icai tii i i iiaiici a	ai Systems	TIANCOCK INLUTIONAL	HUSHTAL		III LI C	I OI I OI III CIVIS	-2332-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fai	Ture to report ca	an resul	t in all interim	FORM APPROVE	D
payments made	since the beginning of the cos-	t reporting period being	deemed overpayme	ents (42	2 USC 1395g).	OMB NO. 0938	3-0050
						EXPIRES 05-3	31-2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX COS	ST REPORT CERTIFICATION	Provi der CCN: 15-		Peri od:	Worksheet S	
AND SETTLEMENT	SUMMARY				From 01/01/2016		
					To 12/31/2016	Date/Time Pr 5/16/2017 10	
						5/16/2017 10): 23 am
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically filed co	ost report			Date: 5/16/20	17 Time:	10:23 am
use only	2. [] Manually submitted cos	t report					
	3. [0] If this is an amended	report enter the number	of times the prov	vider re	esubmitted this d	ost report	
	4. [F] Medicare Utilization.	Enter "F" for full or "L	." for low.			·	
Contractor	5. [1]Cost Report Status 6	. Date Received:		10. NF	PR Date:		
use only	(1) Ås Submitted 7	. Contractor No.		11. Cc	ontractor's Vendo	or Code:	4
	(2) Settled without Audit 8	. [N] Initial Report fo	r this Provider C	CCN 12. [0]If line 5, co	olumn 1 is 4:	Enter
	(3) Settled with Audit	.[N]Final Report for	this Provider CCN	V	number of tim		
	(4) Reopened						
	(5) Amended						

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANCOCK REGIONAL HOSPITAL (15-0037) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	Officer or	Admi ni strator	of Drovidor(c)
		Admir in Strator	of Provider(S)
T: 11			
Title			

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	60, 810	52, 803	0	6, 860	1.00
2.00	Subprovi der - IPF	0	498	0		0	2.00
3.00	Subprovi der - 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		6, 906		0	10.00
200.00	Total	0	61, 308	59, 709	0	6, 860	200.00

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.

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0037 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/16/2017 10:17 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: . 10 NORTH STATE STREET 1.00 PO Box: 1.00 State: IN 2.00 City: GREENFIELD Zi p Code: 46140-County: HANCOCK 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal HANCOCK REGIONAL 150037 26900 07/01/1966 Ν Р 0 3.00 1 HOSPI TAI Subprovi der - IPF HANCOCK REGIONAL GERO 4.00 15S037 26900 4 12/01/1996 Ν Ρ Ν 4.00 PSYCH UNIT 5 00 Subprovi der - IRF 5 00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospital -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 Hospital -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce HANCOCK REGIONAL 151547 26900 02/02/1996 14.00 14.00 HOSPI CE 15.00 Hospital -Based Health Clinic - RHC KNI GHTSTOWN RURAL 153987 26900 09/22/1998 N 0 Ν 15.00 HEALTH Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2016 12/31/2016 20.00 Type of Control (see instructions) 21.00 9 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22 01 22 01 Υ period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes 22.02 22.02 Ν Ν or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the

23.00	will cit like thou is used to determine mean card days on i	11103 24 0110	17 OI 23 DCI	OW: III COIG		9	14	23.00
	1, enter 1 if date of admission, 2 if census days, o	r 3 if date	of discha	rge. Is the				
	method of identifying the days in this cost reportin	g period di	fferent from	om the meth	od			
	used in the prior cost reporting period? In column	2, enter "Y	" for yes	or "N" for	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	el i gi bl e		, and the second	
			days		unpai d			
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
24. 00	If this provider is an IPPS hospital, enter the	39	889	0	0	400	0	24.00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
	,	'		'		'		'

Ν

23.00

cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with

Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column

42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23 00

Health Financial Systems HANCOCK F	REGI ONAL I	HOSPI TAL			In Lieu	of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provi der CC	CN: 15-0037	Period: From 01/0			eet S-2	
						Date/T	ime Pre 017 10:	
	In-State	In-State	Out-of	Out-of	Medi ca	id C	ther	17 4111
	Medicaid aid days	Medicaid eligible	State Medicaid	State Medi cai d	HMO da	·	di cai d days	
		unpai d days	paid days	el i gi bl e unpai d				
	1.00	2. 00	3. 00	4. 00	5. 00		5. 00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	0	0	0	0		0		25. 00
Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state								
Medicaid eligible unpaid days in column 4, Medicaid								
HMO paid and eligible but unpaid days in column 5.				Urban/R	Rural S	Date of	Geogr	
26.00 Enter your standard geographic classification (not wag	, ctatus	at the be	ainnina of	1.			00	26. 00
cost reporting period. Enter "1" for urban or "2" for	rural.		•		'			
27.00 Enter your standard geographic classification (not wag reporting period. Enter in column 1, "1" for urban or	ge) status "2" for r	s at the en cural. If a	d of the co pplicable,	st	1			27. 00
enter the effective date of the geographic reclassific 35.00 If this is a sole community hospital (SCH), enter the	cation in	column 2.		n	0			35. 00
effect in the cost reporting period.	Tulliber of	perrous s	CH Status I					35.00
				Begi n		Endi 2.		
36.00 Enter applicable beginning and ending dates of SCH sta of periods in excess of one and enter subsequent dates		script line	36 for num					36. 00
37.00 If this is a Medicare dependent hospital (MDH), enter		er of perio	ds MDH stat	us	0			37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the	e MDH tran	nsitional p	ayment in	N	ı			37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)	yes or '	'N" for no.	(see					
38.00 If line 37 is 1, enter the beginning and ending dates								38. 00
greater than 1, subscript this line for the number of enter subsequent dates.	peri ods i	n excess o	f one and					
				Y/		Y, 2.		
39.00 Does this facility qualify for the inpatient hospital				ume Y				39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(ii) or "N" for no. Does the facility meet the mileage requ								
CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes o 40.00 Is this hospital subject to the HAC program reduction						1	J	40. 00
"N" for no in column 1, for discharges prior to Octobe	er 1. Ente	er "Y" for					•	10.00
no in column 2, for discharges on or after October 1.	(see ms	tructrons)			V	XVIII		
Prospective Payment System (PPS)-Capital					1.00	2.00	3. 00	
45.00 Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions)	for disp	proporti ona	te share in	accordance	N	N	N	45. 00
46.00 Is this facility eligible for additional payment excep					N	N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III.	L, Pt. I	II and Wks	t. L-1, Pt.	I through				
47.00 Is this a new hospital under 42 CFR §412.300 PPS capit 48.00 Is the facility electing full federal capital payment?		,			N N	N N	N N	47. 00 48. 00
Teaching Hospitals						1	14	
56.00 Is this a hospital involved in training residents in a or "N" for no.	ipproved (GME program	s? Enter "	Y" for yes	N			56.00
57.00 If line 56 is yes, is this the first cost reporting pe GME programs trained at this facility? Enter "Y" for					1			57.00
is "Y" did residents start training in the first month	of this	cost repor	ting period	? Enter "\				
for yes or "N" for no in column 2. If column 2 is "Y" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II,			T E-4. IT C	olumn 2 IS				
58.00 If line 56 is yes, did this facility elect cost reimbu defined in CMS Pub. 15-1, chapter 21, §2148? If yes, c			ans' servic	es as	N			58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes,	complete	e Wkst. D-2			N			59.00
60.00 Are you claiming nursing school and/or allied health c provider-operated criteria under §413.85? Enter "Y" f					Y			60.00
	Y/N	IME	Direct GM	IE IN	IE	Di rec	t GME	
	1. 00	2. 00	3. 00	4.		5.		41.00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in					0. 00		U. UC	61.00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care		0. 00		0. 00				61. 01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								
instructions)								

Health Financial Systems HANCOCK HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AL HOSPITAL Provider CO		eri od:	u of Form CMS-2 Worksheet S-2	
			F	rom 01/01/2016 o 12/31/2016	Part I Date/Time Pre 5/16/2017 10:	pared: 17 am
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2. 00	3. 00	4. 00	5. 00	
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0. 00	0.00			61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0. 00	0.00			61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0. 00	0.00			61.06
	Program Name Program Code Unweigl				Unweighted Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4. 00	61, 10
for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 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 and enter in column 4, direct GME FTE unweighted count.				0.00	0. 00	61. 20
			(UDOA)		1. 00	
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital				iod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruction of the first point of the first	a Teach gram. (:	<u>see instructio</u>	ter (THC) into ns)	your hospital	0. 00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se	ettings	during this c		period? Enter	N	63.00
"Y" for yes or "N" for no in column 1. If yes, comple	ete lin	es 64-67. (see	instructions) Unweighted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTES in Hospital	1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	nnrovi	der Settings	1.00 This base year	2.00	3.00 reporting	
period that begins on or after July 1, 2009 and befor 64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor	0.00		64. 00			
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	all nom d nom-p n colum	nprovider rimary care n 3 the ratio				
Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2. 00	3.00	4. 00	5. 00	

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0037 Peri od: Worksheet S-2 From 01/01/2016 Part I 12/31/2016 Date/Time Prepared: 5/16/2017 10:17 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?	Y			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most	N	N	0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.				
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75.00
subprovi der? Enter "Y" for yes and "N" for no.				

Higher Tall, AND MOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CON: 15-003 Perform (0.17/31/2016) From (0.17/31/2016) From (0.17/31/2016) Dentify Time Provider CON: 15-003 Perform (0.17/31/2016)		Financial Systems HANCOCK REGION	IAL_HOSPI TAL		1	n Li eu	u of For	m CMS-	2552-10
76. 00 F Fine 75 yes. Column 1: Did the facility have an approved GWF teaching program in the most recent cost reporting period ending on or before November 15, 2004? Inter """ for yes or "N" for no. Column 2: Bid this facility train residents in a new teaching program in accordance with 42 GFR 412.424 (c)(1)(11)(0)? Enter "" for yes or "N" for no. Column 3: If column 2 is Y; Indicate which program year beginn during this costs reporting period. (see Instructions) Long Term Care Hospital PPS 80.00 is this a long term care hospital (100)? Enter "" for yes and "N" for no. Column 3: If column 2 is Y; Indicate with program year beginn during this costs reporting period. (see Instructions) 85.00 is this a long term care hospital without nother hospital for part or all of the cost reporting period? Enter "N" for yes or "	10SPI TAI	L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-0037		/2016		et S-2	2
70.00 If Title 75 yes. Column 1: Bid the facility have an approved DE teaching program in the most of the count cost event implant and use in many of the New Progress of the count cost event implant and the column of the New Progress of the Column 1: If the column 2 is yes. If the column 3 i								me Pre	epared:
76.00 If 11ne 75 yes. Column 1: Did the facility have an approved GME teaching program in the most necrot reporting period ending on or before Movember 15, 2009? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.44 (d) (1) (1) (1) (D)? Enter "Y" for yes or "N" for no. Out um 2: Is Y. A. (1) (1) (1) (1) (D)? Enter "Y" for yes or "N" for no. Out out 7: Is Y. (1) (1) (1) (D)? Enter "Y" for yes or "N" for no. Out 15 this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Out 15 this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "N" for yes and "N" for no. 85.00 Is this a new hospital under 42 CFR Section 5413.40(f)(1)(1) TEFRA? Enter "Y" for yes or "N" for no. 85.00 Is this facility teaching the form of the cost reporting period? Enter "N" for yes and "N" for no. 87.00 Is this facility stable ause (II)" LTCH classified under section 1886(d)(1)(8)(iv)(II)? Enter "Y" N						_	5/16/20)17 10:	17 am
75.00 If I line 75 yes. Column 1: Did the facility have an approved GME teaching program in the most reporting period ending on or before Movember 15, 2004? Enter "Y" For yos or "N" For no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 GFR 412.44 (c) (1) (till) (0)? Enter "Y" For yes or "N" For no. Column 3: Feel Jumn 2: 15 Y.						1 00	2 00	2 00	-
recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d) (1) (iii) (D)? Enter "Y" for yes or "N" for no. Column 3: If column 2: 3 Y. Indicate which programs year begind unique this cost reporting period. (see instructions) long Item Care Hospital PS	76 00 1	f line 75 yes: Column 1: Did the facility have an approved	CME teaching	program in t	he most				76.00
no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CRF 42 (d) (1) (III) (D)P Enter "" for yes or "N" for no. Oolumn 3: If column 2: If so, the program year began during this cost reporting period. (see instructions) 1.00 1.						1	"	0	70.00
CFR 412.424 (d)(1)(11)(1)(0)? Enter "Y" for yes or "N" for no. Column 3: If column 2:15 Y, indicate which program year began during this cost reporting period (see instructions)									
Long Term Care Hospital PPS 1.00 Long Term Care Hospital PPS N N To for no. Long Term Care Hospital PPS N N To for no. Long Term Care Hospital PPS N N Long Term Care Hospital PPS N N Long Term Care Hospital PPS N N Long Term Care Hospital PPS Long Term Care PPS N N N N Long Term Care Hospital PPS Long Term Care PPS N N N N Long Term Care Hospital PPS Long Term Care PPS Long Te									
Long Term Care Hospital PPS	<u>i</u>	ndicate which program year began during this cost reporting	g period. (see	e instruction	ıs)				
Long Term Care Hospital PPS									1
83.00 is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. "Y" for yes and "N"							1. (00	
81.00 S. this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. IEFRA Providers N		5	"N"						00.00
Title Providers State St					na noni od?	Fn+on			80.00
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training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. 117.00 Is this facility legally-required to carry mal practice insurance? Enter "Y" for yes or "N"			t roimburcomor	at for LOD	N				107.00
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reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 116.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for ye		3 1 3	•	,					
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 In the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 N is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. No list this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for			,	9					
Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 N 1.00 N 1.00 N 1.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 N is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, \$2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Y			CRNA fee sche	edul e? See 4	2 N				108.00
1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	C	FR Section §412.113(c). Enter "Y" for yes or "N" for no.							
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 116.00 Is this facility legally-required to carry mal practice insurance? Enter "Y" for yes or "N" for y									-
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no. N	100 001	f this hasnital qualifies as a CAU as a seat assistant and				J			100.00
for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no. N			IN	l N	l N		"	ı	109.00
1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no. N									
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information		z. , zz z is is is said that apy.		1					
the current cost reporting period? Enter "Y" for yes or "N" for no. 1.00 2.00 3.00							1. (00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 117.00 Is this facility legally-required to carry mal practice insurance? Enter "Y" for yes or "N" for Y				on project (410A Demo)f	or	N	I	110.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 N is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Y	t	he current cost reporting period? Enter "Y" for yes or "N"	for no.						
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 N is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Y						1) 0.55	0.05	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1	18.4	Good Language Cost Donorting Information				1.00	2.00	3.00	
is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for		T J	r "N" for no i	n column 1	If column 1	T N	1	0	115. 00
3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for								"	1113.00
psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Y									
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. N N 117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Y									
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Y	P	ub. 15-1, chapter 22, §2208.1.	•						
									116.00
		3 0 3 .	rance? Enter "	'Y" for yes o	or "N" for	Y			117. 00
no.	1		Havo F-4 : 1	1 6 4 6 -		_			110 00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is 2			nicy? Enter 1	ir the polic	y is	2			118. 00
claim-made. Enter 2 if the policy is occurrence.	lC	ranii-iiiaue. Enter 2 ff the porfey IS occurrence.				I	I	I	I

Health Financial Systems HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CM	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Peri od:	Worksheet S	
			From 01/01/2016 Fo 12/31/2016	Date/Time I	Prepared:
		Donas di coma	1	5/16/2017	10: 17 am
		Premiums	Losses	Insurance	
		1 00	2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 488, 20	2.00	3.00	0118.01
118.02 Are mal practice premiums and paid losses reported in a cost of		*b *b	1. 00 N	2. 00	110.00
Administrative and General? If yes, submit supporting schedu			IN IN		118. 02
and amounts contained therein.	3				
119.00 DO NOT USE THIS LINE	Harml ood nro	vicion in ACA	N	N.	119. 00 120. 00
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in			IN IN	N	120.00
"N" for no. Is this a rural hospital with < 100 beds that qua	lifies for t	he Outpatient			
Hold Harmless provision in ACA §3121 and applicable amendment	s? (see inst	ructions)			
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost implan	itable device	s charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no.		· ·			1200
122.00 Does the cost report contain state health or similar taxes? E			N		122. 00
for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.	worksneet A	Tine number			
Transplant Center Information				l	
125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, ent	er the certi	fication date			126. 00
in column 1 and termination date, if applicable, in column 2.		dati di data			1.20.00
127.00 f this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2.	r the certif	ication date			127. 00
128.00 If this is a Medicare certified liver transplant center, ente		ication date			128. 00
in column 1 and termination date, if applicable, in column 2.					
129.00 f this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	the certifi	cation date i	n		129. 00
130.00 If this is a Medicare certified pancreas transplant center, e	nter the cer	ti fi cati on			130. 00
date in column 1 and termination date, if applicable, in colu					
131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu		ertification			131. 00
132.00 If this is a Medicare certified islet transplant center, ente		ication date			132. 00
in column 1 and termination date, if applicable, in column 2.					100.00
133.00 f this is a Medicare certified other transplant center, ente in column 1 and termination date, if applicable, in column 2.		ication date			133. 00
134.00 If this is an organ procurement organization (0P0), enter the		in column 1			134.00
and termination date, if applicable, in column 2.					
All Providers 140.00 Are there any related organization or home office costs as de	fined in CMS	Pub 15_1	N	Ι	140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If y					140.00
are claimed, enter in column 2 the home office chain number.		tions)			
1.00 2.00 If this facility is part of a chain organization, enter on li		ough 143 the n	3.00	of the home	9
office and enter the home office contractor name and contract		agn 143 the n	alle and address	or the nom	
141. 00 Name: Contractor's Name:		Contracto	r's Number:		141.00
142.00 Street: PO Box: 143.00 Ci ty: State:		Zi p Code:			142. 00 143. 00
Tro. color ty.		21 p 0000.			110.00
				1.00	
144.00 Are provider based physicians' costs included in Worksheet A?				Y	144. 00
			1.00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, line 74,	are the cost	s for	N	N	145. 00
inpatient services only? Enter "Y" for yes or "N" for no in c no, does the dialysis facility include Medicare utilization f					
period? Enter "Y" for yes or "N" for no in column 2.	01 11113 0031	reporting			
146.00 Has the cost allocation methodology changed from the previous			N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15 yes, enter the approval date (mm/dd/yyyy) in column 2.	-2, chapter	4U, §4020) If			
jyos, enter the approvar date (iiiii/dd/yyyy) iii cordiiii 2.					
				1.00	
147.00Was there a change in the statistical basis? Enter "Y" for ye 148.00Was there a change in the order of allocation? Enter "Y" for				N N	147. 00 148. 00
149.00 Was there a change to the simplified cost finding method? Ent			no.	N N	149.00
·	,				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi der CC	N: 15-003	7 Per Fro To	riod: om 01/0 12/3	01/2016 31/2016	Worksheet S- Part I Date/Time Pi 5/16/2017 10	- repared:
		Part A	Part	В	Ti tl	e V	Title XIX	
		1. 00	2. 00)	3.	00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or								
155. 00 Hospi tal		N	N		N	J	N	155.00
156. 00 Subprovi der – IPF		N	N		N	J	N	156.00
157. 00 Subprovi der – IRF		N	N		N	J	N	157.00
158. 00 SUBPROVI DER								158.00
159. 00 SNF		N	N		N	J	N	159.00
160.00 HOME HEALTH AGENCY		N	N		N	J	N	160.00
161. 00 CMHC			N		N	J	N	161.00
							1. 00	-
Multicampus							1.00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more camp	uses in d	li ffere	nt CBSA	As?	N	165.00
· ·	Name	County	State	Zip C	ode	CBSA	FTE/Campus	
	0	1. 00	2.00	3.0	0	4.00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0	00 166. 00
							1. 00	
Health Information Technology (HI					Act			
167.00 s this provider a meaningful use							Y	167. 00
168.00 f this provider is a CAH (line 1 reasonable cost incurred for the			e 167 is	"Y"),	enter t	the		0168.00
168.01 If this provider is a CAH and is	not a meaningful user,	does this provide			hardsh	ni p		168. 01
exception under §413.70(a)(6)(ii) 169.00If this provider is a meaningful					") ent	ter the	9	99169. 00
transition factor. (see instructi		and 15 not a onn	(11110 100	, 13 11), 011	.01 1110	, ·	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	,				Begi n	ni ng	Endi ng	
					1. (00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and endi	ng date for the re	eporti ng		10/01	/2015	09/30/2016	170.00
					1. (00	2. 00	-
171.00 f ine 167 is "Y", does this pro	vider have any days for	individuals enrol	lled in		N		2.00	0171.00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line 2, col	I. 6? Ent		.,	•		

Health Financial Syst	ems HANCOCK REGI	ONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL	HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	2
				From 01/01/2016 To 12/31/2016	Date/Time Pre	
				Y/N	5/16/2017 10: Date	17 am
				1.00	2. 00	
	ction: Enter Y for all YES responses. Enter	N for all NO r	esponses. Ente	er all dates in	the	
mm/dd/yyyy for COMPLETED BY A						-
	ization and Operation					1
	er changed ownership immediately prior to t			N		1.00
reporting peri	od? If yes, enter the date of the change in	column 2. (see	instructions) Y/N	Date	V/I	
			1.00	2. 00	3. 00	
	er terminated participation in the Medicare		N			2.00
	column 2 the date of termination and in coll' for involuntary.	umn 3, "V" Tor				
	r involved in business transactions, includ	ling management	N			3.00
	h individuals or entities (e.g., chain home					
	ply companies) that are related to the prov cal staff, management personnel, or members					
	hrough ownership, control, or family and ot					
rel ati onshi ps?	(see instructions))/ /NI	T	D . I .	
			Y/N 1.00	Type 2. 00	3. 00	
Financial Data	and Reports		1.00	2. 00	0.00	
	e the financial statements prepared by a Co		Y	Α		4.00
	<pre>lumn 2: If yes, enter "A" for Audited, "C" iewed. Submit complete copy or enter date a</pre>					
	instructions) If no, see instructions.					
	eport total expenses and total revenues dif iled financial statements? If yes, submit r		N			5.00
those on the r	rred financial statements? If yes, submit i	econci i i a ti on.		Y/N	Legal Oper.	
				1. 00	2. 00	
	tional Activities costs claimed for nursing school? Column 2). If was is t	ho providor i	s N		6.00
	ator of the program?	i. II yes, is t	ne provider is	S IN		0.00
7.00 Are costs clai	med for Allied Health Programs? If "Y" see			Υ		7.00
	chool and/or allied health programs approve	ed and/or renewe	d during the	N		8.00
	period? If yes, see instructions. med for Interns and Residents in an approve	ed graduate medi	cal education	N		9.00
program in the	current cost report? If yes, see instructi	ons.				
	d Intern and Resident GME program initiated period? If yes, see instructions.	lor renewed in	the current	N		10.00
	irectly assigned to cost centers other than	ı I & R in an Ap	proved	N		11.00
	am on Worksheet A? If yes, see instructions		•			
					Y/N 1. 00	
Bad Debts					1.00	
	r seeking reimbursement for bad debts? If y				Y	12.00
	yes, did the provider's bad debt collectior , submit copy.	n policy change	during this co	ost reporting	N	13.00
	yes, were patient deductibles and/or co-pay	ments waived? I	f yes, see ins	structi ons.	N	14.00
Bed Complement		11				45.00
15.00 Did total beds	available change from the prior cost repor		_yes, see rnst t A		t B	15.00
		Y/N	Date	Y/N	Date	
DC OD Do+o		1.00	2.00	3. 00	4. 00	
PS&R Data 16.00 Was the cost r	eport prepared using the PS&R Report only?	l N		N		16. 00
	mn 1 or 3 is yes, enter the paid-through					
date of the PS instructions)	&R Report used in columns 2 and 4 .(see					
	eport prepared using the PS&R Report for	Υ	04/06/2017	Υ	04/06/2017	17. 00
totals and the	provider's records for allocation? If					
	1 or 3 is yes, enter the paid-through date					
	nd 4. (see instructions) 17 is yes, were adjustments made to PS&R	N		N		18. 00
Report data fo	r additional claims that have been billed					
	cluded on the PS&R Report used to file this	5				
	f yes, see instructions. 17 is yes, were adjustments made to PS&R	N		N		19.00
Report data fo	r corrections of other PS&R Report					
information?	f yes, see instructions.	1	1			I

Heal th	Financial Systems HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CM	IS-2552-10			
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0037	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S Part II	S-2 Prepared:			
		Descr	iption	Y/N	Y/N	10. 17 dill			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00			
20.00	Report data for Other? Describe the other adjustments:			IN.	IN	20.00			
	· · · · · · · · · · · · · · · · · · ·	Y/N	Date	Y/N	Date				
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3. 00 N	4. 00	21.00			
21.00	records? If yes, see instructions.	14		14		21.00			
					1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)						
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se	e instructions	•			22. 00			
23. 00	Have changes occurred in the Medicare depreciation expense			ring the cost		23.00			
	reporting period? If yes, see instructions.								
24. 00	24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions								
25. 00	5.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.								
26. 00									
27. 00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? I	f yes, submit		27. 00			
20.00	copy. Interest Expense								
28. 00	Were new loans, mortgage agreements or letters of credit eperiod? If yes, see instructions.	enterea into au	iring the cos	reporting		28. 00			
29. 00	Did the provider have a funded depreciation account and/or		ebt Service	Reserve Fund)		29. 00			
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If ye:	s, see		30.00			
31. 00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If ye:	s, see		31.00			
	instructions. Purchased Services								
32. 00	Have changes or new agreements occurred in patient care searrangements with suppliers of services? If yes, see instr		ned through c	ontractual		32. 00			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to compet	itive bidding? If		33.00			
	Provi der-Based Physi ci ans								
34. 00	,	arrangement wit	h provi der-b	ased physicians?		34.00			
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based		35.00			
	physicians during the cost reporting period? If yes, see i	nstructi ons.		V /N	Do+o				
				Y/N 1.00	<u>Date</u> 2.00				
	Home Office Costs								
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office	?		36. 00 37. 00			
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	fice different	from that o	f		38.00			
39. 00	the provider? If yes, enter in column 2 the fiscal year er	nd of the home	offi ce.			39.00			
40. 00	see instructions. If line 36 is yes, did the provider render services to the	•	,			40.00			
	instructions.	1							
		1.	00	2.0	00				
41 00	Cost Report Preparer Contact Information	TINA		41.00					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		41.00					
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LI	_C			42.00			
43. 00	preparer. Enter the telephone number and email address of the cost	317-713-7946		TSEVERS@BLUEANI	DCO. COM	43.00			
	report preparer in columns 1 and 2, respectively.								

Health Financial Systems HA	ANCOCK REGIONAL	HOSPI TAL			In Lieu	of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	TI ONNAI RE	Provi der	CCN: 15-0037	Peri From To	n 01/01/2016	Worksheet S-2 Part II Date/Time Pro 5/16/2017 10:	epared:
			3. 00				
Cost Report Preparer Contact Information			0.00				
41.00 Enter the first name, last name and the title/		IAGER					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 re	port						42.00
preparer.							
43.00 Enter the telephone number and email address o							43.00
report preparer in columns 1 and 2, respective	l y.						

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0037

					Т	o 12/31/2016	Date/Time Pre 5/16/2017 10:	
							1/P Days /	17 alli
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		37	13, 542	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
2 00	for the portion of LDP room available beds)							2 00
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4. 00	HMO I RF Subprovi der						_	4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	
6.00	Hospital Adults & Peds. Swing Bed NF			27	10 540	0.00	0	6.00
7. 00	Total Adults and Peds. (exclude observation			37	13, 542	0.00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00		24	l 8, 784	0.00	0	8.00
9. 00	CORONARY CARE UNIT	31.00		24	0, 704	0.00	U	9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY							13.00
14. 00	Total (see instructions)			61	22, 326	0.00	0	14.00
15. 00	CAH visits			01	22, 320	0.00	0	15.00
16. 00	SUBPROVI DER - I PF	40. 00		10	3, 660		0	16.00
17. 00	SUBPROVI DER - I RF	41. 00	1	0			0	17.00
18. 00	SUBPROVI DER	41.00		O	٥			18.00
19. 00	SKILLED NURSING FACILITY							19.00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101. 00					0	1
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	116. 00		7	2, 562			24.00
24. 10	HOSPICE (non-distinct part)	30.00	1		,			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
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00

Provider CCN: 15-0037

Peri od: Worksheet S-3 From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/16/2017 10:17 am

						5/16/2017 10:	17 am
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
						'	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 059	23	3, 679			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	737	1, 281				2.00
3.00	HMO IPF Subprovider	5	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 059	23	3, 679			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	2, 587	8	5, 460			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3, 646	31	9, 139	0.00	837. 35	
15.00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF	2, 739	0	3, 030			1
17. 00	SUBPROVI DER - I RF	0	0	0	0. 00	0.00	
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	1
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	894	0.00	18. 44	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	94	0	2, 159			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			1
27.00	Total (sum of lines 14-26)				0.00	876. 22	27. 00
28.00	Observation Bed Days		0	103			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			37			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	16	32			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00

Provider CCN: 15-0037

				To	12/31/2016	Date/Time Pre 5/16/2017 10:	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 179	229	2, 714	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			209	97		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1, 179	220	2, 714	
15.00	CAH visits	0.00	U	1, 179	229	2, /14	15.00
16. 00		0.00	0	209	0	231	16.00
	SUBPROVIDER - I PF	0.00	-	209	0	231	
17. 00	SUBPROVIDER - I RF	0.00	0	U	۷	U	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0.00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
		1	'	ı	Į		, , , , , ,

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION HANCOCK REGIONAL HOSPITAL Provider CCN: 15-0037

					11	0 12/31/2010	Date/lime Pre 5/16/2017 10:	
		Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200.00	40, 773, 804	О	40, 773, 804	1, 267, 453. 00	32. 17	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	О	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	О	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0 0	0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC services		103, 458	О	103, 458	4, 006. 00	25. 83	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	d		0. 00		
7. 01	Contracted interns and residents (in an approved programs)		0	O	0	0. 00	0. 00	7. 01
8. 00	Home office and/or related organization personnel	44.00	0	0	0	0.00		
9. 00 10. 00	SNF Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS	44. 00	5, 801, 218	122, 425	5, 923, 643	0. 00 187, 733. 00		9. 00 10. 00
	Contract Labor: Direct Patient Care		226, 845	0	226, 845	3, 784. 00	59. 95	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	O	0	0. 00	0. 00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		254, 473	О	254, 473	2, 215. 00	114. 89	13. 00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		0	O	0	0. 00	0. 00	14. 00
14. 01	Home office salaries		0	0	0	0. 00	0. 00	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	0. 00	
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	O	0	0. 00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		8, 845, 975	0	8, 845, 975			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		0	O	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 673, 422 0	0	1, 673, 422 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	o	0			21. 00
22. 00	Physician Part A - Administrative		0	o	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		26, 981 0	0	26, 981 0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	o o	0			25. 00
25. 50 25. 51	Home office wage-related Related orgainzation		0	0	0			25. 50 25. 51
25. 52	wage-related Home office: Physician Part A - Administrative -		0	o	0			25. 52
25. 53	wage-related Home office & Contract Physicians Part A - Teaching - wage-related		0	O	0			25. 53

From 01/01/2016 Part II Date/Time Prepared: 12/31/2016 5/16/2017 10:17 am Worksheet A Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Line Number Sal ari es Related to Reported ion of (col.2 ± col. Sal ari es Salaries in (from 3) col. 4 Worksheet A-6) 1. 00 2.00 3.00 4.00 5.00 6.00 OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 425, 773 425, 773 9, 873. 00 43, 12 26, 00 7, 180, 125 -122, 425 7, 057, 700 27.00 Administrative & General 5.00 198, 489. 00 35. 56 27.00 28.00 Administrative & General under 774, 034 774, 034 4,003.00 193. 36 28.00 contract (see inst.) 29.00 Maintenance & Repairs 0.00 29.00 6.00 0 0.00 Operation of Plant 7.00 29. 62 30.00 973, 239 0 973, 239 32, 856. 00 30.00 31.00 Laundry & Linen Service 8.00 0.00 0.00 31.00 32.00 Housekeepi ng 9.00 1,002,116 0 1,002,116 63, 052, 00 15. 89 32.00 Housekeeping under contract 33.00 0.00 0.00 33.00 (see instructions) 34.00 10.00 1, 250, 874 -812, 023 438, 851 24, 455. 00 17. 95 34.00 Di etary Dietary under contract (see 0.00 35.00 35.00 0.00 instručtions) 17. 53 36.00 Cafeteri a 11.00 0 812, 023 812, 023 46, 334. 00 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 Nursing Administration Central Services and Supply 22, 930. 00 46. 52

1,066,629

1, 497, 045

70,078

651, 124

0

0

0

0

0

-16, 592

1,066,629

1, 480, 453

651, 124

O

0

70,078

4, 244. 00

36, 184. 00

25, 770. 00

0 00

0.00

38.00

39.00

40.00

41.00

0.00 42.00

0.00 43.00

16.51

40. 91

25.27

13.00

14.00

15.00

16.00

17.00

18.00

38.00

39.00

40.00

41.00

42.00

Pharmacy

Records Li brary

Social Service

43.00 Other General Service

Medical Records & Medical

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0037	Peri od: Worksheet S-3

110311	AL WAGE TIMES THE ONWATTON			Trovider c		From 01/01/2016 To 12/31/2016		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		41, 444, 380	0	41, 444, 38	0 1, 267, 450. 00	32. 70	1.00
	instructions)							
2.00	Excluded area salaries (see		5, 801, 218	122, 425	5, 923, 64	3 187, 733. 00	31. 55	2.00
	instructions)							
3.00	Subtotal salaries (line 1		35, 643, 162	-122, 425	35, 520, 73	7 1, 079, 717. 00	32. 90	3.00
	minus line 2)							
4.00	Subtotal other wages & related		481, 318	0	481, 31	8 5, 999. 00	80. 23	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 845, 975	0	8, 845, 97	5 0.00	24. 90	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		44, 970, 455	-122, 425	44, 848, 03	0 1, 085, 716. 00	41. 31	6.00
7.00	Total overhead cost (see		14, 891, 037	-139, 017	14, 752, 02	0 468, 190. 00	31. 51	7.00
	instructions)							

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0037		Worksheet S-3
		From 01/01/2016	Part IV

	To 12/31/2016	Date/Time Pre 5/16/2017 10:	pared: 17 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 371, 433	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	5, 918	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	5, 699, 220	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	239, 315	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	135, 827	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	85, 623	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	126, 557	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	2, 777, 151	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	16, 339	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22.00	Day Care Cost and Allowances	14, 440	22. 00
23.00	Tuition Reimbursement	74, 555	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10, 546, 378	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0037	From 01/01/2016	Worksheet S-3 Part V Date/Time Prepared:

		10 12/31/2010	5/16/2017 10:	
	Cost Center Description	Contract	Benefit Cost	
		Labor		
		1. 00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1. 00	Total facility's contract labor and benefit cost	226, 845	10, 546, 378	1.00
2.00	Hospi tal	226, 845	10, 546, 378	2.00
3. 00	Subprovi der - IPF	0	0	3.00
4. 00	Subprovi der - I RF	0	0	4.00
5. 00	Subprovi der - (0ther)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6.00
7. 00	Swing Beds - NF	0	0	7.00
8. 00	Hospi tal -Based SNF			8.00
9. 00	Hospi tal -Based NF			9.00
10. 00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	
	Separately Certified ASC			12.00
13. 00	Hospi tal -Based Hospi ce	0	0	
	Hospital-Based Health Clinic RHC	0	0	
15. 00	Hospital-Based Health Clinic FQHC			15.00
	Hospi tal -Based-CMHC			16.00
	Renal Dialysis			17.00
18. 00	Other	0	0	18. 00

Health Financial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0037	Peri od: From 01/01/2016	Worksheet S-8	3
		Component	CCN: 15-3987	To 12/31/2016		
				RHC I	5/16/2017 10: Cost	17 am
				KIIC I	COST	
				1.	00	
Clinic Address and Identification 1.00 Street				224 WEST MAIN	CTDEET	1 1 00
1.00 Street		Ci	ty	State	ZIP Code	1.00
		1.	00	2. 00	3. 00	
2.00 City, State, ZIP Code, County		KNI GHTSTOWN		I N	46148	2.00
					1. 00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for	urban		0	3.00
			Gra	nt Award	Date	
Source of Federal Funds				1. 00	2. 00	
4.00 Community Health Center (Section 330(d), PHS	Act)		1	37632	07/01/2015	4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5.00
6.00 Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7.00 Appal achi an Regional Commission 8.00 Look-Alikes						7.00
9. 00 OTHER (SPECIFY)						9. 00
				1.00	0.00	
10.00 Does this facility operate as other than a h	nosnital_hased F	PHC or ENHC2 F	nter "V" for	1. 00 N	2.00	10.00
yes or "N" for no in column 1. If yes, indic						10.00
2. (Enter in subscripts of line 11 the type o						
hours.)	Sund	day	1	Monday	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3.00	4. 00	5. 00	
Facility hours of operations (1) 11.00 Clinic			08: 00	16: 00	08: 00	11.00
11.00 CITILIC			06.00	10.00	06.00	11.00
				1.00	2. 00	
12.00 Have you received an approval for an excepti				N.		12.00
13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				N	0	13.00
number of providers included in this report.						
numbers below.		·	1 5		2011	
			Prov	ider name 1.00	CCN number 2.00	
14.00 RHC/FQHC name, CCN number					2.00	14.00
	Y/N	V	XVIII	XI X	Total Visits	
15.00 Have you provided all or substantially all	1.00	2. 00	3. 00	4. 00	5. 00	15. 00
GME cost? Enter "Y" for yes or "N" for no in						13.00
column 1. If yes, enter in columns 2, 3 and						
4 the number of program visits performed by						
Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
number of total visits for this provider.						
(see instructions)		0	lntv.			
			inty 00			
2.00 City, State, ZIP Code, County	l l	HENRY				2.00
	Tuesday		esday	Thur		
	6. 00	7.00	8. 00	from 9.00	to 10.00	
Facility hours of operations (1)	0.00	7.00	0.00	7. 00	10.00	

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	}
		Component		From 01/01/2016 To 12/31/2016		nared:
		Component	CCN. 13 3707	10 12/31/2010	5/16/2017 10:	17 am
				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

Provider CCN: 15-0037	Heal th	Financial Systems		HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Hospice CN: 15-1547 To 12/31/2016 Date/Time Prepared: 5/16/2017 10:17 am	HOSPI T	AL-BASED HOSPICE IDENTIFICATION	I DATA		Provider C	CN: 15-0037			
Days Title XVIII Title XIX Title XVIII Title XIX Nursing Facility Title XIX Nursing Facility Facility Title XVIII Title XIX Nursing Facility Facility Title XIX Nursing Facility Title XVIII Title XIX Nursing Facility Title XVIII Title XIX Nursing Facility Title XVIII Title XIX Title XIX Nursing Facility Title XVIII Title XIX Title XVIII Title XIX Nursing Facility Title XVIII Title XIX Title					Hospi ce CC	N: 15-1547		Date/Time Pre	pared:
Days Title XVIII Title XIX Title XVIII Title XIX Nursing Facility Facility Facility Title XVIII Title XIX Skilled Nursing Facility Facility Facility Skilled Nursing Facility Facility Skilled Nursing Facility Skilled S							Hospi ce I		
Title XVIII									
Skilled Nursing Facility					I	1			
Nursing Facility 5)			Title XVIII	Title XIX			All Other		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015 1.00									
1.00 2.00 3.00 4.00 5.00 6.00						Facility		5)	
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015 1.00			1 00	2 00		4 00	5.00	6.00	
1.00		PART I - ENROLLMENT DAYS FOR CO					3.00	0.00	
2.00	1. 00			EIII ODO BEOTIM	The BELVILLE COLL	1			1.00
4.00									2.00
Total Hospice Days	3.00	Hospice Inpatient Respite Care							3.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015 6.00	4.00	Hospice General Inpatient Care							4.00
6.00 Number of patients receiving	5.00								5. 00
Nospice care			REPORTING PER	ODS BEGINNING	BEFORE OCTOBE	R 1, 2015			
Total number of unduplicated Continuous Care hours billable to Medicare R.00 Average Length of Stay (line 5 Jine 6) 9.00 Unduplicated census count 9.00 Unduplicated census count 9.00 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 Total (sum of cols. 1 through 3) 1.00 2.00 3.00 4.00 Total (sum of cols. 1 through 3) 1.00 2.00 3.00 4.00 Total (sum of cols. 1 through 3) 1.00 2.00 3.00 4.00 Total (sum of cols. 1 through 3) 1.00 2.00 3.00 4.00 Total (sum of cols. 1 through 3) 1.00	6. 00								6. 00
Continuous Care hour's billable to Medicare	7 00								7 00
8.00	7.00								7.00
1 1 1 2 1 2 2 2 2 2		to Medicare							
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 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 10.00 Hospice Continuous Home Care 0 0 0 0 0 10.00 11.00 Hospice Routine Home Care 6,075 71 520 6,666 11.00 12.00 Hospice Inpatient Respite Care 307 0 0 0 307 12.00 13.00 Hospice General Inpatient Care 398 0 17 415 13.00 14.00 Total Hospice Days 6,780 71 537 7,388 14.00 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 15.00	8.00								8. 00
NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4. Title XVIII					ļ				
Title XVIII									9.00
Col s. 1 through 3	NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
Name					Title XVIII	Title XIX	0ther		
1.00 2.00 3.00 4.00									
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 10.00 Hospice Continuous Home Care 0 0 0 0 0 10.00 11.00 Hospice Routine Home Care 6,075 71 520 6,666 11.00 12.00 Hospice Inpatient Respite Care 307 0 0 0 307 12.00 13.00 Hospice General Inpatient Care 398 0 17 415 13.00 14.00 Total Hospice Days 6,780 71 537 7,388 14.00 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 15.00 15.00					1.00	2.00	2.00		
10. 00 Hospi ce Conti nuous Home Care 0 0 0 0 10. 00 11. 00 Hospi ce Routi ne Home Care 6, 075 71 520 6, 666 11. 00 12. 00 Hospi ce Inpati ent Respi te Care 307 0 0 307 12. 00 13. 00 Hospi ce General Inpati ent Care 398 0 17 415 13. 00 14. 00 Total Hospi ce Days 6, 780 71 537 7, 388 14. 00 PART IV - CONTRACTED STATI STI CAL DATA FOR COST REPORTING PERI ODS BEGI NNI NG ON OR AFTER OCTOBER 1, 2015 15. 00 0 0 0 0 15. 00		DADT III ENDOLLMENT DAVS EOD	COST DEDODTING	DEDIANS DECLI				4.00	
11. 00 Hospice Routine Home Care 6, 075 71 520 6, 666 11. 00 12. 00 Hospice Inpatient Respite Care 307 0 0 307 12. 00 13. 00 Hospice General Inpatient Care 398 0 17 415 13. 00 14. 00 Total Hospice Days 6, 780 71 537 7, 388 14. 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 15. 00	10 00		COST KLFOKITIN	FERIODS BEGIN	I ON OK AI	I COUDER I	· ·	0	10 00
12. 00 Hospi ce Inpati ent Respi te Care 307 0 0 307 12. 00 13. 00 Hospi ce General Inpati ent Care 398 0 17 415 13. 00 14. 00 Total Hospi ce Days 6, 780 71 537 7, 388 14. 00 PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 15. 00 Hospi ce Inpati ent Respi te Care 0 0 0 0 15. 00					6 075			- 1	
13.00 Hospi ce General Inpatient Care 398 0 17 415 13.00 14.00 Total Hospi ce Days 6,780 71 537 7,388 14.00 PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 15.00 Hospi ce Inpatient Respite Care 0 0 0 0 15.00						l .		·	
14. 00 Total Hospice Days 6, 780 71 537 7, 388 14. 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 15. 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 15.00									
			AL DATA FOR COS	ST REPORTING PI	ERIODS BEGINNII	NG ON OR AFTE	R OCTOBER 1, 201	5	
16.00 Hospice General Inpatient Care 0 0 0 16.00					l .	l .		-	15.00
	16.00	Hospice General Inpatient Care			0		0 0	0	16. 00

Heal th	Financial Systems HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der C	CN: 15-0037	Peri od:	Worksheet S-1		
	THE STOOMS ENGINES THIS THIS GETT STILL STILL	1.00.40.		From 01/01/2016		•	
				To 12/31/2016			
					5/16/2017 10:	17 am	
	La company of the com				1. 00		
	Uncompensated and indigent care cost computation			>			
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3	divided by I	ine 202 colur	nn 8)	0. 276155	1. 00	
	Medicaid (see instructions for each line)				0 (0) (5)		
2.00	Net revenue from Medicaid				3, 606, 654	2.00	
3. 00	Did you receive DSH or supplemental payments from Medicaid?					3.00	
4. 00	If line 3 is "yes", does line 2 include all DSH or supplemen			ď?	_	4.00	
5. 00	If line 4 is "no", then enter DSH or supplemental payments f	rom Medicaid			0	5.00	
6. 00	Medi cai d charges				11, 262, 104		
7. 00	Medicaid cost (line 1 times line 6)				3, 110, 086		
8. 00	Difference between net revenue and costs for Medicaid program	m (line 7 mi	nus sum of li	nes 2 and 5; if	0	8. 00	
	< zero then enter zero)	6 1 11	`				
	Children's Health Insurance Program (CHIP) (see instructions	for each III	ne)				
9.00	Net revenue from stand-alone CHIP				0		
10.00	Stand-al one CHIP charges				0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00	
12. 00	Difference between net revenue and costs for stand-alone CHI	P (line 11 m	inus line 9;	if < zero then	0	12.00	
	enter zero)		6 1 11	`			
40.00	Other state or local government indigent care program (see in					40.00	
13.00	Net revenue from state or local indigent care program (Not in					13.00	
14. 00	Charges for patients covered under state or local indigent call	are program	(Not include	d in lines 6 or	0	14.00	
45.00	10)	4.4)				45.00	
15.00	State or local indigent care program cost (line 1 times line			45	0	15.00	
16. 00	Difference between net revenue and costs for state or local	indigent car	e program (I	ne 15 minus line	0	16. 00	
	13; if < zero then enter zero)						
17 00	Uncompensated care (see instructions for each line)	E			0	17 00	
18.00	Private grants, donations, or endowment income restricted to				0	17. 00 18. 00	
	Government grants, appropriations or transfers for support or			os (sum of lines	0		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and lo	cai indigent	care program	ns (sum of fines	U	19. 00	
	8, 12 and 16)		Uni nsured	Insured	Total (oal 1		
			patients	patients	Total (col. 1 + col. 2)		
			1.00	2. 00	3.00		
20. 00	Charity care charges for the entire facility (see instruction	ne)	4, 383, 6		4, 383, 686	20.00	
21. 00	Cost of patients approved for charity care (line 1 times line		1, 210, 5		1, 210, 577		
22. 00	Partial payment by patients approved for charity care	6 20)	1,210,3	0 0	1, 210, 377		
23. 00			1, 210, 5	-	1, 210, 577		
23.00	cost of charty care (fine 21 millios fine 22)		1,210,3	77	1, 210, 377	23.00	
					1. 00		
24. 00	Does the amount in line 20 column 2 include charges for patie	ent days hev	ond a Length	of stay limit	1.00	24. 00	
24.00	imposed on patients covered by Medicaid or other indigent ca		ond a rength	or stay rrimit		24.00	
25. 00			rogram's Len	nth of stav limit	0	25. 00	
26. 00							
27. 00	Medicare bad debts for the entire hospital complex (see inst		,		11, 862, 832 162, 133		
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense		us line 27)		11, 700, 699		
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt			ne 28)	3, 231, 207		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	cpc//sc (1111	5 1 11/1105 111	.5 20)	4, 441, 784		
	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			4, 441, 784		
	production of the first and an arrangement of the first production of the firs	55)			., , , 0 1		

Health Financial Systems	HANCOCK REGIONAL		N 45 0007 D		u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CC		eriod: rom 01/01/2016	Worksheet A	
			ļτ			pared:
	1	1			5/16/2017 10:	17 am
Cost Center Description	Sal ari es	0ther		Reclassi fi cat	Reclassified	
			+ col . 2)	ions (See A-6)	Trial Balance (col. 3 +-	
				A-0)	col . 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	11.00	2.00	0.00		0.00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT		9, 800, 388	9, 800, 388	0	9, 800, 388	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	425, 773	8, 104, 928	8, 530, 701	О	8, 530, 701	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	7, 180, 125	10, 666, 526	17, 846, 651	-699, 142	17, 147, 509	5.00
7.00 00700 OPERATION OF PLANT	973, 239	4, 808, 670	5, 781, 909	3, 408	5, 785, 317	7.00
9. 00 00900 HOUSEKEEPI NG	1, 002, 116	764, 378	1, 766, 494	l .	1, 766, 494	
10. 00 01000 DI ETARY	1, 250, 874	979, 877	2, 230, 751	-1, 448, 265	782, 486	
11. 00 01100 CAFETERI A	1 0// /20	212 (05	1 270 214	.,	1, 448, 265	
13. 00 O1300 NURSI NG ADMI NI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY	1, 066, 629 70, 078	212, 685 52, 681	1, 279, 314 122, 759	l .	1, 279, 314 122, 759	
15. 00 01500 PHARMACY	1, 497, 045	8, 366, 389	9, 863, 434	l .	9, 842, 488	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	651, 124	258, 637	909, 761		920, 835	
23. 00 02300 PARAMED ED PRGM	103, 569	17, 613	121, 182		121, 182	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 689, 780	660, 905	3, 350, 685	l .	3, 350, 685	
31.00 03100 INTENSIVE CARE UNIT	3, 437, 613	642, 725	4, 080, 338	l .	4, 080, 338	
40. 00 04000 SUBPROVI DER - PF	1, 235, 734	237, 833	1, 473, 567	0	1, 473, 567	
41. 00 O4100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	2, 461, 936	2, 455, 868	4, 917, 804	ol	4, 917, 804	50.00
51. 00 05100 RECOVERY ROOM	2, 461, 936	33, 231	260, 237	0	260, 237	51.00
53. 00 05300 ANESTHESI OLOGY	227,000	145, 024	145, 024	0	145, 024	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 787, 831	1, 704, 756	4, 492, 587	l .	4, 492, 587	1
60. 00 06000 LABORATORY	1, 637, 935	2, 456, 296	4, 094, 231		4, 099, 645	
65. 00 06500 RESPIRATORY THERAPY	1, 182, 377	214, 428	1, 396, 805	7, 236	1, 404, 041	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 054, 640	117, 038	1, 171, 678	0	1, 171, 678	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	306, 053	25, 413	331, 466	0	331, 466	67.00
68. 00 06800 SPEECH PATHOLOGY	166, 284	18, 353	184, 637	0	184, 637	1
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	547, 618	222, 235	769, 853	· .	796, 277	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 236, 634 2, 608, 747	3, 236, 634 2, 608, 747	0	3, 236, 634 2, 608, 747	71.00
73.00 07300 DRUGS CHARGED TO PATTENTS		2,000,747	2,000,747	0	2,000,747	73.00
76. 00 03020 CARDI AC		0	0	0	0	76.00
76. 01 03160 CARDI OPULMONARY	53, 263	5, 253	58, 516	o	58, 516	1
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	103, 458	245, 852	349, 310	0	349, 310	88. 00
90. 00 09000 CLI NI C	0	0	0		0	90.00
90. 01 09001 WOUND CLINIC	667, 135	205, 477	872, 612	0	872, 612	
90. 02 09002 DI ABETES CLINI C	41, 856	6, 146	48, 002	0	48, 002	
90. 03 09003 ASTHMA CLINIC 90. 04 09004 ANDIS CLINIC	42 427	29, 697	73, 134	0	72 124	90. 03 90. 04
90. 05 09005 PRIME TIME	43, 437	100, 341	100, 341	l .	73, 134 100, 341	1
90. 06 09006 SHELBYVILLE WOUND CLINIC	272, 752	156, 555	429, 307		429, 307	
90. 07 04951 0NCOLOGY	574, 681	910, 590	1, 485, 271		1, 485, 271	90.07
90. 08 04950 ANDERSON WOMENS CENTER	258, 334	40, 722	299, 056		299, 056	
91. 00 09100 EMERGENCY	2, 341, 594	570, 487	2, 912, 081	0	2, 912, 081	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE	1, 178, 493	895, 125	2, 073, 618	Ol	2, 073, 618	116 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	37, 490, 382	61, 978, 503	99, 468, 885	l .	98, 802, 353	
NONREI MBURSABLE COST CENTERS	37, 470, 302	01, 770, 303	77, 400, 003	000, 332	70, 002, 333	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190. 01 19001 PROFESSI ONAL BUI LDI NG	0	548, 863	548, 863	-32, 610	516, 253	190. 01
190. 02 19002 PHYSICIAN BUILDING	0	62, 641	62, 641		62, 641	190. 02
190. 03 19003 PRI VATE DUTY	191, 424	219, 815	411, 239		411, 239	
190. 04 19004 MARKETI NG	0	0	0	699, 142	699, 142	
190. 05 19005 SPORTS PHYSI CALS	52, 141	4, 728	56, 869	l .	56, 869	
190. 06 19006 FOUNDATI ON	219, 804	37, 011	256, 815		256, 815	
190. 07 19007 ASC 190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2, 812	2, 812 0	l .		190. 07 190. 08
190.09 19009 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1, 362, 229	2, 047, 822	3, 410, 051		3, 410, 051	
190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS	805, 568	477, 587	1, 283, 155	l .	1, 283, 155	
190. 11 19011 MORRI STOWN CLINI C	003, 300	477, 307	1, 203, 133 N			190. 10
190. 12 19012 03PUREMED	166	16, 456	16, 622	o	16, 622	
190. 13 19013 MCCORD WELLNESS	465, 325	370, 564	835, 889	l .	835, 889	
190. 14 19014 3 WEST UNIT	186, 765	179, 228	365, 993		365, 993	
190. 15 19015 NEUROLOGY PHYSI CI AN	0	79, 500	79, 500	l .	79, 500	
190. 16 19016 THORACI	0	38, 570	38, 570	l .	38, 570	
200.00 TOTAL (SUM OF LINES 118-199)	40, 773, 804	66, 064, 100	106, 837, 904	<u> </u> 0	106, 837, 904	1200.00

Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 5/16/2017 10:17 am

			5/16/2017 10:	17 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
	/ 00	Allocation	_	
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT	-548, 312	9, 252, 076		1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 392, 631	6, 138, 070		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	-3, 996, 937		•	5.00
7. 00 00700 OPERATION OF PLANT	-20, 533	5, 764, 784	•	7.00
9. 00 00900 HOUSEKEEPI NG	-67, 600			9.00
10. 00 01000 DI ETARY	-458, 855			10.00
11. 00 01100 CAFETERI A	-52, 526			11.00
13.00 01300 NURSING ADMINISTRATION	-14, 811	1, 264, 503		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	-35, 915	86, 844		14.00
15. 00 01500 PHARMACY	-829, 597	9, 012, 891		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-71, 987	848, 848	3	16.00
23. 00 02300 PARAMED ED PRGM	-45, 060	76, 122	2	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-173, 493			30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	4, 080, 338		31.00
40. 00 04000 SUBPROVI DER - I PF	-96, 000			40.00
41. 00 04100 SUBPROVI DER - RF	0	0)	41.00
ANCILLARY SERVICE COST CENTERS	F27 F00	4 200 207		F0 00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	-527, 508 0		•	50.00 51.00
53. 00 05100 RECOVERT ROOM 53. 00 05300 ANESTHESI OLOGY	-136, 598			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-19, 381	4, 473, 206		54.00
60. 00 06000 LABORATORY	-179, 288			60.00
65. 00 06500 RESPI RATORY THERAPY	-182, 992	1, 221, 049		65.00
66. 00 06600 PHYSI CAL THERAPY	0			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	, , , , , ,		67.00
68.00 06800 SPEECH PATHOLOGY	0	184, 637		68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0	l '	l I	68. 01
69. 00 06900 ELECTROCARDI OLOGY	-428	795, 849		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 236, 634		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 608, 747	'	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l e		73.00
76. 00 03020 CARDI AC	0	l		76. 00
76. 01 03160 CARDI OPULMONARY	0	58, 516		76. 01
OUTPATIENT SERVICE COST CENTERS	11 1/1	207.04/		00.00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	-11, 464	337, 846 0	l I	88.00
90. 01 09000 CLINI C	0	872, 612		90.00
90. 02 09002 DI ABETES CLI NI C	0	48, 002		90.01
90. 03 09003 ASTHMA CLINIC	0	40,002		90.02
90. 04 09004 ANDIS CLINIC	-4, 125	69, 009		90.03
90. 05 09005 PRI ME TI ME	7, 123	100, 341		90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	-6, 707	422, 600		90.06
90. 07 04951 ONCOLOGY	-571, 713			90.07
90. 08 04950 ANDERSON WOMENS CENTER	-7, 215		•	90.08
91. 00 09100 EMERGENCY	-60, 369	l '		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY	0	0		101.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE	-86, 502			116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-10, 598, 547	88, 203, 806	<u> </u>	118.00
NONREI MBURSABLE COST CENTERS	1			100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 PROFESSIONAL BUILDING	0	516, 253	1	190. 00 190. 01
190. 01 1900 1 PROFESSIONAL BUILDING	0			190.01
190. 02 19002 PHYSICIAN BUILDING 190. 03 19003 PRIVATE DUTY	0	62, 641 411, 239		190. 02
190. 04 19004 MARKETI NG	0			190.03
190. 05 19005 SPORTS PHYSI CALS	0	56, 869		190.05
190. 06 19006 FOUNDATION	0	1		190.06
190. 07 19007 ASC	0			190.07
190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,312)	190.08
190. 09 19009 HANCOCK OB	0	3, 410, 051		190.09
190. 10 19010 HANCOCK WELLNESS	0	1, 283, 155	l I	190. 10
190. 11 19011 MORRI STOWN CLINIC	0	0		190. 11
190. 12 19012 03PUREMED	0	16, 622		190. 12
190. 13 19013 MCCORD WELLNESS	0	835, 889		190. 13
190. 14 19014 3 WEST UNIT	0	365, 993	3	190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	0		•	190. 15
190. 16 19016 THORACI	0	,		190. 16
200.00 TOTAL (SUM OF LINES 118-199)	-10, 598, 547	96, 239, 357	<u>'</u>	200. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provider CCN: 15-00:	Period: Worksheet A-6 From 01/01/2016
		To 12/31/2016 Date/Time Prepared:

					5/16/2017 10	: 17 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	A - CAFETERIA RECLASS					4
1.00	CAFETERI A	<u>11.</u> 00		63 <u>6, 2</u> 42		1.00
	TOTALS		812, 023	636, 242		_
	B - PLANT RECLASS					4
1. 00	OPERATION OF PLANT	7. 00	•	3, 408		1.00
2.00	MEDICAL RECORDS & LIBRARY	16. 00	•	11, 074		2.00
3. 00	ELECTROCARDI OLOGY	69. 00	•	10, 892		3. 00
4. 00	RESPI RATORY THERAPY	<u>65.</u> 00	0_	<u>7, 2</u> 36		4. 00
	TOTALS		0	32, 610		_
	C - MARKETING RECLASS					4
1. 00	MARKETI NG	1 <u>90.</u> 04		<u>576, 7</u> 17		1.00
	TOTALS		122, 425	576, 717		_
	D - OUTPATIENT PROCEDURE					4
1. 00	LABORATORY	60. 00	.,	1, 114		1.00
2.00	ELECTROCARDI OLOGY	<u>69.</u> 00	+	<u>3, 240</u>		2.00
	TOTALS		16, 592	4, 354		
500.00	Grand Total: Increases		951, 040	1, 249, 923		500.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0037	Period: Worksheet A-6
		From 01/01/2016
		To 12/31/2016 Date/Time Prepared:

					11	o 12/31/2016 Date/IIMe Pr 5/16/2017 10	epared:
		Decreases				37 107 2017 10	. 17 (3111
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	10. 00	812, 023	636, 242	0		1.00
	TOTALS		812, 023	636, 242			
	B - PLANT RECLASS						
1.00	PROFESSI ONAL BUILDING	190. 01	0	32, 610	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		000	0_	0	0		4. 00
	TOTALS		0	32, 610			
	C - MARKETING RECLASS						
1.00	ADMI NI STRATI VE & GENERAL	500	122, 425	57 <u>6, 7</u> 17	0		1.00
	TOTALS		122, 425	576, 717			
	D - OUTPATIENT PROCEDURE						
1. 00	PHARMACY	15. 00	16, 592	4, 354	0		1.00
2.00		0.00	0	0	0		2. 00
	TOTALS		16, 592	4, 354			
500.00	Grand Total: Decreases		951, 040	1, 249, 923			500.00

				-	Го 12/31/2016	Date/Time Pre 5/16/2017 10:	pared: 17 am
			<u>'</u>	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	1, 241, 194	0	(0	0	1.00
2.00	Land Improvements	6, 578, 254	1, 072, 303	(1, 072, 303	0	2.00
3.00	Buildings and Fixtures	45, 256, 069	2, 195, 256	(2, 195, 256	126, 052	3.00
4.00	Building Improvements	59, 255, 788	3, 005, 518	(3, 005, 518	26, 900	4. 00
5.00	Fixed Equipment	6, 023, 237	11, 722, 139	(11, 722, 139	8, 800, 849	5.00
6.00	Movable Equipment	71, 534, 950	9, 426, 740	(9, 426, 740	125, 199	6.00
7.00	HIT designated Assets	0	0	(0	0	7.00
8.00	Subtotal (sum of lines 1-7)	189, 889, 492	27, 421, 956	(27, 421, 956	9, 079, 000	8.00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	189, 889, 492	27, 421, 956	(27, 421, 956	9, 079, 000	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_	T			
1. 00	Land	1, 241, 194	0				1.00
2.00	Land Improvements	7, 650, 557	0				2.00
3. 00	Buildings and Fixtures	47, 325, 273	0				3.00
4.00	Building Improvements	62, 234, 406	0				4.00
5.00	Fi xed Equi pment	8, 944, 527	0				5.00
6. 00	Movable Equipment	80, 836, 491	0				6. 00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	208, 232, 448	0				8.00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	208, 232, 448	0	l			10.00

Heal th	Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-0037	Peri od: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part II Date/Time Pre 5/16/2017 10:	pared:
			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, COLUI	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	9, 800, 388	0		0 0	0	1.00
3.00	Total (sum of lines 1-2)	9, 800, 388	0		0 0	0	3.00
		SUMMARY C	F CAPITAL				
	Cost Center Description	Other	Total (1)				
	·	Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	9, 800, 388		-		1.00
3.00	Total (sum of lines 1-2)	0	9, 800, 388				3.00

Heal th	Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7		
					From 01/01/2016 Fo 12/31/2016		nared:	
					12/31/2010	5/16/2017 10:		
		COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL		
					5 (
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance		
			Leases	for Ratio (col. 1 -	instructions)			
				col. 2)				
		1, 00	2.00	3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	47, 325, 273	0	47, 325, 27	1. 000000	0	1.00	
3.00	Total (sum of lines 1-2)	47, 325, 273		47, 325, 27	1. 000000	0	3.00	
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
		_		1				
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
			Capital-Relat	cols. 5 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 & FIXT	0	0		9, 800, 388	-546, 461	1.00	
3.00	Total (sum of lines 1-2)	0	0		9, 800, 388	-546, 461	3.00	
			SL	JMMARY OF CAPI	TAL			
			i					
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
			(see	instructions)				
			instructions)		ed Costs (see instructions)	9 (nrough 14)		
		11. 00	12. 00	13.00	14. 00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	10.00	1 1. 00	10.00		
1.00	NEW CAP REL COSTS-BLDG & FIXT	-1, 851	0		0	9, 252, 076	1.00	
3.00	Total (sum of lines 1-2)	-1, 851	0		0	9, 252, 076	3.00	

ADJUST	WENTS TO EXPENSES			Provider CCN. 15-0037	From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
			Тс	Expense Classification o p/From Which the Amount is		5/16/2017 10:	17 am
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00	Investment income - NEW CAP	1. 00	2.00	3.00 EW CAP REL COSTS-BLDG &	4.00	5. 00	1.00
1. 00	REL COSTS-BLDG & FLXT (chapter 2)			IXT	1.00	U	1.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0 * ;	** Cost Center Deleted ***	2.00	0	2.00
3. 00	Investment income - other (chapter 2)		0		0.00	0	
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	
6. 00 7. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	
7.00	Tel ephone servi ces (pay stati ons excluded) (chapter 21)		o o		0.00	O	7.00
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 847, 675		0.00	0	•
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12. 00	(chapter 23) Rel ated organi zati on	A-8-1	0			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		o		0.00	0	13.00
14.00	Cafeteria-employees and guests		Ō		0. 00	0	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15.00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20.00	Vending machines		O		0.00	0	
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		U		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OR	ESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OPI	HYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation (chapter 21)		0 * :	** Cost Center Deleted ***	114. 00		25. 00
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			EW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		I	** Cost Center Deleted ***	2. 00	0	27. 00
28.00	Non-physician Anesthetist		0 * ;	** Cost Center Deleted ***			28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 00	CCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		OAI	DULTS & PEDIATRICS	30.00		30. 99
	instructions)						

From 01/01/2016 12/31/2016 Date/Time Prepared: 5/16/2017 10:17 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Cost Center Description Line # Wkst. A-7 Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 32.00 Depreciation and Interest 33.00 HRH MMO RENTAL INCOME В -1,851 NEW CAP REL COSTS-BLDG & 1.00 10 33.00 FI XT HRH OTHER REVENUE SALES TAX 44, 633 ADMI NI STRATI VE & GENERAL 33.02 В 5.00 33.02 33.03 HRH OTHER REVENUE В -27, 202 ADMINISTRATIVE & GENERAL 5.00 33.03 MISCELLANEOUS REVE -1, 431 ADMINISTRATIVE & GENERAL 33.05 HRH OTHER REVENUE CHARGE 5.00 33.05 CARD-OTHER 33 07 HRH MED STAFF SERV QA B -13, 300 ADMINISTRATIVE & GENERAL 5 00 33 07 APPLICATION FE 33.08 HRH MEDICAL DUES MEDICAL STAFF -19, 050 ADMINISTRATIVE & GENERAL 5.00 33.08 В 33.09 HRH PAT FIN. SERV. BUSINESS В -2, 040 ADMI NI STRATI VE & GENERAL 5.00 33.09 SERV-COP -464, 580 ADMI NI STRATI VE & GENERAL HRH INFO SERVICES 33.11 В 5.00 33.11 MI SCELLANEOUS REVE 33.12 HRH ACCOUNTING MISCELLANEOUS В -2, 259 ADMI NI STRATI VE & GENERAL 5.00 33.12 REVENUE HRH ACCOUNTING MANAGEMENT FEES -9, 116 ADMI NI STRATI VE & GENERAL 33, 13 5.00 33.13 R -36, 000 ADMINISTRATIVE & GENERAL 33. 14 HRH EXEC ADMIN MISCELLANEOUS В 5.00 33.14 REVENUE 33.17 HRH PURCHASING MISCELLANEOUS -29 ADMINISTRATIVE & GENERAL 5.00 33.17 REVENUE HRH COMMUNICATIONS 33 18 B -3 188 ADMINISTRATIVE & GENERAL 5 00 33 18 MISCELLANEOUS REV 33.19 HRH COMMUNICATIONS PHONE LEASE -184, 349 ADMINISTRATIVE & GENERAL 5.00 33.19 В REVEN 33. 20 HRH COMM EDUCATION В -280 ADMINISTRATIVE & GENERAL 5.00 33. 20 MI SCELLANEOUS REV HRH COMM EDUCATION EDUCATION 33.21 В -8. 150 ADMINISTRATIVE & GENERAL 5.00 33.21 SERVI CE HRH COMM EDUCATION CAR SEAT -3, 845 ADMINISTRATIVE & GENERAL 33. 22 33. 22 5.00 STATE FU 33, 23 0.00 33, 23 -22, 933 ADMINISTRATIVE & GENERAL 33.26 HRH GAIN/LOSS INVENTORY B 5.00 ol 33.26 33.27 HRH GAIN/LOSS GROSS VARIANCE 10, 264 ADMINISTRATIVE & GENERAL 5.00 33.27 INVENTO 33. 28 HRH SECURITY MISCELLANEOUS -1, 200 ADMI NI STRATI VE & GENERAL 33.28 В 5.00 REVENUE HRH HPN IT DEPT MISC REVENUE -177, 221 ADMINISTRATIVE & GENERAL 33 29 B 5 00 33 29 HRH PLANT OFFSITE SERVICES -20, 083 OPERATION OF PLANT 7.00 33.31 33.31 9.00 HRH HOUSEKEEPING ENVIRONMENTAL -67, 600 HOUSEKEEPI NG 33.34 33.34 В SERVI HRH NUTRITIONAL SER -4, 637 DI ETARY 10.00 33.35 33.35 В REBATES/REFUNDS 33.36 HRH NUTRITIONAL SER LTACH -57, 188 DI ETARY 10.00 33.36 В REVENUE 33.38 HRH CLINICAL EDUCAT AHA COURSE В -14, 811 NURSING ADMINISTRATION 13.00 33.38 RFVFN 33 40 HRH OTHER REVENUE B -30, 924 CENTRAL SERVICES & SUPPLY 14 00 33 40 REBATES/REFUNDS 33.41 HRH OTHER REVENUE DI SCOUNTS В -4, 991 CENTRAL SERVICES & SUPPLY 14.00 33.41 EARNED O HRH PHARMACY MI SCELLANEOUS -3. 209 PHARMACY 33 42 B 15 00 33 42 REVENUE 33.43 HRH PHARMACY REBATES/REFUNDS -30, 689 PHARMACY 15.00 33.43 -658, 166 PHARMACY 33.44 HRH ASSOCIATE PHARM RETAIL В 15.00 33.44 PHARMACY-

-108, 064 PHARMACY

-29, 469 PHARMACY

15.00

15.00

0 33.45

33.46

В

В

PHARMACY

33.45

33.46

HRH ASSOCIATE PHARM HOSPICE

HRH ASSOCIATE PHARM

MI SCELLANEOUS RE

From 01/01/2016 | Worksneet A-8 | To 12/31/2016 | Date/Time Prepared:

					o 12/31/2016	Date/Time Pre 5/16/2017 10:	pared: 17 am
	·			Expense Classification on	37 107 2017 10.	17 (1111	
				To/From Which the Amount is	to be Adjusted		
					-		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)	2.00	2.00	4.00	Ref.	
33. 47	HRH HEALTH INFO SER MEDICAL	1. 00 B	2. 00	3. 00 MEDI CAL RECORDS & LI BRARY	4. 00 16. 00	5. 00	33. 47
33.47	RECORDS-	D	-3, 421	WEDICAL RECORDS & LIBRARY	10.00	U	33.47
33. 48	HRH HEALTH INFO SER	В	-68 566	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 48
33. 40	MI SCELLANEOUS RE	В	00, 300	WEDI GAE REGORDS & ELBRART	10.00	O	33. 40
33. 49	XRAY SCHOOL TUITION REVENUE	В	-45, 060	PARAMED ED PRGM	23. 00	0	33. 49
33. 50	HRH ANDIS UNIT REBATES/REFUNDS		·	ADULTS & PEDIATRICS	30.00	0	33. 50
33. 55	HRH DIAG IMAGING HEARTBEATS	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 55
	REVENUE		,				
33. 56	HRH PIC-CT MISCELLANEOUS	В	26	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 56
	EXPENSE						
33. 58	HRH MMO-RAD HEARTBEATS REVENUE	В	-770	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 58
33. 61	HRH LAB WATER TESTING	В	-75, 150	LABORATORY	60.00	0	33. 61
33. 62	HRH LAB HEARTBEATS REVENUE	В	-41, 601	LABORATORY	60.00	0	33. 62
33. 64	HRH SLEEP STUDY CLINIC	В	-57, 216	RESPI RATORY THERAPY	65. 00	0	33. 64
	MANAGMENT						
33. 65	HRH SLEEP STUDY SLEEP STUDY	В	-109, 276	RESPI RATORY THERAPY	65. 00	0	33. 65
	FEES	_					
33. 67	HRH CARDIO SERV HEARTBEATS	В	-428	ELECTROCARDI OLOGY	69. 00	0	33. 67
	REVENUE	6		BUBAL UEAL TU OLIANI O	00.00		
33. 68	HRH KNI GHTSTOWN OFF	В	-52	RURAL HEALTH CLINIC	88. 00	0	33. 68
33. 72	KNI GHTSTOWN OFF-	В	/ 707	SHELBYVILLE WOUND CLINIC	00.04	0	22 72
33. 72	HRH MCCORDS WOUND PHYS OTHER REVENUE	В	-6, 707	SHELBYVILLE WOUND CLINIC	90. 06	U	33. 72
33. 74	HRH MED ONCOLOGY MISCELLANEOUS	В	_80_551	ONCOLOGY	90. 07	0	33. 74
33.74	REVEN	Ь	-00, 551	ONCOLOGI	70.07	O	33.74
33. 77	HRH E R REBATES/REFUNDS	В	-369	EMERGENCY	91. 00	0	33. 77
33. 81	HRH HOSPICE MISCELLANEOUS	В		HOSPI CE	116. 00	0	33. 81
00.0.	REVENUE	J	00,002			ŭ	00.0.
33. 82	MOW	Α	-397, 030	DI ETARY	10. 00	0	33. 82
33. 83	CAFETERIA GUEST MEALS	А		CAFETERI A	11. 00	0	33. 83
33.84	PHYSICIAN RECRUITMENT FEES	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 84
33.85	DONATIONS & SPONSORSHIPS	А		ADMINISTRATIVE & GENERAL	5. 00	0	33. 85
33. 86	ADVERTISING FEE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 86
33. 87	ADVERTISING FEE	А		ADMINISTRATIVE & GENERAL	5. 00	0	33. 87
33. 88	ADVERTISING FEE	Α	-	RURAL HEALTH CLINIC	88. 00	0	33. 88
33. 92	ADVERTISING FEE	Α		ANDERSON WOMENS CENTER	90. 08	0	33. 92
33. 93	SELF INSURANCE CLAIM EXPENSE	Α		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 93
33. 94	I HA LOBBYI NG EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 94
33. 95	AHA LOBBYING EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 95
33. 96	PHY OFFICE BLDG	Α	·	NEW CAP REL COSTS-BLDG &	1. 00	10	
				FIXT			
33. 99	PHY OFFICE BLDG	А		RADI OLOGY-DI AGNOSTI C	54. 00	0	
34.00	PHY OFFICE BLDG	Α		RURAL HEALTH CLINIC	88. 00	0	
34. 01	I NTEREST REVENUE	В	-1, 851	NEW CAP REL COSTS-BLDG &	1. 00	11	34. 01
				FIXT	_		
34. 02	RENTAL PROPERTIES EXPENSE	A		ADMI NI STRATI VE & GENERAL	5. 00	0	
34. 03	RENTAL PROPERTIES EXPENSE	А	-278, 581	NEW CAP REL COSTS-BLDG &	1. 00	10	34. 03
24.21	DENTAL PROPERTIES SYSTAGE			FIXT	7.00	_	24.24
34. 04	RENTAL PROPERTIES EXPENSE	A		OPERATION OF PLANT	7. 00	0	
34. 05	TELEPHONE SERVICES	A		ADMINISTRATIVE & GENERAL	5. 00	0	34. 05
34.06	HAF EXPENSE	А		ADMINISTRATIVE & GENERAL	5. 00	0	34.06
50.00	TOTAL (sum of lines 1 thru 49)		-10, 598, 547				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2016 Provi der CCN: 15-0037

						To 12/31/2016		epared: 17 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	274, 980	274, 980	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	172, 775	172, 775	0	0	0	2.00
3.00	40.00	SUBPROVI DER - I PF	96, 000	96, 000	0	0	0	3.00
4.00	50.00	OPERATING ROOM	527, 508	527, 508	0	0	0	4.00
5.00	53.00	ANESTHESI OLOGY	136, 598	136, 598	0	0	0	5.00
6.00	60.00	LABORATORY	115, 098	27, 830	87, 268	260, 300	420	6.00
7.00	65. 00	RESPI RATORY THERAPY	16, 500	16, 500	0	0	0	7.00
8.00	88. 00	RURAL HEALTH CLINIC	5, 490	5, 490	0	0	0	8.00
9.00	90. 04	ANDIS CLINIC	4, 125	4, 125	0	0	o	9.00
10.00	90. 07	ONCOLOGY	491, 162	491, 162	0	0	o	10.00
11.00	91.00	EMERGENCY	60,000	60, 000	0	0	o	11.00
200.00			1, 900, 236	1, 812, 968	87, 268		420	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0				2.00
3.00	40. 00	SUBPROVI DER - I PF	0	0	0		0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	52, 561	2, 628	0	0	0	6.00
7.00	65. 00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00		RURAL HEALTH CLINIC	0	0	0	0	0	8.00
9.00		ANDIS CLINIC	0	0	0	0	0	9.00
10.00	90. 07	ONCOLOGY	0	0	0	0	0	10.00
11.00	91. 00	EMERGENCY	0	0	0	0	0	11.00
200.00			52, 561	2, 628		0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADMINISTRATIVE & GENERAL	0	0	_	,		1.00
2.00		ADULTS & PEDIATRICS	0	0		,		2.00
3.00		SUBPROVI DER - I PF	0	0		,0,000		3.00
4. 00	•	OPERATING ROOM	0	0	0	527, 508	1	4.00
5. 00		ANESTHESI OLOGY	0	0	0	136, 598		5. 00
6. 00		LABORATORY	0	52, 561				6. 00
7. 00		RESPI RATORY THERAPY	0	0	-			7. 00
8. 00		RURAL HEALTH CLINIC	0	0		0, ., 0		8.00
9. 00		ANDIS CLINIC	0	0		4, 125		9.00
10. 00	•	ONCOLOGY	0	0		491, 162		10.00
11. 00	•	EMERGENCY	0	0	J	00,000		11. 00
200. 00	1		0	52, 561	34, 707	1, 847, 675		200.00

| Period: | Worksheet B | From 01/01/2016 | Part | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0037

Cost Center Description					o 12/31/2016	Date/Time Pre	
No. Control Description			CAPI TAI			5/16/2017 10:	1/ am
FIXT BENEFITS							
REMEMBL SERVICE COST CENTERS 1.00	Cost Center Description	Net Expenses		EMPLOYEE	Subtotal	ADMI NI STRATI V	
Cross Section Color Co			FLXT			E & GENERAL	
Col. 73				DEPARIMENT			
CERREAL SERVICE COST CENTERS 1, 100							
1.00			1. 00	4. 00	4A	5. 00	
0.000 DOCKOOL DEPLOYMER BENEFIT IS REPORTED NO. 1, 10, 10, 10, 10, 10, 10, 10, 10, 10,							
0.0000 DOSCO ADMINISTRATIVE & CENERAL 13,150,572 705,506 1,086,507 14,911,677 14,741,677 5,00 0.0000 DOSCO PLUSEKEEPING 5,44,744 5,100,894 60,046 154,144 1,913,083 1,151,896 1,000 1,	1 I	1			,		
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000	1 1	1				14 041 677	1
0.000 0.00	· · · · · · · · · · · · · · · · · · ·	1				1	1
0.000 01000 DETARY 323, 631 315, 130 67, 503 500, 648 279, 679 11.00 11.00 61100 CAFETERI A 1, 395, 739 0 124, 694 1, 24, 694 10.00 13.00 61200 MIRSS ING AIRLHINISTRATION 1, 204, 503 0 164, 604 1, 420, 570 12.00		1					
13.00 01300 NIRESH NG ADM INISTRATION 1, 264, 503 0 164, 667 1, 429, 570 262, 557 13, 00 15. 00 16100 PARAMACU 1.00 14000 PARAMACU 1.00	10. 00 01000 DI ETARY	1					1
14.00 01400 CENTRAL SERVICES & SUPPLY 86.8 B44		1	0				1
15.00 01500 PHARMACY 9,012,891 51,343 227,720 9,291,945 1,707,742 15.00 23.00 02300 PARAMED ED PROM 76.122 36.549 15.931 128.602 23.636 23.00 23.00 23.00 PARAMED ED PROM 76.122 36.549 15.931 128.602 23.636 23.00 23		1	0	•		1	1
16.00			U E1 242			1	1
		1					1
INPATE NOT NOTE OF THE SERVICE COST CENTERS 3,177, 192 618, 921 413, 737 4,209, 850 773, 728 30,00 03000 (AUTIS & PERIOR TRICES 3,177, 192 618, 921 713, 392 190,078 774, 728 30,00 03000 (INTENSIVE CARE UNIT 4,000, 338 648, 590 528, 767 5,257, 695 966, 312 31,00 041,00 041,00 041,000 04		· ·				l .	•
31.00 03100 INTENSIVE CARE UNIT 4.080, 338 6.48, 990 5.28, 767 5.287, 695 966, 312 31.00 04.00 04000 04000 04000 041000 04100 04100 04100 04100 04100 04100 04100 04100 04100 04100 04100	INPATIENT ROUTINE SERVICE COST CENTERS		·				
40.00 04000 SUBPROVIDER - IPF 1.377, 567 173, 392 190, 078 1.741, 037 331, 985 40.00						l .	
11.00 04100 SUBPROVIDER - INF							•
MACL LARY SERVICE COST CENTERS 50.00 50.00 65000 6PERATING ROM 4.390, 296 683, 916 378, 690 5.452, 902 1.002, 189 50.00 51.00 61000 6PERATING ROM 260, 237 57, 652 34, 918 322, 807 6.4, 842 51.00 0.00 60.00 6.							•
50.00		0	0		, 0		41.00
53.00 05300 ANESTHESI OLOGY 8.426 0 0 0 8.426 1.549 53.00		4, 390, 296	683, 916	378, 690	5, 452, 902	1, 002, 189	50.00
54 00 05400 RADIO LOGY-DI AGNOSTI C 4, 473, 206 706, 895 428, 819 5, 608, 920 1, 030, 863 54 00 06500 06500 LABORATORY 3, 920, 357 158, 925 256, 606 4, 331, 887 796, 158 60, 06		1					
00.00 0.00000 LABORATORY 3.920, 357 158, 925 252, 606 4, 331, 887 796, 158 60.00 65.00 0.6500 RESPIRATORY THERAPY 1, 221, 049 64, 016 181, 871 1, 466, 956 269, 608 65.00 65.00 0.6500 RESPIRATORY THERAPY 1, 171, 678 105, 760 162, 223 1, 439, 661 264, 595 66.00 67		1	ı	-			
65.00 O6500 RESPIRATORY THERAPY 1, 121, 049 64, 016 181, 871 1, 466, 936 269, 600 66.00 O6600 OR500 OR50							•
66.00 06600 PHYSI CAL THERAPY 1,171, 678 105,760 162,223 1,439,661 264,595 66.00 67.00 06700 0CCUMATIONAL THERAPY 331,466 0,47,076 378,542 69,572 67.00 68.00 06800 05800 SPEECH PATHOLOGY 184,637 0 25,577 210,214 38,635 68.00 06900							•
88. 00 06800 SPEECH PATHOLOGY 184, 637 0 25, 577 210, 214 38, 635 68, 10							
68.01 06801 06CURATI ONAL HEALTH		331, 466	0	47, 076	378, 542	69, 572	67.00
69.00 06900 0600 0600 0600 0600 0600 073,040 086,124 1.085,742 199,549 09.00 170.00			0			l	1
17.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 236, 634 127, 597 0 3, 364, 231 618, 312 71, 00 72, 00 72, 00 73, 00 073, 00 073, 00 073, 00 073, 00 073, 00 073, 00 073, 00 073, 00 073, 00 0 0 0 0 0 0 0 0 0		_	202 760	1	ή	l .	1
17.0 07200 IMPL. DEV. CHARGED TO PATIENT 2, 608, 747 0 0 2, 608, 747 479, 462 72.00 73.00 073.00	· · · · · · · · · · · · · · · · · · ·		·				1
17.0 03020 CARDI AC 0 0 0 0 0 0 0 0 0		1		1		i .	1
10 03160 CARDI OPULMONARY 58, 516 61, 976 8, 193 128, 685 23, 651 76, 01		0	0	C	0		
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE S		0	(1.07/	0.103	0	1	1
88. 00 08800 RURAL HEALTH CLINIC 337,846 0 15,914 353,760 65,018 88. 00 90.		58, 516	61, 9/6	8, 193	128, 685	23, 651	76.01
90. 01 09001 WOUND CLINIC		337, 846	0	15, 914	353, 760	65, 018	88. 00
90. 02 09002 DI ABETES CLI NI C		0	0	C	0		90.00
90. 03 09003 ASTHMA CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·	78, 891			l .	•
90. 04 09004 ANDIS CLINIC 69,009 70,815 6,681 146,505 26,926 90,04 90. 05 09005 PRIME TIME 100,341 0 0 100,341 18,442 90,05 90. 06 09006 SHELBYVILLE WOUND CLINIC 422,600 0 41,954 464,554 85,380 90,06 90. 07 04951 ONCOLOGY 913,558 377,814 88,396 1,379,768 253,588 90,07 90. 08 04950 ANDERSON WOMENS CENTER 291,841 0 39,736 331,577 60,941 90,08 91. 00 99100 EMERGENCY 2,851,712 601,136 360,179 3,813,027 700,796 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 2,851,712 601,136 360,179 3,813,027 700,796 91.00 92. 00 OBSERVATI ON BEDS (NON-DISTINCT PART) 101000 10100 10100 10100 10100 101000 10100 101000 101000 101000 10100		48, 002	0			l .	•
90. 05 09005 PRIME TIME 100, 341 0 100, 341 18, 442 90. 05 90. 06 09005 SHELBYVILLE WOUND CLINIC 422, 600 0 41, 954 464, 554 85, 380 90. 06 90. 07 09451 0NCOLOGY 913, 558 377, 814 88, 396 1, 379, 768 25, 588 90. 06 90. 08 04950 ANDERSON WOMENS CENTER 291, 841 0 39, 736 331, 577 60, 941 90. 08 91. 00 0 0 0 0 0 0 0 0 0		60 000	70 915	-	_		•
90. 06 09006 SHELBYVI LLE WOUND CLI NI C 422, 600 0 41, 954 464, 554 85, 380 90. 07 090. 07 04951 0NCOLOGY 913, 558 377, 814 88, 396 1, 379, 768 253, 588 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 291, 841 0 39, 736 331, 577 60, 941 90. 08 91. 00 9100 EMERGENCY 2, 851, 712 601, 136 360, 179 3, 813, 027 700, 796 91. 00 0 0 0 0 0 0 0 0 0			70,019	1			
90. 08 04950 ANDERSON WOMENS CENTER 291, 841 0 39, 736 331, 577 60, 941 90. 08 91. 00 92. 00 09200 BMERGENCY 2, 851, 712 601, 136 360, 179 3, 813, 027 700, 796 91. 00 92. 00 09200 BMERGENCY 0 0 0 0 0 0 0 0 0			Ö				
91. 00 09100 EMERGENCY 2, 851, 712 601, 136 360, 179 3, 813, 027 700, 796 91. 00 92. 00 085ERVATI ON BEDS (NON-DISTINCT PART) 92. 00 010100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 00 101. 00 0 0 0 0 0 0 0 0 0			377, 814	88, 396	1, 379, 768	253, 588	90. 07
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			0				
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O		2, 851, 712	601, 136	360, 179		1	•
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0					0		92.00
116.00 11600 HOSPI CE 1,987,116 294,517 181,273 2,462,906 452,657 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 88,203,806 6,730,705 5,682,367 85,158,555 12,905,136 118.00 NONREI MBURSABLE COST CENTERS		0	0	C	0	0	101.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 88, 203, 806 6, 730, 705 5, 682, 367 85, 158, 555 12, 905, 136 118. 00				ı			
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00							
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 190. 00 190. 01 19001 19001 19001 19001 19001 19001 19001 19002 19002 19002 19002 19002 19003 190		88, 203, 800	6, 730, 705	5, 082, 307	85, 158, 555	12, 905, 136	118.00
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS 190. 06 19006 FOUNDATI ON 190. 07 19007 ASC 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB 190. 09 19009 HANCOCK WELLNESS 190. 13 19013 MCCORD WELLNESS 190. 13 19013 MCCORD WELLNESS 190. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	C	0	0	190. 00
190. 03 19003 PRI VATE DUTY 411, 239 0 29, 444 440, 683 80, 993 190. 03 190. 04 190. 04 190. 04 190. 05 19005 SPORTS PHYSI CALS 56, 869 0 8, 020 64, 889 11, 926 190. 05 190. 06 190. 06 190. 06 190. 06 190. 07 19007 ASC 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS 10 0 0 123, 911 1, 407, 066 258, 605 190. 10 190. 12 190. 13 19013 MCCORD WELLNESS 10 0 0 0 0 0 190. 13 190. 13 19013 MCCORD WELLNESS 10 0 29, 444 440, 683 80, 993 190. 03 190. 04 18, 831 717, 973 131, 956 190. 04 190. 09 180, 04 190. 09 180, 05 190. 05 180, 05 190. 190. 05 190. 05 190. 05 190. 05 190. 190. 05 190. 05 190. 190. 05 190. 190. 05 190. 05 190. 05 190. 05 190. 190. 05 190. 05 190. 190. 05 190. 190. 05 190. 190. 05 190. 190. 05 190. 190. 05 190. 190. 05 190. 190. 05 190. 05 190. 190. 05 190. 190. 05 190. 05 190. 190. 05 190. 05 190. 190. 05 190. 05 190. 05 190. 05 190. 190. 05 190. 05 190. 05 190. 05 190. 05 190. 05 190. 05 190. 05 190. 190. 05	190. 01 19001 PROFESSI ONAL BUI LDI NG	516, 253	1, 990, 887	C	2, 507, 140	460, 787	190. 01
190. 04 19004 MARKETI NG 699, 142 0 18, 831 717, 973 131, 956 190. 04 190. 05 19005 SPORTS PHYSI CALS 56, 869 0 8, 020 64, 889 11, 926 190. 05 190. 06 19006 FOUNDATI ON 256, 815 65, 539 33, 810 356, 164 65, 459 190. 06 190. 07 19007 ASC 2, 812 0 0 2, 812 517 190. 07 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB 3, 410, 051 123, 490 209, 535 3, 743, 076 687, 940 190. 08 190. 10 19010 HANCOCK WELLNESS 1, 283, 155 0 123, 490 209, 535 3, 743, 076 687, 940 190. 10 190. 11 19011 MORRI STOWN CLI NI C 0 0 0 0 0 190. 11 190. 12 19012 19012 19012 19012 19013 MCCORD WELLNESS 835, 889 0 71, 575 907, 464 166, 783 190. 13		1	0	1			
190. 05 19005 SPORTS PHYSI CALS 190. 06 19006 FOUNDATI ON 190. 07 19007 ASC 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS 190. 123, 490 190. 123, 490 190. 123, 490 190. 124, 490 190. 125, 490 190. 125, 490 190. 126 190. 127, 490 190. 128, 19012 190. 128, 19012 190. 129, 19012 190. 129, 19012 19013 MCCORD WELLNESS 1835, 889 190. 18, 020 18, 020 18, 020 18, 020 18, 020 18, 020 18, 020 18, 020 18, 020 18, 020 190. 04 18, 020 190. 05 18, 020 190. 04 18, 020 190. 05 18, 020 190. 06 190. 06 190. 07 190. 07 190. 07 190. 08 190. 190. 190 190. 190. 190 190. 190. 190 190. 19			0				
190. 06 19006 FOUNDATION 256, 815 65, 539 33, 810 356, 164 65, 459 190. 06 190. 07 19007 ASC 2, 812 0 0 2, 812 517 190. 07 190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 190. 08 190.09 19009 HANCOCK WELLNESS 3, 410, 051 123, 490 209, 535 3, 743, 076 687, 940 190. 09 190. 11 19010 HANCOCK WELLNESS 1, 283, 155 0 123, 911 1, 407, 066 258, 605 190. 11 190. 11 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 190. 11 190. 13 19013 MCCORD WELLNESS 835, 889 0 71, 575 907, 464 166, 783 190. 13) 0				
190. 07 19007 ASC 2, 812 0 0 2, 812 517 190. 07 190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 0 190. 08 190. 09 19009 HANCOCK 0B 3, 410, 051 123, 490 209, 535 3, 743, 076 687, 940 190. 09 190. 10 19010 HANCOCK WELLNESS 1, 283, 155 0 123, 911 1, 407, 066 258, 605 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 0 0 190. 11 190. 12 19012 03PUREMED 16, 622 0 26 16, 648 3, 060 190. 12 190. 13 19013 MCCORD WELLNESS 835, 889 0 71, 575 907, 464 166, 783 190. 13		1				1	1
190. 09 19009 HANCOCK OB 3, 410, 051 123, 490 209, 535 3, 743, 076 687, 940 190. 09 190. 10 19010 HANCOCK WELLNESS 1, 283, 155 0 0 0 0 0 0 190. 10 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 0 190. 11 190. 12 19012 03PUREMED 16, 622 0 26 16, 648 3, 060 190. 12 190. 13 19013 MCCORD WELLNESS 835, 889 0 71, 575 907, 464 166, 783 190. 13	190. 07 19007 ASC	1	0				
190. 10 19010 HANCOCK WELLNESS 1, 283, 155 0 123, 911 1, 407, 066 258, 605 190. 10 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 0 190. 11 190. 12 19012 O3PUREMED 16, 622 0 26 16, 648 3, 060 190. 12 190. 13 19013 MCCORD WELLNESS 835, 889 0 71, 575 907, 464 166, 783 190. 13			0		_	l	
190. 11 19011 MORRI STOWN CLINI C 0 0 0 0 190. 11 190. 12 19012 03PUREMED 16, 622 0 26 16, 648 3, 060 190. 12 190. 13 19013 MCCORD WELLNESS 835, 889 0 71, 575 907, 464 166, 783 190. 13							
190. 12 19012 03PUREMED 16, 642 0 26 16, 648 3, 060 190. 12 190. 13 19013 MCCORD WELLNESS 835, 889 0 71, 575 907, 464 166, 783 190. 13		1, 283, 155 N) O				
190. 13 19013 MCCORD WELLNESS 835, 889 0 71, 575 907, 464 166, 783 190. 13		16, 622	Ö		-	3, 060	190. 12
190. 14 19014 3 WEST UNIT 365, 993 341, 455 28, 728 736, 176 135, 302 190. 14		835, 889				166, 783	190. 13
	190. 14 19014 3 WEST UNIT	365, 993	341, 455	28, 728	736, 176	135, 302	190. 14

Health Financial Systems	HANCOCK REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B	·	
				From 01/01/2016 To 12/31/2016			
		CAPI TAL RELATED COSTS					
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMINI STRATI V		
	for Cost	FLXT	BENEFITS		E & GENERAL		
	Allocation (from Wkst A		DEPARTMENT				
	col. 7)						
	0	1.00	4. 00	4A	5. 00		
190. 15 19015 NEUROLOGY PHYSI CI AN	79, 500	0		0 79, 500	14, 611	190. 15	
190. 16 19016 THORACI	38, 570	0		0 38, 570	,	190. 16	
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0		201. 00	
202.00 TOTAL (sum lines 118-201)	96, 239, 357	9, 252, 076	6, 206, 24	96, 239, 357	14, 941, 677	202. 00	

Provider CCN: 15-0037

Peri od: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/16/2017 10:17 am

					12/31/2010	5/16/2017 10:	
	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	
						N	
	GENERAL SERVICE COST CENTERS	7. 00	9. 00	10. 00	11. 00	13. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	7, 417, 374					7. 00
9.00	00900 HOUSEKEEPI NG	54, 802	2, 319, 491				9. 00
10.00	01000 DI ETARY	287, 611	38, 533	1, 162, 212	4 0/0 /40		10.00
11.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	63, 497 0	0	1, 863, 619		11. 00 13. 00
13. 00 14. 00	01400 CENTRAL SERVICES & SUPPLY	0	96, 317	0	52, 117 9, 912	1, 743, 244 11, 500	1
	01500 PHARMACY	46, 860	70, 257	0	82, 817	96, 086	•
	01600 MEDICAL RECORDS & LIBRARY	98, 634	84, 509	Ö	58, 572	0	16.00
23.00	02300 PARAMED ED PRGM	33, 358	97, 347	0	6, 869	7, 969	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	564, 872	645, 858	331, 707	173, 648	201, 471	30.00
31. 00	03100 NTENSI VE CARE UNI T	591, 950		483, 222	255, 630	296, 588	•
40.00	04000 SUBPROVI DER - I PF	158, 251	106, 564	268, 162	87, 085	101, 039	1
41. 00	04100 SUBPROVIDER - IRF ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	41.00
50. 00	05000 OPERATING ROOM	624, 191	258, 533	0	134, 741	156, 330	50.00
51. 00	05100 RECOVERY ROOM	52, 618	95, 198	0	12, 969	15, 047	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	645, 164	94, 638	0	191, 978	222, 739	54.00
60.00	06000 LABORATORY	145, 046	90, 310	0	142, 148	164, 924	60.00
65. 00	06500 RESPI RATORY THERAPY	58, 426	69, 168	0	80, 523	93, 425	1
66.00	06600 PHYSI CAL THERAPY	96, 524	80, 387	0	63, 011	73, 107	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	20, 054	0 0	67. 00 68. 00
68. 01	06801 OCCUPATI ONAL HEALTH	0		0	8, 648 0	0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	185, 974	0	0	35, 180	Ö	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	116, 454	156, 739	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 OUTPATI ENT SERVI CE COST CENTERS	56, 564	0	0	5, 591	0	76. 01
88. 00	08800 RURAL HEALTH CLINIC	0	O	0	9, 287	0	88. 00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 WOUND CLINIC	72, 002	0	0	30, 795	0	90. 01
90. 02	09002 DI ABETES CLINIC	0	0	0	3, 673	0	90. 02
90. 03	09003 ASTHMA CLINIC	0	0	0	0	0	90. 03
90.04	09004 ANDIS CLINIC	64, 631	0	0	3, 648	0	90.04
90. 05 90. 06	09005 PRIME TIME 09006 SHELBYVILLE WOUND CLINIC	0	0	0	15, 303	0	90. 05 90. 06
90. 00	04951 ONCOLOGY	344, 820		0	38, 573	0	90.00
	04950 ANDERSON WOMENS CENTER	0	o	0	19, 549	_	1
91.00	09100 EMERGENCY	548, 640	138, 483	0	157, 767	183, 046	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
404.00	OTHER REIMBURSABLE 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	268, 798	ol	79, 121	81, 748	94, 847	116 00
118. 00	l i	5, 116, 190		1, 162, 212	1, 781, 836		1
	NONREI MBURSABLE COST CENTERS		· · · · · ·		· · ·	· · · ·	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19001 PROFESSI ONAL BUI LDI NG	1, 817, 026	0	0	0		190. 01
	19002 PHYSI CI AN BUI LDI NG	0	0	0	0		190. 02
	19003 PRI VATE DUTY 19004 MARKETI NG	0	0	0	21, 656		190. 03
	19005 SPORTS PHYSICALS	0	0	0	7, 598 4, 441		190. 04
	19006 FOUNDATION	59, 816		0	15, 742		190.06
	19007 ASC	0	o	0	0	-	190. 07
	19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	О	0	0	0	190. 08
190. 09	19009 HANCOCK OB	112, 706	0	0	20, 797		190. 09
	19010 HANCOCK WELLNESS	0	0	0	0		190. 10
	19011 MORRI STOWN CLINIC	0	0	0	0		190. 11
	19012 03PUREMED	0	0	0	7		190. 12
	19013 MCCORD WELLNESS 19014 3 WEST UNIT	0 311, 636		0	0 11, 542		190. 13 190. 14
	19014 3 WEST UNIT 19015 NEUROLOGY PHYSICIAN	311, 036 N	ا	0	11, 542 N		190. 14
	19016 THORACI	0	0	0	0		190. 15
200.00					· ·		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 01/01/2016	Worksheet B	
				To 12/31/2016		
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMI NI STRATI O	
					N	
	7. 00	9. 00	10.00	11.00	13.00	
202.00 TOTAL (sum lines 118-201)	7, 417, 374	2, 319, 491	1, 162, 212	1, 863, 619	1, 743, 244	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0037 Period: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

			T	12/31/2016	Date/Time Pre 5/16/2017 10:	
Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	PARAMED ED PRGM	Subtotal	17 diii
	14. 00	15. 00	16. 00	23. 00	24. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT						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						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	233, 294	44 000 745				14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	4, 999	11, 300, 715 0	1, 493, 069			15. 00 16. 00
23. 00 02300 PARAMED ED PRGM		0	1, 493, 009	297, 781		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>		277,701		20.00
30. 00 03000 ADULTS & PEDI ATRI CS	4, 262	0	401, 642	0	7, 307, 038	30.00
31.00 03100 INTENSIVE CARE UNIT	9, 180	0	50, 150	o	8, 043, 880	31.00
40. 00 04000 SUBPROVI DER - I PF	690	0	41, 352	0	2, 824, 165	40. 00
41. 00 04100 SUBPROVI DER - RF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS	10 105		F27 007	ما	0.1// 000	
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	10, 105 310	0	527, 897 0	U O	8, 166, 888 593, 791	50. 00 51. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	9, 975	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 424	0	60, 268	297, 781	8, 154, 775	54.00
60. 00 06000 LABORATORY	53, 965	Ö	133, 734	0	5, 858, 172	60.00
65. 00 06500 RESPIRATORY THERAPY	670	0	0	o	2, 038, 756	65.00
66. 00 06600 PHYSI CAL THERAPY	93	0	0	0	2, 017, 378	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	90	0	0	0	468, 258	67. 00
68. 00 06800 SPEECH PATHOLOGY	106	0	0	0	257, 603	68.00
68. 01 06801 0CCUPATI ONAL HEALTH	0	0	0	0	1 575 011	68. 01
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	839	0	68, 627 0	0	1, 575, 911	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	132, 156	0	0	0	4, 387, 892 3, 088, 209	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		11, 300, 715	3, 079	0	11, 303, 794	73.00
76. 00 03020 CARDI AC	0	0	0	o	0	76. 00
76. 01 03160 CARDI OPULMONARY	34	0	0	О	214, 525	76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	613	0	0	0	428, 678	88. 00
90. 00 09000 CLI NI C	0	0	0	0	1 251 240	90.00
90. 01 09001 WOUND CLINIC 90. 02 09002 DIABETES CLINIC	686	0	0	U	1, 351, 340	90.01
90. 02 09002 DEABETES CLINIC 90. 03 09003 ASTHMA CLINIC	0	0	0	0	68, 126 0	90. 02 90. 03
90. 04 09004 ANDIS CLINIC	4	0	0	Ö	241, 714	90. 04
90. 05 09005 PRI ME TI ME	0	o	0	Ö	118, 783	90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	282	0	0	o	565, 519	90.06
90. 07 04951 ONCOLOGY	987	0	0	0	2, 017, 736	90. 07
90. 08 04950 ANDERSON WOMENS CENTER	175	0	0	0	412, 242	1
91. 00 09100 EMERGENCY	8, 239	0	206, 320	0	5, 756, 318	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>				101.00
116. 00 11600 HOSPI CE	2, 038	0	0	0	3, 442, 115	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	232, 954	11, 300, 715	1, 493, 069	297, 781	80, 713, 581	118. 00
NONREI MBURSABLE COST CENTERS				.1		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190. 01 19001 PROFESSI ONAL BUILDI NG	0	0	0	0	4, 784, 953 74, 154	
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY	135	0	0	0	568, 593	1
190. 04 19004 MARKETI NG	0	0	0	0	857, 527	1
190. 05 19005 SPORTS PHYSI CALS	o	Ö	0	ol	81, 256	
190. 06 19006 FOUNDATI ON	0	0	0	o	497, 181	
190. 07 19007 ASC	0	0	0	o	3, 329	190. 07
190.08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 08
190. 09 19009 HANCOCK OB	184	0	0	0	4, 564, 703	1
190. 10 19010 HANCOCK WELLNESS	0	0	0	0	1, 665, 671	
190. 11 19011 MORRI STOWN CLINI C	0	0	0	0		190. 11
190. 12 19012 03PUREMED 190. 13 19013 MCCORD_WELLNESS	0	0	0	0	19, 715 1, 074, 247	190. 12
190. 13 19013 MCCORD WELENESS 190. 14 19014 3 WEST UNIT	21	0	0	0	1, 074, 247	
190. 15 19015 NEUROLOGY PHYSI CI AN	0	0	0	ol Ol	94, 111	
190. 16 19016 THORACI		o	0	ő		190. 16
200.00 Cross Foot Adjustments				o	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	HANCOCK REGION	AL HOSPITAL		In Lie	u of Form CMS-:	<u> 2552-10</u>
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Peri od:	Worksheet B	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	
					5/16/2017 10:	<u>17 am</u>
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	
202.00 TOTAL (sum lines 118-201)	233, 294	11, 300, 715	1, 493, 06	9 297, 781	96, 239, 357	202.00

HANCOCK REGIONAL HOSPITAL

Health Financial Systems In Lieu of Form CMS-2552-10 Worksheet B
Part I
Date/Time Prepared:
5/16/2017 10: 17 am COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0037 Peri od: From 01/01/2016 To 12/31/2016 Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 26. 00 25. 00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 1.00 1.00 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 9.00 00900 HOUSEKEEPI NG 9.00 10. 00 01000 DI ETARY 10.00 11.00 13.00

	01300 NURSING ADMINISTRATION				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00					15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16. 00
23. 00					23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDI ATRI CS	0	7, 307, 038		30. 00
31. 00		0	8, 043, 880		31. 00
40.00	04000 SUBPROVI DER - I PF	0	2, 824, 165		40.00
41.00	04100 SUBPROVI DER - I RF	0	0		41. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	8, 166, 888	!	50.00
51.00	05100 RECOVERY ROOM	0	593, 791	!	51.00
53.00	05300 ANESTHESI OLOGY	o	9, 975	!	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	8, 154, 775	!!	54.00
60.00	06000 LABORATORY	o	5, 858, 172		60.00
65.00	06500 RESPIRATORY THERAPY	l ol	2, 038, 756		65. 00
66.00	06600 PHYSI CAL THERAPY	o	2, 017, 378		66. 00
67. 00	1		468, 258	•	67. 00
68. 00	06800 SPEECH PATHOLOGY		257, 603		68. 00
68. 01	06801 OCCUPATI ONAL HEALTH		207,000	•	68. 01
69. 00	06900 ELECTROCARDI OLOGY		1, 575, 911		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4, 387, 892	•	71. 00
72.00			3, 088, 209	· ·	72.00
	07300 DRUGS CHARGED TO PATIENTS		11, 303, 794		73.00
76.00			11, 303, 794		76. 00
76. 00	03160 CARDI OPULMONARY	0			76. 00 76. 01
76.01	OUTPATIENT SERVICE COST CENTERS	U U	214, 525		70.01
00 00			420, 470		00 00
88. 00 90. 00		0	428, 678		88. 00
	09000 CLINIC	0	0		90.00
90. 01	09001 WOUND CLINIC	0	1, 351, 340		90. 01
90. 02	09002 DI ABETES CLI NI C	0	68, 126		90. 02
90. 03	09003 ASTHMA CLINIC	0	0		90. 03
90. 04	09004 ANDIS CLINIC	0	241, 714		90. 04
90. 05	09005 PRIME TIME	0	118, 783		90. 05
90. 06	09006 SHELBYVI LLE WOUND CLINIC	0	565, 519		90. 06
90. 07	04951 ONCOLOGY	0	2, 017, 736		90. 07
90. 08	04950 ANDERSON WOMENS CENTER	0	412, 242		90. 08
91.00	09100 EMERGENCY	0	5, 756, 318		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	0	10	01.00
	SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPI CE	0	3, 442, 115	1:	16.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	o	80, 713, 581	11:	18. 00
	NONREI MBURSABLE COST CENTERS		,		
190.00	19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	11	90.00
	1 19001 PROFESSI ONAL BUILDING	0	4, 784, 953		90. 01
	19002 PHYSI CI AN BUI LDI NG	ا	74, 154	· ·	90. 02
	19003 PRI VATE DUTY		568, 593		90. 03
	1 19004 MARKETI NG		857, 527		90. 04
	19005 SPORTS PHYSI CALS		81, 256		90. 05
	19006 FOUNDATION		497, 181		90.06
	7 1900 ASC		3, 329		90. 00 90. 07
	1900 ASC 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		3, 329		90. 07 90. 08
		0			90. 08 90. 09
	P 19009 HANCOCK OB	0	4, 564, 703		
	10010 HANCOCK WELLNESS		1, 665, 671	[1]	90. 10
190. 10	19010 HANCOCK WELLNESS	0			00 64
190. 10 190. 1	1 19011 MORRI STOWN CLINIC	0	0	19	90. 11
190. 10 190. 12 190. 12	19011 MORRISTOWN CLINIC 19012 O3PUREMED	0 0	0 19, 715	10 10	90. 12
190. 10 190. 12 190. 12 190. 13	1 19011 MORRI STOWN CLINIC 2 19012 O3PUREMED 3 19013 MCCORD WELLNESS	0 0	0 19, 715 1, 074, 247	10 10 10	90. 12 90. 13
190. 10 190. 12 190. 13 190. 13	1 19011 MORRISTOWN CLINIC 2 19012 03PUREMED 3 19013 MCCORD WELLNESS 4 19014 3 WEST UNIT	0 0	0 19, 715 1, 074, 247 1, 194, 677	10 10 10 10	90. 12 90. 13 90. 14
190. 10 190. 12 190. 12 190. 14 190. 14	1 19011 MORRI STOWN CLINIC 2 19012 O3PUREMED 3 19013 MCCORD WELLNESS	0 0	0 19, 715 1, 074, 247	10 10 10 10 10	90. 12 90. 13

Heal th Final	ncial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lieu	u of Form CMS-	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der CO	CN: 15-0037	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/16/2017 10:	
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
		25. 00	26. 00				
200.00	Cross Foot Adjustments	0	0				200.00
201. 00	Negative Cost Centers	0	0				201.00
202. 00	TOTAL (sum lines 118-201)	0	96, 239, 357				202.00

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0037

				1	o 12/31/2016	Date/Time Pre 5/16/2017 10:	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	i i diii
		0	1.00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		I	ı			1 00
1. 00 4. 00 5. 00 7. 00 9. 00 10. 00 13. 00 14. 00 15. 00 23. 00	+ I	000000000000000000000000000000000000000	705, 508 351, 299 60, 046 315, 130 0 0 51, 343	705, 508 351, 299 60, 046 315, 130 ((51, 343 108, 071	11, 918 1, 645 1, 694 742 1, 372 1, 803 118 2, 502 1, 100	717, 426 55, 296 16, 883 6, 233 13, 420 12, 607 862 81, 971 9, 329	1. 00 4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		30, 347	30, 34	173	1, 133	23.00
30. 00 31. 00 40. 00 41. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	000000000000000000000000000000000000000	648, 590 173, 392	173, 392	5, 810 2, 088	37, 152 46, 399 15, 365 0	30. 00 31. 00 40. 00 41. 00
50. 00		0	683, 916	683, 916	4, 161	48, 122	50. 00
51. 00 53. 00 54. 00 60. 00 65. 00 66. 00 67. 00	+ I	000000000000000000000000000000000000000	57, 652 0 706, 895 158, 925 64, 016	57, 652 (706, 895 158, 925 64, 016	384 0 4, 711 2, 775 1, 998 1, 782	3, 114 74 49, 499 38, 229 12, 946 12, 705 3, 341	51. 00 53. 00 54. 00 60. 00 65. 00 66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	Ö			1, 855	68. 00
68. 01 69. 00 71. 00 72. 00 73. 00 76. 00 76. 01	06801 OCCUPATI ONAL HEALTH 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 03020 CARDI AC 03160 CARDI OPULMONARY 0UTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0	203, 769 127, 597 0 0	127, 597 ((0 0	0 9, 582 29, 689 23, 022 0 0 1, 136	68. 01 69. 00 71. 00 72. 00 73. 00 76. 00
88. 00		0	0		175	3, 122	88. 00
90. 00 90. 01 90. 02 90. 03 90. 04	09001 WOUND CLINIC 09002 DIABETES CLINIC 09003 ASTHMA CLINIC 09004 ANDIS CLINIC	000000000000000000000000000000000000000	0 78, 891 0 0 70, 815	70, 815	1, 127 71 0 73	0 9, 303 480 0 1, 293	90. 00 90. 01 90. 02 90. 03 90. 04
90.05	09005 PRIME TIME 09006 SHELBYVILLE WOUND CLINIC	0	0		0 461	886 4 100	90. 05 90. 06
90. 07 90. 08 91. 00	04951 ONCOLOGY 04950 ANDERSON WOMENS CENTER	0 0	0		971 437 3, 957	12, 176 2, 926 33, 650	90. 07 90. 08
101.00	10100 HOME HEALTH AGENCY	0	0	(0	0	101. 00
116. 00 118. 00	SPECIAL PURPOSE COST CENTERS D 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	000				21, 735 619, 637	
190. 0 190. 0	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1 19001 PROFESSI ONAL BUILDING 2 19002 PHYSICIAN BUILDING 3 19003 PRIVATE DUTY	000000000000000000000000000000000000000		1, 990, 887 (0 0 0 324	22, 126 553	190. 00 190. 01 190. 02 190. 03
190. 04 190. 04 190. 04	4 19004 MARKETI NG 5 19005 SPORTS PHYSI CALS 6 19006 FOUNDATI ON 7 19007 ASC	0 0	0 0 0 65, 539	65, 539 (207 88 371	6, 336 573 3, 143	190. 04 190. 05 190. 06 190. 07
190. 00 190. 00 190. 10	9 19009 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 9 19009 HANCOCK OB 0 19010 HANCOCK WELLNESS 1 19011 MORRISTOWN CLINIC	000000000000000000000000000000000000000	0 123, 490 0	d	0	0 33, 033 12, 417	190. 08 190. 09
190. 1: 190. 1: 190. 1:	2 19012 O3PUREMED 3 19013 MCCORD WELLNESS 4 19014 3 WEST UNIT 5 19015 NEUROLOGY PHYSICIAN	000000000000000000000000000000000000000		341, 455 (786 316	147 8, 008 6, 497	190. 12 190. 13 190. 14 190. 15

Heal th Financi	ial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF	CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
					From 01/01/2016 To 12/31/2016		pared.
					12,01,2010	5/16/2017 10:	17 am
			CAPI TAL				
			RELATED COSTS				
Co	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
		Assigned New	FLXT		BENEFITS	E & GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs					
		0	1. 00	2A	4. 00	5. 00	
190. 16 19016 TI	HORACI	0	0		0 0	340	190. 16
200. 00 Cı	ross Foot Adjustments				0		200.00
201. 00 Ne	legative Cost Centers		0		0 0	0	201.00
202. 00 To	OTAL (sum lines 118-201)	o	9, 252, 076	9, 252, 07	68, 177	717, 426	202. 00

Provider CCN: 15-0037

| Peri od: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | Part II | | P

		1 1		To		5/16/2017 10:	
	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	
		7. 00	9. 00	10.00	11.00	13. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	1					1 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT	408, 240					7. 00
9.00	00900 HOUSEKEEPI NG	3, 016	81, 639				9.00
	01000 DI ETARY 01100 CAFETERI A	15, 830 0	1, 356 2, 235	339, 291 0	17, 027		10.00 11.00
	01300 NURSING ADMINISTRATION		2, 233	0	476	14, 886	13.00
	01400 CENTRAL SERVICES & SUPPLY	o	3, 390	0	91	98	14.00
	01500 PHARMACY	2, 579	2, 473	0	757	820	1
	01600 MEDICAL RECORDS & LIBRARY 02300 PARAMED ED PRGM	5, 429 1, 836	2, 974 3, 426	0	535 63	0 68	16. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	1, 630	3, 420	0	03	00	23.00
30.00	03000 ADULTS & PEDIATRICS	31, 090	22, 732	96, 837	1, 587	1, 720	30.00
	03100 INTENSIVE CARE UNIT	32, 580	4, 687	141, 070	2, 335	2, 534	31.00
	04000 SUBPROVI DER - I PF	8, 710	3, 751	78, 286	796	863	40.00
41. 00	04100 SUBPROVIDER - IRF ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	41.00
50.00	05000 OPERATING ROOM	34, 354	9, 100	0	1, 231	1, 335	50.00
	05100 RECOVERY ROOM	2, 896	3, 351	0	118	128	•
	05300 ANESTHESI OLOGY	0	0	0	1 754	1 000	53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	35, 509 7, 983	3, 331 3, 179	0	1, 754 1, 299	1, 902 1, 408	54. 00 60. 00
	06500 RESPIRATORY THERAPY	3, 216	2, 434	0	736	798	65.00
	06600 PHYSI CAL THERAPY	5, 313	2, 829	0	576	624	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	183	0	67.00
	06800 SPEECH PATHOLOGY 06801 OCCUPATIONAL HEALTH	0	0	0	79 0	0	68. 00 68. 01
	06900 ELECTROCARDI OLOGY	10, 236	0	0	321	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 409	5, 517	0	0	0	71.00
72.00	07200 IMPL. 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 OPULMONARY	3, 113	0		51	0	76.00
, 0, 0,	OUTPATIENT SERVICE COST CENTERS	57	<u> </u>	<u> </u>	<u> </u>		70.0.
	08800 RURAL HEALTH CLINIC	0	0		85	0	
	09000 CLI NI C 09001 WOUND CLI NI C	0	0	0	0	0	90.00
	09002 DI ABETES CLI NI C	3, 963	0	0	281 34	0	90. 01 90. 02
	09003 ASTHMA CLINIC	0	Ö	Ö	0	0	90.03
	09004 ANDIS CLINIC	3, 557	0	0	33	0	90. 04
	09005 PRIME TIME	0	0	0	0	0	90.05
90. 06 90. 07	09006 SHELBYVILLE WOUND CLINIC 04951 ONCOLOGY	18, 978	0	0	140 352	0	90. 06 90. 07
90. 08	04950 ANDERSON WOMENS CENTER	0	0	0	179	0	90.08
	09100 EMERGENCY	30, 196	4, 874	0	1, 441	1, 563	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	l	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	1	-				
	11600 HOSPI CE	14, 794	0	,	747		116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	281, 587	81, 639	339, 291	16, 280	14, 671	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	0	0	0	0	190. 00
190. 01	19001 PROFESSI ONAL BUILDING	100, 006	0	0	0	0	190. 01
	19002 PHYSI CI AN BUI LDI NG	0	0	0	0		190. 02
	19003 PRI VATE DUTY 19004 MARKETI NG	0	0	0	198 69		190. 03 190. 04
	19005 SPORTS PHYSI CALS		0	0	41		190.04
190.06	19006 FOUNDATI ON	3, 292	0	0	144		190. 06
	19007 ASC	0	0	0	0		190. 07
	19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0 (202	0	0	0		190.08
	19009 HANCOCK OB 19010 HANCOCK WELLNESS	6, 203	O O		190 0		190. 09 190. 10
	19011 MORRI STOWN CLINI C		0		ő		190. 10
190. 12	19012 03PUREMED	0	0	0	o	0	190. 12
	19013 MCCORD WELLNESS	0	0	0	0		190. 13
	19014 3 WEST UNIT 19015 NEUROLOGY PHYSICIAN	17, 152 0	0	0	105 0		190. 14 190. 15
	19016 THORACI		0		ő		190. 16
200.00							200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201.00

Health Financial Systems	HANCOCK REGION	IAL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0037	Peri od:	Worksheet B	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	
					5/16/2017 10:	<u> 17 am</u>
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMI NI STRATI O	
					N	
	7. 00	9. 00	10.00	11.00	13. 00	
202.00 TOTAL (sum lines 118-201)	408, 240	81, 639	339, 29	1 17, 027	14, 886	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2017 | 10/2

Control Cont				11) 12/31/2010	Date/lime Pre 5/16/2017 10:	
SIPPLY 11 INSWY 1	Cost Center Description		PHARMACY				
STREAM STRANGE CHAT CRAYERS 14.00 16.00 22.00 24.00					PRGM		
DEFERMAL SERVICE COST CENTERS 1.00 1.0			15 00		23 00	24 00	
1.00 000000	GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	23.00	24.00	
5.00 DOSCOL ARIM NISTRATIVE & CEMENT 7.00 DOSCOL OPERATION OF PLANT 9.00 DOSCOL OPERATION OF PLANT 9.00 DOSCOL OPERATION OF PLANT 9.00 DOSCOL OPERATION OF PLANT 13.00 DOSCOL OPERATION OF PLANT 13.00 DOSCOL OPERATION OF PLANT 13.00 DOSCOL OPERATION OF PLANT 14.00 DOSCOL OPERATION OF PLANT 14.00 DOSCOL OPERATION OF PLANT 15.00 DOSCOL OPERATION OF PLA							1.00
0,000 0,0	1						ł
9.00 0000000000000000000000000000000000	i i						ł
10.00 01000 DETARY							ł
11.00 10100 CAFETERIA							1
13.100 103100 MINSI NE ARMIN INSTRATION							1
15.00 01500 MARMACY 0 0 0 0 0 127,438 15.00 16.0							1
16.00 10-tool MEDICAL RECORDS & LISRAWY 0 0 127, 438 16.00 23 00 230		4, 559					
0 0 0 0 43,252 23 00 0 0 0 43,252 23 00	15. 00 01500 PHARMACY	98	142, 543				15.00
IMPATE INT. ROUTINE SERVICE COST CENTERS 83 0 34.281 848,949 30.00 30.00 30.00 30.00 30.00 31.00 11TENSIVE CARE UNIT 179 0 4.280 883.464 31.00 31.00 31.00 11TENSIVE CARE UNIT 179 0 4.280 883.464 31.00 31.00 31.00 11TENSIVE CARE UNIT 179 0 4.280 883.464 31.00		1	_				
30.00 30.0		0	0	0	43, 252		23.00
31.00		0.2	٥	24 201		040 040	20 00
0.000 0.0000 SURPROVIDER - I PF		1	_				•
		1 1	_				1
MICHILARY SERVICE COST CENTERS			_				•
51.00 05100 RECOVERY ROOM 6 0 0 67.49 51.00							
53.00 03500 AMESTHESIOLOGY 0 0 0 74 53.00		197	_			-	
54.00 05400 RADIOLOSY-DIAGNOSTIC 47		1 1	0				•
0.000 0.0000 LABORATORY 1, 0.055 0		1 '1	0	-			1
65.00 06500 RESPIRATORY THERAPY 13 0 0 86, 157 65.00		1	0				1
66.00 06600 PHYSICAL THERAPY 2	l .	1 ' 1	0				
67. 00 06700 OCCUPATIONAL THERAPY 2	1 1	2	o	0			
68.01 06801 05CUPATI ONAL HEALTH 0		2	o	0			1
69 00 06900 ELECTROCARDIOLOGY 16	68.00 06800 SPEECH PATHOLOGY	2	o	0		2, 217	68. 00
17.00	i i	1	0	-			1
17.20 17.2		1	0				1
173.00 07300 074.00 075.00 07		1	0	-			1
76. 00 03020 CARDIN CA		-	142 543	-			•
10 0316 CARDI OPULNONARY 1 0 0 66, 367 76, 01							•
88.00 GBROOR RURAL HEALTH CLINIC 12 0 0 3,394 88.00 09.00 09000 CLINIC 0 0 0 0 0 0 0 0 0		1	_	-			•
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0						·	
99.01 09001 09001 00100 CLI NI C							
99. 02 09002 DIABETES CLINIC 0 0 0 585 90. 02 90. 03 09003 ASTHMA CLINIC 0 0 0 0 0 0 90. 04 09004 ANDIS CLINIC 0 0 0 0 0 75, 771 90. 05 09005 PIME TIME 0 0 0 0 0 886 90. 05 90. 06 09006 SHELBYVILLE WOUND CLINIC 6 0 0 0 4, 707 90. 07 04951 ONCOLOGY 19 0 0 410, 310 90. 08 04950 ANDERSON WOMENS CENTER 3 0 0 0 3, 3, 545 90. 08 04950 ANDERSON WOMENS CENTER 3 0 0 0 3, 3, 545 90. 08 04950 ANDERSON WOMENS CENTER 3 0 0 0 0 91. 00 09000 DISPERVATION BEDS (NON-DISTINCT PART) 161 0 17, 610 694, 588 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 70. 00 97. 00 0700 DISPERVATION BEDS (NON-DISTINCT PART) 70. 00 70. 00 97. 00 0700 DISPERVATION BEDS (NON-DISTINCT PART) 70. 00 70. 00 98. 00 0700 DISPERVATION BEDS (NON-DISTINCT PART) 70. 00 70. 00 70. 00 99. 00 0900 OSEPRATION BEDS (NON-DISTINCT PART) 70. 00 70. 00 70. 00 99. 00 0900 OSEPRATION BEDS (NON-DISTINCT PART) 70. 00 70. 00 70. 00 99. 00 0100 HOME HEALTH AGENCY 70. 00 70. 00 70. 00 70. 00 99. 00 1000 DISPECT PARTITION 70. 00 70		1	-				•
90. 03 09003 ASTHMA CLINIC		1 1	0	0			1
90. 04 09004 ANDIS CLINIC 0 0 0 75,771 90. 04 90. 05 09005 PRIME TIME 0 0 0 0 886 90. 05 90. 06 09006 SHELBYVI LLE WOUND CLINIC 6 0 0 0 41,707 90. 07 04951 ONCOLOGY 19 0 0 0 410, 310 91. 08 04950 ANDERSON WOMENS CENTER 3 0 0 3,545 90. 08 04950 ANDERSON WOMENS CENTER 3 0 0 3,545 90. 08 04950 ANDERSON WOMENS CENTER 161 0 17,610 694,588 91. 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 07200 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 07500 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 07500 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 07500 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 07500 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 07500 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 07500 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 07500 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0		1	0	0			•
90.05 09005 PRIME TIME		-	ő	0		_	•
90. 07 04951 0NCOLOGY 19 0 0 410, 310 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 3 0 0 3.5, 545 90. 07 90. 08 04950 ANDERSON WOMENS CENTER 3 0 0 0 694, 588 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 92. 00 0 0 0 0 0THO 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 0THO 1000 HOME HEALTH AGENCY 0 0 0 0 0 0 0 101. 00 0THO 1000 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0		0	o	0			•
90. 08 04950 ANDERSON WOMENS CENTER 3 0 0 17,610 694,588 90. 08 91. 00 09200 DEBERGENCY 161 0 17,610 694,588 91. 00 92. 00 09200 DEBERGENCY 0 0 0 0 0 0 0 0 0	90.06 09006 SHELBYVILLE WOUND CLINIC	6	o	0		4, 707	90.06
91. 00 091.00 BEREGENCY 092.00 DESERVATION BEDS (NON-DISTINCT PART) 92. 00 DESERVATION BEDS (NON-DISTINCT PART)	· · · · · · · · · · · · · · · · · · ·	1 1	0	0		-	•
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 101. 00		1	0	0			
OTHER REIMBURSABLE COST CENTERS O		161	O	17,610		694, 588	
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00							92.00
SPECIAL PURPOSE COST CENTERS 40		O	ol	0		0	101.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 4,552 142,543 127,438 0 6,456,287 118.00 190.0	SPECIAL PURPOSE COST CENTERS	,					
NONRE MBURSABLE COST CENTERS 190.00 190000 GI FT. FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00			0				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 190. 01 19001 PROFESSI ONAL BUI LDI NG 0 0 0 0 0 190. 02 19002 PHYSI CI AN BUI LDI NG 0 0 0 0 190. 03 19003 PRI VATE DUTY 3 0 0 4, 629 190. 02 190. 04 19004 MARKETI NG 0 0 0 0 0 190. 05 19005 SPORTS PHYSI CALS 0 0 0 0 190. 07 19007 ASC 0 0 0 190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 190. 09 19009 HANCOCK OB 4 0 0 190. 10 19010 HANCOCK WELLNESS 0 0 0 190. 11 19011 MORRI STOWN CLI NI C 0 0 190. 12 19012 03PUREMED 0 0 190. 14 19014 3 WEST UNI T 0 0 0 190. 15 19015 NEUROLOGY PHYSI CI AN 0 190. 16 19016 TORACI TORACI 0 0 100. 10 19010 TORACI 0 0 10 190. 15 19016 TORACI 0 0 10 190. 16 19016 TORACI TORACI 0 10 190. 10 19010 TORACI 0 0 10 190. 15 19016 TORACI 0 0 10 190. 15 19016 TORACI 0 0 10 190. 16 19016 TORACI 0 0 10 190. 15 19016 TORACI 0 0 10 190. 16 19016 TORACI 0 0 10 190. 17 10 0 10 190. 10 190. 10 10 10 10 10 10 10 10 10 10 10 10 10		4, 552	142, 543	127, 438	0	6, 456, 287	118. 00
190. 01 19001 PROFESSI ONAL BUI LDI NG 190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 3 0 0 0 4, 629 190. 03 190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ما	0		0	100.00
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 3 0 0 0 4, 629 190. 03 190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS 190. 06 19006 FOUNDATI ON 190. 07 19007 ASC 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS 190. 11 19011 MORRI STOWN CLI NI C 190. 12 19012 19012 19012 19013 MCCORD WELLNESS 190. 13 19013 MCCORD WELLNESS 190. 14 19014 3 WEST UNI T 190. 15 19015 NEUROLOGY PHYSI CI AN 190. 16 19016 THORACI 190. 17 1901 THORACI 190. 18 19018 THORACI 190. 1900 O O O O O O O O O O O O O O O O O O		1	_	-			
190. 03 19003 PRI VATE DUTY 190. 04 19004 MARKETI NG 0 0 0 0 6, 612 190. 04 190. 05 19005 SPORTS PHYSI CALS 0 0 0 0 702 190. 05 190. 06 19006 FOUNDATI ON 0 0 0 0 72, 489 190. 06 190. 07 19007 ASC 0 0 0 0 0 72, 489 190. 06 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 0 165, 222 190. 09 190. 10 19010 HANCOCK OB 4 0 0 0 165, 222 190. 09 190. 11 19011 MORRI STOWN CLI NI C 0 0 0 0 190. 11 190. 12 19012 O3PUREMED 0 0 0 0 147 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 0 365, 525 190. 13 190. 14 19014 3 WEST UNI T 190. 15 19015 NEUROLOGY PHYSI CI AN 190. 16 19016 THORACI 0 0 0 0 340, 252 200. 00		1	-	-			
190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS 0 0 0 0 0 702 190. 05 190. 06 19006 FOUNDATI ON 0 0 0 0 72, 489 190. 06 190. 07 19007 ASC 0 0 0 0 0 25 190. 07 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 09 19009 HANCOCK OB 190. 09 19009 HANCOCK WELLNESS 0 0 0 0 165, 222 190. 09 190. 10 19010 MORRI STOWN CLI NI C 0 0 0 190. 11 190. 12 19012 O3PUREMED 0 0 0 0 147 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 147 190. 13 190. 14 19014 3 WEST UNI T 0 0 0 365, 525 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 190. 16 19016 190. 10 19016 190. 10 19016 190. 10 19016 190. 10 19016 190. 10 19016 190. 10 19017 NEUROLOGY PHYSI CI AN 190. 16 19016 190. 10 19016 190. 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		3	Ö				
190. 06 19006 FOUNDATION 0 0 0 72, 489 190. 06 190. 07 19007 ASC 0 0 0 0 25 190. 07 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 190. 08 190. 09 19009 HANCOCK OB 4 0 0 0 165, 222 190. 09 190. 10 19010 HANCOCK WELLNESS 0 0 0 0 183, 778 190. 10 190. 11 19011 MORRI STOWN CLINI C 0 0 0 0 190. 11 190. 12 19012 19012 03PUREMED 0 0 0 0 147 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 0 8, 794 190. 13 190. 14 19014 3 WEST UNI T 0 0 0 0 8, 794 190. 13 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 340, 252 200. 00 0 0 0 340 190. 16 190. 16 19016 THORACI 0 0 0 0 0 340, 252 200. 00		l o	o	7			
190. 07 19007 ASC 0 0 0 0 25 190. 07 190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 190. 08 190. 09 19009 HANCOCK OB 4 0 0 165, 222 190. 09 190. 10 190. 10 190. 10 190. 11 19011 MORRI STOWN CLINI C 0 0 0 147 190. 12 19012 O3PUREMED 0 0 0 0 147 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 0 147 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 0 147 190. 12 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 0 8, 794 190. 13 190. 14 19014 3 WEST UNI T 0 0 0 0 365, 525 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 0 340, 190. 15 190. 16 19016 THORACI 0 0 0 0 340, 252 200. 00	190. 05 19005 SPORTS PHYSI CALS	0	О	0		702	190. 05
190. 08 19008 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 190. 08 190. 09 19009 HANCOCK 0B 4 0 0 165, 222 190. 09 190. 10 19010 HANCOCK WELLNESS 0 0 0 0 0 13, 778 190. 10 190. 11 19011 MORRI STOWN CLINI C 0 0 0 0 147 190. 11 19012 03 PUREMED 0 0 0 0 147 190. 12 19012 03 PUREMED 0 0 0 0 8, 794 190. 13 19013 MCCORD WELLNESS 0 0 0 0 8, 794 190. 13 190. 14 190. 14 190. 14 190. 14 190. 14 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 365, 525 190. 14 190. 15 190. 16		0	0	0			
190. 09 19009 HANCOCK OB 4 0 0 165, 222 190. 09 190. 10 19010 HANCOCK WELLNESS 0 0 0 0 13, 778 190. 10 190. 11 19011 MORRI STOWN CLINI C 0 0 0 0 190. 11 190. 12 19012 O3PUREMED 0 0 0 0 147 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 8, 794 190. 13 190. 14 19014 3 WEST UNI T 0 0 0 365, 525 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 340, 190. 16 190. 16 19016 THORACI 0 0 0 340, 252 200. 00		0	0	0			
190. 10 19010 HANCOCK WELLNESS 0 0 0 0 13, 778 190. 10 190. 11 19011 MORRI STOWN CLI NI C 0 0 0 0 190. 11 190. 12 190.12 190.12 190.13 190.13 MCCORD WELLNESS 0 0 0 0 8, 794 190. 13 190.14 190.14 3 WEST UNI T 0 0 0 365, 525 190. 14 190.15 190.15 190.15 NEUROLOGY PHYSI CI AN 0 0 0 340, 190. 16 190.16 190.16 Cross Foot Adjustments 43, 252 200. 00		0	0	0			
190. 11 19011 MORRI STOWN CLINI C 0 0 0 0 190. 11 190. 12 190. 12 190. 12 190. 13 190. 13 190. 13 190. 13 190. 13 190. 14 190. 14 190. 15 190. 15 190. 15 190. 15 190. 16 190.		4	0	0			
190. 12 19012 03PUREMED 0 0 0 147 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 88, 794 190. 13 190. 14 190. 14 190. 14 190. 14 190. 15 190. 15 190. 15 190. 16 190. 16 190. 16 190. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0			
190. 13 19013 MCCORD WELLNESS 0 0 0 0 8, 794 190. 13 190. 14 190. 14 190. 14 190. 15 190. 15 190. 15 190. 16 190. 16 190. 16 190. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0			
190. 14 19014 3 WEST UNIT 0 0 0 365, 525 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 369, 525 190. 15 190. 16 19			ől	0			
190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 702 190. 15 190. 16 19016 THORACI 0 0 0 340 190. 16 200. 00 Cross Foot Adjustments 43, 252 200. 00			o	0			
200.00 Cross Foot Adjustments 43,252 43,252 200.00	190. 15 19015 NEUROLOGY PHYSICIAN	0	o	0		702	190. 15
200. 00 Cross Foot Adjustments 43, 252 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00			o	0		340	190. 16
201.00				_		43, 252	200.00
	ZUI. UU Negative Cost Centers	<u> </u> 0	O	0	0	0	<u> </u> 201.00

Health Financial Systems	HANCOCK REGIONA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	
					5/16/2017 10:	17 am_
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	
202.00 TOTAL (sum lines 118-201)	4, 559	142, 543	127, 43	43, 252	9, 252, 076	202. 00

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0037 Period: Worksheet B

From 01/01/2016 Part II Date/Time Prepared: 12/31/2016 5/16/2017 10:17 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 848, 949 30.00 03100 INTENSIVE CARE UNIT 0 31.00 888, 464 31.00 04000 SUBPROVI DER - I PF 0 40.00 40 00 286, 794 04100 SUBPROVI DER - I RF 41.00 41.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 827, 474 50.00 05100 RECOVERY ROOM 0 51.00 67,649 51.00 53.00 05300 ANESTHESI OLOGY 0 74 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 0 808, 792 54.00 60 00 06000 LABORATORY 226 268 60 00 06500 RESPIRATORY THERAPY 65.00 86, 157 65.00 66.00 06600 PHYSI CAL THERAPY 129, 591 66.00 06700 OCCUPATI ONAL THERAPY 67.00 00000000 4,043 67.00 06800 SPEECH PATHOLOGY 68 00 2, 217 68 00 06801 OCCUPATI ONAL HEALTH 68.01 68.01 06900 ELECTROCARDI OLOGY 230, 727 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 171, 796 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 23, 022 72 00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 142, 806 73.00 03020 CARDI AC 76.00 76.00 03160 CARDI OPULMONARY 0 76.01 66, 367 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 3, 394 90 00 09000 CLI NI C 0 C 90 00 0 09001 WOUND CLINIC 90.01 90.01 93, 578 09002 DIABETES CLINIC 90.02 585 90.02 90.03 09003 ASTHMA CLINIC 000000 0 90.03 09004 ANDIS CLINIC 90.04 75, 771 90.04 90.05 90.05 09005 PRIME TIME 886 90.06 09006 SHELBYVILLE WOUND CLINIC 4,707 90.06 90 07 04951 ONCOLOGY 410, 310 90.07 04950 ANDERSON WOMENS CENTER 90.08 90.08 3, 545 91.00 09100 EMERGENCY 694, 588 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 357, 733 116, 00 SUBTOTALS (SUM OF LINES 1-117) 0 118.00 6, 456, 287 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 190. 01 19001 PROFESSI ONAL BUILDING 0 0 0 2, 113, 019 190.01 190. 02 19002 PHYSICIAN BUILDING 190.02 553 190. 03 19003 PRI VATE DUTY l190. 03 4,629 6, 612 190. 04 19004 MARKETI NG 190.04 190. 05 19005 SPORTS PHYSI CALS 000000000000 702 190.05 190. 06 19006 FOUNDATI ON 72, 489 190. 06 190. 07 19007 ASC 25 190.07 190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 190.08 190. 09 19009 HANCOCK OB 165, 222 190.09 190. 10 19010 HANCOCK WELLNESS 190 10 13, 778 190. 11 19011 MORRI STOWN CLINIC 190. 11 C 190. 12 19012 03PUREMED 147 190.12 190. 13 19013 MCCORD WELLNESS 8. 794 190. 13 190. 14 19014 3 WEST UNIT 365, 525 190. 14 190. 15 19015 NEUROLOGY PHYSICIAN 702 190. 15 190. 16 19016 THORACI 340 190. 16

Heal th Finar	ncial Systems	HANCOCK REGION	AL HOSPITAL		In Lieu	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0037	Peri od:	Worksheet B	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre	epared:
						5/16/2017 10:	17 am_
	Cost Center Description	Intern &	Total				
		Resi dents					
		Cost & Post					
		Stepdown					
		Adjustments					
		25. 00	26. 00				
200.00	Cross Foot Adjustments	0	43, 252				200.00
201.00	Negative Cost Centers	0	0				201.00
202.00	TOTAL (sum lines 118-201)	0	9, 252, 076				202.00

	Financial Systems	HANCOCK REGION		.		u or form CMS-2	
COST A	ALLOCATION - STATISTICAL BASIS		Provider C	F	Period: From 01/01/2016 To 12/31/2016		pared:
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1. 00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	340, 218 2, 507 25, 943 12, 918 2, 208 11, 588 0	40, 348, 031 7, 057, 700 973, 239 1, 002, 116 438, 851 812, 023 1, 066, 629	-14, 941, 677 C C C C	6, 265, 785 1, 913, 083 706, 264 1, 520, 643	298, 850 2, 208 11, 588 0	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	70, 078	s c	97, 623	0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 888 3, 974	1, 480, 453 651, 124		.,,	1, 888 3, 974	1
23. 00	02300 PARAMED ED PRGM	1, 344	103, 569) C	128, 602	1, 344	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	22.750	2 (00 700		4 200 050	22.750	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	22, 759 23, 850	2, 689, 780 3, 437, 613			22, 759 23, 850	30.00
40. 00	04000 SUBPROVI DER - I PF	6, 376	1, 235, 734			6, 376	
41.00	04100 SUBPROVI DER - I RF	0	0	1			41.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	25, 149	2, 461, 936	1		25, 149	50.00
51.00	05100 RECOVERY ROOM	2, 120	227, 006	1	,	2, 120	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 25, 994	2, 787, 831				53. 00 54. 00
60.00	06000 LABORATORY	5, 844	1, 642, 235	1	5, 608, 920 4, 331, 887	5, 844	
65. 00	06500 RESPIRATORY THERAPY	2, 354	1, 182, 377	1		2, 354	
66.00	06600 PHYSI CAL THERAPY	3, 889	1, 054, 640	1	1, 439, 661	3, 889	
67. 00	06700 OCCUPATI ONAL THERAPY	0	306, 053	c c	378, 542	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	166, 284	1	210, 214	0	
68. 01	06801 OCCUPATI ONAL HEALTH	7 403	0 FF0 010	1	-	7 403	68. 01 69. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	7, 493 4, 692	559, 910 0		.,	7, 493 4, 692	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		2, 608, 747	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	o c		0	73.00
76. 00	03020 CARDI AC	0	0) c		0	76. 00
76. 01	03160 CARDI OPULMONARY	2, 279	53, 263	S] C	128, 685	2, 279	76. 01
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	O	103, 458	sl c	353, 760	0	88. 00
90.00	09000 CLINIC	0	103, 436			0	90.00
90. 01	09001 WOUND CLINIC	2, 901	667, 135				
90. 02	09002 DI ABETES CLINIC	0	41, 856				
	09003 ASTHMA CLINIC	0	0) c	0	0	
90. 04	09004 ANDIS CLINIC	2, 604	43, 437		,	2, 604	
90. 05 90. 06	O9005 PRIME TIME O9006 SHELBYVILLE WOUND CLINIC		272, 752		100, 341 464, 554	0	90. 05 90. 06
90. 07	04951 ONCOLOGY	13, 893	574, 681				
90.08	04950 ANDERSON WOMENS CENTER	0	258, 334			0	90.08
91. 00	09100 EMERGENCY	22, 105	2, 341, 594	C	3, 813, 027	22, 105	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	O	0) C) 0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		1	,		101.00
	11600 H0SPI CE	10, 830	1, 178, 493	C	2, 462, 906	10, 830	116. 00
118.00		247, 502	36, 942, 184	-14, 941, 677	70, 216, 878	206, 134	118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol) (0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	73, 209	0	1	-		190.00
	19002 PHYSI CI AN BUI LDI NG	0	0		62, 641		190.02
	19003 PRI VATE DUTY	0	191, 424	. c	440, 683	0	190. 03
	19004 MARKETI NG	0	122, 425		717, 973		190. 04
	19005 SPORTS PHYSICALS	0	52, 141		64, 889		190.05
	19006	2, 410	219, 804 0) C	356, 164 2, 812		190. 06 190. 07
	19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0				190.07
190.09	19009 HANCOCK OB	4, 541	1, 362, 229	1	-	4, 541	190. 09
	19010 HANCOCK WELLNESS	0	805, 568		1, 407, 066	-	190. 10
	19011 MORRI STOWN CLINI C	0	0	1	0		190. 11
	2 19012 03PUREMED	0	166 465 225		16, 648		190. 12 190. 13
	19013 MCCORD WELLNESS 19014 3 WEST UNIT	12, 556	465, 325 186, 765				190. 13
. , 0. 1-		1 12, 550	100, 700	1	700, 170	12,000	1.70.17

Heal th F	Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALI	LOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI V	OPERATION OF	
		FI XT	BENEFITS	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		·	SALARI ES)				
		1. 00	4. 00	5A	5. 00	7. 00	
190. 15 1	9015 NEUROLOGY PHYSICIAN	0	0)	79, 500	0	190. 15
190. 16 1	9016 THORACI	o	0)	0 38, 570	0	190. 16
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	9, 252, 076	6, 206, 247		14, 941, 677	7, 417, 374	1
202 00	Part I)	07.404550	0 450040		0 400700	04 040700	000 00
203.00	Unit cost multiplier (Wkst. B, Part I)	27. 194552		1	0. 183790		1
204. 00	Cost to be allocated (per Wkst. B, Part II)		68, 177		717, 426	408, 240	204.00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 001690)	0. 008825	1. 366036	205. 00

11)

COST ALLOCATION - STATISTICAL BASIS		Provi der CC	CN: 15-0037 P	eri od:	Worksheet B-1	
			F T	rom 01/01/2016 o 12/31/2016	Date/Time Pre	pared:
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	5/16/2017 10: CENTRAL	17 am
oost conton beschiptron	(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI O	SERVICES &	
	SERVI CE)	DAYS)		N (MANHOURS)	SUPPLY (COSTED	
				(WANHOURS)	REQUIS.)	
	9. 00	10. 00	11. 00	13.00	14.00	
1. 00 GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT	T T	1				1.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT	200 0/0					7.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	393, 860 6, 543	13, 132				9. 00 10. 00
11. 00 01100 CAFETERI A	10, 782	13, 132	819, 939			11.00
13.00 01300 NURSING ADMINISTRATION	0	О	22, 930			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	16, 355	0	4, 361		5, 713, 437	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	11, 930 14, 350	0	36, 437 25, 770		122, 415 0	15. 00 16. 00
23. 00 02300 PARAMED ED PRGM	16, 530	Ö	3, 022		6	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	109, 670	3, 748	76, 400		104, 376 224, 810	ı
31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	22, 610 18, 095	5, 460 3, 030	112, 470 38, 315		16, 900	40.00
41. 00 04100 SUBPROVI DER - RF	0	0, 000	00, 010		0	41.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	43, 900 16, 165	0	59, 282 5, 706		247, 467 7, 585	50.00 51.00
53. 00 05300 ANESTHESI OLOGY	10, 103	0	3, 700		7, 383	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 070	O	84, 465	84, 465	59, 374	54.00
60. 00 06000 LABORATORY	15, 335	0	62, 541		1, 321, 614	•
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	11, 745 13, 650	0	35, 428 27, 723		16, 404 2, 274	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	o	8, 823		2, 214	1
68.00 06800 SPEECH PATHOLOGY	O	o	3, 805		2, 586	1
68. 01 06801 0CCUPATI ONAL HEALTH	0	0	0		0	68. 01
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	26, 615	0	15, 478	0	20, 546 3, 236, 619	69. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	Ö	Ö	o	0, 200, 017	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 03020 CARDI AC 76. 01 03160 CARDI OPULMONARY	0	0	0 2, 460	0	0 829	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	<u> </u>		2, 400	<u> </u>	027	70.01
88. 00 08800 RURAL HEALTH CLINIC	0	0	4, 086	0	15, 023	88. 00
90. 00 09000 CLI NI C	0	0	13 540	-	0	90.00
90. 01 09001 WOUND CLINIC 90. 02 09002 DIABETES CLINIC	0	0	13, 549 1, 616		16, 793 163	90. 01 90. 02
90. 03 09003 ASTHMA CLINIC	O	o	0,010		0	90.03
90. 04 09004 ANDIS CLINIC	O	О	1, 605	0	88	
90. 05 09005 PRIME TIME	0	0	(722	0	0	•
90. 06 09006 SHELBYVILLE WOUND CLINIC 90. 07 04951 ONCOLOGY		0	6, 733 16, 971		6, 911 24, 161	•
90. 08 04950 ANDERSON WOMENS CENTER	o	Ō	8, 601		4, 276	
91. 00 09100 EMERGENCY	23, 515	0	69, 413	69, 413	201, 778	•
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101. 00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0 393, 860	894 13, 132	35, 967 783, 957		49, 900 5, 705, 112	
NONREIMBURSABLE COST CENTERS	J 373, 80U	13, 132	103, 951	001, 530	3, 705, 112	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
190. 01 19001 PROFESSI ONAL BUILDI NG	0	0	0	0		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY	0	0	9, 528	9, 528		190. 02 190. 03
190. 04 19004 MARKETI NG		ő	3, 343			190.03
190. 05 19005 SPORTS PHYSI CALS	0	o	1, 954			190. 05
190. 06 19006 FOUNDATI ON		0	6, 926			190. 06 190. 07
190. 07 19007 ASC 190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		O O	0			190.07
190. 09 19009 HANCOCK OB		ő	9, 150	o o		190.09
190. 10 19010 HANCOCK WELLNESS	0	О	0	0		190. 10
190. 11 19011 MORRI STOWN CLINIC	0	0	0	0		190. 11 190. 12
190. 12 19012 03PUREMED 190. 13 19013 MCCORD WELLNESS		ol Ol	3 0	0		190. 12
190. 14 19014 3 WEST UNIT		ő	5, 078	O	514	190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	0	0	0	0		190. 15
190. 16 19016 THORACI	0	0	C	0	0	190. 16

Heal th Finar	ncial Systems	HANCOCK REGIONAL	_ HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC	F	Period: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Pre 5/16/2017 10:	pared:
	Cost Center Description	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERIA (MANHOURS)	NURSI NG ADMI NI STRATI O N (MANHOURS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)	
		9. 00	10. 00	11. 00	13.00	14. 00	
200. 00 201. 00 202. 00	Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	2, 319, 491	1, 162, 212	1, 863, 619	1, 743, 244	233, 294	200. 00 201. 00 202. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	5. 889126 81, 639	88. 502284 339, 291			0. 040833 4, 559	203. 00 204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 207279	25. 836963	0. 020766	0. 022518	0. 000798	205. 00

| Period: | Worksheet B-1 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Provi der CCN: 15-0037

					te/Time Prepared:
Cost Center Description	PHARMACY	MEDI CAL	PARAMED ED	5/	16/2017 10:17 am
	(COSTED	RECORDS &	PRGM		
	REQUIS.)	LI BRARY (TI ME	(ASSIGNED TIME)		
		SPENT)	IIWL)		
	15. 00	16. 00	23. 00		
GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT					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					7.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9.00
11. 00 01100 CAFETERI A					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	100	3, 394			15. 00 16. 00
23. 00 02300 PARAMED ED PRGM	0	3, 374	10	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS	-		_		
30. 00 03000 ADULTS & PEDI ATRI CS	0	913		0	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	0	114 94		0	31. 00 40. 00
41. 00 04100 SUBPROVI DER - RF	o	0		o o	41.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0	1, 200		0	50.00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	0	0		0	51. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	o	137	10		54.00
60. 00 06000 LABORATORY	O	304		0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	•	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	O O	•	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	ł	o o	68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0		0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	156		0	69.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	100	7		o	73.00
76. 00 03020 CARDI AC	O	0		0	76.00
76. 01 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0		0	76. 01
88. 00 08800 RURAL HEALTH CLINIC	0	0		ol	88. 00
90. 00 09000 CLI NI C	0	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. 04 09004 ANDIS CLINIC	o	0		o o	90.04
90. 05 09005 PRI ME TI ME	O	0		0	90.05
90. 06 09006 SHELBYVI LLE WOUND CLINI C	0	0	l	0	90.06
90. 07 04951 ONCOLOGY 90. 08 04950 ANDERSON WOMENS CENTER	0	0		0	90. 07 90. 08
91. 00 09100 EMERGENCY	Ö	469		o	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	0	O	I	0	101.00
SPECIAL PURPOSE COST CENTERS	l d	U		O	101.00
116. 00 11600 H0SPI CE	0	0		0	116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	100	3, 394	10	0	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O		0	190.00
190. 01 19001 PROFESSI ONAL BUILDING	o	0	•	o o	190.00
190. 02 19002 PHYSICIAN BUILDING	O	0		0	190. 02
190. 03 19003 PRI VATE DUTY	0	0		0	190. 03
190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS	0	0		0	190. 04 190. 05
190. 06 19006 FOUNDATION		0		ŏ	190.05
190. 07 19007 ASC	0	o		0	190. 07
190. 08 19008 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	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		ol		ő	190. 10
190. 12 19012 03PUREMED		o		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	ł	0	190. 14 190. 15
190. 16 19016 THORACI	0	0		0	190. 15
·	. 1		•	*	· · · · · · · · · · · · · · · · · · ·

Health Financial Systems	HANCOCK REGION	AL HOSDITAL		In Liou	u of Form CMS-2) 552 10
ilear tii i i ilaici ar Systems	TIANCOCK KEGI ON	AL HOSFITAL		III LIEU	J OI TOTIII CW3-2	332-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0037	Peri od:	Worksheet B-1	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	pared:
					5/16/2017 10:	17 am
Cost Center Description	PHARMACY	MEDI CAL	PARAMED ED			
	(COSTED	RECORDS &	PRGM			
	REQUIS.)	LI BRARY	(ASSI GNED			

					37 107 2017 10. 17 aiii	
	Cost Center Description	PHARMACY	MEDI CAL	PARAMED ED		
		(COSTED	RECORDS &	PRGM		
		REQUIS.)	LI BRARY	(ASSI GNED		
			(TIME	TIME)		
			SPENT)	,		
		15. 00	16. 00	23. 00		
200.00	Cross Foot Adjustments				200.00	0
201. 00	Negative Cost Centers				201. 0	Ю
202. 00	Cost to be allocated (per Wkst. B,	11, 300, 715	1, 493, 069	297, 781	202. 00	Ю
	Part I)					
203. 00	Unit cost multiplier (Wkst. B, Part I)	113, 007. 15000	439. 914260	2, 977. 810000	203. 0	Ю
		0				
204. 00	Cost to be allocated (per Wkst. B,	142, 543	127, 438	43, 252	204. 00	Ю
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	1, 425. 430000	37. 548026	432. 520000	205. 0	Ю
	11)					

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0037	Peri od: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

					To 12/31/2016		pared: 17 am
			Title	XVIII	Hospi tal	PPS	
			<u>'</u>		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	, , , , , , , , , , , , , , , , , , ,	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	,				
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 307, 038		7, 307, 03	3 0	7, 307, 038	30.00
31.00	03100 INTENSIVE CARE UNIT	8, 043, 880		8, 043, 88	o	8, 043, 880	31.00
40.00	04000 SUBPROVI DER - I PF	2, 824, 165		2, 824, 16	5 0	2, 824, 165	40.00
41.00	04100 SUBPROVI DER - I RF	0			o	0	41.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8, 166, 888		8, 166, 88	8 0	8, 166, 888	50.00
51.00	05100 RECOVERY ROOM	593, 791		593, 79	1 0	593, 791	51.00
53.00	05300 ANESTHESI OLOGY	9, 975		9, 97	5 0	9, 975	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 154, 775		8, 154, 77	5 0	8, 154, 775	54.00
60.00	06000 LABORATORY	5, 858, 172		5, 858, 17	2 34, 707	5, 892, 879	60.00
65.00	06500 RESPI RATORY THERAPY	2, 038, 756	0	2, 038, 75	6 0	2, 038, 756	65.00
66.00	06600 PHYSI CAL THERAPY	2, 017, 378	0	2, 017, 37	8 0	2, 017, 378	66.00
67.00	06700 OCCUPATI ONAL THERAPY	468, 258	0	468, 25	8 0	468, 258	67.00
68.00	06800 SPEECH PATHOLOGY	257, 603	0	257, 60	3 0	257, 603	68. 00
68. 01	06801 OCCUPATI ONAL HEALTH	o	0		o	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	1, 575, 911		1, 575, 91	1 0	1, 575, 911	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 387, 892		4, 387, 89	2 0	4, 387, 892	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	3, 088, 209		3, 088, 20	9 0	3, 088, 209	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11, 303, 794		11, 303, 79	4 0	11, 303, 794	73.00
76.00	03020 CARDI AC	O			o	0	76. 00
76. 01	03160 CARDI OPULMONARY	214, 525		214, 52	5 0	214, 525	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	428, 678		428, 67	8 0	428, 678	88. 00
90.00	09000 CLI NI C	0			0	0	90.00
90. 01	09001 WOUND CLINIC	1, 351, 340		1, 351, 34	0	1, 351, 340	90. 01
90. 02	09002 DI ABETES CLINIC	68, 126		68, 12	6 0	68, 126	90. 02
90. 03	09003 ASTHMA CLINIC	0			0	0	90. 03
90.04	09004 ANDIS CLINIC	241, 714		241, 71	4 0	241, 714	90. 04
90.05	09005 PRIME TIME	118, 783		118, 78	3 0	118, 783	90. 05
90.06	09006 SHELBYVILLE WOUND CLINIC	565, 519		565, 51	9 0	565, 519	90.06
90. 07	04951 ONCOLOGY	2, 017, 736		2, 017, 73	6 0	2, 017, 736	90. 07
90.08	04950 ANDERSON WOMENS CENTER	412, 242		412, 24	2 0	412, 242	90. 08
91.00	09100 EMERGENCY	5, 756, 318		5, 756, 31	8 0	5, 756, 318	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	199, 002		199, 00	2	199, 002	92.00
	OTHER REIMBURSABLE COST CENTERS	,		,			
101.00	10100 HOME HEALTH AGENCY	0			0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	3, 442, 115		3, 442, 11		3, 442, 115	
200.00		80, 912, 583	0	,,		80, 947, 290	1
201.00	l l	199, 002		199, 00		199, 002	1
202.00	Total (see instructions)	80, 713, 581	0	80, 713, 58	1 34, 707	80, 748, 288	202.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0037	Period: From 01/01/2016	

					o 12/31/2016	Date/Time Pre 5/16/2017 10:	pared:
			Title	xVIII	Hospi tal	PPS	17 alli
			Charges	, , , , , , , , , , , , , , , , , , , ,	nospi tui	110	
	Cost Center Description	Inpati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	ocat contain boost per an	patront	output. o	+ col . 7)	Ratio	Inpatient	
				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1 21 22					
30.00	03000 ADULTS & PEDIATRICS	6, 982, 171		6, 982, 171			30.00
31. 00	03100 INTENSIVE CARE UNIT	11, 690, 903		11, 690, 903			31.00
40.00	04000 SUBPROVI DER - I PF	3, 793, 506		3, 793, 506			40.00
41. 00	04100 SUBPROVI DER - I RF	0		0			41.00
	ANCILLARY SERVICE COST CENTERS	'			'		1
50.00	05000 OPERATING ROOM	9, 535, 877	12, 131, 853	21, 667, 730	0. 376915	0.000000	50.00
51.00	05100 RECOVERY ROOM	946, 469	1, 294, 270	2, 240, 739	0. 264998	0.000000	51.00
53.00	05300 ANESTHESI OLOGY	18, 191	955	19, 146	0. 520997	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 416, 494	55, 005, 978	59, 422, 472	0. 137234	0.000000	54.00
60.00	06000 LABORATORY	6, 618, 167	32, 054, 880	38, 673, 047	0. 151479	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	3, 302, 624	4, 991, 355	8, 293, 979	0. 245812	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	861, 015	4, 021, 779	4, 882, 794	0. 413161	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	579, 839	749, 145	1, 328, 984	0. 352343	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	122, 914	471, 207	594, 121	0. 433587	0.000000	68.00
68. 01	06801 OCCUPATI ONAL HEALTH	O	0	0	0. 000000	0.000000	68. 01
69.00	06900 ELECTROCARDI OLOGY	5, 244, 568	9, 160, 494	14, 405, 062	0. 109400	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 124, 682	3, 261, 448	5, 386, 130	0. 814665	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6, 345, 656	1, 171, 814	7, 517, 470	0. 410804	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 527, 994	41, 215, 394	50, 743, 388	0. 222764	0.000000	73.00
76.00	03020 CARDI AC	0	0	0	0. 000000	0.000000	76.00
76. 01	03160 CARDI OPULMONARY	0	350, 776	350, 776	0. 611573	0.000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	398, 980	398, 980			88. 00
90.00	09000 CLI NI C	0	0	0	0. 000000	0.000000	90.00
90. 01	09001 WOUND CLINIC	17, 600	3, 482, 687	3, 500, 287	0. 386065	0.000000	90. 01
90. 02	09002 DI ABETES CLINIC	0	54, 209	54, 209	1. 256729	0.000000	
90. 03	09003 ASTHMA CLINIC	0	0	0	0. 000000	0.000000	90. 03
90.04	09004 ANDIS CLINIC	0	42, 703	42, 703	5. 660352	0.000000	90.04
90. 05	09005 PRIME TIME	55	365, 310	365, 365	0. 325108	0.000000	90.05
90.06	09006 SHELBYVI LLE WOUND CLINIC	1, 865	1, 745, 992	1, 747, 857	0. 323550	0.000000	90.06
90. 07	04951 ONCOLOGY	21, 597	3, 970, 171	3, 991, 768	0. 505474	0.000000	90. 07
90.08	04950 ANDERSON WOMENS CENTER	12, 488	3, 070, 026	3, 082, 514	0. 133736	0.000000	90.08
91.00	09100 EMERGENCY	4, 290, 926	31, 521, 931	35, 812, 857	0. 160733	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	139, 021	2, 525, 202	2, 664, 223	0. 074694	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	C			101.00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	891, 208	1, 732, 089		1		116. 00
200.00		77, 485, 830	214, 790, 648	292, 276, 478			200.00
201.00	1 1						201. 00
202.00	Total (see instructions)	77, 485, 830	214, 790, 648	292, 276, 478			202.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0037	Peri od: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/16/2017 10:17 am

				10 12/31/2010	5/16/2017 10: 17 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31. 00	03100 I NTENSI VE CARE UNI T				31.00
40.00	04000 SUBPROVI DER – I PF				40.00
41. 00	04100 SUBPROVI DER – I RF				41.00
41.00	ANCI LLARY SERVI CE COST CENTERS				41.00
50.00	05000 OPERATING ROOM	0. 376915			50.00
51.00	05100 RECOVERY ROOM	0. 370413			51.00
	05300 ANESTHESI OLOGY	0. 204998			53.00
53.00	I I	1			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 137234			54.00
60.00	06000 LABORATORY	0. 152377			60.00
65.00	06500 RESPI RATORY THERAPY	0. 245812			65.00
66.00	06600 PHYSI CAL THERAPY	0. 413161			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 352343			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 433587			68. 00
68. 01	06801 0CCUPATI ONAL HEALTH	0. 000000			68. 01
69.00	06900 ELECTROCARDI OLOGY	0. 109400			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 814665			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 410804			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 222764			73.00
76.00	03020 CARDI AC	0. 000000			76.00
76. 01	03160 CARDI OPULMONARY	0. 611573			76. 01
	OUTPATIENT SERVICE COST CENTERS	<u> </u>			
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLI NI C	0. 000000			90.00
90. 01	09001 WOUND CLINIC	0. 386065			90. 01
90. 02	09002 DI ABETES CLI NI C	1. 256729			90.02
90. 03	09003 ASTHMA CLINIC	0. 000000			90.03
90. 04	09004 ANDIS CLINIC	5. 660352			90.04
90.05	09005 PRIME TIME	0. 325108			90.05
90.06	09006 SHELBYVI LLE WOUND CLINIC	0. 323550			90.06
90.00	04951 ONCOLOGY	0. 525550			90.00
90.07	I I	0. 505474			90.07
90.08		1			
	09100 EMERGENCY	0. 160733			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 074694			92. 00
101 00	OTHER REIMBURSABLE COST CENTERS				101 00
101.00	10100 HOME HEALTH AGENCY				101.00
	SPECIAL PURPOSE COST CENTERS				
	11600 HOSPI CE				116.00
200.00	1 1				200. 00
201.00	i i				201. 00
202.00	Total (see instructions)	1			202.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0037	Period: Worksheet C From 01/01/2016 Part I
		To 12/31/2016 Date/Time Prepared

					To 12/31/2016		pared:
			Ti tl	e XIX	Hospi tal	Cost	17 diii
			11 61	e xix	Costs	1 0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	,				
		col . 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30.00	03000 ADULTS & PEDI ATRI CS	7, 307, 038		7, 307, 03		, ,	
31.00	03100 INTENSIVE CARE UNIT	8, 043, 880		8, 043, 88		8, 043, 880	1
40.00	04000 SUBPROVI DER - I PF	2, 824, 165		2, 824, 16		2, 824, 165	1
41. 00	04100 SUBPROVI DER - I RF	0			0 0	0	41.00
	ANCILLARY SERVICE COST CENTERS				-		
50.00	05000 OPERATING ROOM	8, 166, 888		8, 166, 88		8, 166, 888	
51.00	05100 RECOVERY ROOM	593, 791		593, 79		593, 791	1
53.00	05300 ANESTHESI OLOGY	9, 975		9, 97		9, 975	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 154, 775		8, 154, 77		8, 154, 775	
60.00	06000 LABORATORY	5, 858, 172		5, 858, 17			1
65.00	06500 RESPIRATORY THERAPY	2, 038, 756	0	_, -,,		2, 038, 756	1
66.00	06600 PHYSI CAL THERAPY	2, 017, 378	0	_, _, ,		2, 017, 378	
67.00	06700 OCCUPATI ONAL THERAPY	468, 258	0	468, 25		468, 258	1
68.00	06800 SPEECH PATHOLOGY	257, 603	0	257, 60		257, 603	1
68. 01	06801 OCCUPATI ONAL HEALTH	0	Ü		0	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	1, 575, 911		1, 575, 91		1, 575, 911	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	4, 387, 892		4, 387, 89		4, 387, 892	
73.00	07300 DRUGS CHARGED TO PATTENTS	3, 088, 209 11, 303, 794		3, 088, 20 11, 303, 79		3, 088, 209 11, 303, 794	
76.00	03020 CARDI AC	11, 303, 794			0 0	11, 303, 794	1
76. 00	03160 CARDI OPULMONARY	214, 525		214, 52		214, 525	1
70.01	OUTPATIENT SERVICE COST CENTERS	214, 323		214, 32	.5 0	214, 323	70.01
88. 00	08800 RURAL HEALTH CLINIC	428, 678		428, 67	8 0	428, 678	88. 00
90.00	09000 CLINIC	0			0 0	0	90.00
90. 01	09001 WOUND CLINIC	1, 351, 340		1, 351, 34		1, 351, 340	1
90. 02	09002 DI ABETES CLI NI C	68, 126		68, 12		68, 126	
90. 03	09003 ASTHMA CLINIC	0			0 0	0	1
90. 04	09004 ANDIS CLINIC	241, 714		241, 71	-	241, 714	
90. 05	09005 PRIME TIME	118, 783		118, 78		118, 783	
90.06	09006 SHELBYVILLE WOUND CLINIC	565, 519		565, 51		565, 519	1
90. 07	04951 ONCOLOGY	2, 017, 736		2, 017, 73	6 0	2, 017, 736	90. 07
90.08	04950 ANDERSON WOMENS CENTER	412, 242		412, 24		412, 242	
91.00	09100 EMERGENCY	5, 756, 318		5, 756, 31		5, 756, 318	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	199, 002		199, 00	2	199, 002	92.00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0			0	0	101.00
	SPECIAL PURPOSE COST CENTERS						1
	11600 H0SPI CE	3, 442, 115		3, 442, 11		3, 442, 115	
200.00		80, 912, 583	0				
201.00		199, 002		199, 00		199, 002	
202.00	Total (see instructions)	80, 713, 581	0	80, 713, 58	34, 707	80, 748, 288	202.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0037	Period: Worksheet C From 01/01/2016 Part I

To 12/31/2016 Date/Time Prepared: 5/16/2017 10:17 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TEFRA** + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6. 982. 171 6. 982. 171 30.00 31.00 03100 INTENSIVE CARE UNIT 11, 690, 903 11, 690, 903 31.00 04000 SUBPROVI DER - I PF 3, 793, 506 3, 793, 506 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 535, 877 12, 131, 853 21, 667, 730 0. 376915 0.000000 50.00 51.00 05100 RECOVERY ROOM 946, 469 1, 294, 270 2, 240, 739 0. 264998 0.000000 51.00 0.520997 05300 ANESTHESI OLOGY 18. 191 19.146 0.000000 53.00 955 53.00 55, 005, 978 05400 RADI OLOGY-DI AGNOSTI C 4, 416, 494 54.00 59, 422, 472 0.137234 0.000000 54 00 60.00 06000 LABORATORY 6, 618, 167 32, 054, 880 38, 673, 047 0.151479 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 3, 302, 624 4, 991, 355 8, 293, 979 0.245812 0.000000 65.00 06600 PHYSI CAL THERAPY 861, 015 4, 021, 779 4.882.794 0.000000 66.00 0.413161 66.00 67.00 06700 OCCUPATI ONAL THERAPY 579, 839 749, 145 1, 328, 984 0.352343 0.000000 67.00 06800 SPEECH PATHOLOGY 68 00 122, 914 471, 207 594, 121 0.433587 0.000000 68.00 06801 OCCUPATI ONAL HEALTH 0.000000 0.000000 68.01 68.01 14, 405, 062 69 00 06900 ELECTROCARDI OLOGY 5, 244, 568 9, 160, 494 0.109400 0.000000 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 124, 682 3, 261, 448 5, 386, 130 0.814665 0.000000 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 6, 345, 656 1, 171, 814 7, 517, 470 0.410804 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 9, 527, 994 41, 215, 394 50, 743, 388 0.222764 0.000000 73.00 76.00 03020 CARDI AC 0.000000 0.000000 76.00 76.01 03160 CARDI OPULMONARY 350, 776 350, 776 0.611573 0.000000 76.01 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 398, 980 398, 980 1.074435 0.000000 88 00 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 09001 WOUND CLINIC 3, 500, 287 90.01 17,600 3, 482, 687 0.386065 0.000000 90.01 09002 DIABETES CLINIC 54, 209 0.000000 90.02 0 54, 209 1.256729 90.02 09003 ASTHMA CLINIC 90.03 0 0.000000 0.000000 90.03 90.04 09004 ANDIS CLINIC 0 42,703 42,703 5.660352 0.000000 90.04 09005 PRIME TIME 90.05 55 365, 310 365, 365 0.325108 0.000000 90.05 90 06 09006 SHELBYVILLE WOUND CLINIC 1 865 1, 745, 992 1 747 857 0.323550 0.000000 90 06 90.07 04951 ONCOLOGY 21, 597 3, 970, 171 3, 991, 768 0.505474 0.000000 90.07 90.08 04950 ANDERSON WOMENS CENTER 12, 488 3, 070, 026 3, 082, 514 0.133736 0.000000 90.08 91.00 09100 EMERGENCY 4, 290, 926 31, 521, 931 35, 812, 857 0.160733 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 139, 021 0.074694 0.000000 92 00 92 00 2, 525, 202 2, 664, 223 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 0 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 891, 208 1, 732, 089 2, 623, 297 116.00 292, 276, 478 200.00 Subtotal (see instructions) 214, 790, 648 200.00 77, 485, 830 201.00 Less Observation Beds 201.00 77, 485, 830 214, 790, 648 Total (see instructions) 292, 276, 478 202.00 202.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0037	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/16/2017 10:17 am

					5/16/2017 10: 17	am_
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
	·	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				3	30.00
31.00	03100 INTENSIVE CARE UNIT				3	31. 00
40.00	04000 SUBPROVI DER - I PF				4	40.00
41. 00						41. 00
00	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000			5	50.00
51. 00	1	0. 000000				51. 00
53. 00	l l	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000			•	50.00
65.00		0. 000000			•	55.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000				57. 00
68. 00	1	0. 000000				58.00
68. 01	06801 OCCUPATI ONAL HEALTH	0. 000000				58. 01
	06900 ELECTROCARDI OLOGY	0. 000000				59. 00
71. 00		0. 000000				71. 00
71.00		0. 000000				72.00
72.00						72.00 73.00
		0.000000				
76.00	03020 CARDI AC	0.000000				76.00
76. 01	03160 CARDI OPULMONARY	0. 000000			/	76. 01
00 00	OUTPATIENT SERVICE COST CENTERS	0.000000				20.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				38.00
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	09001 WOUND CLINIC	0. 000000				90. 01
90. 02		0. 000000				90. 02
90. 03	09003 ASTHMA CLINIC	0. 000000				90. 03
90. 04	09004 ANDIS CLINIC	0. 000000				90. 04
90. 05	09005 PRIME TIME	0. 000000				90. 05
90. 06	09006 SHELBYVI LLE WOUND CLINIC	0. 000000				90.06
90. 07	04951 ONCOLOGY	0. 000000				90. 07
90. 08	04950 ANDERSON WOMENS CENTER	0. 000000				90.08
91.00		0. 000000				91. 00
92.00		0. 000000			9	92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				10	01.00
	SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPI CE					16.00
200.00	Subtotal (see instructions)				20	00.00
201.00	Less Observation Beds				20	01.00
202.00	Total (see instructions)				20	02.00

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2016	Worksheet D Part I	
				Го 12/31/2016		
		Title	e XVIII	Hospi tal	PPS	.,
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	T	T		,		
30. 00 ADULTS & PEDIATRICS	848, 949		848, 94			
31. 00 I NTENSI VE CARE UNI T	888, 464		888, 46			
40. 00 SUBPROVI DER - I PF	286, 794	0	286, 79	1		
41. 00 SUBPROVI DER - I RF	0	0	1	0	0. 00	
200.00 Total (lines 30-199)	2, 024, 207		2, 024, 20	7 12, 272		200.00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	/ 00	col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00				
30.00 ADULTS & PEDIATRICS	1, 059	237, 714				30.00
31. 00 INTENSIVE CARE UNIT	2, 587				ļ	31.00
40. 00 SUBPROVI DER - I PF	2, 739				l	40.00
41. 00 SUBPROVIDER - TPF	2,739	259, 240	1		l	41.00
200.00 Total (lines 30-199)	6, 385	1			ļ	200.00
200.00 10tal (111165 30-179)	0, 303	917, 917	1		l	200.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS Provider CCN: 15-0037	Period: Worksheet D

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co	F	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 5/16/2017 10:	pared:
			: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	827, 474					
51. 00 05100 RECOVERY ROOM	67, 649		•	1		
53. 00 05300 ANESTHESI OLOGY	74					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	808, 792		0. 013611			
60. 00 06000 LABORATORY	226, 268			· · ·		
65. 00 06500 RESPIRATORY THERAPY	86, 157	8, 293, 979	0. 010388	1, 781, 905	18, 510	65.00
66. 00 06600 PHYSI CAL THERAPY	129, 591	4, 882, 794			11, 930	
67. 00 06700 OCCUPATI ONAL THERAPY	4, 043	1, 328, 984	0. 003042	270, 093	822	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 217	594, 121	0. 003732	77, 101	288	68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0. 000000	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	230, 727	14, 405, 062	0. 016017	1, 941, 833	31, 102	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	171, 796	5, 386, 130	0. 031896	932, 014	29, 728	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	23, 022	7, 517, 470	0. 003062	3, 016, 015	9, 235	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	142, 806	50, 743, 388	0. 002814	4, 064, 228	11, 437	73.00
76. 00 03020 CARDI AC	0	0	0. 000000	0	0	76.00
76. 01 03160 CARDI OPULMONARY	66, 367	350, 776	0. 189201	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						1
88. 00 08800 RURAL HEALTH CLINIC	3, 394	398, 980	0. 008507	0	0	88. 00
90. 00 09000 CLI NI C	0	0	0. 000000	0	0	90.00
90. 01 09001 WOUND CLINIC	93, 578	3, 500, 287	0. 026734	4, 798	128	90. 01
90. 02 09002 DI ABETES CLI NI C	585	54, 209	0. 010792	0	0	90. 02
90.03 09003 ASTHMA CLINIC	0	0	0. 000000	0	0	90.03
90. 04 09004 ANDIS CLINIC	75, 771	42, 703	1. 774372	0	0	90.04
90. 05 09005 PRIME TIME	886	365, 365	0.002425	48	0	90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	4, 707	1, 747, 857	0.002693	0	0	90.06
90. 07 04951 ONCOLOGY	410, 310	3, 991, 768	0. 102789	0	0	90.07
90. 08 04950 ANDERSON WOMENS CENTER	3, 545	3, 082, 514	0. 001150	8, 232	9	90.08
91. 00 09100 EMERGENCY	694, 588			2, 624, 494	50, 902	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	23, 120				1	92.00
200.00 Total (lines 50-199)	4, 097, 467	267, 186, 601		24, 645, 747	356, 061	200.00

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co		Peri od:	Worksheet D	
				From 01/01/2016 To 12/31/2016		nared:
				10 12/31/2010	5/16/2017 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Allied Health	All Other	Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost		minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	,	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	'	0	0	31.00
40. 00 04000 SUBPROVI DER - I PF	0	0	'	0	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	0		0	0	41.00
200. 00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	Inpatient	Inpatient		
	Days	(col. 5 ÷ col. 6)	Program Days	Program Pass-Through		
		COI. 6)		Cost (col. 7		
				x col. 8)		
	6, 00	7. 00	8. 00	9, 00	1	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00		
30. 00 03000 ADULTS & PEDIATRICS	3, 782	0.00	1, 05	9 0	,	30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 460				,	31.00
40. 00 04000 SUBPROVI DER - I PF	3, 030				,	40.00
41. 00 04100 SUBPROVI DER - RF	0	0.00		o o	,	41.00
200.00 Total (lines 30-199)	12, 272		6, 38	5 0	,	200.00
		'		"	•	

Health Financial Systems	HANCOCK REGIONAL	. HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0037		Worksheet D
THROUGH COSTS			From 01/01/2016	Part IV

I TROUGH C	.00313			Ţ	0 12/31/2016	Date/Time Pre 5/16/2017 10:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Allied Health	All Other	Total Cost	
		Anesthetist	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS						
1	000 OPERATING ROOM	0	0	0	0	0	00.00
	100 RECOVERY ROOM	0	0	0	0	0	51.00
4	300 ANESTHESI OLOGY	0	0	0	0	0	53.00
4	400 RADI OLOGY-DI AGNOSTI C	0	0	297, 781	0	297, 781	54.00
4	000 LABORATORY	0	0	0	0	0	60.00
	500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
	600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
	700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
	801 OCCUPATI ONAL HEALTH	0	0	0	0	0	68. 01
	900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
	300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
4	020 CARDI AC	0	0	0	0	0	76. 00
	160 CARDI OPULMONARY	0	0	0	0	0	76. 01
	TPATIENT SERVICE COST CENTERS				<u> </u>		
	800 RURAL HEALTH CLINIC	0	0	1	_	0	88. 00
	000 CLI NI C	0	0	0	0	0	90.00
	001 WOUND CLINIC	0	0	0	0	0	90. 01
	002 DI ABETES CLI NI C	0	0	0	0	0	90. 02
	003 ASTHMA CLINIC	0	0	0	0	0	90. 03
	004 ANDIS CLINIC	0	0	0	0	0	90.04
	005 PRIME TIME	0	0	0	0	0	90.05
	006 SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
	951 ONCOLOGY	0	0	0	0	0	90. 07
	950 ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
	100 EMERGENCY	0	0	0	0	0	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	, ,
200.00	Total (lines 50-199)	0	0	297, 781	0	297, 781	200. 00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0037	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared:

			Т	o 12/31/2016	Date/Time Pre 5/16/2017 10:	
		Title	e XVIII	Hospi tal	PPS	.,
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS		04 (/7 700		0.00000	0.000.117	
50. 00 05000 OPERATING ROOM	0	, ,				50.00
51. 00 05100 RECOVERY ROOM	0	2, 240, 739				
53. 00 05300 ANESTHESI OLOGY	0	19, 146				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	297, 781	59, 422, 472	1		2, 509, 532	54.00
60. 00 06000 LABORATORY	0	38, 673, 047				60.00
65. 00 06500 RESPI RATORY THERAPY	0	8, 293, 979	1		1, 781, 905	65.00
66. 00 06600 PHYSI CAL THERAPY	0	4, 882, 794			449, 515	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 328, 984			· ·	67.00
68. 00 06800 SPEECH PATHOLOGY	0	594, 121			· ·	68. 00
68. 01 06801 0CCUPATI ONAL HEALTH	0	0	0.00000			68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	14, 405, 062	l .			1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 386, 130			· ·	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	7, 517, 470	l .			•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	50, 743, 388				
76. 00 03020 CARDI AC	0	0				76.00
76. 01 03160 CARDI OPULMONARY	0	350, 776	0.000000	0. 000000	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	398, 980			0	
90. 00 09000 CLI NI C	0	0	0.00000			90.00
90. 01 09001 WOUND CLINIC	0	3, 500, 287				90. 01
90. 02 09002 DI ABETES CLI NI C	0	54, 209			0	90. 02
90. 03 09003 ASTHMA CLINIC	0	0	0.00000		0	90. 03
90. 04 09004 ANDIS CLINIC	0	42, 703			0	90.04
90. 05 09005 PRI ME TI ME	0	365, 365	0.000000	0. 000000	48	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	1, 747, 857			0	90.06
90. 07 04951 ONCOLOGY	0	3, 991, 768	0.000000	0. 000000	0	90. 07
90.08 04950 ANDERSON WOMENS CENTER	0	3, 082, 514	0.000000	0.000000	8, 232	90.08
91. 00 09100 EMERGENCY	0	35, 812, 857	0.000000	0. 000000	2, 624, 494	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 664, 223	0.000000	0. 000000	103	92.00
200.00 Total (lines 50-199)	297, 781	267, 186, 601			24, 645, 747	200. 00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

HANCOCK REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

Period: From 01/01/2016 Part IV

To 12/31/2016 Date/Time Prepared:

5/16/	/2017 10:17 am
Title XVIII Hospital	PPS
Cost Center Description Inpatient Outpatient Outpatient	
Program Program Program	
Pass-Through Charges Pass-Through	
Costs (col. 8 Costs (col. 9	
x col . 10) x col . 12)	
11.00 12.00 13.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 0 2, 575, 191 0	50.00
51. 00 05100 RECOVERY ROOM 0 283, 950 0	51.00
53. 00 05300 ANESTHESI OLOGY 0 728 0	53.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 12, 575 15, 416, 169 77, 250	54.00
60. 00 06000 LABORATORY 0 4, 420, 474 0	60.00
65. 00 06500 RESPI RATORY THERAPY 0 1, 437, 620 0	65.00
66. 00 06600 PHYSI CAL THERAPY 0 41, 494 0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 24, 375 0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 48, 446 0	68. 00
68. 01 06801 0CCUPATI ONAL HEALTH 0 0 0	68. 01
69. 00 06900 ELECTROCARDI OLOGY 0 3, 917, 537 0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 816,115 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 278,205 0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 11, 333, 850 0	73.00
76. 00 03020 CARDI AC 0 0 0	76.00
76. 01 03160 CARDI OPULMONARY 0 150, 102 0	76. 01
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 0 0 0	88.00
90. 00 09000 CLI NI C 0 0 0	90.00
90. 01 09001 WOUND CLINIC 0 2, 320, 692 0	90. 01
90. 02 09002 DI ABETES CLINI C 0 47 0	90. 02
90. 03 09003 ASTHMA CLINIC 0 0 0	90. 03
90. 04 09004 ANDIS CLINIC 0 3, 238 0	90.04
90. 05 09005 PRI ME TI ME 0 20, 492 0	90.05
90. 06 09006 SHELBYVI LLE WOUND CLINI C 0 304, 721 0	90.06
90. 07 04951 0NCOLOGY 0 552, 186 0	90. 07
90. 08 04950 ANDERSON WOMENS CENTER 0 639 0	90. 08
91. 00 09100 EMERGENCY 0 6, 331, 038 0	91.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 1,635,243 0	92.00
200. 00 Total (lines 50-199) 12, 575 51, 912, 552 77, 250	200.00

From 01/01/2016 Part V Date/Time Prepared: 12/31/2016 5/16/2017 10:17 am Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To inst.) Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 376915 2, 575, 191 970, 628 50.00 05100 RECOVERY ROOM 0 0 0. 264998 51.00 283, 950 0 51.00 75, 246 0 53.00 05300 ANESTHESI OLOGY 0. 520997 728 379 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.137234 15, 416, 169 0 2, 115, 623 54.00 60.00 06000 LABORATORY 0. 151479 4, 420, 474 78 0 669, 609 60.00 0 1, 437, 620 65.00 06500 RESPIRATORY THERAPY 0.245812 0 353, 384 65.00 66.00 06600 PHYSI CAL THERAPY 0.413161 41, 494 0 0 17, 144 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 352343 24, 375 0 8, 588 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 0.433587 48.446 21,006 68.00 06801 OCCUPATI ONAL HEALTH 0 68.01 0.000000 Ω 68.01 69.00 06900 ELECTROCARDI OLOGY 0.109400 3, 917, 537 0 0 428, 579 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0.814665 816, 115 0 664, 860 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 0 410804 278, 205 0 0 114 288 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 222764 11, 333, 850 269 25, 043 2, 524, 774 73.00 76.00 03020 CARDI AC 0.000000 0 0 76.00 03160 CARDI OPULMONARY 0.611573 150, 102 91, 798 76.01 76.01 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 90.00 09000 CLI NI C 0.000000 0 90.00 90.01 09001 WOUND CLINIC 0.386065 2, 320, 692 0 0 895, 938 90.01 90 02 09002 DIABETES CLINIC 1. 256729 0 0 90.02 47 59 0 90.03 09003 ASTHMA CLINIC 0.000000 0 90.03 09004 ANDIS CLINIC 3, 238 0 18, 328 90.04 5.660352 90.04 0 09005 PRIME TIME 0. 325108 20, 492 0 90.05 6,662 90.05 09006 SHELBYVILLE WOUND CLINIC 0 304, 721 98, 592 90.06 0.323550 90.06 90.07 04951 ONCOLOGY 0.505474 552, 186 0 0 279, 116 90.07 90.08 04950 ANDERSON WOMENS CENTER 0.133736 639 0 0 85 90.08 09100 EMERGENCY 0 1, 017, 607 91 00 0.160733 6, 331, 038 0 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.074694 1, 635, 243 0 0 122, 143 92.00 10, 494, 436 200. 00 200.00 Subtotal (see instructions) 51, 912, 552 347 25, 043 Less PBP Clinic Lab. Services-Program 201.00 201.00 0 Only Charges

51, 912, 552

347

25.043

10, 494, 436 202. 00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems HANCOCK REC	IONAL HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE CO	ST Provi der CCN: 15-0037	From 01/01/2016 F	Worksheet D Part V Date/Time Prepared

				To 12/31/2016	Date/Time Prepar 5/16/2017 10:17	red: am
		Ti tl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins	.			
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0		0		50	0. 00
51. 00 05100 RECOVERY ROOM	0		ol		51	1.00
53. 00 05300 ANESTHESI OLOGY	0		o			3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		ol		54	4. 00
60. 00 06000 LABORATORY	12		o		•	0.00
65. 00 06500 RESPIRATORY THERAPY	0		ol			5. 00
66. 00 06600 PHYSI CAL THERAPY	0		o l			6. 00
67. 00 06700 OCCUPATI ONAL THERAPY					•	7. 00
68. 00 06800 SPEECH PATHOLOGY						8. 00
68. 01 06801 OCCUPATI ONAL HEALTH						8. 01
69. 00 06900 ELECTROCARDI OLOGY						9. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						1. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0					2. 00
73. 00 07300 DRUGS CHARGED TO PATIENT	60	5, 57	9			2. 00 3. 00
	00	5, 57	1			3. 00 6. 00
76. 00 03020 CARDI AC	0		0			6. 00 6. 01
76. 01 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	1	U			6. U I
88. 00 08800 RURAL HEALTH CLINIC	1 0	I	o		0.0	8. 00
90. 00 09000 CLINIC			0			0.00
1 I	0					0. 00 0. 01
	0					
90. 02 09002 DI ABETES CLINI C	0					0. 02
90. 03 09003 ASTHMA CLINIC	0					0. 03
90. 04 09004 ANDIS CLINIC	0		0			0.04
90. 05 09005 PRI ME TI ME	0		0			0. 05
90. 06 O9006 SHELBYVILLE WOUND CLINIC	0		0			0. 06
90. 07 04951 ONCOLOGY	0		0			0. 07
90.08 04950 ANDERSON WOMENS CENTER	0		0			0. 08
91. 00 09100 EMERGENCY	0		0			1. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0			2.00
200.00 Subtotal (see instructions)	72	5, 57	9			0.00
201.00 Less PBP Clinic Lab. Services-Program	0				201	1. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	72	5, 57	9		202	2. 00

Walth Standard Cartan	HANDOOK BEGLON	UAL LICCOL TAL		111	G F OHG (2552.40
Health Financial Systems	NAL HOSPITAL	ON 15 0007	Period:	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL CUSIS	Provi der C	CN: 15-0037	From 01/01/2016	Worksheet D Part II	
		Component	CCN: 15-S037	To 12/31/2016		pared: 17 am
		Title	: XVIII	Subprovi der – I PF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)		·			
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	827, 474	21, 667, 730	0. 03818	33, 407	1, 276	50.00
51.00 05100 RECOVERY ROOM	67, 649	2, 240, 739	0. 03019	3, 472	105	51.00
53. 00 05300 ANESTHESI OLOGY	74	19, 146	0. 00386	39	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	808, 792	59, 422, 472	0. 0136	101, 051	1, 375	54.00
60. 00 06000 LABORATORY	226, 268	38, 673, 047	0. 0058	51 422, 870	2, 474	60.00
65. 00 06500 RESPIRATORY THERAPY	86, 157	8, 293, 979	0. 01038	38 179, 886	1, 869	65.00
66. 00 06600 PHYSI CAL THERAPY	129, 591	4, 882, 794	0. 02654	40 63, 356	1, 681	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 043	1, 328, 984	0.00304	108, 801	331	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 217	594, 121	0.00373	18, 431	69	68.00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0	0.00000	00	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	230, 727	14, 405, 062			253	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	171, 796				1, 797	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	23, 022	7, 517, 470	0.0030	13, 632	42	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	142, 806				1, 090	
76. 00 03020 CARDI AC	0		1		0	76.00
76. 01 03160 CARDI OPULMONARY	66, 367	350, 776			0	76. 01
OUTPATIENT SERVICE COST CENTERS			•			
88. 00 08800 RURAL HEALTH CLINIC	3, 394	398, 980	0.00850	07 0	0	88. 00
90. 00 09000 CLI NI C	0		0. 00000	00 0	0	90.00
90. 01 09001 WOUND CLINIC	93, 578	3, 500, 287	0. 02673	2, 281	61	90. 01
90. 02 09002 DI ABETES CLINIC	585	54, 209	0. 01079		0	90. 02
90. 03 09003 ASTHMA CLINIC	0		1	00	0	90. 03
90. 04 09004 ANDIS CLINIC	75, 771	42, 703			0	90.04
90. 05 09005 PRI ME TI ME	886				0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	4, 707				0	90.06
90. 07 04951 0NCOLOGY	410, 310				0	90. 07
90. 08 04950 ANDERSON WOMENS CENTER	3, 545				_	90.08
91. 00 09100 EMERGENCY	694, 588				1, 238	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
200. 00 Total (lines 50-199)	4, 074, 347		1	1, 474, 976	-	

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der (CCN: 15-0037	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2016	Part IV	
		Component	CCN: 15-S037	To 12/31/2016	Date/Time Pre 5/16/2017 10:	pared:
		Ti +I	e XVIII	Subprovi der -	PPS	17 alli
		11 (1)	C XVIII	I PF	113	
Cost Center Description	Non Physician	Nursi ng	Allied Healt		Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	(0	0 0	0	
51.00 05100 RECOVERY ROOM	0	(0	0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	(0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(0 297, 7		297, 781	54.00
60. 00 06000 LABORATORY	0	(0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	(0	0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	(0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	(0	0	0	
68. 01 06801 OCCUPATI ONAL HEALTH	0	(0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	(0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	(0	0	
	0	(0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CARDI AC		(0 0	0	
76. 00 03020 CARDI AC 76. 01 03160 CARDI OPULMONARY		(0 0		
OUTPATIENT SERVICE COST CENTERS	J U		<u> </u>	0 0		70.01
88. 00 08800 RURAL HEALTH CLINIC	O		O	0 0	0	88.00
90. 00 09000 CLINI C	0	·		0 0	0	
90. 01 09001 WOUND CLINIC	0	(0 0	l o	90. 01
90. 02 09002 DI ABETES CLINI C	0	(0 0	l ő	1
90. 03 09003 ASTHMA CLINIC	o	(ol	0 0	0	1
90. 04 09004 ANDIS CLINIC	0	(o	0 0	0	90.04
90. 05 09005 PRIME TIME	0	(ol	0 0	0	90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	0	(ol	0 0	0	90.06
90. 07 04951 ONCOLOGY	0	(o	0 0	0	90. 07
90.08 04950 ANDERSON WOMENS CENTER	0	(0	0 0	0	90.08
91. 00 09100 EMERGENCY	0	(0	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(0	0 0	0	92.00
200.00 Total (lines 50-199)	0	(0 297, 7	81 0	297, 781	200.00

Health Financial Systems	HANCOCK REGION				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der C		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2016 To 12/31/2016		pared: 17 am
		Title	: XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	21, 667, 730			33, 407	50.00
51.00 05100 RECOVERY ROOM	0	2, 240, 739			3, 472	
53. 00 05300 ANESTHESI OLOGY	0	19, 146			39	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	297, 781	59, 422, 472			101, 051	54.00
60. 00 06000 LABORATORY	0	38, 673, 047			422, 870	
65. 00 06500 RESPI RATORY THERAPY	0	8, 293, 979			179, 886	1
66. 00 06600 PHYSI CAL THERAPY	0	4, 882, 794			63, 356	
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 328, 984			108, 801	67.00
68. 00 06800 SPEECH PATHOLOGY	0	594, 121			18, 431	68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0			0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	14, 405, 062			15, 820	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 386, 130			56, 344	71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENT	0	7, 517, 470		0.000000	13, 632	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	50, 743, 388			387, 491	73.00
76. 00 03020 CARDI AC	0	0			0	76. 00
76. 01 03160 CARDI OPULMONARY	0	350, 776	0.00000	0.000000	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	398, 980			0	88. 00
90. 00 09000 CLI NI C	0	0	0.00000		0	90.00
90. 01 09001 WOUND CLINIC	0	3, 500, 287	0.00000	0.000000	2, 281	90. 01
90. 02 09002 DI ABETES CLINIC	0	54, 209	0.00000	0.000000	0	90. 02
90.03 09003 ASTHMA CLINIC	0	0	0.00000	0.000000	0	90.03
90. 04 09004 ANDIS CLINIC	0	42, 703	0.00000	0.000000	0	90.04
90.05 09005 PRIME TIME	0	365, 365	0.00000	0.000000	7	90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	0	1, 747, 857	0. 00000	0. 000000	0	90.06
90. 07 04951 ONCOLOGY	0	3, 991, 768	0. 00000	0. 000000	0	90. 07
90.08 04950 ANDERSON WOMENS CENTER	0	3, 082, 514	0. 00000	0. 000000	4, 256	90.08
91. 00 09100 EMERGENCY	0	35, 812, 857	0. 00000	0. 000000	63, 832	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 664, 223	0. 00000	0. 000000	0	92.00
200.00 Total (lines 50-199)	297, 781	267, 186, 601			1, 474, 976	200.00

Health Financial Systems	HANCOCK REGIONAL		011 45 0007		u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provi der C	CN: 15-0037	Period: From 01/01/2016	Worksheet D Part IV	
Inkough COSIS		Component	CCN: 15-S037	To 12/31/2016		
		Title	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description		Outpati ent	Outpati ent		•	
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col . 10)	10.00	x col . 12)			
ANCILLARY SERVICE COST CENTERS	11. 00	12. 00	13. 00			
50. 00 05000 OPERATING ROOM	O	0		0		50.00
51. 00 05100 RECOVERY ROOM	0	0	1	0		51.00
53. 00 05300 ANESTHESI OLOGY	0	0	1	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	506	0		0		54.00
60. 00 06000 LABORATORY	o	0		0		60.00
65. 00 06500 RESPIRATORY THERAPY	O	0		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68. 00
68. 01 06801 OCCUPATI ONAL HEALTH	0	0)	0		68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0	1	0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0)	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0		73.00
76. 00 03020 CARDI AC	0	0	1	0		76.00
76. 01 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0	<u>'</u>	U		76. 01
88. 00 08800 RURAL HEALTH CLINIC	O	0	VI.	0		88.00
90. 00 09000 CLINI C		0	1	0		90.00
90. 01 09001 WOUND CLINIC		0	1	0		90.00
90. 02 09002 DI ABETES CLI NI C	0	0	ó	0		90.02
90. 03 09003 ASTHMA CLI NI C	0	0		0		90.03
90. 04 09004 ANDI S CLI NI C	o	0		Ö		90.04
90. 05 09005 PRIME TIME	o	0		0		90. 05
90. 06 09006 SHELBYVILLE WOUND CLINIC	O	0		0		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	0	0)	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0		92.00
200.00 Total (lines 50-199)	506	0)	0		200.00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0037	Peri od:	Worksheet D-1	
			From 01/01/2016 To 12/31/2016		
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00 Inpatient days (including private room days	and swing-bed day	rs, excluding newborn)		3, 782	1.00
2.00 Inpatient days (including private room days,	excluding swing-	bed and newborn days)		3, 782	2.00
3.00 Private room days (excluding swing-bed and o	bservation bed da	ys). If you have only p	rivate room days,	0	3. 00

PART I - ALL PROVIDER COMPONENTS 1.00		Cost Conter Description	PPS	
Impattint Days Impattint days (including private room days and swing-bed days, excluding neeborn) 3,782 1.00 Impattint days (including private room days, excluding swing-bed and neoborn days) 3,782 2.00 Impattint days (including private room days, excluding swing-bed and neoborn days) 3,782 2.00 1.00		Cost Center Description	1. 00	
Impatrient days (including private room days and swing-bed days, excluding neroborn) 3,782 2. 2. 2. 2. 2. 2. 2.		PART I - ALL PROVIDER COMPONENTS		
Inpatient days (Including private room days, excluding swing-bed and newborn days) 1, 1, 2, 3, 1, 3, 1, 3, 1, 3, 1, 3, 1, 3, 3, 1, 3, 1, 3, 3, 1, 3, 1, 3, 1, 3, 1, 3, 1, 3, 1, 3, 1, 3, 3, 1, 3, 1, 3, 3, 1, 3, 1, 3, 3, 1, 3, 1, 3, 3, 1, 3, 1, 3, 3, 1, 3, 3, 1, 3, 3, 1, 3, 3, 1, 3, 3, 1, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,				
Private room days (excluding swing-bed and observation bed days). If you have only private room days do not complete this line. 3,679				1.00
5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line) 7.00 Intal swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 10.00 Swing-bed SNF type inpatient days applicable to the program (excluding private room days) 11.00 Swing-bed SNF type inpatient days applicable to titles Viril only (including private room days) after December 31 of the cost reporting period (see Instructions) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (see Instructions) 18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (see Instructions) 19.00 Medically necessary private room days applicable to services after December 31 of the cost reporting period (line 8 x line 18) 20.00 Medicaler rate for swing-bed SNF servic		Private room days (excluding swing-bed and observation bed days). If you have only private room days,		2. 00 3. 00
6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,059 9, 100) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 1,059 9, 100) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 1,059 9, 100) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding sprivate room days) after December 31 of the cost reporting period (see instructions) 10.00 Swing-bed NF type inpatient days applicable to title XVI in a long limit of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Total nursery days (title V or XIX only) (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Total nursery days (title V or XIX only) (including private room days) after December 31 of the cost on the private room days applicable to services through December 31 of the cost on the private room days applicable to services through December 31 of the cost on the private room days after December 31 of the cost on the private room days applicable to services after December 31 of the cost on the private room days applicable to services after December 31 of the cost reporting period (line proper line) (line S x line 1) (line S x line 1)		Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	3, 679 0	4. 00 5. 00
7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (see instructions) 100 months of the cost reporting period (see instructions) 100 months of the cost reporting period (see instructions) 100 months of the cost reporting period (see instructions) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost reporting period (if calendar year, enter 0 on this line) 100 months of the cost 100 m	6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0 10.	8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
through December 31 of the cost reporting period (see instructions) 1.00 Singly-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Singly-bed NF type inpatient days applicable to title 8 v or XIX only (including private room days) 0 12. through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Modically necessary private room days applicable to titles V or XIX only (including private room days) 0 14. Own dically necessary private room days applicable to the Program (excluding swing-bed days) 0 15. Own dically necessary private room days applicable to the Program (excluding swing-bed days) 0 15. Own dically necessary private room days applicable to the Program (excluding swing-bed days) 0 15. Own dical nursery days (title V or XIX only) 0 15. Own dical care rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17. reporting period (including period days) 1.00 Modica reporting period 0.00 Modica dicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. Own dical dirate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. reporting period 0.00 Modical dirate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. Own dical dirate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. Own dical dirate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. Own dical dirate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17) 19. Own dical general inpatient routine service cost (see instructions) 19. Own dical general inpatient routine service december 31 of the cost reporting period (line 5 x line 18) 19. Own dispersion of the period of the cost 0.00 19. Own dispersion of the period 0.00 19. Own dispe	9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 059	9. 00
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through December 31 of the cost reporting period 13.00 Ming-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 15.00 Total nursery days (title V or XIX only) 0 16. 17.00 Nersery days (title V or XIX only) 0 16. 18.00 Nursery days (title V or XIX only) 0 16. 18.10 Nersery days (title V or XIX only) 0 16. 18.10 Nersery days (title V or XIX only) 19.10 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of the cost reporting period (line of the cost reporting period (line of the cost x x line 17) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of the x x line 18) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of the x x line 18) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of the x x line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of the x x line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of the x line 30) 19.00 Swing-bed cost applicable to	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
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19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
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7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 307, 038) 38. 00 Algiusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 20. 00 25. 21. 00 26. 22. 00 26. 00 26. 23. 00 24. 00 26. 24. 00 26. 00 26. 25. 00 26. 00 26. 26. 00 26. 00 26. 27. 00 26. 00 26. 28. 00 29. 00 20. 29. 00 29. 00 29. 30. 00 30. 00 30. 30. 00		x line 18)	0	24. 00
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 7, 307, 038 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28. 29. 00 9rivate room charges (excluding swing-bed charges) 0 30. 00 Semi-private room charges (excluding swing-bed charges) 0 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31. 32. 00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32. 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33. 34. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00 34. 35. 00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 307, 038 27 minus line 36) 0 Adjusted general inpatient routine service cost per diem (see instructions) 1, 932. 06 38. 39. 00 Program general inpatient routine service cost (line 9 x line 38) 2, 046, 052 39.	26 00		0	26. 00
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31. 00 Average private room per diem charge (line 29 ÷ line 3) 32. 00 Average semi-private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 + line 4) 35. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 36. 00 Private room cost differential (line 34 x line 31) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 307, 038) 37. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 20. 00 28. 29. 20. 00 29. 30. 00 20. 00 30. 30. 00 30. 30. 00 00 00 00 31. 30. 00 00 00 00 32. 31. 00 00 00 00 00 00 00 00 00 00 00 00 00		General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	-	
30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 32. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 33. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 32. 00 Average per diem private room cost differential (line 34 x line 31) 33. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 307, 038 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 2, 046, 052 39.	28. 00		0	28. 00
31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 307, 038 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 2, 046, 052 39.				
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 31.00 Average private room per diem charge (line 30 ÷ line 4) 32.00 Overage per diem private room per diem charge (line 30 ÷ line 4) 32.00 Overage per diem private room cost differential (line 34 x line 31) 39.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Overage per diem private room per diem charge (line 30 ÷ line 4) 30.00 Overage per diem private room per diem charge (line 30 ÷ line 4) 30.00 Overage per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Overage per diem private room cost differential (line 34 x line 31) 31.00 Overage per diem private room cost differential (line 32 minus line 33) (see instructions) 31.00 Overage per diem private room cost differential (line 32 minus line 33) (see instructions) 32.00 Overage per diem private room cost differential (line 32 minus line 33) (see instructions) 32.00 Overage per diem private room cost differential (line 32 minus line 33) (see instructions) 32.00 Overage per diem private room cost differential (line 32 minus line 33) (see instructions) 32.00 Overage per diem private room cost differential (line 32 minus line 33) (see instructions) 33.00 Overage per diem private room cost differential (line 32 minus line 33) (see instructions) 34.00				
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 34. 34. 35. 36. 37. 36. 37. 37. 38. 38. 38. 39. 39. 30.		,		
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 932.06 39.00 Program general inpatient routine service cost (line 9 x line 38) 2, 046, 052 39.				•
35. 00 Average per diem private room cost differential (line 34 x line 31) 0. 00 35. 36. 00 Private room cost differential adjustment (line 3 x line 35) 36. 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 307, 038 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 932. 06 38. 39. 00 Program general inpatient routine service cost (line 9 x line 38) 2, 046, 052 39.				
36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 307, 038 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 932. 06 39. 00 Program general inpatient routine service cost (line 9 x line 38) 2, 046, 052 39.				•
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 307, 038 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 932. 06 38. 39. 00 Program general inpatient routine service cost (line 9 x line 38) 2, 046, 052 39.				36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,932.06 38. 39.00 Program general inpatient routine service cost (line 9 x line 38) 2,046,052 39.		General inpatient routine service cost net of swing-bed cost and private room cost differential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,932.06 38. 39.00 Program general inpatient routine service cost (line 9 x line 38) 2,046,052 39.		PART II - HOSPITAL AND SUBPROVIDERS ONLY		
39.00 Program general inpatient routine service cost (line 9 x line 38) 2,046,052 39.		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
40. Or procedurally necessary private room cost appricable to the Program (Title 14 x Title 33)				39. 00 40. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,046,052 41.			-	

4.00	Semi-private room days (excluding swing-bed and observation bed days)	3, 6/9	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 059	9.00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)	_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		44.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
10 00	reporting period	0.00	10 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period	0. 00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	7, 307, 038	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	7, 307, 030	22. 00
22.00	5 x line 17)	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
20.00	In In a 18)	J	20.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
21.00	7 x line 19)	J	21.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)	_	
26. 00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7, 307, 038	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	7, 307, 038	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 932. 06	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 046, 052	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 046, 052	41.00

	Financial Systems	HANCOCK REGION		ON 45 0007		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od: From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/16/2017 10:	pared: 17 am
	Cost Contor Dosorintion	Total	Title	XVIII Average Per	Hospital Program Days	PPS Program Cost	
	Cost Center Description	Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col. 2)		col . 4)	
42 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00	4. 00	5. 00	42.00
12.00	Intensive Care Type Inpatient Hospital Units	<u> </u>					12.00
43.00	INTENSIVE CARE UNIT	8, 043, 880	5, 460	1, 473. 2	4 2, 587	3, 811, 272	
44. 00 45. 00	BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (W					6, 490, 813	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		12, 348, 137	49.00
50.00	Pass through costs applicable to Program inp	patient routine	services (fro	m Wkst. D, sur	m of Parts I and	658, 671	50.00
						2/0 /2/	F1 00
51. 00	and IV)	batient anciliar	y services (i	rom wkst. D, s	sum or Parts II	368, 636	51.00
52.00	Total Program excludable cost (sum of lines					1, 027, 307	
53. 00	OU Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11, 320, 830	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
	Difference between adjusted inpatient operat	ting cost and ta	arget amount (line 56 minus	line 53)	0	
58.00							58.00
59. 00	.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year					0. 00	
61. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		.S (TITIES 54 X	60), 01 1% 0	the target		
62. 00						0	
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							63.00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ets after Decemb	or 21 of the	cost roporting	a pariod (Saa	0	65.00
03.00	instructions)(title XVIII only)	sts arter becenik	ber 31 of the	cost reporting	g perrou (See		03.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	I only). For	0	66.00
67. 00	1	ne costs through	December 31	of the cost re	eporting period	0	67.00
(0.00	(line 12 x line 19)		24 . 6				
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after L	December 31 of	the cost repo	orting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70.00
71. 00	Adjusted general inpatient routine service of	,			,		71.00
72.00	Program routine service cost (line 9 x line	,	. (1: 14)	: 25)			72.00
73. 00 74. 00	Medically necessary private room cost application of the service o						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•		,	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76.00
77. 00	Program capital-related costs (line 9 x line						77.00
78. 00	Inpatient routine service cost (line 74 minu	,					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for comp	, ,			nus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		(,		81.00
82.00	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions					103	87. 00
67.00							
88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 932. 06 199, 002	

Health Financial Systems	HANCOCK REGIONA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THRO	OUGH COST					
90.00 Capital-related cost	848, 949	7, 307, 038	0. 11618	2 199, 002	23, 120	90.00
91.00 Nursing School cost	O	7, 307, 038	0.00000	199, 002	ol	91.00
92.00 Allied health cost	0	7, 307, 038	0.00000	199, 002	0	92.00
93.00 All other Medical Education	o	7, 307, 038	0.00000	199, 002	0	93.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0037	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-S037		
	Title XVIII	Subprovi der -	PPS
Cost Center Description		I PF	

PART - ALL PROVIDER COMPONENTS 1.00
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 3.030 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.030 Or Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if cale ndary year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale ndary year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale ndary year, enter 0 on this line) 7.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days applicable to title XVIII only (including private room days) Through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or X
1.00 Inpatient days (including private room days, axcluding swing-bed days, excluding newborn) 3,030
Inpatient days (including private room days, excluding swing-bed and newborn days) 3,030
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20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 0.00 2
21.00 Total general inpatient routine service cost (see instructions) 2,824,165 2
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0)
x line 18)
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 2
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 2 x line 20)
26.00 Total swing-bed cost (see instructions)
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2,824,165 2
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges)
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)
32.00 Average private room per diem charge (line 29 ÷ line 3)
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 3
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 3
35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 3
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,824,165)
27 minus line 36)
PART II - HOSPITAL AND SUBPROVIDERS ONLY
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 932.07
39.00 Program general inpatient routine service cost (line 9 x line 38) 2,552,940 3
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,552,940 4 2,552,940 4

	Financial Systems	HANCOCK REGION				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST			F	Period: From 01/01/2016	Worksheet D-1	
					To 12/31/2016	5/16/2017 10:	
				e XVIII	Subprovi der -	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1. 00	2. 00	3.00	4.00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	0	C	0.00	0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					359, 819	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)((see instructi	ons)		2, 912, 759	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sum	of Parts I and	259, 246	50.00
51. 00		atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	14, 172	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				273, 418	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital re	elated, non-ph	nysician anesth	etist, and	2, 639, 341	1
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	ł
56.00	Target amount (line 54 x line 55)				>	0	56.00
57. 00 58. 00	00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 5 0 Bonus payment (see instructions) 0 5						
59. 00							
60.00	0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61. 00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						61.00
42.00	amount (line 56), otherwise enter zero (see instructions)						62.00
	2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						64. 00
65. 00	9 1	ts after Decemb	per 31 of the	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + lin	ne 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service c	ost per diem (I		, ,			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	n (line 14 x l	ine 35)			72.00 73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	ice costs (line	e 72 + line 73	3)	art II. column		74. 00 75. 00
	26, line 45)		costs (ITOIII	WOLKSHEET B, F	art II, cordiiii		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				us line 79)		79. 00 80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi		1)				81. 00 82. 00
83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (see instruction					83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		nns)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	diem (line 27 ÷				0. 00 0	88. 00
07.00	Topsel various bed cost (Time of X Time oo) (Se	c manuchons)	,		I	U	1 07.00

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016		
		Component (CCN: 15-S037	To 12/31/2016	Date/Time Pre 5/16/2017 10:	
		T: +1 o	XVIII	Cubaravi dan		17 alli
		litte	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	286, 794	2, 824, 165	0. 10155	0 0	0	90.00
91.00 Nursing School cost	0	2, 824, 165	0.00000	00	0	91.00
92.00 Allied health cost	0	2, 824, 165	0. 00000	00	0	92.00
93.00 All other Medical Education	0	2, 824, 165	0. 00000	0 0	0	93.00

Heal th	Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0037	Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/16/2017 10:	
			Title XIX	Hospi tal	Cost	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days	and swing-bed day	rs, excluding newborn)		3, 782	1.00
2.00	Inpatient days (including private room days,	excluding swing-	bed and newborn days)		3, 782	2.00
3. 00	Private room days (excluding swing-bed and do not complete this line.	observation bed da	ys). If you have only p	rivate room days,	0	3. 00

	Cost Conton Decembring	LOST	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 782	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 782 0	2. 00 3. 00
	do not complete this line.		
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	3, 679	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	23	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period		12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	
16.00	Nursery days (title V or XIX only)	0	16. 00
17.00	SWING BED ADJUSTMENT	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	19. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	7, 307, 038	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7, 307, 038	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	20.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	7, 307, 038	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 932. 06	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	44, 437	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	44, 437	41.00

	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	23	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	
	SWI NG BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21.00	Total general inpatient routine service cost (see instructions)	7, 307, 038	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5×1) ine 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line α line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7×1 ine 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 \times line 20)	0	25. 00
26.00	Total swing-bed cost (see instructions)	0	20.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7, 307, 038	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		29.00
30.00	Semi-private room charges (excluding swing-bed charges)		
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7, 307, 038	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 932, 06	38 00
39.00	Program general inpatient routine service cost per diem (see instructions)	1, 932. 06	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	44, 437	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	44, 437	
	3 3 4 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	11, 101	. ==

	ancial Systems	HANCOCK REGIONA		CN. 1E 0007		u of Form CMS-2	
COMPUTATIO	ON OF INPATIENT OPERATING COST		Provider C		Peri od: From 01/01/2016		
				To 12/31/2016		Date/Time Pre 5/16/2017 10:	pared: 17 am
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00 NUD	CEDY (+: +I - V 0 VIVI · ·)	1. 00	2. 00	3. 00	4. 00	5. 00	12.00
	SERY (title V & XIX only) ensive Care Type Inpatient Hospital Units	<u> </u>					42. 00
43. 00 I NT	ENSIVE CARE UNIT	8, 043, 880	5, 460	1, 473. 2	8	11, 786	1
	ONARY CARE UNIT N INTENSIVE CARE UNIT						44. 00 45. 00
	GICAL INTENSIVE CARE UNIT						46.00
47. 00 OTH	ER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00 Pro	gram inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			27, 053	48. 00
	al Program inpatient costs (sum of lines	41 through 48)(s	see instructi	ons)		83, 276	49. 00
	S THROUGH COST ADJUSTMENTS s through costs applicable to Program inp	patient routine :	services (fro	m Wkst. D. su	m of Parts I and	0	50.00
[111])		·				
	s through costs applicable to Program inp IV)	patient ancillary	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
	al Program excludable cost (sum of lines	50 and 51)				0	52.00
	al Program inpatient operating cost exclu		lated, non-ph	ysician anest	hetist, and	0	53.00
	lical education costs (line 49 minus line GET AMOUNT AND LIMIT COMPUTATION	52)					1
54.00 Pro	gram discharges					0	54.00
	get amount per discharge					0.00	1
	get amount (line 54 x line 55) Ference between adjusted inpatient operat	ting cost and tar	rget amount (line 56 minus	line 53)	0	
58. 00 Bon	us payment (see instructions)	9			ŕ	0	58. 00
	ser of lines 53/54 or 55 from the cost re ket basket	eporting period e	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
	ser of lines 53/54 or 55 from prior year	cost report, upo	dated by the	market basket		0. 00	60.00
61.00 If	line 53/54 is less than the lower of line	es 55, 59 or 60 e	enter the Les	ser of 50% of	the amount by	0	61.00
	ch operating costs (line 53) are less tha unt (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
62. 00 Rel	ief payment (see instructions)	ŕ				0	62.00
63. 00 AII	0	63.00					
	GRAM INPATIENT ROUTINE SWING BED COST licare swing-bed SNF inpatient routine cos	sts through Decer	mber 31 of th	e cost report	ing period (See	0	64.00
	tructions)(title XVIII only)		04 . 6 . 1				/ 5 00
	licare swing-bed SNF inpatient routine cos tructions)(title XVIII only)	sts after Decembe	er 31 of the	cost reportin	g period (See	0	65.00
66. 00 Tota	al Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line	65)(title XVI	II only). For	0	66. 00
	l (see instructions) Le V or XIX swing-bed NF inpatient routin	ne costs through	December 31	of the cost r	enorting period	0	67.00
	ne 12 x line 19)	ic costs till odgil	December 51	or the cost is	oper tring period		07.00
	<pre>le V or XIX swing-bed NF inpatient routin ne 13 x line 20)</pre>	ne costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
1 7	al title V or XIX swing-bed NF inpatient	routine costs (!	line 67 + lin	e 68)		0	69.00
	T III - SKILLED NURSING FACILITY, OTHER N				\		70.00
1	<pre>Illed nursing facility/other nursing facil usted general inpatient routine service c</pre>	•		•)		70.00
72.00 Pro	gram routine service cost (line 9 x line	71)		ŕ			72.00
	lically necessary private room cost applic al Program general inpatient routine serv						73.00
1	ital-related cost allocated to inpatient	•		,	Part II, column		75.00
1 .	line 45)	0)					7, 00
1	diem capital-related costs (line 75 ÷ li gram capital-related costs (line 9 x line	•					76. 00 77. 00
78. 00 I np	atient routine service cost (line 74 minu	us line 77)					78.00
	regate charges to beneficiaries for exces al Program routine service costs for comp				nue Lino 70)		79. 00 80. 00
	atient routine service costs for comp atient routine service cost per diem limi		ost rimitatio	(11116 /6 11111	1110 /7)		81.00
82. 00 I np	atient routine service cost limitation (I	ine 9 x line 81)					82.00
	sonable inpatient routine service costs (gram inpatient ancillary services (see in		S)				83. 00 84. 00
	lization review - physician compensation		ns)				85.00
86. 00 Tota	al Program inpatient operating costs (sum	n of lines 83 thr					86. 00
ים א כוו	T IV - COMPUTATION OF OBSERVATION BED PAS						
	al observation bed days (see instructions	3)				1031	1 87. nn
87. 00 Tota 88. 00 Adj	al observation bed days (see instructions usted general inpatient routine cost per ervation bed cost (line 87 x line 88) (se	diem (line 27 ÷	line 2)			103 1, 932. 06 199, 002	88. 00

Health Financial Systems	HANCOCK REGION	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUG	H COST					
90.00 Capital -related cost	848, 949	7, 307, 038	0. 11618	2 199, 002	23, 120	90.00
91.00 Nursing School cost	0	7, 307, 038	0.00000	0 199, 002	0	91.00
92.00 Allied health cost	0	7, 307, 038	0.00000	0 199, 002	0	92.00
93.00 All other Medical Education	0	7, 307, 038	0.00000	0 199, 002	0	93.00

Health Financial Systems HANCOCK REGIONA				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0037	Period: From 01/01/2016	Worksheet D-3	3
			To 12/31/2016		epared:
				5/16/2017 10:	
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	3	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			999, 314		30.00
31. 00 03100 NTENSI VE CARE UNI T			5, 505, 906		31.00
40. 00 04000 SUBPROVI DER - 1 PF			21, 013	l	40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 3769			50.00
51. 00 05100 RECOVERY ROOM		0. 2649		101, 297	7 51.00
53. 00 05300 ANESTHESI OLOGY		0. 5209			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1372			
60. 00 06000 LABORATORY		0. 1523			
65. 00 06500 RESPI RATORY THERAPY		0. 2458			1
66. 00 06600 PHYSI CAL THERAPY		0. 4131			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3523	· ·		
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 OCCUPATI ONAL HEALTH		0. 4335	· ·	33, 430	
68. 01 06801 0CCUPATI ONAL HEALTH 69. 00 06900 ELECTROCARDI OLOGY		0. 0000 0. 1094		1	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1094		759, 279	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 4108			
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 2227			
76. 00 03020 CARDI AC		0.0000		1	1
76. 01 03160 CARDI OPULMONARY		0. 6115			
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 00
90. 00 09000 CLI NI C		0.0000	00 0	0	90.00
90. 01 09001 WOUND CLINIC		0. 3860	65 4, 798	1, 852	90. 01
90. 02 09002 DI ABETES CLI NI C		1. 2567			
90. 03 09003 ASTHMA CLINIC		0.0000		0	
90. 04 09004 ANDIS CLINIC		5. 6603		0	
90. 05 09005 PRI ME TI ME		0. 3251		16	
90. 06 09006 SHELBYVI LLE WOUND CLI NI C		0. 3235			
90. 07 04951 ONCOLOGY		0. 5054			
90. 08 04950 ANDERSON WOMENS CENTER		0. 1337	· ·		
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1607			
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (sum of lines 50-94 and 96-98)		0. 0746	94 103 24, 645, 747		
201.00 Less PBP Clinic Laboratory Services-Program only charg	os (lino 61)		24, 045, 747	6, 490, 813	201.00
202.00 Net Charges (line 200 minus line 201)	es (TITIE OI)		24, 645, 747		201.00
202.00 INCLUDIAL YES (TITLE 200 IIII IIUS TITLE 201)		1	24, 043, 747	I	1202. UU

	ncial Systems HANCOCK REGIONAL NCILLARY SERVICE COST APPORTIONMENT		CN: 15-0037	Peri od:	u of Form CMS-: Worksheet D-3	
				From 01/01/2016		
		Component	CCN: 15-S037	To 12/31/2016	Date/Time Pre 5/16/2017 10:	epared: 17 am
		Titl€	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2)	
I NPA	FIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	ADULTS & PEDIATRICS			0		30.00
	INTENSIVE CARE UNIT			0		31.00
	SUBPROVI DER - I PF			3, 415, 009		40.00
1	SUBPROVI DER - I RF			0		41.00
ANCI I	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 3769	15 33, 407	12, 592	50.00
	RECOVERY ROOM		0. 2649	·	920	
1	ANESTHESI OLOGY		0. 5209		20	
1	RADI OLOGY-DI AGNOSTI C		0. 1372		13, 868	
	LABORATORY		0. 1523		64, 436	
	RESPI RATORY THERAPY PHYSI CAL THERAPY		0. 2458		44, 218 24, 174	
	O OCCUPATIONAL THERAPY		0. 4131 0. 3523		26, 176 38, 335	
1	SPEECH PATHOLOGY		0. 4335		7, 991	
1	OCCUPATI ONAL HEALTH		0.0000		0	68. 01
	ELECTROCARDI OLOGY		0. 1094		1, 731	
1	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 8146		45, 901	
	IMPL. DEV. CHARGED TO PATIENT		0. 4108	04 13, 632	5, 600	72.00
73.00 0730	DRUGS CHARGED TO PATIENTS		0. 2227	64 387, 491	86, 319	73.00
	CARDI AC		0.0000		0	
	CARDI OPULMONARY		0. 6115	73 0	0	76. 01
	ATIENT SERVICE COST CENTERS			0.0		
	RURAL HEALTH CLINIC		0.0000		0	
	CLINIC		0.0000		0	
1	1 WOUND CLINIC 2 DIABETES CLINIC		0. 3860 1. 2567		881 0	90.01
	B ASTHMA CLINIC		0.0000		0	
	4 ANDIS CLINIC		5. 6603		0	
1	PRIME TIME		0. 3251		2	90.05
1	SHELBYVILLE WOUND CLINIC		0. 3235		0	
	ONCOLOGY		0. 5054		0	
90. 08 04950	ANDERSON WOMENS CENTER		0. 1337	36 4, 256	569	90.08
91.00 0910	EMERGENCY		0. 1607	33 63, 832	10, 260	91.00
92.00 0920	OBSERVATION BEDS (NON-DISTINCT PART)		0. 0746	94 0	0	
200.00	Total (sum of lines 50-94 and 96-98)			1, 474, 976	359, 819	
201.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202. 00	Net Charges (line 200 minus line 201)		1	1, 474, 976		202.00

Health Financial Systems HANCOCK F INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	REGIONAL HOSPITAL Provider CCN: 15-0037	Period:	u of Form CMS-2 Worksheet D-3	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0037	From 01/01/2016		
		To 12/31/2016	Date/Time Pre 5/16/2017 10:	epared:
	Title XIX	Hospi tal	Cost	17 dili
Cost Center Description	Ratio of Co		Inpatient	
'	To Charge		Program Costs	
		Charges	(col. 1 x	
			col. 2)	
	1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	
30. 00 03000 ADULTS & PEDI ATRI CS		37, 554		30.00
31. 00 03100 I NTENSI VE CARE UNI T		17, 543	l	31.00
40. 00 04000 SUBPROVI DER - PF		C		40.00
41. 00 04100 SUBPROVI DER - RF		C		41.00
ANCILLARY SERVICE COST CENTERS	0.27/	015 22 040	0.750	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	0. 376	·		1
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	0. 264 0. 520			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 520			
60. 00 06000 LABORATORY	0. 137			1
65. 00 06500 RESPI RATORY THERAPY	0. 131			
66. 00 06600 PHYSI CAL THERAPY	0. 243			
67. 00 06700 OCCUPATI ONAL THERAPY	0. 413			
68. 00 06800 SPEECH PATHOLOGY	0. 433			
68. 01 06801 0CCUPATI ONAL HEALTH	0.000			
69. 00 06900 ELECTROCARDI OLOGY	0. 109			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 814			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 410		0,001	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 222		5, 341	
76. 00 03020 CARDI AC	0.000			1
76. 01 03160 CARDI OPULMONARY	0. 611		Ō	1
OUTPATIENT SERVICE COST CENTERS		·		
88. 00 08800 RURAL HEALTH CLINIC	1. 074	435 C	0	88. 00
90. 00 09000 CLI NI C	0.000	000	0	90.00
90. 01 09001 WOUND CLINIC	0. 386	065 7	3	90.01
90. 02 09002 DI ABETES CLI NI C	1. 256	729 C	0	90. 02
90. 03 09003 ASTHMA CLINIC	0.000		0	1 ,0,00
90. 04 09004 ANDIS CLINIC	5. 660		0	1
90. 05 09005 PRI ME TI ME	0. 325		0	1 /0.00
90. 06 09006 SHELBYVI LLE WOUND CLINIC	0. 323		0	1 ,0.00
90. 07 04951 ONCOLOGY	0. 505			
90. 08 04950 ANDERSON WOMENS CENTER	0. 133	736l C	0	90.08

0

0

27, 053 200. 00

1, 463

90.08

91.00 92.00

201.00

202.00

0. 133736

0. 160733

0. 074694

101, 224

90. 08 04950 ANDERSON WOMENS CENTER

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net Charges (line 200 minus line 201)

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

91. 00 09100 EMERGENCY

200.00

201.00

202.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0037	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/16/2017 10:17 am
	T		550

		Title XVIII	Hospi tal	5/16/2017 10: PPS	17 am	
	THE WITH HOSPITAL					
			1. 00			
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00	
1. 01	DRG amounts other than outlier payments for discharges occurringtructions)	see	6, 805, 799	1.00		
1. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	2, 311, 378	1. 02	
1. 03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or discharges occurring	prior to October	0	1. 03	
1. 04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	for discharges occurring	on or after	0	1. 04	
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			38, 625 0	2. 00 2. 01	
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2. 02	
3. 00	Managed Care Simulated Payments			0	3.00	
4. 00	Bed days available divided by number of days in the cost repollndirect Medical Education Adjustment			60. 72	4.00	
5. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	·			5.00	
6. 00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00	
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified	under 42 CFR §412.105(f		0. 00 0. 00	7. 00 7. 01	
8. 00	If the cost report straddles July 1, 2011 then see instruction Adjustment (increase or decrease) to the FTE count for allops affiliated programs in accordance with 42 CFR 413.75(b), 413.	thic and osteopathic pro	9	0. 00	8. 00	
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl the cost report straddles July 1, 2011, see instructions.	ots under section 5503 c	of the ACA. If	0. 00	8. 01	
8. 02	The amount of increase if the hospital was awarded FTE cap slunder section 5506 of ACA. (see instructions)	0. 00	8. 02			
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lininstructions)	es (8, 8,01 and 8,02) (see	0. 00	9. 00	
11. 00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	0. 00	10. 00 11. 00 12. 00			
13. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	0. 00 0. 00	13.00	
	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 clo	sure			16. 00 17. 00	
	Adjusted rolling average FTE count	Sui C			18.00	
	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19. 00	
	Prior year resident to bed ratio (see instructions)			0. 000000		
	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 000000 0	21. 00 22. 00	
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0		
	Indirect Medical Education Adjustment for the Add-on for Sect		140 405			
	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C).	ent cap stots under 42 s	ec. 412.105	0. 00		
	IME FTE Resident Count Over Cap (see instructions)	lower of line 22 or line	24 (500		24.00	
25. 00	If the amount on line 24 is greater than -0-, then enter the instructions)	Tower or line 23 or line	e 24 (See	0.00	25. 00	
	Resident to bed ratio (divide line 25 by line 4)			0. 000000		
	IME payments adjustment factor. (see instructions)			0. 000000 0		
	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)				28. 00 28. 01	
	Total IME payment (sum of lines 22 and 28)				29.00	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	1)		0	29. 01	
	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	tions)	1. 84	30.00	
	Percentage of Medicaid patient days (see instructions)	<i>y</i> = (1, 2, 1, 1, 2, 1, 1, 2, 1, 1, 2, 1, 1, 2, 1, 1, 2, 1, 1, 1, 2, 1, 1, 2, 1, 1, 2, 1, 1, 2,	,	14. 42		
	Sum of lines 30 and 31				32.00	
	Allowable disproportionate share percentage (see instructions	5)		3. 32		
34. 00	Disproportionate share adjustment (see instructions)			75, 673	34.00	

	Fig. 1.1. C	LIOCOL TAI	111	C. E OHC. C	NEED 40	
	Financial Systems HANCOCK REGIONAL ATION OF REIMBURSEMENT SETTLEMENT		Peri od:	u of Form CMS-2 Worksheet E	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0037	From 01/01/2016			
			To 12/31/2016	Date/Time Pre		
		T: 11 - 20/111	11	5/16/2017 10:	<u>17 am</u>	
		Title XVIII	Hospi tal Pri or to 10/1	PPS		
			1.00	2. 00		
	Uncompensated Care Adjustment		11.00	2100		
35.00	Total uncompensated care amount (see instructions)		6, 406, 145, 534	5, 977, 483, 147	35.00	
35. 01	Factor 3 (see instructions)		0. 000038334	0. 000039044	35. 01	
35. 02	Hospital uncompensated care payment (If line 34 is zero, en	ter zero on this line)	245, 574	233, 383	35. 02	
35. 03	(see instructions)	ount (see instructions)	183, 845	58, 825	35. 03	
	Pro rata share of the hospital uncompensated care payment amount of the uncompensated care (sum of columns 1 and 2 on line 35.0		242, 670		36.00	
00.00	Additional payment for high percentage of ESRD beneficiary di				00.00	
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40. 00	
	652, 682, 683, 684 and 685 (see instructions)		_			
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, (683, 684 an 685. (see	0		41. 00	
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding MS-	_DPCs 652 682 683 684	0		41. 01	
41.01	an 685. (see instructions)	-5103 032, 002, 003, 004	0		41.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adjustment)	0.00		42.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	82, 683, 684 an 685. (see	0		43.00	
	instructions)					
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) Average weekly cost for dialysis treatments (see instructions	e)	0.00		45. 00	
46. 00	Total additional payment (line 45 times line 44 times line 47		0.00		46.00	
47. 00	Subtotal (see instructions)		9, 474, 145		47. 00	
48.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48.00	
	only. (see instructions)					
				Amount		
49. 00	Total payment for inpatient operating costs (see instructions	e)		1. 00 9, 474, 145	49. 00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I am			734, 573		
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	ine 49 see instructions).		0	52.00	
53.00	Nursing and Allied Health Managed Care payment			7, 495		
54.00	Special add-on payments for new technologies			0	54.00	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of	60)		0	54. 01 55. 00	
56. 00	Cost of physicians' services in a teaching hospital (see inti			0	56.00	
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57. 00	
58.00	Ancillary service other pass through costs from Wkst. D, Pt.		,	12, 575	58.00	
59. 00	Total (sum of amounts on lines 49 through 58)			10, 228, 788		
60.00	Primary payer payments			0	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus	S IINE 6U)		10, 228, 788 1, 189, 860		
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			1, 189, 860		
	Allowable bad debts (see instructions)			82, 563		
65.00	Adjusted reimbursable bad debts (see instructions)			53, 666		
66.00	Allowable bad debts for dual eligible beneficiaries (see ins	82, 563	66.00			
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9, 080, 358	67. 00 68. 00			
68. 00						
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	0	69.00			
70. 00 70. 50					70. 00 70. 50	
70. 30					70. 30	
70. 89	Pioneer ACO demonstration payment adjustment amount (see ins	0	70.89			
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70. 90			
70. 91	HSP bonus payment HRR adjustment amount (see instructions)	0	70. 91			
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92	
70. 93	, , ,			29, 399		
70. 94 70. 95	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-4, 135 0	70. 94 70. 95	
70. 73	. 95 Recovery of accelerated depreciation					

Health Financial Systems HANCOCK REGIONAL	_ HOSPI TAL		In Lie	ı of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0037	Peri od:	Worksheet E	
			From 01/01/2016	Part A	
			To 12/31/2016	Date/Time Pre 5/16/2017 10:	
	Title	XVIII	Hospi tal	PPS	17 diii
	-	FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		2016	244, 733	70. 96
the corresponding federal year for the period prior to 10/1)					
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column 0		2017	101, 476	70. 97
the corresponding federal year for the period ending on or at	fter 10/1)			_	
70.98 Low Volume Payment-3				0	70. 98
70.99 HAC adjustment amount (see instructions)	(0 0 70)			0	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			9, 451, 831	71.00
71.01 Sequestration adjustment (see instructions)				189, 037	
72.00 Interim payments 73.00 Tentative settlement (for contractor use only)				9, 201, 984	72. 00 73. 00
73.00 Tentative settrement (for contractor use only) 74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72	2 and 72)			0 60, 810	
75.00 Protested amounts (nonallowable cost report items) in accorda				1, 026, 694	
CMS Pub. 15-2, chapter 1, §115.2	ance with			1, 020, 094	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			l		
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	structions)			0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2	ori de ti ono,			0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instr	ructions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruc				0	93.00
94.00 The rate used to calculate the time value of money (see instr				0. 00	94.00
95.00 Time value of money for operating expenses (see instructions))			0	95.00
96.00 Time value of money for capital related expenses (see instruc	ctions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
102.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00 HRR adjustment factor (see instructions)	`		0. 0000	0. 0000	
104.00 HRR adjustment amount for HSP bonus payment (see instructions	5)		0	0	104. 00

W/S F, Part A							To 12/31/2016		pared:
Fire					Title	· XVIII	Hospi tal		17 alli
1.00 DRG amounts other than outlier 1.00 0 0 0 0 0 0 0 0 0							On/After	•	
1.01 Displayments for displayers 1.01 6,805,799 0 6,805,799 0 6,805,799 1.02 2.311,378 2.311,378 1.02 2.311,378 1.02 2.311,378 2.311,378 1.02 2.311,378 2.311,378 1.02 2.311,378 1			·				4. 00		
1.01 Disk amounts other than outlier 1.01 6.805,799 0 6.805,799 0 6.805,799 1.02 2.311,378 2	1. 00	II I	1. 00	0	0		0 0	0	1.00
1.02 DRG amounts other than ord left 1.02 2.311,378 0 2.311,378 2.311,378 1 2.311,378 2.311,378 1 2.311,378 1 2.311,378	1. 01	DRG amounts other than outlier payments for discharges	1. 01	6, 805, 799	0	6, 805, 79	9	6, 805, 799	1. 01
Departing payment for Model 4 BRCI Coccurring prior to October 1 Oct	1. 02	DRG amounts other than outlier payments for discharges	1. 02	2, 311, 378	0		2, 311, 378	2, 311, 378	1. 02
DRC for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 BPCI occurring on or after 1 CPCI october 1 BPCI occurring on or after 1 CPCI october 1 BPCI occurring on or after 1 CPCI october 1 BPCI occurring on or after 1 CPCI occurring on or after 1 CPCI october 1 BPCI occurring outlier 2 CPCI october 1 BPCI oc	1. 03	operating payment for Model 4 BPCI occurring prior to	1. 03	0	0		0	0	1. 03
2.00 Outlier payments for 2.00 38,625 0 21,659 16,966 38,625 2 discharges (See instructions) Control of the payments for 2.02 0 0 0 0 0 0 0 0 0	1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2.01 Out er payments for 2.02 0 0 0 0 0 0 2 3 3 3 3 3 3 3 3 3	2. 00	Outlier payments for	2. 00	38, 625	0	21, 65	9 16, 966	38, 625	2. 00
Page	2. 01	Outlier payments for	2. 02	0	0		0 0	0	2. 01
payments	3. 00	reconciliation	2. 01	0	0		0 0	0	3.00
5.00 Amount from Worksheet E, Part 21.00 0.0000000 0.00000000	4. 00	payments		0	0		0 0	0	4.00
ME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	5. 00			0. 000000	0. 000000	0. 00000	0. 000000		5.00
ME payment adjustment for managed care (see instructions)	6. 00	IME payment adjustment (see	22. 00	0	0		0 0	0	6. 00
Instructions Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA IME payment adjustment factor (see Instructions) 1	6. 01	IME payment adjustment for	22. 01	0	0		0 0	0	6. 01
1 1 1 1 2 2 2 2 2 2									
See instructions Section Secti	7 00						0 000000		7 00
Instructions Rotations R		(see instructions)			0.000000			0	7. 00 8. 00
For managed care (see instructions)		instructions)			0			_	8. 00
1 1 1 1 1 1 1 1 1 1	0.01	for managed care (see instructions)		J	S			0	
Care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Sisproportionate Share Adjustment Sisproportionate Share Adjustment Sisproportionate Share percentage (see instructions) In 20		lines 6 and 8)			0				
10.00	9. 01	care (sum of lines 6.01 and 8.01)	-	0	0		0 0	0	9. 01
11.00 Disproportionate share 34.00 75,673 0 56,488 19,185 75,673 11 34.00 11.01 Disproportionate share 34.00 242,670 0 183,845 58,825 242,670 11 240,670 242,670 2	10. 00	Allowable disproportionate		0. 0332	0. 0332	0. 033	2 0. 0332		10.00
11.01 Uncompensated care payments 36.00 242,670 0 183,845 58,825 242,670 11	11. 00	instructions) Disproportionate share	34. 00	75, 673	0	56, 48	8 19, 185	75, 673	11.00
12.00 Total ESRD additional payment (see instructions) 46.00 0 0 0 0 0 12 13.00 Subtotal (see instructions) 47.00 9,474,145 0 7,067,791 2,406,354 9,474,145 13 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from 68.00 0 0 0 0 0 0 17 17.02 Credits received from 68.00 0 0 0 0 0 0 0 0 0	11. 01	Uncompensated care payments				183, 84	58, 825	242, 670	11. 01
13. 00 Subtotal (see instructions)	12. 00	Total ESRD additional payment		RD beneficiary 0			0 0	0	12.00
(see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 49.00 9,474,145 0 7,067,791 2,406,354 9,474,145 15 16.00 Payment for inpatient program capital 50.00 734,573 0 546,093 188,480 734,573 16 17.00 Special add-on payments for new technol ogies 54.00 0 0 0 0 0 0 0 17.01 Net organ aquisition cost 17 0 0 0 0 0 0 0 0 17.02 Credits received from manufacturers for replaced 68.00 0 0 0 0 0 0 0		Subtotal (see instructions) Hospital specific payments		9, 474, 145 0	0	7, 067, 79	1 2, 406, 354 0 0		ı
16. 00 Payment for inpatient program capital 50. 00 734, 573 0 546, 093 188, 480 734, 573 16 17. 00 Special add-on payments for new technol ogies 54. 00 0 0 0 0 0 0 0 17 17. 01 Net organ aquisition cost 17. 02 Credits received from manufacturers for replaced 68. 00 0 0 0 0 0 0 0 0	15. 00	(see instructions) Total payment for inpatient	49. 00	9, 474, 145	0	7, 067, 79	1 2, 406, 354	9, 474, 145	15. 00
17. 00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 17.01 0	16. 00	Payment for inpatient program	50. 00	734, 573	0	546, 09	3 188, 480	734, 573	16. 00
17. 01 Net organ aquisition cost 17. 02 Credits received from 68.00 0 0 0 0 17 manufacturers for replaced	17. 00	Special add-on payments for	54. 00	0	0		0 0	0	17. 00
		Net organ aquisition cost Credits received from manufacturers for replaced		0	0		0 0	0	17. 01 17. 02

Haal th	Financial Systems		HANCOCK REGION	NAL HOSDITAL		Inlie	u of Form CMS-2	2552_10
	LUME CALCULATION EXHIBIT 4		TIANGOCK REGIO	Provi der CO		Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibi Date/Time Pre 5/16/2017 10:	t 4 pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		l i ne	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		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	7, 613, 88	2, 594, 834	10, 208, 718	19 00
171.00	1005.017.2	W/S L, line	(Amounts from L)	9	7, 0.0, 00	2,071,001	10/ 200/ 710	171.00
		0	1. 00	2.00	3.00	4.00	5. 00	
20.00	Capital DRG other than outlier	1. 00	732, 940	0	545, 75	2 187, 188	732, 940	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	1, 633	0	34	1, 292	1, 633	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	734, 573	0	546, 09	188, 480	734, 573	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor	70.0/			0. 03214			27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			244, 73	13	244, 733	28.00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				101, 476	101, 476	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00
	as as a more to more E, it. A.	I		ı	l	T .	ı	1

Health Financial SystemsHANCOCK REGIONALHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0037 Period: Worksheet E From 01/01/2016 Part A Exhibit 5 To 12/31/2016 Date/Time Prepared:

				1	0 12/31/2016	Date/lime Pre 5/16/2017 10:	
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
			A)				
		0	1.00	2. 00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1. 00					1.00
1. 01	DRG amounts other than outlier payments for	1. 01	6, 805, 799	6, 805, 799		6, 805, 799	1. 01
	discharges occurring prior to October 1						
1. 02	DRG amounts other than outlier payments for	1. 02	2, 311, 378		2, 311, 378	2, 311, 378	1. 02
1 02	discharges occurring on or after October 1 DRG for Federal specific operating payment	1 02		0		0	1 02
1. 03	for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
	11 Model 4 BPCI occurring prior to october						
1. 04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
1.04	for Model 4 BPCI occurring on or after	1.04			O	0	1.04
	October 1						
2.00	Outlier payments for discharges (see	2. 00	38, 625	21, 659	16, 965	38, 624	2. 00
	instructions)		· I	•			
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
	BPCI						
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	3.00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
	(see instructions)	00.00				0	, 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6.00
6. 01	<pre>IME payment adjustment for managed care (see instructions)</pre>	22. 01	0	0	U	0	6. 01
	Indirect Medical Education Adjustment for the	e Add-on for S	ection 122 of t	the MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
7.00	instructions)	27.00	0.00000	0.00000	0.00000		7.00
8.00	IME adjustment (see instructions)	28. 00	o	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
	care (see instructions)						
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	0	0	0	0	9. 01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33. 00	0. 0332	0. 0332	0. 0332		10. 00
11. 00	(see instructions)	34. 00	75, 673	56, 488	19, 185	75, 673	11. 00
11.00	Disproportionate share adjustment (see instructions)	34.00	75,073	50, 400	17, 105	75,075	11.00
11. 01	Uncompensated care payments	36. 00	242, 670	183, 845	58, 825	242, 670	11. 01
	Additional payment for high percentage of ES			1007010	00,020	2.2,0,0	
12.00	Total ESRD additional payment (see	46.00	0	0	0	0	12.00
	instructions)						
13.00	Subtotal (see instructions)	47. 00	9, 474, 145	7, 067, 792	2, 406, 353	9, 474, 145	13.00
14.00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14.00
	and MDH, small rural hospitals only.) (see						
	instructions)						
15. 00	Total payment for inpatient operating costs	49. 00	9, 474, 145	7, 067, 792	2, 406, 353	9, 474, 145	15. 00
4, 00	(see instructions)	50.00	704 570	544 000	400 400	704 570	4 / 00
16.00	Payment for inpatient program capital	50. 00	734, 573	546, 093	188, 480	734, 573	16.00
17.00	Special add-on payments for new technologies	54. 00	ا ا	0	O	0	17.00
17. 01 17. 02	Net organ acquisition cost	49.00		0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	"	0	U	0	17. 02
18. 00	Capital outlier reconciliation adjustment	93. 00	ا	n	n	0	18. 00
10.00	amount (see instructions)	75.00					10.00
19. 00	SUBTOTAL			7, 613, 885	2, 594, 833	10, 208, 718	19. 00
	1	1					

Heal th	Financial Systems	HANCOCK REGIO	NAI HOSDITAI		In lie	u of Form CMS-2	2552_10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA				Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibi	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	732, 940	545, 752	187, 188	732, 940	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	1, 633	34	1, 292	1, 633	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	734, 573	546, 093	188, 480	734, 573	26. 00
	,	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	244, 733	244, 733	3	244, 733	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	101, 476		101, 476	101, 476	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	29, 399	13, 50	15, 892	29, 399	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-4, 135	-1, 36°	-2, 774	-4, 135	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(0	0	31. 01
						(Amt to	

0 70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

1.00

2.00

0

3.00

0

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

32.00

100.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15	From 01/01/2016	Worksheet E Part B Date/Time Prepared: 5/16/2017 10:17 am
	Title XVII	I Hospi tal	PPS

		10 12/3	1/2016 Date	6/11me Prej 6/2017 10:	
		Title XVIII Hospit		PPS	17 alli
		THE AVIII		113	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5, 651	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)	1	0, 417, 186	2.00
3.00	PPS payments	·		8, 861, 420	3.00
4.00	Outlier payment (see instructions)			19, 997	4.00
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0. 00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		77, 250	9.00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 651	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			25, 390	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			25, 390	14.00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for			0	
16. 00	Amounts that would have been realized from patients liable fo		basi s	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)	1 (61) (40)		25, 390	
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds line II) (se	e	19, 739	19. 00
20.00	instructions)	Ly if line 11 eyeseds line 10) (se			20.00
20. 00	Excess of reasonable cost over customary charges (complete on	Ty IT TITLE IT exceeds TITLE 18) (Se	е	0	20. 00
21. 00	<pre>instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH se</pre>	o instructions)		5, 651	21. 00
22. 00	Interns and residents (see instructions)	e Histi deti olis)		0,001	
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ructions)		8, 958, 667	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0, 730, 007	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (fo	r CAH, see instructions)		1, 885, 454	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)		l .	7, 078, 864	
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, I			0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00	Subtotal (sum of lines 27 through 29)			7, 078, 864	
31. 00	Primary payer payments			1, 694	
32. 00	Subtotal (line 30 minus line 31)			7, 077, 170	32.00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI)	CES)			00.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			144 072	
34. 00 35. 00	Allowable bad debts (see instructions)			166, 872 108, 467	
36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		166, 872	
	Subtotal (see instructions)	ructions)		7, 185, 637	
	MSP-LCC reconciliation amount from PS&R			7, 105, 057	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		o l	39. 50
39. 98	Partial or full credits received from manufacturers for repla	•		ő	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	ded devices (see Thati detroils)		ő	39. 99
40. 00	Subtotal (see instructions)			7, 185, 637	40.00
40. 01	Sequestration adjustment (see instructions)			143, 713	
41.00	Interim payments			6, 989, 121	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			52, 803	43.00
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2, chapter 1,		0	44.00
	§115. 2	·			
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money			0. 00	
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

Peri od: Worksheet E-1 From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/16/2017 10:17 am

1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate	Title Inpatien mm/dd/yyyy 1.00	XVIII t Part A Amount 2.00 9.201.984	Hospi tal Par mm/dd/yyyy 3.00	PPS T B	
1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate	mm/dd/yyyy	Amount 2.00	mm/dd/yyyy		
1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		2. 00		Amount	
1.00 Total interim payments paid to provider 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate				Amount	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate			5.00	4. 00	
submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate				6, 855, 426	1. 00
submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		0	j	0	2.00
services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					
3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					
amount based on subsequent revision of the interim rate					
					3.00
for the cost reporting period. Also show date of each					
payment. If none, write "NONE" or enter a zero. (1)					
Program to Provider					
3. 01 ADJUSTMENTS TO PROVIDER		0		133, 695	3. 01
3. 02		0		0	3. 02
3. 03		0		0	3. 03
3. 04		0		0	3. 04
3. 05		0		0	3. 05
Provi der to Program					
3.50 ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51		0		0	3. 51
3. 52		0		0	3. 52
3. 53		0		0	3.53
3. 54		0		0	3.54
3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98)		0		133, 695	3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.99)		9, 201, 984		6, 989, 121	4.00
(transfer to Wkst. E or Wkst. E-3, line and column as					
appropri ate)					
TO BE COMPLETED BY CONTRACTOR					
5.00 List separately each tentative settlement payment after					5. 00
desk review. Also show date of each payment. If none,					
write "NONE" or enter a zero. (1)					
Program to Provi der 5.01 TENTATI VE TO PROVI DER		0		0	E 01
5.01 TENTATI VE TO PROVI DER 5.02		0			5. 01 5. 02
5. 02		0			5. 02
Provider to Program				0	5.05
5. 50 TENTATI VE TO PROGRAM		0		0	5. 50
5. 51		0			5. 51
5. 52		0			5. 52
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines		0			5. 99
5. 50-5. 98)		· ·			
6.00 Determined net settlement amount (balance due) based on					6.00
the cost report. (1)					
6. 01 SETTLEMENT TO PROVI DER		60, 810		52, 803	6. 01
6. 02 SETTLEMENT TO PROGRAM		0		0	6. 02
7.00 Total Medicare program liability (see instructions)		9, 262, 794		7, 041, 924	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
	()	1. 00	2. 00	
8.00 Name of Contractor				1	8.00

Health Financial Systems	HANCOCK REGION	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR S	ERVI CES RENDERED	Provi der C	CN: 15-0037	Period: From 01/01/2016	Worksheet E-1	
		Component	CCN: 15-S037	To 12/31/2016		
		Title	e XVIII	Subprovi der - I PF	PPS	
		I npati en	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	

				I PF		
		I npati en	t Part A	Par	t B	
					A 1	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Total interior promote sold to provide	1. 00	2.00	3. 00	4. 00	1 00
1.00	Total interim payments paid to provider		2, 474, 017		0	
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					1
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER		0		0	
3. 02			0		0	
3. 03			0		0	
3. 04			0		0	
3. 05	Provider to Program		0		U	3.05
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 50	ADJUSTIMENTS TO PROGRAM		0		0	
3. 52			0		0	
3. 52			0		0	
3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	
3. 99	3. 50-3. 98)		0		U	3.99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 474, 017		0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2,474,017		0	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					i
5. 00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5.01
5. 02			0		0	5.02
5. 03			0		0	5.03
	Provider to Program					1
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		498		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		2, 474, 515		0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8.00

Heal th	Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0037	Peri od: From 01/01/2016	Worksheet E-1	
				To 12/31/2016		pared:
					5/16/2017 10:	
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					
1.00	Total hospital discharges as defined in AARA			e 14	2, 714	
2. 00	Medicare days from Wkst. S-3, Pt. I, col. 6		1-12		3, 646	2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col				737	3. 00
4. 00	Total inpatient days from S-3, Pt. I col. 8		1-12		9, 139	4.00
5. 00	Total hospital charges from Wkst C, Pt. I, C				292, 276, 478	5. 00
6. 00	Total hospital charity care charges from Wks				4, 383, 686	
7. 00	CAH only - The reasonable cost incurred for line 168	the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8. 00	Calculation of the HIT incentive payment (se	ee instructions)			0	8.00
9. 00	Sequestration adjustment amount (see instruc				0	9. 00
10.00	Calculation of the HIT incentive payment aft		(see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS 8					
30.00	Initial/interim HIT payment adjustment (see	instructions)			0	30.00
	Other Adjustment (specify)	,			0	31.00
	Balance due provider (line 8 (or line 10) mi	nus line 30 and l	ine 31) (see instruction	ns)	0	32.00
				·		

	Financial Systems HANCOCK REGILATION OF REIMBURSEMENT SETTLEMENT	ONAL HOSPITAL Provider CCN: 15-0037	Peri od:	u of Form CMS-2 Worksheet E-3	
0/12001	STITUTE OF RETURNING SETTEEMENT	Component CCN: 15-S037	From 01/01/2016 To 12/31/2016	Part II	pared:
		Title XVIII	Subprovi der -	PPS	17 alli
			IPF		
				1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	l medical education payments)	2, 669, 337	1.00
2.00	Net IPF PPS Outlier Payments	1.9	ĺ	23, 760	2.00
3.00	Net IPF PPS ECT Payments			0	3.00
4. 00	Unweighted intern and resident FTE count in the most rece 15, 2004. (see instructions)	ent cost report filed on or	before November	0. 00	4.00
4. 01	Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted wi			0. 00	4. 01
5. 00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions)			0.00	5.00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth	noried of a "now	0.00	
0.00	teaching program" (see instuctions)	The new program growth	perrou or a new	0.00	0.00
7. 00	Current year's unweighted L&R FTE count for residents wit teaching program" (see instuctions)	hin the new program growth	period of a "new	0. 00	7.00
8. 00	Intern and resident count for IPF PPS medical education a	diustment (see instructions	,	0.00	8.00
9. 00	Average Daily Census (see instructions)	ag astillerit (see Tristi deti oris		8. 278689	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	I to the power of .5150 -1}.		0. 000000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and	11)		2, 693, 097	12.00
13.00	Nursing and Allied Health Managed Care payment (see instr			0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)				14.00
15.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	15.00
16.00	Subtotal (see instructions)			2, 693, 097	16.00
17.00	Primary payer payments			0	
18. 00	Subtotal (line 16 less line 17).			2, 693, 097	
19. 00	Deducti bl es			155, 708	
20.00	Subtotal (line 18 minus line 19)			2, 537, 389	
21.00	Coi nsurance			12, 880	
22.00	Subtotal (line 20 minus line 21)			2, 524, 509	
23.00	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		0	
24. 00	Adjusted reimbursable bad debts (see instructions)			0	24.00
25. 00 26. 00	Allowable bad debts for dual eligible beneficiaries (see	INSTRUCTIONS)		0	25. 00 26. 00
26.00	Subtotal (sum of lines 22 and 24) Direct graduate medical education payments (from Wkst. E-	4 line 40)		2, 524, 509 0	
28. 00	Other pass through costs (see instructions)	4, ITHE 49)		506	
29. 00	Outlier payments reconciliation			0	
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	
30. 99	Recovery of Accelerated Depreciation	,		0	
31 00	1		ļ	2 525 015	

Ω

0

0 51.00

0.00

498

23, 760

31.00

32.00

33.00

34.00

35.00

50.00

52.00

0 53.00

2, 525, 015

50, 500 2, 474, 017

31.00

32.00

33.00

34.00

35.00

Interim payments

TO BE COMPLETED BY CONTRACTOR

53.00 Time Value of Money (see instructions)

§115. 2

Total amount payable to the provider (see instructions)

50.00 Original outlier amount from Worksheet E-3, Part II, line 2

51.00 Outlier reconciliation adjustment amount (see instructions)

Balance due provider/program (line 31 minus lines 31.01, 32 and 33)

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,

Sequestration adjustment (see instructions)

Tentative settlement (for contractor use only)

52.00 The rate used to calculate the Time Value of Money

Health Financial Systems	HANCOCK REGIONAL HOSPITAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:	: 15-0037	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/16/2017 10:17 am

			0 12/31/2010	5/16/2017 10:	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		83, 276		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		83, 276	0	4.00
5.00	Inpatient primary payer payments		O		5.00
6.00	Outpati ent pri mary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		83, 276	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				
8.00	Routine service charges		54, 875		8.00
9.00	Ancillary service charges		101, 224	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		156, 099	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for	1 3	0	0	14.00
45 00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			45.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	
16.00	Total customary charges (see instructions)		156, 099	0	
17. 00	Excess of customary charges over reasonable cost (complete onl	y it line 16 exceeds	72, 823	0	17.00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	ly if line 4 exceeds line		0	18.00
16.00	16) (see instructions)	y II IIIle 4 exceeds IIIle	١	U	10.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see insti	cuctions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line		83, 276	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				21.00
22.00	Other than outlier payments		0 ol	0	22. 00
	Outlier payments		o	0	
	Program capital payments		O		24.00
25.00	Capital exception payments (see instructions)		O		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		O	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		83, 276	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	83, 276	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	83, 276	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		83, 276	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		83, 276	0	
41.00	Interim payments		76, 416	0	
42.00	Balance due provider/program (line 40 minus line 41)		6, 860	0	
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				I

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10
BALANCE SHEET (If you are nonproprietary and do not maintain Provider CCN: 15-0037 Period: Worksheet G

Health Financial Systems

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

Date/Time Prepared: 5/16/2017 10:17 am

37		General Fund	Speci fi c	Endowment	5/16/2017 10: Plant Fund	1/ am
			Purpose Fund	Fund		
	CURRENT ASSETS	1. 00	2.00	3. 00	4. 00	
1. 00	Cash on hand in banks	6, 221, 106	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes recei vable	0	0	0	0	3.00
4. 00 5. 00	Accounts recei vabl e Other recei vabl e	13, 526, 759	0	0	0	4. 00 5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	0		0	0	6.00
7.00	Inventory	22, 893, 568	0	0	0	7. 00
8. 00	Prepai d expenses	0	0	0	0	8. 00
9. 00 10. 00	Other current assets Due from other funds	62, 069, 515	0	0	0	9.00
11. 00	Total current assets (sum of lines 1-10)	104, 710, 948		0		
00	FIXED ASSETS	10177107710	<u> </u>			
12.00	· ·	9, 394, 466		0		
13.00	Land improvements	0		0		
14. 00 15. 00	Accumulated depreciation Buildings	0 113, 321, 538	0	0	0	14. 00 15. 00
16. 00	Accumulated depreciation	-129, 025, 483		0	0	16.00
17. 00		0	Ö	0	Ő	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
	Fi xed equipment	0	0	0	0	19.00
20.00		0	0	0	0	
21. 00 22. 00) 0	0	0	0	21. 00 22. 00
23. 00		75, 917, 586	-	0	0	23. 00
24. 00	Accumul ated depreciation	0	0	0	0	24. 00
25.00		0	0	0	0	25. 00
	Accumul ated depreciation	0	0	0	0	26. 00
27. 00		0	0	0	0	27. 00 28. 00
29. 00	Accumul ated depreciation Minor equipment-nondepreciable	0	0	0	_	
30. 00	· · · · · · · · · · · · · · · · · · ·	69, 608, 107		0		
	OTHER ASSETS					
31.00		0	0	0	0	
32.00	Deposits on leases	0	0	0	0	
33. 00 34. 00	Due from owners/officers Other assets	8, 050, 336	- 1	0	0	
35. 00	1	8, 050, 336	1	0	_	
36.00	Total assets (sum of lines 11, 30, and 35)	182, 369, 391	0	0	0	36.00
07.00	CURRENT LI ABILITIES	- (10 (70				
37. 00 38. 00	. 3	5, 612, 673 4, 948, 401	0	0		
39. 00	Payroll taxes payable	4, 940, 401		0	0	39.00
40.00		Ö	Ö	0	Ő	
41.00	Deferred income	0	0	0	0	41.00
42.00	. 3	0				42.00
43. 00 44. 00	Due to other funds	0 3, 191, 808	0	0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	13, 752, 882				
10.00	LONG TERM LIABILITIES	10, 702, 002	9	0		10.00
46.00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	0	0	0	0	
48. 00	· ·	0	0	0	0	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	0	0	0		
51. 00		13, 752, 882		0		
	CAPITAL ACCOUNTS					
52.00	General fund balance	168, 616, 509	1			52.00
53.00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00				0		56.00
57. 00				_	0	
58. 00					0	58. 00
EO 00	replacement, and expansion	140 /1/ 500		^	_	E0 00
59. 00 60. 00	1	168, 616, 509 182, 369, 391	1	0	0	
55. 55	[59]	102, 307, 371		O		00.00
	•	•			•	•

					То	12/31/2016	Date/Time Pre 5/16/2017 10:	
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	
	I -	1. 00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		156, 406, 261	1		0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		12, 210, 248 168, 616, 509	1		0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)		100, 010, 309		0	U	C	
5. 00	Additions (credit adjustments) (specify)				0		C	1
6. 00		o			0		C	
7. 00		o			0		C	
8.00		o			0		C	8.00
9.00		o			0		C	9.00
10.00	Total additions (sum of line 4-9)		0)		0		10.00
11. 00	Subtotal (line 3 plus line 10)		168, 616, 509	1		0		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0		C	
13.00		0			0		C	
14. 00 15. 00		0			0		C	
16.00					0		C	
17. 00					0		0	
18. 00	Total deductions (sum of lines 12-17)		0			0		18.00
19. 00	Fund balance at end of period per balance		168, 616, 509			Ö		19.00
	sheet (line 11 minus line 18)							
		Endowment	PI ant	Fund				
		Fund						
		6. 00	7.00	8.00				
1.00	Fund balances at beginning of period	0			0			1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)				_			2.00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4.00
5. 00 6. 00			0					5. 00 6. 00
7. 00			0					7.00
8. 00			0					8.00
9. 00			0					9.00
10.00	Total additions (sum of line 4-9)	o			0			10.00
11.00	Subtotal (line 3 plus line 10)	О			0			11.00
12.00	Deductions (debit adjustments) (specify)		0)				12.00
13.00			0	1				13. 00
14. 00			0					14. 00
15. 00			0	1				15. 00
16.00			0	1				16.00
17. 00	T-t-1 deductions (com of lines 12 17)		0	1				17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance				0			18. 00 19. 00
19.00	sheet (line 11 minus line 18)				U			19.00

| Peri od: | Worksheet G-2 | From 01/01/2016 | Parts | & II | To 12/31/2016 | Date/Time Prepared: Health Financial Systems HA Provi der CCN: 15-0037

			10	12/31/2016	Date/IIme Prep 5/16/2017 10:	
	Cost Center Description		npati ent	Outpati ent	Total	17 diii
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u>'</u>				
	General Inpatient Routine Services					
1.00	Hospi tal		6, 982, 171		6, 982, 171	1.00
2.00	SUBPROVI DER - I PF		3, 793, 506		3, 793, 506	2.00
3. 00	SUBPROVI DER - I RF		0		0	3.00
4.00	SUBPROVI DER					4.00
5. 00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7. 00 8. 00	SKILLED NURSING FACILITY NURSING FACILITY					7. 00 8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		10, 775, 677		10, 775, 677	10.00
10.00	Intensive Care Type Inpatient Hospital Services		10, 773, 077		10, 773, 077	10.00
11. 00	INTENSIVE CARE UNIT		11, 690, 903		11, 690, 903	11.00
12. 00	CORONARY CARE UNIT		, ,		, ,	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	11, 690, 903		11, 690, 903	16.00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		22, 466, 580		22, 466, 580	17. 00
18. 00	Ancillary services		49, 644, 490	165, 881, 347	215, 525, 837	18. 00
19.00	Outpati ent servi ces		4, 473, 395	46, 788, 388	51, 261, 783	19.00
20.00	RURAL HEALTH CLINIC		0	398, 980	398, 980	20.00
21. 00 22. 00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY		0	0	0	21. 00 22. 00
23. 00	AMBULANCE SERVICES			۷	U	23. 00
24.00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE		891, 208	1, 732, 089	2, 623, 297	26.00
27. 00	PRI VATE DUTY/DI ETARY		0	443, 828	443, 828	27. 00
27. 01	SELF INSURED CHARGES		908, 156	2, 856, 254	3, 764, 410	27. 01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	78, 383, 829	218, 100, 886	296, 484, 715	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			106, 837, 904		29.00
30. 00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33. 00 34. 00
34. 00 35. 00			0			34. 00 35. 00
36.00	Total additions (sum of lines 30-35)		U	0		36.00
37.00	DEDUCT (SPECIFY)		0	o _l		37.00
38. 00	DEDUCT (SECOTET)		o			38. 00
39. 00			0			39. 00
40.00			Ō			40.00
41. 00			Ö			41. 00
42.00	Total deductions (sum of lines 37-41)			o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		106, 837, 904		43.00
	to Wkst. G-3, line 4)					

	ieu of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0037 Period: From 01/01/20	Worksheet G-3	
To 12/31/20	16 Date/Time Prep	
	5/16/2017 10: 1	17 am_
	1.00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	296, 484, 715	1.00
2.00 Less contractual allowances and discounts on patients' accounts	193, 000, 144	2.00
3.00 Net patient revenues (line 1 minus line 2)	103, 484, 571	3.00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	106, 837, 904	4.00
5.00 Net income from service to patients (line 3 minus line 4)	-3, 353, 333	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 miscellaneous communication services	0	8. 00 9. 00
9.00 Revenue from television and radio service 10.00 Purchase discounts	0	9. 00 10. 00
11.00 Rebates and refunds of expenses	0	11. 00
12.00 Parking Lot receipts		12.00
13.00 Revenue from Laundry and Linen service		13. 00
14.00 Revenue from meals sold to employees and quests		14. 00
15.00 Revenue from rental of living quarters		15. 00
16.00 Revenue from sale of medical and surgical supplies to other than patients		
17.00 Revenue from sale of drugs to other than patients		17. 00
18.00 Revenue from sale of medical records and abstracts		18. 00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)		
20.00 Revenue from gifts, flowers, coffee shops, and canteen		20.00
21.00 Rental of vending machines		21. 00
22.00 Rental of hospital space	0	22.00
23.00 Governmental appropriations		23. 00
24. 00 OTHER OPERATING INCOME	9, 796, 495	
24. 01 NON OPERATING INCOME	5, 754, 011	
25.00 Total other income (sum of lines 6-24)	15, 550, 506	
26.00 Total (line 5 plus line 25)	12, 197, 173	26.00
27. 00 GAIN/LOSS INVENTORY ASSETS	-13, 075	27.00
28.00 Total other expenses (sum of line 27 and subscripts)	-13, 075	28.00
29.00 Net income (or loss) for the period (line 26 minus line 28)	12, 210, 248	29.00
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1, 178, 493

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67.00 0

68 00

69.00

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O 70.00

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2, 073, 618 100. 00

Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

67.00

68 00

69.00

70 00

71.00

100.00 TOTAL

ADVERTI SI NG3

THRIFT STORE*

TELEHEALTH/TELEMONI TORI NG*

NURSING FACILITY ROOM & BOARD*

OTHER NONREIMBURSABLE (SPECIFY)*

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

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	OSMEDAL OFFICE OF SOUT OFFITEDO	6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS		0		1.00
1.00	CAP REL COSTS MARIE FOLLOW	0	0		1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP* EMPLOYEE BENEFITS DEPARTMENT*	0	0		2.00
4. 00					3.00
5. 00	ADMINISTRATIVE & GENERAL* PLANT OPERATION & MAINTENANCE*	-86, 502	381, 930 595, 571		5.00
6. 00	LAUNDRY & LINEN SERVICE*	0	0 393, 371		6.00
7. 00	HOUSEKEEPI NG*	0	0		7.00
8. 00	DI ETARY*	0	5, 998		8.00
9. 00	NURSI NG ADMI NI STRATI ON*	0	3, 990		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11. 00	MEDICAL RECORDS*	0	0		11.00
12. 00	STAFF TRANSPORTATION*	0	0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14. 00	PHARMACY*	0	124, 628		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	3, 827		15. 00
16. 00	OTHER GENERAL SERVICE (DELETED)*	0	0,027		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	J			17.00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS				17.33
25. 00	I NPATI ENT CARE-CONTRACTED**	0	0		25. 00
26. 00	PHYSICIAN SERVICES**	0	o		26.00
27. 00	NURSE PRACTITIONER**	0	0		27. 00
28. 00	REGI STERED NURSE**	0	874, 688		28. 00
29. 00	LPN/LVN**	0	0		29. 00
30.00	PHYSI CAL THERAPY**	0	o		30.00
31.00	OCCUPATIONAL THERAPY**	0	o		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	o		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	o		33.00
34.00	SPI RI TUAL COUNSELI NG**	0	163		34.00
35.00	DI ETARY COUNSELI NG**	0	59		35.00
36.00	COUNSELING - OTHER**	0	o		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	252		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	o		38.00
39.00	PATI ENT TRANSPORTATION**	0	o		39.00
40.00	I MAGING SERVICES**	0	0		40.00
41.00	LABS & DI AGNOSTI CS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
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
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46. 00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAI SI NG*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64. 00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65. 00	OTHER PHYSICIAN SERVICES*	0	0		65. 00
66. 00	RESI DENTI AL CARE*	0	0		66.00
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
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	101AL	-86, 502	1, 987, 116		100.00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Health Financial Systems	HANCOCK REGIONA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE ROUTINE HOME	Provi der CO	N: 15-0037	Peri od:	Worksheet 0-2)
CARE			45 45 47	From 01/01/2016	D. I. (Time D.	
		Hospi ce CCN	l: 15-1547	To 12/31/2016	Date/Time Pre 5/16/2017 10:	
				Hospi ce I	3/ 10/ 2017 10.	17 4111
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
		- · · · · · · ·	(col. 1 +	CATIONS		
			col. 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 INPATIENT CARE-CONTRACTED						25. 00
26.00 PHYSICIAN SERVICES	0	0		0 0	0	26.00
27. 00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28. 00 REGI STERED NURSE	783, 736	0	783, 73	36 0	783, 736	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 OCCUPATI ONAL 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 SPIRITUAL COUNSELING	146	0	14	16 0	146	34.00
35. 00 DI ETARY COUNSELI NG	53	0	Ĺ	53 0	53	35.00
36.00 COUNSELING - OTHER	0	0		0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	226	0	22	26 0	226	37.00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	0		0 0	0	38.00
39. 00 PATI ENT TRANSPORTATI ON	0	0		0 0	0	39.00
40.00 I MAGING SERVICES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
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)	0	0		0 0	0	46.00
100.00 TOTAL *	784, 161	0	784, 16	51 0	784, 161	100.00
* Transfer the amount in column 7 to Wkst 0-5 col	umn 1 line 51		-			

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

Transfer the amount fire cordinary to meet. O 3, cordinary, fire 31.						
		ADJUSTMENTS	TOTAL (col. 5			
			± col. 6)			
		6. 00	7. 00			
	I RECT PATIENT CARE SERVICE COST CENTERS				ı	
	NPATI ENT CARE-CONTRACTED				25.00	
	PHYSICIAN SERVICES	0	0		26. 00	
	IURSE PRACTITIONER	0	0		27. 00	
	REGI STERED NURSE	0	783, 736		28. 00	
29. 00 L	PN/LVN	0	0		29. 00	
30. 00 P	PHYSI CAL THERAPY	0	0		30.00	
31.00 0	OCCUPATI ONAL THERAPY	0	0		31.00	
32. 00 S	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00	
33.00 M	MEDICAL SOCIAL SERVICES	0	0		33.00	
34.00 S	SPIRITUAL COUNSELING	0	146		34.00	
35. 00 D	DIETARY COUNSELING	0	53		35.00	
36. 00 C	COUNSELING - OTHER	0	0		36.00	
37. 00 H	HOSPICE AIDE & HOMEMAKER SERVICES	0	226		37.00	
38. 00 D	OURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00	
39. 00 P	PATIENT TRANSPORTATION	0	0		39.00	
40. 00 II	MAGING SERVICES	0	0		40.00	
41. 00 L	ABS & DIAGNOSTICS	0	0		41.00	
42.00 M	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00	
43.00 0	OUTPATI ENT SERVI CES	0	0		43.00	
44. 00 P	PALLIATIVE RADIATION THERAPY	0	0		44.00	
45. 00 P	PALLIATIVE CHEMOTHERAPY	0	0		45.00	
46. 00 0	THER PATIENT CARE SERVICES (SPECIFY)	0	0		46. 00	
100. 00 T	OTAL *	0	784, 161		100.00	

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

Health Financial Systems	HANCOCK REGIONA	L HOSPITAL		In Lie	u of Form CMS-:	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HO	SPICE INPATIENT	Provider CC	N: 15-0037	Peri od:	Worksheet 0-3	3
RESPITE CARE		Hospi ce CCN	l: 15-1547	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/16/2017 10:	epared: 17 am
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col . 1 +	CATI ONS		
	1. 00	2.00	col. 2) 3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
25. 00 INPATIENT CARE-CONTRACTED	0	O		0	0	25. 00
26. 00 PHYSI CLAN SERVI CES	l ől	0			0	1
27. 00 NURSE PRACTITIONER		0		0 0	0	1
28. 00 REGISTERED NURSE	39, 606	0	39, 6	06 0	39, 606	
29. 00 LPN/LVN	l ol	0	•	0 0	0	29. 00
30. 00 PHYSI CAL THERAPY	o	0		0 0	0	30.00
31. 00 OCCUPATIONAL THERAPY	o	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	o	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	7	0		7 0	7	34.00
35. 00 DI ETARY COUNSELI NG	3	0		3 0	3	35.00
36. 00 COUNSELING - OTHER	0	0		0	0	1 00.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	11	0		11 0	11	37.00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN						38. 00
39. 00 PATIENT TRANSPORTATION	0	0		0 0	0	1 0 / 1 0 0
40. 00 I MAGING SERVICES	0	0		0	0	1 .0.00
41. 00 LABS & DI AGNOSTI CS	O	0		0	0	
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	O O	0		0	0	1 .2.00
43.00 OUTPATIENT SERVICES 44.00 PALLIATIVE RADIATION THERAPY		0		0	0	1 .0.00
45. 00 PALLIATIVE RADIATION THERAPY		0		0	0	44. 00 45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)		0			0	
100.00 TOTAL *	39, 627	0	39, 6	27 0	Ĭ	100.00
100.00 101112	57,021	9	37,0	2,1	37,027	1100.00

^{45.00} PALLIATIVE CHEMOTHERAPY
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)
100.00 TOTAL *

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	39, 606	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	7	34.00
35.00	DI ETARY COUNSELI NG	0	3	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	11	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	39, 627	100.00

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

Health Financial Systems	HANCOCK REGIONA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOS	SPICE GENERAL	Provi der CC	N: 15-0037	Peri od:	Worksheet 0-4	ļ
I NPATI ENT CARE		Hospi ce CCN	l: 15-1547	From 01/01/2016 To 12/31/2016		nared:
		nospi ce con	1. 15 1547	10 12/31/2010	5/16/2017 10:	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED	0	0		0	0	20.00
26. 00 PHYSICIAN SERVICES	0	0		0	0	26. 00
27. 00 NURSE PRACTITIONER	0	0		0	0	1 = 7.00
28. 00 REGI STERED NURSE	51, 346	0	51, 3	46 0	51, 346	
29. 00 LPN/LVN	0	0		0	0	
30. 00 PHYSI CAL THERAPY	이	0		0 0	0	00.00
31. 00 OCCUPATI ONAL THERAPY	0	0		0	0	000
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
33. 00 MEDICAL SOCIAL SERVICES	0	0		0	0	00.00
34. 00 SPI RI TUAL COUNSELI NG	10	0		10 0	10	
35. 00 DI ETARY COUNSELING	3	0		3 0	3	
36. 00 COUNSELING - OTHER	이	0		0 0	0	
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	15	0		15 0	15	
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN						38. 00
39. 00 PATI ENT TRANSPORTATI ON	0	0		0	0	07.00
40.00 I MAGING SERVICES	0	0		0	0	
41.00 LABS & DIAGNOSTICS	0	0		0	0	1
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0	0	
43. 00 OUTPATIENT SERVICES	0	0		0	0	1 .0.00
44. 00 PALLIATIVE RADIATION THERAPY	0	0		0	0	44.00
45. 00 PALLI ATI VE CHEMOTHERAPY	0	0		0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0	0	1 .0.00
100. 00 TOTAL *	51, 374	0	51, 3	74 0	51, 374	100.00

^{45.00} PALLIATIVE CHEMOTHERAPY
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)
100.00 TOTAL *

* 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	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	51, 346	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	10	34.00
35.00	DI ETARY COUNSELI NG	0	3	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	15	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38. 00
39.00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o	46.00
100.00	TOTAL *	0	51, 374	100.00

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

	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET LES FOR ALLOCATION	Provi der (Period: From 01/01/2016 To 12/31/2016	Worksheet 0-5 Date/Time Pre	
		•		11! 1	5/16/2017 10:	
	Descriptions		HOSPI CE	Hospi ce I GENERAL	TOTAL	
	Descriptions		DI RECT EXPENSES (see	SERVICE EXPENSES FROM WKST B PART I (see	EXPENSES (sum of cols. 1 + 2)	
			1.00	instructions) 2.00	3. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	3.00	
1. 00	CAP REL COSTS-BLDG & FLXT		T i	0 294, 517	294, 517	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP			0 271,017	271,017	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT		1 (0 181, 273	181, 273	3.00
4.00	ADMINISTRATIVE & GENERAL		381, 93	·	916, 335	4.00
5.00	PLANT OPERATION & MAINTENANCE		595, 57	1 268, 798	864, 369	5.00
6.00	LAUNDRY & LINEN SERVICE			0	0	6.00
7.00	HOUSEKEEPI NG		1	0	0	7. 00
8.00	DI ETARY		5, 99		85, 119	
9. 00	NURSI NG ADMI NI STRATI ON		1	94, 847	94, 847	9. 00
10.00	ROUTINE MEDICAL SUPPLIES		•	0 2, 038	2, 038	
11. 00	MEDI CAL RECORDS			0	0	11. 00
12.00	STAFF TRANSPORTATION		1	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION		1	0	0	13.00
14.00	PHARMACY		124, 62		124, 628	
15.00	PHYSI CI AN ADMINI STRATI VE SERVI CES		3, 82		3, 827	15.00
16.00	OTHER GENERAL SERVICE (DELETED)		1	0 0	0	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES LEVEL OF CARE			1 0	U	17.00
50.00	HOSPICE CONTINUOUS HOME CARE		T	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		784, 16	-	784, 161	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE		39, 62		39, 627	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE		51, 37		51, 374	
	NONREI MBURSABLE COST CENTERS			1	, ,	
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		1	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES		l .	0	0	65.00
66.00	RESI DENTI AL CARE		l .	0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG		•	0	0	68.00
69. 00	THRI FT STORE		1	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)		1	0	0	71.00

0 99.00

3, 442, 115 100. 00

1, 454, 999

1, 987, 116

99. 00 NEGATI VE COST CENTER 100. 00 TOTAL

Health Financial Systems		HANCOCK REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL	-BASED HOSPICE GENERAL	SERVI CE COSTS	Provi der CCN: 15-0037	Peri od: From 01/01/2016	Worksheet 0-6

15-1547 To 12/31/2016 Date/Time Prepared: Hospi ce CCN: 5/16/2017 10:17 am Hospi ce I TOTAL CAP REL BLDG CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions **EXPENSES** & FIX EQUI P **BENEFITS DEPARTMENT** 2.00 0 1.00 3.00 ЗА GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT 1.00 294, 517 294, 517 1.00 2.00 2 00 CAP REL COSTS-MVBLE EQUIP 0 3.00 EMPLOYEE BENEFITS DEPARTMENT 181, 273 181, 273 3.00 4.00 ADMINISTRATIVE & GENERAL 916, 335 916, 335 4.00 0 5.00 PLANT OPERATION & MAINTENANCE 864, 369 0 0 864, 369 5.00 0 LAUNDRY & LINEN SERVICE 0 0 6.00 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 7.00 8.00 DI ETARY 85, 119 0 0 0 85, 119 8.00 0 NURSING ADMINISTRATION 94, 847 0 94, 847 9.00 0 9.00 2, 038 ROUTINE MEDICAL SUPPLIES 2,038 0 10.00 10.00 0 0 11.00 MEDICAL RECORDS 0 11.00 12.00 STAFF TRANSPORTATION 0 12.00 0 0 VOLUNTEER SERVICE COORDINATION 0 13.00 0 0 13.00 0 0 0 14.00 PHARMACY 124, 628 0 124, 628 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 3,827 15.00 15.00 3,827 0 OTHER GENERAL SERVICE (DELETED) 0 16,00 16.00 0 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 0 17.00 EVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 HOSPICE ROUTINE HOME CARE 51.00 784, 161 163, 558 947, 719 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 39, 627 125, 231 0 7, 533 172, 391 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 51, 374 169, 286 0 10, 182 230, 842 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM 60.00 0 0 60.00 0 0 61.00 0 0 61.00 62.00 FUNDRAI SI NG 0 62.00 000000000 0 0 0 0 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 0 63.00 0 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 RESIDENTIAL CARE 0 0 66.00 0 0 0 66.00 0 67 00 ADVERTI SI NG 0 0 67.00 0 TELEHEALTH/TELEMONI TORI NG 0 68.00 0 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00 0 71 00 OTHER NONREIMBURSABLE (SPECIFY) 0 71.00 0 0 0 99. 00 NEGATI VE COST CENTER 0 99.00

3, 442, 115

294, 517

181, 273

3, 442, 115 100. 00

100.00 TOTAL

Health Financial Systems		HANCOCK REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL	-BASED HOSPICE GENERAL	SERVI CE COSTS	Provi der CCN: 15-0037	Peri od: From 01/01/2016	Worksheet 0-6

15-1547 To 12/31/2016 Date/Time Prepared: Hospi ce CCN: 5/16/2017 10:17 am Hospi ce I ADMI NI STRATI V PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions LINEN SERVICE E & GENERAL OPERATION & MAI NTENANCE 4.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 916, 335 4.00 PLANT OPERATION & MAINTENANCE 5.00 313, 587 1, 177, 956 5.00 LAUNDRY & LINEN SERVICE 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 30, 881 0 0 0 0 0 0 0 0 116,000 8.00 NURSING ADMINISTRATION 34, 410 9.00 0 9.00 ROUTINE MEDICAL SUPPLIES 0 10.00 10.00 739 11.00 MEDICAL RECORDS 0 11.00 12.00 STAFF TRANSPORTATION 0 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 0 13.00 14.00 PHARMACY 45, 214 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 1, 388 15.00 OTHER GENERAL SERVICE (DELETED) 0 0 16.00 16.00 0 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 HOSPICE ROUTINE HOME CARE 51.00 343, 826 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 62, 542 500, 876 0 0 49, 324 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 83, 748 677,080 0 0 66, 676 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM 60.00 0 60.00 0 61.00 C 61.00 62.00 FUNDRAI SI NG 0000000 0 0 0 0 0 0 0 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 63.00 PALLIATIVE CARE PROGRAM 0 64.00 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 69.00 THRIFT STORE 0 C 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 71.00 0 0 0 0 99. 00 NEGATI VE COST CENTER 0 0 99.00

916, 335

1, 177, 956

116, 000 100. 00

100.00 TOTAL

Health Financial Systems		HANCOCK REGIONAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED H	OSPI CE GENERAL	SERVI CE COSTS	Provider CCN: 15-0037	Peri od:	Worksheet 0-6

Hospi ce CCN: Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL RECORDS SERVI CE TRANSPORTATIO COORDI NATI ON SUPPLI ES Ν N 11.00 9.00 10.00 12.00 13.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 2 00 CAP REL COSTS-MVBLE EQUIP 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 129, 257 9.00 9.00 ROUTINE MEDICAL SUPPLIES 2,777 10.00 10.00 11.00 MEDICAL RECORDS 0 0 11.00 0 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 0 13.00 0 13.00 0 14.00 PHARMACY 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 OTHER GENERAL SERVICE (DELETED) 0 16.00 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 0 50.00 0 0 0 0 0 HOSPICE ROUTINE HOME CARE 51.00 116, 625 2,506 0 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 5, 371 115 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 7, 261 156 0 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM 60.00 60.00 0 0 0 0 0 0 0 0 0 61.00 0000000 0 61.00 62.00 FUNDRAI SI NG 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 PALLIATIVE CARE PROGRAM 64.00 64.00 0 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 66.00 67 00 ADVERTI SI NG Ω 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 68.00 0 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 Ω 71.00 99.00 99. 00 NEGATI VE COST CENTER 0 0 0 100.00 TOTAL 129, 257 2,777 0 100.00
 Heal th Financial
 Systems
 HANCOCK REGIONSTALLOCATION

 - HOSPITAL-BASED
 HOSPICE GENERAL
 SERVICE COSTS
 In Lieu of Form CMS-2552-10 HANCOCK REGIONAL HOSPITAL

Provider CCN: 15-0037 | Period: | Worksheet 0-6 | Part | | Hospice CCN: 15-1547 | To | 12/31/2016 | Date/Time Prepared: | 5/16/2017 | 10:17 am

						5/16/2017 10:	17 am
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
			ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES	(DELETED)	CARE SERVICES		
		14. 00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP					I	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					I	3.00
4.00	ADMINISTRATIVE & GENERAL					I	4.00
5.00	PLANT OPERATION & MAINTENANCE					I	5.00
6. 00	LAUNDRY & LINEN SERVICE					I	6.00
7. 00	HOUSEKEEPI NG					I	7.00
8. 00	DI ETARY					I	8.00
9. 00	NURSING ADMINISTRATION					I	9.00
10.00	ROUTINE MEDICAL SUPPLIES					I	10.00
11. 00	MEDI CAL RECORDS					I	11.00
	STAFF TRANSPORTATION					I	12.00
13. 00	VOLUNTEER SERVICE COORDINATION					I	13.00
	PHARMACY	169, 842				I	14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	0				I	15. 00
	OTHER GENERAL SERVICE (DELETED)	0	0,210	1		I	16. 00
	PATIENT/RESIDENTIAL CARE SERVICES				0	I	17. 00
17.00	LEVEL OF CARE				<u> </u>		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0) (i	0	50.00
	HOSPICE ROUTINE HOME CARE	153, 244	4, 705		1	1, 568, 625	
	HOSPICE INPATIENT RESPITE CARE	7, 058					
	HOSPICE GENERAL INPATIENT CARE	9, 540					
	NONREI MBURSABLE COST CENTERS	., ., .,			-	.,,	
60.00	BEREAVEMENT PROGRAM	0				0	60.00
61.00	VOLUNTEER PROGRAM	0				0	61.00
62.00	FUNDRAI SI NG	0				0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	63.00
64.00	PALLIATIVE CARE PROGRAM	0				0	1
65.00	OTHER PHYSICIAN SERVICES	0				0	65.00
66.00	RESI DENTI AL CARE	0	l 0) (o	0	66.00
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
	NURSING FACILITY ROOM & BOARD					0	1
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		o	Ō	1
	NEGATI VE COST CENTER	0	Ö		o	Ō	1
100.00		169, 842	5, 215			3, 442, 115	
	ı	* * * * * * * * * * * * * * * * * * * *	, , ,	'			

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENER	RAL SERVICE COSTS	Provi der CCN:		Peri od: From 01/01/2016	Worksheet 0-6	
STATISTICAL BASIS		Hospi ce CCN:		To 12/31/2016		
				Hospi ce I		
Cost Center Descriptions	CAP REL BLDG CA	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI O	ADMI NI STRATI V	

						5/16/2017 10:	17 am
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE		ADMI NI STRATI V	
	·	& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
		,	VALUE)	(GROSS		COSTS)	
				SALARI ES)			
		1. 00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	722					1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	, 22					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0		7, 388			3.00
4. 00	ADMINISTRATIVE & GENERAL			7,300	-916, 335	2, 525, 780	4.00
5. 00	PLANT OPERATION & MAINTENANCE	0			-710, 333	864, 369	5.00
6. 00	LAUNDRY & LINEN SERVICE	0				0 0 0 0	6.00
		0					
7.00	HOUSEKEEPI NG	0				0	7.00
8.00	DI ETARY	0			0	85, 119	8.00
9. 00	NURSI NG ADMI NI STRATI ON	0	0		0	94, 847	9.00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0		0	2, 038	1
11. 00	MEDI CAL RECORDS	0	0		0	0	11. 00
12. 00	STAFF TRANSPORTATION	0	0)	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0) (0	0	13.00
14.00	PHARMACY	0	0) (0	124, 628	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0) (0	3, 827	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0) (0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			C	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			6, 666	0	947, 719	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	307	0	307	0	172, 391	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	415	l .	•			1
	NONREI MBURSABLE COST CENTERS		-				
60.00	BEREAVEMENT PROGRAM	0	0) (0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	_	1	_	Ö	61.00
62. 00	FUNDRAI SI NG	0				Ö	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				o o	63.00
64. 00	PALLIATIVE CARE PROGRAM	0				Ö	64.00
65. 00	OTHER PHYSICIAN SERVICES					0	65.00
66. 00	RESI DENTI AL CARE	0				0	66.00
67. 00	ADVERTI SI NG	0				0	67.00
		0					
68. 00	TELEHEALTH/TELEMONI TORI NG					0	68.00
69. 00	THRI FT STORE	0	1	ן כ	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	_			0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	1 0	ין כ	0	0	
99. 00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	294, 517		181, 273		916, 335	
101.00	UNIT COST MULTIPLIER	407. 918283	0. 000000	24. 536140)	0. 362793	101. 00

Health Financial Systems	HANCOCK REGI	ONAL HOSPITAL	In Lie	u of Form CMS-25	52-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GEN	ERAL SERVICE COSTS	Provider CCN: 15-0037	Peri od:	Worksheet 0-6	
STATISTICAL BASIS			From 01/01/2016		
		Hospi ce CCN: 15-1547	To 12/31/2016		
				5/16/2017 10: 17	am
			Hospi ce I		
Cost Center Descriptions	PLANT	LAUNDRY & HOUSEKEEPI	NG DI ETARY	NURSI NG	

			Hospi ce CCI	N: 15-1547 T	o 12/31/2016	Date/Time Pre 5/16/2017 10:	
					Hospi ce I	07 107 2017 10.	17 (311)
	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (I N-FACI LI TY DAYS)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (I N-FACI LI TY DAYS)	NURSI NG ADMI NI STRATI O N (DI RECT NURS. HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	2. 00	2.22		2.22		
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	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 (DELETED) PATIENT/RESIDENTIAL CARE SERVICES	722 0 0 0 0 0 0 0 0 0 0 0	0	0 0 0 0 0 0 0 0	722	7, 388 0 0 0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
50. 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE ROUTINE HOME CARE					6, 666	
52.00	HOSPICE INPATIENT RESPITE CARE	307	0	0	307	307	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	415	0	0	415	415	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	
61.00	VOLUNTEER PROGRAM FUNDRAISING	0		0		0	
62. 00 63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	62. 00 63. 00
64. 00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0				0	65.00
66. 00	RESI DENTI AL CARE	0	0	0	0	0	66.00
67. 00	ADVERTI SI NG	0		0	Ü	o o	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		o o	68.00
69. 00	THRI FT STORE	0		0		Ō	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	1
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			0	116, 000		
101.00	UNIT COST MULTIPLIER	1, 631. 518006	0. 000000	0. 000000	160. 664820	17. 495533	101. 00

COST A	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI TICAL BASIS	HANCOCK REGION ERVICE COSTS	Provi der Co		In Lie Period: From 01/01/2016 To 12/31/2016)
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATION N (MI LEAGE)	VOLUNTEER	PHARMACY (CHARGES)	
		10. 00	11. 00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00	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 (DELETED) PATIENT/RESIDENTIAL CARE SERVICES	7, 388	7, 388		0 0 0 0 0 0 0	7, 388 0	15. 00
FO 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE		0				
50. 00 51. 00 52. 00 53. 00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	0 6, 666 307 415	0 6, 666 307 415		0 0 0 0 0 0 0 0	6, 666 307	51. 00 52. 00
60.00	BEREAVEMENT PROGRAM				0 0	0	60.00
61. 00 62. 00	VOLUNTEER PROGRAM FUNDRAI SI NG				0 0	0	61. 00 62. 00

2,777

0. 375880

0.000000

63.00

64.00

67.00

68.00

69. 00 70. 00

71.00

99.00

0 65.00

0 66.00

0

0

169, 842 100. 00 22. 988901 101. 00

0 0 0

0

0

0.000000

0.000000

63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS

PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD

71.00 OTHER NONREIMBURSABLE (SPECIFY)

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)
101.00 UNIT COST MULTIPLIER

66.00 RESIDENTIAL CARE

ADVERTI SI NG

99.00 NEGATIVE COST CENTER

64.00

65.00

67.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOS STATISTICAL BASIS	SPICE GENERAL SERVICE COSTS Provider CCN: Hospice CCN:	From 01/01/2016 Part II

						5/16/2017 10:17 am
					Hospi ce I	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/		
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
		E SERVICES	(DELETED)	CARE SERVICE	S	
		(PATI ENT	(SPECI FY	(IN-FACILITY	/	
		DAYS)	BASIS)	DAYS)		
		15. 00	16. 00	17. 00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FLXT					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	HOUSEKEEPI NG					7.00
8.00	DI ETARY					8.00
9. 00	NURSI NG ADMI NI STRATI ON					9.00
	ROUTINE MEDICAL SUPPLIES					10.00
	MEDI CAL RECORDS					11.00
	STAFF TRANSPORTATION					12. 00
13. 00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	7, 388				15.00
16.00	OTHER GENERAL SERVICE (DELETED)		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			72	22	17. 00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
	HOSPICE ROUTINE HOME CARE	6, 666	0			51.00
	HOSPICE INPATIENT RESPITE CARE	307	0	30	07	52.00
	HOSPICE GENERAL INPATIENT CARE	415	0			53.00
00.00	NONREI MBURSABLE COST CENTERS	110	<u> </u>	<u>'</u>	10	
60.00	BEREAVEMENT PROGRAM		0			60.00
	VOLUNTEER PROGRAM		0			61.00
	FUNDRAI SI NG		0			62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
			0			64.00
	PALLIATIVE CARE PROGRAM		0			· · · · · · · · · · · · · · · · · · ·
	OTHER PHYSICIAN SERVICES		0			65.00
	RESI DENTI AL CARE	0	0		0	66.00
	ADVERTI SI NG		0			67.00
	TELEHEALTH/TELEMONI TORI NG		0			68.00
	THRI FT STORE		0			69.00
	NURSING FACILITY ROOM & BOARD					70.00
71 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	71.00
					i i	1 00 00
99. 00	NEGATIVE COST CENTER					99. 00
99. 00 100. 00	NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	5, 215	0		0	100.00

Hool +b	Financial Systems	HANCOCK REGIO	NAI HOSDITAI		In Lia	u of Form CMS-2	DEE2 10
	TIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV		Provider C	°N: 15_0037 I	Period:	Worksheet 0-7	
	OF CARE	VICE 60313 BI	Hospi ce CCI		From 01/01/2016 Fo 12/31/2016		pared:
-					Hospi ce I		
			·	Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	HCHC	HRHC	HI RC	
		0	1. 00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66.00			0	0	1.00
2.00	OCCUPATI ONAL THERAPY	67.00			0	0	2.00
3.00	SPEECH PATHOLOGY	68.00			0	0	3.00
3. 01	OCCUPATI ONAL HEALTH	68. 01			0	0	3. 01
4.00	DRUGS CHARGED TO PATIENTS	73.00			0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0. 151479		0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0. 814665		0	0	7. 00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00					9. 00
10.00	CARDI AC	76.00	0. 000000		0	0	10.00
10. 01	CARDI OPULMONARY	76. 01	0. 611573		0	0	10. 01
11. 00	Totals (sum of lines 1-11)						11.00
		Charges by		Shared Servi	ce Costs by LOC		
		LOC (from					
		Provi der					
		Records)					
	Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	,	HGIP (col. 1	
			x col. 2)	x col. 3)	x col. 4)	x col. 5)	
		5. 00	6. 00	7. 00	8. 00	9. 00	

0 66. 00 67. 00 68. 00 68. 01 73. 00 96. 00 60. 00 71. 00 93. 00 55. 00 76. 01 Charges by LOC (from	0. 352343 0. 433587 0. 000000 0. 222764 0. 151479 0. 814665	000000000000000000000000000000000000000	0 0		2. 00 3. 00 3. 01 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
67. 00 68. 00 68. 01 73. 00 96. 00 60. 00 71. 00 93. 00 55. 00 76. 01	0. 352343 0. 433587 0. 000000 0. 222764 0. 151479 0. 814665	0 0 0 0 0	0 0	0 0 0 0	2. 00 3. 00 3. 01 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
67. 00 68. 00 68. 01 73. 00 96. 00 60. 00 71. 00 93. 00 55. 00 76. 01	0. 352343 0. 433587 0. 000000 0. 222764 0. 151479 0. 814665	0 0 0 0 0	0 0	0 0 0 0	2. 00 3. 00 3. 01 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
68. 00 68. 01 73. 00 96. 00 60. 00 71. 00 93. 00 55. 00 76. 00	0. 433587 0. 000000 0. 222764 0. 151479 0. 814665	000000000000000000000000000000000000000	0	0 0 0	3. 00 3. 01 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
68. 01 73. 00 96. 00 60. 00 71. 00 93. 00 55. 00 76. 00 76. 01	0. 000000 0. 222764 0. 151479 0. 814665 0. 000000	0 0 0	0	0 0 0	3. 01 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
73. 00 96. 00 60. 00 71. 00 93. 00 55. 00 76. 00 76. 01	0. 222764 0. 151479 0. 814665 0. 000000	0 0	_	0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
96. 00 60. 00 71. 00 93. 00 55. 00 76. 00 76. 01	0. 151479 0. 814665 0. 000000	0 0	0 0	0 0	5. 00 6. 00 7. 00 8. 00 9. 00
60. 00 71. 00 93. 00 55. 00 76. 00 76. 01	0. 151479 0. 814665 0. 000000	0	0	0	6. 00 7. 00 8. 00 9. 00
71. 00 93. 00 55. 00 76. 00 76. 01 Charges by	0. 814665 0. 000000	0	0	0	7. 00 8. 00 9. 00
93. 00 55. 00 76. 00 76. 01	0. 000000	0	0	0	8. 00 9. 00
55. 00 76. 00 76. 01 Charges by	0. 000000		0		9.00
76.00 76.01 Charges by	0. 000000		0		
76.01 Charges by			0		
Charges by	0. 611573	1 0			
			0	0	1
					11. 00
LOC (from		Shared Service	e Costs by LOC		
Provi der					
Records)	HOUG (I 1	UDUC (I 1	III DC (I 1	UCLD (I 1	
HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
5.00	x col. 2)	x col. 3)	x col. 4)	x col. 5)	
5.00	0.00	7.00	0.00	7.00	
	1 0	0	0	0	1.00
	1				
	0	0	0	1	
	0	0	0	o o	
					5.00
0	0	0	0	0	1
	0				
		Ĭ			8.00
					9.00
0	0	0	0	0	
					10.01
					11.00
I	1	٠ ٠			1 00
	000000000000000000000000000000000000000	5.00 6.00 0	5.00 6.00 7.00 0	5.00 6.00 7.00 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 6.00 7.00 8.00 9.00 0 0 0 0 0 0 0

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL			In Lieu	of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COS	Т	Provi der	CCN:	15-0037	od: 01/01/2016	Worksheet 0-8
		Hospi ce (CCN:			Date/Time Prepared:

		Hospi ce cciv	15-1547	0 12/31/2016	5/16/2017 10:	pared: 17 am
				Hospi ce I		
	·		TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)	40)			0. 00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	9 10)	0	0		4.00
5. 00	Program cost (line 3 times line 4)		0	0		5.00
4 00	HOSPICE ROUTINE HOME CARE	7 001 7			1 5/0 /05	4 00
6. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7 line 11)	/, COI. /,			1, 568, 625	6. 00
7. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				6, 666	7. 00
8. 00	Total average cost per diem (line 6 divided by line 7)				235. 32	8.00
9. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	no 11)	6, 075	71	255. 52	9.00
	Program cost (line 8 times line 9)	(11)	1, 429, 569			10.00
10.00	HOSPICE INPATIENT RESPITE CARE		1, 427, 307	10, 700		10.00
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	7. col. 8.			797, 894	11.00
	line 11)	,,			,	
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				307	12.00
	Total average cost per diem (line 11 divided by line 12)				2, 599. 00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 12)	307	0		14.00
15.00	Program cost (line 13 times line 14)	·	797, 893	0		15.00
	HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7, col. 9,			1, 075, 596	16.00
	line 11)					
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17.00
18. 00	Total average cost per diem (line 16 divided by line 17)				2, 591. 80	
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 13)	398	-		19. 00
20. 00	Program cost (line 18 times line 19)		1, 031, 536	0		20.00
	TOTAL HOSPICE CARE					
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 442, 115	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				· ·	22.00
23.00	Average cost per diem (line 21 divided by line 22)				465. 91	23.00

	Figure 1 1 Control of the Control of	LONAL HOCKLEAN		. C. E OHC. (2550 40
		I ONAL HOSPI TAL		u of Form CMS-2	2552-10
CALCUL	LATION OF CAPITAL PAYMENT	Provider CCN: 15-0037	Peri od:	Worksheet L	
			From 01/01/2016 To 12/31/2016	Parts I-III Date/Time Pre	narod:
			10 12/31/2010	5/16/2017 10:	
		Title XVIII	Hospi tal	PPS	.,
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			732, 940	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2. 00	Capital DRG outlier payments			1, 633	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3. 00	Total inpatient days divided by number of days in the co	st reporting period (see ins	tructions)	25. 16	
4.00	Number of interns & residents (see instructions)			0. 00	
5. 00	Indirect medical education percentage (see instructions)			0. 00	
6. 00	Indirect medical education adjustment (multiply line 5 b	y the sum of lines 1 and 1.0	1, columns 1 and	0	6. 00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Par 30) (see instructions)	t A patient days (Worksheet	E, part A line	0. 00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see i	netructione)		0.00	8.00
9. 00	Sum of lines 7 and 8	nstructions)		0.00	
10.00	Allowable disproportionate share percentage (see instruc	tions)			10.00
11. 00					
	Total prospective capital payments (see instructions)	0 734, 573			
12.00	Total prospective capital payments (see instructions)			734, 373	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instruction	ns)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
	DADT III COMPUTATION OF EVOEDTION DAVMENTS			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum	stances (see instructions)		0	
3. 00	Net program inpatient capital costs for extraordinary circum			0	
4. 00	Applicable exception percentage (see instructions))		0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4	`		0.00	
6. 00	Percentage adjustment for extraordinary circumstances (s	,		0. 00	
7. 00	Adjustment to capital minimum payment level for extraord		v lino 4)	0.00	
7. 00 8. 00	1 3	Thary circumstances (Time 2	x iiile 6)	0	
9. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as	annli aabla)		0	ł
10.00	Current year comparison of capital minimum payment level		loog line ()	0	•
				0	
11. 00	Carryover of accumulated capital minimum payment level o Worksheet L, Part III, line 14)	ver capital payment (from pr	ror year	U	11.00
12.00	Net comparison of capital minimum payment level to capit	al payments (line 10 plus li	ne 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive,			0	
14. 00	Carryover of accumulated capital minimum payment level o			0	
	(if line 12 is negative, enter the amount on this line)	The second second	. 3	Ü	
15. 00	,	e instructions)		0	15. 00
16. 00				0	
	Current year exception offset amount (see instructions)	•		0	17. 00
			'		

ANALYS	Financial Systems IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-0037	Peri od:	Worksheet M-1	
			Component	CCN: 1E 2007	From 01/01/2016	Data/Time Dro	norod.
			Component	CCN: 15-3987	To 12/31/2016	Date/Time Pre 5/16/2017 10:	
					RHC I	Cost	
		Compensation	Other Costs		1 Recl assi fi cat	Reclassi fied	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 + col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS		2.00	0.00	1. 00	0.00	
1.00	Physi ci an	0	C		0 0	0	1.00
2.00	Physician Assistant	0	C		0 0	0	2.00
3.00	Nurse Practitioner	40, 685	C	40, 6	85 0	40, 685	3.00
4.00	Visiting Nurse	0	C		0	0	
5. 00	Other Nurse	0	C		0 0	0	
6.00	Clinical Psychologist	0	C		0 0	0	
7.00	Clinical Social Worker	0	C		0 0	0	
8.00	Laboratory Technician	25 000	C	25.0	0 0	0	
9. 00 10. 00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	25, 900 66, 585	C	, .		25, 900 66, 585	
11. 00	Physician Services Under Agreement	00, 505	C	1	0 0	00, 363	1
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	
13. 00	Other Costs Under Agreement	Ö	C		0 0	0	
14. 00	Subtotal (sum of lines 11 through 13)	Ö	C		0 0	0	
15.00	Medical Supplies	0	C		0 0	0	
16.00	Transportation (Health Care Staff)	0	C		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	C		0 0	0	17.00
	Professional Liability Insurance	0	C		0	0	
19.00	Other Health Care Costs	0	C		0	0	
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	C		0 0	0	1
22. 00	Total Cost of Health Care Services (sum of	66, 585	C	66, 5	85 0	66, 585	22.00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0	C		0 0	0	23.00
24. 00	Dental	Ö	C		0 0	0	
25.00	Optometry	0	C		0 0	0	25.00
25. 01	Tel eheal th	0	C		0 0	0	25. 01
25. 02	Chronic Care Management	0	C		0 0	0	25. 02
26. 00	All other nonreimbursable costs	0	C		0 0	0	26.00
27. 00	Nonallowable GME costs						27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C		0	0	28. 00
	through 27)						
20.00	FACILITY OVERHEAD	0	C		0 0	0	29.00
29. 00 30. 00	Facility Costs Administrative Costs	36, 873	245, 852		-	282, 725	
31. 00	Total Facility Overhead (sum of lines 29 and	·	245, 852			282, 725	1
51.00	30)	30, 073	245, 052	202, 7		202, 723] 31.00
32. 00	Total facility costs (sum of lines 22, 28	103, 458	245, 852	349, 3	10 0	349, 310	32.00
	and 31)						1

HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	Provi der C	CN: 15-0037	Peri od:		
	Component	CCN: 15-3987	To 12/31/2016	Date/Time Pre	pared: 17 am
			RHC I	Cost	
Adjustments	Net Expenses				
	for				
	Allocation				
	(col. 5 +				
	col. 6)				
6, 00	7. 00				
	Adj ustments	Adjustments Net Expenses for Allocation (col. 5 + col. 6)	Adjustments Net Expenses for Allocation (col. 5 + col. 6)	Provider CCN: 15-0037	Provider CCN: 15-0037

All Coation (col. 5 + col. 6) Col. 5 + col. 6) Col. 5 + col. 6) Col. 6 Col			·	for		
FACILITY HEALTH CARE STAFF COSTS				Allocation		
FACILITY HEALTH CARE STAFF COSTS				(col. 5 +		
FACILITY HEALTH CARE STAFF COSTS 1.00 2.00				col. 6)		
1.00			6. 00	7. 00		
2.00						
3.00	1.00	Physi ci an	0	0		1.00
4.00	2.00	Physician Assistant	0	0		2.00
5.00	3.00	Nurse Practitioner	0	40, 685		3.00
6.00 Clinical Psychologist	4.00	Visiting Nurse	0	0		4.00
7.00	5.00	Other Nurse	0	0		5.00
8.00	6.00	Clinical Psychologist	0	0		6.00
9.00 Other Facility Health Care Staff Costs 0 25,900	7.00	Clinical Social Worker	0	0		7. 00
10.00 Subtotal (sum of lines 1 through 9) 0 66,585	8.00	Laboratory Techni ci an	0	0		8. 00
11.00 Physician Services Under Agreement 0 0 0 12.00 Physician Supervision Under Agreement 0 0 0 0 13.00 14.	9.00	Other Facility Health Care Staff Costs	0	25, 900		9. 00
12.00 Physician Supervision Under Agreement 0 0 0 0 0 13.00 0 0 0 0 0 0 0 0 0	10.00	Subtotal (sum of lines 1 through 9)	0	66, 585		10.00
13.00	11.00	Physician Services Under Agreement	0	0		11.00
14. 00 15. 00 16. 00 16. 00 17. on Medical Supplies 10. 00 10. 00 11. on Medical Supplies 10. 00 11. on Medical Equipment 11. on Medical Equipment 12. on Medical Equipment 13. on Medical Equipment 14. on Medical Supplies 15. on Medical Supplies 16. on Medical Equipment 17. on Medical Equipment 18. on Medical Supplies 18. on Medical Supplies 18. on Medical Supplies 18. on Medical Supplies 19. on Medic	12.00	Physician Supervision Under Agreement	0	0		12.00
15.00 Medical Supplies	13.00	Other Costs Under Agreement	0	0		13.00
16.00 Transportation (Health Care Staff) 0 0 0 0 17.00 17.00 Depreciation-Medical Equipment 0 0 0 0 17.00 18.00 Professional Liability Insurance 0 0 0 0 18.00 19.00 Other Health Care Costs 0 0 0 19.00 20.00 Allowable GME Costs 20.00 21.00 Subtrail (sum of lines 15 through 20) 0 0 0 0 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 22.00 Pharmacy 0 0 0 24.00 24.00 25.00 Optometry 0 0 0 25.00 25.00 Optometry 0 0 0 25.00 25.00 26.00 All other nonreimbursable costs 0 0 0 25.00 26.00 All other nonreimbursable Costs (sum of lines 23 0 0 0 0 0 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0	14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
17. 00 Depreciation-Medical Equipment 0 0 0 18. 00 Professional Liability Insurance 0 0 0 0 18. 00 19. 00 Other Health Care Costs 0 0 0 0 20. 00 Allowable GME Costs 20. 00 21. 00 Subtotal (sum of lines 15 through 20) 0 0 0 22. 00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23. 00 24. 00 Dental 0 0 0 25. 00 Optometry 0 0 0 25. 01 Tel eheal th 0 0 0 25. 02 Chronic Care Management 0 0 0 26. 00 All other nonreimbursable costs 0 0 27. 00 Nonal lowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 29. 00 Facility Overhead (sum of lines 29 and -11, 464 271, 261 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261 31. 00 31. 00 Total Facility Overhead (sum of lines 29 and -11, 464 271, 261	15.00	Medical Supplies	0	0		15.00
18.00 Professional Liability Insurance 0 0 0 0 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 20.00 20.00 21.00 21.00 21.00 21.00 22.00 2	16.00	Transportation (Health Care Staff)	0	0		16.00
18.00 Professional Liability Insurance 0 0 0 0 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 20.00 20.00 21.00 21.00 21.00 21.00 22.00 2	17.00		0	0		17. 00
19.00 Other Heal th Care Costs 0 0 0 19.00 20.00 20.00 21.00 20.00 21.00 22.00			0	0		18. 00
21.00 Subtotal (sum of lines 15 through 20) 0 0 0 0 0 0 0 0 0			0	0		19. 00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00	20.00	Allowable GME Costs				20.00
Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00	21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy	22.00	Total Cost of Health Care Services (sum of	0	66, 585		22. 00
23.00 Pharmacy						
24.00 Dental O O O O O O O O O						
25. 00 Optometry O	23.00		0	0		
25. 01 Tel eheal th	24.00	1	0	0		
25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28. 00 29. 00 Facility Overhead 29. 00 Administrative Costs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Optometry	0	0		
26. 00			0	0		
27.00 Nonallowable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28.00		1	0	0		
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 through 27) FACILITY OVERHEAD 29.00 Administrative Costs			0	0		
through 27) FACILITY OVERHEAD 29.00 Facility Costs						
FACILITY OVERHEAD 29.00 Facility Costs 0 0 29.00 30.00 Administrative Costs -11,464 271,261 30.00 31.00 Total Facility Overhead (sum of lines 29 and -11,464 271,261 31.00	28. 00	,	0	0		28. 00
29.00 Facility Costs 0 29.00 30.00 Administrative Costs -11, 464 271, 261 30.00 31.00 Total Facility Overhead (sum of lines 29 and -11, 464) 271, 261 31.00						
30.00 Administrative Costs -11,464 271,261 30.00 31.00 Total Facility Overhead (sum of lines 29 and -11,464 271,261 31.00			-1		T	
31.00 Total Facility Overhead (sum of lines 29 and -11,464 271,261 31.00			- 1			
	31. 00		-11, 464	271, 261		31.00
30)		1 /				
32.00 Total facility costs (sum of lines 22, 28 -11,464 337,846 32.00	32.00		-11, 464	337, 846		32.00
and 31)		[and 31)	l		I	1

	Financial Systems	HANCOCK REGIO	NAL HOSPI TAL			u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2016 To 12/31/2016	Date/Time Pre	narod:
			Component	CCN. 13-3707	10 12/31/2010	5/16/2017 10:	
					RHC I	Cost	
	·	Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions		T				
1.00	Physi ci an	0.00		•	0 0		1.00
2. 00	Physician Assistant	0.00			0 0		2.00
3. 00	Nurse Practitioner	0. 78	, , ,				3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 78		1	1, 638	2, 159	4.00
5.00	Visiting Nurse	0.00)		0	5.00
6.00	Clinical Psychologist	0.00)		0	6.00
7.00	Clinical Social Worker	0.00	l .)		0	7.00
7. 01	Medical Nutrition Therapist (FOHC only)	0.00	l .	<u>'</u>		0	7.01
7. 02	Diabetes Self Management Training (FQHC	0.00	0	'		0	7. 02
8. 00	only) Total FTEs and Visits (sum of lines 4	0. 78	2, 159	,		2, 159	8.00
6.00	through 7)	0.76	2, 139	1		2, 139	0.00
9. 00	Physician Services Under Agreements		0	,		0	9.00
7. 00	Thysreran services under Agreements			1			7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES			
	Total costs of health care services (from Wk					66, 585	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			66, 585	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, l	ine 31)		271, 261	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			90, 832	15.00
16.00	Total overhead (sum of lines 14 and 15)					362, 093	16.00
17.00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					362, 093	
	Overhead applicable to hospital-based RHC/FC					362, 093	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		428, 678	20.00

	Financial Systems HANCOCK REGIONAL			u of Form CMS-2	
SERVI (ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0037	Peri od: From 01/01/2016	Worksheet M-3	
SERVIC	ES	Component CCN: 15-3987	To 12/31/2016	Date/Time Pre 5/16/2017 10:	
		Title XVIII	RHC I	Cost	
				4 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		428, 678	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		18, 226	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			410, 452	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	11		2, 159	
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	line 9)		0 2, 159	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			190. 11	7.00
7.00	inaj de teu ecce per viere (ilia e di videa sij ilia e)		Cal cul ati on		7.00
			Prior to	On or After	
			January 1 1.00	<u>January 1</u> 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20) 6 or your contractor)	80. 44	81. 32	8. 00
9. 00	Rate for Program covered visits (see instructions)	ne e. yeu. commacter,	80. 44	81. 32	
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		0	94	
11.00	Program cost excluding costs for mental health services (line		0		11.00
12. 00 13. 00	Program covered visits for mental health services (from conti Program covered cost from mental health services (line 9 x li		0	0	
14. 00	Limit adjustment for mental health services (see instructions	,	0	0	
15. 00	Graduate Medical Education Pass Through Cost (see instruction	,		_	15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	7, 644	
16. 01	Total program charges (see instructions) (from contractor's re			20, 849	
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times			0	16. 02 16. 03
16. 03	Total Program non-preventive costs ((Time 16.02/Time 16.01) times 16.0			2, 634	
10.01	(Titles V and XIX see instructions.)	and roy trines . coy		2,001	10.01
16.05	Total program cost (see instructions)		0	2, 634	16. 05
17. 00	Primary payer amounts			0	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		4, 351	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		3, 300	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			2, 634	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		6, 604	
22.00	Total reimbursable Program cost (line 20 plus line 21)	,		9, 238	22. 00
23.00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
25.00	Allowable bad debts for dual eligible beneficiaries (see instantional other ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	15)		0	
26. 00	Net reimbursable amount (see instructions)	/		9, 238	
26. 01	Sequestration adjustment (see instructions)			185	26. 01
27. 00	Interim payments			2, 147	
28. 00	Tentative settlement (for contractor use only)	and 20)		0	28. 00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 27, Protested amounts (nonallowable cost report items) in accorda			6, 906 0	29. 00 30. 00
30.00	chapter I, §115.2	ance with two rub. 15-11	'	O	30.00
			. '		•

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0037	Peri od: From 01/01/2016	Worksheet M-4
VACCINE COST		Component CCN: 15-3987		Date/Time Prepared: 5/16/2017 10:17 am
		Title XVIII	RHC I	Cost

			5/16/2017 10:	17 alli
	Title XVIII	RHC I	Cost	
		Pneumococcal	I nfl uenza	
		1.00	2. 00	
Health care staff cost (from Wkst. M-1, col. 7, line 10)		66, 585	66, 585	1.00
Ratio of pneumococcal and influenza vaccine staff time to tot	e 0. 000265	0. 010000	2.00	
Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			666	3.00
Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	237	1, 910	4.00
Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	255	2, 576	5.00
Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22	66, 585	66, 585	6.00
Total overhead (from Wkst. M-2, line 19)		362, 093	362, 093	7.00
Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0.003830	0. 038687	8.00
divided by line 6)				
Overhead cost - pneumococcal and influenza vaccine (line 7 x	1, 387	14, 008	9.00	
Total pneumococcal and influenza vaccine cost and its (their) administration (sum of			16, 584	10.00
lines 5 and 9)				
		3		11.00
		547. 33	146. 76	12.00
	istered to Program	0	45	13.00
	heir) administration	0	6, 604	14.00
			18, 226	15.00
			6, 604	16. 00
· · · · · · · · · · · · · · · · · · ·	amount to Wkst. M-3,			
[line 21)				
	Ratio of pneumococcal and influenza vaccine staff time to tot Pneumococcal and influenza vaccine health care staff cost (li Medical supplies cost - pneumococcal and influenza vaccine (f Direct cost of pneumococcal and influenza vaccine (line 3 plu Total direct cost of the hospital-based RHC/FQHC (from Worksh Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9) Total number of pneumococcal and influenza vaccine injections Cost per pneumococcal and influenza vaccine injection (line 1 Number of pneumococcal and influenza vaccine injections admin beneficiaries Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3 Total Program cost of pneumococcal and influenza vaccine and	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total health care staff time Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) Medical supplies cost - pneumococcal and influenza vaccine (from your records) Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections administered to Program beneficiaries Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their)	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total health care staff time Pneumococcal and influenza vaccine health care staff tost (line 1 x line 2) Medical supplies cost - pneumococcal and influenza vaccine (from your records) Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 do, 585 divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (from your records) 3 Cost per pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (from your records) 3 Cost per pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (from your records) 3 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	Title XVIII RHC Cost Pneumococcal Influenza 1.00 2.00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOH SERVICES RENDERED TO PROGRAM BENEFICIARIES	C PROVIDER FOR	Provider CCN: 15-0037 Component CCN: 15-3987	Period: From 01/01/2016 To 12/31/2016	
		Odinponorre doit. 10 0707	7270172010	5/16/2017 10: 17 am

		Component CCN. 13-3707	10 12/31/2010	5/16/2017 10:	
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			2, 147	1.00
2. 00	2.00 Interim payments payable on individual bills, either submitted or to be submitted to			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amoun				3.00
	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)				
0.01	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	Danid dan da Buranan			0	3.0
2 50	Provider to Program			0	ا م در
3. 50 3. 51					3. 50 3. 5
				0	
3. 52				0	3.52
3. 53				1	3.50
3. 54	Subtatal (sum of lines 2 01 2 40 minus sum of lines 2 50 2	00)		0	3. 5 ⁴ 3. 99
3. 99 4. 00	3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line			2, 147	4.00
4.00	27)	ster to worksheet w-s, time		2, 147	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.00
0.00	each payment. If none, write "NONE" or enter a zero. (1)	SK TOVION. 71130 SHOW date o	•		0.00
	Program to Provider				
5. 01				0	5. 01
5.02				0	5. 02
5.03				0	5.03
	Provider to Program				
5.50				0	5. 50
5. 51				0	5.51
5. 52				0	5. 52
5. 99	. 99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 99
6.00	5.00 Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6. 01	SETTLEMENT TO PROVIDER			6, 906	6. 0 ²
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			9, 053	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8. 00	Name of Contractor				8. 00