 0	0	9. 00
10.00	Medical Social Services	0	C		0 0	0	10. 00
11. 00	Spiritual Counseling	0	C		0 0	0	11. 00
12.00	Di etary Counsel i ng	0	C		0 0	0	12.00
13.00	Counseling - Other	0	C		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	C		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	(o c	0	15. 00
16.00	Other	0	(o c	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	(o c	0	17. 00
18.00	Anal gesi cs	0	(o c	0	18. 00
19.00	Sedatives / Hypnotics	0	C		0 0	0	19. 00
20.00	Other - Specify	0	C		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	C		0 0	0	21.00
22.00	Patient Transportation	0	C		0 0	0	22. 00
23.00	I maging Services	0	C		0 0	0	23. 00
24.00	Labs and Diagnostics	0	C		0 0	0	24. 00
25.00	Medical Supplies	0	C		0 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	C		0 0	0	26. 00
27.00	Radi ati on Therapy	0	(o c	0	27. 00
28.00	Chemotherapy	0	(o c	0	28. 00
29.00	Other	0	(o c	0	29. 00
30.00	Bereavement Program Costs	0	(o c	0	30.00
31.00	Volunteer Program Costs	0	l c		o c	0	31.00
32.00	Fundrai si ng	0	l c		o c	0	32. 00
33.00	Other Program Costs	0			o c	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	252, 819			0 77, 385	106, 370	34. 00
35.00	Unit Cost Multiplier (see instructions)						35. 00

OSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 150037 | Period: From 01/01/2014 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/27/2015 11:52 am

						5/27/2015 11:	52 am
					Hospi ce I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
		SERVICES &		RECORDS &	PRGM	(cols. 4A-23)	
		SUPPLY		LI BRARY			
		14. 00	15. 00	16. 00	23. 00	24. 00	
1.00	Administrative and General	3, 288	0	0	0	754, 207	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physi ci an Servi ces	0	0	0	0	248, 404	4.00
5.00	Nursing Care	0	0	0	0	658, 190	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physi cal Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	87, 781	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	131, 853	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Anal gesi cs	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radi ati on Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	o	0	0	0	1, 401, 794	29.00
30.00	Bereavement Program Costs	o	0	0	0	0	30.00
31.00	Volunteer Program Costs	o	0	0	0	0	31.00
32.00	Fundrai si ng	o	0	0	0	0	32.00
33.00	Other Program Costs	o	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	3, 288	0	0	0	3, 282, 229	34.00
35. 00	Unit Cost Multiplier (see instructions)						35. 00
	•					. '	

Provider CCN: 150037 | Period: | Worksheet K-5 | Part | Hospice CCN: 151547 | To | 12/31/2014 | Date/Time Prepared: | Part | Par

Cost Center Description
Residents Cost Residents Cost Residents Cost Residents Cost Residents Cost Residents Res
Report Stepdown Adjustments Stepdown Adjustments 25) (See Part II) 26 ± 27) Report 25 × 25 × 25 × 26 × 27 × 26 × 27 × 27 × 28 × 27 × 28 × 27 × 28 × 28
Stepdown Adjustments 25.00 26.00 27.00 28.00
Adjustments 25.00 26.00 27.00 28.00
25.00 26.00 27.00 28.00
1.00 Administrative and General 2.00 Inpatient - General Care 0 0 0 0 0 0 2.00 3.00 Inpatient - Respite Care 0 0 0 0 0 0 3.00 4.00 Physician Services 0 248,404 74,109 322,513 4.00 5.00 Nursing Care 0 658,190 196,364 854,554 5.00 6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 7.00 Physical Therapy 0 0 0 0 0 0 8.00 Occupational Therapy 0 0 0 0 0 9.00 Speech/ Language Pathology 0 0 0 0 0 10.00 Medical Social Services 0 87,781 26,188 113,969 10.00 11.00 Spiritual Counseling 0 0 0 0 12.00 Dietary Counseling 0 0 0 0 13.00 Counseling - Other 0 0 0 0 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00 15.00 15.00 15.00 15.00 15.00 16.00 16.00 17,00 17,00 17,00 17.00 17.00 17.00 17.00 17.00 18.00 18.00 18.00 18.00 18.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00
2.00 Inpatient - General Care 0 0 0 0 0 0 3.00 3.00 Inpatient - Respite Care 0 0 0 0 0 3.00 4.00 Physician Services 0 248,404 74,109 322,513 4.00 5.00 Nursing Care 0 658,190 196,364 854,554 5.00 6.00 Nursing Care-Continuous Home Care 0 0 0 0 6.00 7.00 Physical Therapy 0 0 0 0 0 6.00 8.00 Occupational Therapy 0 0 0 0 0 0 9.00 Speech/ Language Pathology 0 0 0 0 0 9.00 10.00 Medical Social Services 0 87,781 26,188 113,969 10.00 11.00 Spiritual Counseling 0 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 0 12.00 14.00 <
3.00 Inpatient - Respite Care 0 0 0 0 3.00 4.00 Physician Services 0 248, 404 74, 109 322, 513 4.00 5.00 Nursing Care 0 658, 190 196, 364 854, 554 5.00 6.00 Nursing Care-Continuous Home Care 0 0 0 0 6.00 7.00 Physical Therapy 0 0 0 0 0 7.00 8.00 Occupational Therapy 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 9.00 10.00 Medical Social Services 0 87,781 26,188 113,969 10.00 11.00 Spiritual Counseling 0 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 0 12.00 13.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
4.00 Physician Services 0 248, 404 74, 109 322, 513 4.00 5.00 Nursing Care 0 658, 190 196, 364 854, 554 5.00 6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 6.00 7.00 Physical Therapy 0 0 0 0 0 7.00 8.00 Occupational Therapy 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 9.00 10.00 Medical Social Services 0 87,781 26,188 113,969 10.00 11.00 Spiritual Counseling 0 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 0 12.00 13.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
5.00 Nursi ng Care 0 658, 190 196, 364 854, 554 5.00 6.00 Nursi ng Care-Conti nuous Home Care 0 0 0 0 0 6.00 7.00 Physi cal Therapy 0 0 0 0 0 7.00 8.00 Occupati onal Therapy 0 0 0 0 0 8.00 9.00 Speech/ Language Pathol ogy 0 0 0 0 9.00 10.00 Medi cal Soci al Servi ces 0 87,781 26,188 113,969 10.00 11.00 Spiri tual Counsel ing 0 0 0 0 11.00 12.00 Di etary Counsel ing 0 0 0 0 12.00 13.00 Counsel ing - Other 0 0 0 0 0 13.00 14.00 Home Heal th Ai de and Homemaker 0 131,853 39,337 171,190 14.00
6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 7.00 Physical Therapy 0 0 0 0 0 0 0 7.00 8.00 Occupational Therapy 0 0 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 0 9.00 10.00 Medical Social Services 0 87,781 26,188 113,969 10.00 11.00 Spiritual Counseling 0 0 0 0 11.00 Dietary Counseling 0 0 0 0 12.00 Dietary Counseling 0 0 0 0 0 12.00 13.00 Counseling 0 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
7.00 Physical Therapy 0 0 0 0 0 7.00 8.00 Occupational Therapy 0 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 9.00 10.00 Medical Social Services 0 87,781 26,188 113,969 10.00 11.00 Spiritual Counseling 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
8.00 Occupational Therapy 0 0 0 0 0 0 0 0 9.00 9.00 Speech/ Language Pathology 0 0 0 0 0 9.00 10.00 Medical Social Services 0 87,781 26,188 113,969 10.00 11.00 Spiritual Counseling 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
9.00 Speech/ Language Pathology 0 0 0 0 9.00 10.00 Medical Social Services 0 87,781 26,188 113,969 10.00 11.00 Spiritual Counseling 0 0 0 0 0 12.00 Dietary Counseling 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
10.00 Medical Social Services 0 87,781 26,188 113,969 10.00 11.00 Spiritual Counseling 0 0 0 0 0 12.00 Dietary Counseling 0 0 0 0 0 13.00 Counseling - Other 0 0 0 0 0 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
11.00 Spiritual Counseling 0 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
12.00 Dietary Counseling 0 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
13.00 Counseling - Other 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
14.00 Home Health Aide and Homemaker 0 131,853 39,337 171,190 14.00
15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 15.00
16.00 Other 0 0 0 0 16.00
17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00
18.00 Anal gesi cs 0 0 0 0 0 18.00
19.00 Sedatives / Hypnotics 0 0 0 19.00
20.00 Other - Specify 0 0 0 0 20.00
21.00 Durable Medical Equipment/Oxygen 0 0 0 21.00
22.00 Patient Transportation 0 0 0 0 0 22.00
23.00 Imaging Services 0 0 0 23.00
24.00 Labs and Diagnostics 0 0 0 0 0 24.00
25.00 Medical Supplies 0 0 0 25.00
26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 26.00
27.00 Radiation Therapy 0 0 0 0 27.00
28.00 Chemotherapy 0 0 0 0 28.00
29. 00 Other 0 1, 401, 794 418, 209 1, 820, 003 29. 00
30.00 Bereavement Program Costs 0 0 0 0 30.00
31.00 Volunteer Program Costs 0 0 0 0 31.00
32.00 Fundraising 0 0 0 0 0 32.00
33.00 Other Program Costs 0 0 0 0 33.00
34.00 Total (sum of lines 1 thru 33) (2) 0 3,282,229 3,282,229 34.00
35.00 Unit Cost Multiplier (see instructions) 0.298339 35.00

Hospi ce CCN:

						5/2//2015 11:	52 alli
					Hospi ce I		
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE	BENEFITS DEPARTMENT	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM.	PLANT (SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		1.00	SALARI ES) 4. 00	5A	5. 00	7. 00	
1.00	Administrative and General	9, 240	2, 403, 900	-	265, 460	9, 240	1. 00
2.00	Inpatient - General Care	9, 240	2, 403, 700		203, 400	9, 240	2.00
3.00			0			0	3. 00
4.00	Inpatient - Respite Care Physician Services		0		209, 774	0	4. 00
4. 00 5. 00	Nursing Care		0			0	5. 00
		0	0		555, 833		
6.00	Nursing Care-Continuous Home Care	0	0			0	6.00
7.00	Physical Therapy	0	0			0	7. 00
8.00	Occupational Therapy	0	0			0	8. 00
9.00	Speech/ Language Pathology	0	0		74 120	0	9.00
10.00	Medical Social Services	0	0		74, 130	0	10.00
11.00	Spiritual Counseling	0	0			-	11.00
12.00	Di etary Counseling	0	0			0	12.00
13.00	Counseling - Other	1	0		111 240		13.00
14.00	Home Health Aide and Homemaker	0	0		111, 348	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15.00
16.00	Other District Laboratory	0	0		0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18. 00	Anal gesi cs	0	0		0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0	0	19.00
20.00	Other - Specify	0	0		0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
22. 00	Pati ent Transportation	0	0		0	0	22. 00
23. 00	I maging Services	0	0		0	0	23. 00
24. 00	Labs and Diagnostics	0	0		0	0	24. 00
25. 00	Medical Supplies	0	0		0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0)	0	0	26. 00
27. 00	Radiation Therapy	0	0) (0	0	27. 00
28. 00	Chemotherapy	0	0) (,	0	28. 00
29. 00	0ther	0	0) (1, 183, 797	0	29. 00
30. 00	Bereavement Program Costs	0	0) (0	0	30.00
31.00	Volunteer Program Costs	0	0) (0	0	31.00
32.00	Fundrai si ng	0	0) (0	0	32.00
33.00	Other Program Costs	0	0) (0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	9, 240	2, 403, 900	•	2, 400, 342	9, 240	34.00
35. 00	Total cost to be allocated	112, 114	153, 346		442, 025	252, 819	35. 00
36. 00	Unit Cost Multiplier (see instructions)	12. 133550	0. 063791	1	0. 184151	27. 361364	36. 00

STATISTICAL BASIS Hospi ce CCN:

						5/27/2015 11:	52 am_
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI ON	SERVICES &	
		SERVI CE)	DAYS)			SUPPLY	
					(MANHOURS)	(COSTED	
						REQUIS.)	
		9. 00	10.00	11. 00	13. 00	14. 00	
1.00	Administrative and General	0	0	32, 73	9 30, 858	81, 547	1. 00
2.00	Inpatient - General Care	0	0		0 0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0 0	0	3. 00
4.00	Physi ci an Servi ces	0	0		0 0	0	4. 00
5.00	Nursing Care	0	0		0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6. 00
7.00	Physi cal Therapy	0	0		0 0	0	7. 00
8.00	Occupational Therapy	0	0		0	0	8. 00
9.00	Speech/ Language Pathology	0	0		0	0	9. 00
10.00	Medical Social Services	0	0		0	0	10.00
11. 00	Spiritual Counseling	0	0		0	0	11. 00
12.00	Di etary Counsel i ng	0	0		0	0	12.00
13.00	Counseling - Other	0	0		0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18. 00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21. 00
22. 00	Patient Transportation	0	0		0 0	0	22. 00
23.00	I maging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27. 00	Radi ati on Therapy	0	0		0 0	0	27. 00
28.00	Chemotherapy	0	0		0 0	0	28. 00
29.00	Other	0	0		0 0	0	29. 00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	o	0		lo lo	0	31. 00
32.00	Fundrai si ng	o	0		lo lo	0	32.00
33.00	Other Program Costs	0	0		lo lo	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	o	0	32, 73	9 30, 858	81, 547	34.00
35.00	Total cost to be allocated	o	0	77, 38	5 106, 370	3, 288	35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	2. 36369	3. 447080	0. 040320	36. 00

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provi der CCN: 150037
 Peri od: From 01/01/2014
 Worksheet K-5

 Hospi ce CCN: 151547
 To 12/31/2014
 Date/Time Prepared: 5/27/2015 11: 52 am

 Heal th Financial
 Systems
 HANCOCK

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

STATISTICAL BASIS

						5/2//2015 11:52 am
					Hospi ce I	
	Cost Center Description	PHARMACY	MEDI CAL	PARAMED ED		
		(COSTED	RECORDS &	PRGM		
		REQUIS.)	LI BRARY	(ASSI GNED		
			(TIME	TIME)		
			SPENT)			
		15. 00	16. 00	23. 00		
1.00	Administrative and General	0	0		0	1.00
2.00	Inpatient - General Care	0	0		0	2. 00
3.00	Inpatient - Respite Care	0	0		0	3.00
4.00	Physi ci an Servi ces	0	0		0	4. 00
5.00	Nursi ng Care	0	0		0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	6. 00
7.00	Physi cal Therapy	0	0		0	7. 00
8.00	Occupational Therapy	0	0		0	8. 00
9.00	Speech/ Language Pathology	0	0		0	9. 00
10.00	Medical Social Services	O	0		0	10.00
11.00	Spiritual Counseling	O	0		0	11. 00
12.00	Di etary Counsel i ng	O	0		0	12. 00
13.00	Counseling - Other	o	0		0	13. 00
14.00	Home Health Aide and Homemaker	O	0		0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	ol	0		0	15. 00
16. 00	Other	o	0		0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	0		0	17. 00
18. 00	Anal gesi cs	o	0		0	18. 00
19. 00	Sedatives / Hypnotics	l ol	0		0	19.00
20.00	Other - Specify	o	0		0	20. 00
21. 00	Durable Medical Equipment/Oxygen	o	0		0	21. 00
22. 00	Pati ent Transportation	o	0		0	22. 00
23. 00	I maging Services	o	0		0	23. 00
24.00	Labs and Diagnostics	o	0		0	24. 00
25.00	Medical Supplies	o	0		0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0		0	26. 00
27.00	Radiation Therapy	o	0		0	27. 00
28. 00	Chemotherapy	o	0		0	28. 00
29. 00	Other	o	0		0	29. 00
30.00	Bereavement Program Costs	o	0		0	30.00
31.00	Volunteer Program Costs	O	0		0	31.00
32.00	Fundrai si ng	0	0		0	32. 00
33. 00	Other Program Costs		0		0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)		0		0	34.00
35. 00	Total cost to be allocated		0		0	35. 00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 00000	00	36. 00
					1	1

COMPUTATION OF TOTAL HOSPICE SHARED COSTS	Heal th	Financial Systems	HANCOCK REGIONAL HO	OSPI TAL			In Lie	u of Form CMS-2	2552-10
Hospice CCN: 151547 To 12/31/2014 Date/Time Prepared: 5/27/2015 11: 52 am	COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 1				
Cost Center Description									
Cost Center Description				Hospi ce (JCN:	151547	10 12/31/2014		
Cost Center Description							Hospi ca I	3/2//2013 11.3	02 alli
I, col. 11		Cost Center Description	Wks+	C Part	Cost	to Chara		Hospica Shared	
I i ne		cost center bescriptron							
ANCILLARY SERVICE COST CENTERS					"	atio			
ANCI LLARY SERVI CE COST CENTERS				11110					
ANCI LLARY SERVI CE COST CENTERS				0		1. 00			
2. 00 OCCUPATI ONAL THERAPY 67. 00 0. 347980 0 0 2. 00 3. 00 SPEECH PATHOLOGY 68. 00 0. 503278 0 0 3. 00 3. 01 OCCUPATI ONAL HEALTH 68. 01 0. 000000 0 0 3. 01 4. 00 DRUGS CHARGED TO PATI ENTS 73. 00 0. 230744 0 0 4. 00 5. 00 DURABLE MEDI CAL EQUI P-RENTED 96. 00 0 5. 00 5. 00 6. 01 BLOOD LABORATORY 60. 00 0. 166382 0 0 6. 00 6. 01 BLOOD LABORATORY 60. 01 0. 718295 0 0 7. 00 8. 00 OTHER OUTPATI ENT SERVICE COST CENTER 93. 00 8. 00 8. 00 9. 00 RADI OLOGY-THERAPEUTI C 55. 00 9. 00 9. 00 10. 01 CARDI AC 76. 00 0. 000000 0 0 10. 00 10. 01 CARDI OPULMONARY 76. 01 0. 444575 0 0 10. 01		ANCILLARY SERVICE COST CENTERS						2. 00	
2.00 OCCUPATI ONAL THERAPY 67.00 0.347980 0 2.00 3.00 SPEECH PATHOLOGY 68.00 0.503278 0 0 3.00 3.01 OCCUPATI ONAL HEALTH 68.01 0.000000 0 0 3.01 4.00 DRUGS CHARGED TO PATI ENTS 73.00 0.230744 0 0 4.00 5.00 DURABLE MEDI CAL EQUI P-RENTED 96.00 0 5.00 6.01 LABORATORY 60.00 0.166382 0 0 6.00 6.01 BLOOD LABORATORY 60.01 0.718295 0 0 7.00 8.00 OTHER OUTPATI ENT SERVICE COST CENTER 93.00 8.00 8.00 9.00 RADI OLOGY-THERAPEUTI C 55.00 9.00 10.01 CARDI AC 76.00 0.000000 0 0 10.00 10.01 CARDI OPULMONARY 76.01 0.444575 0 10.01	1.00	PHYSI CAL THERAPY		66. 00		0. 45669	1 0	0	1. 00
3.00 SPEECH PATHOLOGY 3.01 OCCUPATI ONAL HEALTH 4.00 DRUGS CHARGED TO PATI ENTS 5.00 DURABLE MEDI CAL EQUI P-RENTED 6.00 LABORATORY 6.01 BLOOD LABORATORY 6.01 BLOOD LABORATORY 6.01 BLOOD LABORATORY 7.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8.00 OTHER OUTPATI ENT SERVI CE COST CENTER 9.00 RADI OLOGY-THERAPEUTI C 10.00 CARDI AC 10.01 CARDI OPULMONARY 68.00 0.503278 0.00 0.000000 0.000000 0.000000 0.000000 0.000000		OCCUPATIONAL THERAPY						0	2. 00
3. 01 OCCUPATI ONAL HEALTH 4. 00 DRUGS CHARGED TO PATI ENTS 5. 00 DURABLE MEDI CAL EQUI P-RENTED 6. 00 LABORATORY 6. 01 BLOOD LABORATORY 6. 01 BLOOD LABORATORY 6. 00 OTHER OUTPATI ENT SERVI CE COST CENTER 9. 00 RADI OLOGY-THERAPEUTI C 10. 00 CARDI AC 10. 01 CARDI OPULMONARY 68. 01 O. 000000 0 0. 230744 0 0 0 4. 00 68. 01 60. 00 60. 00 60. 01 60. 01 71. 00 71. 00 93. 00 93. 00 94. 00 96. 00 9		SPEECH PATHOLOGY						0	
4. 00 DRUGS CHARGED TO PATI ENTS 73. 00 0. 230744 0 0 4. 00 5. 00 DURABLE MEDI CAL EQUI P-RENTED 96. 00 5. 00 6. 00 LABORATORY 60. 00 0. 166382 0 0 6. 00 6. 01 BLOOD LABORATORY 60. 01 60. 01 6. 01 7. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 00 0. 718295 0 0 7. 00 8. 00 OTHER OUTPATI ENT SERVI CE COST CENTER 93. 00 9. 00 8. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 01		OCCUPATIONAL HEALTH						0	
6. 00 LABORATORY 60. 00 0. 166382 0 0 6. 00 6. 00 6. 01 60		DRUGS CHARGED TO PATIENTS						0	
6. 01 BLOOD LABORATORY 7. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 8. 00 OTHER OUTPATI ENT SERVI CE COST CENTER 93. 00 9. 00 RADI OLOGY-THERAPEUTI C 10. 00 CARDI AC 10. 01 CARDI OPULMONARY 60. 01 71. 00 93. 00 93. 00 95. 00 90. 00. 000000 00 00 00 00 00 00 00 00 00 00 00	5.00	DURABLE MEDICAL EQUIP-RENTED		96.00)				5.00
7. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 00 0. 718295 0 7. 00 8. 00 9. 00 RADI OLOGY-THERAPEUTI C 93. 00 10. 00 CARDI AC 76. 00 0. 000000 0 10. 00 10. 01 CARDI OPULMONARY 76. 01 0. 444575 0 0 10. 01	6.00	LABORATORY		60.00)	0. 16638	2 0	0	6.00
8. 00 OTHER OUTPATIENT SERVICE COST CENTER 93. 00 9. 00 RADI OLOGY-THERAPEUTI C 55. 00 10. 00 CARDI AC 76. 00 0. 000000 0 0 10. 00 10. 01 CARDI OPULMONARY 76. 01 0. 444575 0 0 10. 01	6. 01	BLOOD LABORATORY		60. 01	İ				6. 01
9. 00 RADI OLOGY-THERAPEUTI C 55. 00 9. 00 10. 00 CARDI AC 76. 00 0. 000000 0 10. 00 10. 01 CARDI OPULMONARY 76. 01 0. 444575 0 0 10. 01	7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	o l	0. 71829	5 0	0	7.00
10. 00 CARDI AC 76. 00 0. 000000 0 0 10. 00 10. 01 CARDI OPULMONARY 76. 01 0. 444575 0 0 10. 00	8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00	ol .				8.00
10. 01 CARDI OPULMONARY 76. 01 0. 444575 0 0 10. 01	9.00	RADI OLOGY-THERAPEUTI C		55.00					9. 00
	10.00	CARDI AC		76.00		0.00000	0	0	10.00
11.00 Totals (sum of lines 1-10) 0 11.00	10. 01	CARDI OPULMONARY		76. 01		0. 44457	5 0	0	10. 01
	11. 00	Totals (sum of lines 1-10)						0	11.00

Heal th	Financial Systems HANCOCK REGIO	NAL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPICE PER DIEM COST		Provi der	CCN: 150037	Peri od:	Worksheet K-6	
					From 01/01/2014		
			Hospice C	CN: 151547	To 12/31/2014	Date/Time Pre	pared:
			-			5/27/2015 11:	52 am
					Hospi ce I		
		Ti t	le XVIII	Title XIX	Other	Total	
			1.00	2. 00	3. 00	4. 00	
1.00	Total cost (see instructions)					3, 282, 229	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)					4, 495	2. 00
3.00	Average cost per diem (line 1 divided by line 2)					730. 20	3. 00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line		4, 175				4. 00

3, 048, 585

22, 636

0

289

211, 028

5.00

6.00

7.00

8.00

9.00

10. 00 11. 00

12.00

13.00

5.00

6.00

7.00

8.00

9.00

Aggregate Medicare cost (line 3 time line 4)

10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)
11.00 Aggregate NF cost (line 3 times line 10)

13.00 Aggregate cost for other days (line 3 times line 12)

12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)

Aggregate SNF cost (line 3 time line 8)

Unduplicated Medicaid Days (Worksheet S-9, column 2, line

Aggregate Medicaid cost (line 3 time line 60)
Upduplicated SNF Days (Worksheet S-9, column 3, line 5)

	Financial Systems HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150037	Peri od: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Pre 5/27/2015 11:	pared:
		Title XVIII	Hospi tal	PPS	
	DART I FILLY PROCRECTIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			652, 113	1. 00
1.00	Model 4 BPCI Capital DRG other than outlier			052, 113	1. 00
2. 00	Capital DRG outlier payments			1, 013	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost rep	ortina period (see inst	ructions)	24. 12	3. 00
4.00	Number of interns & residents (see instructions)	3 1 1 (11 11	,	0.00	4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01)	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A pa 30) (see instructions)	tient days (Worksheet E	, part A line	0. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instruc	tions)		0. 00	8. 00
9.00	Sum of lines 7 and 8			0. 00	
10. 00	Allowable disproportionate share percentage (see instructions)			0. 00	
11. 00	Disproportionate share adjustment (line 10 times the sum of li			0	11.00
12. 00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2	.01, 6 and 11)		653, 126	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 00 5. 00
5.00	Total Tripatrent program capital cost (Trile 3 x Trile 4)			U	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1. 00
	Program inpatient capital costs for extraordinary circumstance	s (see instructions)		0	2.00
2.00					
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
3. 00 4. 00	Applicable exception percentage (see instructions)			0. 00	4. 00
3. 00 4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	tructions)		0.00	4. 00 5. 00
3. 00 4. 00 5. 00 6. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins		Lino 6)	0. 00 0 0. 00	4. 00 5. 00 6. 00
3. 00 4. 00 5. 00 6. 00 7. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary		line 6)	0. 00 0 0. 00 0	4. 00 5. 00 6. 00 7. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	circumstances (line 2 x	line 6)	0. 00 0 0. 00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic	circumstances (line 2 x able)	,	0. 00 0 0. 00 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca Carryover of accumulated capital minimum payment level over ca	circumstances (line 2 x able) pital payments (line 8	less line 9)	0. 00 0 0. 00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca	circumstances (line 2 x able) pital payments (line 8 pital payment (from pri	less line 9) or year	0.00 0.00 0.00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14)	circumstances (line 2 x able) pital payments (line 8 pital payment (from pri ments (line 10 plus lin	less line 9) or year e 11)	0.00 0.00 0.00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay	circumstances (line 2 x able) pital payments (line 8 pital payment (from pri ments (line 10 plus lin the amount on this line	less line 9) or year e 11)	0.00 0.00 0.00 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over ca (if line 12 is negative, enter the amount on this line)	circumstances (line 2 x able) pital payments (line 8 pital payment (from pri ments (line 10 plus lin the amount on this line pital payment for the f	less line 9) or year e 11)	0.00 0.00 0 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 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	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over ca (if line 12 is negative, enter the amount on this line)	circumstances (line 2 x able) pital payments (line 8 pital payment (from pri ments (line 10 plus lin the amount on this line pital payment for the f	less line 9) or year e 11)	0.00 0.00 0.00 0 0 0	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

Heal th	Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED) Provi der		Peri od:	Worksheet M-1	
HEALTH	CENTER COSTS		0		From 01/01/2014		
			Componen	CCN: 153987	Γο 12/31/2014	Date/Time Prep 5/27/2015 11:	pared: 52 am
					Rural Health	Cost	<u> </u>
					Clinic (RHC) I		
		Compensation	Other Costs		Recl assi fi cati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1.00	Physi ci an	14, 280	0	14, 28		14, 280	1. 00
2.00	Physician Assistant	0	Ö	11,20		0	2. 00
3. 00	Nurse Practitioner	118, 193	O	118, 19	3 0	118, 193	3. 00
4.00	Visiting Nurse	0	O		0	0	4. 00
5.00	Other Nurse	0	0		0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	6. 00
7.00	Clinical Social Worker	0	0		0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9. 00	Other Facility Health Care Staff Costs	23, 540	0	23, 54		23, 540	
10. 00	Subtotal (sum of lines 1 through 9)	156, 013	0	156, 01	3 0	156, 013	10. 00
11. 00	Physician Services Under Agreement	0	0	1	0	0	11. 00
	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	[C	1	0 إد	0	13.00

0

0

29, 326

29, 326

185, 339

156, 013

0

0

0

0

0

0

0

79, 076

29, 326

108, 402

264, 415

156, 013

0

0

0

79, 076

79, 076

79, 076

14.00

15.00

16.00

17.00

18.00

19.00

20.00

22.00

23.00

24.00

25.00

0 26.00

29. 00

30.00

31.00

32.00

0

0

0 21.00

0

0

0 27.00

0 28.00

79, 076

29, 326

108, 402

264, 415

156, 013

14.00

15.00

16.00

17.00

19.00

20.00

21.00

22.00

23.00

24.00

25.00

26.00

27.00

28.00

29.00

30.00

31.00

32.00

Subtotal (sum of lines 11 through 13)

Subtotal (sum of lines 15 through 20)

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Transportation (Health Care Staff)

Depreciation-Medical Equipment

Other Health Care Costs

Allowable GME Costs

lines 10, 14, and 21)

Nonallowable GME costs

Administrative Costs

Pharmacy

Optometry

through 27) FACILITY OVERHEAD

and 31)

Facility Costs

Dental

Professional Liability Insurance

COSTS OTHER THAN RHC/FQHC SERVICS

All other nonreimbursable costs

Medical Supplies

Health Financial Systems	HANCOCK REGIONAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
	HEALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 150037		Worksheet M-1
HEALTH CENTER COSTS		Component CCN: 153987	From 01/01/2014 To 12/31/2014	
			Rural Health	Cost

				Clinic (RHC) I	COST
		Adjustments	Net Expenses		
			for Allocation		
			(col. 5 + col.		
			6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	0	14, 280		1. 00
2.00	Physician Assistant	0	0		2. 00
3.00	Nurse Practitioner	0	118, 193		3.00
4.00	Visiting Nurse	0	0		4. 00
5.00	Other Nurse	0	0		5. 00
6.00	Clinical Psychologist	0	0		6. 00
7.00	Clinical Social Worker	0	0		7. 00
8.00	Laboratory Techni ci an	0	0		8. 00
9.00	Other Facility Health Care Staff Costs	0	23, 540		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	156, 013		10.00
11.00	Physician Services Under Agreement	0	0		11. 00
12.00	Physician Supervision Under Agreement	0	0		12. 00
13.00	Other Costs Under Agreement	0	0		13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14. 00
15. 00	Medical Supplies	0	0		15. 00
16.00	Transportation (Health Care Staff)	0	0		16. 00
17.00	Depreciation-Medical Equipment	0	0		17. 00
18.00	Professional Liability Insurance	0	0		18. 00
19.00	Other Health Care Costs	0	0		19. 00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of	0	156, 013		22. 00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23. 00
24.00	Dental	0	0		24. 00
25.00	Optometry	0	0		25. 00
26.00	All other nonreimbursable costs	0	0		26. 00
27.00	Nonallowable GME costs	0	0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
	through 27)				
	FACILITY OVERHEAD				
29. 00	Facility Costs	0	,		29. 00
30. 00	Administrative Costs	-6, 670			30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	-6, 670	101, 732		31. 00
	30)	, .=-			
32. 00	Total facility costs (sum of lines 22, 28	-6, 670	257, 745		32. 00
	and 31)				l

Heal th	Financial Systems	HANCOCK REGIO	NAL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES			Provi der	CCN: 150037	Peri od:	Worksheet M-2	
				Component	CCN: 153987	From 01/01/2014 To 12/31/2014	Date/Time Pre	nanad.
				Component	L CCN: 153987	To 12/31/2014	5/27/2015 11:	
						Rural Health	Cost	
						Clinic (RHC) I		
		Number of FTE	Tota	al Visits		Minimum Visits		
		Personnel			Standard (1)	(col. 1 x col.		
		1.00		0.00	0.00	3)	4	
	WICLTC AND DODUCTIVITY	1.00		2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							<u> </u>
1 00	Posi ti ons Physi ci an	0.00		0		0 0		1.00
1. 00 2. 00	Physician Assistant	0.00		0	•	0 0		2.00
3. 00	Nurse Practitioner	1. 06		1, 547	1	-		3.00
4. 00	Subtotal (sum of lines 1 through 3)	1.06		1, 547		2, 226		4.00
5.00	Visiting Nurse	0. 00		1, 547		2, 220	2, 220	5.00
6.00	Clinical Psychologist	0.00		0			0	6.00
7. 00	Clinical Social Worker	0.00		0			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		0			0	7. 01
7. 01	Di abetes Self Management Training (FQHC	0.00		0			0	7. 02
7.02	only)	0.00		O			· ·	7.02
8. 00	Total FTEs and Visits (sum of lines 4	1.06		1, 547			2, 226	8.00
	through 7)			.,			_,	
9.00	Physician Services Under Agreements			22			22	9. 00
	* * * * * * * * * * * * * * * * * * * *							
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO							
10.00				ne 22)			156, 013	
11. 00							0	11. 00
12. 00	Cost of all services (excluding overhead) (s		and	11)			156, 013	
13.00	Ratio of RHC/FQHC services (line 10 divided						1. 000000	
14.00				_			101, 732	
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions	5)			77, 470	
16.00							179, 202	
17.00	Allowable GME overhead (see instructions)						0	17. 00
18.00		10 1: - 10	2)				179, 202	
19.00	1 ''		,	10)			179, 202	
∠0. 00	Total allowable cost of RHC/FQHC services (s	uni of tines 10	and	19)			335, 215	J 20.00

ALCUL	Financial Systems HANCOCK REGIONAL ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	HOSPITAL Provi der CCN: 150037	Peri od:	u of Form CMS-2 Worksheet M-3	
		Component CCN: 153987	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 11:	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1.00	
. 00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lir	ne 20)		335, 215	1.0
00	Cost of vaccines and their administration (from Wkst. M-4, lir	ne 15)		10, 196	
00	Total allowable cost excluding vaccine (line 1 minus line 2)			325, 019	
00	Total Visits (from Worksheet M-2, column 5, line 8)			2, 226	
00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		22	
. 00	Total adjusted visits (line 4 plus line 5)			2, 248 144, 58	
00	Adjusted cost per visit (line 3 divided by line 6)	,	Cal cul ati on		/.
			Prior to January 1	On on After January 1	
			1. 00	2. 00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	79. 80	8.
00	Rate for Program covered visits (see instructions)	, ,	0.00	79. 80	
	CALCULATION OF SETTLEMENT				
0. 00	Program covered visits excluding mental health services (from		0	269	
. 00	Program cost excluding costs for mental health services (line		0	21, 466	
2. 00	Program covered visits for mental health services (from contra		0	0	12
3.00	Program covered cost from mental health services (line 9 x lin	,	0	0	
1. 00 5. 00	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions		٩	0	
5. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			21, 466	
5. 01	Total program charges (see instructions) (from contractor's red			56, 568	1
5. 02	Total program preventive charges (see instructions) (from provi			0	16
5. 03	Total program preventive costs ((line 16.02/line 16.01) times			0	1
5. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)			13, 087	16.
5. 05	Total program cost (see instructions)			13, 087	16.
7. 00	Primary payer amounts			0	17.
3. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		5, 107	18
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		10, 292	19
0. 00	Net Medicare cost excluding vaccines (see instructions)			13, 087	20
1.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		2, 193	
2. 00	Total reimbursable Program cost (line 20 plus line 21)			15, 280	
3. 00	Allowable bad debts (see instructions)			0	23
3. 01	Adjusted reimbursable bad debts (see instructions)	quati ana)		0	
1. 00 5. 00	Allowable bad debts for dual eligible beneficiaries (see instr OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uctions)		0	
5. 50	Pioneer ACO demonstration payment adjustment (see instructions	=)		0	
5. 00	Net reimbursable amount (see instructions)	-,		15, 280	
6. 01	Sequestration adjustment (see instructions)			306	1
7. 00	Interim payments			12, 339	1
8. 00	Tentative settlement (for contractor use only)			0	28.
9. 00	Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		2, 635	29.
0.00	Protested amounts (nonallowable cost report items) in accordan	aco with CMC Dub 1E II	1	0	30.

Health Financial Systems HANCOCK R	EGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Peri od:	Worksheet M-4	
		From 01/01/2014	Data /Tima Dray	aanad.
	Component CCN: 153987	To 12/31/2014	5/27/2015 11:	
	Title XVIII	Rural Health	Cost	
		Pneumococcal	I nfl uenza	
		1. 00	2. 00	
1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10	0)	156, 013	156, 013	1.00
2.00 Ratio of pneumococcal and influenza vaccine staff time	to total health care staff time	0. 001276	0. 010338	2.00
3.00 Pneumococcal and influenza vaccine health care staff co	ost (line 1 x line 2)	199	1, 613	3.00
4.00 Medical supplies cost - pneumococcal and influenza vac	cine (from your records)	1, 239	1, 694	4.00

		1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	156, 013	156, 013	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0. 001276	0. 010338	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	199	1, 613	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1, 239	1, 694	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1, 438	3, 307	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	156, 013	156, 013	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	179, 202	179, 202	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5	0. 009217	0. 021197	8.00
	divided by line 6)			
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1, 652		
10. 00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of	3, 090	7, 106	10. 00
	lines 5 and 9)			
	Total number of pneumococcal and influenza vaccine injections (from your records)	19		11. 00
12. 00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	162. 63		12.00
13. 00	Number of pneumococcal and influenza vaccine injections administered to Program	1	44	13. 00
	beneficiaries			
14. 00	Program cost of pneumococcal and influenza vaccine and its (their) administration	163	2, 030	14. 00
45.00	(line 12 x line 13)		40.404	45.00
15. 00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum		10, 196	15.00
1/ 00	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		2 102	1/ 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and its (their)		2, 193	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,			
	line 21)			

Health Financial Systems	HANCOC	K REGIONAL H	IOSPI TAL				In Lie	u of Form (CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVIDER F	OR SERVICES	Provi der	CCN:	150037	Perio		Worksheet	M-5
RENDERED TO PROGRAM BENEFICIARIES			Component	CCN:	153987		01/01/2014 12/31/2014	Date/Ti me	
								5/27/2015	11:52 am
						Rur	al Health	Co	st

Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services reported in the cost reporting period. If none, write "NONE" or enter a zero or services reporting period. If none, write "NONE" or enter a zero or evision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				Rural Health	Cost	
Total interim payments paid to provider 1.00 2.00 1.00 1.00 1.00 2.00 1.00						
1.00 2.00						
10						
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 or 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)				1. 00		
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 payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program Provider to Program Provider to Program Provider to Program Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) List separately each retractive lument payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Provider to Program Subtotal (sum of lines 3.01-3.49 minus sum of lines 4.2, and 3.99) (transfer to Worksheet M-3, line 22) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 22) District Separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM Determined net se	1. 00				12, 339	1. 0
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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			period. If none, write			
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 Provider to Program Frovider to Program Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Its separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Provider to Program Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM To tal Medicare program Hability (see instructions) Contractor Number (Mo/Day/Yr) To Bate Market Also Show date of each payment. If none, write "NONE" or enter a zero. (1) Provider to Program Contractor Number (Mo/Day/Yr) To tal Medicare program Hability (see instructions) Contractor Number (Mo/Day/Yr) To tal Medicare program Hability (see instructions) Contractor Number (Mo/Day/Yr) To tal Medicare program Hability (see instructions) Contractor Number (Mo/Day/Yr)						
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Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)						
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)						
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) To BE COMPLETED BY CONTRACTOR						
27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 5.0					ı "	
TO BE COMPLETED BY CONTRACTOR	4. 00		sfer to Worksheet M-3, line		12, 339	4.00
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.02 SETTLEMENT TO PROGRAM .00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 01	· · · · · · · · · · · · · · · · · · ·			2, 635	6. 0
.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr)	6. 02					6. 0
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