	icial Systems	HANCOCK REGIONAL			u of Form CMS-2552-10
		1395g; 42 CFR 413.20(b)). Fai e cost reporting period being			FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL ANI AND SETTLEM		EX COST REPORT CERTIFICATION	Provi der CCN: 15-0037	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 9:57 am
PART I - COS	ST REPORT STATUS				
Provi der use only	<ol> <li>[X] Electronically fi</li> <li>[] Manually submitte</li> <li>[0] If this is an ame</li> <li>[F] Medicare Utilization</li> </ol>		of times the provider r " for low.	Date: 5/29/20 resubmitted this co	
Contractor use only	5. [ 1 ]Cost Report Statu (1) As Submitted (2) Settled without Au (3) Settled with Audit (4) Reopened (5) Amended	7. Contractor No. dit 8. [ N ] Initial Report fo	or this Provider CCN 12.	NPR Date: Contractor's Vendo [ 0 ]If line 5, co number of tim	or Code: 4 Iumn 1 is 4: Enter es reopened = 0-9.
PART II - C	ERTLELCATION				
MI SREPRESEN ADMI NI STRAT PROVI DED OR ADMI NI STRAT	TATION OR FALSIFICATION OF A VE ACTION, FINE AND/OR IMPR PROCURED THROUGH THE PAYMEN VE ACTION, FINES AND/OR IMP	NY INFORMATION CONTAINED IN T ISONMENT UNDER FEDERAL LAW. T DIRECTLY OR INDIRECTLY OF A RISONMENT MAY RESULT. L OFFICER OR ADMINISTRATOR OF	FURTHERMORE, IF SERVICE KICKBACK OR WERE OTHER	S IDENTIFIED IN TH	IS REPORT WERE
el e Exp and com exc hea	ctronically filed or manuall enses prepared by HANCOCK RE ending 12/31/2018 and to th plete and prepared from the ept as noted. I further cer	ad the above certification st y submitted cost report and t GIONAL HOSPITAL (15-0037) f e best of my knowledge and be books and records of the prov tify that I am familiar with the services identified in th	he Balance Sheet and St for the cost reporting p lief, this report and s ider in accordance with the laws and regulation	atement of Revenue eriod beginning O1 tatement are true, applicable instru s regarding the pr	and 1/01/2018 correct, uctions, rovision of
Γ		n the above certification stat cation statement to be the leg			
		(Si gned)	)		
			Officer or Admini	strator of Provid	er(s)

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
			2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	158, 936	-101, 427	0	-119, 433	1.00
2.00	Subprovider - IPF	0	526	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		11, 745		0	10.00
200.00	Total	0	159, 462	-89, 682	0	-119, 433	200.00

Title

Date

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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	HANCOCK REGION		ler CCN: 1	15-0037	Period: From 01/01/2 To 12/31/2	2018	Workshe Part I	eet S-2 ime Pre	epare
	1.00	2.00		3.00		4	. 00	5727720	517 7.0	
	Hospital and Hospital Health Care Co									
	Street: . 10 NORTH STATE STREET	PO Box:								1.
00	City: GREENFIELD	State: IN		e: 46140-		ty: HANCOCK			(5	2.
		Component Name	CCN Number	CBSA Number	Provi der Type	Date Certified		ent Syst , O, or		
			Number	Number	lighe		V	XVIII		-
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	Hospital and Hospital-Based Componer		2.00	0.00		0.00	0.00	1 1.00	1 0.00	
00	Hospi tal	HANCOCK REGIONAL	150037	26900	1	07/01/1966	Ν	Р	0	3.
		HOSPI TAL								
00	Subprovider - IPF	HANCOCK REGIONAL GERO	15S037	26900	4	12/01/1996	Ν	P	N	4.
		PSYCH UNIT								-
00	Subprovider - IRF									5
00	Subprovider - (Other)									6
)0 )0	Swing Beds – SNF Swing Beds – NF									8
00										
	Hospital-Based SNF Hospital-Based NF									10
00	Hospi tal -Based OLTC									11
	Hospital -Based HHA									12
00	Separately Certified ASC								1	13
	Hospi tal -Based Hospi ce	HANCOCK REGIONAL	151547	26900		02/02/1996				14
	•	HOSPI CE								1
00	Hospital-Based Health Clinic - RHC	KNIGHTSTOWN RURAL	153987	26900		09/22/1998	Ν	0	N	15
~ ~		HEALTH								
	Hospital-Based Health Clinic - FQHC									16
	Hospital-Based (CMHC) I									17
	Renal Dialysis									18
. 00	Other					From:		Тс	\	19
								2.		-
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	HOSPITAL Provider CC	N: 15-0037	Peri od:	TH LIEU		neet S-2	2552-10 2
				From 01/ To 12/		Part I Date/1		epared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Me	Other edi cai d days	
24.00 LE this provides is as LDDC baseled, aster the	1.00	2.00	3.00	4.00	5.00		6.00	2 24 00
<ul> <li>24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.</li> <li>25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 5, 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.</li> </ul>	0	0		с с		0		24.00
					Rural S 00		f Geogr .00	-
26.00 Enter your standard geographic classification (not w		at the beg	ginning of t		1	2.		26.00
<ul> <li>cost reporting period. Enter "1" for urban or "2" fo</li> <li>Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o</li> <li>enter the effective date of the geographic reclassif</li> </ul>	age) status r "2" for r	ural. 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			35.00
					ni ng: 00		li ng: . 00	-
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent date		cript line	36 for numb	er				36.00
37.00 If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	r the numbe	-		IS	0			37.00
37.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions?								37.01
instructions) 38.00 If line 37 is 1. enter the beginning and ending date:	s of MDH st	atus. Ifli	ne 37 is					38.00
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.					/N		( /NI	38.00
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o					/N 00		<u>/N</u> 00	38.00
<ul> <li>38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number or enter subsequent dates.</li> <li>39.00 Does this facility qualify for the inpatient hospitat hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i</li> </ul>	f periods i I payment a ), (ii), or the mileage	n excess of djustment f (iii)? Ent requiremen	for low volu for low volu ter in colum	me In		2.		_
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<ul> <li>88.00 If line 37 is 1, enter the beginning and ending date: greater than 1, subscript this line for the number or enter subsequent dates.</li> <li>89.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)</li> <li>10.00 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</li> <li>Prospective Payment System (PPS)-Capital</li> <li>Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions)</li> <li>16.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.</li> <li>17.00 Is this a new hospital under 42 CFR §412.300(b) PPS 6</li> <li>18.00 Is the facility electing full federal capital payment Teaching Hospitals</li> </ul>	f periods in l payment an ), (ii), or the mileage ii)? Enter n adjustmen ber 1. Enter . (see inst . (see inst . (see inst . t. L, Pt. I capital? Ei t? Enter "	djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina il and Wkst nter "Y for Y" for yes	Fone and For low volu ter in colum ts in ? "Y" for yes (" for yes or res or "N" for e share in ary circumst :. L-1, Pt. - yes or "N" or "N" for	accordance ances I through for no. no.	00 Y N 1.00 N N N	2. XVIII 2.00 N N N	N I XIX 3.00 N N N	40. 00 45. 00 47. 00
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<ul> <li>38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.</li> <li>39.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)</li> <li>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</li> <li>45.00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)</li> <li>46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.</li> <li>47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of 18 this a hospitals</li> <li>56.00 Is this a hospital involved in training residents in or "N" for no.</li> <li>57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon</li> </ul>	f periods in I payment ac ), (ii), or the mileage ii)? Enter n adjustmen ber 1. Enter . (see inst . (see inst mt for disp eption for t. L, Pt. I capital? Ei t? Enter " approved G period durin r yes or "N th of this of Y", completed I, if applind	djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs ng which re for no in cost report e Worksheet cable.	For low volu er in columnts in ? "Y" for yes (" for yes or (" for yes or (" for yes or (" for yes or "N" for es share in ary circumst :. L-1, Pt. - yes or "N" or "N" for s? Enter "Y esidents in a column 1. :ing period? : E-4. If co	1. me n s s r ior accordance ances l through for no. no. " for yes approved lf column ' Enter "Y i umn 2 i s	00 Y N 1.00 N N N N N 1	2. XVIII 2.00 N N N	N I XIX 3.00 N N N	40. 00 45. 00 48. 00

ealth Financial Systems HANCOCK OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AL HOSPITAL Provider C	F	eriod: rom 01/01/2018 o 12/31/2018	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 5/29/2019 9:5	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	1
<ul> <li>0.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (</li> <li>0.01 If line 60 is yes, complete columns 2 and 3 for each</li> </ul>	(see ins	structions)	Y	23.00	1	60. 0 60. 0
instructions)	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	-
1.00 Did your hospital receive FTE slots under ACA	1.00	2.00	0.00	0.00		61.0
<ul> <li>section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see</li> </ul>						61. C
<ul> <li>instructions)</li> <li>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)</li> </ul>						61.0
<ul> <li>1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)</li> </ul>						61.0
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.(
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
	Pro	ogram Name	2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.		1.00	2.00	0.00		61.1
1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.1
					1.00	-
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				od for which	1	62.0
your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s	ng Health Cen see instructio	ter (THC) into			62.
"Y" for yes or "N" for no in column 1. If yes, complex	ettings	during this c		uctions)	N Ratio (col. 1/	63.
			FTĔs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovid	der Settings	1.00 This base year	2.00 is your cost r	3.00 Teporting	
period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June ty train n-primar all non d non-pr n column	30, 2010. med residents y care provider imary care n 3 the ratio	0.00	-		64.

	EX IDENTIFICATION D	ATA Provider	Fr	eriod: com 01/01/2018	Workshee Part I		
			To	12/31/2018	Date/Tir 5/29/20	ne Prep 19 9:57	ared 'am
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (co	ol. 3/	cim
			FTES	FTEs in	(col. 3		
			Nonprovider Site	Hospi tal	4))		
	1.00	2.00	3.00	4.00	5.00	C	
.00 Enter in column 1, if line 63			0.00	0.00	0. (	000000	65. (
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3							
divided by (column 3 + column							
4)). (see instructions)			Unweighted	Unweighted	Ratio (co	ol 1/	
			FTEs	FTEs in	(col. 1		
			Nonprovi der	Hospi tal	2))		
			Si te 1.00	2.00	2.00		
Section 5504 of the ACA Current \	Year FTF Residents i	n Nonnrovider Settir			<u>3.00</u>		
beginning on or after July 1, 201 00 Enter in column 1 the number of u	10	·					
FTEs that trained in your hospita	al. Enter in column	3 the ratio of					
(column 1 divided by (column 1 +	<u>column 2)). (see in</u> Program Name		Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (co (col. 3 - 4))	+ col.	
		structions)	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 4))	+ col.	67.
.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	Program Name	structions) Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col. 3 4))	+ col.	67.
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3	Program Name	structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital 4.00 0.00	(col. 3 4)) 5.00 0 0.0	+ col .	67.
<ul> <li>Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)</li> </ul>	Program Name 1.00 PS	structions) Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col. 3 4)) 5.00 0.0	+ col . 0 0000000 3.00	
00       Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)         Inpatient Psychiatric Facility PF 00	Program Name 1.00 PS ychiatric Facility (	structions) Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col. 3 4)) 5.00 0 0.0	+ col . 0 0000000 3.00	
<ul> <li>00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)</li> <li>Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions)</li> </ul>	Program Name 1.00 1.00 PS ychiatric Facility ( the facility have a afore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y	Program Code Program Code 2.00 1PF), or does it con n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o.	(col. 3 4)) 5.00 0 0.0	+ col . D D D D D D D D D D D D D	70.
<ul> <li>00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</li> <li>Inpatient Psychiatric Facility PF for yes or "N" for no.</li> <li>100 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFC column 3: If column 2 is Y, indic</li> </ul>	Program Name 1.00 1.00 PS ychiatric Facility ( the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y y PPS nabilitation Facilit	structions)         Program Code         2.00         1PF), or does it con         n approved GME teach         004? Enter "Y" for         ility train resident         )(D)? Enter "Y" for         tear began during thi	FTËs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o.	(col. 3 4)) 5.00 0 0.0	+ col . ) ) ) ) ) ) ) ) ) ) ) ) )	67. ( 70. ( 71. ( 75. (

Heal th	Financial Systems HANCOCK REGIONA	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0037	Peri od:	Worksheet S-	2
				From 01/01/2018 To 12/31/2018	Part I Date/Time Pro	epared:
					5/29/2019 9:	57 am
					1.00	_
	Long Term Care Hospital PPS				1.00	
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for	no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part of	r all of the	cost reportin	g period? Enter	N	81.00
	"Y" for yes and "N" for no.		•			
	TEFRA Providers				-	
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)				N	85.00
	Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	a unit) under	42 CFR Secti	on		86.00
	Is this hospital an extended neoplastic disease care hospital	l classified	under section		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					07.00
				V	XI X	
				1.00	2.00	
	Title V and XIX Services					
	Does this facility have title V and/or XIX inpatient hospital	l services? E	nter "Y" for	N	Y	90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through tl	he cost renor	t either in	N	Y	91.00
	full or in part? Enter "Y" for yes or "N" for no in the appli					/1.00
	Are title XIX NF patients occupying title XVIII SNF beds (dua				N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applical					
93.00	Does this facility operate an ICF/IID facility for purposes of	of title V an	d XIX? Enter	N	N	93.00
04 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for n	o in the	N	N	94.00
	applicable column.			N	N	94.00
	If line 94 is "Y", enter the reduction percentage in the appl	licable colum	ın.	0.00	0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes			N	N	96.00
	applicable column.					
	If line 96 is "Y", enter the reduction percentage in the appl			0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the in			Y	Y	98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo column 1 for title V, and in column 2 for title XIX.	or yes or in				
	Does title V or XIX follow Medicare (title XVIII) for the rep	porting of ch	arges on Wkst	. Y	Y	98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti					
	title XIX.					
	Does title V or XIX follow Medicare (title XVIII) for the cal			Y	Y	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on for title V, and in column 2 for title XIX.	r "N" Tor no	IN COLUMN I			
	Does title V or XIX follow Medicare (title XVIII) for a criti	ical access h	ospital (CAH)	Ν	N	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes					10.00
	for title V, and in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) for a CAH			N	N	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in	column 1 for	title V, and			
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add ba	ck the RCF di	sallowance on	Y	Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co					10.00
	column 2 for title XIX.					
98.06	Does title V or XIX follow Medicare (title XVIII) when cost i			Y	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	1 for title	V, and in			
	Rural Providers					-
	Does this hospital qualify as a CAH?			N		105.00
	If this facility qualifies as a CAH, has it elected the all-i	inclusive met	hod of paymen	t N		106.00
	for outpatient services? (see instructions)					
	If this facility qualifies as a CAH, is it eligible for cost			N		107.00
	training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.			+		
	reimbursed. If yes complete Wkst. D-2, Pt. II.	25 and the p				
108.00	Is this a rural hospital qualifying for an exception to the (	CRNA fee sche	dul e? See 42	N		108.00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		_			
		Physi cal	Occupationa		Respiratory	_
100.00	If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
	therapy services provided by outside supplier? Enter "Y"	IN		IN IN	IN	109.00
	for yes or "N" for no for each therapy.					
440 -				4404	1.00	110
	Did this hospital participate in the Rural Community Hospital Demonstration)for the current cost reporting period? Enter "\				N	110.00
	complete Worksheet E, Part A, lines 200 through 218, and Worl					
	applicable.			5		

leal th Financial Systems HANCOCK REGIONAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider Co	CN: 15-0037	Period: From 01/01		Workshe Part I	eet S-2 me Pre	epared:
III.00 If this facility qualifies as a CAH, did it participate in the Frontier Control Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, or integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	1.00 N	)	2.(	00	111.00
			1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 3 either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N"	is "E", enter rm care (incl he definitior	in column udes	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "		"N" for	N Y			117.00
no. 118.00Is the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	if the policy	/ is	2			118.00
	Premi ums	Losse	es	Insur	ance	
	1.00	2.0	0	3. (	00	-
118.01 List amounts of malpractice premiums and paid losses:	813, 4	.99	C		(	0118.01
		1.00	)	2. (	00	
118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein. 119.00 DO NOT USE THIS LINE	ost centers	N				118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pros §3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	" for yes or he Outpatient			N		120.00
121.00Did this facility incur and report costs for high cost implantable device:	s charged to	Y				121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.						122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certi in column 1 and termination date, if applicable, in column 2.		2				126. 00
127.00 If this is a Medicare certified heart transplant center, enter the certif	ication date					127.00
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certified	ication date					128.00
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	cation date i	n				129.00
30.00 If this is a Medicare certified pancreas transplant center, enter the cer	ti fi cati on					130.00
date in column 1 and termination date, if applicable, in column 2. I31.00 If this is a Medicare certified intestinal transplant center, enter the co	erti fi cati on					131.00
date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified islet transplant center, enter the certif	ication date					132.00
in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certif						133.00
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the OPO number						134. 00
and termination date, if applicable, in column 2. All Providers						
140.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home		s N				140.00

	X IDENTIFICATION DATA	NAL HOSPITAL Provider CCM	№ 15-0037		i od: m 01/01/2018 12/31/2018	u of Form CMS Worksheet S- Part I Date/Time Pr 5/29/2019 9:	2 epared:
1.00	2.				3.00		
If this facility is part of a cha				e name	and address	of the	
home office and enter the home of 41.00Name:	Contractor name and Contractor's Name:	contractor numbe		octor's	Number:		141.0
42.00 Street:	PO Box:		Contra		s number.		141.0
43. 00 Ci ty:	State:		Zip Co	de:			143.0
						1.00	
44.00 Are provider based physicians' cos	sts included in Worksheet	A?				Y	144.0
				-	1.00	2.00	_
45.00  f costs for renal services are cl	aimed on Wkst. A, line 74	4, are the costs	for			2.00	145. C
inpatient services only? Enter "Y	' for yes or "N" for no ir	n column 1. If co	olumn 1 is	s			
no, does the dialysis facility in	clude Medicare utilization	n for this cost i	reporting				
period? Enter "Y" for yes or "N"		weby filed east	nonor+2		N		146.0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in				lf	N		146.0
yes, enter the approval date (mm/d		.5 2, Grapter 40	2, 37020)				
						1.00	
47.00 Was there a change in the statisti						N	147.0
48.00Was there a change in the order o 49.00Was there a change to the simplifi				For po		N N	148. 0 149. 0
49. 00 was there a change to the simplifi		Part A	Part E		Title V	Title XIX	147.0
		1,00	2.00		3.00	4,00	-
Does this facility contain a prov	der that qualifies for a	n exemption from	the appli	i cati o		r of costs	
or charges? Enter "Y" for yes or	'N" for no for each compor			B. (See			
55.00Hospi tal		N	N		N	N	155.0
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N	N N		N N	N N	156. ( 157. (
58. 00 SUBPROVIDER		IN I	IN		IN	IN IN	157.0
59. 00 SNF		N	Ν		Ν	N	159.0
60.00HOME HEALTH AGENCY		N	N		N	N	160. 0
61.00 CMHC			Ν		Ν	N	161. C
							_
Multicompue						1.00	_
Multicampus 65.00 s this hospital part of a Multica	ampus bospital that has or	e or more campus	ses in dif	ferent	CBSAs2	N	165.0
Enter "Y" for yes or "N" for no.		ie of more campa.		reren	0000031		100.0
	Name	County	State	Zip Co		FTE/Campus	
	0	1.00	2.00	3.00	0 4.00	5.00	
66.00 If line 165 is yes, for each						0.0	00166. C
campus enter the name in column O, county in column 1, state in							
column 2, zip code in column 3,							
	1						
CBSA in column 4, FTE/Campus in							
CBSA in column 4, FTE/Campus in						4.00	
CBSA in column 4, FTE/Campus in column 5 (see instructions)	D incentive in the Ameri		Doi nuostr	mant A		1.00	
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI					ct		167 (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use	r under §1886(n)? Enter "	Y" for yes or "I	N" for no.			1.00 Y	
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful used 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I	r under §1886(n)? Enter " D5 is "Y") and is a meanir HIT assets (see instructio	'Y" for yes or "I ngful user (line ons)	N" for no. 167 is "Υ	("), er	nter the		
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is n	r under §1886(n)? Enter " D5 is "Y") and is a meanir HIT assets (see instruction not a meaningful user, doe	'Y" for yes or "N ngful user (line ons) es this provider	۳ for no. 167 is ۳۱ qualify f	("), er For a h	nter the		0168. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?	r under §1886(n)? Enter " D5 is "Y") and is a meanir HIT assets (see instruction not a meaningful user, doo ? Enter "Y" for yes or "N"	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in	۳ for no. 167 is ۳۱ qualify f structior	("), er For a h is)	nter the nardshi p	Y	0168. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful of	r under §1886(n)? Enter " 25 is "Y") and is a meanir HIT assets (see instructic not a meaningful user, doe ? Enter "Y" for yes or "N" user (line 167 is "Y") and	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in	۳ for no. 167 is ۳۱ qualify f structior	("), er For a h is)	nter the nardshi p	Y	0168.0
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?	r under §1886(n)? Enter " 25 is "Y") and is a meanir HIT assets (see instructic not a meaningful user, doe ? Enter "Y" for yes or "N" user (line 167 is "Y") and	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in	۳ for no. 167 is ۳۱ qualify f structior	("), er For a h is)	nter the nardship n, enter the	Y 9. 9	0168.0
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful of	r under §1886(n)? Enter " 25 is "Y") and is a meanir HIT assets (see instructic not a meaningful user, doe ? Enter "Y" for yes or "N" user (line 167 is "Y") and	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in	۳ for no. 167 is ۳۱ qualify f structior	("), er For a h is)	nter the nardshi p	Y	0168.0
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)' 59.00 If this provider is a meaningful user transition factor. (see instruction)	r under §1886(n)? Enter " D5 is "Y") and is a meanir HIT assets (see instruction not a meaningful user, doo ? Enter "Y" for yes or "N" user (line 167 is "Y") and ons)	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in d is not a CAH (l	۷" for no. ۱67 is "۱ qualify f nstructior ine 105 i	("), er For a h is)	nter the nardship ), enter the Beginning	Y 9. 9 Endi ng	0168. ( 168. ( 99169. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user i8.00 If this provider is a CAH (line 10 reasonable cost incurred for the I seception under \$413.70(a)(6)(ii)' 99.00 If this provider is a meaningful user transition factor. (see instruction	r under §1886(n)? Enter " D5 is "Y") and is a meanir HIT assets (see instruction not a meaningful user, doo ? Enter "Y" for yes or "N" user (line 167 is "Y") and ons)	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in d is not a CAH (l	۷" for no. ۱67 is "۱ qualify f nstructior ine 105 i	("), er For a h is)	nter the nardship ), enter the Beginning 1.00	Y 9. 9 Endi ng 2. 00	0168. ( 168. ( 99169. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is a exception under §413.70(a) (6) (ii) 7 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	r under §1886(n)? Enter " D5 is "Y") and is a meanir HIT assets (see instruction not a meaningful user, doo ? Enter "Y" for yes or "N" user (line 167 is "Y") and ons)	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in d is not a CAH (l	۷" for no. ۱67 is "۱ qualify f nstructior ine 105 i	("), er For a h is)	nter the nardship 0, enter the Beginning 1.00 10/01/2016	Y 9.9 Endi ng 2.00 12/31/2016	0168. ( 168. ( 99169. (
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is i exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	r under §1886(n)? Enter " D5 is "Y") and is a meanin HIT assets (see instructio not a meaningful user, doe ? Enter "Y" for yes or "N" user (line 167 is "Y") and ons) beginning date and ending	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in d is not a CAH (l date for the rep	N" for no. 167 is "N qualify f nstructior ine 105 i porting	("), er For a h is)	nter the nardship 0, enter the Beginning 1.00 10/01/2016 1.00	Y 9.9 Endi ng 2.00 12/31/2016 2.00	0 168. ( 168. ( 29 169. ( 
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii) for coll f this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	r under §1886(n)? Enter " D5 is "Y") and is a meaning HIT assets (see instruction enter a meaningful user, doe ? Enter "Y" for yes or "N" user (line 167 is "Y") and ons) Deginning date and ending vider have any days for in	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in d is not a CAH (l date for the rep ndividuals enroll	N" for no. 167 is "N qualify f instruction ine 105 i porting ed in	("), er For a h ns) s "N")	nter the nardship 0, enter the Beginning 1.00 10/01/2016	Y 9.9 Endi ng 2.00 12/31/2016 2.00	0 168. ( 168. ( 29 169. ( 
CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is i exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	r under §1886(n)? Enter " D5 is "Y") and is a meaning HT assets (see instruction a meaningful user, dow ? Enter "Y" for yes or "N" user (line 167 is "Y") and ons) Deginning date and ending wider have any days for in reported on Wkst. S-3, Pt.	'Y" for yes or "I ngful user (line ons) es this provider ' for no. (see in d is not a CAH (l date for the rep ndividuals enroll l, line 2, col.	N" for no. 167 is "N qualify f instruction ine 105 i porting ed in 6? Enter	("), er For a h hs) s "N")	nter the nardship 0, enter the Beginning 1.00 10/01/2016 1.00	Y 9.9 Endi ng 2.00 12/31/2016 2.00	167. ( 0168. ( 168. ( 99169. ( 170. ( 0171. (

OSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0037	Period: From 01/01/2018 To 12/31/2018		epared:
				Y/N	Date	
		6 11 110		1.00	2.00	_
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	TOT ALL NU RE	esponses. Ente	er all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the	begi nni ng of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in co	olumn 2. (see				_
			Y/N	Date	<u>V/I</u>	
. 00	Has the provider terminated participation in the Medicare Pr	rogram2 lf	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	n 3, "V" for				
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	N			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports	field Dublic	Y	A		
. 00 . 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, ilable in	Y N	A		4.0
. 00	those on the filed financial statements? If yes, submit reco					5.0
			1	Y/N	Legal Oper.	
				1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see ins	structions.		Y		7.0
. 00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	and/or renewed	0	Ň		8.0
. 00	Are costs claimed for Interns and Residents in an approved g		cal education	N		9.0
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		the current	Ν		10. 0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V (N	11. 0
				-	<u>Y/N</u> 1.00	+
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes,	, see instruct	tions.		Y	12.0
	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.	5 0	0		Ν	13.0
4.00	If line 12 is yes, were patient deductibles and/or co-paymer	nts waived? If	yes, see ins	structions.	N	14.0
5 00	Bed Complement Did total beds available change from the prior cost reportir	na period? If	Ves see inst	tructions	N	15.0
5.00	The total beds available change from the piror cost reportin	<u><u>v</u> i</u>	-t A	Par		15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.0
7.00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	Y	03/05/2019	Y	03/05/2019	17.0
	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)					
3. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.0
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.

SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0037	Period: From 01/01 To 12/31	/2018 Par /2018 Dat	ksheet S t II e/Time P	- repared
	Descr	iption	Y/N	5/2	<u>9/2019 9</u> Y/N	
		0	1.00		3.00	
.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		Ν	20.0
	Y/N	Date	Y/N		Date	
	1.00	2.00	3.00		4.00	01.0
.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N			21.0
AND TED BY ANT DELIDURED AND TEEDA HADDITAL C AND Y (EVAL					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PI CHILDRENS F	IUSPITALS)				
.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions					22. (
.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		sals made dur	ring the cos	t		23.
.00 Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	eporting peri	od?		24.
.00 Have there been new capitalized leases entered into during instructions.	the cost repor	rting period	?lfyes, see	e		25.
.00 Were assets subject to Sec.2314 of DEFRA acquired during th instructions.		0.	5			26.
.00 Has the provider's capitalization policy changed during the copy. Interest Expense	e cost reportir	ng period? I1	f yes, submi <sup>.</sup>	t		27.
.00 Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into dur	ring the cost	t reporting			28.
.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ebt Service F	Reserve Fund)	)		29.
.00 Has existing debt been replaced prior to its scheduled matu instructions.		debt? If yes	s, see			30.
.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	s, see			31.
Purchased Services .00 Have changes or new agreements occurred in patient care ser		ed through co	ontractual			32.
arrangements with suppliers of services? If yes, see instru 10 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding	g?lf		33.
Provi der-Based Physi ci ans						
.00 Are services furnished at the provider facility under an ar	rangement with	n provider-ba	ased physicia	ans?		34.
If yes, see instructions. .00 If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-bas	sed		35.
physicians during the cost reporting period? If yes, see in	nstructions.		Y/N		Data	_
			1.00		Date 2.00	
Home Office Costs			1.00		2.00	_
.00 Were home office costs claimed on the cost report?						36.
.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	?			37.
If yes, see instructions. .00 If line 36 is yes, was the fiscal year end of the home off						38.
the provider? If yes, enter in column 2 the fiscal year end .00 If line 36 is yes, did the provider render services to othe			5,			39.
see instructions. .00 If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see				40.
	1	00		2 00		_
Cost Report Preparer Contact Information	I. I.	00		2.00		
	TI NA		SEVERS			41.
	BLUE & CO.					42.
preparer. .00 Enter the telephone number and email address of the cost	217 712 7044				2014	43.
	317-713-7946		I JEVER3@B	LUEANDCO.		∥ 43.

Heal th	Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 15-0037	Period:	Worksheet S-2	
					From 01/01/2018 To 12/31/2018		pared: <u>7 am</u>
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the titl	e/position	MANAGER				41.00
	held by the cost report preparer in columns	1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost	report					42.00
	preparer.						
43.00	Enter the telephone number and email address	of the cost					43.00
	report preparer in columns 1 and 2, respecti	vel y.					

NUSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2018 To 12/31/2018		
					10 12/31/2018	Date/Time Prep 5/29/2019 9:5	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e	4.00	5.00	
1 00	Userital Adults & Dada (aslumas E. (. 7 and	1.00	2.00	3.00	4.00	5.00	1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	37	13, 50	0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		37	13, 50	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	24	8, 76	0.00	0	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)		61	22, 26	0.00	0	14.00
15.00	CAH visits	10.00	10	0.45		0	15.00
16.00	SUBPROVIDER - IPF	40.00 41.00	10 0	3, 65		0	16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	41.00	U		0	0	17.00 18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						20.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )	101100					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	89.00				0	26.25
27.00	Total (sum of lines 14-26)		78				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
22 00	outpatient days (see instructions)						22 00
33.00	LTCH non-covered days LTCH site neutral days and discharges				1		33.00 33.01

IOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2018 To 12/31/2018		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	1, 156	51 1, 284		1		2.00
. 00	HMO IPF Subprovider	0	0				3.00
. 00	HMO IRF Subprovider	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 156	51	3, 44	1		7.00
8. 00	INTENSIVE CARE UNIT	1, 868	46	4, 75	9		8.00
. 00	CORONARY CARE UNIT						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY						13.00
4.00	Total (see instructions)	3, 024	97	8, 20	0.00	608.51	
5.00	CAH visits	0,024	0		0.00	000.01	15.00
6.00	SUBPROVIDER - IPF	2,003	0		6 0.00	17.33	
7.00	SUBPROVIDER - IRF	2,003	0		0.00		
8.00	SUBPROVIDER - TRF	U	0		0.00	0.00	18.00
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.00
1.00	OTHER LONG TERM CARE		_				21.00
2.00	HOME HEALTH AGENCY	0	0		0 0.00	0.00	•
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
4.00	HOSPI CE	0	0	95	4 0.00	17.46	
4. 10	HOSPICE (non-distinct part)				0		24.10
25.00	CMHC - CMHC						25.0
6. 00	RURAL HEALTH CLINIC	243	0	3, 20	0.00	4.35	26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26.2
7.00	Total (sum of lines 14-26)				0.00	647.65	27.0
8.00	Observation Bed Days		0	1, 73	1		28.0
9.00	Ambul ance Trips	0					29.00
0.00	Employee discount days (see instruction)			6	5		30.0
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	23	5	0		32.0
2.01	Total ancillary labor & delivery room	0	20		0		32.0
	outpatient days (see instructions)				~		02.0
3. 00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	0					33.0

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	HANCOCK REGIONAL	Provider C	N. 15-0037	Peri od:	u of Form CMS-2 Worksheet S-3	
1103F1 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		FI OVI dei Ci	50. 13-0037	From 01/01/2018 To 12/31/2018	Part I	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider		0	9.	46 24 0 210 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	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						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 21. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00 0.00 0.00	0 0 0	1	46 24 76 0 0 0	246	
22.00 23.00 24.00 24.10 25.00 26.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00 0. 00 0. 00					22.00 23.00 24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0.00 0.00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges				0 0		33. 00 33. 01

PI T	AL WAGE INDEX INFORMATION			Provider C	1	Period: From 01/01/2018 Fo 12/31/2018		parec
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							1
D	Total salaries (see	200.00	47, 531, 924	0	47, 531, 924	4 1, 344, 562. 00	35.35	1.0
C	instructions) Non-physician anesthetist Part		C	o		0.00	0.00	2.
D C	A Non-physician anesthetist Part		C			0.00	0.00	3.
)	B		Ĺ			0.00	0.00	3.
C	Physician-Part A - Administrative		C	0		0.00	0.00	4.
1	Physicians - Part A - Teaching		C	0		0.00	0. 00	4.
0	Physician and Non Physician-Part B		1, 509, 573	0	1, 509, 573	3 10, 064. 00	150.00	5.
D	Non-physician-Part B for		229, 149	0	229, 149	8, 871.00	25.83	6.
	hospital -based RHC and FQHC							
)	services Interns & residents (in an	21.00	C	o		0.00	0.00	7.
	approved program)		-					
1	Contracted interns and residents (in an approved		C	0		0.00	0.00	7.
	programs)							
C	Home office and/or related organization personnel		C	0		0.00	0.00	8
D	SNF	44.00	C	0		0.00	0.00	9
00	Excluded area salaries (see		7, 547, 681	164, 977	7, 712, 658	3 203, 987. 82	37. 81	10
	instructions) OTHER WAGES & RELATED COSTS							
	Contract Labor: Direct Patient		201, 980	0	201, 980	3, 230. 85	62.52	11
00	Care Contract Labor: Top Level		C			0.00	0.00	12
50	management and other					0.00	0.00	1.5
	management and administrative services							
00	Contract Labor: Physician-Part		176, 055	i o	176, 05	5 1, 610. 06	109.35	13
~	A - Administrative							1.4
00	Home office and/or related organization salaries and		C	0		0.00	0.00	14
	wage-related costs							
	Home office salaries Related organization salaries		C	-		0.00		
	Home office: Physician Part A		C	-		0.00		
20	- Administrative Home office and Contract		C	0		0.00	0.00	16
50	Physicians Part A - Teaching		C			0.00	0.00	
	WAGE-RELATED COSTS		0.000.000		0.000.000			1 17
00	Wage-related costs (core) (see instructions)		8, 982, 929		8, 982, 929	7		
00	Wage-related costs (other)		C	0		C		18
00	(see instructions) Excluded areas		383, 407	, o	383, 40	7		19
	Non-physician anesthetist Part		C			D		20
00	A Non-physician anesthetist Part		9, 503	0	9, 503	3		21
	В				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
00	Physician Part A - Administrative		C	0	(			22
	Physician Part A - Teaching		C			D		22
	Physician Part B Wage-related costs (RHC/FQHC)		139, 002 54, 163		139, 002 54, 163			23
	Interns & residents (in an		54, 103 C		54, 10.			24
	approved program)							0.5
50	Home office wage-related (core)		C	0				25
51	Related organization		C	0		D		25
52	wage-related (core) Home office: Physician Part A		C	0	(	b		25
	- Administrative - wage-related (core)							
53	Home office & Contract		C	0		D		25
	Physicians Part A - Teaching -							
	wage-related (core) OVERHEAD COSTS - DIRECT SALARIE	S		I	I		I	
	Employee Benefits Department	4.00	533, 672	2 0	533, 672	2 12, 938. 74	41.25	26

Heal th	Financial Systems		HANCOCK REGIO	NAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2018 To 12/31/2018		pared:
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		980, 007	0	980, 00	7 6, 881. 24	142. 42	28.00
29.00	Maintenance & Repairs	6.00	0	0	(	0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 055, 841	0	1, 055, 84	1 34, 609. 81	30. 51	30.00
31.00	Laundry & Linen Service	8.00	0	0	(	0.00	0.00	31.00
32.00	Housekeepi ng	9.00	1, 422, 043	0	1, 422, 04	3 84, 059. 32	16. 92	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	1, 429, 180	-989, 487	439, 693	3 23, 595. 32	18.63	34.00
35.00	Dietary under contract (see instructions)		0	0	(	0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	989, 487	989, 48	7 53, 097. 00	18.64	36.00
37.00	Maintenance of Personnel	12.00	0	0	(	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1, 218, 229	0	1, 218, 22	9 27, 145. 61	44.88	38.00
39.00	Central Services and Supply	14.00	57,007		57,00	7 2, 415. 78	23.60	39.00
40.00	Pharmacy	15.00	1, 852, 368	-27, 751	1, 824, 61	7 40, 483. 67	45.07	40.00
41.00	Medi cal Records & Medi cal Records Library	16. 00	606, 304		606, 30	4 23, 639. 22	25. 65	41.00
42.00	Soci al Servi ce	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

Heal th	Financial Systems		HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2018	Worksheet S-3 Part III	
						To 12/31/2018		pared:
							5/29/2019 9:5	7 am
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid 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	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		46, 773, 209	0	46, 773, 20	9 1, 332, 508. 24	35. 10	1.00
	instructions)							
2.00	Excluded area salaries (see		7, 547, 681	164, 977	7, 712, 65	8 203, 987. 82	37.81	2.00
	instructions)							
3.00	Subtotal salaries (line 1		39, 225, 528	-164, 977	39, 060, 55	1 1, 128, 520. 42	34. 61	3.00
	minus line 2)							
4.00	Subtotal other wages & related		378, 035	0	378, 03	5 4, 840. 91	78.09	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 982, 929	0	8, 982, 92	9 0.00	23.00	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		48, 586, 492	-164, 977	48, 421, 51	5 1, 133, 361. 33	42.72	6.00
7.00	Total overhead cost (see		18, 138, 367	-192, 728	17, 945, 63	9 529, 527. 46	33.89	7.00
	instructions)							
		•		•	•			•

Heal th	Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE RELATED COSTS		Provider CCN	: 15-0037	Period: From 01/01/2018 To 12/31/2018		pared:
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contr					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (se					1, 710, 452	3.00
4.00	Qualified Defined Benefit Plan Cost (see i					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension P					0	6.00
7.00	Employee Managed Care Program Administrati	on Fees				3, 675, 598	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded					0	8.00
8.01	Health Insurance (Self Funded without a Th					0	8.01
8.02	Health Insurance (Self Funded with a Third	Party Administrato	~)			0	8.02
8.03	Heal th Insurance (Purchased)					0	8.03
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					517, 048	
11.00	Life Insurance (If employee is owner or be					154, 892	
12.00	Accident Insurance (If employee is owner o					0	12.00
13.00	Disability Insurance (If employee is owner					105, 785	
14.00	Long-Term Care Insurance (If employee is o	wher or beneficiary	)			0	
15.00	'Workers' Compensation Insurance					1, 646	
16.00	Retirement Health Care Cost (Only current	year, not the extra	ordi nary accru	al require	d by FASB 106.	0	16.00
	Non cumulative portion)						
17 00	TAXES					2 202 254	17 00
	FICA-Employers Portion Only Medicare Taxes - Employers Portion Only					3, 293, 256	17.00 18.00
18.00 19.00	Unemployment Insurance					0	
	1 5					8, 831	
20.00	OTHER					0	20.00
21.00	Executive Deferred Compensation (Other Tha	n Datiromant Cast D	ported on lin	oc 1 throu	ah Lahaya (caa	0	21.00
21.00	instructions))	II Keti Tement Cost K		les i thiou	gii 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					33, 589	
23.00	Tuition Reimbursement					67, 906	
24.00	Total Wage Related cost (Sum of lines 1 -2	3)				9, 569, 003	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					0	25.00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0037	Peri od:	Worksheet S-3	
			From 01/01/2018		
			To 12/31/2018	Date/Time Prep 5/29/2019 9:5	
Cost Center Description			Contract Labor		
oust center bescription			1.00	2.00	
PART V - Contract Labor and Benefit Co	st		1.00	2.00	
Hospital and Hospital-Based Component					
1.00 Total facility's contract labor and be			201, 980	9, 569, 003	1.00
2.00 Hospi tal			201, 980	9, 569, 003	2.00
3.00 Subprovider - IPF			0	0	3.00
4.00 Subprovider - IRF			0	0	4.00
5.00 Subprovider - (Other)			0	0	5.00
6.00 Swing Beds - SNF			0	0	6.00
7.00 Swing Beds - NF			0	0	7.00
8.00 Hospital-Based SNF					8.00
9.00 Hospital-Based NF					9.00
10.00 Hospital-Based OLTC					10.00
11.00 Hospital-Based HHA			0	0	11.00
12.00 Separately Certified ASC					12.00
13.00 Hospital-Based Hospice			0	0	13.00
14.00 Hospital-Based Health Clinic RHC			0	0	
15.00 Hospital-Based Health Clinic FQHC					15.00
16.00 Hospital-Based-CMHC					16.00
17.00 Renal Dialysis					17.00
18.00 Other			0	0	18.00

Heal th	Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	
			Component		From 01/01/2018 To 12/31/2018		
					RHC I	Cost	
					1	. 00	-
	Clinic Address and Identification						
1.00	Street				224 WEST MAIN		1.00
				ty 00	State 2.00	ZIP Code	
2.00	City, State, ZIP Code, County		KNI GHTSTOWN	00	2.00	3.00 \\46148	2.00
2100							2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u		Award	0	3.00
					<u>Award</u> .00	Date 2.00	
	Source of Federal Funds					2100	
4.00	Community Health Center (Section 330(d), PHS			13	7632	07/01/2015	4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00 7.00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	J(d), PHS ACT)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)				_		9.00
					1.00	2.00	
10.00	Does this facility operate as other than a ho	ospital-based F	RHC or FOHC? Fr	ter "Y" for	1.00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of a	other operation	ns in column			10.00
		Sur	nday	Мо	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC	[	1	08:00	16: 00	08:00	11.00
11.00				00.00	10.00	00.00	11.00
					1.00	2.00	
	Have you received an approval for an exception Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. ´	100-04, chapter	9, section	Ν	0	12.00 13.00
	number of providers included in this report. numbers below.						
					ler name	CCN number	
14 00	RHC/FQHC name, CCN number				. 00	2.00	14.00
00		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	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)						
				unty			
2.00				00			2.00
2.00	City, State, ZIP Code, County	Tuesday	HENRY	esday	Thu	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
44 00	Facility hours of operations (1)	4 . 00		4 (	00.00	11 ( . 00	144.05
11.00	CLI NI C	16:00	08: 00	16: 00	08: 00	16:00	11.00

Health Financial Systems	HANCOCK REGIO	NAL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0037	Period:	Worksheet S-8	
		Component	CCN: 15-3987	From 01/01/2018 To 12/31/2018	Date/Time Pre	narod
		component	CCN: 13-3707	10 12/31/2010	5/29/2019 9:5	
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)			_			
11. 00 CLINIC	08: 00	16: 00				11.00

Hospice CON:         15-1547         From         01/01/2018         PARTS I         THROUGD Date/Time Preparation           Unduplicated Days         It is XVIII         Ti tile XVIII         Ti tile XVIII         Nursing Facility         All Other         Cols (sum of Cols 1, 2 & 5)           Image: Cols Cols Cols Cols Cols Cols Cols Cols		Financial Systems		HANCOCK REGIO				u of Form CMS-2		
PART I         -         ENROLLMENT DAYS         FOR COST REPORTING         PERIODS BEGINNING         BEFORE         OCTOBER         1.         2015           1.00         2.00         3.00         4.00         5.00         6.00           1.00         2.00         3.00         4.00         5.00         6.00           1.00         2.00         3.00         4.00         5.00         6.00           1.00         2.00         3.00         4.00         5.00         6.00           1.00         2.00         3.00         4.00         5.00         6.00           1.00         2.00         3.00         4.00         5.00         6.00           1.00         2.00         3.00         4.00         5.00         6.00           1.00         Hospice Continuous Home Care         Image: Continuous Care         I	HOSPI T	AL-BASED HOSPICE IDENTIFICATION	DATA				From 01/01/2018	Date/Time Pre	GH IV pared:	
Days         Title XVIII         Title XVIII         Title XIX         All Other         Total (sum of cols. 1, 2 & 5)           PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         0         6.00         5.00         6.00           PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         0         6.00         5.00         6.00           1.00         2.00         3.00         4.00         5.00         6.00           PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         0         0         0         0           0.00         Hospice Continuous Home Care         0         0         0         0         0           0.01         Hospice Routine Home Care         0         0         0         0         0           0.01         Hospice Care inpatient Care         0         0         0         0         0         0           0.01         Indue of patients receiving hospice care         0         0         0         0         0         0         0           0.00         Average Length of Stay (Line 5         /         1         0         0         0         0         0         0         0         0         0							Hospi ce I			
Image: second			Unduplicated							
PART 1         ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNI NG BEFORE OCTOBER 1, 2015         Col s. 1, 2 & 5)           1.00         2.00         3.00         4.00         5.00         6.00           Hospice Continuous Home Care         0         4.00         5.00         6.00           00         Hospice Routine Home Care         0         0         6.00           00         Hospice Continuous Home Care         0         0         0         0           00         Hospice Continuous Home Care         0         0         0         0         0           00         Hospice Continuous Home For patient Respite Care         0         0         0         0         0         0           00         Hospice Care         0										
PART 1 - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         Solution         Facility         Solution           00         Hospice Continuous Home Care         0         4.00         5.00         6.00           10.00         Hospice Continuous Home Care         0         1.00         2.00         3.00         4.00         5.00           10.00         Hospice Continuous Home Care         0         1.00         2.00         1.00         2.00         3.00         4.00         5.00         6.00           10.00         Hospice Continuous Home Care         0         0.01         1.00         2.00         1.00         2.00         1.00         2.015         1.00         1.00         2.015         1.01 <td></td> <td></td> <td>Title XVIII</td> <td>Title XIX</td> <td></td> <td></td> <td>All Other</td> <td></td> <td></td>			Title XVIII	Title XIX			All Other			
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         1.00       PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         1.00       Hospice Continuous Home Care         3.00       Hospice Continuous Home Care         1.00       Hospice Continuous Home Care         1.00       Hospice Continuous Home Care         1.00       Hospice Contail Hospice Care         1.00       Hospice Care         1.00       Total Hospice Days         Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         Number of patients receiving         hospice care         7.00         Total number of unduplicated         Continuous Care hours billable         Average Length of Stay (line 5         / line 6)         9.00         Unduplicated census count         IOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.         Title XVIII       Title XIX       Other         IOTO Hospice Court nuous Home Care       0       0       0         IONO       Hospice Coutine Home Care       0       0       0       0         IONO       Hospice Coutinuous Game Care       0       0       0       0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>										
PART I       ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015       4.00       5.00       6.00         1.00       Hospic c Continuous Home Care       Hospic c Continuous Home Care       1.00       2.00       3.00       4.00       5.00       6.00         1.00       Hospic c Continuous Home Care       Hospic c Continuous Home Care       1.00       2.015       1.00       1.0						Facility		5)		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         1.00       Hospice Continuous Home Care         0.01       Hospice Routine Home Care         0.02       Hospice Routine Home Care         0.03       Hospice Routine Home Care         0.04       Hospice Care Inpatient Respite Care         0.05       Total Hospice Days         0.06       Number of patients receiving hospice care         1.00       Average Length of Stay (Line 5         2.00       Average Length of Stay (Lin										
1.00       Hospice Continuous Home Care Hospice Routine Home Care 2.00       Hospice Continuous Home Care Hospice Routine Home Care Total Hospice Days       Image: Continuous Home Care Hospice Care       Image: Continuous Care Hospice Days         Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         Number of patients receiving hospice care Continuous Care hours billable to Medicare 8.00       Image: Continuous Care hours 1 and 2 also include the days reported in columns 3 and 4.         Title XVIII       Title XVIII       Title XIX       Other       Total (sum of cols. 1 through 3)         O         O       Image: Continuous Home Care       Ima							5.00	6.00		
2.00       Hospice Routine Home Care Hospice General Inpatient Respite Care Total Hospice Days       Image: Construct of the construction			IST REPORTING P	PERIODS BEGINNI	NG BEFORE OCIO	BER 1, 2015				
3.00       Hospice Inpatient Respite Care         4.00       Hospice General Inpatient Care         5.00       Total Hospice Days         Part 11 - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         5.00       Number of patients receiving hospice care         7.00       Total number of unduplicated Continuous Care hours billable to Medicare         8.00       Average Length of Stay (line 5 / line 6)         9.00       Unduplicated census count         NOTE:       Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.         Title XVIII         Title XVIII       Title XIX         0       0       0         0.00       Hospice Continuous Home Care       0       0         11.00       2.00       3.00       4.00         Part II - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015         10.00       Hospice Continuous Home Care       0       0       0         11.00       2.00       3.00       4.00         11.00       0       0       0       0         11.00       2.00       3.00       4.00         11.00       2.00       3.00       4.00         11.00       2.00									1.00	
4.00       Hospice General Inpatient Care Total Hospice Days       Image: Construct of the spice Days         Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         5.00       Number of patients receiving hospice care to Medicare       Image: Construct of the spice care to Medicare         8.00       Average Length of Stay (line 5 / line 6)       Image: Construct of the spice care spice care       Image: Construct of the spice care spice care         9.00       Unduplicated census count       Image: Construct of the spice care spice care       Image: Construct of the spice care spice care         9.00       Unduplicated census count       Image: Construct of the spice care spice care       Image: Construct of the spice care spice care spice care         9.00       Unduplicated census count       Image: Construct of the spice care									2.00	
5.00       Total Hospice Days									3.00	
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015         Number of patients receiving hospice care         100         Total number of unduplicated Continuous Care hours billable to Medicare         3.00       Average Length of Stay (line 5 / line 6)         9.00       Unduplicated census count         IOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.         Title XVIII         Title XVIII         PART 111 - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015         10.00       Hospice Continuous Home Care         11.00       0         12.00       Hospice Routine Home Care         12.00       1, 243         00       0         12.00       Hospice Care Inpatient Respite Care         00       0         13.00       Hospice Inpatient Care         93       0       0         14.00       Total Hospice Days         PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015         15.00       Hospice Inpatient Respite Care									4.00	
6.00       Number of patients receiving hospice care       Image: Continuous Care hours billable to Medicare       Image: Continuous Home Care hours bill	5.00								5.00	
hospice care       Total number of unduplicated         Continuous Care hours billable       to Medicare         Average Length of Stay (line 5       / line 6)         0.00       Unduplicated census count         IOTE:       Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.         Title XVIII         Title XVIII         Title XVIII         Total (sum of cols. 1 through 3)         1.00         PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015         IO.00         Hospice Continuous Home Care       0       0       0         11.00       Lospice Continuous Home Care       1, 243       0       0       1, 243         12.00       Hospice Inpatient Respite Care       60       0       0       93       0       1, 396         14.00       Total Hospice General Inpatient Care       1, 396       0       1, 396       0       1, 396         14.00       Hospic ce Inpatient Respite Care       0       0       0       1, 396       0       1, 396         15.00       Hospic ce Inpatient Respite Care       0       0       0       1, 396       0       1, 396 </td <td></td> <td></td> <td>REPORTING PERI</td> <td>ODS BEGINNING</td> <td>BEFORE OCTOBER</td> <td>1, 2015</td> <td></td> <td></td> <td></td>			REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015				
7.00       Total number of unduplicated Continuous Care hours billable to Medicare       Image: Continuous Home Care hours billable to Medicare       Image: Conteo hours	5.00								6.00	
Continuous Care hours billable to Medicare Average Length of Stay (line 5 / line 6)       Image: Continuous Care hours billable to Medicare       Image: Continuous Care hours billable to Cols. 1 through 3)         1.00       2.00       3.00       4.00         PART 111 - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015       Image: Continuous Home Care 1.00       Image: Continuous Home Care 1.243       Ima	7 00								7 00	
a.ou       to Medicare         Average Length of Stay (line 5       / line 6)         y.ou       Unduplicated census count         NOTE:       Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.         Title XVIII         Title XVIX         Other<	7.00								7.00	
8.00       Average Length of Stay (line 5 / line 6)       Average Length of Stay (line 5 / line 6)       Image Length of Stay (line 5 / line 6)       Image Length of Stay (line 5 / line 6)       Image Length of Stay (line 5 / line 6)         9.00       Unduplicated census count       Image Length of Stay (line 5 / line 6)         VOTE:       Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.       Image Length of Stay (line 5 / line 6)       Image Length of Stay (line 5 / line 6)         VOTE:       Part III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015       Image Length of Stay (line 3)         10.00       Hospice Continuous Home Care       0       0       0         11.00       Hospice Inpatient Respite Care       60       0       0         11.00       Hospice General Inpatient Care       93       0       0       1, 396         11.00       Hospice Days       1, 396       0       0       1, 396       0       1, 396         11.00       Hospice Days       1, 396       0       0       1, 396       0       1, 396         12.00       Hospice Continuous Home Care       0       0       0       1, 396       0       1, 396 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>										
/ line 6)       // line 6)       // line 6)       // line 6)         9.00       Unduplicated census count       // line 6)       // line 6)         NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.         Title XVIII         Title XIX         Other         Total (sum of cols. 1 through 3)         1.00         PART 111 - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015         IO         O         O         O         O         O         O         O         O         O         O         O         O         O         O       O <td co<="" td=""><td>8 00</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>8.00</td></td>	<td>8 00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>8.00</td>	8 00								8.00
P.00       Unduplicated census count       Image: Constraint of the spice con	5.00								0.00	
NOTE:       Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.         Title XVIII       Title XIX       Other       Total (sum of cols. 1 through 3)         1.00       2.00       3.00       4.00         PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015       0       0       0       0         10.00       Hospice Continuous Home Care       0       0       0       0       0       0       0         11.00       Hospice Continuous Home Care       0 </td <td>9 00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>9.00</td>	9 00								9.00	
Title XVIII       Title XIX       Other       Total (sum of cols. 1 through 3)         1.00       2.00       3.00       4.00         PART 111 - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015       0       0       0         10.00       Hospice Continuous Home Care       0       0       0       0         11.00       Hospice Continuous Home Care       0       0       0       0         12.00       Hospice Inpatient Respite Care       60       0       0       0         13.00       Hospice General Inpatient Care       93       0       0       93         14.00       Total Hospice Days       1, 396       0       1, 396       0       1, 396         14.00       Hospice Inpatient Respite Care       0       0       0       0       1, 396         15.00       Hospice Inpatient Respite Care       0       0       0       0       0			also include :	the days report	ted in columns	3 and 4			71.00	
cols1 through 3)1.002.003.004.001.002.003.004.0010.00Hospice Continuous Home Care00011.00Hospice Routine Home Care00012.00Hospice General Inpatient Respite Care600013.00Hospice Days1,39601,39614.00PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015015.00Hospice Inpatient Respite Care0015.00Hospice Inpatient Respite Care0015.000000										
through 3)1.002.003.004.00PART 111 - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 201510.00Hospice Continuous Home Care00011.00Hospice Routine Home Care000011.00Hospice Inpatient Respite Care6000013.00Hospice General Inpatient Care93009314.00Total Hospice Days1,396001,39615.00Hospice Inpatient Respite Care0000					litle XVIII	litle XIX	Other			
1.002.003.004.00PART 111 - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 201510.00Hospice Continuous Home Care00011.00Hospice Routine Home Care000011.00Hospice Routine Home Care1, 243001, 24312.00Hospice General Inpatient Care60006013.00Hospice General Inpatient Care93009314.00Total Hospice Days1, 396001, 39615.00Hospice Inpatient Respite Care000015.00Hospice Inpatient Respite Care0000										
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 201510.00Hospice Continuous Home Care00011.00Hospice Routine Home Care1, 243001, 24312.00Hospice Inpatient Respite Care60006013.00Hospice General Inpatient Care93009314.00Total Hospice Days1, 396001, 39615.00Hospice Inpatient Respite Care000015.00Hospice Inpatient Respite Care0000					1.00	2.00	2.00	<u> </u>		
10.00Hospice Continuous Home Care000011.00Hospice Routine Home Care1,243001,24312.00Hospice Inpatient Respite Care60006013.00Hospice General Inpatient Care93009314.00Total Hospice Days1,396001,39615.00Hospice Inpatient Respite Care000015.00Hospice Inpatient Respite Care0000		DADT III ENDOLIMENT DAVS FOR	COST DEDODTI NO					4.00		
11.00Hospice Routine Home Care1,243001,24312.00Hospice Inpatient Respite Care6006013.00Hospice General Inpatient Care930014.00Total Hospice Days1,396001,396PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 201500015.00Hospice Inpatient Respite Care0000	10 00		CUST REPORTING	PERIODS DEGIN		ER UCTUBER I		0	10.00	
12.00Hospice Inpatient Respite Care6006013.00Hospice General Inpatient Care93009314.00Total Hospice Days1,396001,396PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 201515.00Hospice Inpatient Respite Care000					1 242		0	Ŭ	10100	
13.00Hospice General Inpatient Care9309314.00Total Hospice Days1,396001,396PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 201515.00Hospice Inpatient Respite Care000							-		12.00	
It. 00     Total Hospice Days     1,396     0     1,396       PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015     15.00     Hospice Inpatient Respite Care     0     0     0							-		12.00	
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015           15.00         Hospice Inpatient Respite Care         0         0         0         0         0         0										
15.00         Hospice Inpatient Respite Care         0	14.00		I DATA FOR COS						14.00	
	15 00		L DATA FOR COS	T REFORTING FL	1	1			15.00	
16.00 Hospice General Inpatient Care 0 0 0							0 0		16.00	

Heal th	Financial Systems HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-0037	Period:	Worksheet S-1	0
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 columr	18)	0. 249418	1.00
	Medicaid (see instructions for each line)	2		,		
2.00	Net revenue from Medicaid				6, 240, 681	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen			ii d?	Y	4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments f Medicaid charges	rom Medical	a		0 37, 673, 181	5.00 6.00
8.00 7.00	Medicaid cost (line 1 times line 6)				9, 396, 369	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of lir	es 2 and 5 <sup>.</sup> if	3, 155, 688	8.00
01.00	< zero then enter zero)				0, 100, 000	
	Children's Health Insurance Program (CHIP) (see instructions f	or each lin	e)			
9.00	Net revenue from stand-al one CHIP				0	9.00
	Stand-allone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(lipo 11 mi	nuc lino 0, i	f < zoro thon		11.00
12.00	enter zero)		nus i ne 7, i		0	12.00
	Other state or local government indigent care program (see ins	tructions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not inc	luded on li	nes 2, 5 or 9	)	0	13.00
14.00	Charges for patients covered under state or local indigent car	e program (	Not included	in lines 6 or	0	14.00
15 00	10)					15 00
15.00	State or local indigent care program cost (line 1 times line 1 Difference between net revenue and costs for state or local in		program (Lir	o 15 minus lino	0	15.00 16.00
10.00	13; if < zero then enter zero)	argent care			0	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and state	e∕local indig	ent care program	ns (see	
47.00	instructions for each line)					1 1 7 00
	Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of				0	17.00 18.00
18.00				(sum of lines	0 3, 155, 688	
17.00	8, 12 and 16)	i indigent			0, 100, 000	17.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fa	cility	3, 144, 95	1, 895, 118	5, 040, 075	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	784, 40	)9 1, 895, 118	2, 679, 527	21.00
00.00	instructions)	66				
22.00	Payments received from patients for amounts previously written charity care	orr as		0 0	0	22.00
23.00	5		784, 40	1, 895, 118	2, 679, 527	23.00
				.,		
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie		ond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t		care program	's length of	0	25.00
	stay limit	5	1 5	5		
26.00					12, 281, 865	
	Medicare reimbursable bad debts for the entire hospital comple				0	27.00
	Medicare allowable bad debts for the entire hospital complex (	see instruc	tions)		12 201 0/5	
	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt ex	nonco (coc	instructions)		12, 281, 865	
29.00 30.00		heuze (zee	instructions)		3, 063, 318 5, 742, 845	
	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			8, 898, 533	
000					0,0,0,000	1 31. 50

RECLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	HANCOCK REGIONAL F EXPENSES	Provider CC		eri od:	u of Form CMS-2 Worksheet A	2552-10
				T	rom 01/01/2018 5 12/31/2018	Date/Time Pre 5/29/2019 9:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS		10,000,001	40.000.004	a	10.000.001	
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	533, 672	10, 292, 324 6, 859, 907	10, 292, 324 7, 393, 579	0	10, 292, 324 7, 393, 579	1.00 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	8, 983, 716	15, 932, 347	24, 916, 063	-1, 012, 920	23, 903, 143	
7.00	00700 OPERATION OF PLANT	1, 055, 841	5, 238, 755	6, 294, 596	1, 603	6, 296, 199	
9.00	00900 HOUSEKEEPI NG	1, 422, 043	849, 777	2, 271, 820	0	2, 271, 820	
10.00	01000 DI ETARY	1, 429, 180	1, 174, 653	2, 603, 833	-1, 802, 753	801,080	
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 1, 218, 229	0 315, 716	0 1, 533, 945	1, 802, 753 0	1, 802, 753 1, 533, 945	
14.00	01400 CENTRAL SERVICES & SUPPLY	57,007	49, 541	106, 548	-81	106, 467	14.00
15.00	01500 PHARMACY	1, 852, 368	12, 507, 690	14, 360, 058	-11, 735, 374	2, 624, 684	
16.00	01600 MEDICAL RECORDS & LIBRARY	606, 304	210, 541	816, 845	5, 210	822, 055	
23.00	02300 PARAMED ED PRGM	121, 555	18, 977	140, 532	-2, 184	138, 348	23.00
30.00	03000 ADULTS & PEDIATRICS	2, 811, 780	685, 104	3, 496, 884	-12, 509	3, 484, 375	30.00
31.00	03100 I NTENSI VE CARE UNI T	3, 179, 078	701, 573	3, 880, 651	-22, 899	3, 857, 752	
40.00	04000 SUBPROVI DER – I PF	1, 221, 718	239, 240	1, 460, 958	-474	1, 460, 484	
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
50.00	ANCI LLARY SERVI CE COST CENTERS	3, 179, 952	3, 091, 898	6, 271, 850	-50, 561	6, 221, 289	50.00
51.00	05100 RECOVERY ROOM	320, 969	38, 803	359, 772	-1, 209	358, 563	
53.00	05300 ANESTHESI OLOGY	0	137, 470	137, 470	0	137, 470	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 143, 350	1, 982, 221	5, 125, 571	-299, 042	4, 826, 529	
60.00	06000 LABORATORY	1, 588, 872	2,652,479	4, 241, 351	5, 738	4, 247, 089	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 385, 872 1, 128, 098	218, 786 112, 495	1, 604, 658 1, 240, 593	3, 173 -555	1, 607, 831 1, 240, 038	
67.00	06700 OCCUPATI ONAL THERAPY	326, 741	25, 318	352, 059	-555	352, 059	
68.00	06800 SPEECH PATHOLOGY	168, 924	17,089	186, 013	0	186, 013	
68.01	06801 OCCUPATI ONAL HEALTH	0	0	0	0	0	68.01
69.00	06900 ELECTROCARDI OLOGY	630, 279	302, 696	932, 975	14, 078	947,053	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 579, 721	3, 579, 721	0	3, 579, 721	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	1, 459, 164 0	1, 459, 164 0	0 12, 352, 652	1, 459, 164 12, 352, 652	
76.00	03020 CARDI AC	0	0	0	12, 332, 032	12, 332, 032	76.00
76. 01	03160 CARDI OPULMONARY	63, 782	6, 734	70, 516	-15	70, 501	76.01
	OUTPATIENT SERVICE COST CENTERS	000 1 10	044 047	440.404		444 500	
88.00 90.00	08800 RURAL HEALTH CLINIC 09000 CLINIC	229, 149 0	211, 347	440, 496 0	-28, 988	411, 508 0	88.00 90.00
90.01	09001 WOUND CLINIC	498, 846	245, 932	744, 778	-9, 861	734, 917	1
90. 02	09002 DIABETES CLINIC	49, 606	8, 092	57, 698	0	57, 698	
90.03	09003 ASTHMA CLINIC	0	0	0	0	0	
	09004 ANDIS CLINIC 09005 PRIME TIME	121, 691 0	36, 196 119, 621	157, 887 119, 621	-5	157, 882 119, 621	
90.05 90.06	09006 SHELBYVILLE WOUND CLINIC	223, 854	133, 209	357, 063	-5, 136	351, 927	
90.07	04951 ONCOLOGY	915, 742	1, 095, 939	2, 011, 681	-21, 473	1, 990, 208	
90.08	04950 ANDERSON WOMENS CENTER	320, 720	27, 247	347, 967	-115	347, 852	
91.00	09100 EMERGENCY	2, 538, 578	619, 376	3, 157, 954	-33, 941	3, 124, 013	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
		1, 309, 460	1,031,541		-140, 889	2, 200, 112	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	42, 636, 976	72, 229, 519	114, 866, 495	-995, 777	113, 870, 718	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001 PROFESSI ONAL BUILDI NG	65	339, 083	339, 148	-15, 342	323, 806	
	19002 PHYSI CI AN BUI LDI NG	0	8, 987	8, 987	0		190. 02
	19003 PRI VATE DUTY	550, 261	554, 014	1, 104, 275	1 012 020	1, 104, 275	
	19004 MARKETI NG 19005 SPORTS PHYSI CALS	56, 681	0 4, 910	0 61, 591	1, 012, 920 0	1, 012, 920 61, 591	
	19006 FOUNDATI ON	185, 464	1, 160, 451	1, 345, 915	0	1, 345, 915	
190.07	19007 ASC	0	7, 725	7, 725	-528		190. 07
	19008 OTHER NONREI MBURSABLE	0	57, 783	57, 783	0		190.08
	19009 HANCOCK OB	1, 612, 198	4, 998, 757	6, 610, 955	-13	6, 610, 942	
	19010 HANCOCK WELLNESS 19011 MORRI STOWN CLINIC	789, 648 0	313, 505 1, 800	1, 103, 153 1, 800	0	1, 103, 153 1 800	190. 10
	19012 03PUREMED	0	1, 000	0	0		190. 12
190.13	19013 MCCORD WELLNESS	603, 616	251, 199	854, 815	0	854, 815	190. 13
	19014 3 WEST UNIT	189, 128	205, 277	394, 405	-90	394, 315	
	19015 NEUROLOGY PHYSI CI AN	594,060	417, 104	1, 011, 164	0	1,011,164	
	19016 THORACI 19017 HANCOCK ENDO	0	193, 165 108 - 241	193, 165 108 - 241	0	193, 165 108, 241	
	TTOTAT ANULUUN ENDU	U	108, 241	108, 241	0	108, 241	1170.1

Health Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CO		eriod: rom 01/01/2018	Worksheet A	
				o 12/31/2018		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
190.18 19018 HANCOCK FOOT & ANKLE	313, 827	142, 818	456, 645	-1, 170	455, 475	190. 18
190. 19 19019 HANCOCK RHEUM	0	84, 982	84, 982	0	84, 982	190. 19
200.00 TOTAL (SUM OF LINES 118 through 199)	47, 531, 924	81, 079, 320	128, 611, 244	0	128, 611, 244	200. 00

CLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	HANCOCK REGIO F EXPENSES	Provi der CCN:	15-0037	Peri od: From 01/01/2018	u of Form CMS-25 Worksheet A	552-1
					To 12/31/2018	Date/Time Prepa 5/29/2019 9:57	
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00			372772017 7.37	
	GENERAL SERVICE COST CENTERS	0.00	7.00				
00	00100 NEW CAP REL COSTS-BLDG & FIXT	-506, 918					1.0
00 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	-2, 426, 560 -8, 155, 780					4.0 5.0
00	00700 OPERATION OF PLANT	-8, 155, 780 -18, 807					5.0
00	00900 HOUSEKEEPING	-159, 292					9.0
0. 00	01000 DI ETARY	-447, 077					10.0
I. 00	01100 CAFETERI A	-138, 207					11. C
	01300 NURSI NG ADMI NI STRATI ON	-19,960					13. (
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	-32, 590 -979, 527					14. ( 15. (
	01600 MEDICAL RECORDS & LIBRARY	-57, 100	1				16.0
	02300 PARAMED ED PRGM	-45,560					23.0
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	-51, 392 C					30. 0 31. 0
	04000 SUBPROVIDER - IPF	-96,000					40.0
	04100 SUBPROVI DER – I RF	C					41. (
	ANCI LLARY SERVICE COST CENTERS	l .	1				
	05000 OPERATING ROOM	-1, 280, 767					50.0
	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	C -136, 948					51. ( 53. (
1. 00	05400 RADI OLOGY-DI AGNOSTI C	-37, 733	1				54. (
0. 00	06000 LABORATORY	-224, 838					60.
	06500 RESPI RATORY THERAPY	-90, 479					65.0
5.00	06600 PHYSI CAL THERAPY	C					66. (7
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY						67. 68.
	06801 OCCUPATI ONAL HEALTH	C					68.
	06900 ELECTROCARDI OLOGY	-6, 100	940, 953				69.
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	-81					71.
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS						72. 73.
	03020 CARDI AC						76.0
	03160 CARDI OPULMONARY	C					76.0
	OUTPATIENT SERVICE COST CENTERS	2.000	400 500				00 (
	08800 RURAL HEALTH CLINIC 09000 CLINIC	-2, 988					88. ( 90. (
	09001 WOUND CLINIC	-5, 244	729, 673				90. (
	09002 DIABETES CLINIC	-711					90.
0.03	09003 ASTHMA CLINIC 09004 ANDIS CLINIC	C	-				90.
). 04 ). 05	09004 ANDIS CLINIC 09005 PRIME TIME	-4, 166 C					90. 90.
	09006 SHELBYVILLE WOUND CLINIC	C					90.
	04951 ONCOLOGY	-817, 540					90.
	04950 ANDERSON WOMENS CENTER	0	347, 852				90.
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	-60, 478	3, 063, 535				91. 92.
	OTHER REIMBURSABLE COST CENTERS						, 2.
01.00	10100 HOME HEALTH AGENCY	C	0			11	101.
14 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	-709	2, 199, 403			1	116.
18.00 18.00		-15, 803, 552					118. (
	NONREI MBURSABLE COST CENTERS	10,000,002	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C					190. (
	19001 PROFESSI ONAL BUILDI NG	C					190.
	19002 PHYSI CI AN BUI LDI NG 19003 PRI VATE DUTY		-,				190. 190.
	19004 MARKETI NG	C					190.
	19005 SPORTS PHYSI CALS	C				11	190.
	19006 FOUNDATI ON	C	1,010,710				190.
	19007 ASC	C					190.
	19008 OTHER NONREI MBURSABLE 19009 HANCOCK OB		57, 783 6, 610, 942				190. 190.
	19010 HANCOCK WELLNESS	C					190.
90.11	19011 MORRI STOWN CLINIC	C				11	190.
	19012 03PUREMED	C	0				190.
	19013 MCCORD WELLNESS		854, 815				190. 100
7U. 14	19014 3 WEST UNIT 19015 NEUROLOGY PHYSICIAN						190. 190.
		, U	1,011,104			11.	
90.15	19016 THORACI	C	193, 165			11	190.
90. 15 90. 16 90. 17			108, 241			11	190. 190. 190.

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-0037	Period: From 01/01/2018	Worksheet A
					Date/Time Prepared: 5/29/2019 9:57 am
Cost Center Description	Adjustments N	et Expenses			
	(See A-8) Fo	r Allocation			
	6.00	7.00			
200.00 TOTAL (SUM OF LINES 118 through 199)	-15, 803, 552	112, 807, 692			200.00

Heal th	Financial Systems		HANCOCK REGION	ΔΙ ΗΩSPITAI		Inlie	u of Form CMS-2	552-10
	SIFICATIONS			Provi der C	CN: 15-0037	Peri od:	Worksheet A-6	.002 10
RECENS				in ovrider o	011. 10 0007	From 01/01/2018		
						To 12/31/2018	Date/Time Prep	
						1	5/29/2019 9:57	am
	Cost Costor	Increases	Colora	Other				
	Cost Center 2.00	Li ne # 3.00	<u>Salary</u> 4.00	5.00				
	A - CAFETERIA	3.00	4.00	5.00		· · · ·		
1.00	CAFETERI A	11.00	989, 487	813, 266				1.00
1.00	TOTALS		989, 487	813, 266				1.00
	B - PLANT	I I	707,407	013, 200				
1.00	OPERATION OF PLANT	7.00	0	1, 603				1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	5, 210				2.00
3.00	ELECTROCARDI OLOGY	69.00	o	5, 125				3.00
4.00	RESPI RATORY THERAPY	65.00	0	3, 404				4.00
	TOTALS			15, 342				
	C - MARKETING	<u> </u>	-1					
1.00	MARKETING	190.04	164, 977	847, 943				1.00
	TOTALS		164, 977	847, 943				
	D - OUTPATIENT PROCEDURE							
1.00	LABORATORY	60.00	4, 823	1, 372				1.00
2.00	ELECTROCARDI OLOGY	69.00	22, 928	6, 525				2.00
	TOTALS		27, 751	7, 897				
	E – DRUG RECLASS							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	12, 352, 652				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
20. 00 21. 00		0.00	0	0				20.00
		0.00	0	0				21.00
22.00		0.00 0.00	0	0				22.00
23.00 24.00		0.00	0	0				23.00
24.00 25.00		0.00	0	0				24.00 25.00
25.00 26.00		0.00	0	0				25.00 26.00
26.00		0.00	0	0				28.00 27.00
27.00	TOTALS — — — — —	<u> </u>		12, 352, 652				21.00
500 00	Grand Total: Increases		1, 182, 215	14, 037, 100				500.00
000.00		I I	.,	,, 100			1.	

ECLAS	SIFICATIONS			Provider (	CCN: 15-0037	Peri od:	Worksheet A-6
						From 01/01/2018 To 12/31/2018	Date/Time Prepare 5/29/2019 9:57 an
		Decreases					0/2//2017/10/ 4
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	·	
	6.00	7.00	8.00	9.00	10.00		
	A – CAFETERIA						
00	DI ETARY		<u>989, 4</u> 87	<u>813, 2</u> 66		o	1
	TOTALS		989, 487	813, 266			
	B – PLANT				1		
00	PROFESSI ONAL BUI LDI NG	190.01	0	15, 342		0	1
00		0.00	0	0		0	2
00		0.00	0	0		0	3
00		0.00	0	0		익	4
	TOTALS		0	15, 342			
00	C - MARKETING	E ool	1/4 077	0.47.040			
00	ADMI NI STRATI VE & GENERAL		164,977	847,943		o	1
	TOTALS D - OUTPATIENT PROCEDURE		164, 977	847, 943			
00	D - OUTPATTENT PROCEDURE PHARMACY	15.00	27 751	7, 897		0	1
00	PHARMACY	0.00	27, 751	7,897		0	2
00	TOTALS		27, 751	7, 897		<u> </u>	2
	E - DRUG RECLASS		27,751	1,091			
00	CENTRAL SERVICES & SUPPLY	14.00	0	81		0	1
00	PHARMACY	15.00	0	11, 699, 726		0	2
00	PARAMED ED PRGM	23.00	Ő	2, 184		o	3
00	ADULTS & PEDIATRICS	30.00	0	12, 509		0	4
00	INTENSIVE CARE UNIT	31.00	Ő	22, 899		0	5
00	SUBPROVIDER - IPF	40.00	0	474		0	6
00	OPERATING ROOM	50,00	0	50, 561		0	7
00	RECOVERY ROOM	51.00	0	1, 209		0	8
00	RADI OLOGY-DI AGNOSTI C	54.00	0	299, 042		0	9
0. 00	LABORATORY	60.00	0	457		0	10
. 00	RESPI RATORY THERAPY	65.00	0	231		0	11
. 00	PHYSI CAL THERAPY	66.00	0	555		0	12
l. 00	ELECTROCARDI OLOGY	69.00	0	20, 500		0	14
. 00	CARDI OPULMONARY	76.01	0	15		0	15
. 00	RURAL HEALTH CLINIC	88.00	0	28, 988		0	16
. 00	WOUND CLINIC	90. 01	0	9, 861		0	17
. 00	ANDIS CLINIC	90.04	0	5		0	18
. 00	SHELBYVILLE WOUND CLINIC	90.06	0	5, 136		0	19
. 00	ONCOLOGY	90.07	0	21, 473		0	20
. 00	ANDERSON WOMENS CENTER	90.08	0	115		0	21
2.00	EMERGENCY	91.00	0	33, 941		0	22
8.00	HOSPICE	116.00	0	140, 889		0	23
. 00	ASC	190.07	0	528		0	24
5.00	HANCOCK OB	190.09	0	13		0	25
5.00	3 WEST UNIT	190.14	0	90		0	26
. 00	HANCOCK FOOT & ANKLE	<u> </u>	0	1, 170	<u> </u>	o	27
	TOTALS Grand Total: Decreases		0	12, 352, 652		_	500

Heal th	Financial Systems	HANCOCK REGION	IAL HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0037		riod: om 01/01/2018 12/31/2018		pared:
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	1, 022, 119	316		0	316	0	1.00
2.00	Land Improvements	7, 498, 607	0		0	0	0	2.00
3.00	Buildings and Fixtures	115, 068, 992	2, 739, 233		0	2, 739, 233	22, 405	3.00
4.00	Building Improvements	235, 570	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	78, 715, 821	4, 411, 572		0	4, 411, 572	3, 466, 741	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	202, 541, 109	7, 151, 121		0	7, 151, 121	3, 489, 146	
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	202, 541, 109	7, 151, 121		0	7, 151, 121	3, 489, 146	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	1,022,435	0					1.00
2.00	Land Improvements	7, 498, 607	0					2.00
3.00	Buildings and Fixtures	117, 785, 820	0					3.00
4.00	Building Improvements	235, 570	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	79, 660, 652	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	206, 203, 084	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	206, 203, 084	0					10.00

Heal th	Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0037	Period: From 01/01/2018	Worksheet A-7 Part II	
					To 12/31/2018		pared: 7 am
			SL	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 WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	9, 032, 221	0		0 870, 967	389, 136	1.00
3.00	Total (sum of lines 1-2)	9, 032, 221	0		0 870, 967	389, 136	3.00
		SUMMARY C	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	10, 292, 324				1.00
3.00	Total (sum of lines 1-2)	0	10, 292, 324				3.00

Health Financial Systems	HANCOCK REGIO	NAL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period:	Worksheet A-7	
				rom 01/01/2018 o 12/31/2018		pared <sup>.</sup>
					5/29/2019 9:5	
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
cost center bescription	GIUSS ASSELS	Leases	for Ratio	instructions)	This ance	
		Louses	(col. 1 - col.			
			2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00 NEW CAP REL COSTS-BLDG & FIXT	117, 785, 819		,			1.00
3.00 Total (sum of lines 1-2)	117, 785, 819					3.00
	ALLOCA	TION OF OTHER O	CAPITAL	SUMMARY C	F CAPITAL	
Cont Conton Description		0+1	Tatal (aum af	Demos al atl an	1	
Cost Center Description	Taxes	Other Capital-Relate	Total (sum of cols. 5	Depreciation	Lease	
		d Costs	through 7)			
	6.00	7.00	8, 00	9,00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0	(	9, 032, 221	-505, 381	1.00
3.00 Total (sum of lines 1-2)	0	0	(	9, 032, 221		3.00
		SL	JMMARY OF CAPI	ΓAL .		
Cost Center Description		Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capital -Relate		
				d Costs (see	through 14)	
	11.00	12.00	13.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	-1, 537	870, 967	389, 136	0	9, 785, 406	1.00
3.00 Total (sum of lines 1-2)	-1, 537					3.00
3.00  10tal (Suii 01 11185 1-2)	-1,007	0/0,907	309, 130	ט וי	7, 763, 400	3.00

ADJUST	MENTS TO EXPENSES				eriod: rom 01/01/2018	Worksheet A-8	
					o 12/31/2018	Date/Time Prep 5/29/2019 9:57	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
. 00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1.0
1.00	REL COSTS-BLDG & FIXT (chapter 2)		-	FIXT	1.00	0	1. 0
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.0
. 00	Investment income - other (chapter 2)		0		0.00	0	3.0
. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.0
. 00	Refunds and rebates of expenses (chapter 8)		О		0.00	0	5.0
. 00	Rental of provider space by suppliers (chapter 8)		О		0.00	0	6.0
. 00	Tel ephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.0
. 00	Television and radio service (chapter 21)		0		0.00	0	8. 0
. 00 0. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -3, 328, 008		0.00	0 0	9. 0 10. 0
1. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 0
2. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12.0
	Laundry and linen service Cafeteria-employees and guests		0		0.00 0.00	0	
	Rental of quarters to employee and others		О		0.00	0	15.0
6. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 0
7.00	Sale of drugs to other than patients		0		0.00	0	17.0
8. 00	Sale of medical records and abstracts		0		0.00	0	18. 0
9. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.0
	Vending machines Income from imposition of interest, finance or penalty charges (chapter 21)		0 0		0.00 0.00		
2. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.0
3. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	OI	RESPI RATORY THERAPY	65.00		23.0
4.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	OI	PHYSI CAL THERAPY	66.00		24.C
5.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.0
6. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG &	1.00	0	26.0
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2.00	0	27. C
	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00	0	28. 0 29. 0
	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	00	DCCUPATI ONAL THERAPY	67.00		30. C
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 9
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31. 0
	limitation (chapter 14) CAH HIT Adjustment for		o		0.00	0	32. 0

	Financial Systems MENTS TO EXPENSES		HANCOCK REGIO	Provider CCN: 15-0037 F	Period: From 01/01/2018	eu of Form CMS-2 Worksheet A-8	2002
					To 12/31/2018	Date/Time Prep 5/29/2019 9:57	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
33.00	HRH MMO RENTAL INCOME	В		NEW CAP REL COSTS-BLDG & FLXT	1.00		33. 0
3. 01	HRH HUMAN RESOURCES MI SCELLANEOUS RE	В	-311, 329	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 0
3. 02 3. 03	HRH OTHER REVENUE SALES TAX HRH OTHER REVENUE	B B		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00		
3. 04	MI SCELLANEOUS REVE HRH ACCT ACCRUALS	В	-334, 989	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 05	MI SCELLANEOUS REVE HRH MED STAFF SERV QA	В	-11, 700	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 06	APPLICATION FE HRH MED STAFF SERV	В	-7, 952	ADMI NI STRATI VE & GENERAL	5.00	0	33. (
3. 07	MI SCELLANEOUS REV HRH MEDI CAL DUES MEDI CAL STAFF	В	-35,900	ADMI NI STRATI VE & GENERAL	5.00	0	33. 0
3. 08	DUES HRH PAT FIN. SERV. BUSINESS	В	-2, 564	ADMI NI STRATI VE & GENERAL	5.00	0	33. (
3. 09	SERV-COP HRH INFO SERVICES	В	-162, 025	ADMI NI STRATI VE & GENERAL	5.00	0	33. (
3. 10	MI SCELLANEOUS REVE HRH HPN IT DEPT MI SCELLANEOUS	В	-361, 984	ADMI NI STRATI VE & GENERAL	5.00	0	33. <sup>-</sup>
3. 11	REVENU HRH ACCOUNTING MISCELLANEOUS	В	-182, 433	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 12	REVENUE HRH ACCOUNTING MANAGEMENT FEES	В	-9, 945	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 13	HRH EXEC ADMIN MISCELLANEOUS REVENUE	В	-143, 369	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 14	HRH PURCHASING MISCELLANEOUS REVENUE	В	-700	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 15	HRH COMMUNI CATI ONS MI SCELLANEOUS REV	В	-572	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 16	HRH COMMUNICATIONS PHONE LEASE REVEN	В	-163, 304	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 17	HRH COMM EDUCATION EDUCATION SERVICE	В	-5, 752	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 18	HRH COMM EDUCATION CAR SEAT STATE FU	В	-1, 001	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 19	HRH TOBACCO AWARENE EDUCATION SERVIC	В	-2, 604	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 20	HRH POP HEALTH MI SCELLANEOUS REVENUE	В	-200	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3. 22	HRH GAIN/LOSS GROSS VARIANCE	В	21, 340	ADMI NI STRATI VE & GENERAL	5.00	0	33.
3.23	HRH PLANT OFFSITE SERVICES	В		OPERATION OF PLANT	7.00		33.
3.24	HRH HOUSEKEEPING ENVIRONMENTAL SERVI	В		HOUSEKEEPI NG	9.00		
3. 25	HRH NUTRITIONAL SER LTACH REVENUE	В			10.00		33.
3. 26	HRH NUTRITIONAL SER REBATES/REFUNDS	В		DI ETARY	10.00		33.
3. 27	HRH CLINICAL EDUCAT AHA COURSE REVEN	В		NURSING ADMINISTRATION	13.00		33.
3. 28	HRH CLINICAL EDUCAT EDUCATION SERVIC	В		NURSING ADMINISTRATION	13.00		33.
3. 29	HRH OTHER REVENUE REBATES/REFUNDS	В	-24, 237	CENTRAL SERVICES & SUPPLY	14.00	0	33.
3. 30	HRH OTHER REVENUE DI SCOUNTS EARNED O	В	-8, 353	CENTRAL SERVICES & SUPPLY	14.00	0	33.
3. 31	HRH PHARMACY MI SCELLANEOUS REVENUE	В	-63, 647	PHARMACY	15.00	0	33.
3. 32 3. 33	HRH PHARMACY REBATES/REFUNDS HRH ASSOCIATE PHARM RETAIL PHARMACY-	B B		PHARMACY PHARMACY	15.00 15.00		33. 33.
3. 34	HRH ASSOCIATE PHARM HOSPICE PHARMACY	В	-138, 464	PHARMACY	15.00	0	33.
3. 35	HRH ASSOCIATE PHARM PHARMACY	В	-15, 385	PHARMACY	15.00	0	33.
33. 36	MEDS TO HRH ASSOCIATE PHARM	В	- 30, 502	PHARMACY	15.00	о	33.
33. 37	MI SCELLANEOUS RE HRH HEALTH INFO SER MEDICAL RECORDS-	В	-642	MEDICAL RECORDS & LIBRARY	16.00	0	33. 3

DJUST	MENTS TO EXPENSES			Provider CCN: 15-0037	Peri od:	Worksheet A-8	3
00001					From 01/01/2018		
					To 12/31/2018	Date/Time Prep 5/29/2019 9:5	
				Expense Classification of			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	-
	cost center bescription	1.00	2.00	3.00	4.00	5.00	-
3.38	HRH HEALTH INFO SER	В	-56, 458	MEDICAL RECORDS & LIBRARY	16.00	0	33.
3.39	MI SCELLANEOUS RE	P			22.00		
3.39	HRH X-RAY SCHOOL TUITION-X-RAY SCHOO	В	-45, 560	PARAMED ED PRGM	23.00	0	33
3.40	HRH ANDIS UNIT REBATES/REFUNDS	В	-722	ADULTS & PEDIATRICS	30.00	0	33
3. 41	HRH SURGERY REBATES/REFUNDS	В		OPERATING ROOM	50.00	0	33
3. 42	HRH OTHER REVENUE SALE OF USED	В	-409	RADI OLOGY-DI AGNOSTI C	54.00	0	33.
2 42		P	04 177		F4 00		
3. 43 3. 44	HRH MMO EXPENSE REIMBURSEMENT HRH LAB WATER TESTING	B		RADI OLOGY-DI AGNOSTI C LABORATORY	54.00 60.00	0	
3.45	HRH LAB DI RECT TESTS	В		LABORATORY	60.00	0	
3.46	HRH SLEEP STUDY CLINIC	В		RESPIRATORY THERAPY	65.00	0	
	MANAGMENT						
3. 47	HRH SLEEP STUDY SLEEP STUDY	В	-12, 695	RESPI RATORY THERAPY	65.00	0	33
3. 48	FEES HRH CATH LAB REBATES/REFUNDS	В	-6 100	ELECTROCARDI OLOGY	69.00	0	33
3.49	HRH MED ONCOLOGY MI SCELLANEOUS	В		ONCOLOGY	90.07	0	
	REVEN	_	,			-	
3. 50	HRH E R REBATES/REFUNDS	В		EMERGENCY	91.00	0	
3. 51	MOW	В	-354,037		10.00	0	
3.52	CAFETERIA GUEST MEALS	В			11.00	0	
3. 53 3. 54	PHYSICIAN RECRUITMENT FEES DONATIONS & SPONSORSHIPS	B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00	0	
3.54	ADVERTISING FEE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
3.56	ADVERTISING FEE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
3.57	ADVERTISING FEE	В		ADULTS & PEDIATRICS	30.00	0	
3. 58	ADVERTISING FEE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33
3. 59	ADVERTISING FEE	В		ONCOLOGY	90.07	0	
3.60	ADVERTISING FEE	В		HOSPICE	116.00	0	
3.61	I HA LOBBYING EXPENSE	B B		ADMINI STRATI VE & GENERAL	5.00	0	
3.62 3.63	AHA LOBBYING EXPENSE PHY OFFICE BLDG	В		ADMINISTRATIVE & GENERAL NEW CAP REL COSTS-BLDG &	5.00 1.00	10	
5. 05		D		FIXT	1.00	10	1 3
3.64	PHY OFFICE BLDG	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33
3.65	PHY OFFICE BLDG	А		RURAL HEALTH CLINIC	88.00	0	
3.66	INTEREST REVENUE	А		NEW CAP REL COSTS-BLDG &	1.00	11	33
3.67	RENTAL PROPERTIES EXPENSE	А		FIXT NEW CAP REL COSTS-BLDG &	1.00	10	33
5.07		~		FIXT	1.00	10	
3. 68	RENTAL PROPERTIES EXPENSE	А		ADMINISTRATIVE & GENERAL	5.00	0	33
3. 69	RENTAL PROPERTIES EXPENSE	А		OPERATION OF PLANT	7.00		
3. 70	RENTAL PROPERTIES EXPENSE	A		MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	33
3. 71	TELEPHONE SERVICES	А		ADMI NI STRATI VE & GENERAL	5.00	0	33
3.72		A		ADMI NI STRATI VE & GENERAL	5.00		
3.73		А		EMPLOYEE BENEFITS DEPARTMEN			
0.00			-15, 803, 552			1	50
	(Transfer to Worksheet A, column 6, line 200.)						

(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
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							eu of Form CMS-	
PROVIDER BASED PHYSICIAN ADJUSTMENT			Fr		eriod: Worksheet A-8-2 rom 01/01/2018			
					T	To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
	Wkst. A Line #		Total	Professi onal	Provi der		Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6. 00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	231, 316				0	
2.00 3.00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	67, 500 27, 044			0	0	
4.00		ADMINISTRATIVE & GENERAL	347,000			0	0	4.00
5.00		ADMINISTRATIVE & GENERAL	15, 000			0	0	5.00
6.00		ADMINISTRATIVE & GENERAL	132, 258			0	0	6.00
7.00 8.00		ADULTS & PEDIATRICS SUBPROVIDER - IPF	42, 957 96, 000			0	0	7.00 8.00
9.00		OPERATING ROOM	1, 278, 257			0	0	9.00
10.00		OPERATING ROOM	2, 181	2, 181	0	0	0	
11.00		LABORATORY	125, 000			260, 300	452	
12.00 13.00		RESPIRATORY THERAPY WOUND CLINIC	12, 000 5, 244			0	0	12.00 13.00
13.00		DI ABETES CLINIC	5, 244	5, 244		0	0	14.00
15.00		ANDIS CLINIC	4, 166			0	0	15.00
16.00		ONCOLOGY	773, 223			0	0	16.00
17.00			60,000			0	0	17.00
18.00 200.00	53.00	ANESTHESI OLOGY	136, 948 3, 356, 805			0	452	18.00 200.00
	Wkst. A Line #		Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		I denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00 2.00		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	0			0	0	
2.00		ADMINISTRATIVE & GENERAL				0	0	2.00 3.00
4.00		ADMI NI STRATI VE & GENERAL	0		0	0	0	4.00
5.00		ADMINISTRATIVE & GENERAL	0	0	-	0	0	5.00
6.00		ADMI NI STRATI VE & GENERAL	0	0	0	0	0	6.00
7.00 8.00		ADULTS & PEDIATRICS SUBPROVIDER - IPF			0	0	0	7.00 8.00
9.00		OPERATI NG ROOM	0	, o	-	0	0	
10. 00		OPERATING ROOM	0	-	0	0	0	10. 00
11.00			56, 565	2, 828		0	0	11.00
12.00 13.00		RESPIRATORY THERAPY WOUND CLINIC		0	0	0	0	12.00 13.00
14.00		DI ABETES CLINIC	0	-		0	0	
15.00		ANDIS CLINIC	0	0	0	0	0	15.00
16.00		ONCOLOGY	0	0	0	0	0	16.00
17.00 18.00		EMERGENCY ANESTHESI OLOGY		0	0	0	0	17.00 18.00
200.00	00.00		56, 565	-		0	0	
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
1.00	1.00		15.00	16.00	17.00	18.00		1.00
1.00 2.00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL		-	0	231, 316 67, 500		1.00 2.00
3.00		ADMI NI STRATI VE & GENERAL	0			27,044		3.00
4.00		ADMINISTRATIVE & GENERAL	0					4.00
5.00		ADMINI STRATI VE & GENERAL	0			15,000		5.00
6.00 7.00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	0		0	132, 258 42, 957		6.00 7.00
8.00		SUBPROVIDER - IPF	0	-	0	96, 000		8.00
9.00	50.00	OPERATING ROOM	0		0	1, 278, 257		9.00
10.00		OPERATING ROOM	0		0	2, 181		10.00
11.00 12.00		LABORATORY RESPI RATORY THERAPY	0		0	96, 203 12, 000		11. 00 12. 00
12.00 13.00		WOUND CLINIC				12, 000 5, 244		12.00
14.00		DI ABETES CLINIC	0			711		14.00
15.00		ANDIS CLINIC	0			4, 166		15.00
16.00 17.00		ONCOLOGY EMERGENCY	0		0	773, 223		16.00 17.00
17.00		ANESTHESI OLOGY	0		0	60, 000 136, 948		17.00
200.00			0					200. 00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HANCOCK REGION	Provider CC	N: 15-0037 P	In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
001 A	LEGONTION GENERAL SERVICE COSTS			F	om 01/01/2018	Part I	
				T	b 12/31/2018	Date/Time Pre 5/29/2019 9:5	pared: 7 am
			CAPI TAL				
	Cost Conton Description	Not Experses	RELATED COSTS		Subtatal		
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FIXT	EMPLOYEE BENEFI TS	Subtotal	ADMI NI STRATI VE & GENERAL	
		Allocation	11/1	DEPARTMENT		& OLNEIKAL	
		(from Wkst A		DELYNCIMENT			
		col . 7)					
		0	1.00	4.00	4A	5.00	
. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	9, 785, 406	9, 785, 406				1.00
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 967, 019		5, 036, 792			4.00
. 00	00500 ADMINISTRATIVE & GENERAL	15, 747, 363	735, 881	945, 094	17, 428, 338	17, 428, 338	
. 00	00700 OPERATION OF PLANT	6, 277, 392		113, 154	6, 885, 104	1, 258, 094	
. 00	00900 HOUSEKEEPI NG	2, 112, 528		152, 400	2, 326, 379	425, 092	
0.00	01000 DI ETARY	354,003	322, 506	47, 122	723, 631	132, 227	10.00
	01100 CAFETERI A	1, 664, 546	0	106, 043	1, 770, 589	323, 534	
	01300 NURSING ADMINISTRATION	1, 513, 985	0	130, 558	1, 644, 543	300, 502	
	01400 CENTRAL SERVICES & SUPPLY	73, 877	0	6, 109	79, 986	14, 616	
		1, 645, 157	166, 485	195, 544	2,007,186	366, 767	
	01600 MEDICAL RECORDS & LIBRARY 02300 PARAMED ED PRGM	764, 955 92, 788	110, 601 37, 405	64, 978 13, 027	940, 534 143, 220	171, 861 26, 170	
5.00	INPATIENT ROUTINE SERVICE COST CENTERS	72, 100	J 37, 405	13, 027	143, 220	20, 170	23.00
0.00	03000 ADULTS & PEDI ATRI CS	3, 432, 983	633, 407	301, 338	4, 367, 728	798, 102	30.00
1.00	03100 INTENSIVE CARE UNIT	3, 857, 752	663, 771	340, 702	4, 862, 225	888, 460	1
	04000 SUBPROVI DER – I PF	1, 364, 484	177, 451	130, 932	1, 672, 867	305, 678	40.00
1.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	4, 940, 522	699, 924	340, 795	5, 981, 241	1, 092, 934	
	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	358, 563	59, 002 0	34, 398 0	451, 963	82, 586	
	05400 RADI OLOGY-DI AGNOSTI C	522 4, 788, 796	723, 441	336, 873	522 5, 849, 110	95 1, 068, 790	1
	06000 LABORATORY	4, 022, 251	162, 645	170, 796	4, 355, 692	795, 903	
	06500 RESPI RATORY THERAPY	1, 517, 352	65, 514	148, 524	1, 731, 390	316, 372	
	06600 PHYSI CAL THERAPY	1, 240, 038	108, 235	120, 898	1, 469, 171	268, 457	
7.00	06700 OCCUPATIONAL THERAPY	352, 059	0	35, 017	387, 076	70, 729	67.00
8.00	06800 SPEECH PATHOLOGY	186, 013	0	18, 104	204, 117	37, 298	68.00
	06801 OCCUPATI ONAL HEALTH	0	0	0	0	0	68.01
	06900 ELECTROCARDI OLOGY	940, 953	208, 538	70, 004	1, 219, 495	222, 835	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	3, 579, 640	130, 583	0	3, 710, 223	677, 958	
	07200 I MPL. DEV. CHARGED TO PATIENT	1, 459, 164	0	0	1, 459, 164	266, 629	
	07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC	12, 352, 652	0	0	12, 352, 652 0	2, 257, 119 0	1
	03160 CARDI AC	70, 501	63, 427	6, 836	140, 764	25, 721	
0.01	OUTPATIENT SERVICE COST CENTERS	70,001	00, 127	0,000	110,701	20,721	1 /0.01
8.00	08800 RURAL HEALTH CLINIC	408, 520	0	24, 558	433, 078	79, 135	88.00
	09000 CLI NI C	0	0	0	0	0	
	09001 WOUND CLINIC	729, 673		53, 461	863, 872	157, 853	
	09002 DI ABETES CLINIC	56, 987	0	5, 316	62, 303	11, 384	
	09003 ASTHMA CLINIC	0	0	0	0	0	
	09004 ANDES CLENIC 09005 PRIME TIME	153, 716 119, 621	72, 472	13, 042	239, 230 119, 621	43, 714 21, 858	
	09006 SHELBYVILLE WOUND CLINIC	351, 927	0	23, 990	375, 917	68, 690	
	04951 ONCOLOGY	1, 172, 668	386, 657	98, 140	1, 657, 465	302, 864	
	04950 ANDERSON WOMENS CENTER	347,852		34, 372	382, 224	69, 843	
	09100 EMERGENCY	3, 063, 535	615, 206	272, 059	3, 950, 800	721, 918	91.00
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
01.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
1/ 00	SPECIAL PURPOSE COST CENTERS	2 100 402	201 411	140.005	2 ( 41 140	402 (00	111/ 00
	11600 HOSPI CE	2, 199, 403		140, 335	2, 641, 149 94, 890, 569	482,609	
18.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	98, 067, 166	7, 151, 082	4, 494, 519	94, 890, 569	14, 154, 397	1118.00
90 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19001 PROFESSI ONAL BUILDING	323, 806	-	7	2, 361, 299	431, 473	
	19002 PHYSI CI AN BUI LDI NG	8, 987	0	0	8, 987		190.02
	19003 PRI VATE DUTY	1, 104, 275	0	58, 971	1, 163, 246	212, 556	
	19004 MARKETI NG	1, 012, 920	0	17, 681	1, 030, 601	188, 319	
	19005 SPORTS PHYSI CALS	61, 591	0	6, 075	67, 666	12, 364	
	19006 FOUNDATI ON	1, 345, 915	67, 073	19, 876	1, 432, 864	261, 823	
		7,197	0	0	7, 197		190.07
	19008 OTHER NONREI MBURSABLE 19009 HANCOCK OB	57, 783 6, 610, 942	0 180, 318	0 172, 779	57, 783	10, 559	
	19009 HANCOCK OB 19010 HANCOCK WELLNESS	1, 103, 153		84, 627	6, 964, 039 1, 187, 780	1, 272, 518 217, 039	
	19010 HANCOCK WELLNESS 19011 MORRI STOWN CLINIC	1, 103, 153		84, 627	1, 187, 780		190.10
		1,000	0	0	1,000		190.12
	19012 03PUREMED						
90.12	19012 03PUREMED 19013 MCCORD WELLNESS	0 854, 815	0	64, 690	919, 505	168, 018	

Health Financial Systems	HANCOCK REGIO	NAL_HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0037	Period: From 01/01/2018 To 12/31/2018		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
	<u>col.7)</u> 0	1.00	4.00	4A	5.00	
190. 15 19015 NEUROLOGY PHYSI CI AN	1, 011, 164	0	63, 66	5 1, 074, 829		190. 15
190. 16 19016 THORACI	193, 165	0		0 193, 165	35, 296	190. 16
190. 17 19017 HANCOCK ENDO	108, 241	0		0 108, 241	19, 779	190. 17
190.18 19018 HANCOCK FOOT & ANKLE	455, 475	0	33, 63	489, 108	89, 373	190. 18
190. 19 19019 HANCOCK RHEUM	84, 982	0		0 84, 982	15, 529	190. 19
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	112, 807, 692	9, 785, 406	5, 036, 79	112, 807, 692	17, 428, 338	202.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	HANCOCK REGION	IAL HOSPITAL Provider CC		Period:	u of Form CMS-: Worksheet B	2552-10
				From 01/01/2018 To 12/31/2018	Date/Time Pre	
Cost Center Description	OPERATION OF	HOUSEKEEPING	DI ETARY	CAFETERI A	5/29/2019 9:5 NURSI NG	
	PLANT 7.00	9.00	10.00	11.00	ADMI NI STRATI ON 13. 00	
GENERAL SERVICE COST CENTERS	1				<b>F</b>	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						4.00 5.00
7.00 00700 OPERATION OF PLANT	8, 143, 198					7.00
9. 00 00900 HOUSEKEEPI NG	106, 121	2, 857, 592				9.00
10. 00 01000 DI ETARY	556, 943	47, 472	1, 460, 27			10.00
11. 00 01100 CAFETERIA	0	78, 227		0 2, 172, 350		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	0 118, 661		0 70, 042 0 6, 234		•
15. 00 01500 PHARMACY	287, 507	86, 556		0 103, 140		
16.00 01600 MEDI CAL RECORDS & LI BRARY	190, 999	104, 114		0 61, 145		•
23.00 02300 PARAMED ED PRGM	64, 595	119, 931		0 9, 714	0	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 000 044	705 (04		4 407 450	010,000	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	1, 093, 844 1, 146, 278	795, 694 164, 043	441, 63 594, 82		213, 999 283, 033	•
40. 00 04000 SUBPROVIDER - IPF	306, 444	131, 286	304, 89			•
41. 00 04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
ANCI LLARY SERVI CE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	101 902	318, 510		0 147, 971	168, 921	50.00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	101, 892	117, 283 0		0 19, 148 0 0	21, 858 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	116, 593		0 232, 381	265, 283	•
60. 00 06000 LABORATORY	0	111, 261		0 152, 522	174, 117	60.00
65. 00 06500 RESPI RATORY THERAPY	0	85, 214		0 103, 029		
66. 00 06600 PHYSI CAL THERAPY	186, 913	99, 036		0 74, 740		•
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		0 23, 805 0 10, 339	0	67.00 68.00
68. 01 06800 OCCUPATIONAL HEALTH	0	0		0 10, 339	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	360, 129	193, 101		40, 886	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	225, 507	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 76. 00 03020 CARDIAC	0	0		0 0 0 0	0	73.00 76.00
76. 01 03160 CARDI OPULMONARY	109, 533	0		0 6,667	0	76.00
OUTPATIENT SERVICE COST CENTERS	107,000			0,007		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0		88.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 WOUND CLINIC 90. 02 09002 DIABETES CLINIC	0	0		0 38, 994 0 4, 216	0	90. 01 90. 02
90. 03 09003 ASTHMA CLINIC	0	0		0 4,210	0	90.02
90. 04 09004 ANDIS CLINIC	125, 154	0		0 8, 767	0	90.04
90. 05 09005 PRIME TIME	0	0		0 0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	0		0 14, 544 0 73, 184	0	70.00
90.07 04951 ONCOLOGY 90.08 04950 ANDERSON WOMENS CENTER	667, 726	170, 610		0 73, 184		•
91. 00 09100 EMERGENCY	1, 062, 411	0		0 186, 080		•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REI MBURSABLE COST CENTERS						101 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
116. 00 11600 HOSPI CE	520, 512	0	118, 91	6 93, 722	106, 992	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 112, 508	2, 857, 592	1, 460, 27	3 2, 036, 960	1, 950, 398	118.00
NONREI MBURSABLE COST CENTERS		ol				100.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 PROFESSI ONAL BUI LDI NG	0	0		0 0 0 0		190. 00 190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	0		0 0		190.02
190. 03 19003 PRI VATE DUTY	0	0		0 56, 666		190. 03
190. 04 19004 MARKETI NG	0	0		0 12, 104		190. 04
190. 05 19005 SPORTS PHYSI CALS	0	0		0 0		190.05
190. 06 19006 FOUNDATI ON 190. 07 19007 ASC	115, 829	0		0 15,509 0 0		190. 06 190. 07
190. 08 19008 OTHER NONREI MBURSABLE	0	0				190.07
190. 09 19009 HANCOCK OB	311, 394	0		0 31, 403		190.09
190. 10 19010 HANCOCK WELLNESS	0	0		0 0	0	190. 10
190. 11 19011 MORRI STOWN CLINIC	0	0		0 0		190. 11
190. 12 19012 03PUREMED	0	0		0 0		190.12
190. 13 19013 MCCORD WELLNESS 190. 14 19014 3 WEST UNIT	0 603, 467	0		0 0 0 11, 361		190. 13 190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	003,407	0		0 8, 347		190. 14
190. 16 19016 THORACI	o o	o		0 0		190. 16
190. 17 19017 HANCOCK ENDO	0	0		0 0		190. 17
190. 18 19018 HANCOCK FOOT & ANKLE	0	0		0 0		190.18
190. 19 19019 HANCOCK RHEUM	0	0		0 0	0	190. 19

Health Fin	ancial Systems	HANCOCK REGIO	HANCOCK REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0037		Period:	Worksheet B			
					From 01/01/2018 To 12/31/2018		nared		
			_		12/01/2010	5/29/2019 9:5			
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG			
		PLANT				ADMI NI STRATI ON			
		7.00	9.00	10.00	11.00	13.00			
200.00	Cross Foot Adjustments						200.00		
201.00	Negative Cost Centers	0	0	0	0 0	0	201.00		
202.00	TOTAL (sum lines 118 through 201)	8, 143, 198	2, 857, 592	1, 460, 273	3 2, 172, 350	2, 015, 087	202.00		

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2018	Worksheet B Part I	
			T		Date/Time Pre 5/29/2019 9:5	pared:
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
	SERVICES & SUPPLY		RECORDS &	PRGM		
	14.00	15.00	LI BRARY 16.00	23.00	24.00	
GENERAL SERVICE COST CENTERS						1.00
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 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	224 (12					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	226, 613 4, 828	2, 973, 727				14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	1, 538, 455			16.00
23.00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	363, 630		23.00
30. 00 03000 ADULTS & PEDIATRICS	3, 851	0	413, 851	0	8, 316, 161	30.00
31. 00 03100 I NTENSI VE CARE UNI T	7, 543	0	51, 675	0	8, 246, 017	31.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	543	0	42, 609 0	0	2, 963, 494 0	40.00
ANCI LLARY SERVICE COST CENTERS	0	V	0	V	0	41.00
50. 00 05000 OPERATI NG ROOM	8, 290	0	543, 944	0	8, 261, 811	50.00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	233	0	0	0	794, 963 617	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 253	0	62, 100	363, 630	7, 960, 140	
60. 00 06000 LABORATORY	53, 792	0	137, 799	0	5, 781, 086	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	672 62	0	0	0	2, 354, 293 2, 183, 701	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	21	0	0	0	481, 631	1
68. 00 06800 SPEECH PATHOLOGY	88	0	0	0	251, 842	
68. 01 06801 0CCUPATI ONAL HEALTH 69. 00 06900 ELECTROCARDI OLOGY	0 853	0	0	0	0 2, 037, 299	68.01 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	131, 495	0	70, 713	0	4, 815, 896	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1, 725, 793	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CARDIAC	0	2, 973, 727 0	3, 173 0	0	17, 586, 671 0	73.00 76.00
76. 01 03160 CARDI OPULMONARY	38	0	0	0	282, 723	
0UTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	E10 010	00 00
90. 00 09000 CLINIC	0	0	0	0	512, 213 0	88.00 90.00
90. 01 09001 WOUND CLINIC	487	0	0	0	1, 061, 206	
90. 02 09002 DI ABETES CLI NI C 90. 03 09003 ASTHMA CLI NI C	21	0	0	0	77, 924 0	90.02 90.03
90. 04 09004 ANDIS CLINIC	14	0	0	0	416, 879	
90. 05 09005 PRIME TIME	0	0	0	0	141, 479	
90. 06 09006 SHELBYVILLE WOUND CLINIC 90. 07 04951 0NC0L0GY	247 1, 358	0	0	0	459, 398 2, 702, 597	90.06 90.07
90.08 04950 ANDERSON WOMENS CENTER	225	0	0	0	650, 200	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	7, 224	0	212, 591	0	6, 353, 450	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE	1,850	0	0	0	3, 965, 750	116 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	225, 988		1, 538, 455		90, 385, 234	
NONREI MBURSABLE COST CENTERS						100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 PROFESSI ONAL BUILDING	0	0	0	0	0 2, 792, 772	190.00 190.01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	0	0	0		190.02
190. 03 19003 PRI VATE DUTY	78	0	0	0	1, 497, 235	1
190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS	0	0	0	0	1, 231, 024 80, 030	190. 04 190. 05
190. 06 19006 FOUNDATI ON	0	0	0	0	1, 826, 025	
190. 07 19007 ASC	1	0	0	0		190.07
190. 08 19008 OTHER NONREI MBURSABLE 190. 09 19009 HANCOCK OB	362	0	0	0	68, 342 8, 579, 716	190. 08 190. 09
190. 10 19010 HANCOCK WELLNESS	0	0	0	0	1, 404, 819	190. 10
190. 11 19011 MORRI STOWN CLINIC 190. 12 19012 03PUREMED	0	0	0	0		190. 11 190. 12
190. 12 19012 03POREMED 190. 13 19013 MCCORD_WELLNESS	0	0	0	0	0 1, 087, 523	
190.14 19014 3 WEST UNIT	43	0	0	0	1, 518, 511	190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN 190. 16 19016 THORACI	0	0	0	0	1, 279, 576 228, 461	
190. 17 19018 HORACI 190. 17 19017 HANCOCK ENDO	0	0	0	0	128, 020	190. 17
190.18 19018 HANCOCK FOOT & ANKLE	141	0	0	0	578, 622	

Health Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period:	Worksheet B Part I	
				From 01/01/2018 To 12/31/2018		
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
	SERVICES &		RECORDS &	PRGM		
	SUPPLY		LI BRARY			
	14.00	15.00	16.00	23.00	24.00	
190. 19 19019 HANCOCK RHEUM	0	0		0 0	100, 511	190. 19
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	226, 613	2, 973, 727	1, 538, 45	5 363, 630	112, 807, 692	202.00

Health Financial Systems	HANCOCK REGIONAL	- HOSPI TAL	In Lieu	ı of Form CMS-2552	2-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0037	Period: From 01/01/2018	Worksheet B Part I	
				Date/Time Prepare 5/29/2019 9:57 an	
Cost Center Description	Intern &	Total		0/2//2017 7.0/ 4	
	Residents Cost & Post				
	Stepdown				
	Adjustments 25.00	26.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					. 00 . 00
5. 00 00500 ADMINI STRATI VE & GENERAL					5. 00
7.00 00700 OPERATION OF PLANT					. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					). 00 ). 00
11. 00 01100 CAFETERIA					. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					8.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY					. 00 5. 00
16.00 01600 MEDICAL RECORDS & LIBRARY				16	. 00
23. 00 02300 PARAMED ED PRGM				23	8. 00
30. 00 03000 ADULTS & PEDIATRICS	0	8, 316, 161		30	). 00
31. 00 03100 I NTENSI VE CARE UNI T	0	8, 246, 017			. 00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0	2, 963, 494 0			). 00 . 00
41. 00 04100 SUBPROVI DER – I RF ANCI LLARY SERVI CE COST CENTERS	0	0		41	. 00
50. 00 05000 OPERATI NG ROOM	0	8, 261, 811			0. 00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	0	794, 963 617			. 00 3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	7, 960, 140			. 00
60. 00 06000 LABORATORY	0	5, 781, 086			. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	2, 354, 293 2, 183, 701			5.00 5.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	481, 631			. 00 . 00
68.00 06800 SPEECH PATHOLOGY	0	251, 842			8. 00
68. 01 06801 OCCUPATI ONAL HEALTH 69. 00 06900 ELECTROCARDI OLOGY	0	0 2, 037, 299			3. 01 9. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 815, 896			. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 725, 793			2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CARDI AC	0	17, 586, 671 0			8.00 5.00
76. 01 03160 CARDI OPULMONARY	0	282, 723			5. 00 5. 01
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC	0	E10 010			8. 00
88. 00  08800  RURAL_HEALTH_CLINIC 90. 00  09000  CLINIC	0	512, 213 0			). 00
90. 01 09001 WOUND CLINIC	0	1, 061, 206			0. 01
90. 02 09002 DI ABETES CLI NI C 90. 03 09003 ASTHMA CLI NI C	0	77, 924 0			). 02 ). 03
90. 03 09003 ASTRIA CETNIC 90. 04 09004 ANDIS CLINIC	0	416, 879			). 03 ). 04
90. 05 09005 PRI ME TI ME	0	141, 479			0. 05
90. 06 09006 SHELBYVILLE WOUND CLINIC 90. 07 04951 ONCOLOGY	0	459, 398 2, 702, 597			). 06 ). 07
90.08 04950 ANDERSON WOMENS CENTER	0	650, 200			). 07 ). 08
91.00 09100 EMERGENCY	0	6, 353, 450			. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0			92	2. 00
101.00 10100 HOME HEALTH AGENCY	0	0		101	. 00
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE	0	3, 965, 750		116	. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117		90, 385, 234			3. 00 3. 00
NONREI MBURSABLE COST CENTERS	T T				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 PROFESSI ONAL BUI LDI NG	0	0 2, 792, 772			). 00 ). 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	10, 629			0. 02
190. 03 19003 PRI VATE DUTY	0	1, 497, 235			0.03
190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS	0	1, 231, 024 80, 030			). 04 ). 05
190. 06 19006 FOUNDATI ON	Ő	1, 826, 025		190	0. 06
190. 07 19007 ASC	0	8, 513			0.07
190. 08 19008 OTHER NONREI MBURSABLE 190. 09 19009 HANCOCK OB	0	68, 342 8, 579, 716			). 08 ). 09
190. 10 19010 HANCOCK WELLNESS	Ō	1, 404, 819		190	). 10
190. 11 19011 MORRI STOWN CLINIC	0	2, 129			). 11
190. 12 19012 03PUREMED 190. 13 19013 MCCORD WELLNESS	0	0 1, 087, 523			). 12 ). 13
190.14 19014 3 WEST UNIT	Ő	1, 518, 511		190	). 14
190. 15 19015 NEUROLOGY PHYSI CI AN 190. 16 19016 THORACI	0	1, 279, 576 228, 461			). 15 ). 16
	I V	220, 401		1190	, 10

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CC	CN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared: 5/29/2019 9:57 am	:	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26.00					
190. 17 19017 HANCOCK ENDO	0	128, 020	1		190. 1		
190.18 19018 HANCOCK FOOT & ANKLE	0	578, 622			190. 18		
190. 19 19019 HANCOCK RHEUM	0	100, 511			190. 19		
200.00 Cross Foot Adjustments	0	0			200.00	10	
201.00 Negative Cost Centers	0	0			201.00	0	
202.00 TOTAL (sum lines 118 through 201)	0	112, 807, 692			202.00	0	

	Financial Systems TION OF CAPITAL RELATED COSTS	HANCOCK REGIO	NAL HOSPITAL Provider CC	N: 15-0037 P	In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
					rom 01/01/2018	Part II	pared.
			CAPI TAL			5/29/2019 9:5	7 am
			RELATED COSTS				
	Cost Center Description	Directly Assigned New	NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFI TS	ADMI NI STRATI VE & GENERAL	
		Capi tal			DEPARTMENT	α GENERAL	
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1.00	2A	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	69, 773	69, 773	69, 773		4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	735, 881	735, 881	13,076	748, 957 54, 062	
9.00	00900 HOUSEKEEPING		494, 558 61, 451	494, 558 61, 451	1, 568 2, 112	18, 267	
	01000 DI ETARY	0	322, 506	322, 506	653	5, 682	
	01100 CAFETERI A	0	0	0	1, 469	13, 903	
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0	0	1, 809 85	12, 913 628	
	01500 PHARMACY		166, 485	166, 485	2, 710	15, 760	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	110, 601	110, 601	900	7, 385	
23.00	02300 PARAMED ED PRGM	0	37, 405	37, 405	181	1, 125	23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	633, 407	633, 407	4, 175	34, 295	30. 00
	03100 I NTENSI VE CARE UNI T	0		663, 771	4, 721	38, 178	
	04000 SUBPROVIDER - IPF	0		177, 451	1, 814	13, 135	
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	699, 924	699, 924	4, 722	46, 965	50.00
	05100 RECOVERY ROOM	0	59,002	59,002	477	3, 549	
	05300 ANESTHESI OLOGY	0	0	0	0	4	
	05400 RADI OLOGY-DI AGNOSTI C	0	723, 441	723, 441	4,668	45, 927	
	06000 LABORATORY 06500 RESPI RATORY THERAPY		162, 645 65, 514	162, 645 65, 514	2, 367 2, 058	34, 201 13, 595	
	06600 PHYSI CAL THERAPY	0	108, 235	108, 235	1, 675	11, 536	
	06700 OCCUPATI ONAL THERAPY	0	0	0	485	3, 039	
	06800 SPEECH PATHOLOGY	0	0	0	251 0	1, 603	
	06801 OCCUPATI ONAL HEALTH 06900 ELECTROCARDI OLOGY		208, 538	208, 538	970	0 9, 575	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	130, 583	130, 583	0	29, 133	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	11, 457	
	07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC	0	0	0	0	97, 032 0	
	03160 CARDI OPULMONARY		63, 427	63, 427	95	1, 105	
	OUTPATIENT SERVICE COST CENTERS	1	· · · · · ·				
	08800 RURAL HEALTH CLINIC	0	0	0	340	3, 401	1
	09000 CLINIC 09001 WOUND CLINIC		80, 738	80, 738	741	0 6, 783	
	09002 DI ABETES CLINIC	0	00,700	0	74		90.02
	09003 ASTHMA CLINIC	0	0	0	0	0	
	09004 ANDES CLENIC 09005 PRIME TIME	0	72, 472	72, 472	181 0	1, 878 939	
	09006 SHELBYVILLE WOUND CLINIC	0	0	0	332	2, 952	
	04951 ONCOLOGY	0	386, 657	386, 657	1, 360	13, 014	
	04950 ANDERSON WOMENS CENTER	0	0	0	476	3,001	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)		615, 206	615, 206 0	3, 770	31, 022	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS		· · ·				
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	0	301, 411	301, 411	1, 945	20, 738	1116 00
118.00		0		7, 151, 082	62, 260		
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PROFESSIONAL BUILDING	0	2 027 494	0 2 027 494	0		190.00
	19002 PHYSI CI AN BUI LDI NG		2, 037, 486 0	2, 037, 486 0	0	18, 541 71	190. 01
	19003 PRI VATE DUTY	0	0	0	817		190.03
	19004 MARKETI NG	0	0	0	245		190. 04
	19005 SPORTS PHYSI CALS 19006 FOUNDATI ON	0	0 67, 073	0 67, 073	84 275	531 11, 251	190.05
	19008 FOUNDATION 19007 ASC		07,073	07, 073 N	∠/5 0		190.00
190. 08	19008 OTHER NONREI MBURSABLE	0	0	0	0	454	190. 08
	19009 HANCOCK OB	0	180, 318	180, 318	2, 394	54, 682	
	19010 HANCOCK WELLNESS	0	0	0	1, 173		190.10
	19011 MORRI STOWN CLINIC 19012 03PUREMED		0	0	0		190. 11 190. 12
	19013 MCCORD WELLNESS	0	0	0	896		190. 12
	19014 3 WEST UNIT	0	349, 447	349, 447	281		190.14
190.15	19015 NEUROLOGY PHYSI CI AN	0	0	0	882	8, 440	190. 15

Health Financial Systems	HANCOCK REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0037	Period: From 01/01/2018	Worksheet B Part II	
				To 12/31/2018		pared:
					5/29/2019 9:5	7 am
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Di rectl y	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	Assigned New	FLXT		BENEFI TS	& GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4.00	5.00	
190. 16 19016 THORACI	0	0		0 0	1, 517	190. 16
190. 17 19017 HANCOCK ENDO	0	0		0 0	850	190. 17
190.18 19018 HANCOCK FOOT & ANKLE	0	0		0 466	3, 840	190. 18
190. 19 19019 HANCOCK RHEUM	0	0		0 0	667	190. 19
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	9, 785, 406	9, 785, 40	69, 773	748, 957	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	HANCOCK REGIO	NAL HOSPITAL Provider CC		ri od:	u of Form CMS-2 Worksheet B	2552-10
				Fr   Tc	om 01/01/2018 12/31/2018	Part II Date/Time Pre	pared:
	Cost Center Description	OPERATION OF	HOUSEKEEPING	DI ETARY	CAFETERIA	5/29/2019 9:5 NURSI NG	7 am
		PLANT 7.00	9.00	10.00		ADMI NI STRATI ON	
	GENERAL SERVICE COST CENTERS	7.00	9.00	10.00	11.00	13.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	550, 188					5.00 7.00
9.00	00900 HOUSEKEEPI NG	7, 170					9.00
10.00	01000 DI ETARY	37, 629		367, 949			10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	2, 436	0	17, 808 574	15, 296	11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	0	3, 696	0	574	15, 298	14.00
	01500 PHARMACY	19, 425	2, 696	0	845	894	
	01600 MEDI CAL RECORDS & LI BRARY	12, 905		0	501	530	
23.00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	4, 364	3, 735	0	80	0	23.00
30.00	03000 ADULTS & PEDIATRICS	73, 905	24, 782	111, 280	1, 537	1, 624	30.00
	03100 I NTENSI VE CARE UNI T	77, 446		149, 880	2, 033	2, 148	
	04000 SUBPROVIDER - IPF	20, 705		76, 825	762	806	
41.00	04100 SUBPROVIDER - IRF ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	41.00
50.00	05000 OPERATI NG ROOM	0	9, 920	0	1, 213	1, 282	50.00
51.00	05100 RECOVERY ROOM	6, 884	3, 653	0	157	166	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	3, 631 3, 465	0 0	1, 905 1, 250	2, 014 1, 322	54.00 60.00
65.00	06500 RESPIRATORY THERAPY	0	2,654	0	845	893	65.00
66.00	06600 PHYSI CAL THERAPY	12, 629	3, 084	0	613	648	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	195	0	67.00
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 OCCUPATI ONAL HEALTH	0	0	0	85 0	0	68.00 68.01
	06900 ELECTROCARDI OLOGY	24, 332	6, 014	0	335	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 236	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC	0	0	0	0	0	73.00 76.00
	03160 CARDI AC	7,401	0	0	55	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90. 00 90. 01	09000 CLINIC 09001 WOUND CLINIC	0	0	0	0 320	0	90.00 90.01
	09002 DI ABETES CLINIC	0	0	0	35	0	90.02
	09003 ASTHMA CLINIC	0	0	0	0	0	90. 03
90.04	09004 ANDIS CLINIC	8, 456	0	0	72	0	90.04
	09005 PRIME TIME 09006 SHELBYVILLE WOUND CLINIC		0	0	0 119	0	90. 05 90. 06
	04951 ONCOLOGY	45, 114	0	0	600	0	
	04950 ANDERSON WOMENS CENTER	0	5, 314	0	224	0	90. 08
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	71, 781	0	0	1, 525	1, 612	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS		II				92.00
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	05.1/0			7.0		
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	35, 168 480, 550		29, 964 367, 949	768 16, 699	812 14, 805	116.00
	NONREI MBURSABLE COST CENTERS	480, 550	<u> </u>	307, 949	10, 077	14, 805	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19001 PROFESSI ONAL BUILDI NG	0	0	0	0		190.01
	19002 PHYSI CI AN BUI LDI NG 19003 PRI VATE DUTY	0	0	0	0 465		190. 02 190. 03
	19004 MARKETI NG	0	0	0	403 99		190.03
	19005 SPORTS PHYSI CALS	0	0	0	0		190.05
	19006 FOUNDATI ON	7,826	0	0	127		190. 06
	19007 ASC	0	0	0	0		190. 07 190. 08
	19008 OTHER NONREI MBURSABLE 19009 HANCOCK OB	21,039	0	0	257		190.08
	19010 HANCOCK WELLNESS	0	0	0	0		190.10
190.11	19011 MORRI STOWN CLINIC	0	0	0	0		190. 11
	19012 03PUREMED	0	0	0	0		190.12
	19013 MCCORD WELLNESS 19014 3 WEST UNIT	40, 773	0	0	0 93		190. 13 190. 14
	19015 NEUROLOGY PHYSI CI AN	0	0	0	68		190. 14
190.16	19016 THORACI	0	0	0	0	0	190. 16
	19017 HANCOCK ENDO	0	0	0	0		190.17
	19018 HANCOCK FOOT & ANKLE 19019 HANCOCK RHEUM	0 0	0	0	0		190. 18 190. 19
		. 0	<u>ا</u>	0	9	0	1

Health Fin	ancial Systems	HANCOCK REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS			Provider C	Provider CCN: 15-0037		Worksheet B		
					From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	narod	
			_		10 12/31/2018	5/29/2019 9:5		
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG		
		PLANT				ADMI NI STRATI ON		
		7.00	9.00	10.00	11.00	13.00		
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers	0	0		0 0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	550, 188	89, 000	367, 94	9 17, 808	15, 296	202.00	

Health Financial Systems	HANCOCK REGIONA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	Fi	eriod: rom 01/01/2018	Worksheet B Part II	
			Т	0 12/31/2018	Date/Time Pre 5/29/2019 9:5	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
	SERVICES & SUPPLY		RECORDS & LI BRARY	PRGM		
	14.00	15.00	16.00	23.00	24.00	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         NEW         CAP         REL         COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT 9. 00 00900 HOUSEKEEPING						7.00 9.00
10. 00 01000 DI ETARY						10.00
						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	4, 514					13.00 14.00
15. 00 01500 PHARMACY	96	208, 911				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	136, 065	44,000		16.00
23. 00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	46, 890		23.00
30. 00 03000 ADULTS & PEDI ATRI CS	77	0	36, 602		921, 684	30.00
31. 00 03100 I NTENSI VE CARE UNI T	150	0	4, 570		948, 006	
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	11	0	3, 768 0		299, 366 0	
ANCI LLARY SERVI CE COST CENTERS					Ŭ	
50. 00 05000 OPERATING ROOM	165	0	48, 109		812, 300	
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	5	0	0		73, 893 4	51.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	45	0	5, 492		787, 123	
60. 00 06000 LABORATORY	1,072	0	12, 187		218, 509	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	13	0	0		85, 572 138, 421	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0		3, 719	
68.00 06800 SPEECH PATHOLOGY	2	0	0		1, 941	
68. 01 06801 OCCUPATI ONAL HEALTH 69. 00 06900 ELECTROCARDI OLOGY	0	0	0		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 619	0	6, 254		249, 781 183, 825	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		11, 457	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	208, 911	281		306, 224	
76. 00 03020 CARDI AC 76. 01 03160 CARDI OPULMONARY	1	0	0		0 72, 084	76.00 76.01
OUTPATIENT SERVICE COST CENTERS		Ĩ				
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0	0	0		3, 741 0	88.00 90.00
90. 01 09001 WOUND CLINIC	10	0	0		88, 592	
90. 02 09002 DI ABETES CLI NI C	0	0	0		598	
90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC	0	0	0		0 83, 059	
90. 05 09005 PRIME TIME	0	0	0		83, 039 939	
90.06 09006 SHELBYVILLE WOUND CLINIC	5	0	0		3, 408	90.06
90.07 04951 0NCOLOGY 90.08 04950 ANDERSON WOMENS CENTER	27	0	0		446, 772 9, 019	
91. 00 09100 EMERGENCY	144	0	18, 802		743, 862	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	0	0	0		0	101.00
SPECIAL PURPOSE COST CENTERS	0		0		0	101.00
116.00 11600 HOSPI CE	37	0	0	_	390, 843	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	4, 501	208, 911	136, 065	0	6, 884, 742	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190. 01 19001 PROFESSI ONAL BUILDING	0	0	0		2, 056, 027	
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY	0	0	0		71 10, 909	190.02
190. 04 19004 MARKETI NG	0	0	0			190.03
190. 05 19005 SPORTS PHYSI CALS	0	0	0		615	190. 05
190. 06 19006 FOUNDATI ON	0	0	0		86, 552	
190. 07 19007 ASC 190. 08 19008 OTHER NONREI MBURSABLE	0	0	0			190. 07 190. 08
190. 09 19009 HANCOCK OB	7	ō	0		258, 697	190. 09
190. 10 19010 HANCOCK WELLNESS	0	0	0		10, 499	
190. 11 19011 MORRI STOWN CLINIC 190. 12 19012 03PUREMED	0	0	0			190. 11 190. 12
190. 13 19013 MCCORD WELLNESS	0	0 0	0 0		8, 116	190. 13
190. 14 19014 3 WEST UNIT	1	0	0		396, 594	
190. 15 19015 NEUROLOGY PHYSI CI AN 190. 16 19016 THORACI		0	0			190. 15 190. 16
190. 17 19017 HANCOCK ENDO	0	Ö	0		850	190. 17
190. 18 19018 HANCOCK FOOT & ANKLE	3	0	0		4, 309	190. 18

Health Financial Systems	HANCOCK REGION	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2018 To 12/31/2018		
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
	SERVICES &		RECORDS &	PRGM		
	SUPPLY		LI BRARY			
	14.00	15.00	16.00	23.00	24.00	
190. 19 19019 HANCOCK RHEUM	0	0	(	)	667	190. 19
200.00 Cross Foot Adjustments				46, 890	46, 890	200.00
201.00 Negative Cost Centers	0	0	(	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	4, 514	208, 911	136, 06	5 46, 890	9, 785, 406	202.00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lieu of Form CM	S-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0037	Period: Worksheet B From 01/01/2018 Part II	3
			To 12/31/2018 Date/Time P 5/29/2019 9	Prepared:
Cost Center Description	Intern &	Total	372772017 7	
	Residents Cost & Post			
	Stepdown			
	Adjustments	24.00		
GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT				5.00 7.00
9. 00 00900 HOUSEKEEPING				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERIA				11.00
13.00 01300 NURSI NG ADMINI STRATI ON 14.00 01400 CENTRAL SERVICES & SUPPLY				13.00 14.00
15. 00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
23. 00 02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS				23.00
30. 00 03000 ADULTS & PEDIATRICS	0	921, 684		30.00
31.00 03100 INTENSIVE CARE UNIT	0	948, 006		31.00
40. 00 04000 SUBPROVI DER - I PF	0	299, 366		40.00
41. 00 04100 SUBPROVI DER - I RF ANCI LLARY SERVI CE COST CENTERS	0	0		41.00
50. 00 05000 OPERATING ROOM	0	812, 300		50.00
51.00 05100 RECOVERY ROOM	0	73, 893		51.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4		53.00 54.00
60. 00 06000 LABORATORY	0	787, 123 218, 509		60.00
65. 00 06500 RESPIRATORY THERAPY	0	85, 572		65.00
66. 00 06600 PHYSI CAL THERAPY	0	138, 421		66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	3, 719 1, 941		67.00 68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0		68.01
69. 00 06900 ELECTROCARDI OLOGY	0	249, 781		69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	S 0	183, 825		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 457 306, 224		72.00
76. 00 03020 CARDI AC	0	0		76.00
76. 01 03160 CARDI OPULMONARY	0	72, 084		76.01
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	3, 741		88.00
90. 00 09000 CLINIC	0	0		90.00
90. 01 09001 WOUND CLINIC	0	88, 592		90. 01
90. 02 09002 DI ABETES CLINIC	0	598 0		90. 02 90. 03
90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC	0	83, 059		90.03
90. 05 09005 PRIME TIME	0	939		90. 05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	3, 408		90.06
90. 07 04951 ONCOLOGY 90. 08 04950 ANDERSON WOMENS CENTER	0	446, 772 9, 019		90. 07 90. 08
91.00 09100 EMERGENCY	0	743, 862		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	) 0			92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	0	0		101.00
SPECIAL PURPOSE COST CENTERS		0		
116. 00 11600 H0SPI CE	0	390, 843		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1 NONREI MBURSABLE COST CENTERS	17) 0	6, 884, 742		118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190. 01 19001 PROFESSI ONAL BUI LDI NG	0	2, 056, 027		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	71		190.02
190. 03 19003  PRI VATE_DUTY 190. 04 19004  MARKETI NG	0	10, 909 8, 436		190. 03 190. 04
190. 05 19005 SPORTS PHYSI CALS	0	615		190.05
190. 06 19006 FOUNDATI ON	0	86, 552		190.06
190. 07 19007 ASC 190. 08 19008 OTHER NONREI MBURSABLE	0	57 454		190. 07 190. 08
190. 09 19008 OTHER NORRET MORSABLE 190. 09 19009 HANCOCK OB	0	258, 697		190.08
190. 10 19010 HANCOCK WELLNESS	0	10, 499		190. 10
190. 11 19011 MORRI STOWN CLINIC	0	14		190.11
190. 12 19012 03PUREMED 190. 13 19013 MCCORD_WELLNESS		0 8, 116		190. 12 190. 13
190. 14 19014 3 WEST UNIT	0	396, 594		190.13
190. 15 19015 NEUROLOGY PHYSI CI AN	0	9, 390		190.15
190. 16 19016 THORACI	0	1, 517		190. 16

Health Financial Systems	HANCOCK REGIONAL	HOSPITAL		In Lieu	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0037	Period: From 01/01/2018	Worksheet B Part II
				To 12/31/2018	Date/Time Prepared: 5/29/2019 9:57 am
Cost Center Description	Intern &	Total			
	Residents Cost				
	& Post				
	Stepdown				
	Adjustments				
	25.00	26.00			
190. 17 19017 HANCOCK ENDO	0	850			190. 17
190.18 19018 HANCOCK FOOT & ANKLE	0	4, 309			190. 18
190. 19 19019 HANCOCK RHEUM	0	667			190. 19
200.00 Cross Foot Adjustments	0	46, 890			200.00
201.00 Negative Cost Centers	0	0			201.00
202.00 TOTAL (sum lines 118 through 201)	0	9, 785, 406			202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	HANCOCK REGION		CN: 15-0037 P	In Lie Period:	u of Form CMS-: Worksheet B-1	
				F	rom 01/01/2018 0 12/31/2018	Date/Time Pre	
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	5/29/2019 9:5 OPERATI ON OF PLANT (SOUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
13. 00 14. 00 15. 00 16. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02300 PARAMED ED PRGM	351, 600 2, 507 26, 441 17, 770 2, 208 11, 588 0 0 0 0 5, 982 3, 974 1, 344	46, 998, 252 8, 818, 739 1, 055, 841 1, 422, 043 439, 693 989, 487 1, 218, 229 57, 007 1, 824, 617 606, 304 121, 555	-17, 428, 338	6, 885, 104 2, 326, 379 723, 631 1, 770, 589 1, 644, 543 79, 986 2, 007, 186 940, 534	169, 431 2, 208 11, 588 0 0 0 5, 982 3, 974 1, 344	9.00 10.00 11.00 13.00 14.00 15.00 16.00
	O3000 ADULTS & PEDIATRICS	22, 759	2, 811, 780			22, 759	•
40.00	03100   INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF ANCI LLARY SERVI CE COST CENTERS	23, 850 6, 376 0	3, 179, 078 1, 221, 718 0	C	1, 672, 867	23, 850 6, 376 0	40.00
50.00	05000 OPERATING ROOM	25, 149	3, 179, 952	2 C	5, 981, 241	0	50.00
53.00 54.00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	2, 120 0 25, 994	320, 969 0 3, 143, 350		522 5, 849, 110	2, 120 0 0	53.00 54.00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	5, 844 2, 354	1, 593, 695 1, 385, 872		4, 355, 692 1, 731, 390	0	60.00 65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 889 0	1, 128, 098 326, 741	0		3, 889 0	67.00
69.00 71.00 72.00	06800 SPEECH PATHOLOGY 06801 OCCUPATIONAL HEALTH 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC	0 0 7,493 4,692 0 0 0 0	168, 924 0 653, 207 0 0 0 0 0 0		0 1, 219, 495 3, 710, 223 1, 459, 164 12, 352, 652	0 0 7, 493 4, 692 0 0 0	68. 01 69. 00 71. 00 72. 00
76. 01	03160 CARDI OPULMONARY	2, 279	63, 782	C	140, 764	2, 279	76.01
90. 00 90. 01 90. 02 90. 03	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 WOUND CLINIC 09002 DIABETES CLINIC 09003 ASTHMA CLINIC	0 0 2,901 0 0	229, 149 0 498, 846 49, 606 0		0 863, 872 62, 303 0	0 0 0 0 0	90. 00 90. 01 90. 02 90. 03
90.05	09004 ANDIS CLINIC 09005 PRIME TIME 09006 SHELBYVILLE WOUND CLINIC	2,604 0 0	121, 691 0 223, 854	C	239, 230 119, 621 375, 917	2, 604 0 0	90.05
90.07	04951 ONCOLOGY 04950 ANDERSON WOMENS CENTER	13, 893	915, 742 320, 720			13, 893 0	90. 07 90. 08
91.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	22, 105	2, 538, 578			22, 105	•
101.00	OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	101.00
116. 00 118. 00		10, 830 256, 946	1, 309, 460 41, 938, 327			10, 830 147, 986	116. 00 118. 00
190. 01 190. 02 190. 03 190. 04 190. 05 190. 06	NORREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PROFESSI ONAL BUI LDI NG 19002 PHYSI CI AN BUI LDI NG 19003 PRI VATE DUTY 19004 MARKETI NG 19005 SPORTS PHYSI CALS 19006 FOUNDATI ON 19007 ASC	0 73, 209 0 0 0 0 2, 410 0	0 65 0 550, 261 164, 977 56, 681 185, 464		2, 361, 299 8, 987 1, 163, 246 1, 030, 601 67, 666	0 0 0 0 2, 410	190. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07
190. 08 190. 09 190. 10 190. 11 190. 12 190. 13	19008 OTHER NONREIMBURSABLE 19009 HANCOCK OB 19010 HANCOCK WELLNESS 19011 MORRISTOWN CLINIC 19012 O3PUREMED 19013 MCCORD WELLNESS	0 6,479 0 0 0 0 0	0 0 1, 612, 198 789, 648 0 0 603, 616		57, 783 6, 964, 039 1, 187, 780 1, 800 0 919, 505	0 6, 479 0 0 0 0 0	190. 08 190. 09 190. 10 190. 11 190. 12 190. 13
190.14	19014 3 WEST UNIT	12, 556	189, 128	6  C	764, 031	12, 556	190. 14

Health Financial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
	CAPI TAL RELATED COSTS		<b>D</b>			
Cost Center Description	NEW BLDG & FLXT	EMPLOYEE BENEFI TS	Reconciliatio	n ADMI NI STRATI VE		
		DEPARTMENT		& GENERAL (ACCUM.	PLANT	
	(SQUARE FEET)	(GROSS		COST)	(SQUARE FEET)	
	1	SALARI ES)		0031)	ILLI)	
	1.00	4,00	5A	5,00	7.00	
190. 15 19015 NEUROLOGY PHYSI CI AN	0	594,060	-	0 1, 074, 829	0	190. 15
190. 16 19016 THORACI	0	0		0 193, 165	0	190. 16
190. 17 19017 HANCOCK ENDO	0	0		0 108, 241		190. 17
190.18 19018 HANCOCK FOOT & ANKLE	0	313, 827		0 489, 108	0	190. 18
190. 19 19019 HANCOCK RHEUM	0	0		0 84, 982	0	190. 19
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	9, 785, 406	5, 036, 792		17, 428, 338	8, 143, 198	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	27.831075	0. 107170		0. 182727		•
204.00 Cost to be allocated (per Wkst. B,		69, 773		748, 957	550, 188	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part		0. 001485		0.007852	3. 247269	205.00
						00/ 00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	HANCOCK REGION	AL HOSPITAL Provider CO	CN: 15-0037 F	In Lie Period:	u of Form CMS- Worksheet B-1	
			F	rom 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
Cost Center Description	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI ON (MANHOURS)	5/29/2019 9:5 CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS	1				<b></b>	1 1 00
1.00       00100       NEW CAP REL COSTS-BLDG & FIXT         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMI NI STRATI VE & GENERAL         7.00       00700       OPERATI ON OF PLANT         9.00       00000       HOUSEKEEPI NG         10.00       01000       DI ETARY         11.00       01100       CAFETERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVI CES & SUPPLY         15.00       01600       MEDI CAL RECORDS & LI BRARY         23.00       02300       PARAMED ED PRGM         INPATI ENT ROUTI NE SERVI CE COST CENTERS       02000	393, 860 6, 543 10, 782 0 16, 355 11, 930 14, 350 16, 530	11, 715 0 0 0 0 0 0 0	841, 937 27, 146 2, 416 39, 974 23, 698 3, 765	684, 126 2, 416 39, 974 323, 698 5000	6, 169, 116 131, 439 0 13	15. 00 16. 00 23. 00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	109, 670 22, 610	3, 543 4, 772	72, 653 96, 090		104, 832 205, 340	•
40. 00 04000 SUBPROVI DER - I PF	18, 095	2, 446	36, 045		14, 792	
41.00 04100 SUBPROVIDER - IRF	0	0	(	0 0	0	41.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	43,900	0	57, 349	57, 349	225, 694	50.00
51. 00 05100 RECOVERY ROOM	16, 165	0	7, 421		6, 336	
53. 00 05300 ANESTHESI OLOGY	0	0	C	-	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	16, 070 15, 335	0	90, 064 59, 113		61, 322 1, 464, 412	
65. 00 06500 RESPI RATORY THERAPY	11, 745	0	39, 931		18, 284	
66. 00 06600 PHYSI CAL THERAPY	13, 650	0	28, 967		1, 682	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	9, 226		572	•
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 OCCUPATI ONAL HEALTH	0	0	4,007		2, 395 0	68.00 68.01
69. 00 06900 ELECTROCARDI OLOGY	26, 615	0	15, 846	-	23, 229	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	3, 579, 705	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CARDIAC	0	0			0	73.00 76.00
76. 01 03160 CARDI OPULMONARY	0	0	2, 584	-	1, 038	
OUTPATIENT SERVICE COST CENTERS	· · ·					
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0	0			0	88.00 90.00
90. 01 09001 WOUND CLINIC	0	0	15, 113		13, 250	
90. 02 09002 DIABETES CLINIC	0	0	1, 634		563	90. 02
90. 03 09003 ASTHMA CLINIC	0	0	(	,		90.03
90. 04 09004 ANDIS CLINIC 90. 05 09005 PRIME TIME	0	0	3, 398		375 0	1
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	0	5, 637	0	6, 737	
90. 07 04951 ONCOLOGY	0	0	28, 364		36, 977	•
90. 08 04950 ANDERSON WOMENS CENTER 91. 00 09100 EMERGENCY	23, 515	0	10, 580 72, 119		6, 118 196, 657	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	72, 115	/2,119	170, 037	92.00
OTHER REI MBURSABLE COST CENTERS	· · ·			1		
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(	0 0	0	101.00
116. 00 11600 HOSPI CE	0	954	36, 324	36, 324	50, 370	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	393, 860	11, 715				
NONREI MBURSABLE COST CENTERS					0	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 PROFESSI ONAL BUILDING	0	0				190. 00 190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	0	0	0 0		190.02
190. 03 19003 PRI VATE DUTY	0	0	21, 962			190. 03
190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS	0	0	4, 691			190. 04 190. 05
190. 06 19006 FOUNDATI ON	0	0	6, 011			190.05
190. 07 19007 ASC	0	0	C	0 0		190. 07
190. 08 19008 OTHER NONREI MBURSABLE	0	0	(	0		190.08
190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS	0	0	12, 171			190. 09 190. 10
190. 11 19011 MORRI STOWN CLINIC	0	0				190. 10
190. 12 19012 03PUREMED	0	0	C	0	0	190. 12
190. 13 19013 MCCORD WELLNESS	0	0		0		190.13
190. 14 19014 3 WEST UNIT 190. 15 19015 NEUROLOGY PHYSI CI AN	0	0	4, 403 3, 235			190. 14 190. 15
190. 16 19016 THORACI	0	0	(			190. 16
	· · ·					

Health Fina	ncial Systems	HANCOCK REGIONAL	HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provider C	CN: 15-0037	Peri od:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI ON		
		SERVICE)	DAYS)			SUPPLY	
					(MANHOURS)	(COSTED	
						REQUIS.)	
	1	9.00	10.00	11.00	13.00	14.00	
	7 HANCOCK ENDO	0	0	)	0 0		190. 17
	8 HANCOCK FOOT & ANKLE	0	0		0 0		190. 18
	9 HANCOCK RHEUM	0	0		0 0	0	190. 19
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 857, 592	1, 460, 273	2, 172, 3	2, 015, 087	226, 613	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 255350	124. 649851	2. 5801	2. 945491	0. 036733	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	89, 000	367, 949	17, 80	08 15, 296	4, 514	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 225969	31. 408365	0. 0211	0. 022358	0.000732	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Heal th Financial Systems	HANCOCK	REGIONAL H		N 45 0007		u of Form CMS	
COST ALLOCATION - STATISTICAL BASIS		P	rovider CC		Period: From 01/01/2018	Worksheet B	
					To 12/31/2018	Date/Time P 5/29/2019 9	repared: :57 am
Cost Center Description	PHARM (COS <sup>-</sup>		EDICAL CORDS &	PARAMED ED PRGM			
	REQUI	S.) L	I BRARY	(ASSI GNED			
			(TIME SPENT)	TIME)			
	15. (		16.00	23.00			
GENERAL SERVICE COST CENTERS1.0000100 NEW CAP REL COSTS-BLDG &	FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTM							4.00
5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT							5.00 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		100					14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRAR	/	100 0	3, 394				15.00 16.00
23.00 02300 PARAMED ED PRGM		0	0	10	0		23.00
I NPATI ENT ROUTI NE SERVI CE COST           30. 00         03000         ADULTS & PEDI ATRI CS	CENTERS	0	913		0		30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	114		0		31.00
40. 00 04000 SUBPROVIDER - IPF		0	94		0		40.00
41. 00 04100 SUBPROVIDER - IRF ANCILLARY SERVICE COST CENTERS		0	0		0		41.00
50.00 05000 OPERATI NG ROOM		0	1, 200		0		50.00
51.00 05100 RECOVERY ROOM		0	0		0		51.00
53. 00   05300  ANESTHESI OLOGY 54. 00   05400  RADI OLOGY-DI AGNOSTI C		0	137	10			53.00 54.00
60. 00 06000 LABORATORY		0	304		0		60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0	0		0		65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY		0	0		0		68.00
68. 01 06801 0CCUPATI 0NAL HEALTH 69. 00 06900 ELECTROCARDI 0LOGY		0 0	0		0		68. 01 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED	TO PATI ENTS	Ö	156		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PAT 73.00 07300 DRUGS CHARGED TO PATIENTS		0 100	0		0		72.00 73.00
73.00 07300 DRUGS CHARGED TO PATTENTS 76.00 03020 CARDI AC		0	0		0		73.00
76. 01 03160 CARDI OPULMONARY		0	0		0		76. 01
0UTPATIENT SERVICE COST CENTER: 88.00 08800 RURAL HEALTH CLINIC	5	0	0		0		88.00
90. 00 09000 CLINIC		Ö	0		0		90.00
90. 01 09001 WOUND CLINIC		0	0		0		90.01
90. 02 09002 DI ABETES CLINIC 90. 03 09003 ASTHMA CLINIC		0	0		0		90. 02 90. 03
90. 04 09004 ANDIS CLINIC		0	0		0		90.04
90. 05 09005 PRIME TIME 90. 06 09006 SHELBYVILLE WOUND CLINIC		0	0		0		90. 05 90. 06
90. 07 04951 ONCOLOGY		0	0		0		90.07
90.08 04950 ANDERSON WOMENS CENTER		0	0		0		90.08
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DIS	STINCT PART)	0	469		0		91.00 92.00
OTHER REIMBURSABLE COST CENTER	· · · ·	1	1				
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		0	0		0		101.00
116.00 11600 HOSPI CE		0	0		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1	through 117)	100	3, 394	10	0		118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOF	P & CANTEEN	0	0		0		190.00
190. 01 19001 PROFESSI ONAL BUILDING		o	0		0		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY		0	0		0		190. 02 190. 03
190. 04 19004 MARKETI NG		0	0		0		190.03
190. 05 19005 SPORTS PHYSI CALS		0	0		0		190.05
190. 06 19006 FOUNDATI ON 190. 07 19007 ASC		0	0		0		190. 06 190. 07
190.08 19008 OTHER NONREI MBURSABLE		Ō	0		0		190. 08
190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS		0	0		0		190. 09 190. 10
190. 11 19011 MORRI STOWN CLINIC		o	0		ŏ		190. 10
190. 12 19012 03PUREMED		0	0		0		190. 12
190. 13 19013 MCCORD WELLNESS 190. 14 19014 3 WEST UNIT		0 0	0		0		190. 13 190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN		õ	0		0		190. 15
190. 16 19016 THORACI		0	0		0		190. 16

Heal th	Financial Systems	HANCOCK REGION	AL HOSPI TAL		In Lie	u of Form CMS-2552-1	-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Prepared: 5/29/2019 9:57 am	
	Cost Center Description	PHARMACY (COSTED REQUI S. )	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)			
		15.00	16.00	23.00			
	19017 HANCOCK ENDO	0	0		0	190. 1	
190.18	19018 HANCOCK FOOT & ANKLE	0	0		0	190. 1	18
190.19	19019 HANCOCK RHEUM	0	0		0	190. 1	19
200.00	Cross Foot Adjustments					200. 0	00
201.00	Negative Cost Centers					201.0	00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 973, 727	1, 538, 455	363, 63	30	202.0	00
203.00	Unit cost multiplier (Wkst. B, Part I)	29, 737. 270000	453. 286682	3, 636. 30000	00	203. 0	00
204.00	Cost to be allocated (per Wkst. B, Part II)	208, 911	136, 065	46, 89	90	204.0	00
205.00	Unit cost multiplier (Wkst. B, Part	2, 089. 110000	40. 089864	468.90000	00	205.0	00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206. 0	00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.0000	00	207.0	00

Health Financial Systems	HANCOCK REGION	IAL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018	Worksheet C Part I Data (Tima Dra	norod.
				To 12/31/2018	Date/Time Pre 5/29/2019 9:5	pared: 7 am
		Title	× XVIII	Hospi tal	PPS	/ Cill
				Costs		
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						
30. 00 03000 ADULTS & PEDIATRICS	8, 316, 161		8, 316, 16	1 0	8, 316, 161	30.00
31.00 03100 INTENSIVE CARE UNIT	8, 246, 017		8, 246, 01	7 0	8, 246, 017	31.00
40. 00 04000 SUBPROVI DER - I PF	2, 963, 494		2, 963, 49	4 0	2, 963, 494	40.00
41.00 04100 SUBPROVIDER - IRF	0			0 0	0	41.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	8, 261, 811		8, 261, 81	1 0	8, 261, 811	•
51.00 05100 RECOVERY ROOM	794, 963		794, 96	3 0	794, 963	
53. 00 05300 ANESTHESI OLOGY	617		61		617	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 960, 140		7, 960, 14		7, 960, 140	•
60. 00 06000 LABORATORY	5, 781, 086		5, 781, 08		5, 781, 086	
65. 00 06500 RESPI RATORY THERAPY	2, 354, 293	0	_/ = = / = .		2, 354, 293	
66. 00 06600 PHYSI CAL THERAPY	2, 183, 701	0	2, 100, 70		2, 183, 701	
67.00 06700 OCCUPATI ONAL THERAPY	481, 631	0			481, 631	
68.00 06800 SPEECH PATHOLOGY	251, 842	0	251, 84		251, 842	•
68. 01 06801 OCCUPATI ONAL HEALTH	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	2, 037, 299		2, 037, 29		2, 037, 299	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			4, 815, 89		4, 815, 896	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 725, 793		1, 725, 79		1, 725, 793	
73.00 07300 DRUGS CHARGED TO PATIENTS	17, 586, 671		17, 586, 67		17, 586, 671	
76. 00 03020 CARDI AC	0			0 0	0	
76. 01 03160 CARDI OPULMONARY	282, 723		282, 72	3 0	282, 723	76.01
OUTPATIENT SERVICE COST CENTERS	<b>540.040</b>		540.04		<b>E40.040</b>	
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	512, 213		512, 21		512, 213	
90. 00 109000 CLINIC 90. 01 109001 WOUND CLINIC	0 1, 061, 206		1, 061, 20	-	0 1, 061, 206	
90. 02 09002 DI ABETES CLINIC	77, 924		77, 92		77, 924	
90. 02 09002 DIABETES CEINIC 90. 03 09003 ASTHMA CLINIC	11, 924			0 0	0	•
90. 03 09003 ASTRIMA CETNIC 90. 04 09004 ANDIS CLINIC	416, 879		416, 87		416, 879	•
90. 05 09005 PRIME TIME	141, 479		141, 47		141, 479	
90. 06 09006 SHELBYVILLE WOUND CLINIC	459, 398		459, 39		459, 398	•
90. 07 04951 ONCOLOGY	2, 702, 597		2, 702, 59		2, 702, 597	
90. 08 04950 ANDERSON WOMENS CENTER	650, 200		650, 20		650, 200	
91. 00 09100 EMERGENCY	6, 353, 450		6, 353, 45		6, 353, 450	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			2, 783, 31		2, 783, 310	•
OTHER REI MBURSABLE COST CENTERS	2,700,010		2//00/01	0	2//00/010	12.00
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
					-	1 .
SPECIAL PURPOSE COST CENTERS						
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE	3, 965, 750		3, 965, 75	0	3, 965, 750	116.00
	3, 965, 750 93, 168, 544	0			3, 965, 750 93, 168, 544	
116. 00 11600 HOSPI CE		0		4 0		200.00

	ancial Systems	HANCOCK REGION		N 15 0007		u of Form CMS-	2002-10
COMPUTATIO	N OF RATIO OF COSTS TO CHARGES		Provider C	JN: 15-0037	Period: From 01/01/2018	Worksheet C Part I	
					To 12/31/2018	Date/Time Pre	pared:
						5/29/2019 9:5	7 am
				XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		6.00	7.00	8.00	9.00	Rati o 10.00	
	TIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
	DO ADULTS & PEDIATRICS	6, 885, 512		6, 885, 51	2		30.00
	DO I NTENSI VE CARE UNI T	11, 339, 967		11, 339, 96			31.00
	00 SUBPROVI DER – I PF	3, 241, 674		3, 241, 67			40.00
	00 SUBPROVI DER – I RF	0		0/2///0/	0		41.00
	LLARY SERVICE COST CENTERS	-			-		-
	OO OPERATING ROOM	8, 570, 040	12, 598, 264	21, 168, 30	0. 390292	0. 000000	50.00
51.00 0510	DO RECOVERY ROOM	779, 114	1, 497, 782	2, 276, 89	0. 349143	0. 000000	51.00
53.00 0530	DO ANESTHESI OLOGY	972, 051	1, 824, 836	2, 796, 88	0. 000221	0. 000000	53.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	2, 339, 038	63, 589, 327	65, 928, 36	0. 120739	0. 000000	54.00
60.00 0600	DOLABORATORY	4, 960, 084	40, 009, 004	44, 969, 08	0. 128557	0. 000000	60.00
65.00 0650	00 RESPI RATORY THERAPY	3, 175, 836	6, 057, 703	9, 233, 53	0. 254972	0. 000000	65.00
66.00 0660	00 PHYSI CAL THERAPY	731, 853	4, 418, 264	5, 150, 11	7 0. 424010	0.00000	66.00
67.00 0670	00 OCCUPATI ONAL THERAPY	537, 729	831, 548	1, 369, 27	7 0. 351741	0.00000	67.00
	DO SPEECH PATHOLOGY	133, 208	540, 771	673, 97		0. 000000	
	01 OCCUPATIONAL HEALTH	0	0		0 0.000000	0. 000000	
	00 ELECTROCARDI OLOGY	2, 850, 450	12, 496, 124			0. 000000	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 035, 190	5, 931, 012	8, 966, 20		0. 000000	
	DOIMPL. DEV. CHARGED TO PATIENT	2, 682, 370	1, 638, 390			0. 000000	
	DO DRUGS CHARGED TO PATIENTS	6, 614, 503	79, 344, 797			0.00000	
	20 CARDI AC	0	0		0 0.000000	0.00000	
	60 CARDI OPULMONARY	0	433, 808	433, 80	0. 651724	0.00000	76.01
	PATIENT SERVICE COST CENTERS						
	DO RURAL HEALTH CLINIC	0	0		0	0 000000	88.00
		0	0		0 0.000000	0.00000	
		16, 827	4,075,004			0.00000	
	D2 DI ABETES CLINIC	0	75, 219			0.00000	
	03 ASTHMA CLINIC 04 ANDIS CLINIC	0	0		0 0.000000	0.00000	
	D5 PRIME TIME	0 100	73, 838			0. 000000 0. 000000	
	DE SHELBYVILLE WOUND CLINIC	100	415, 402 1, 443, 692			0. 000000	
	51 ONCOLOGY	1,236	6, 512, 672			0. 000000	
	50 ANDERSON WOMENS CENTER	7,000	3, 595, 956			0. 000000	
	DO EMERGENCY	3, 188, 614	45, 097, 189			0.000000	
	00 OBSERVATION BEDS (NON-DISTINCT PART)	3, 100, 014	4, 726, 688			0.000000	
	R REIMBURSABLE COST CENTERS	- U	1, 720, 000	1,720,00	0.000000	0.00000	1 2.00
	DO HOME HEALTH AGENCY	0	0		0		101.00
	CIAL PURPOSE COST CENTERS	۰ ۹			-		1.0
116.001160		1,002,355	2,092,995	3, 095, 35	50		116.00
200.00	Subtotal (see instructions)	63, 064, 751	299, 320, 285				200.00
201.00	Less Observation Beds						201.00
201.00					1		

Health Financial Systems	HANCOCK REGIONAL	Provider CCN: 15-0037	Period:	u of Form CMS-2552 Worksheet C
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0037	From 01/01/2018	Part I
			To 12/31/2018	Date/Time Prepare
		Title XVIII	Hospi tal	5/29/2019 9:57 am PPS
Cost Center Description	PPS Inpatient		nospi tui	110
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.
31. 00 03100 INTENSIVE CARE UNIT				31.
IO. 00 04000 SUBPROVI DER – I PF				40.
1. 00 04100 SUBPROVIDER - IRF				41.
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 390292			50.
1.00 05100 RECOVERY ROOM	0. 349143			51.
3. 00 05300 ANESTHESI OLOGY	0. 000221			53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 120739			54.
0. 00 06000 LABORATORY	0. 128557			60.
5. 00 06500 RESPI RATORY THERAPY	0. 254972			65.
6. 00 06600 PHYSI CAL THERAPY	0. 424010			66.
7.00 06700 OCCUPATI ONAL THERAPY	0. 351741			67.
8.00 06800 SPEECH PATHOLOGY	0. 373664			68.
8.01 06801 OCCUPATI ONAL HEALTH	0. 000000			68.
9. 00 06900 ELECTROCARDI OLOGY	0. 132753			69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 537117			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 399419			72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 204593			73.
6. 00 03020 CARDI AC	0. 000000			76.
6. 01 03160 CARDI OPULMONARY	0. 651724			76.
OUTPATIENT SERVICE COST CENTERS				
8.00 08800 RURAL HEALTH CLINIC				88.
0. 00 09000 CLINIC	0. 000000			90.
0. 01 09001 WOUND CLINIC	0. 259347			90.
0. 02 09002 DIABETES CLINIC	1. 035962			90.
0.03 09003 ASTHMA CLINIC	0. 000000			90.
0. 04 09004 ANDIS CLINIC	5. 645860			90.
0. 05 09005 PRIME TIME	0. 340501			90.
0.06 09006 SHELBYVILLE WOUND CLINIC	0. 318211			90.
0. 07 04951 ONCOLOGY	0. 414896			90.
0.08 04950 ANDERSON WOMENS CENTER	0. 180463			90.
1.00 09100 EMERGENCY	0. 131580			91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 588850			92.
OTHER REIMBURSABLE COST CENTERS				
01. 00 10100 HOME HEALTH AGENCY				101.
SPECIAL PURPOSE COST CENTERS				
16.00 11600 HOSPI CE				116.
200.00 Subtotal (see instructions)				200.
201.00 Less Observation Beds				201.
202.00  Total (see instructions)				202.

Health Financial Systems		ONAL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	5	Provi der	CCN: 15-0037	Period: From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/29/2019 9:5	pared:
		Tit	tle XIX	Hospi tal	Cost	7 аш
				Costs		
Cost Center Description	Total Cost	Therapy Limi	t Total Costs	RCE	Total Costs	
	(from Wkst. E			Di sal I owance		
	Part I, col.					
	26)	2.00	2.00	1.00	F 00	
INPATIENT ROUTINE SERVICE COST CE	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	8, 316, 16	1	8, 316, 16	0	8, 316, 161	30.00
31. 00 03100 I NTENSI VE CARE UNI T	8, 246, 0		8, 246, 01		-, ,	•
40. 00 04000 SUBPROVIDER - I PF	2, 963, 49		2, 963, 49			
41. 00 04100 SUBPROVIDER - IRF	2,,,00,,1	0	2,,,00,11	0 0		
ANCI LLARY SERVICE COST CENTERS	ł	-1		-1 -		1
50. 00 05000 OPERATI NG ROOM	8, 261, 8	1	8, 261, 81	1 0	8, 261, 811	50.00
51.00 05100 RECOVERY ROOM	794, 96	53	794, 96	03 0	794, 963	51.00
53. 00 05300 ANESTHESI OLOGY	6	17	61	7 0	617	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	7, 960, 14		7, 960, 14		.,	•
60. 00 06000 LABORATORY	5, 781, 08		5, 781, 08		5, 781, 086	•
65. 00 06500 RESPI RATORY THERAPY	2, 354, 29		0 2, 354, 29		2, 354, 293	
66.00 06600 PHYSI CAL THERAPY	2, 183, 70		0 2, 183, 70		2, 183, 701	
67.00 06700 OCCUPATIONAL THERAPY	481, 63		0 481, 63			
68. 00 06800 SPEECH PATHOLOGY	251, 84		0 251, 84		251, 842	•
68. 01 06801 OCCUPATI ONAL HEALTH	2 027 20	0	0 2 027 20	0 0	, s	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO	2, 037, 29 PATI ENTS 4, 815, 89		2, 037, 29		2, 037, 299 4, 815, 896	•
72. 00 07200 IMPL. DEV. CHARGED TO PATIE			1, 725, 79		1, 725, 793	
73. 00 07300 DRUGS CHARGED TO PATIENTS	17, 586, 67		17, 586, 67			
76. 00 03020 CARDI AC	11,000,01	0	17,000,07	0 0		
76. 01 03160 CARDI OPULMONARY	282, 72	-	282, 72		-	
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	512, 21	3	512, 21	3 0	512, 213	88. 00
90. 00 09000 CLINIC		0		0 0	0	90.00
90. 01 09001 WOUND CLINIC	1, 061, 20	06	1, 061, 20	06 0	.,	
90. 02 09002 DI ABETES CLINIC	77,92		77, 92		77, 924	•
90. 03 09003 ASTHMA CLINIC		0		0 0	0	
90. 04 09004 ANDIS CLINIC	416, 8		416, 87			
90. 05 09005 PRIME TIME	141, 4		141, 47		141, 479	•
90. 06 09006 SHELBYVILLE WOUND CLINIC 90. 07 04951 0NCOLOGY	459, 39		459, 39		459, 398 2, 702, 597	
90.07 04951 ONCOLOGY 90.08 04950 ANDERSON WOMENS CENTER	650, 20		2, 702, 59		650, 200	
91. 00 09100 EMERGENCY	6, 353, 45		6, 353, 45		6, 353, 450	
92. 00 09200 OBSERVATION BEDS (NON-DISTI			2, 783, 31		2, 783, 310	•
OTHER REIMBURSABLE COST CENTERS	2,700,0		2,700,01		2,700,010	/2.00
101.00 10100 HOME HEALTH AGENCY		0		0	0	101.00
SPECIAL PURPOSE COST CENTERS	L					1
116. 00 11600 HOSPI CE	3, 965, 75	50	3, 965, 75	50	3, 965, 750	116.00
200.00 Subtotal (see instructions)	93, 168, 54		0 93, 168, 54			
201.00 Less Observation Beds	2, 783, 3		2, 783, 31		2, 783, 310	•
202.00 Total (see instructions)	90, 385, 23	34	0 90, 385, 23	34 0	90, 385, 234	202.00

leal th Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	HANCOCK REGION		CN. 1E 0027	Peri od:	u of Form CMS- Worksheet C	2002 1
COMPUTATION OF RAILO OF COSIS TO CHARGES		Provider C	UN: 15-0037	From 01/01/2018 Part I		
				To 12/31/2018	Date/Time Pre	pared.
					5/29/2019 9:5	7 am
	-	Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
	( 00	7.00	0.00	0.00	Ratio	
INDATIENT DOUTINE CEDVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	( 00E E12		( 00F F1	2		30.00
	6, 885, 512		6, 885, 51			
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	11, 339, 967		11, 339, 96			31.00
41. 00 04100 SUBPROVIDER - TPF 41. 00 04100 SUBPROVIDER - TRF	3, 241, 674		3, 241, 67	0		40.00
ANCI LLARY SERVICE COST CENTERS	0			0		41.00
50. 00 05000 OPERATI NG ROOM	8, 570, 040	12, 598, 264	21, 168, 30	0. 390292	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	779, 114	1, 497, 782			0. 000000	
53. 00 05300 ANESTHESI OLOGY	972,051	1, 824, 836			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 339, 038	63, 589, 327			0. 000000	
50. 00 105400 KADI 02001-DI AGNOSTI C	4, 960, 084	40, 009, 004			0.000000	
55. 00 06500 RESPI RATORY THERAPY	3, 175, 836	6, 057, 703			0. 000000	
56. 00 06600 PHYSI CAL THERAPY	731, 853	4, 418, 264			0. 000000	
57. 00 06700 OCCUPATI ONAL THERAPY	537, 729	831, 548			0. 000000	
58. 00 06800 SPEECH PATHOLOGY	133, 208	540, 771			0.000000	
58. 01 06801 OCCUPATI ONAL HEALTH	133, 200	040,771		0 0.000000	0.000000	
59. 00 06900 ELECTROCARDI OLOGY	2, 850, 450	12, 496, 124			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 035, 190	5, 931, 012			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 682, 370	1, 638, 390			0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 614, 503	79, 344, 797			0. 000000	
76. 00 03020 CARDI AC	0, 011, 000	0		0 0.000000	0. 000000	
76. 01 03160 CARDI OPULMONARY	0	433, 808			0. 000000	
OUTPATIENT SERVICE COST CENTERS		1007 000	100/00	01001721	0100000	1 1 0 1 0
38. 00 08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0, 000000	88. 00
20. 00 09000 CLINIC	0	0		0 0.000000	0. 000000	
90. 01 09001 WOUND CLINIC	16, 827	4,075,004	4, 091, 83		0.000000	
PO. 02 09002 DIABETES CLINIC	0	75, 219			0.000000	
PO. 03 09003 ASTHMA CLINIC	0	0		0 0.000000	0.000000	
90. 04 09004 ANDIS CLINIC	0	73, 838	73, 83		0. 000000	
20. 05 09005 PRIME TIME	100	415, 402			0.000000	
PO. 06 09006 SHELBYVILLE WOUND CLINIC	0	1, 443, 692			0.000000	
90. 07 04951 ONCOLOGY	1,236	6, 512, 672			0.000000	
PO. 08 04950 ANDERSON WOMENS CENTER	7,000	3, 595, 956	3, 602, 95	0. 180463	0. 000000	90.08
91. 00 09100 EMERGENCY	3, 188, 614	45, 097, 189	48, 285, 80	0. 131580	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4, 726, 688			0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	1, 002, 355	2, 092, 995	3, 095, 35	i0		116. 00
200.00 Subtotal (see instructions)	63, 064, 751	299, 320, 285	362, 385, 03	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	63, 064, 751	299, 320, 285	362, 385, 03	6		202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	HANCOCK REGIONAL	Provider CCN: 15-0037	Period:	u of Form CMS-2552- Worksheet C
CUMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN. 15-0037	From 01/01/2018 To 12/31/2018	Part I Date/Time Prepare 5/29/2019 9:57 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient	·		
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.
31. 00 03100 I NTENSI VE CARE UNI T				31.
40. 00 04000 SUBPROVI DER – I PF				40.
41. 00 04100 SUBPROVI DER – I RF				41.
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.
51.00 05100 RECOVERY ROOM	0. 000000			51.
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.
0. 00 06000 LABORATORY	0. 000000			60.
5. 00 06500 RESPI RATORY THERAPY	0. 000000			65.
6.00 06600 PHYSI CAL THERAPY	0. 000000			66.
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.
8. 00 06800 SPEECH PATHOLOGY	0. 000000			68.
8. 01 06801 0CCUPATI ONAL HEALTH	0. 000000			68.
9. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.
76. 00 03020 CARDI AC	0. 000000			76.
76. 01 03160 CARDI OPULMONARY	0. 000000			76.
OUTPATIENT SERVICE COST CENTERS	0.000000			/0.
8. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.
0. 00 09000 CLINIC	0. 000000			90.
0. 01 09001 WOUND CLINIC	0.000000			90. 90.
0. 02 09002 DI ABETES CLINIC	0.000000			90. 90.
0. 02 09002 DTABETES CETNIC 0. 03 09003 ASTHMA CLINIC	0.000000			90. 90.
0. 04 09003 ASTRIMA CETNIC 0. 04 09004 ANDIS CLINIC	0.000000			90. 90.
0. 05 09005 PRIME TIME	0.000000			90. 90.
0.05 09005 PRIME TIME 0.06 09006 SHELBYVILLE WOUND CLINIC	0. 000000			90. 90.
0.06 09006 SHELBYVILLE WOUND CLINIC 0.07 04951 ONCOLOGY	0.000000			90.
0.08 04950 ANDERSON WOMENS CENTER	0. 000000			90.
1.00 09100 EMERGENCY	0. 000000			91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.
OTHER REIMBURSABLE COST CENTERS				101
01. 00 10100 HOME HEALTH AGENCY				101.
SPECIAL PURPOSE COST CENTERS	1			11/
16.00 11600 HOSPI CE				116.
200.00 Subtotal (see instructions)				200.
201.00 Less Observation Beds				201.
202.00  Total (see instructions)				202.

Health Financial Systems	HANCOCK REGION	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	921, 684	0	921, 68			
31.00 INTENSIVE CARE UNIT	948, 006		948, 00			
40. 00 SUBPROVIDER - IPF	299, 366	0	299, 36	6 2, 466		
41.00 SUBPROVIDER - IRF	0	0		0 0	0.00	41.00
200.00 Total (lines 30 through 199)	2, 169, 056		2, 169, 05	6 12, 397		200.00
Cost Center Description	lnpatient Program days	Inpatient Program Capital Cost (col. 5 x col.				
		6)				
	6,00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 156	206, 011				30. 00
31.00 INTENSIVE CARE UNIT	1, 868					31.00
40. 00 SUBPROVIDER - IPF	2,003	243, 164				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
200.00 Total (lines 30 through 199)	5, 027	821, 281				200.00

ealth Financial Systems PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provider C	CN: 15-0037	In Lie Period:	Worksheet D	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/29/2019 9:5	pared:
		Title	XVIII	Hospi tal	PPS	7 аш
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	-		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1	-			
0.00 05000 OPERATING ROOM	812, 300					
1.00 05100 RECOVERY ROOM	73, 893					
3. 00 05300 ANESTHESI OLOGY	4	2///0/00/				
4. 00 05400 RADI OLOGY-DI AGNOSTI C	787, 123	65, 928, 365			24, 705	54.00
0. 00 06000 LABORATORY	218, 509	44, 969, 088	0. 00485	59 2, 783, 102	13, 523	60.00
5. 00 06500 RESPI RATORY THERAPY	85, 572	9, 233, 539	0. 00926	1, 619, 409	15, 009	65.00
6. 00 06600 PHYSI CAL THERAPY	138, 421	5, 150, 117	0. 02687	7 354, 789	9, 536	66.0
7.00 06700 OCCUPATIONAL THERAPY	3, 719	1, 369, 277	0. 00271	6 218, 308	593	67.0
8.00 06800 SPEECH PATHOLOGY	1, 941	673, 979	0. 00288	69, 869	201	68.00
8.01 06801 OCCUPATI ONAL HEALTH	0	0	0. 00000	0 0	0	68. 0 <sup>1</sup>
9. 00 06900 ELECTROCARDI OLOGY	249, 781	15, 346, 574	0. 01627	76 1, 733, 713	28, 218	69.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	183, 825	8, 966, 202	0. 02050	02 711, 728	14, 592	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	11, 457			2, 150, 065	5, 702	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	306, 224	85, 959, 300	0. 00356	2, 864, 866	10, 205	73.00
6. 00 03020 CARDI AC	0				0	76.00
6. 01 03160 CARDI OPULMONARY	72,084	433, 808			0	76.0
OUTPATIENT SERVICE COST CENTERS						1
8.00 08800 RURAL HEALTH CLINIC	3, 741	0			0	
0. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.0
0.01 09001 WOUND CLINIC	88, 592	4, 091, 831	0. 02165	51 1, 378	30	90.0 <sup>°</sup>
0. 02 09002 DIABETES CLINIC	598	75, 219	0. 00795	50 O	0	90.0
0.03 09003 ASTHMA CLINIC	0	0	0.00000	0 0	0	90.0
0. 04 09004 ANDIS CLINIC	83, 059	73, 838	1. 12488	0	0	90.0
0. 05 09005 PRIME TIME	939	415, 502	0. 00226	0 0	0	90.0
0.06 09006 SHELBYVILLE WOUND CLINIC	3, 408	1, 443, 692	0.00236	0	0	90.0
0. 07 04951 ONCOLOGY	446, 772	6, 513, 908	0. 06858	37 1, 104	76	90.0
0.08 04950 ANDERSON WOMENS CENTER	9,019				0	90.0
1.00 09100 EMERGENCY	743, 862				45, 290	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	308, 474				0	
00.00 Total (lines 50 through 199)	4, 633, 317			20, 609, 008	271, 507	

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C		Period: From 01/01/2018 To 12/31/2018		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		·	·			
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		o o	0	31.00
40. 00 04000 SUBPROVI DER - I PF	0	0		0 0	0	1
41. 00 04100 SUBPROVIDER - IRF	0	0		0 0	0	
200.00 Total (lines 30 through 199)	0			0 0	-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
obst benter beschiption	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	0 . 001. 0)		
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00 03000 ADULTS & PEDI ATRI CS	0	0	5, 17	2 0.00	1, 156	30.00
31. 00 03100 I NTENSI VE CARE UNI T	-	0	4, 75			
40. 00 04000 SUBPROVIDER - IPF	0	0	2,46			
41. 00 04100 SUBPROVIDER - IRF	0	0	2,10	0 0.00		
200.00 Total (lines 30 through 199)			12, 39			200.00
Cost Center Description	I npati ent	Ŭ	1 12,07	,	0,027	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T						31.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
	0					
41.00 04100 SUBPROVIDER - IRF	0					41.00
200.00  Total (lines 30 through 199)	0					200. 00

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provider C	CN: 15-0037	Period: From 01/01/2018 To 12/31/2018		pared: 7 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown	Ŭ	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	363, 630	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0		0 0	0	68.01
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03020 CARDI AC	0	0		0 0	0	76.00
76. 01 03160 CARDI OPULMONARY	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS				<u> </u>		/ 01 01
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 WOUND CLINIC	0	0		0 0	0	90.01
90. 02 09002 DI ABETES CLINIC	0	0		0 0	0	90.02
90. 03 09003 ASTHMA CLINIC	0	0		0 0	0	90.03
90. 04 09004 ANDIS CLINIC	0	0		0 0	0	90.04
90. 05 09005 PRIME TIME	0	0		0 0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	0		0 0	0	90.06
90. 07 04951 ONCOLOGY	0	0		0 0	0	90.07
90. 08 04950 ANDERSON WOMENS CENTER	0	0		0 0	0	90.08
91. 00 09100 EMERGENCY	0	0			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	-	
	0	0	Т	с <sub>1</sub> 0	505,050	200.00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2018 To 12/31/2018		narod
				10 12/31/2010	5/29/2019 9:5	7 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50. 00 05000 OPERATI NG ROOM	0	0		0 21, 168, 304		
51.00 05100 RECOVERY ROOM	0	0		0 2, 276, 896		•
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 796, 887		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	363, 630				
60. 00 06000 LABORATORY	0	0		0 44, 969, 088		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 9, 233, 539		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 150, 117		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 369, 277		
68.00 06800 SPEECH PATHOLOGY	0	0		0 673, 979		
68. 01 06801 OCCUPATI ONAL HEALTH	0	0		0 0	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 15, 346, 574	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 8, 966, 202		
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 4, 320, 760		•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 85, 959, 300		
76. 00 03020 CARDI AC	0	-		0 0		
76. 01 03160 CARDI OPULMONARY	0	0		0 433, 808	0.00000	76.01
OUTPATIENT SERVICE COST CENTERS	1				0.00000	
88.00 08800 RURAL HEALTH CLINIC	0	-		0 0		•
90. 00 09000 CLINIC	0	0		0 0	0.00000	•
90. 01 09001 WOUND CLINIC	0	0		0 4, 091, 831	0.000000	
90. 02 09002 DI ABETES CLI NI C	0	0		0 75, 219		
90. 03 09003 ASTHMA CLINIC	0	0		0 0		•
90. 04 09004 ANDIS CLINIC	0	0		0 73,838		•
90. 05 09005 PRIME TIME	0	0		0 415, 502	0.000000	•
90. 06 09006 SHELBYVILLE WOUND CLINIC 90. 07 04951 0NCOLOGY	0			0 1, 443, 692		•
	0			0 6, 513, 908		
	0			0 3, 602, 956 0 48, 285, 803		
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0			0 48, 285, 803 0 4, 726, 688		
200.00 Total (lines 50 through 199)	0	-				92.00 200.00
	1 0	303, 030	1 303, 03	0 337,022,333	I	l∠00. 00

Health Financial Systems	HANCOCK REGIONA			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	Provider C	CN: 15-0037	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/29/2019 9:5	pared:
		Title	XVIII	Hospi tal	PPS	7 ani
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.	U	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	2, 490, 351		0 3, 371, 487	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	254, 682		0 330, 620	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	346, 455		0 396, 405	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.005516	2,069,261	11, 41	18, 735, 436	103, 345	54.00
60. 00 06000 LABORATORY	0. 000000	2, 783, 102		0 5, 353, 174	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 619, 409		0 1, 586, 823		65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	354, 789		0 60,074		66.00
67.00 06700 OCCUPATIONAL THERAPY	0, 000000	218, 308		0 38, 335		67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	69, 869		0 66, 516		68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0. 000000	0		0 0		68.01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 733, 713		0 3, 964, 626	-	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	711, 728		0 716, 941	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	2, 150, 065		0 606, 092	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 864, 866		0 29, 291, 586		73.00
76. 00 03020 CARDI AC	0. 000000	2,001,000		0 0	0	76.00
76. 01 03160 CARDI OPULMONARY	0. 000000	0		0 182,400	-	76.01
OUTPATIENT SERVICE COST CENTERS	0.000000	0	<u> </u>	0 102,400	0	/0.01
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	1 88. 00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 WOUND CLINIC	0. 000000	1, 378		0 1, 547, 715	0	90.01
90. 02 09002 DI ABETES CLINIC	0. 000000	0		0 0	0	90.02
90. 03 09003 ASTHMA CLINIC	0. 000000	0		0 0	0	90.03
90. 04 09004 ANDIS CLINIC	0. 000000	0		0 18, 421	0	90.04
90. 05 09005 PRIME TIME	0. 000000	0		0 88, 163	0	90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	0. 000000	0		0 585, 108		90.06
90. 07 04951 ONCOLOGY	0. 000000	1, 104		0 2, 102, 603		90.07
90. 08 04950 ANDERSON WOMENS CENTER	0. 000000	., 101		0 313, 373		90.08
91. 00 09100 EMERGENCY	0. 000000	2, 939, 928		0 8, 460, 634		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 707, 720		0 2, 481, 869		92.00
200.00 Total (lines 50 through 199)	0.000000	20, 609, 008	11, 41			
	I I	20,007,000	1 1, 4		100,040	

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0037	Peri od:	Worksheet D	
				From 01/01/2018	Part V	
				To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
		Title	× XVIII	Hospi tal	PPS	
			Charges	nospi tui	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	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 SERVI CE COST CENTERS					_	
50.00 O5000 OPERATI NG ROOM	0. 390292	3, 371, 487		0 0	1, 315, 864	50.00
51.00 05100 RECOVERY ROOM	0. 349143			0 0	115, 434	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000221			0 0	88	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 120739			0 0	2, 262, 098	54.00
60. 00 06000 LABORATORY	0. 128557	5, 353, 174		0 0	688, 188	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 254972	1, 586, 823		0 0	404, 595	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 424010			0 0	25, 472	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 351741	38, 335		0 0	13, 484	67.00
68.00 06800 SPEECH PATHOLOGY	0. 373664			0 0	24, 855	68.00
68.01 06801 OCCUPATI ONAL HEALTH	0. 000000	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 132753			0 0	526, 316	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 537117			0 0	385, 081	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 399419			0 0	242, 085	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 204593			0 21, 981	5, 992, 853	
76. 00 03020 CARDI AC	0. 000000			0 0		
76. 01 03160 CARDI OPULMONARY	0. 651724	182, 400		0 0	118, 874	76.01
OUTPATIENT SERVICE COST CENTERS	1	1	1		1	-
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
90. 00 09000 CLINIC	0. 000000			0 0	-	
90. 01 09001 WOUND CLINIC	0. 259347			0 0	401, 395	
90. 02 09002 DI ABETES CLI NI C	1. 035962			0 0	0	
90. 03 09003 ASTHMA CLINIC	0. 000000			0 0	0	
90. 04 09004 ANDIS CLINIC	5. 645860			0 0	104, 002	
90. 05 09005 PRIME TIME	0. 340501	88, 163		0 0	30, 020	
90. 06 09006 SHELBYVILLE WOUND CLINIC	0. 318211			0 0	186, 188	
90. 07 04951 ONCOLOGY	0. 414896			0 0		
90. 08 04950 ANDERSON WOMENS CENTER	0. 180463			0 0		•
91.00 09100 EMERGENCY	0. 131580			0 92	1, 113, 250	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 588850			0 0	1, 461, 449	
200.00 Subtotal (see instructions)		80, 298, 401		0 22,073		•
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
0nly Charges 202.00 Net Charges (line 200 - line 201)		80, 298, 401		0 22, 073	16, 340, 505	202. 00

	Financial Systems IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	HANCOCK REGIO	Provider C	N. 15 0027	Peri od:	u of Form CMS Worksheet D	-2002-1
AFFURI	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	FIOVICEI C	311. 15-0037	From 01/01/2018	Part V	
					To 12/31/2018	Date/Time Pr	repared:
			Title	XVIII	Hospi tal	5/29/2019 9: PPS	57 am
		Cos	sts			110	
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.) 6.00	(see inst.) 7.00				
	ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50.00	05000 OPERATING ROOM	0	0				50.0
51.00	05100 RECOVERY ROOM	0	-				51.0
53.00	05300 ANESTHESI OLOGY	0	0				53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
50.00	06000 LABORATORY	0	0				60.0
65.00	06500 RESPI RATORY THERAPY	0	0				65.0
6.00	06600 PHYSI CAL THERAPY	0	0				66. C
57.00	06700 OCCUPATI ONAL THERAPY	0	0				67. C
68.00	06800 SPEECH PATHOLOGY	0	0				68. C
58.01	06801 OCCUPATI ONAL HEALTH	0	0				68. C
59.00	06900 ELECTROCARDI OLOGY	0	0				69. C
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0				71.0
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0 4, 497				72.0
76.00	03020 CARDI AC		4, 497	1			76.0
76.00	03160 CARDI OPULMONARY	0					76.0
/0.01	OUTPATIENT SERVICE COST CENTERS	0	0	I			/0.0
38.00	08800 RURAL HEALTH CLINIC	0	0				88. 0
90.00	09000 CLINIC	0	0				90.0
0. 01	09001 WOUND CLINIC	0	0				90.0
0. 02	09002 DIABETES CLINIC	0	0				90.0
0. 03	09003 ASTHMA CLINIC	0	0				90.0
0. 04	09004 ANDIS CLINIC	0	0				90.0
0. 05	09005 PRIME TIME	0	0				90.0
0. 06	09006 SHELBYVILLE WOUND CLINIC	0	0				90.0
90.07	04951 ONCOLOGY	0	0				90.0
90.08	04950 ANDERSON WOMENS CENTER	0	0				90.0
91.00	09100 EMERGENCY	0	12				91.0
92.00 200.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) Subtotal (see instructions)		4, 509				92. 0 200. 0
200. OC 201. OC			4, 509				200.0
201.00	Only Charges	0					201.0
202.00		0	4, 509				202.0

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS         Provider CCN: 15-0037 Component CCN: 15-0037 To 12/31/2018         Worksheet D From U/01/2018         Worksheet D From U/01/2	Health Financial Systems	HANCOCK REGIO	NAL_HOSPITAL		In Lie	eu of Form CMS-:	2552-10
Component CCN: 15-5037         To         12/31/2018         Date/Time Prepared: 15           Subprovider - PF           Cost Center Description           Capital Related Cost (from Wkst. 6, Part I, col. 26)         Total Charges Natio of Cost (col. 1 + col. 26)         Inpatient Cost Centre Cost (col. 1 + col. 26)         Inpatient Cost Centre Cost (col. 1 + col. 26)         Copital Costs (col um 3 x) (col um 4)         Copital Costs (col um 4)           ANCILLARY SERVICE COST CENTERS           Colspan="2">Colspan="2"           Colspan= 2	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0037			
Cost Center Description         Capital Related Cost (from Wkst. B, Part II, col. 20)         Total Charges (col. 1 + col. 20)         Ratio of Cost (col um 3, x) col um 4)         Capital (col um 3, x) col um 4)           50, 00         05000         0PERATING ROOM         812, 300         21, 168, 304         0.038373         15, 564         597         50, 00           50, 00         05000         0PERATING ROOM         812, 300         21, 168, 304         0.038373         15, 564         597         50, 00           51, 00         05100         RESUMEST LLGY         787, 123         65, 228, 365         0         0         51, 00           54, 00         05400         RAUCHERAPY         218, 509         44, 969, 088         0.038373         15, 564         597         50, 00           54, 00         05400         RAUDLERAPY         218, 509         44, 969, 088         0.004857         11, 143         54, 00           65, 00         06500         RESTIRTORY         THERAPY         818, 421         5, 512, 539         0.000266         93, 211         864         65, 00           66, 00         06600         PHEGOP         1, 34, 421         71, 91, 349, 277         0.002271         83, 356         226 67, 00           68, 01         0600         00000			Component	CON. 15 5027	From 01/01/2018	Part II	narod
Cost Center Description         Capital Related cost (from Wkst. 6, Part II. col. 26)         Total Charges (rol. 1 + col. 26)         Total Charges (col. 1 + col. 20)         Inpatient Program Column 4)         Capital Column 4)           50.00         D5000 0PERATI NB ROM         812,300         2,168,304         0.038373         15,564         507         50.00           50.00         D5000 0PERATI NB ROM         812,300         2,168,304         0.038373         15,564         507         50.00           51.00         D51.00         D53.00         D6300 ANESTHESI OLOGY         73,893         2,276,896         0.032453         0         51.00         53.00         53.00         0.000001         123         0         53.00         53.00         0.000001         123         0         53.00         53.00         53.00         0.002607         144, 690,088         0.002687         19,403         521.00         53.00         54.00         55.20         55.00         56.00         53.00         55.20         55.20         55.20         55.20         55.20         55.00         55.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         55.20         55.20         55.20         56.00         56.00         56.00         56.00			component	CCN: 15-5037	10 12/31/2018		pareu: 7 am
Cost Center Description         Capital Related Cost (from Wkst. B) Part I1, col. 26)         Total Charges (and Cost (from Wkst. B) Part I1, col. 8)         Total Charges (col. 1 + col. 8)         Total Charges (col. 2)         Total Charges (col. 2)         Capital Costs (col. 1 + col. 2)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 (PERPATINK ROM         812,300         21,168,304         0.038373         15,564         597           50.00         05000 (REOVERY ROM         73,893         2,276,896         0.032453         0         0         51.00           53.00         05000 (REDOVERY ROM         78,7123         65,928,805         0.01199         97,437         1,163         54.00           64.00         06000 (REDOVERY ROM         218,509         44,969,088         0.004859         376,139         1,828         60.00           65.00         06500 (DECOVERY ROT THERAPY         3,719         1,369,277         0.002280         11,261         326         66.00           66.00         06000 PEECHANDOLOGY         1,941         673,979         0.002280         11,261         326         67.00           71.00         000000 ELECTROCARN 0LOGY         1,941         673,979         0.002280         <			Title	e XVIII	Subprovider -		
Image: Program         Column 3 x column 4)           ANCILLARY SERVICE COST CENTERS         Part 1, col. 260         Col. 1 + col. 8)         Col. 1 + col. 20         Column 4)           50:00         05000         0PERATING ROOM         812,300         21,168,304         0.032453         0         50.00           51:00         05000         0PERATING ROOM         73,893         2,2766,896         0.032453         0         0         51.00           54:00         05400         0ALBORTORY         218,509         44,969,088         0.04859         376,139         1,828         60.00           65:00         065000         RESPIRATORY         85,572         9,233,559         0.009268         93,211         664,500         66.00         66.00         06600         PASTICAL THERAPY         3,814,21         5,150,117         0.002716         83,356         226         67.00         67.00         67.00         66.00         000000000         0         68.01							
ANCI LLARY SERVICE COST CENTERS         Part I, col.         Col. <thcol.< th="">         Col.         Col.<td>Cost Center Description</td><td></td><td></td><td></td><td></td><td></td><td></td></thcol.<>	Cost Center Description						
Part II. col.         8)         2)         and           26)         2.00         3.00         4.00         5.00           50.00         05000         OPERATING ROOM         73.893         2,276.896         0.038373         15,564         597         50.00           51.00         05100         RCCOVERY ROOM         73.893         2,276.896         0.032453         0         0         51.00           53.00         05300         ANCOT LASS 10.0GY         4         2,766.896         0.032453         0         0         53.00           54.00         05400         RADIOLOGY-DIAGNOSTIC         787.123         65.928.365         0.011939         97.437         1.163         54.00           65.00         06500         RESPI RATORY THERAPY         218.509         44.969.088         0.004859         376.139         1.8624         65.00           66.00         06600         PHYSI CAL THERAPY         3.119         1.369.277         0.002716         83.356         226         67.00         67.00         67.00         67.00         66.00         0         66.00         0         66.01         0.002880         11.261         32.6         68.00         0.002861         0.016276         9.515 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         50.00           50.00         05000         0PERATING ROOM         812,300         21,168,304         0.038373         15,564         597         50.00           51.00         051000         RECOVER ROOM         73,893         2,276,896         0.032453         0         0         51.00           53.00         05300         ANSETHESI 0LOGY         4         2,276,897         0.000001         123         0         53.30           54.00         05400 RADIOLOGY-DI AGNOSTI C         787,123         65,592,855         0.011939         97,437         1,163         54.00           66.00         066000 PHYSI CAL THERAPY         85,572         9,233,539         0.00268         93,211         864         65.00           66.00         06000 SPECH PATHOLOGY         1,941         67.397         0.002716         83,356         226         67.00           68.01         06600 SPECH PATHOLOGY         1,941         67.397         0.002800         11,261         32         68.00           68.01         06600 SPECH PATHOLOGY         1,3741         0         0.002652         0         0         72.00           73.00					. Charges	column 4)	
I.00         2.00         3.00         4.00         5.00           50.00         05000         OPERATI NG ROOM         812,300         21,168,304         0.038373         15,564         597         50.00           51.00         05100         RECOVERY ROOM         73,893         2,276,896         0.032453         0         0         51.00           53.00         05300         AUSILLARY SERVICE         787,123         65,928,365         0.011939         97,437         1,163         54.00           64.00         06500         RESPI RATORY THERAPY         218,509         44,969,088         0.004859         376,139         1,828         66.00           65.00         06600         RESPI RATORY THERAPY         138,421         5,150,117         0.026877         19,403         521         66.00           66<00			8)	2)			
ANCILLARY SERVICE COST CENTERS           50.00         05000 (DPERATING ROOM         812,300         21,168,304         0.038373         15,564         597         50.00           51.00         05100 RECOVERY ROOM         73,893         2,276,996         0.032453         0         0         51.00           53.00         0K85THESI OLOGY         4         2,796,996         0.032453         0         0         51.00           54.00         05400 (RADICACY -DI AGNOSTI C         787,123         65.928,365         0.011939         97,437         1,163,54.00           66.00         06600 RESPI RATORY THERAPY         218,509         44,969,088         0.004859         376,139         1,828         60.00           66.00         06600 PHYSI CAL THERAPY         138,421         5,150,117         0.022716         83,356         226         67.00           67.00         06700 OCUPATI ONAL HEALTH         0         0         0.000000         0         0         68.00           68.01         06800 SPECH PATHOLOGY         1,941         67.37,979         0.0022861         11,261         32.66         67.00           69.00         06900 ELECTROCARDI OLOGY         249,781         15,346,574         0.016276         9,515         155							
50.00       05000       0PERATING ROOM       812,300       21,168,304       0.038373       15,564       597       50.00         51.00       05100       NECOVERY ROOM       73,893       2,276,896       0.032453       0       0       51.00         54.00       05300       ANESTHESI 0LOGY       42,796,887       0.000001       123       0       53.00         54.00       05400       RADI 0LOGY - DI AGNOSTI C       787,123       65.928,365       0.011939       97,437       1,163       54.00         06.00       06000       LOBORATORY       218,509       44,969,088       0.004268       93,211       864       65.00         66.00       06500       RESPI RATORY THERAPY       138,421       5150,117       0.022687       19,403       521       66.00         67.00       06700       OCUPATI IONAL THERAPY       1,341,457       43.20,779       0.002716       83,356       226 67.00       68.01         68.01       06800       SPECH PATHOLOGY       1,941       673,979       0.00280       11,261       32       68.00         71.00       06000       LELECTRCARDI OLOGY       249,781       15,346,574       0.016276       9,515       155       65       00 <t< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></t<>		1.00	2.00	3.00	4.00	5.00	
51:00       RECOVERY ROOM       73,893       2,276,896       0.032453       0       0       51.00         53:00       05300       ANESTHESI OLOGY       4       2,796,887       0.000001       123       0       53.00         60:00       CABORATORY       218,509       44,969,088       0.004859       376,139       1.828       60.00         65:00       06500       RESPI RATORY THERAPY       38,572       9,233,539       0.009268       93,211       864       65.00         66:00       06600       PHYSI CAL THERAPY       38,572       9,233,539       0.009268       93,211       8.46       66.00         67:00       06700       0CCUPATI ONAL THERAPY       3,719       1,369,277       0.002800       11,261       32       68.00       68.00       6800       6800       6800       6800       6800       6800       6800       6800       6800       6800       6900       0       0       0       0       68.00       6800       6800       6800       6800       6800       6800       6800       6800       6800       6800       6800       6800       6800       68.00       68.00       68.00       68.00       68.00       68.00       68.00							
53.00       05300       ANESTHESI OLOGY       1       2,796,887       0.000001       123       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       787,123       65,928,365       0.011339       97,437       1,163       54.00         65.00       06500       LESPI RATORY THERAPY       85,572       9,233,539       0.009268       93,211       864       65.00         66.00       06600       PHYSI CAL THERAPY       138,421       5,150,117       0.026877       19,403       521       66.00         68.00       06600       DCUPATI ONAL THERAPY       3,719       1,369,277       0.002216       83,356       226       67.00         68.01       0C6000       DCUPATI ONAL HEALTH       0       0       0.000000       0       68.00         68.01       0C6000       DUPLICAL SUPPLIES CHARGED TO PATI ENTS       183,825       8,966,202       0.022502       44,351       909       71.00         71.00       03200       CARDI APLI ENS       306,224       85,959,300       0.003562       238,150       848       73.00         76.00       03200       CARDI APLI ENS CENTERS       3.741       0       0.000000       0       76.00       76.10      <							
54.00       05400       RADI OLOGY-DI AGNOSTI C       787, 123       65, 928, 365       0.011939       97, 437       1, 163       54.00         60.00       06500       RESPI RATORY       18, 509       44, 669, 088       0.004859       376, 139       1, 828       60.00         65.00       06500       RESPI RATORY THERAPY       85, 572       9, 233, 539       0.002868       93, 211       864       65.00         66.00       06600       PHYSI CAL THERAPY       138, 421       5, 150, 117       0.022887       19, 403       521       66.00         67.00       06700       OCUPATI IONAL THERAPY       3, 719       1, 369, 277       0.002716       83, 356       226       67.00         68.01       06801       SCUPATI IONAL HEALTH       0       0       0       0.000000       0       68.01         69.00       06900       ELCTROCARDI OLOGY       249, 781       15, 346, 574       0.016276       9, 515       155       69.00       72.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       11, 457       4, 320, 760       0.002652       0       0       73.00       03020 CARDI OLAL       72.00       72.00       72.00       72.00       72.00       72.00       73.0		73, 893					
60.00         06000         LABORATORY         218,509         44,969,088         0.004859         376,139         1,828         60.00           65.00         06500         RESPI RATORY THERAPY         85,572         9,233,539         0.009268         93,211         864         65.00           67.00         06600         PHYSI CAL THERAPY         138,421         5,150,117         0.022687         19,403         521         66.00           68.00         06600         SPECCH PATHOLOGY         1,941         673,979         0.002880         11,261         32         68.00           68.01         06600         SPECCH PATHOLOGY         1,941         673,979         0.002880         11,261         32         68.00           640.00         G6900         ELECTROCARDIOLOGY         249,781         15,346,574         0.016276         9,515         155         69.00           71.00         OT100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         183,825         8,966,202         0.02652         0         0         72.00           72.00         TOZO         IMPL         DEV         CHARGED TO PATI ENTS         306,224         85,959,300         0.003562         238,150         848         73.00           76.01<		4					
65.00       06500       RESPI RATORY THERAPY       85,572       9,233,539       0.009268       93,211       864       65.00         66.00       06700       0CCUPATI ONAL THERAPY       138,421       5,150,117       0.026877       19,403       521       66.00         67.00       06700       0CCUPATI ONAL THERAPY       3,719       1,369,277       0.002716       83,356       226       67.00         68.01       06800       SPEECH PATHOLOGY       1,941       673,979       0.002880       11,261       32       68.01         69.00       06900       ELECTROCARDIOLOGY       249,781       15,346,574       0.016276       9,515       155       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       183,825       8,966,202       0.020502       44,351       909       71.00         73.00       07300       DRUGS CHARGED TO PATIENT       11,457       4,320,760       0.00252       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENT       306,224       85,959,300       0.03552       238,150       848       73.00         76.00       03202       CARDI OPULMONARY       72.084       433,808       0.16616       0       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
66.00       06600       PHYSI CAL THERAPY       138, 421       5, 150, 117       0.026877       19, 403       521       66.00         67.00       0CCUPATI ONAL THERAPY       3, 719       1, 369, 277       0.002716       83, 356       226       67.00         68.00       OSECP PATHOLOGY       1, 941       673, 979       0.002880       11, 261       32       68.00         68.01       OCCUPATI ONAL HEALTH       0       0.000000       0       68.01         69.00       OSPOE ELECTROCARDI OLOGY       249, 781       15, 346, 574       0.016276       9, 515       155       69.00         71.00       O7200       IMPL. DEV. CHARGED TO PATI ENTS       183, 825       8, 966, 202       0.020562       0       0       72.00         73.00       O7300       DRUGS CHARGED TO PATI ENTS       306, 224       85, 959, 300       0.030562       238, 150       848       73.00         76.00       O3000       RURAL HEALTH CLINIC       3, 741       0       0.000000       0       76.00         70.01       WOUND CLINIC       88, 592       4, 091, 831       0.021651       348       89.01         90.02       09000       CLINIC       679       0       0       0.000000							
67.00       06700       OCCUPATI ONAL THERAPY       3,719       1,369,277       0.002716       83,356       226       67.00         68.00       06800       SPEECH PATHOLOGY       1,941       673,979       0.002880       11,261       32       68.00         68.01       OCCUPATI ONAL HEALTH       0       0       0.000000       0       68.01         69.00       OGS00       ELECTROCARDI OLOGY       249,781       15,346,574       0.016276       9,515       155       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       183,825       8,966,202       0.020502       44,351       909       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       306,224       85,959,300       0.003562       238,150       848       73.00         73.00       03020       CARDI OPULMONARY       72,084       433,808       0.166166       0       0       76.01         03160       CARAL HEALTH CLINIC       3,741       0       0.000000       0       88.00         90.01       09000       CLINIC       3,741       0       0.000000       0       90.02         90.02       090020       DABETES CLINIC       3,741<							
68.00       06800       SPEECH PATHOLOGY       1,941       673,979       0.002880       11,261       32       68.00         68.01       06801       OCCUPATI ONAL HEALTH       0       0       0.000000       0       68.01         69.00       0ELECTROCARDI OLOGY       249,781       15,346,574       0.016276       9,515       155       69.00         71.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       183,825       8,966,202       0.020502       244,351       909       71.00         72.00       07200       IMPL       DEV. CHARGED TO PATI ENTS       183,825       8,959,300       0.003562       238,150       848       73.00         73.00       0300       DRUGS CHARGED TO PATI ENTS       306,224       85,959,300       0.003562       238,150       848       73.00         76.00       03160       CARDI AC       0       0       0.000000       0       76.01         01701       MESIO RURAL HEALTH CLINIC       3,741       0       0.000000       0       90.00         90.00       09000       CLINIC       598       75,219       0.007950       0       0       0.02         90.02       DI ABETES CLINIC       59,897       73,838<							
68. 01       0C4001       0CUPATI ONAL HEALTH       0       0       0.000000       0       0       68. 01         69. 00       06900       ELECTROCARDI OLOGY       249, 781       15, 346, 574       0.016276       9, 515       155       69. 00         71. 00       OT100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       183, 825       8, 966, 202       0.020502       44, 351       909       71. 00         72. 00       07200       IMPL.       DEV. CHARGED TO PATI ENT       11, 457       4, 320, 760       0.002652       0       0       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       306, 224       85, 959, 300       0.003562       238, 150       848       73. 00         76. 00       03020       CARDI AC       0       0       0.000000       0       76. 01         0140       CARDI OPULMONARY       72, 084       433, 808       0.166166       0       0       76. 01         0140       CARDI OPULMONARY       72, 084       433, 808       0.166166       0       0       88. 00       90. 01         0000       09000       CLINIC       3, 741       0       0.000000       0       90. 02       90.02       90.04       90.02 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
69.00       06900       ELECTROCARDIOLOGY       249,781       15,346,574       0.016276       9,515       155       69.00         71.00       MEDICAL SUPPLIES CHARGED TO PATIENTS       183,825       8,966,202       0.020502       44,351       909       71.00         72.00       O7200       IMPL. DEV. CHARGED TO PATIENT       11,457       4,320,760       0.002652       0       0       72.00         73.00       DRUGS CHARGED TO PATIENTS       306,224       85,959,300       0.003562       238,150       848       73.00         76.00       03160       CARDI AC       0       0       0.000000       0       76.00         76.01       03160       CARDI OPULMONARY       72,084       433,808       0.166166       0       0       76.01         0000       09000       CLI NI C       3,741       0       0.000000       0       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.02       90.02       DI ABETES CLINIC       598       75,219       0.007950       0       90.02       90.04       90.04       90.04       90.04							
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       183,825       8,966,202       0.020502       44,351       909       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       11,457       4,320,760       0.002652       0       0       72.00         73.00       DRUGS CHARGED TO PATI ENTS       306,224       85,959,300       0.03562       238,150       848       73.00         76.00       03020       CARDI AC       0       0       0.000000       0       76.00         76.01       03160       CARDI OPULMONARY       72.084       433,808       0.166166       0       0       76.01         0017PAT1 ENT SERVICE COST CENTERS       3,741       0       0.000000       0       88.00       90.02       90.02       DI ABETES CLI NI C       598       75,219       0.007950       0       90.03       90.03       90.04       ANDI S CLI NI C       83,059       73,838       1.124881       0       90.05       90.05		-	-				
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       11,457       4,320,760       0.002652       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       306,224       85,959,300       0.003562       238,150       848       73.00         76.00       03020       CARDI AC       0       0       0.000000       0       76.00         70.01       03160       CARDI OPULMONARY       72.084       433,808       0.166166       0       0       76.00         0017PATIENT SERVICE COST CENTERS       0       0       0.000000       0       0       88.00         90.00       09000       CLINIC       3,741       0       0.000000       0       90.00         90.01       09001       WUND CLINIC       88,592       4,091,831       0.021651       348       890.01         90.02       09002       DI ABETES CLINIC       598       75.219       0.007950       0       90.02       90.03       90.03       90.04       90.04       90.04       90.04       90.04       90.04       90.04       90.04       90.04       90.04       90.04       90.04       90.04       90.04       90.05       90.04       90.06       90.04 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
73.00       07300       DRUGS CHARGED TO PATIENTS       306, 224       85, 959, 300       0.003562       238, 150       848       73.00         76.00       03202       CARDI AC       0       0       0.000000       0       0       76.00         03160       CARDI OPULMONARY       72,084       433,808       0.166166       0       0       76.01         0UTPATIENT SERVICE COST CENTERS       0       0.000000       0       0.000000       0       88.00         90.00       09000       CLINIC       0       0.000000       0       0       90.00         90.01       09001       WOUND CLINIC       88,592       4,091,831       0.021651       348       8       90.01         90.02       09002       DI ABETES CLINIC       598       75,219       0.007950       0       90.02       90.02         90.03       09004       ANDI S CLINIC       83,059       73.838       1.124881       0       90.02       90.02         90.05       09005       PRIME TIME       939       415,502       0.002260       0       90.03       90.04         90.04       09004       ANDI S CLINIC       3,408       1,443,692       0.002361       0						909	
76.00         03020         CARDI AC         0         0         0.000000         0         0         76.00           76.01         03160         CARDI OPULMONARY         72,084         433,808         0.166166         0         0         76.01           0UTPATI ENT SERVICE         COST CENTERS						-	
76. 01         03160         CARDI OPULMONARY         72,084         433,808         0.166166         0         0         76. 01           OUTPATI ENT SERVICE COST CENTERS         0         0.000000         0         0         0         88.00           90. 00         09000         CLINIC         0         0         0.000000         0         0         90.00           90. 01         09001         WOND CLINIC         88,592         4,091,831         0.021651         348         89.00           90. 02         09002         DIABETES CLINIC         598         75,219         0.007000         0         90.02           90. 03         09003         ASTHMA CLINIC         83,059         73,838         1.124881         0         90.01           90. 04         09004         ANDIS CLINIC         83,059         73,838         1.124881         0         90.05           90. 05         09005         PRIME TIME         939         415,502         0.002260         0         90.06           90. 04         09004         SHELBYVI LLE WOUND CLINIC         3,408         1,443,692         0.002361         0         90.06           90. 05         ONCOLOGY         446,772         6,513,908		306, 224	85, 959, 300			848	
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         3,741         0         0.000000         0         0         88.00           90.00         09000         CLINIC         0         0         0.000000         0         0         90.00           90.01         09001         WOUND CLINIC         88.592         4.091,831         0.021651         348         8         90.01           90.02         DIABETES CLINIC         598         75,219         0.007950         0         0         90.02           90.03         09003         ASTHMA CLINIC         0         0         0.000000         0         90.03           90.04         09004         ANDIS CLINIC         83,059         73,838         1.124881         0         0         90.02           90.05         09005         PRIME TIME         939         415,502         0.002260         0         90.05         90.06           90.06         09006         SHELBYVI LLE WOUND CLINIC         3,408         1,443,692         0.002361         0         0         90.06           90.07         04951         NICOLOGY         446,772         6,513,908         0.068587         0		-	-				
88.00       08800       RURAL HEALTH CLINIC       3,741       0       0.000000       0       0       88.00         90.00       09000       CLINIC       0       0       0.000000       0       90.00         90.01       09001       WOUND CLINIC       88,592       4,091,831       0.021651       348       8       90.01         90.02       09002       DIABETES CLINIC       598       75,219       0.007950       0       0       90.02         90.03       09004       ANDIS CLINIC       0       0       0.000000       0       90.02         90.03       09004       ANDIS CLINIC       0       0       0.000000       0       90.02         90.04       09004       ANDI S CLINIC       83,059       73,838       1.124881       0       0       90.04         90.05       09005       PRIME TIME       939       415,502       0.002260       0       90.05       90.05         90.06       09006       SHELBYVILLE WOUND CLINIC       3,408       1,443,692       0.002361       0       0       90.06         90.07       04950       ANDERSON WOMENS CENTER       9,019       3,602,956       0.002503       0       0		72, 084	433, 808	0. 1661	66 0	0	76.01
90.00         09000         CLINIC         0         0         0.000000         0         0         90.00           90.01         09001         WOUND CLINIC         88,592         4,091,831         0.021651         348         8         90.01           90.02         09002         DIABETES CLINIC         598         75,219         0.007950         0         0         90.02           90.03         09003         ASTHMA CLINIC         0         0         0         0.000000         0         90.03         90.04           90.04         09004         ANDIS CLINIC         83,059         73,838         1.124881         0         0         90.04           90.05         09005         PRIME TIME         939         415,502         0.002260         0         90.05           90.06         09006         SHELBYVILLE WOUND CLINIC         3,408         1,443,692         0.002361         0         90.06           90.07         04950         ANDERSON WOMENS CENTER         9,019         3,602,956         0.002503         0         0         90.08           91.00         09100         EMERGENCY         743,862         48,285,803         0.015405         52,491         809 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></td<>			-				
90.01         09001         WOUND CLINIC         88,592         4,091,831         0.021651         348         8         90.01           90.02         09002         DLABETES CLINIC         598         75,219         0.007950         0         90.02           90.03         09003         ASTHMA CLINIC         0         0         0.000000         0         90.03           90.04         09004         ANDIS CLINIC         83,059         73,838         1.124881         0         0         90.04           90.05         09005         PRIME TIME         939         415,502         0.002260         0         90.05           90.06         09006         SHELBYVILLE WOUND CLINIC         3,408         1,443,692         0.002260         0         90.05           90.07         04951         ONCOLOGY         446,772         6,513,908         0.068587         0         0         90.07           90.08         04950         ANDERSON WOMENS CENTER         9,019         3,602,956         0.002503         0         0         90.08           91.00         09100         EMERGENCY         743,862         48,285,803         0.015405         52,491         809         91.00           92		3, 741	0				
90. 02         09002         DI ABETES CLI NI C         598         75, 219         0.007950         0         0         90. 02           90. 03         09003         ASTHMA CLI NI C         0         0         0         0.000000         0         90. 03           90. 04         09004         ANDI S CLI NI C         83, 059         73, 838         1.124881         0         0         90. 04           90. 05         09005         PRI ME TI ME         939         415, 502         0.002260         0         90. 05           90. 06         09006         SHELBYVI LLE WOUND CLI NI C         3, 408         1, 443, 692         0.002361         0         90. 06           90. 07         04951         ONCOLOGY         446, 772         6, 513, 908         0.068587         0         0         90. 08           90. 08         04950         ANDERSON WOMENS CENTER         9, 019         3, 602, 956         0.002503         0         0         90. 08           91. 00         09100         EMERGENCY         743, 862         48, 285, 803         0.015405         52, 491         809         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         4, 726, 688         0		-	-			-	
90.03         09003         ASTHMA CLINIC         0         0         0.000000         0         0         90.03           90.04         09004         ANDIS CLINIC         83,059         73,838         1.124881         0         0         90.04           90.05         09005         PRIME TIME         939         415,502         0.002260         0         0         90.05           90.06         09006         SHELBYVILLE WOUND CLINIC         3,408         1,443,692         0.002361         0         0         90.06           90.07         04951         ONCOLOGY         446,772         6,513,908         0.068587         0         0         90.07           90.08         04950         ANDERSON WOMENS CENTER         9,019         3,602,956         0.002503         0         0         90.08           91.00         09100         EMERGENCY         743,862         48,285,803         0.015405         52,491         809         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         4,726,688         0.000000         0         0         92.00						8	
90. 04         09004         ANDI S CLINI C         83,059         73,838         1.124881         0         0         90.04           90. 05         09005         PRI ME TI ME         939         415,502         0.002260         0         0         90.05           90. 06         09006         SHELBYVI LLE WOUND CLINI C         3,408         1,443,692         0.002361         0         0         90.06           90. 07         04951         NOCOLOGY         446,772         6,513,908         0.068587         0         0         90.07           90. 08         04950         ANDERSON WOMENS CENTER         9,019         3,602,956         0.002503         0         0         90.08           91.00         09100         EMERGENCY         743,862         48,285,803         0.015405         52,491         809         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         4,726,688         0.000000         0         0         92.00						0	
90. 05         09005         PRI ME TI ME         939         415, 502         0.002260         0         0         90. 05           90. 06         09006         SHELBYVI LLE WOUND CLINIC         3, 408         1, 443, 692         0.002361         0         0         90. 05           90. 07         04951         ONCOLOGY         446, 772         6, 513, 908         0.068587         0         0         90. 07           90. 08         04950         ANDERSON WOMENS CENTER         9, 019         3, 602, 956         0.002503         0         0         90. 08           91. 00         09100         EMERGENCY         743, 862         48, 285, 803         0.015405         52, 491         809         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         4, 726, 688         0.000000         0         0         92. 00		-	-			0	
90. 06         09006         SHELBYVILLE WOUND CLINIC         3,408         1,443,692         0.002361         0         0         90. 06           90. 07         04951         0NCOLOGY         446,772         6,513,908         0.068587         0         0         90. 07           90. 08         04950         ANDERSON WOMENS CENTER         9,019         3,602,956         0.002503         0         90. 08           91. 00         09100         EMERGENCY         743,862         48,285,803         0.015405         52,491         809         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0         4,726,688         0.000000         0         0         92. 00						0	
90. 07         04951         0NCOLOGY         446, 772         6, 513, 908         0.068587         0         90. 07           90. 08         04950         ANDERSON WOMENS CENTER         9, 019         3, 602, 956         0.002503         0         90. 08           91. 00         09100         EMERGENCY         743, 862         48, 285, 803         0.015405         52, 491         809         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0         4, 726, 688         0.000000         0         0         92. 00						0	
90. 08         04950         ANDERSON WOMENS CENTER         9, 019         3, 602, 956         0.002503         0         90. 08           91. 00         09100         EMERGENCY         743, 862         48, 285, 803         0.015405         52, 491         809         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         4, 726, 688         0.000000         0         0         92. 00						0	
91. 00         09100         EMERGENCY         743, 862         48, 285, 803         0. 015405         52, 491         809         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DISTINCT PART)         0         4, 726, 688         0. 000000         0         0         92. 00						0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 4, 726, 688 0. 000000 0 92. 00	90.08 04950 ANDERSON WOMENS CENTER	9,019	3, 602, 956	0. 00250	03 0	0	90.08
		743, 862	48, 285, 803			809	
200. 00         Total (lines 50 through 199)         4, 324, 843         337, 822, 533         1, 041, 349         7, 960         200. 00		-				-	
	200.00  Total (lines 50 through 199)	4, 324, 843	337, 822, 533	3	1, 041, 349	7, 960	200. 00

Health Financial Systems	HANCOCK REGION	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-0037	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S037	From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre	pared <sup>.</sup>
		•			5/29/2019 9:5	7 am
		Title	e XVIII	Subprovider -	PPS	
Cast Castas Description		hunging Cabaal	Numerica Cale	I PF		
Cost Center Description		Post-Stepdown		Allied Health Post-Stepdown	Allied Health	
	Cost	Adjustments		Adj ustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	363, 630	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0		0 0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03020 CARDI AC	0	0		0 0	0	76.00
76. 01 03160 CARDI OPULMONARY	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 WOUND CLINIC	0	0		0 0	0	90.01
90. 02 09002 DI ABETES CLI NI C	0	0		0 0	0	90. 02
90. 03 09003 ASTHMA CLINIC	0	0		0 0	0	90.03
90. 04 09004 ANDIS CLINIC	0	0		0 0	0	90.04
90. 05 09005 PRIME TIME	0	0		0 0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	0		0 0	0	90.06
90.07 04951 ONCOLOGY	0	0		0 0	0	90.07
90. 08 04950 ANDERSON WOMENS CENTER	0	0		0 0	0	90.08
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	91.00 92.00
200.00 Total (lines 50 through 199)	0	0		0 0	363, 630	
	I U	0	1	ч U	303, 030	200.00

Health Financial Systems	HANCOCK REGION			In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018		
		Component	CCN: 15-S037	To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				-		
50.00 05000 OPERATI NG ROOM	0	0		0 21, 168, 304		
51.00 05100 RECOVERY ROOM	0	0		0 2, 276, 896		
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 796, 887		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	363, 630	363, 63			54.00
60. 00 06000 LABORATORY	0	0		0 44, 969, 088		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 9, 233, 539		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 150, 117	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 369, 277	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 673, 979	0.000000	68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0		0 0	0.000000	68.01
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 15, 346, 574	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 8, 966, 202	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 4, 320, 760	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 85, 959, 300	0.000000	73.00
76. 00 03020 CARDI AC	0	0		0 0	0.000000	76.00
76. 01 03160 CARDI OPULMONARY	0	0		0 433, 808	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88.00
90. 00 09000 CLINIC	0	0		0 0	0.000000	90.00
90. 01 09001 WOUND CLINIC	0	0		0 4, 091, 831	0.000000	90.01
90. 02 09002 DI ABETES CLINIC	0	0		0 75, 219	0.000000	90.02
90. 03 09003 ASTHMA CLINIC	0	0		0 0	0.000000	90.03
90. 04 09004 ANDIS CLINIC	0	0		0 73, 838	0.00000	90.04
90. 05 09005 PRIME TIME	0	0		0 415, 502	0.000000	90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	0	0		0 1, 443, 692	0.000000	90.06
90. 07 04951 ONCOLOGY	0	0		0 6, 513, 908	0.000000	90.07
90.08 04950 ANDERSON WOMENS CENTER	0	0		0 3, 602, 956	0. 000000	90.08
91.00 09100 EMERGENCY	0	0		0 48, 285, 803	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 4, 726, 688	0.000000	92.00
200.00 Total (lines 50 through 199)	0	363, 630	363, 63	0 337, 822, 533		200.00

Health Financial Systems	HANCOCK REGIONA	L HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO	CN: 15-0037	Period:	Worksheet D	
THROUGH COSTS		Component (	CCN: 15-S037	From 01/01/2018 To 12/31/2018		narodi
		component (	JUN: 10-3037	10 12/31/2018	5/29/2019 9:5	7 am
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000	45 5/4				50.00
50. 00 05000 OPERATING ROOM	0. 000000	15, 564		0 0		50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	-	51.00
53. 00 05300 ANESTHESI OLOGY	0.00000	123		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.005516	97, 437		37 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	376, 139		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	93, 211		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	19, 403		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	83, 356		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	11, 261		0 0	0	68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0. 000000	0		0 0	0	68.01
69. 00 06900 ELECTROCARDI OLOGY	0.000000	9, 515		0 0	0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		44, 351		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000 0. 000000	0 238, 150		0 0	0	72.00 73.00
75. 00 07500 DR0GS CHARGED TO PATTENTS 76. 00 03020 CARDI AC	0. 000000	238, 150		0 0		76.00
76. 01 03160 CARDI OPULMONARY	0. 000000	0				76.00
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	70.01
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
90. 00 09000 CLINIC	0. 000000	0		0 0		90.00
90. 01 09001 WOUND CLINIC	0. 000000	348		0 0	0	90.00
90. 02 09002 DI ABETES CLINIC	0. 000000	0		0 0	0	90.01
90. 03 09003 ASTHMA CLINIC	0, 000000	0		0 0	0	90.02
90. 04 09004 ANDIS CLINIC	0. 000000	0		0 0	0	90.04
90. 05 09005 PRIME TIME	0. 000000	0		0 0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0. 000000	0		0 0	0	90.06
90. 07 04951 ONCOLOGY	0. 000000	0		0 0	0	90.07
90. 08 04950 ANDERSON WOMENS CENTER	0. 000000	0		0 0	0	90.08
91. 00 09100 EMERGENCY	0. 000000	52, 491		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	-	92.00
200.00 Total (lines 50 through 199)		1,041,349	5	37 0		200.00
	1 I		-	-	-	

	Financial Systems HANCOCK REGIONAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037	Period: From 01/01/2018	u of Form CMS-2 Worksheet D-1	
			To 12/31/2018	Date/Time Prep 5/29/2019 9:5	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed day			5, 172	
	Inpatient days (including private room days, excluding swing-			5, 172	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only pr	Tvate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation b			3, 441	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	- 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roc	om days) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	g swing-bed and	1, 156	9
00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private i	room days)	0	10
	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
00	through December 31 of the cost reporting period	V oply (including privat	to room days)	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progr			0	
	Total nursery days (title V or XIX only)			0	1
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 d	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	res after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	0.00	20
00	reporting period			0 01/ 1/1	1 21
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	8, 316, 161 0	
	5 x line 17)	•	51	-	
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting	a pariod (line 9	0	25
. 00	x line 20)		g per lou (The a	0	25
	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		8, 316, 161	27
00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)		3 /	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 22) (see instrum	stions)	0.00	
	Average per diem private room charge differential (line 32 mi		50 01157	0.00 0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	8, 316, 161	
	27 minus line 36)		·		1
	PART II – HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD J	JUSIMENIS			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 607. 92	38
. 00 . 00		e instructions) e 38)		1, 607. 92 1, 858, 756 0	39

Int         3.00       Int         4.00       COF         5.00       BUF         6.00       SUF         7.00       OTH         8.00       Pro         9.00       Tot         0.00       Pas         0.00       Pas         0.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         6.00       Tan         6.00       Tan         7.00       Did         8.00       Bor         9.00       Les         1.00       If         amo       amo         2.00       Rel         3.00       Al I	RSERY (title V & XIX only) tensive Care Type Inpatient Hospital Units TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS Ss through costs applicable to Program inpat 1) ss through costs applicable to Program inpat d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud d ical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	11 through 48)(s atient routine s atient ancillary 50 and 51)	2.00 4,759 , line 200) see instruction services (from	XVIII Average Per Di em (col . 1 col . 2) 3.00 1, 732.7	÷ 4.00	5/29/2019 9:5 PPS Program Cost (col. 3 x col. 4) 5.00	57 am 42.0 43.0 44.0 45.0 46.0 47.0
Int         3.00       Int         4.00       COF         5.00       BUF         6.00       SUF         7.00       OTH         8.00       Pro         9.00       Tot         0.00       Pas         0.00       Pas         0.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         6.00       Tan         6.00       Tan         7.00       Did         8.00       Bor         9.00       Les         1.00       If         amo       amo         2.00       Rel         3.00       Al I	RSERY (title V & XIX only) tensive Care Type Inpatient Hospital Units TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS ss through costs applicable to Program inpat 1) ss through costs applicable to Program inpat d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	Inpatient Cost 1.00 8,246,017 8,246,017 st. D-3, col. 3, 11 through 48)(s atient routine s atient ancillary 50 and 51)	Total Inpati ent Days 2.00 4,759 , line 200) see instruction services (from	Average Per Diem (col. 1 col. 2) 3.00 1,732.7	+ Program Days + 4.00	PPS Program Cost (col. 3 x col. 4) 5.00 3,236,721 1.00 4,779,820	42. ( 43. ( 44. ( 45. ( 46. ( 47. (
Int         3. 00       Int         4. 00       COF         5. 00       BUF         6. 00       SUF         7. 00       OTF         9. 00       Tot         9. 00       Tot         9. 00       Tot         1. 00       Pase         0. 00       Tot         3. 00       Tot         3. 00       Tot         3. 00       Tot         5. 00       Tar         6. 00       Les         7. 00       Dif         9. 00       Les         1. 00       If         0. 00       Les         1. 00       If         3. 00       Al I	RSERY (title V & XIX only) tensive Care Type Inpatient Hospital Units TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS ss through costs applicable to Program inpat 1) ss through costs applicable to Program inpat d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	Inpatient Cost 1.00 8,246,017 8,246,017 st. D-3, col. 3, 11 through 48)(s atient routine s atient ancillary 50 and 51)	Total Inpati ent Days 2.00 4,759 , line 200) see instruction services (from	Average Per Diem (col. 1 col. 2) 3.00 1,732.7	+ Program Days + 4.00	Program Cost (col. 3 x col. 4) 5.00 3,236,721 1.00 4,779,820	42. 43. 44. 45. 46. 47.
Int         3. 00       Int         4. 00       COF         5. 00       BUF         6. 00       SUF         7. 00       OTH         PAS       Pas         0. 00       Pas         0. 00       Pas         0. 00       Pas         0. 00       Pas         1. 00       Pas         2. 00       Tot         3. 00       Tot         5. 00       Tan         6. 00       Tan         6. 00       Tan         7. 00       Dirt         8. 00       Bor         9. 00       Les         1. 00       If         whit       amo         2. 00       Rel         3. 00       Al I	RSERY (title V & XIX only) tensive Care Type Inpatient Hospital Units TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS Ss through costs applicable to Program inpat 1) ss through costs applicable to Program inpat d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud d ical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	1.00 8,246,017 8,246,017 st. D-3, col. 3, 11 through 48)(s atient routine s atient ancillary 50 and 51)	2.00 4,759 , line 200) see instruction services (from	<u>col . 2)</u> <u>3.00</u> 1,732.7 ns)	4.00	4) 5. 00 3, 236, 721 1. 00 4, 779, 820	42. 43. 44. 45. 46. 47.
Int         3. 00       INT         4. 00       COF         5. 00       BUF         6. 00       SUF         7. 00       OT         9. 00       Tot         9. 00       Tot         9. 00       Tot         11. 00       Pas         0. 00       Tot         3. 00       Tot         3. 00       Tot         6. 00       Tan         6. 00       Tan         6. 00       Tan         6. 00       Les         1. 00       Les         1. 00       If         whit       amo         0. 00       Les         1. 00       If         amo       amo         2. 00       Rel         3. 00       Al I	tensive Care Type Inpatient Hospital Units TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS ss through costs applicable to Program inpation 1) ss through costs applicable to Program inpation tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost excluded d LV) tal Program inpatient operating cost excluded dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	8,246,017 8,246,017 st. D-3, col. 3, 11 through 48)(s atient routine s atient ancillary 50 and 51)	4,759 , line 200) see instruction services (from	3.00 1,732.7 ns)		5. 00 3, 236, 721 1. 00 4, 779, 820	43. 44. 45. 46. 47.
Int         3.00       Int         4.00       COF         5.00       BUF         6.00       SUF         7.00       OTH         8.00       Pro         9.00       Tot         0.00       Pas         0.00       Pas         0.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         6.00       Tan         6.00       Tan         7.00       Did         8.00       Bor         9.00       Les         1.00       If         amo       amo         2.00       Rel         3.00       Al I	tensive Care Type Inpatient Hospital Units TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS ss through costs applicable to Program inpation 1) ss through costs applicable to Program inpation tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost excluded d LV) tal Program inpatient operating cost excluded dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	8,246,017 8,246,017 st. D-3, col. 3, 11 through 48)(s atient routine s atient ancillary 50 and 51)	4,759 , line 200) see instruction services (from	1, 732. 7 ns)		3, 236, 721 1. 00 4, 779, 820	43. 44. 45. 46. 47.
Int         3.00       Int         4.00       COF         5.00       BUF         6.00       SUF         7.00       OTH         8.00       Pro         9.00       Tot         0.00       Pas         0.00       Pas         0.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         3.00       Tot         6.00       Tan         6.00       Tan         7.00       Did         8.00       Bor         9.00       Les         1.00       If         amo       amo         2.00       Rel         3.00       Al I	tensive Care Type Inpatient Hospital Units TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS ss through costs applicable to Program inpation 1) ss through costs applicable to Program inpation tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost excluded d LV) tal Program inpatient operating cost excluded dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	st. D-3, col. 3, 11 through 48)(s atient routine s atient ancillary 50 and 51)	, line 200) see instruction services (from	ns)	<sup>7</sup> 2 1, 868	<u> </u>	44. 45. 46. 47.
4. 00 COF 5. 00 BUF 6. 00 SUF 7. 00 OTF 8. 00 Pro 9. 00 Pas 111 1. 00 Pas and 2. 00 Tof 3. 00 Tof 4. 00 Pro 5. 00 Taf 6. 00 Taf 6. 00 Taf 6. 00 Taf 6. 00 Taf 6. 00 If 8. 00 Bor 1. 00 Les 1. 00 Les 1. 00 If white amo 2. 00 Rel 3. 00 AI	RONARY CARE UNIT RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS Ss through costs applicable to Program inpation 1) ss through costs applicable to Program inpation 4 IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost excluding tal Program inpatient operating cost excluding tal Program inpatient operating cost excluding from the state of the st	st. D-3, col. 3, 11 through 48)(s atient routine s atient ancillary 50 and 51)	, line 200) see instruction services (from	ns)	<sup>2</sup> 1, 868	<u> </u>	44. 45. 46. 47.
5.00 BUF 6.00 SUF 7.00 OTF 8.00 Pro 9.00 Pas 111 1.00 Pas 2.00 Tof 3.00 Tof 3.00 Tof 4.00 Pro 5.00 Tar 6.00 Tar 6.00 Tar 6.00 Tar 7.00 Di 18 8.00 Bor 5.00 Ces 1.00 Les 1.00 Les	RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS Ss through costs applicable to Program inpation 1) ss through costs applicable to Program inpation 4 IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost excludical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	11 through 48)(s atient routine s atient ancillary 50 and 51)	see instructior services (from			4, 779, 820	45. 46. 47.
6. 00 SUF 7. 00 OTF 8. 00 Pro 9. 00 Tot PAS 0. 00 Pas 111 1. 00 Pas 111 1. 00 Pas 1. 00 Pas 1. 00 Tot 3. 00 Tot 1. 00 Tot 1. 00 Pro 5. 00 Tat 6. 00 Tat 6. 00 Tat 7. 00 Di 1 8. 00 Bor 9. 00 Les 1. 00 Les 1. 00 I f white 2. 00 Rel 3. 00 AI I	RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines SS THROUGH COST ADJUSTMENTS Ss through costs applicable to Program inpa 1) ss through costs applicable to Program inpa d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost excluded dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	11 through 48)(s atient routine s atient ancillary 50 and 51)	see instructior services (from			4, 779, 820	46. 47.
7.00         OTH           8.00         Pro           9.00         Tot           PAS         PAS           0.00         Pas           1.10         Pas           2.00         Tot           3.00         Tot           7.00         Dit           4.00         Pro           5.00         Tat           6.00         Tat           7.00         Dit           8.00         Bor           9.00         Les           1.00         If           whi         amo           2.00         Rel           3.00         Al I	HER SPECIAL CARE (SPECIFY) Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS ss through costs applicable to Program inpa 1) ss through costs applicable to Program inpa d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost excluded dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	11 through 48)(s atient routine s atient ancillary 50 and 51)	see instructior services (from			4, 779, 820	47.
8. 00 Pro 9. 00 Pas 0. 00 Pas 111 1. 00 Pas and 2. 00 Tot 3. 00 Tot TAR 4. 00 Pro 5. 00 Tar 6. 00 Tar 6. 00 Tar 6. 00 Bor 9. 00 Les mai 0. 00 Les 1. 00 If whi amo 2. 00 Rel 3. 00 Al I	Cost Center Description ogram inpatient ancillary service cost (Wks tal Program inpatient costs (sum of lines 4 SS THROUGH COST ADJUSTMENTS ss through costs applicable to Program inpa 1) ss through costs applicable to Program inpa d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	11 through 48)(s atient routine s atient ancillary 50 and 51)	see instructior services (from			4, 779, 820	48.
9.00         Tot           PAS         PAS           0.00         Pas           1.10         Pas           2.00         Tot           3.00         Tot           3.00         Tot           4.00         Pro           5.00         Tar           6.00         Tar           7.00         Dit           8.00         Bor           9.00         Les           1.00         If           amu         amu           2.00         Rel           3.00         AI	tal Program inpatient costs (sum of lines 4 <u>SS THROUGH COST ADJUSTMENTS</u> ss through costs applicable to Program inpa 1) ss through costs applicable to Program inpa d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	11 through 48)(s atient routine s atient ancillary 50 and 51)	see instructior services (from			4, 779, 820	1 48.
9.00 Tot PAS 0.00 Pas 111 1.00 Pas 2.00 Tot 3.00 Tot 4.00 Pro 5.00 Tar 6.00 Tar 6.00 Tar 7.00 Di 1 8.00 Bor 9.00 Les 1.00 Les 1.00 If whit amo 2.00 Rel 3.00 Al 1	tal Program inpatient costs (sum of lines 4 <u>SS THROUGH COST ADJUSTMENTS</u> ss through costs applicable to Program inpa 1) ss through costs applicable to Program inpa d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	11 through 48)(s atient routine s atient ancillary 50 and 51)	see instructior services (from				/ 40.
PAS           0.00         Pas           111         Pas           11.00         Pas           2.00         Tot           3.00         Tot           3.00         Tot           5.00         Tar           6.00         Tar           7.00         Di 1           8.00         Bor           9.00         Les           1.00         If           whit         amo           2.00         Rel           3.00         Al 1	SS THROUGH COST ADJUSTMENTS ss through costs applicable to Program inpa l) ss through costs applicable to Program inpa d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	atient routine s atient ancillary 50 and 51)	services (from			, <u>98/5</u> /9/	
1.00       Pase and	I) ss through costs applicable to Program inpa d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	atient ancillary 50 and 51)		Wkst D sum		7,010,271	- '''
1. 00 Pas and 2. 00 Tot 3. 00 Tot 3. 00 Tot 5. 00 Tan 6. 00 Tan 6. 00 Tan 6. 00 Bon 9. 00 Les 1. 00 Les 1. 00 If whi amo 2. 00 Rel 3. 00 Al I	ss through costs applicable to Program inpa d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	50 and 51)	y services (fro		of Parts I and	578, 117	50.
and 2. 00 Tot 3. 00 Tot 4. 00 Pro 5. 00 Tan 6. 00 Tan 7. 00 Di 1 8. 00 Bor 9. 00 Les 1. 00 Les 1. 00 If whi amo 2. 00 Rel 3. 00 Al I	d IV) tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION	50 and 51)	y services (tro			000.001	
2.00 Tot 3.00 Tot 4.00 Pro 5.00 Tan 6.00 Tan 7.00 Di 1 8.00 Bor 9.00 Les 1.00 If whin 2.00 Rel 3.00 Al I	tal Program excludable cost (sum of lines 5 tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION			DM WKST. D, S	um of Parts II	282, 921	51.
3. 00 Tot med TAR 4. 00 Pro 5. 00 Tar 6. 00 Tar 6. 00 Tar 7. 00 Di 1 8. 00 Bor 9. 00 Les 1. 00 Les 1. 00 If uman ama 2. 00 Rel 3. 00 Al I	tal Program inpatient operating cost exclud dical education costs (line 49 minus line 5 RGET AMOUNT AND LIMIT COMPUTATION					861, 038	3 52.
TAR           4.00         Pro           5.00         Tar           6.00         Tar           7.00         Di 1           8.00         Bor           9.00         Les           1.00         If           whi         amo           2.00         Rel           3.00         Al I	RGET AMOUNT AND LIMIT COMPUTATION		lated, non-phys	sician anesth	etist, and	9, 014, 259	
4.00 Pro 5.00 Tan 6.00 Tan 7.00 Di 1 8.00 Bor 9.00 Les 1.00 Lf whi amo 2.00 Rel 3.00 Al I		52)				L	-
5.00 Tan 6.00 Tan 7.00 Di 1 8.00 Bor 9.00 Les man 0.00 Les 1.00 I f whi am 2.00 Rel 3.00 Al I	ogram discharges					0	54.
7.00 Di 1 8.00 Bor 9.00 Les mai 0.00 Les 1.00 If whi amo 2.00 Rel 3.00 AI	rget amount per discharge					0.00	
8. 00 Bor 9. 00 Les mar 0. 00 Les 1. 00 I f whi am 2. 00 Rel 3. 00 AI I	rget amount (line 54 x line 55)					0	
9.00 Les mar 0.00 Les 1.00 If whi amo 2.00 Rel 3.00 All	0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						
0.00 Les 1.00 If whi amo 2.00 Rel 3.00 All	nus payment (see instructions)	onting popied	anding 1004 up	adated and as	maguaded by the	0	
0.00 Les 1.00 If whi amo 2.00 Rel 3.00 All	sser of lines 53/54 or 55 from the cost reprket basket	orting period e	enaing 1996, up	Juated and co	mpounded by the	0.00	59.
whi amo 2.00 Rel 3.00 All	sser of lines 53/54 or 55 from prior year of	cost report, upo	dated by the ma	arket basket		0.00	60.
2. 00 Rel 3. 00 Al I	line 53/54 is less than the lower of lines					0	61.
2.00 Rel 3.00 Al I	ich operating costs (line 53) are less than		s (lines 54 x 6	50), or 1% of	the target		
3. 00 AI I	ount (line 56), otherwise enter zero (see i lief payment (see instructions)	instructions)				0	62.
PRC	lowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0	
	OGRAM INPATIENT ROUTINE SWING BED COST						
	<pre>dicare swing-bed SNF inpatient routine cost structions)(title XVIII only)</pre>	ts through Decer	mber 31 of the	cost reporti	ng period (See	0	64.
	dicare swing-bed SNF inpatient routine cost	ts after Decembe	er 31 of the co	ost reporting	period (See	0	65.
	structions)(title XVIII only)			sor roportring		j	
	tal Medicare swing-bed SNF inpatient routir	ne costs (line é	64 plus line 65	5)(title XVII	l only). For	0	66.
	H (see instructions)	costs through	December 21 of	f the cost re	porting ported	0	67.
	tle V or XIX swing-bed NF inpatient routine ine 12 x line 19)	e costs through	December 31 01	the cost re	porting period	0	/ 0/.
	tle V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of t	the cost repo	orting period	0	68.
1 -	ine 13 x line 20)			( )			
	tal title V or XIX swing-bed NF inpatient r RT III – SKILLED NURSING FACILITY, OTHER NL					0	) 69.
	illed nursing facility/other nursing facili						70.
	justed general inpatient routine service co	5		. ,		1	71.
	ogram routine service cost (line 9 x line 7	,		25)			72.
	dically necessary private room cost applica tal Program general inpatient routine servi			ie 35)		1	73.
	pital-related cost allocated to inpatient r	•		orksheet B. P	art II, column	1	74.
	, line 45)				,	1	
	r diem capital-related costs (line 75 ÷ lir						76.
	ogram capital-related costs (line 9 x line	,				ľ	77.
	patient routine service cost (line 74 minus gregate charges to beneficiaries for excess	,	rovider records	5)		1	78.
	tal Program routine service costs for compa	· · ·			us line 79)	1	80.
l. 00   Inp	patient routine service cost per diem limit	tati on			ŗ		81.
	patient routine service cost limitation (li	,	•				82.
	asonable inpatient routine service costs (s		s)			1	83.
	ogram inpatient ancillary services (see ins ilization review - physician compensation (		ns)				84. 85.
	tal Program inpatient operating costs (sum					<u> </u>	86.
PAR		5 THROUGH COST					
	RT IV - COMPUTATION OF OBSERVATION BED PASS				I	1, 731	87.
8.00 Adj 9.00 Obs	tal observation bed days (see instructions) justed general inpatient routine cost per o		line 2)		i	1, 607. 92	

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		pared: 7 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	921, 684	8, 316, 161	0. 11083	0 2, 783, 310	308, 474	90.00
91.00 Nursing School cost	0	8, 316, 161	0.00000	0 2, 783, 310	0	91.00
92.00 Allied health cost	0	8, 316, 161	0.00000	0 2, 783, 310	0	92.00
93.00 All other Medical Education	0	8, 316, 161	0. 00000	0 2, 783, 310	0	93.00

OMPUT	Financial Systems HANCOCK REGIONAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-S037	From 01/01/2018 To 12/31/2018	Date/Time Pre	pare
		Title XVIII	Subprovider -	5/29/2019 9:5 PPS	7 am
	Cost Center Description		I PF	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed days			2, 466	1
00	Inpatient days (including private room days, excluding swing-k		iveta noom dave	2,466	2
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	Ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 466	4
00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5
~~	reporting period		04 6 11 1	0	
00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 OF THE COST	0	6
00	Total swing-bed NF type inpatient days (including private room	n davs) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (aveluding	swing had and	2, 003	9
00	newborn days)	the Program (excluding	swing-bed and	2,003	
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruct				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
. 00	through December 31 of the cost reporting period		<b>3</b> ,	0	'-
. 00	Swing-bed NF type inpatient days applicable to titles V or XI>			0	13
~~	after December 31 of the cost reporting period (if calendar ye			0	
. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14   15
5. 00 5. 00	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 21 of t	ha cast	0.00	20
. 00	reporting period	salter becember 31 01 t	ne cost	0.00	20
1.00	Total general inpatient routine service cost (see instructions	5)		2, 963, 494	21
2.00	Swing-bed cost applicable to SNF type services through Decembe	er 31 of the cost report	ing period (line	0	22
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a pariod (line 6	0	23
. 00	x line 18)	ST OF the cost reportin	g period (inte o	0	
. 00	Swing-bed cost applicable to NF type services through December	- 31 of the cost reporti	ng period (line	0	24
	7 x line 19)			0	
5.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	al of the cost reporting	period (Tine 8	0	25
5.00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		2, 963, 494	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abcomuction had ab	07700)	0	1 20
8.00 9.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed ch	arges)	0	28 29
. 00	Semi-private room charges (excluding swing bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27 +	÷line 28)		0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00 0.00	
. 00	Average per diem private room cost differential (line 34 x lir			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 963, 494	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see			1, 201. 74	38
	Program general inpatient routine service cost (line 9 x line			2, 407, 085	
0. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 2, 407, 085	40
00				7 /107 085	. /11

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	HANCOCK REGIONAL	HOSPITAL	CN: 15-0037	In Lie Period:	eu of Form CMS- Worksheet D-1	
			CCN: 15-S037	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Title	XVIII	Subprovider -	5/29/2019 9:5 PPS	7 am
Cost Center Description	Total	Total	Average Per	I PF	Program Cost	
cost center bescription	Inpatient CostIn				(col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Uni	ts					42.00
43. 00 I NTENSI VE CARE UNI T	0	0	0.	0 00	0	
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT						44.00
46. 00 SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
cost center bescription					1.00	
48.00 Program inpatient ancillary service cost			````	·	212, 521	
49.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	es 41 through 48)(se	e instructio	ns)		2, 619, 606	49.00
50.00 Pass through costs applicable to Program i	npatient routine se	rvices (from	Wkst. D, su	m of Parts I and	243, 164	50.00
III) 51.00 Dasa through costs appliable to Drogram	motiont and llary	oomilooo (fr	om Wkot D	num of Donto II	0 407	E1 00
51.00 Pass through costs applicable to Program i and IV)	npatrent and trary	services (II	UNI WKSL. D,	Sum of Parts II	8, 497	51.00
52.00 Total Program excludable cost (sum of line	-				251, 661	
53.00 Total Program inpatient operating cost exe medical education costs (line 49 minus lin		ted, non-phy	sician anest	netist, and	2, 367, 945	53.00
TARGET AMOUNT AND LIMIT COMPUTATION					1	
54.00 Program discharges 55.00 Target amount per discharge					0.00	
56.00 Target amount (line 54 x line 55)					0.00	
57.00 Difference between adjusted inpatient oper	rating cost and targ	et amount (I	ine 56 minus	line 53)	0	
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost	reporting period en	ding 1006 u	ndated and c	ompounded by the	0.00	
market basket	reporting period en	ung 1770, u		shipourded by the	0.00	37.0
60.00 Lesser of lines 53/54 or 55 from prior yea					0.00	
61.00 If line 53/54 is less than the lower of li which operating costs (line 53) are less					0	61.0
amount (line 56), otherwise enter zero (se			00), 00	i the target		
62.00  Relief payment (see instructions) 63.00  Allowable Inpatient cost plus incentive pa	want (coo instruct	i onc)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST	ayment (see mistruct	10113)			0	03.00
64.00 Medicare swing-bed SNF inpatient routine	costs through Decemb	er 31 of the	cost report	ng period (See	0	64.00
instructions)(title XVIII only) 65.00  Medicare swing-bed SNF inpatient routine of	costs after December	31 of the c	ost reportin	a period (See	0	65.00
instructions)(title XVIII only)						
66.00 Total Medicare swing-bed SNF inpatient row CAH (see instructions)	utine costs (line 64	plus line 6	5)(title XVI	ll only). For	0	66.00
67.00 Title V or XIX swing-bed NF inpatient rou	tine costs through D	ecember 31 c	f the cost r	eporting period	0	67.00
(line 12 x line 19)	tipo costo oftor Doc	ombor 21 of	the cost rop	arting pariod	0	40 00
68.00  Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	time costs after Dec		the cost rep	briting period	0	68.00
69.00 Total title V or XIX swing-bed NF inpatien					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER 70.00 Skilled nursing facility/other nursing fac				)		70.00
71.00 Adjusted general inpatient routine service				, ,		71.0
72.00 Program routine service cost (line 9 x lin 73.00 Medically necessary private room cost appl		lipo 14 v li	po 2E)			72.0
73.00  Medically necessary private room cost app 74.00  Total Program general inpatient routine so						74.0
75.00 Capital-related cost allocated to inpatien	-			Part II, column		75.00
26, line 45) 76.00  Per diem capital-related costs (line 75 ÷	line 2)					76.00
77.00 Program capital -related costs (line 9 x li						77.0
78.00 Inpatient routine service cost (line 74 mi	-	uidan naaand				78.0
79.00 Aggregate charges to beneficiaries for exe 30.00 Total Program routine service costs for co				nus line 79)		79.0
31.00 Inpatient routine service cost per diem li	mitation		、 · · - · ···	,		81.0
32.00 Inpatient routine service cost limitation	. ,					82.0
<ul> <li>33.00 Reasonable inpatient routine service cost:</li> <li>34.00 Program inpatient ancillary services (see</li> </ul>						83. 0 84. 0
35.00 Utilization review - physician compensation	on (see instructions					85.0
86.00 Total Program inpatient operating costs (		ugh 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED F 87.00 Total observation bed days (see instruction					0	87.00
88.00 Adjusted general inpatient routine cost pe	er diem (line 27 ÷ l	ine 2)			0.00	88.00
39.00 Observation bed cost (line 87 x line 88)	(see instructions)				0	89.0

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2018	Worksheet D-1	
		Component (		To 12/31/2018		
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	299, 366	2, 963, 494	0. 10101	8 0	0	90.00
91.00 Nursing School cost	0	2, 963, 494	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 963, 494	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 963, 494	0.00000	0 0	0	93.00

	Financial Systems HANCOCK REGIONAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0037	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
	Cast Capton Deceription	Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs. excluding newborn)	1	5, 172	1 1.
	Inpatient days (including private room days, excluding swing-			5, 172	2.
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(ave)		3, 441	4
	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0, 111	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	- 31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	51	9
	newborn days)			-	
00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	5 /	-	
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	/ear, enter O on this lin	ne)	-	
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15 16
	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 o	of the cost	0.00	17
00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to service	as through December 31 of	f the cost	0.00	10
	reporting period	C			
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ıs)		8, 316, 161	21
00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost report	ting period (line	0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the east reportin	a pariod (line 6	0	23
00	x line 18)	ST OF the Cost reportin	ig period (inne o	0	23
00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 8, 316, 161	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			0, 510, 101	2'
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)		28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	<i>,</i>		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	8, 316, 161	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART IT - HOSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			ł
00	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 607. 92	
00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			82, 004 0	39 40
. 00					

OMPUT	Financial Systems FATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0037	Period: From 01/01/2018	eu of Form CMS- Worksheet D-1	
					To 12/31/2018		
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Pe Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	10
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	<u> </u>				<u> </u>	42.
3. 00	INTENSIVE CARE UNIT	8, 246, 017	4, 759	1, 732.	72 46	79, 705	43.
l. 00	CORONARY CARE UNI T						44
5.00	BURN INTENSIVE CARE UNIT						45.
00							46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
						1.00	
. 00 . 00	Program inpatient ancillary service cost (WI Total Program inpatient costs (sum of lines			nc)		91, 680 253, 389	
. 00	PASS THROUGH COST ADJUSTMENTS	41 through 40)(S		115)		203, 309	49
. 00	Pass through costs applicable to Program in	patient routine s	ervices (from	Wkst. D, su	m of Parts I and	0	50
~ ~							
1.00	Pass through costs applicable to Program inp and IV)	batient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	) 51.
2. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.
3.00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	0	
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient opera	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period e	nai ng 1996, u	poated and c	ompounded by the	0.00	59
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upd	ated by the m	arket basket		0.00	60
1.00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% o	f the target		
2.00		Thisti uctions)				0	62
		ment (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Decem	ber 31 of the	cost report	ing period (See	0	64
5.00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	r 31 of the c	ost reportin	g period (See	0	65
	instructions)(title XVIII only)				5 T X		
5.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 o	f the cost r	eportina period	0	67
	(line 12 x line 19)	0					
3. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after De	cember 31 of	the cost rep	orting period	0	68
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (L	ine 67 + line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N						
. 00	Skilled nursing facility/other nursing facil	2			)		70
. 00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv	0	•				74
6. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital-related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 min						78
. 00	Aggregate charges to beneficiaries for exces						79
. 00	Total Program routine service costs for com		st limitation	(line 78 mi	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81
. 00	Reasonable inpatient routine service cost rimitation (						83
. 00	Program inpatient ancillary services (see in	•	-				84
5.00							85
o. 00	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 85)				86
7.00	Total observation bed days (see instructions					1, 731	87
B. 00	Adjusted general inpatient routine cost per		line 2)			1, 607. 92	
J. 00							

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	921, 684	8, 316, 161	0. 11083	0 2, 783, 310	308, 474	90.00
91.00 Nursing School cost	0	8, 316, 161	0.00000	0 2, 783, 310	0	91.00
92.00 Allied health cost	0	8, 316, 161	0. 00000	0 2, 783, 310	0	92.00
93.00 All other Medical Education	0	8, 316, 161	0. 00000	0 2, 783, 310	0	93.00

Health Finar	ncial Systems HANO	COCK_REGIONAL_HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT A	VCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-0037	Peri od:	Worksheet D-3	3
				From 01/01/2018 To 12/31/2018	Date/Time Pre	
		Titlo	XVIII	Hospi tal	5/29/2019 9:5 PPS	
	Cost Center Description	- Intre	Ratio of Cos		Inpatient	
	cost center bescription		To Charges	Program	Program Costs	
			10 charges	Charges	(col. 1 x col.	
				onal ges	2)	
			1.00	2.00	3.00	
	IENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS			992, 940		30.00
	I NTENSI VE CARE UNI T			4, 456, 452		31.00
	SUBPROVIDER - IPF			13, 779		40.00
	SUBPROVIDER - IRF			0		41.00
	LARY SERVICE COST CENTERS		I	0		41.00
	OPERATING ROOM		0. 3902	2, 490, 351	971, 964	50.00
	RECOVERY ROOM		0. 3491		88, 920	
	ANESTHESI OLOGY		0. 0002		77	1
	RADI OLOGY-DI AGNOSTI C		0. 12073		249, 841	1
	LABORATORY		0. 1207		357, 787	1
	RESPIRATORY THERAPY		0. 2549		412, 904	1
	PHYSICAL THERAPY		0. 2349		150, 434	1
	OCCUPATIONAL THERAPY		0. 3517		76, 788	
	SPEECH PATHOLOGY		0.3736		26, 108	
	OCCUPATIONAL HEALTH		0.0000		20, 100	1
	ELECTROCARDI OLOGY		0. 1327			1
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1327		230, 156	
					382, 281	
	IMPL. DEV. CHARGED TO PATIENT		0.3994		858, 777	
	DRUGS CHARGED TO PATIENTS CARDIAC		0. 2045		586, 132	
			0.0000		0	
			0.65172	24 0	0	76.01
	TIENT SERVICE COST CENTERS		0.0000			
	RURAL HEALTH CLINIC		0.0000		0	
			0.0000		0	
	WOUND CLINIC		0. 2593		357	
	DIABETES CLINIC		1.0359		0	
	ASTHMA CLINIC		0.0000		0	
	ANDIS CLINIC		5.6458		0	
	PRIME TIME		0. 34050		0	
	SHELBYVILLE WOUND CLINIC		0. 3182		0	
	ONCOLOGY		0. 4148		458	
	ANDERSON WOMENS CENTER		0. 1804		0	
	EMERGENCY		0. 1315		386, 836	
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 5888		0	
200.00	Total (sum of lines 50 through 94 and 96 th			20, 609, 008	4, 779, 820	
201.00	Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1	20, 609, 008		202.00

NPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0037	Peri od:	Worksheet D-3	;
			001 45 0007	From 01/01/2018		
		Component	CCN: 15-S037	To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
		Ti tl e	e XVIII	Subprovider -	PPS	
				IPF		
	Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	TIENT ROUTINE SERVICE COST CENTERS		1	-	1	1
	0 ADULTS & PEDIATRICS			0		30.
				0		31.
	O SUBPROVIDER - I PF			2, 631, 160		40.0
	O SUBPROVIDER - IRF			0	1	41. (
	LLARY SERVICE COST CENTERS		0,0000		( 075	50
	O OPERATING ROOM		0.3902			
	D RECOVERY ROOM		0. 3491		-	
	O ANESTHESI OLOGY		0.0002			
	0 RADI OLOGY-DI AGNOSTI C		0. 1207			
	O LABORATORY		0. 1285			
	O RESPIRATORY THERAPY		0.2549			
	O PHYSI CAL THERAPY		0. 4240			
	0 OCCUPATIONAL THERAPY		0.3517			
	O SPEECH PATHOLOGY		0. 3736			
	1 OCCUPATI ONAL HEALTH O ELECTROCARDI OLOGY		0.0000		-	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1327			
	OIMPL. DEV. CHARGED TO PATIENT		0. 3371			
	O DRUGS CHARGED TO PATIENTS		0. 2045			
	0 CARDI AC		0.0000			
	O CARDI AC		0.6517		-	
	ATIENT SERVICE COST CENTERS		0.0317	24 0	0	70.
	ORURAL HEALTH CLINIC		0.0000	00	0	88. (
			0.0000			
	1 WOUND CLINIC		0. 2593		-	
	2 DI ABETES CLINIC		1.0359			
	3 ASTHMA CLINIC		0.0000		0	
	4 ANDIS CLINIC		5. 6458		0	
	5 PRIME TIME		0. 3405		0	90.
	6 SHELBYVILLE WOUND CLINIC		0. 3182		0	90.
	1 ONCOLOGY		0. 4148	96 0	0	90.
0. 08 0495	O ANDERSON WOMENS CENTER		0. 1804	63 0	0	90.
91.00 0910			0. 1315	80 52, 491	6, 907	91.
	O OBSERVATION BEDS (NON-DISTINCT PART)		0. 5888	50 0	0	92.
200.00	Total (sum of lines 50 through 94 and 96 through 98)			1, 041, 349	212, 521	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
202.00	Net charges (line 200 minus line 201)		1	1, 041, 349		202.

Health Financial Systems HANCOCK REGIONA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0037	Peri od:	Worksheet D-3	1
			From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
	Ti †I	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
		10 ondriges	Charges	$(col \cdot 1 \times col \cdot$	
			ondi goo	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1100	2100	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			145, 653		30.00
31. 00 03100 I NTENSI VE CARE UNI T			72, 680		31.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVI DER – I RF			0		41.00
ANCI LLARY SERVICE COST CENTERS		1			11.00
50. 00 05000 OPERATING ROOM		0. 3902	92 85, 437	33, 345	50.00
51. 00 05100 RECOVERY ROOM		0. 3491		2, 896	
53. 00 05300 ANESTHESI OLOGY		0.0002		2,070	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1207		2, 849	
60. 00 06000 LABORATORY		0. 1285		6, 459	
65. 00 06500 RESPIRATORY THERAPY		0. 2549		8, 286	
66. 00 06600 PHYSICAL THERAPY		0. 2349		1, 472	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3517		699	
		0.3736			
				309 0	
68. 01   06801   0CCUPATI ONAL HEALTH 69. 00   06900   ELECTROCARDI OLOGY		0.0000			
		0.1327		2, 108	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.5371		11, 418	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3994		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2045		17, 796	
76. 00 03020 CARDI AC		0.0000		0	
76. 01 03160 CARDI OPULMONARY		0. 6517	24 0	0	76.01
		0.0000	00		
88. 00 08800 RURAL HEALTH CLINIC		0.0000		0	
90. 00 09000 CLINIC		0.0000		0	
90. 01 09001 WOUND CLINIC		0. 2593		136	
90. 02 09002 DI ABETES CLI NI C		1.0359		0	
90. 03 09003 ASTHMA CLINIC		0.0000		0	
90. 04 09004 ANDIS CLINIC		5.6458		0	
90. 05 09005 PRI ME TI ME		0. 3405		0	
90. 06 09006 SHELBYVILLE WOUND CLINIC		0. 3182		0	
90. 07 04951 ONCOLOGY		0. 4148		0	
90.08 04950 ANDERSON WOMENS CENTER		0. 1804		0	
91. 00 09100 EMERGENCY		0. 1315		3, 905	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5888		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			369, 344	91, 680	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	369, 344		202.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/29/2019 9:5	pared: 7 am		
		Title XVIII	Hospi tal	PPS			
				1.00			
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS						
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ing prior to Octobor 1	(500	0 5, 407, 642	1.00 1.01		
. 01	instructions)	ing piror to october i	(See	5, 407, 642	1.01		
. 02	DRG amounts other than outlier payments for discharges occurri	ing on or after October	1 (see	1, 758, 212	1. 02		
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or discharges occurring	prior to October	0	1. 03		
. 04	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	on or after	0	1.04		
. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			5, 616	2.00		
. 01	Outlier reconciliation amount			0,010	2.01		
. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	i ons)		0	2.02		
. 00 . 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	0 56.26	3.00		
. 00	Indirect Medical Education Adjustment	Titling period (see this till		30.20	4.00		
. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00		
. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-	on to the cap for	0.00	6.00		
. 00	MMA Section 422 reduction amount to the IME cap as specified u	under 42 CFR §412.105(f)	)(1)(iv)(B)(1)	0.00	7.00		
. 01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR §412.105(f)(1)(	iv)(B)(2) If the	0.00	7.01		
. 00	<ul> <li>cost report straddles July 1, 2011 then see instructions.</li> <li>Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,</li> </ul>						
. 01	1998), and 67 FR 50069 (August 1, 2002).						
00	report straddles July 1, 2011, see instructions.	- +		0.00			
. 02	The amount of increase if the hospital was awarded FTE cap slounder $\S$ 5506 of ACA. (see instructions)		0	0.00	8. 02		
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02)	(see	0.00	9.00		
0. 00	FTE count for allopathic and osteopathic programs in the curre	ent year from your reco	rds		10.00		
1.00	FTE count for residents in dental and podiatric programs.				11.00		
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00	12.00 13.00		
4.00	Total allowable FTE count for the penultimate year if that yea	ar ended on or after Se	ptember 30, 1997,		14.00		
	otherwise enter zero.						
5.00	Sum of lines 12 through 14 divided by 3.				15.00		
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clos	SUF0			16.00 17.00		
	Adjusted rolling average FTE count	suie			18.00		
9.00	Current year resident to bed ratio (line 18 divided by line 4)	).		0.000000			
0. 00	Prior year resident to bed ratio (see instructions)	·		0.000000	20.00		
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.00000	21.00		
	IME payment adjustment (see instructions)			0			
2.01	IME payment adjustment - Managed Care (see instructions)			0	22.01		
3.00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside		CFR 412.105	0.00	23.00		
4.00	(f)(1)(iv)(C ). IME FTE Resident Count Over Cap (see instructions)			0.00	24.00		
5.00	If the amount on line 24 is greater than -O-, then enter the linstructions)	lower of line 23 or line	e 24 (see	0.00			
6.00	Resident to bed ratio (divide line 25 by line 4)			0.000000			
7.00	IME payments adjustment factor. (see instructions)			0.000000			
8.00 8.01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0			
	Total IME payment ( sum of lines 22 and 28)	)		0			
9.00 9.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0)	1)		0			
	Disproportionate Share Adjustment						
0.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instru	ctions)	2.62			
	Percentage of Medicaid patient days (see instructions)				31.00		
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)	)		19.51 5.43	32.0		
	Disproportionate share adjustment (see instructions)	/			33.0		

	Financial Systems HANCOCK REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	L HOSPITAL Provider CCN: 15-0037	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2018 To 12/31/2018	Date/Time Prep	
		Title XVIII	Hospi tal	5/29/2019 9:57 PPS	/ am
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment		4 7(4 (OF 1(2	0 070 070 447	25.00
35.00 35.01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000091834	8, 272, 872, 447 0. 000108296	35.00 35.01
	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (see		895, 918	
	instructions)	, (,			
	Pro rata share of the hospital uncompensated care payment amo		464, 782	225, 821	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		690, 603		36.00
40.00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding		n 46) 0		40.00
40.00	652, 682, 683, 684 and 685 (see instructions)	ui scharges für M3-DR85	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0		41.00
	instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0		41.01
42.00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not quali		42.00		
42.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	0.00 0		42.00	
101 00	instructions)		Ū		
44.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0.000000		44.00
45 00	days)		0.00		45 00
45.00 46.00	Average weekly cost for dialysis treatments (see instructions Total additional payment (line 45 times line 44 times line 41		0.00		45.00 46.00
40.00	Subtotal (see instructions)		7, 959, 350		40.00
48.00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48.00
	only. (see instructions)	•			
				Amount 1.00	
49.00	Total payment for inpatient operating costs (see instructions	:)		7, 959, 350	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I an			584, 449	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0	52.00
	Nursing and Allied Health Managed Care payment			9, 271	53.00
54.00 54.01	Special add-on payments for new technologies Islet isolation add-on payment			0	54.00 54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intr			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. I	II, column 9, lines 30 th	rough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		11, 414	
59.00	Total (sum of amounts on lines 49 through 58)			8, 564, 484	
60.00 61.00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	sline 60)		0 8, 564, 484	60.00 61.00
62.00	Deductibles billed to program beneficiaries			953, 864	62.00
63.00	Coinsurance billed to program beneficiaries			4, 355	
64.00	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		7 404 245	66.00
67.00 68.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS_DRGs (se	e instructions)	7, 606, 265 0	67.00 68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	-	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see i	nstructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.8
70.88	SCH or MDH volume decrease adjustment (contractor use only)	ructions)		0	70.88
70 00	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)			0	
70. 89 70. 90					1
70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	1 10.91
70. 90	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70.92
70. 90 70. 91 70. 92 70. 93					70. 92 70. 93

ALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0037	Peri od:	u of Form CMS-2 Worksheet E	2002
			From 01/01/2018 To 12/31/2018	Part A Date/Time Pre	
	Title	XVIII	Hospi tal	5/29/2019 9:5 PPS	/ am
	in the		(уууу)	Amount	
			0	1.00	
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		2018	66, 392	70.
the corresponding federal year for the period prior to 10/1) 0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		2019	237, 840	
the corresponding federal year for the period ending on or a 0.98 Low Volume Payment-3	fter 10/1)			0	
).99  HAC adjustment amount (see instructions) 1.00  Amount due provider (line 67 minus lines 68 plus/minus lines	(0 % 70)			7 052 070	
1.00  Amount due provider (line 67 minus lines 68 plus/minus lines 1.01  Sequestration adjustment (see instructions)	09 & 70)			7, 952, 978 159, 060	
1.02 Demonstration payment adjustment amount after sequestration				159,000	
2. 00 Interim payments				7, 634, 982	
3.00 Tentative settlement (for contractor use only)				7,034,702	73.
<ul> <li>Balance due provider/program (line 71 minus lines 71.01, 71.</li> <li>73)</li> </ul>	02, 72, and			158, 936	
5.00 Protested amounts (nonallowable cost report items) in accord CMS Pub. 15-2, chapter 1, §115.2	ance with			113, 539	75.
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	6.0.02				
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	
.00 Capital outlier from Wkst. L, Pt. I, line 2 .00 Operating outlier reconciliation adjustment amount (see inst	ructions)			0	91. 92.
.00 Capital outlier reconciliation adjustment amount (see instru	,			0	
.00 The rate used to calculate the time value of money (see inst				0.00	
.00 Time value of money for operating expenses (see instructions				0.00	
5.00 Time value of money for capital related expenses (see instructions	<i>,</i>			0	
			Prior to 10/1		
			1.00	2.00	
HSP Bonus Payment Amount					
00.00 HSP bonus amount (see instructions)			0		100.
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment				0	
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 11.00 HVBP adjustment factor (see instructions)			0. 0000000000	0.000000000	101.
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructio	ns)			0.000000000	101.
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> </ul>	ns)		0.0000000000000000000000000000000000000	0 0. 000000000 0	101. 102.
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>03.00 HRR adjustment factor (see instructions)</li> </ul>			0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction)</li> </ul>	s)	stment	0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103.
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> </ul>	s) tration) Adju		0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103. 104.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>0.00 HVBP adjustment factor (see instructions)</li> <li>00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>00 Is this the first year of the current 5-year demonstration project</li> </ul>	s) tration) Adju		0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103. 104.
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>101.00 HVBP adjustment factor (see instructions)</li> <li>102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>103.00 HRR adjustment factor (see instructions)</li> <li>104.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> </ul>	s) tration) Adju		0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103. 104.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>11.00 HVBP adjustment factor (see instructions)</li> <li>12.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>13.00 HRR adjustment factor (see instructions)</li> <li>14.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>10.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> </ul>	s) tration) Adju eriod under t		0.0000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103. 104. 200.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> </ul>	s) tration) Adju eriod under t		0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 0.0000 0	101. 102. 103. 104. 200. 201.
<ul> <li>100.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>100.00 HVBP adjustment factor (see instructions)</li> <li>100 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>100 HRR adjustment factor (see instructions)</li> <li>100 HRR adjustment factor (see instructions)</li> <li>100 HRR adjustment factor (see instructions)</li> <li>11.00 HRR adjustment amount for HSP bonus payment (see instruction Cost Reimbursement</li> <li>11.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>12.00 Medicare discharges (see instructions)</li> <li>13.00 Case-mix adjustment factor (see instructions)</li> </ul>	s) tration) Adju eriod under t ne 49)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> </ul>	s) tration) Adju eriod under t ne 49)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0 0 0	101. 102. 103. 104. 200. 201. 202. 203.
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>00.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 11, 1i</li> <li>02.00 Medicare discharges (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount</li> </ul>	s) tration) Adju eriod under t ne 49)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204.
00.00       HSP bonus amount (see instructions)         HVBP Adjustment for HSP Bonus Payment         01.00       HVBP adjustment factor (see instructions)         02.00       HVBP adjustment factor (see instructions)         02.00       HVBP adjustment for HSP Bonus payment (see instructions)         03.00       HRR Adjustment for HSP Bonus Payment         04.00       HRR adjustment factor (see instructions)         04.00       HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 2000)         00.00       Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement       Cost Reimbursement         01.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii         02.00       Case-mix adjustment factor (see instructions)         03.00       Case-mix adjustment factor (see instructions)         04.00       Medicare target amount         05.00       Case-mix adjusted target amount (line 203 times line 204)	s) tration) Adju eriod under t ne 49) n first year	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> </ul>	s) tration) Adju eriod under t ne 49) n first year	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP Bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>10.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>200 Medicare discharges (see instructions)</li> <li>300 Case-mix adjustment factor (see instructions)</li> <li>300 Case-mix adjustment factor (see instructions)</li> <li>41.00 Medicare target amount</li> <li>55.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>42.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement</li> </ul>	s) tration) Adju eriod under t ne 49) n first year )	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>10.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>20.00 Medicare discharges (see instructions)</li> <li>30.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A i period)</li> <li>44.00 Medicare target amount</li> <li>45.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>46.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see instruction</li> </ul>	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction)</li> <li>13.00 HRR adjustment for HSP Bonus Payment</li> <li>14.00 HRR adjustment factor (see instructions)</li> <li>15.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Rural Community Hospital Demonstration Project (§410A Demons Cost Reimbursement</li> <li>10.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>200 Medicare discharges (see instructions)</li> <li>200 Medicare target amount factor (see instructions)</li> <li>200 Case-mix adjusted target amount (line 203 times line 204)</li> <li>200 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>200 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> </ul>	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208.
<ul> <li>10.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>11.00 HVBP adjustment factor (see instructions)</li> <li>12.00 HVBP adjustment for HSP Bonus Payment (see instruction)</li> <li>13.00 HRR adjustment for HSP Bonus Payment</li> <li>14.00 HRR adjustment factor (see instructions)</li> <li>14.00 HRR adjustment factor (see instructions)</li> <li>15.00 HRR adjustment service costs (from Wkst. D-1, Pt. II, Ii</li> <li>16.00 Medicare target amount</li> <li>17.00 Medicare target amount</li> <li>16.00 Medicare target amount</li> <li>17.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>16.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>17.00 Medicare target amount</li> <li>17.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>17.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>17.00 Program reimbursement under the S410A Demonstration (see instructions)</li> <li>17.00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0 0.000000000 0 0.0000 0 rati on	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see ins 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Reserved for future use</li> </ul>	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 209. 210.
<ul> <li>10.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>11.00 HVBP adjustment factor (see instructions)</li> <li>22.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instruction HRR adjustment factor (see instructions)</li> <li>23.00 HRR adjustment for HSP Bonus Payment (see instructions)</li> <li>24.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 00.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>20.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>20.00 Case-mix adjustment factor (see instructions)</li> <li>21.00 Medicare target amount</li> <li>22.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>23.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>24.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>25.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>24.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>25.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>26.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>27.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>28.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>29.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>20.00 Reserved for future use</li> </ul>	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 209. 210.
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment for HSP Bonus Payment</li> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment factor (see instructions)</li> <li>05.00 UST this the first year of the current 5-year demonstration project (§410A Demons Rural Community Hospital Demonstration Project (§410A Demons Project Reimbursement Scomputation of Demonstration Target Amount Limitation (N/A i period)</li> <li>04.00 Medicare target amount</li> <li>05.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>06.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>07.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A)</li> <li>09.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>00 Reserved for future use</li> <li>10.00 Total adjustment to Medicare IPPS payments (see instructions Comparision of PPS versus Cost Reimbursement</li> <li>200 Total adjustment to Medicare Part A IPPS payments (from Line PARCH PPS P</li></ul>	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59) )	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons</li> <li>00.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii</li> <li>02.00 Medicare discharges (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount</li> <li>05.00 Case-mix adjustment factor (see instructions)</li> <li>06.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>06.00 Medicare Part A Inpatient Reimbursement</li> <li>07.00 Program reimbursement under the §410A Demonstration (see instruction (see instructions)</li> <li>08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A</li> <li>09.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>00 Reserved for future use</li> <li>01.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59) )	he 21st	0. 000000000 0 0. 0000000000 0 0. 0000 0	0.0000000000 0 0.0000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211.

_OW VC	LUME CALCULATION EXHIBIT 4			Provider C	F	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibi Date/Time Pre 5/29/2019 9:5	pared
		W/S E. Part A	Amounts (from	Title Pre/Post	YVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
. 00	DRG amounts other than outlier	0 1.00	1.00	2.00	3.00	4.00	5.00	1. (
. 01	payments DRG amounts other than outlier payments for discharges	1. 01	5, 407, 642	0	5, 407, 642	2	5, 407, 642	1. (
. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 758, 212	0		1, 758, 212	1, 758, 212	1. (
. 03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	o	) C		0	1. (
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0	0		0	0	1. (
. 00	October 1 Outlier payments for	2.00	5, 616	0	5, 616	0	5, 616	2.
. 01	discharges (see instructions) Outlier payments for	2. 02	0	n	, c	0	0	2.0
. 00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	C	0	0	
. 00	reconciliation Managed care simulated payments	3.00	0	0	) (	0 0	0	4. (
. 00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0.000000	0. 000000		5.
. 00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0.000000	0.000000			0	
. 01	instructions) IME payment adjustment for managed care (see	22.01	0	0	0	0 0	0	
	instructions) Indirect Medical Education Adju	istment for the	Add-on for Se	ction 422 of t	be MMA			
. 00	IME payment adjustment factor	27.00	0. 000000			0. 000000		7.
00	(see instructions) IME adjustment (see	28.00	0	0	c	0	0	8.
01	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	C	0	0	8.
00	instructions) Total IME payment (sum of	29.00	0	0	c	0	0	9.
01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	C	0	0	9.
	Di sproporti onate Share Adjustme		0.0542	0.0542	0.0542	0.0542		10
). 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0543	0. 0543	0. 0543	0. 0543		10.
I. 00	Disproportionate share adjustment (see instructions)	34.00	97, 277	0	73, 409	23, 868	97, 277	11.
l. 01	Uncompensated care payments Additional payment for high per	36.00	690, 603		464, 782	225, 821	690, 603	11.
2. 00	Total ESRD additional payment	46.00	0	ui scharges 0	(	0	0	12.
3. 00 4. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	7, 959, 350 0	0 0		2, 007, 901 0 0	7, 959, 350 0	13. 14.
	small rural hospitals only.) (see instructions)							
5. 00	Total payment for inpatient operating costs (see instructions)	49.00	7, 959, 350	0	5, 951, 449	2, 007, 901	7, 959, 350	15.
5. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	584, 449	0	-142, 389	726, 838	584, 449	16.
7.00	Special add-on payments for new technologies	54.00	0	0	c c	0	0	17.
7. 01 7. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	, c	0	0	17. 17.

	Financial Systems		HANCOCK REGION				u of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 9:5	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
19.00	SUBTOTAL			0	5, 809, 06	0 2, 734, 739	8, 543, 799	19 00
17.00		W/S L, line	(Amounts from L)		0,007,00	2,701,707	0,010,777	17.00
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	583, 560				583, 560	20.00
	Model 4 BPCI Capital DRG other than outlier	1. 01	0			0 0	0	20. 0 <sup>-</sup>
21.00	Capital DRG outlier payments	2.00	889	0	66	5 224	889	21.0
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21.0
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000		22.0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0 0.0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.0
26. 00	Total prospective capital payments (see instructions)	12.00	584, 449	0	-142, 38	9 726, 838	584, 449	26. 0
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 01142 66, 39		66, 392	27.0 28.0
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				237, 840	237, 840	29.0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100. 0

HOSPI T	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	HANCOCK REGION	Provider CC		Period: From 01/01/2018 To 12/31/2018		pared:
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	XVIII Period to 10/01	Hospital 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	0.00	1.00	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5, 407, 642	5, 407, 64	2	5, 407, 642	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1, 758, 212		1, 758, 212	1, 758, 212	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	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	5, 616	5, 61	6 0	5, 616	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
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0 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)	22.01	0		0 0	0	6. 01
	Indirect Medical Education Adjustment for the						7 00
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000				7.00
3. 00 3. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0	0 0	8. 00 8. 01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.00 29.01	0		0 0 0 0	0	9. 00 9. 01
10.00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 0543	0. 054	3 0.0543		10.00
	(see instructions)						
	Disproportionate share adjustment (see instructions)	34.00 36.00	97, 277	73, 40 464, 78			
11.01	Uncompensated care payments Additional payment for high percentage of ESR		690, 603	404, 70	2 225, 821	690, 603	11.01
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	7, 959, 350 0		9 2, 007, 901 0 0	7, 959, 350 0	13. 00 14. 00
15.00	instructions) Total payment for inpatient operating costs	49.00	7, 959, 350	5, 951, 44	9 2, 007, 901	7, 959, 350	15.00
16.00	(see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	584, 449	-142, 38	9 726, 838	584, 449	16. 00
17.00 17.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17. 00 17. 01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	
19.00	SUBTOTAL			5, 809, 06	0 2, 734, 739	8, 543, 799	19.00

Health Financial Systems	HANCOCK REGION	NAL_HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULAT	TION EXHIBIT 5	Provider CO		Period: From 01/01/2018 To 12/31/2018		epared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	583, 560	-143, 05	54 726, 614	583, 560	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	889	60	5 224	889	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0000	0.000	0. 0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	584, 449	-142, 38	39 726, 838	584, 449	26.00
	Wkst. E, Pt. A, line	(Amt. from 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	66, 392	66, 39	92	66, 392	28.00
29.00 Low volume adjustment on or after October 1	70.97	237, 840		237, 840	237, 840	29.00
30.00 HVBP payment adjustment (see instructions)	70, 93	53, 190	48, 30	4, 884	53, 190	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	
31.00 HRR adjustment (see instructions)	70.94	-10, 709	-6, 48	-4, 220	-10, 709	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see	70.99	1.00	2.00	0 0		32.00
instructions) 100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Ν				100. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0037	Period: From 01/01/2018	Worksheet E Part B	2552-10
			To 12/31/2018	Date/Time Pre	
		Title XVIII	Hospi tal	5/29/2019 9:5 PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructi	ons)		4, 509 16, 237, 160	1.00 2.00
3.00	OPPS payments	013)		13, 800, 356	3.0
4.00	Outlier payment (see instructions)			72, 164	4.0
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct	ions)		0 0. 000	4.0 5.0
6.00	Line 2 times line 5	10115)		0.000	6.0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.0
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	( col 12 lino 200		0 103, 345	8.00 9.00
10.00	Organ acquisitions	, col. 13, title 200		103, 345	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 509	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			22, 073	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ie 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			22, 073	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for pa	went for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0,000000	47.00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 22, 073	
19.00	Excess of customary charges over reasonable cost (complete only	ifline 18 exceeds li	ne 11) (see	17, 564	
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds li	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			4, 509	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ictions)		0 13, 975, 865	23.00 24.00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			13, 773, 003	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			2, 593, 487 11, 386, 887	26.00 27.00
27.00	instructions)			11, 300, 007	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 11, 386, 887	
31.00	Primary payer payments			772	
32.00	Subtotal (line 30 minus line 31)			11, 386, 115	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	S)		0	33.00
34.00	Allowable bad debts (see instructions)			0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0	35.00
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	ictions)		0 11, 386, 115	36.00 37.00
38.00	MSP-LCC reconciliation amount from PS&R			11, 380, 115	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	d devices (see instru	tions)	0	39.97 39.98
39.90	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			11, 386, 115	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			227, 722 0	
40.02	Interim payments			11, 259, 820	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)	o with CMS Dub 15 0	chaptor 1	-101, 427	43.00
44.00	Protested amounts (nonallowable cost report items) in accordanc §115.2	е withit cwb Pub. 15-2,	chapter I,	0	44. OC
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91.00 92.00
92.00 93.00	Time Value of Money (see instructions)			0.00	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0037	Period: From 01/01/2018 To 12/31/2018		parec
		Title	XVIII	Hospi tal	PPS	_
		I npati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		7, 569, 6	16 0	11, 053, 060 0	1. ( 2. ( 3. (
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01 02 03 04	ADJUSTMENTS TO PROVIDER	12/31/2018	65, 3	0 0 0	206, 760 0 0	3. 3. 3. 3.
05				0	0	3.
FO	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.
50 51 52 53 54	ADJUSTMENTS TO PROGRAM			0 0 0 0		
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		65, 3	-	206, 760	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7, 634, 9	82	11, 259, 820	4.
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5
0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
D1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	
)3				0	0	5
	Provider to Program	1				
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		158, 9	36	0	6
)2 )0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		7, 793, 9	0 18	101, 427 11, 158, 393	6 7
				Contractor	NPR Date	
			)	Number	(Mo/Day/Yr)	
	Name of Contractor	(	)	1.00	2.00	8

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Component	CN: 15-0037 CCN: 15-S037	Period: From 01/01/2018 To 12/31/2018		
		Title	e XVIII	Subprovider -	PPS	
		Inpatien	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		1, 924, 3	0	0	1. 0 2. 0 3. 0
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					5.0
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	3. (
03				0	0	3.
04 05				0	0	3. 3.
00	Provider to Program		<u> </u>			5.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3. 3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 924, 3	30	0	4.
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider					
01 02	TENTATI VE TO PROVI DER			0	0	5. 5.
02				0	0	5. 5.
00	Provider to Program			0		0.
50	TENTATI VE TO PROGRAM			0	0	5.
51				0	0	5.
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 5.
99 20	5. 50-5. 98) Determined net settlement amount (balance due) based on			U		5. 6.
00	the cost report. (1)					Ο.
01	SETTLEMENT TO PROVIDER		5	26	0	6.
02	SETTLEMENT TO PROGRAM			0	0	6.
00	Total Medicare program liability (see instructions)		1, 924, 8			7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1.00	2.00	

Heal th	Financial Systems HANCOCK	REGIONAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018		
				5/29/2019 9:5	57 am
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST RE	PORTS		1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CAL				1
1.00	Total hospital discharges as defined in AARA §4102 fr	om Wkst. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of li	nes 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line	e 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of li	nes 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 lir				5.00
6.00	Total hospital charity care charges from Wkst. S-10,				6.00
7.00	CAH only - The reasonable cost incurred for the purch line 168	nase of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruc	ctions)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after seques	stration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructi	ons)			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line	30 and line 31) (see instructio	ns)		32.00

CUI	Financial Systems HANCOCK REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	L HOSPITAL Provider CCN: 15-0037	Peri od:	u of Form CMS-2 Worksheet E-3	
_00L		Component CCN: 15-S037	From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	pare
		Title XVIII	Subprovider -	5/29/2019 9:5 PPS	<u>/ an</u>
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and med	lical education payments)		2, 108, 250	1
00	Net IPF PPS Outlier Payments			0	2
00	Net IPF PPS ECT Payments			0	3
00	Unweighted intern and resident FTE count in the most recent c	cost report filed on or b	efore November	0.00	4
	15, 2004. (see instructions)			0.00	
01	Cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou			0.00	4
	[CFR §412. 424(d) (1) (iii) (F) (1) or (2) (see instructions)	it a temporary cap aujust	illerit under 42		
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	
	teaching program" (see instuctions)	, 3 · 3 · ··· P			
00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	
	teaching program" (see instuctions)				
00	Intern and resident count for IPF PPS medical education adjus	stment (see instructions)		0.00	
00	Average Daily Census (see instructions)			6.756164	
00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0.00000	
00 00	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0 2, 108, 250	1
00	Nursing and Allied Health Managed Care payment (see instructi	op)		2, 108, 250	1
00	Organ acquisition (DO NOT USE THIS LINE)	011)		0	1
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	1
00	Subtotal (see instructions)			2, 108, 250	
00	Primary payer payments			0	1
00	Subtotal (line 16 less line 17).			2, 108, 250	18
00	Deducti bl es			144, 648	10
00	Subtotal (line 18 minus line 19)			1, 963, 602	
00	Coinsurance			0	2
00	Subtotal (line 20 minus line 21)			1, 963, 602	
	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		0	2
00	Adjusted reimbursable bad debts (see instructions)	rusti spo)		0	2
00 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (sum of lines 22 and 24)	.ructrons)		1, 963, 602	2
00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		1, 903, 002	2
00	Other pass through costs (see instructions)			537	2
00	Outlier payments reconciliation			007	2
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	30
99	Demonstration payment adjustment amount before sequestration			0	30
00	Total amount payable to the provider (see instructions)			1, 964, 139	
01	Sequestration adjustment (see instructions)			39, 283	
02	Demonstration payment adjustment amount after sequestration			0	3
	Interim payments			1, 924, 330	
00 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 31.0	12  32  and  33		0 526	33
00	Protested amounts (nonallowable cost report items) in accorda		chanter 1	520	34
00	§115. 2	THE WELT CHUS FUD. 19-2,		0	
	TO BE COMPLETED BY CONTRACTOR				1
00	Original outlier amount from Worksheet E-3, Part II, line 2			0	50
	Outlier reconciliation adjustment amount (see instructions)			0	5
00	The rate used to calculate the Time Value of Money			0.00	52
00	Time Value of Money (see instructions)			0	53

UALUUL	ATION OF DEIMDUDSEMENT SETTIEMENT	Provider CCN: 15-0037	Pori od:	Worksheet E-3	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2018 To 12/31/2018	Part VII	pared:
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV COMPUTATION OF NET COST OF COVERED SERVICES	TCES FOR TITLES V OR X	IX SERVICES		-
1.00	Inpatient hospital/SNF/NF services		253, 389		1.00
2.00	Medical and other services		200,007	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	-	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		253, 389	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		050.000	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		253, 389	0	7.00
	Reasonable Charges				-
8.00	Routi ne servi ce charges		218, 332		8.00
9.00	Ancillary service charges		369, 344	0	1
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)		587, 676	0	12.00
12 00	CUSTOMARY CHARGES		0	0	1 1 2 0 0
13.00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for	payment for services o	n O	0	14.00
11.00	a charge basis had such payment been made in accordance with 42			0	11.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15.00
16.00	Total customary charges (see instructions)		587, 676	0	
17.00	Excess of customary charges over reasonable cost (complete only	/ifline 16 exceeds	334, 287	0	17.00
10 00	line 4) (see instructions)	if line 4 exceeds lin		0	18.00
18.00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	TI ITTIE 4 exceeds ITT	le U	0	16.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	1
21.00	Cost of covered services (enter the lesser of line 4 or line 16		253, 389	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	completed for PPS provi			
22.00	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	
24. 00 25. 00	Program capital payments Capital exception payments (see instructions)		0		24.00 25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	1
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		253, 389	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		253, 389	0	
32.00 33.00	Deducti bl es Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	-	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	253, 389	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		253, 389	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	_ 1	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		253, 389	0	
41 00	Interim payments		372, 822	0	
41.00	Palanco duo providor (program (Line 40 minus Line 41)		110 / 22	^	1 12 00
41.00 42.00 43.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance	re with CMS Pub 15-2	-119, 433 0	0	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	Period: From 01/01/2018 To 12/31/2018	Worksheet G Date/Time Pre	pare
		General Fund	Specific Purpose Fund	Endowment Fund	5/29/2019 9:5 Plant Fund	7 am
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	17, 952, 975	(	0	0	1 1.
00	Temporary investments	0	(	-	0	
00	Notes receivable	0	(	0 0	0	3.
00	Accounts receivable	15, 626, 269	(	0 0	0	
00	Other receivable	0	(		0	
00	Allowances for uncollectible notes and accounts receivable	0	(		0	
00	Inventory	31, 980, 240	(	0	0	
00 00	Prepaid expenses Other current assets	80, 683, 499			0	
00	Due from other funds	00,003,499	(	, i	0	
	Total current assets (sum of lines 1-10)	146, 242, 983	(	-	0	
00	FIXED ASSETS	110/212/700	`	,		1
. 00	Land	8, 521, 042	(	0 0	0	12
. 00	Land improvements	0	(	0 0	0	13
. 00	Accumulated depreciation	0	(	0 0	0	
00	Bui I di ngs	118, 021, 389	(	-	0	
. 00	Accumulated depreciation	-142, 546, 489	(	, ,	0	
. 00	Leasehold improvements	0		, ,	0	
. 00 . 00	Accumulated depreciation Fixed equipment	0		,	0	
	Accumulated depreciation			,	0	
	Automobiles and trucks	0	(	,	0	
	Accumul ated depreciation	0	(	o o	0	
	Major movable equipment	83, 852, 459	(	0 0	0	23
	Accumulated depreciation	0	(	0 0	0	24
	Minor equipment depreciable	0	(	0 0	0	
	Accumulated depreciation	0	(	0 0	0	
	HIT designated Assets	0	(	-	0	
	Accumulated depreciation	0	(	, i	0	
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	67, 848, 401	(		0	
. 00	OTHER ASSETS	07, 040, 401			0	1 30
. 00	Investments	0	(	0	0	31
. 00	Deposits on leases	0	(	0	0	
. 00	Due from owners/officers	0	(	0 0	0	33
. 00	Other assets	27, 549, 240	(	0 0	0	34
. 00	Total other assets (sum of lines 31-34)	27, 549, 240	(		0	
. 00	Total assets (sum of lines 11, 30, and 35)	241, 640, 624	(	00	0	36
~~	CURRENT_LIABILITIES	7 404 (07				1
. 00 . 00	Accounts payable	7, 101, 607 5, 361, 013	(		0	
	Salaries, wages, and fees payable Payroll taxes payable	5, 301, 013			0	
	Notes and Loans payable (short term)	0	(	0	0	
	Deferred income	0	(	0	0	
. 00	Accelerated payments	0				42
. 00	Due to other funds	0	(	0 0	0	43
. 00	Other current liabilities	7, 101, 754	(		0	
. 00	Total current liabilities (sum of lines 37 thru 44)	19, 564, 374	(	0 0	0	45
~~	LONG TERM LIABILITIES	0				
. 00 . 00	Mortgage payable Notes payable	0	(		0	
00	Unsecured Loans	0		, ,	0	
00	Other long term liabilities	0	(	-	0	
00	Total long term liabilities (sum of lines 46 thru 49)	0	(	0	0	
00	Total liabilities (sum of lines 45 and 50)	19, 564, 374	(	0 0	0	51
	CAPI TAL ACCOUNTS		-			
00	General fund balance	222, 076, 250				52
00	Specific purpose fund		(		l	53
00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0	0	56
. 00 . 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	"
		222, 076, 250	(	0	0	59
. 00	Total fund balances (sum of lines 52 thru 58)					

Heal th	Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet G-1 Date/Time Pre 5/29/2019 9:5	pared: 7 am
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
			0.00			5.00	
1.00	Fund balances at beginning of period	1.00	2.00 223,250,317	3.00	4.00	5.00	1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (From Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		222, 030, 317 -1, 174, 067 222, 076, 250 0 222, 076, 250			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 222, 076, 250		0 0		18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN:	15-0037		iod: m 01/01/2018 12/31/2018	Worksheet G-2 Parts I & II Date/Time Prep 5/29/2019 9:5	pared:
	Cost Center Description			Inpati ent		Outpati ent	Total	
				1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Services							
1.00	Hospi tal			6, 885, 51			6, 885, 512	1.0
2.00	SUBPROVIDER - IPF			3, 241, 67			3, 241, 674	2.0
3.00	SUBPROVIDER - IRF				0		0	3.0
4.00	SUBPROVIDER				_			4.0
5.00	Swing bed - SNF				0		0	5.0
5.00	Swing bed - NF				0		0	6.0
7.00 3.00	SKILLED NURSING FACILITY NURSING FACILITY							7.0 8.0
9.00 9.00	OTHER LONG TERM CARE							9.0
10.00	Total general inpatient care services (sum of lines 1-9)			10, 127, 18	26		10, 127, 186	
10.00	Intensi ve Care Type Inpatient Hospital Services			10, 127, 10		1	10, 127, 100	10.0
11.00	INTENSIVE CARE UNIT			11, 339, 96	57		11, 339, 967	11.0
12.00	CORONARY CARE UNIT			,, ,			, 307, 707	12.0
13.00	BURN INTENSIVE CARE UNIT							13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T							14.0
15.00	OTHER SPECIAL CARE (SPECIFY)							15.0
16.00	Total intensive care type inpatient hospital services (sum of I	i nes		11, 339, 96	57		11, 339, 967	16.0
	11-15)							
17.00	Total inpatient routine care services (sum of lines 10 and 16)			21, 467, 15	53		21, 467, 153	17.0
18.00	Ancillary services			37, 381, 46	57	231, 211, 628	268, 593, 095	18.0
19.00	Outpatient services			3, 213, 77	77	66, 015, 659	69, 229, 436	19.0
20.00	RURAL HEALTH CLINIC				0	0	0	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER				0	0	0	21.0
22.00	HOME HEALTH AGENCY					0	0	22.0
23.00	AMBULANCE SERVICES							23.0
24.00								24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)			1 000 0		2 002 005	2 005 250	25.0
26.00 27.00	HOSPI CE NRCC			1,002,35	0	2,092,995	3, 095, 350	
27.00 27.01	SELF-INSURANCE			526, 93	~	923, 565 2, 481, 573	923, 565 3, 008, 512	
27.01	DI ETARY SERVI CES			520, 93	0	2, 481, 573	15, 726	
27.02	PRO FEES			84	50	844, 128	844, 988	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 1	to Wkst		63, 592, 55		303, 585, 274	367, 177, 825	
20.00	G-3, Line 1)	to mot		00,072,00		000,000,271	007, 177, 020	20.0
	PART II - OPERATING EXPENSES					1		1
29.00	Operating expenses (per Wkst. A, column 3, line 200)					128, 611, 244		29.0
30.00	ADD (SPECIFY)				0			30.0
31.00					0			31.0
32.00					0			32.0
33.00					0			33.0
34.00					0			34.0
35.00					0			35. C
36.00	Total additions (sum of lines 30-35)					0		36.0
37.00	DEDUCT (SPECI FY)				0			37.0
38.00					0			38.0
39.00					0			39.0
40.00					0			40.0
41.00					0	_		41. C
42.00	Total deductions (sum of lines 37-41)	(+				100 (11 0)		42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42) to Wkst. G-3, line 4)	(transfe	er			128, 611, 244		43.0

Heal th	Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider C	CN: 15-0037	Peri od:	Worksheet G-3	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	arad
					10 12/31/2018	5/29/2019 9:57	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Par					367, 177, 825	1.00
2.00	Less contractual allowances and discounts o	n patients' account	ts			244, 906, 082	2.00
3.00	Net patient revenues (line 1 minus line 2)					122, 271, 743	3.00
4.00	Less total operating expenses (from Wkst. G		13)			128, 611, 244	4.00
5.00	Net income from service to patients (line 3	minus line 4)				-6, 339, 501	5.00
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					0	7.00
8.00	Revenues from telephone and other miscellan	eous communication	servi ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00						0	10.00
11.00						0	11.00
12.00						0	12.00
13.00						0	13.00
	Revenue from meals sold to employees and gu	ests				0	14.00
15.00	<b>J</b>					0	15.00
16.00	· · · · · · · · · · · · · · · · · · ·		nan patients	5		0	16.00
17.00						0	17.00
18.00						0	18.00
	Tuition (fees, sale of textbooks, uniforms,	,				0	19.00
20.00		and canteen				0	20.00
21.00						0	21.00
22.00						0	22.00
23.00						0	23.00
24.00						11, 919, 053	
24.01						-4, 377, 640	
25.00						7, 541, 413	
26.00						1, 201, 912	
27.00						2, 375, 979	
	Total other expenses (sum of line 27 and su					2, 375, 979	
29.00	Net income (or loss) for the period (line 2	6 minus line 28)				-1, 174, 067	29.00

	Financial Systems SIS OF HOSPITAL-BASED HOSPICE COSTS	HANCOCK REGIONA	L HOSPITAL Provider C	CN: 15-0037	In Lie Period:	u of Form CMS- Worksheet O	2552-1
					From 01/01/2018		
			Hospi ce CC	N: 15-1547	To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
		SALARI ES	OTHER	SUBTOTAL (co	Hospi ce I	SUBTOTAL	
				1 plus col.	2) CATIONS		
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	CAP REL COSTS-BLDG & FIXT*		0		0 0	0	1.0
2.00	CAP REL COSTS-MVBLE EQUIP*		C		0 0	0	
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		0 0	0	
4.00	ADMI NI STRATI VE & GENERAL*	194, 685	550, 814	745, 4		745, 499	
5.00	PLANT OPERATION & MAINTENANCE*	0	149, 509			149, 509	
6.00	LAUNDRY & LINEN SERVICE*	0	,		0 0	0	
7.00	HOUSEKEEPI NG*	0	351	3	51 0	351	7.0
3.00	DI ETARY*	0	5, 873			5, 873	
9.00	NURSING ADMINISTRATION*	0	0		0 0	0	
10.00	ROUTI NE MEDI CAL SUPPLI ES*	0	50, 370	50, 3	170 0	50, 370	
11.00	MEDI CAL RECORDS*	0	00,0,0	00,0	0 0	00,070	
12.00	STAFF TRANSPORTATION*	0	9, 820	9,8	20 0	9, 820	
13.00	VOLUNTEER SERVICE COORDINATION*	0	,, 020	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0	0	
14.00	PHARMACY*	0	140, 889	140, 8		0	1
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	,,		0 0	0	
16.00	OTHER GENERAL SERVICE*	0	C		0 0	0	
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	Ŭ	0		0	0	17.0
17.00	DI RECT PATI ENT CARE SERVI CE COST CENTERS					L	1
25.00	INPATIENT CARE-CONTRACTED**		0		0 0	0	25.0
26.00	PHYSI CI AN SERVI CES**	182	Ő		82 0	182	1
27.00	NURSE PRACTITIONER**	149	0		49 0	149	1
28.00	REGI STERED NURSE**	756, 049	84, 162			840, 211	1
29.00	LPN/LVN**	0	01, 102		0 0	010,211	1
30.00	PHYSICAL THERAPY**	0	C		0 0	0	
31.00	OCCUPATIONAL THERAPY**	0	0		0 0	0	
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		0 0	0	
33.00	MEDICAL SOCIAL SERVICES**	0	0		0 0	0	1
34.00	SPI RI TUAL COUNSELI NG**	0	0		0 0	0	34.0
35.00	DI ETARY COUNSELI NG**	0	C		0 0	0	
36.00	COUNSELING - OTHER**	0	0		0 0	0	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	C		0 0	0	
38.00	DURABLE MEDICAL EQUI PMENT/OXYGEN**	0	C		0 0	0	
39.00	PATIENT TRANSPORTATION**	0	25, 171		-	25, 171	
10.00	I MAGI NG SERVI CES**	0	23, 171		0 0	0	
1.00	LABS & DI AGNOSTI CS**	0	0		0 0	0	
2.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		0 0	0	
2.50	DRUGS CHARGED TO PATI ENTS**	0	0		0 0	0	
3.00	OUTPATI ENT SERVI CES**	0	0		0 0	0	
4.00	PALLIATIVE RADIATION THERAPY**	0	0		0 0	0	
14.00	PALLIATIVE CHEMOTHERAPY**	0	0		0 0	0	1
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	179, 901	0		-		
10.00	NONREI MBURSABLE COST CENTERS	177, 701	0	1/7,7		179,901	40.0
0. 00	BEREAVEMENT PROGRAM *	0	0		0 0	0	60.0
50.00 51.00	VOLUNTEER PROGRAM *	0	0		0 0	0	
2.00	FUNDRAI SI NG*	0	0		0 0	0	1
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0			0 0	0	
4.00	PALLIATIVE CARE PROGRAM*	178, 494	14, 582	193, 0	-	193, 076	
4.00 5.00	OTHER PHYSICIAN SERVICES*	170,474	14, 302	173,0	0 0	193, 078	1
6. 00	RESIDENTIAL CARE*	0	0		0 0	0	
7.00	ADVERTI SI NG*	0				0	
8.00		0	0		0 0	0	
9.00	TELEHEALTH/TELEMONI TORI NG* THRI FT STORE*	0	0		0 0	0	
	NURSING FACILITY ROOM & BOARD*	0	0		0 0	0	
0.00		0	0		0 0		
	OTHER NONREIMBURSABLE (SPECIFY)*	1 200 440	1 001 541	2 2 4 1 0		0	
UU. UL	TOTAL	1, 309, 460	1, 031, 541	2, 341, 0	-140, 889	2, 200, 112	100.

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

ANALYSIS	S OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	: 15-0037	Peri od:	Worksheet O	
			Hospi ce CCN:	15-1547	From 01/01/2018 To 12/31/2018	Date/Time P	
					Hospi ce I	5/29/2019 9	: 57 811
		ADJUSTMENTS	TOTAL (col. 5				
		(	± col. 6)				
C		6.00	7.00				_
-	ENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT*	0	0				1.
	CAP REL COSTS-BLDG & FIXT	0	0				2.
	EMPLOYEE BENEFITS DEPARTMENT*	0	0				3.
	ADMI NI STRATI VE & GENERAL*	-709	744, 790				4.
	PLANT OPERATION & MAINTENANCE*	0	149, 509				5.
	_AUNDRY & LINEN SERVICE*	0	0				6.
	HOUSEKEEPING*	0	351				7.
. 00 0	DI ETARY*	0	5, 873				8.
.00	NURSING ADMINISTRATION*	0	0				9.
0.00 F	ROUTINE MEDICAL SUPPLIES*	0	50, 370				10.
1.00 N	MEDI CAL RECORDS*	0	0				11.
	STAFF TRANSPORTATI ON*	0	9, 820				12.
	/OLUNTEER SERVICE COORDINATION*	0	0				13.
	PHARMACY*	0	0				14.
1	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0				15.
	OTHER GENERAL SERVICE*	0	0				16.
	PATIENT/RESIDENTIAL CARE SERVICES						17.
	NIRECT PATIENT CARE SERVICE COST CENTERS	0	0				25.
	PHYSICIAN SERVICES**	0	182				25.
	VURSE PRACTITIONER**	0	149				20.
	REGI STERED NURSE**	0	840, 211				27.
	_PN/LVN**	0	040,211				29.
	PHYSI CAL THERAPY**	0	0				30.
	DCCUPATIONAL THERAPY**	0	o				31.
2.00 5	SPEECH/LANGUAGE PATHOLOGY**	0	o				32.
3.00 N	MEDICAL SOCIAL SERVICES**	0	o				33.
4.00 5	SPI RI TUAL COUNSELI NG**	0	o				34.
5.00 C	DI ETARY COUNSELI NG**	0	0				35.
6.00 0	COUNSELING - OTHER**	0	0				36.
	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0				37.
	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0				38.
	PATIENT TRANSPORTATION**	0	25, 171				39.
	MAGING SERVICES**	0	0				40.
	_ABS & DI AGNOSTI CS**	0	0				41.
1	MEDICAL SUPPLIES-NON-ROUTINE**	0	0				42.
	DRUGS CHARGED TO PATI ENTS** DUTPATI ENT SERVI CES**	0	0				42.
	PALLIATIVE RADIATION THERAPY**	0	0				43.
	PALLIATIVE CHEMOTHERAPY**	0	0				44.
	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	179, 901				46.
	IONREI MBURSABLE COST CENTERS		177,701				- 10.
	BEREAVEMENT PROGRAM *	0	0				60.
	/OLUNTEER PROGRAM *	0	o				61.
	FUNDRAI SI NG*	0	0				62
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
4. OO   F	PALLIATIVE CARE PROGRAM*	0	193, 076				64
5.00 0	OTHER PHYSICIAN SERVICES*	0	o				65
	RESI DENTI AL CARE*	0	o				66
	ADVERTI SI NG*	0	0				67
	TELEHEALTH/TELEMONI TORI NG*	0	0				68
	THRI FT STORE*	0	0				69
	NURSING FACILITY ROOM & BOARD*	0	0				70
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0				71.
T 00 . OC	IUIAL	-709	2, 199, 403				100

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

ealth Financial Systems	HANCOCK REGIONAL				u of Form CMS-2	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE ROUTINE HOME	Provider CC		Peri od:	Worksheet 0-2	
CARE		Hospi ce CCN		From 01/01/2018 To 12/31/2018	Date/Time Pre	nared
			. 10 1017	10 12/01/2010	5/29/2019 9:5	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col		SUBTOTAL	
			1 + col. 2)	CATIONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED						25.00
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	
27.00 NURSE PRACTITIONER	149	0	14		149	
28. 00 REGI STERED NURSE	339, 225	37, 762	376, 98	37 0	376, 987	28.00
29.00 LPN/LVN	0	0		0 0	0	29.0
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.0
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.0
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.0
34. 00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.0
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.0
36. 00 COUNSELING - OTHER	0	0		0 0	0	36.0
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 0	0	37.0
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.0
39.00 PATIENT TRANSPORTATION	0	11, 294	11, 29	94 0	11, 294	39.0
IO. 00 I MAGI NG SERVI CES	0	0		0 0	0	40.0
1.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.0
2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.0
2.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.5
13. 00 OUTPATI ENT SERVICES	0	0		0 0	0	43.0
4.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
15. 00 PALLI ATI VE CHEMOTHERAPY	0	0		0 0	0	45.0
6.00 OTHER PATIENT CARE SERVICES (SPECIFY)	80, 718	0	80, 71	0 0	80, 718	46.00
100. 00 TOTAL *	420, 092	49,056	469, 14		469, 148	

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)			
		6.00	7.00			
	DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED			25.	00	
26.00	PHYSI CI AN SERVI CES	0	C	26.	00	
27.00	NURSE PRACTITIONER	0	149	27.	00	
28.00	REGI STERED NURSE	0	376, 987	28.	00	
29.00	LPN/LVN	0	C	29.	00	
30.00	PHYSI CAL THERAPY	0	C	30.	00	
31.00	OCCUPATIONAL THERAPY	0	C	31.	00	
32.00	SPEECH/LANGUAGE PATHOLOGY	0	C	32.	00	
33.00	MEDICAL SOCIAL SERVICES	0	C	33.	00	
34.00	SPI RI TUAL COUNSELI NG	0	C	34.	00	
35.00	DI ETARY COUNSELI NG	0	C	35.	00	
36.00	COUNSELING - OTHER	0	C	36.	00	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	C	37.	00	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	C	38.	00	
39.00	PATI ENT TRANSPORTATI ON	0	11, 294	39.	00	
40.00	I MAGI NG SERVI CES	0	C	40.	00	
41.00	LABS & DIAGNOSTICS	0	C	41.	00	
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	C	42.	00	
42.50	DRUGS CHARGED TO PATIENTS	0	C	42.	50	
43.00	OUTPATI ENT SERVICES	0	C	43.	00	
44.00	PALLIATIVE RADIATION THERAPY	0	C	44.	00	
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.	00	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	80, 718	46.	00	
100.00	TOTAL *	0	469, 148	100.	00	
* Tran	* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.					

Heal th	Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E INPATIENT	Provider C	CN: 15-0037	Peri od:	Worksheet 0-3	
RESPI T	E CARE		Hospi ce CCI	N: 15-1547	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
					Hospi ce I		_
		SALARI ES	OTHER	SUBTOTAL (col	. RECLASSI FI -	SUBTOTAL	
				1 + col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
26.00	PHYSI CI AN SERVI CES	137	0	1:	37 0	137	26.00
27.00	NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00	REGI STERED NURSE	313, 766	34, 928	348, 69	94 0	348, 694	28.00
29.00	LPN/LVN	0	0		0 0	0	29.00
30.00	PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00	COUNSELING - OTHER	0	0		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	10, 446	10, 44	46 0	10, 446	39.00
40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		0 0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0		0 0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	74, 660	0	74, 60	50 0	74, 660	
100.00	TOTAL *	388, 563	45, 374	433, 93	37 0	433, 937	100.00

 100.00
 TOTAL \*
 388,563

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

		ADJUSTMENTS	TOTAL (col. 5	
		( 00	± col. 6)	
	DUDENT DATIENT ANDE OFDULAE ADAT AFNTEDA	6.00	7.00	
	DI RECT PATIENT CARE SERVICE COST CENTERS	-	-	
25.00	INPATIENT CARE-CONTRACTED	0	0	
26.00	PHYSI CI AN SERVI CES	0	137	
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	348, 694	
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	10, 446	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVICES	l o	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00		o o	l o	45.00
46.00		0	74, 660	
	D TOTAL *	0	433, 937	
	nsfer the amount in column 7 to Wkst. 0-5, col	umn 1 line 52		

Health Financial Systems	HANCOCK REGIONA				u of Form CMS-	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	PICE GENERAL	Provider C	CN: 15-0037	Period: From 01/01/2018	Worksheet 0-4	
INPATIENT CARE		Hospi ce CC	N: 15-1547	To 12/31/2018	Date/Time Pre	pared:
		neepi ee ee		10 12/01/2010	5/29/2019 9:5	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col		SUBTOTAL	
			1 + col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS			1			
25.00 INPATIENT CARE-CONTRACTED		0	0	0 0	0	25.00
26.00 PHYSI CI AN SERVI CES	45	0	2	15 0	45	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28. 00 REGI STERED NURSE	103, 058	11, 472	114, 53	30 0	114, 530	
29.00 LPN/LVN	0	0	)	0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0	)	0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0	)	0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	)	0 0	0	32.00
33. 00 MEDI CAL SOCI AL SERVI CES	0	0	)	0 0	0	33.00
34. 00 SPI RI TUAL COUNSELI NG	0	0	)	0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0	)	0 0	0	35.00
36.00 COUNSELING - OTHER	0	0	)	0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0	)	0 0	0	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39. 00 PATIENT TRANSPORTATION	0	3, 431	3, 43	0	3, 431	39.00
40. 00 I MAGI NG SERVI CES	0	0	)	0 0	0	
41. 00 LABS & DI AGNOSTI CS	0	0	)	0 0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	)	0 0	0	42.00
42. 50 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	0	42.50
43. 00 OUTPATIENT SERVICES	0	0		0 0	0	43.00
44. 00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45. 00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)	24, 523	14 000	24, 52		24, 523	•
100.00 TOTAL *	127, 626	14, 903	142, 52	<u>1</u>	142, 529	1100.00

 46. 00
 OTHER PATIENT CARE SERVICES (SPECIFI)
 24, 320

 100. 00
 TOTAL \*
 127, 626

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	45	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	114, 530	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	3, 431	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	24, 523	46.00
100.00	TOTAL *	0	142, 529	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 53.		

Heal th	Financial Systems HANCOCK REGIONAL	L HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0037	Peri od:	Worksheet 0-5	
EXPENS	SES FOR ALLOCATION			From 01/01/2018		
		Hospi ce CC	N: 15-1547	To 12/31/2018		
				lleeniee	5/29/2019 9:5	/ am
	Descriptions		HOSPICE DIRE	Hospi ce I CT GENERAL	TOTAL EXPENSES	
	Descriptions		EXPENSES (se		(sum of cols.	
				EXPENSES FROM	1 + 2)	
				WKST B PART I		
				(see		
				i nstructi ons)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS		1 1100	2.00	0.00	
1.00	CAP REL COSTS-BLDG & FIXT			0 301, 411	301, 411	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 140, 335	140, 335	3.00
4.00	ADMI NI STRATI VE & GENERAL		744, 7			4.00
5.00	PLANT OPERATION & MAINTENANCE		149, 5			5.00
6.00	LAUNDRY & LINEN SERVICE			0 0		6.00
7.00	HOUSEKEEPI NG		3	51 0		7.00
8.00	DI ETARY		5,8			8.00
9.00	NURSI NG ADMI NI STRATI ON		5,0	0 106, 992		
10.00	ROUTI NE MEDI CAL SUPPLI ES		50, 3			
11.00	MEDICAL SUFFLIES		50, 5	0 1,850		11.00
12.00	STAFF TRANSPORTATION		9,8	0	9,820	
12.00	VOLUNTEER SERVICE COORDINATION		7,0	0	9, 820	13.00
13.00	PHARMACY			0 0	-	14.00
14.00	PHARMACT PHYSI CLAN ADMINI STRATI VE SERVI CES			0	0	14.00
16.00	OTHER GENERAL SERVICES			0 0	-	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES					17.00
17.00	LEVEL OF CARE		1	0	<u>ı</u> 0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE		1	0	0	50.00
51.00	HOSPICE CONTINUOUS HOME CARE		469, 1	-	469, 148	
52.00	HOSPICE INPATIENT RESPITE CARE		433, 9		433, 937	
53.00	HOSPICE GENERAL INPATIENT CARE		142, 5		142, 529	
55.00	NONREIMBURSABLE COST CENTERS		142, 3	27	142, 327	55.00
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64.00	PALLI ATI VE CARE PROGRAM		193, 0	0	193, 076	
65.00	OTHER PHYSI CI AN SERVI CES		175,0	0	0	65.00
66.00	RESI DENTI AL CARE			0	0	
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRI FT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	70.00
99.00	NEGATI VE COST CENTER			õ	0	99.00
	TOTAL		2, 199, 4	03 1, 766, 347	-	
100.00	1.0 <u>-</u>		1 2, 177, 7	1,,00,047	1 0, 700, 700	1.00.00

-	Financial Systems ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	HANCOCK REGIONA	Provider C	N. 15 0027	Period:	eu of Form CMS-2 Worksheet 0-6	
C031 F	ALEUCATION - HUSFITAL-DASED HUSFICE GENERAL	JERVICE COSTS	FIOVICEI CO	JN. 15-0037		B Part I	
			Hospi ce CCN	N: 15-1547	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
					lleoni ee l	5/29/2019 9:5	7 am
	Descriptions	TOTAL EXPENSESC			Hospice I E EMPLOYEE	SUBTOTAL	
	beschiptions	TOTAL EXILINGES	FIX	EQUI P	BENEFITS	JUDIOTAL	
				20011	DEPARTMENT		
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	301, 411	301, 411				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	140, 335	0		0 140, 335	5	3.00
4.00	ADMI NI STRATI VE & GENERAL	1, 321, 121	0		0 0	1, 321, 121	4.00
5.00	PLANT OPERATION & MAINTENANCE	670, 021	0		0 0	670, 021	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0 0	6.00
7.00	HOUSEKEEPING	351	0		0 0	351	7.00
8.00	DI ETARY	124, 789	0		0 0	124, 789	8.00
9.00	NURSING ADMINISTRATION	106, 992	0		0 0	106, 992	9.00
10.00	ROUTINE MEDICAL SUPPLIES	52, 220	0		0 0	52, 220	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	0 0	11.00
12.00	STAFF TRANSPORTATION	9, 820	0		0 0	9, 820	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0 0	13.00
14.00	PHARMACY	0	0		0 0	0 0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0 0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0 0	0 0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		0		0	0	17.00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0			(	0 0	50.00
51.00	HOSPICE ROUTINE HOME CARE	469, 148			62, 966	532, 114	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	433, 937	0		0 58, 240	492, 177	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	142, 529	301, 411		0 19, 129	463, 069	53.00
	NONREIMBURSABLE COST CENTERS	· · ·					1
60.00	BEREAVEMENT PROGRAM	0	0		0 (	0 0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0 0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0 0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0 0	63.00
64.00	PALLIATIVE CARE PROGRAM	193, 076	0		0 0	193, 076	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0 0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0 0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0 0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 (	0 0	68.00
69.00	THRI FT STORE	0	0		0 0	0 0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0 0	71.00
99.00	NEGATI VE COST CENTER	0	0		0 0		99.00
100 00	TOTAL	3, 965, 750	301, 411		0 140, 335	3, 965, 750	100 00

COST A	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	HANCOCK REGION SERVICE COSTS	Provider C			eriod: rom 01/01/2018 o 12/31/2018	u of Form CMS-: Worksheet 0-6 Part I Date/Time Pre 5/29/2019 9:5	pared:
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY &		Hospi ce I HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00		7.00	8.00	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMI NI STRATI VE & GENERAL	1, 321, 121						4.00
5.00	PLANT OPERATION & MAINTENANCE	334, 707	1, 004, 728					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	1	0			6.00
7.00	HOUSEKEEPING	175	0		-	526		7.00
8.00	DI ETARY	62, 338	0			0	187, 127	
9.00	NURSI NG ADMI NI STRATI ON	53, 448	0			0		9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	26, 086	0			0		10.00
11.00	MEDICAL RECORDS	0	0			0		11.00
12.00	STAFF TRANSPORTATION	4, 906	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0			0		13.00
14.00	PHARMACY	0	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	0	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
	LEVEL OF CARE			1		-		
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	265, 817						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	245, 867	0		0	263	73, 383	
53.00	HOSPICE GENERAL INPATIENT CARE	231, 326	1,004,728		0		113, 744	1
	NONREI MBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0	)		0		61.00
62.00	FUNDRAI SI NG	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	96, 451	0			o		64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0			0		65.00
66.00	RESI DENTI AL CARE	0	0		0	0	0	
67.00	ADVERTI SI NG	0	0		-	0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	n n			0 0		68.00
69.00	THRI FT STORE	0	0			0		69.00
	NURSING FACILITY ROOM & BOARD		-			-		70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0	о	0	
	NEGATIVE COST CENTER	0	0		0	0	0	
	TOTAL	1, 321, 121	1,004,728		0	526	187, 127	

Heal th	Financial Systems	HANCOCK REGION	AL HOSPITAL			In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL		Provi der CO Hospi ce CCI			eriod: com 01/01/2018	Worksheet 0-6 Part I Date/Time Pre 5/29/2019 9:5	pared:
					-	Hospi ce I	5/29/2019 9:5	7 am
	Descriptions	NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	ľ	STAFF FRANSPORTATION	VOLUNTEER SERVI CE COORDI NATI ON	
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMI NI STRATI VE & GENERAL							4.00
5.00	PLANT OPERATION & MAINTENANCE							5.00
6.00	LAUNDRY & LINEN SERVICE							6.00
7.00	HOUSEKEEPING							7.00
8.00	DI ETARY							8.00
9.00	NURSI NG ADMI NI STRATI ON	160, 440						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	78, 306					10.00
11.00	MEDI CAL RECORDS	0			0			11.00
12.00	STAFF TRANSPORTATION	0				14, 726		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0				0	0	13.00
14.00	PHARMACY	0				0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				0	0	15.00
16.00	OTHER GENERAL SERVICE	0				0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES							17.00
	LEVEL OF CARE			1				
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	142, 856	69, 723		0	4, 908	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	6, 896	3, 366		0	4, 909	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	10, 688	5, 217		0	4, 909	0	53.00
(0.00	NONREI MBURSABLE COST CENTERS			1				1 / 0 . 00
60.00	BEREAVEMENT PROGRAM	0				0	0	60.00
61.00	VOLUNTEER PROGRAM	0				0	0	61.00
62.00		0				0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	-	63.00
64.00 65.00	PALLIATIVE CARE PROGRAM	0				0	0	64.00
66.00	OTHER PHYSICIAN SERVICES RESIDENTIAL CARE	0				0	0	65.00 66.00
67.00	ADVERTI SI NG	0				0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0				0	0	68.00
69.00	THRIFT STORE	0				0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0				0	0	
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
	TOTAL	160, 440	78, 306		0	14, 726	-	100.00
100.00	1.0	1 100, 440	, 0, 300	1	9	, 720	0	1.00.00

OST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2018 To 12/31/2018	Worksheet 0-6 Part I Date/Time Pre 5/29/2019 9:5	epare
	Descriptions	DUADMACY					
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI VE SERVI CES	OTHER GENERA SERVI CE	AL PATI ENT/ RESI DENTI AL CARE SERVI CES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS		1				
. 00	CAP REL COSTS-BLDG & FIXT						1 1.
. 00	CAP REL COSTS-MVBLE EQUIP						2.
. 00	EMPLOYEE BENEFITS DEPARTMENT						3.
. 00	ADMI NI STRATI VE & GENERAL						4.
. 00	PLANT OPERATION & MAINTENANCE						5.
. 00	LAUNDRY & LINEN SERVICE						6.
. 00	HOUSEKEEPING						7.
. 00	DI ETARY						8.
. 00	NURSI NG ADMI NI STRATI ON						9.
0.00	ROUTINE MEDICAL SUPPLIES						10.
1.00	MEDI CAL RECORDS						11
2.00	STAFF TRANSPORTATION						12
3.00	VOLUNTEER SERVICE COORDINATION						13
4.00	PHARMACY						14
5.00	PHYSICIAN ADMINISTRATIVE SERVICES						15
6.00	OTHER GENERAL SERVICE				0		16
7.00	PATI ENT/RESI DENTI AL CARE SERVI CES				Ŭ O		17
	LEVEL OF CARE			1			
0. 00	HOSPICE CONTINUOUS HOME CARE		D C		0	(	50
1.00	HOSPICE ROUTINE HOME CARE				0	1, 015, 418	
	HOSPICE INPATIENT RESPITE CARE				0 0	826, 861	
3.00	HOSPICE GENERAL INPATIENT CARE				0 0	1, 833, 944	
0.00	NONREI MBURSABLE COST CENTERS				0	1,000,71	-
D. 00	BEREAVEMENT PROGRAM		D		0	C	0 60
1.00	VOLUNTEER PROGRAM				0	C	61
2.00	FUNDRAI SI NG				0	C	62
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		b		0	C	63
4.00	PALLIATIVE CARE PROGRAM		b		0	289, 527	64
5.00	OTHER PHYSI CLAN SERVI CES				0	C	
6.00	RESI DENTI AL CARE		ol c		0 0	C	) 66
7.00	ADVERTI SI NG		b		0	C	
8.00	TELEHEALTH/TELEMONI TORI NG		b		0	C	
9.00	THRI FT STORE		b		0	C	
0.00	NURSING FACILITY ROOM & BOARD					(	
1.00	OTHER NONREI MBURSABLE (SPECIFY)		ol c		0 0	(	
9.00	NEGATI VE COST CENTER				0 0	(	
	TOTAL				0 0	3, 965, 750	

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	HANCOCK REGIONA	Provider CC	NI 15 0027		u of Form CMS-: Worksheet 0-6	
	TICAL BASIS	SERVICE CUSIS	Provider CC	N: 15-0037	Period: From 01/01/2018	Part II	
JIAIIJ	TICAL DASIS		Hospi ce CCN	l: 15-1547	To 12/31/2018	Date/Time Pre	pared:
						5/29/2019 9:5	7 am
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & C		EMPLOYEE	RECONCI LI ATI ON		
				BENEFITS		& GENERAL	
		(SQUARE FEET) (	DULLAR VALUE)	DEPARTMENT (GROSS		(ACCUMULATED COSTS)	
				•		(0313)	
		1.00	2.00	<u>SALARI ES)</u> 3. 00	4A	4, 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	48	4.00	
1.00	CAP REL COSTS-BLDG & FLXT	317					1 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	317	0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1, 309, 46	50		3.00
4.00	ADMI NI STRATI VE & GENERAL	0	0	1,007,10	0 -1, 321, 121	2, 644, 629	
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	670, 021	5.00
5.00 5.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0,0,021	6.00
7.00	HOUSEKEEPING	0	0		0 0	351	7.00
3.00	DI ETARY	0	0		0 0	124, 789	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0 0	106, 992	•
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	0		0 0	52, 220	
11.00	MEDICAL RECORDS	0	0		0 0	02,220	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	9, 820	
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	, 020	13.00
14.00	PHARMACY	0	0		0 0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0	0	17.00
17.00	LEVEL OF CARE		0				17.00
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	1 50. 00
51.00	HOSPICE ROUTINE HOME CARE			587, 53		532, 114	
52.00	HOSPICE INPATIENT RESPITE CARE	0	О	543, 43		492, 177	
53.00	HOSPICE GENERAL INPATIENT CARE	317	o	178, 49		463, 069	
	NONREI MBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	193, 076	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.0
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.0
69.00	THRI FT STORE	0	0		0 0	0	69.0
70.00	NURSING FACILITY ROOM & BOARD				0		70.0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.0
99.00	NEGATIVE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part		0	140, 33		1, 321, 121	
	UNIT COST MULTIPLIER	950. 823344	0. 000000	0. 10717		0. 499549	I

	Financial Systems	HANCOCK REGION				eu of Form CMS-2	
	ALLOCATION - HOSPITAL-BASED HOSPICE GENEI STICAL BASIS	RAL SERVICE COSTS	Provider CO Hospice CCI		Period: From 01/01/2018 To 12/31/2018		pared:
					Hospi ce I	0/2//2017 //0	<u>, am</u>
	Cost Center Descriptions	PLANT OPERATI ON & MAI NTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET	G DI ETARY	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES	317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	, 10	00 0 153 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 396 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 17.\ 00\\ \end{array}$
50. 00 51. 00 52. 00 53. 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	0 317	0		50 60 50 93		50. 00 51. 00 52. 00 53. 00
100.00	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD OTHER NONREI MBURSABLE (SPECI FY) NEGATI VE COST CENTER D COST TO BE ALLOCATED (per Wkst. 0-6, Pa	art I) 1,004,728 3,169.488959	0 0 0 0. 000000	52	-	0 0 0 160, 440	

Heal th	Financial Systems	HANCOCK REGIONA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STICAL BASIS	RVICE COSTS	Provider CC Hospice CCI		Period: From 01/01/2018 To 12/31/2018	Worksheet 0-6 Part II Date/Time Pre 5/29/2019 9:5	pared:
				_	Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS PATI ENT DAYS)	STAFF TRANSPORTATI (MI LEAGE)	VOLUNTEER ON SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	I					
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES	1, 396	0		99 0 0 0 0 0 0 0 0	99 0 0	15.00
50.00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1, 243	0		33 0	33	
52.00	HOSPICE INPATIENT RESPITE CARE	60	0		33 0	33	1
53.00	HOSPICE GENERAL INPATIENT CARE	93	0		33 0	33	1
	NONREI MBURSABLE COST CENTERS	· · · · · ·		I			
100.0	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER ) COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	78, 306 56. 093123	0 0. 000000	, .		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00

	Financial Systems	HANCOCK REGION	NAL_HOSPITAL			u of Form CMS	-2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0037	Period: From 01/01/2018	Worksheet O- Part II	6
STATIS	TICAL BASIS		Hospi ce CC	N: 15-1547	To 12/31/2018	Date/Time Pr 5/29/2019 9:	
					Hospi ce I	5/29/2019 9.	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
	·	ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE	S		
		(PATIENT DAYS)	BASI S)	(IN-FACILIT	Y		
				DAYS)			
		15.00	16.00	17.00			
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15.00
16.00	OTHER GENERAL SERVICE		0				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE	-	_	1			1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0		53.00
(0.00	NONREI MBURSABLE COST CENTERS		0				
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00	FUNDRALSING		0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00	OTHER PHYSICIAN SERVICES		0		0		65.00
66.00	RESIDENTIAL CARE	0	0	1	0		66.00
67.00	ADVERTI SI NG		0	1			67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0	1			68.00
69.00	THRIFT STORE		0	1			69.00
70.00	NURSING FACILITY ROOM & BOARD		~		0		70.00
71.00 99.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	1	U		71.00
	NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0		0		100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000			100.00
101.00	UNIT GOST MULTIFLIER	0.000000	0.00000	U. 0000	50		101.00

Heal th	Financial Systems	HANCOCK REGIONA	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORT	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV	ICE COSTS BY	Provider C	CN: 15-0037	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCI	N: 15-1547	From 01/01/2018 To 12/31/2018		pared: 7 am
					Hospi ce I		
				Charges by	y LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C Part I, Col. 9 line	ost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS					-	
1.00	PHYSI CAL THERAPY	66.00	0. 424010		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0. 351741		0 0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0. 373664		0 0	0	3.00
3.01	OCCUPATIONAL HEALTH	68. 01	0. 000000		0 0	0	3. 01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 204593		0 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0. 128557		0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0. 537117		0 0	0	1.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00					9.00
10.00	CARDIAC	76.00	0. 000000		0 0	0	
10.01	CARDI OPULMONARY	76.01	0. 651724		0 0	0	
11.00	Totals (sum of lines 1–11)	01 1 00					11.00
		Charges by LOC (from Provider		Shared Serv	ice Costs by LOC		
		Records)					
	Cost Center Descriptions			HPHC (col 1	xHIRC (col. 1 x	HGLP (col 1 v	
	cost center bescriptions		col. 2)	col. 3)	col. 4)	col. 5)	
		5.00	6.00	7.00	8.00	9.00	
1.00	ANCI LLARY SERVI CE COST CENTERS PHYSI CAL THERAPY	0	0		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0			0	2.00
2.00	SPEECH PATHOLOGY	0	0		0 0	0	
3.00	OCCUPATIONAL HEALTH	0	0		0 0	0	
4.00	DRUGS CHARGED TO PATIENTS	0	0			0	
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	5.00
6.00	LABORATORY	0	0		0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		0		č o		8.00
9.00	RADI OLOGY-THERAPEUTI C						9.00
10.00	CARDIAC	0	0		0 0	0	•
10.00	CARDI OPULMONARY	0	0		0 0		
	Totals (sum of lines 1-11)		0		0 0		
					1		

	Financial Systems	HANCOCK REGIONAL		N 15 0007		u of Form CMS-2	
ALCULA	TION OF HOSPITAL-BASED HOSPICE PER DIEM COST	I	Provider C	JN: 15-0037	Period: From 01/01/2018	Worksheet 0-8	
			Hospi ce CCI	N: 15-1547	To 12/31/2018	Date/Time Pre	pared
						5/29/2019 9:5	
					Hospi ce I		
				TITLE XVIII	TITLE XIX	TOTAL	
				MEDI CARE	MEDI CAI D		
				1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE						
	Total cost (Wkst. 0-6, Part I, col. 18, line	e 50 plus Wkst. O-	7, col. 6,			0	1. (
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4,					0	
	Total average cost per diem (line 1 divided					0.00	
	Unduplicated program days (Wkst. S-9 col. as	s appropriate, line	e 10)		0 0		4.
	Program cost (line 3 times line 4)				0 0		5.
	HOSPICE ROUTINE HOME CARE						
	Total cost (Wkst. 0-6, Part I, col. 18, line	e 51 plus Wkst. O-	7, col. 7,			1, 015, 418	6.
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4,					1, 243	
	Total average cost per diem (line 6 divided					816. 91	8.
	Unduplicated program days (Wkst. S-9, col. a	as appropriate, lin	ne 11)	1, 2			9.
	Program cost (line 8 times line 9)			1, 015, 4	19 0		10.
	HOSPICE INPATIENT RESPITE CARE						
	Total cost (Wkst. 0-6, Part I, col. 18, line	e 52 plus Wkst. O-	7, col. 8,			826, 861	11.
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4,						12.
	Total average cost per diem (line 11 divided					13, 781. 02	
	Unduplicated program days (Wkst. S-9, col. a	as appropriate, lii	ne 12)		60 0		14.
	Program cost (line 13 times line 14)			826, 8	61 0		15.
	OSPICE GENERAL INPATIENT CARE						
	Total cost (Wkst. 0-6, Part I, col. 18, line	e 53 plus Wkst. O-	7, col. 9,			1, 833, 944	16.
	line 11)						1-
	Total unduplicated days (Wkst. S-9, col. 4,					93	
	Total average cost per diem (line 16 divided					19, 719. 83	
	Unduplicated program days (Wkst. S-9, col. a	as appropriate, lii	ne 13)		93 0		19.
	Program cost (line 18 times line 19)			1, 833, 9	44 0		20.
	TOTAL HOSPICE CARE					0 (7)	
	Total cost (sum of line 1 + line 6 + line 11					3, 676, 223	
	Total unduplicated days (Wkst. S-9, col. 4,					1, 396	
3.00 /	Average cost per diem (line 21 divided by li	ne 22)				2, 633. 40	23.

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0037	Period: From 01/01/2018 To 12/31/2018		
· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS	/ alli
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
00 Capital DRG other than outlier			583, 560	1. (
01 Model 4 BPCI Capital DRG other than outlier			0	
00 Capital DRG outlier payments			889	2.
01 Model 4 BPCI Capital DRG outlier payments			0	2.
00 Total inpatient days divided by number of days in the c	ost reporting period (see inst	ructions)	22. 78	3.
00 Number of interns & residents (see instructions)			0.00	4.
00 Indirect medical education percentage (see instructions	)		0.00	5.
00 Indirect medical education adjustment (multiply line 5	by the sum of lines 1 and 1.01	, columns 1 and	0	6.
1.01) (see instructions)				
00 Percentage of SSI recipient patient days to Medicare Pa	rt A patient days (Worksheet E	, part A line	0.00	7.
30) (see instructions)				
00 Percentage of Medicaid patient days to total days (see	instructions)		0.00	
00 Sum of lines 7 and 8			0.00	
.00 Allowable disproportionate share percentage (see instru	ctions)		0.00	10.
.00 Disproportionate share adjustment (see instructions)			0	
.00 Total prospective capital payments (see instructions)			584, 449	12.
			1.00	
PART II – PAYMENT UNDER REASONABLE COST				
00 Program inpatient routine capital cost (see instruction	·		0	1.
00 Program inpatient ancillary capital cost (see instructi			0	2.
00 Total inpatient program capital cost (line 1 plus line	2)		0	3.
00 Capital cost payment factor (see instructions)			0	4.
00 Total inpatient program capital cost (line 3 x line 4)			0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
00 Program inpatient capital costs (see instructions)			0	1.
00 Program inpatient capital costs for extraordinary circu	mstances (see instructions)		0	2.
00 Net program inpatient capital costs (line 1 minus line			0	3.
00 Applicable exception percentage (see instructions)	2)		0.00	4.
00 Capital cost for comparison to payments (line 3 x line	4)		0.00	
00 Percentage adjustment for extraordinary circumstances (			0.00	
00 Adjustment to capital minimum payment level for extraor		line 6)	0	7.
00 Capital minimum payment level (line 5 plus line 7)			0	
00 Current year capital payments (from Part I, line 12, as	applicable)		0	
.00 Current year comparison of capital minimum payment leve		less line 9)	0	
.00 Carryover of accumulated capital minimum payment level		,	0	
Worksheet L, Part III, line 14)		J		
	tal payments (line 10 plus lin	e 11)	0	12.
			Ő	
.00 Net comparison of capital minimum payment level to capi	enter the amount on this line			
.00 Net comparison of capital minimum payment level to capi .00 Current year exception payment (if line 12 is positive,			0	14.
<ul> <li>.00 Net comparison of capital minimum payment level to capi</li> <li>.00 Current year exception payment (if line 12 is positive,</li> <li>.00 Carryover of accumulated capital minimum payment level</li> </ul>	over capital payment for the f		0	14.
.00 Net comparison of capital minimum payment level to capi	over capital payment for the f		0	
<ul> <li>Net comparison of capital minimum payment level to capi</li> <li>Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line)</li> </ul>	over capital payment for the f ee instructions)		-	15.

неагтп	Financial Systems	HANCOCK REGION	IAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0037	Peri od:	Worksheet M-1	
			Component (	CCN: 15-3987	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 9:5	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Reclassi fied	
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS				-		
1.00	Physi ci an	0	0		0 0		1.00
2.00	Physician Assistant	0	0		0 0		2.00
3.00	Nurse Practitioner	87, 845	0	87, 84	45 0	87, 845	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	0	0		0 0	0	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	8, 693	0	8, 6	93 0	8, 693	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	59, 965	0	59, 9	55 0	59, 965	9.00
10.00	Subtotal (sum of lines 1 through 9)	156, 503	0	156, 50	03 0	156, 503	10.00
11.00	Physician Services Under Agreement	0	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	0		0 0	0	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0 0	
19.00	Other Health Care Costs	0	0		0 0	0	19.00
	Allowable GME Costs	U U	0		0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		0	0	
22.00	Total Cost of Health Care Services (sum of	156, 503	0	156, 50	03 0	-	
22.00	lines 10, 14, and 21)	150, 505	0	150, 50	55 0	100, 000	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	28, 988	28, 9	-28, 988	0	23.00
24.00	Dental	0	0		0 0		24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 0	0	
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs	Ū	0		0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	28, 988	28, 9	-28, 988	0	
20100	through 27)	Ū	20, 700	201 /	20,700		20.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0			0 0	0	29.00
30.00	Admi ni strati ve Costs	72,646	182, 359	255, 00			
31.00	Total Facility Overhead (sum of lines 29 and	72,646	182, 359				1
	30)	, 2, 310		200,0	Ŭ I	200,000	
32.00	Total facility costs (sum of lines 22, 28	229, 149	211, 347	440, 4	-28, 988	411, 508	32.00

Heal th	Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0037	Peri od:	Worksheet M-1	
			Component (	CCN: 15-3987	From 01/01/2018 To 12/31/2018	Date/Time Pre	
					RHC I	5/29/2019 9:5 Cost	
		Adjustments	Net Expenses		KIIC I	0031	
			for Allocation				
			(col. 5 + col.				
		ľ	6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	87, 845	1			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	8, 693				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	59, 965				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	156, 503				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
15.00 16.00	Medical Supplies 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, 503				22.00
22.00	lines 10, 14, and 21)	0	100,000				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	LI					1
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	0				25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
	through 27)						1
~~ ~~	FACILITY OVERHEAD						
29.00	Facility Costs	0	0				29.00
30.00	Administrative Costs	-2, 988	252, 017				30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2, 988	252, 017				31.00
32.00	Total facility costs (sum of lines 22, 28	-2, 988	408, 520				32.00
JZ. UU	and 31)	-2, 900	400, 320				32.00
		I I		1			1

	Financial Systems	HANCOCK REGIO	NAL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period:	Worksheet M-2	
			Component (		From 01/01/2018 To 12/31/2018		narod
			component	JON: 13-3707	10 12/31/2010	5/29/2019 9:5	
			_		RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)			
		1.00	0.00	0.00	3)	4	
	VI SI TS AND PRODUCTI VI TY	1.00	2.00	3.00	4.00	5.00	
	Positions						
1.00	Physi ci an	0.00	0	4, 20	0 0		1.00
2.00	Physician Assistant	0.00			0 0		2.00
3.00	Nurse Practitioner	0.86					3.00
4.00	Subtotal (sum of lines 1 through 3)	0.86			1,806		4.00
5.00	Visiting Nurse	0.00			1,000	0,201	5.00
5.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	0.86	3, 204			3, 204	8.00
	through 7)		_				
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE					1.00	
	Total costs of health care services (from V			VIGES		156, 503	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1						10.00
	Cost of all services (excluding overhead) (					156, 503	
13.00	Ratio of hospital-based RHC/FQHC services (					1,000000	
14.00							
15.00							14.00 15.00
16.00	Total overhead (sum of lines 14 and 15)	<b>J</b> .				355, 710	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					355, 710	
	Overhead applicable to hospital-based RHC/F					355, 710	
20.00	Total allowable cost of hospital-based RHC/	/FQHC services (s	sum of lines 10	and 19)		512, 213	20.00

2VI CES		From 01/01/2018		
	Component CCN: 15-3987	To 12/31/2018	Date/Time Prep	
	Title XVIII	RHC I	5/29/2019 9:57 Cost	/ am
			COST	
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		I		
0 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		512, 213	1. (
00 Cost of vaccines and their administration (from Wkst. M-4, li			28, 801	2.0
10 Total allowable cost excluding vaccine (line 1 minus line 2)			483, 412	
00 Total Visits (from Wkst. M-2, column 5, line 8)			3, 204	
0 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
0  Total adjusted visits (line 4 plus line 5) 0  Adjusted cost per visit (line 3 divided by line 6)			3, 204 150. 88	
O Adjusted cost per visit (The 3 divided by The 6)		Cal cul ati on o		/.
		Prior to Jan.	On or After	
		1 (Rate Period	Jan. 1 (Rate	
		1)	Period 2)	
		1.00	2.00	
0  Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 0  Rate for Program covered visits (see instructions)	0.6 or your contractor)	82.30	83.45	
0 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		82.30	83.45	9.
00 Program covered visits excluding mental health services (from	m contractor records)	0	243	10.
00 Program cost excluding costs for mental health services (Ind	-	0	20, 278	
00 Program covered visits for mental health services (from conti		0	20, 2,0	1
00 Program covered cost from mental health services (line 9 x li		0	0	13.
00 Limit adjustment for mental health services (see instructions		0	0	14.
00 Graduate Medical Education Pass Through Cost (see instruction	ns)			15.
00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	20, 278	
01 Total program charges (see instructions) (from contractor's re			30, 633	
02 Total program preventive charges (see instructions) (from prov			973	
03 Total program preventive costs ((line 16.02/line 16.01) times 04 Total Program non-preventive costs ((line 16 minus lines 16.0			644 14, 093	
(Titles V and XIX see instructions.)	US and TO) trilles . OU)		14, 073	10.
05 Total program cost (see instructions)		0	14, 737	16.
00 Primary payer amounts			0	
00 Less: Beneficiary deductible for RHC only (see instructions)	) (from contractor		2, 018	18.
records)				
00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		5, 528	19.
records)			14 707	0
00 Net Medicare cost excluding vaccines (see instructions) 00 Program cost of vaccines and their administration (from Wkst.	M 4 Lipo 14)		14, 737 11, 810	
00 Total reimbursable Program cost (line 20 plus line 21)	. M-4, THE TO)		26, 547	
00 Allowable bad debts (see instructions)			20, 347	
01 Adjusted reimbursable bad debts (see instructions)			ō	
00 Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	24.
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.
50 Pioneer ACO demonstration payment adjustment (see instruction			0	
99 Demonstration payment adjustment amount before sequestration			0	
00 Net reimbursable amount (see instructions)			26, 547	
<ul><li>01 Sequestration adjustment (see instructions)</li><li>02 Demonstration payment adjustment amount after sequestration</li></ul>			531 0	
00 Interim payments			14, 271	
00 Tentative settlement (for contractor use only)			14, 271	1
	. 02, 27, and 28)		11, 745	
00 Balance due component/program (line 26 minus lines 26.01, 26.				1

Heal th	Financial Systems HANCOCK REGIONAL	HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0037	Peri od:		Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-3987		1/01/2018 2/31/2018	Date/Time Prep 5/29/2019 9:5	
		Title XVIII	RH	IC I	Cost	
				nococcal	I nfl uenza	
			1	1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)			156, 503	156, 503	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot		9	0.000803	0. 010238	
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,		126	1, 602	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f			3, 127	3, 945	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu			3, 253	5, 547	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22	)	156, 503	156, 503	6.00
7.00	Total overhead (from Wkst. M-2, line 19)			355, 710	355, 710	
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5		0. 020786	0. 035443	8.00
	divided by line 6)					
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x			7, 394	12, 607	
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of		10, 647	18, 154	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)		20	225	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)		532.35	80.68	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin beneficiaries	istered to Program		9	87	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration		4, 791	7, 019	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3				28, 801	15.00
16. 00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)			11, 810	16. 00

Health Financial Systems HANCOCK REGION	NAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-0037	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-3987	From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 9:57	
		RHC I	Cost	
			t B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC			14, 271	1.00
2.00 Interim payments payable on individual bills, either submit			0	2.00
the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. It none, write			
3.00 List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
revision of the interim rate for the cost reporting period.				5.00
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3.01			0	3. 01
3. 02			0	3. 02
3. 03			0	3. 03
3.04			0	3.04
3. 05			0	3.05
Provider to Program			-	
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3. 53 3. 54			0	3.53 3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	08)		0	3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trans			14, 271	4.00
27)			,	
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after des	sk review. Also show date o	f		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
5.01			0	5.01
5. 02 5. 03			0	5.02 5.03
Provider to Program			0	5.03
5. 50			0	5, 50
5.51			0	5.50
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.99
6.00 Determined net settlement amount (balance due) based on the	·		-	6.00
6.01 SETTLEMENT TO PROVIDER			11, 745	6.01
6.02 SETTLEMENT TO PROGRAM			0	6. 02
7.00 Total Medicare program liability (see instructions)			26, 016	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	0.00
8.00 Name of Contractor	l			8.00