This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0037 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/26/2023 1:33 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/26/2023 1:33 pm ] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 01/01/2022 and ending 12/31/2022 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Jo	n Miller	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jon Miller			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	459, 962	24, 278	0	-105, 843	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		5, 468		0	10.00
200.00	TOTAL	0	459, 962	29, 746	0	-105, 843	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/26/2023 1:33 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 801 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, T, 0, or N)
V | XVIII | XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HANCOCK REGIONAL 150037 26900 07/01/1966 N 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital -Based Health Clinic - RHC KNI GHTSTOWN RURAL 153987 26900 09/22/1998 N 15.00 N 0 15.00 HEALTH Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 9 21.00 1.00 3.00 2.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate 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 UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be N Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter 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 Ν Ν 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04

3

N

23 00

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

ves or "N" for no.

Health Financial Systems In Lieu of Form CMS-2552-10 HANCOCK REGIONAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0037 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/26/2023 1:33 pm In-State In-State Out-of Out-of Medi cai d 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 pai d days el i gi bl e 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 169 133 1.616 39 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. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Ν Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of

which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/26/2023 1: 33 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 Υ instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 60.01 23 00 1 instructions) Y/N LME Direct GME IME Direct GME 1.00 2.00 3.00 4. 00 5. 00 61.00 Did your hospital receive FTE slots under ACA 0 00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ahted Unwei ahted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 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 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00

"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

N

Health Financial Systems	HANCOCK	REGIONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 01/01/2022	Worksheet S-2 Part I Date/Time Pre 5/26/2023 1:3	pared:
		1	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	У рин
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea			-This base year	is your cost	reporti ng	
period that begins on or after 3  64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1)	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
(	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2. 00	3.00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te	'	,,	
47.00 Enter in column 1, the pro-	1. 00	2. 00	3.00	4. 00	5. 00 0. 000000	47.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

Heal th	Financial Systems HANCOCK REGIONAL HOSPITAL		In	Lieu	ı of Form	n CMS_1	2552_10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CO		eri od:		Workshe		
			rom 01/01/2 o 12/31/2		Part I Date/Ti	me Pre	pared:
					5/26/20		
					1.0	0	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49				NI.		40.00
08.00	For a cost reporting period beginning prior to October 1, 2022, did you o MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fin (August 10, 2022)?				N		68.00
	(magast 10, 2022).						
	Inpatient Psychiatric Facility PPS			1. 00	2.00	3. 00	
70. 00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it cont	ain an IPF sul	provi der?	N			70. 00
71 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachi	na program in	the most	N	l N	0	71.00
71.00	recent cost report filed on or before November 15, 2004? Enter "Y" for y	es or "N" for	no. (see		"	Ü	71.00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for y	in a new tead	chi ng				
	Column 3: If column 2 is Y, indicate which program year began during this						
	(see instructions) Inpatient Rehabilitation Facility PPS						
75. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it c	ontain an IRF		N			75. 00
76 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teachi	na program in	the most	N	l N	0	76.00
70.00	recent cost reporting period ending on or before November 15, 2004? Enter	"Y" for yes (	or "N" for	IN	"	U	70.00
	no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If						
	indicate which program year began during this cost reporting period. (see						
					1. 0	ın	
	Long Term Care Hospital PPS				1.0	0	
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for		noniod? F	n+or	N		80. 00 81. 00
81. 00	Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no.	cost reporting	j periou? E	nter	N		81.00
05.00	TEFRA Provi ders	113/11 6	HAIII C				05.00
86.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Ente Did this facility establish a new Other subprovider (excluded unit) under			no.	N		85. 00 86. 00
07.00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						07.00
87.00	Is this hospital an extended neoplastic disease care hospital classified 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section			N		87.00
			Approved		Numbei		
			Permane Adjustme		Appro Perman		
			(Y/N)		Adj ustr		
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEF	RA target	1.00		2.0		88. 00
	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete c		e				
	89. (see instructions) Column 2: Enter the number of approved permanent adjustments.						
		Wkst. A Line		ve	Appro		
		No.	Date		Perman Adjust		
					Amount	Per	
		1. 00	2. 00		Di scha 3. 0		
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	0.00			3.0		89. 00
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period						
	beginning date) for the permanent adjustment to the TEFRA target amount						
	per discharge. Column 3: Enter the amount of the approved permanent adjustment to the						
	TEFRA target amount per discharge.						
			1. 00		2. 0		
	Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? E yes or "N" for no in the applicable column.	nter "Y" for	N		Y		90.00
91. 00	Is this hospital reimbursed for title V and/or XIX through the cost repor		N		Υ		91.00
92. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column Are title XIX NF patients occupying title XVIII SNF beds (dual certificat				N		92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.	, ,					
93. 00	Does this facility operate an ICF/IID facility for purposes of title V an "Y" for yes or "N" for no in the applicable column.	d XIX? Enter	N		N		93.00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for n	o in the	N		N		94.00
95 NN	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable colum	ın.	0.00		0. 0	10	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for n		N N		N N	-	96.00
97. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable colum	ın.	0.00		0. 0	0	97.00
00	The state of the s		0.00		0.0	-	, ,,, 55

ealth Financial Systems HANCOCK REGIONAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider (		eri od:	u of Form CMS- Worksheet S-:	
		rom 01/01/2022 o 12/31/2022		
		V	5/26/2023 1: 3 XIX	33 pm
		1.00	2.00	
Does title V or XIX follow Medicare (title XVIII) for the interns and restepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
Des title V or XIX follow Medicare (title XVIII) for the reporting of c C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and i title XIX.		Y	Y	98. 0
Descritle V or XIX follow Medicare (title XVIII) for the calculation of bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no		Y	Y	98. 02
for title V, and in column 2 for title XIX.  18.03 Does title V or XIX follow Medicare (title XVIII) for a critical access reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for		N	N	98. 0
for title V, and in column 2 for title XIX.  18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 1 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for a CAL and the column 2 for title XIX.		N	N	98.0
in column 2 for title XIX. 28.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE d Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for		Y	Y	98. 0
column 2 for title XIX. 28.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed f Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title column 2 for title XIX.		Y	Y	98.00
Rural Providers				
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive me for outpatient services? (see instructions)	thod of payment	. N		105. 0 106. 0
07.00 Column 1: If line 105 is Y, is this facility eligible for cost reimburse training programs? Enter "Y" for yes or "N" for no in column 1. (see in Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&	structions)	N		107. 0
approved medical education program in the CAH's excluded IPF and/or IRF Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 s this a rural hospital qualifying for an exception to the CRNA fee sch	• •	N		108. 0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  Physical	Occupati onal	Speech	Respi ratory	
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.	N	N	N	109. 0
			1.00	-
10.00Did this hospital participate in the Rural Community Hospital Demonstrat Demonstration) for the current cost reporting period? Enter "Y" for yes o complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, applicable.	r "N" for no. I	f yes,	N	110. 0
Jappi Cast Ci		1.00	2.00	
	Communi ty	1. 00 N	2. 00	111.0
Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating i Enter all that apply: "A" for Ambulance services; "B" for additional bed for tele-health services.	period? Enter enter the n column 2.			
	1. 00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Model	1.00 N	2.00	3.00	112.0
(PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased				
participation in the demonstration, if applicable.  13.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost				113. 0
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 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	N		(	0115.0
for short term hospital or "98" percent for long term care (includes				116.0
psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			
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 Y			
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	Y	2		117.00

Health Financial Systems	HANCOCK REGIONAL				u of Form CM	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTII	FICATION DATA	Provi der CC	N: 15-0037	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S Part I Date/Time F	Prepared:
			Premi ums	Losses	5/26/2023 1 Insurance	
118.01 List amounts of mal practice premiums and p	aid losses:		1. 00 320, 1	2. 00 90 0	3. 00	0118.01
			·	1.00	2.00	
118.02 Are malpractice premiums and paid losses r Administrative and General? If yes, submi and amounts contained therein.	eported in a cost co t supporting schedul	enter other e listing c	than the ost centers	1. 00 N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for t §3121 and applicable amendments? (see inst "N" for no. Is this a rural hospital with Hold Harmless provision in ACA §3121 and a Enter in column 2, "Y" for yes or "N" for	ructions) Enter in c < 100 beds that qual pplicable amendments	column 1, "Y ifies for t	" for yes or he Outpatien		N	119. 00 120. 00
121.00 Did this facility incur and report costs f patients? Enter "Y" for yes or "N" for no.	or high cost implant	able devices	s charged to	Y		121.00
122.00 Does the cost report contain healthcare re Act?Enter "Y" for yes or "N" for no in col	umn 1. If column 1 i				5. 00	122. 00
the Worksheet A line number where these ta 123.00 Did the facility and/or its subproviders ( services, e.g., legal, accounting, tax pre management/consulting services, from an un for yes or "N" for no.	if applicable) purch paration, bookkeepir	ng, payroll,	and/or			123. 00
If column 1 is "Y", were the majority of t professional services expenses, for service located in a CBSA outside of the main hosp "N" for no.	es purchased from ur	related org	ani zati ons			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-cert			"Y" for yes	N		125. 00
and "N" for no. If yes, enter certificatio 126.00 If this is a Medicare-certified kidney tra			ification da	te		126. 00
in column 1 and termination date, if appli	cable, in column 2.					
127.00  f this is a Medicare-certified heart tran in column 1 and termination date, if appli 128.00  f this is a Medicare-certified liver tran	cable, in column 2.					127. 00 128. 00
in column 1 and termination date, if appli 129.00 If this is a Medicare-certified lung trans		the certif	ication date			129. 00
in column 1 and termination date, if appli	cable, in column 2.					
130.00  f this is a Medicare-certified pancreas t date in column 1 and termination date, if 131.00  f this is a Medicare-certified intestinal	applicable, in colum transplant program,	nn 2. enter the (		n		130. 00 131. 00
date in column 1 and termination date, if 132.00 If this is a Medicare-certified islet tran in column 1 and termination date, if appli	splant program, ente		fication dat	e		132. 00
133.00 Removed and reserved 134.00 If this is a hospital-based organ procurem	·	)() onton t	ha ODO numba	_		133. 00 134. 00
in column 1 and termination date, if appli		o), enter ti	ne oro numbe	I		134.00
All Providers  140.00 Are there any related organization or home chapter 10? Enter "Y" for yes or "N" for n are claimed, enter in column 2 the home of	o in column 1. If ye	es, and home	office cost	N S		140. 00
1.00 If this facility is part of a chain organi	2. 00			3.00	of the home	
office and enter the home office contracto	r name and contracto				or the holle	
· · · · · · · · · · · · · · · · · · ·	tractor's Name: Box:		Contract	or's Number:		141. 00 142. 00
143. 00 Ci ty: Sta	te:		Zi p Code	:		143. 00
					1. 00	
144.00 Are provider based physicians' costs inclu	ded in Worksheet A?				Y	144. 00
				1.00	2. 00	
145.00  f costs for renal services are claimed on inpatient services only? Enter "Y" for yes no, does the dialysis facility include Med period? Enter "Y" for yes or "N" for no i	or "N" for no in co icare utilization fo	olumn 1. If	column 1 is			145. 00
146.00 Has the cost allocation methodology change Enter "Y" for yes or "N" for no in column yes, enter the approval date (mm/dd/yyyy)	d from the previousI 1. (See CMS Pub. 15-			N f		146. 00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		Provi der CC	CN: 15-0037			Worksheet S- Part I Date/Time Pr 5/26/2023 1:	2 repared:
						1.00	
147.00 Was there a change in the statist	ical hasis? Enter "V" for	ves or "N" for	. no			1.00 N	147. 00
148.00 Was there a change in the order o						N N	148. 00
149.00Was there a change to the simplif				for no.		N N	149. 00
		Part A	Part B		itle 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	N	155. 00
156.00 Subprovider - IPF		N	N		N	N	156. 00
157.00 Subprovi der - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER				1			158.00
159. 00 SNF		N	N		N	N N	159.00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N		N N	N N	160. 00 161. 00
181. 00jcwnc			I IN		IV	IV	101.00
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has o	ne or more camp	ouses in di	fferent C	BSAs?	N	165. 00
	Name	County		Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						0.0	00 166. 00
column 5 (see instructions)						1.00	
Health Information Technology (HI	T) incontive in the Ameri	can Pocovory ar	nd Poi nyost	mont Act		1. 00	
167.00 Is this provider a meaningful use						Υ	167. 00
168.00 If this provider is a CAH (line 1					r the	·	168. 00
reasonable cost incurred for the							
168.01 If this provider is a CAH and is	not a meaningful user, do	es this provide	er qualify	for a har	dshi p		168. 01
exception under §413.70(a)(6)(ii)							
169.00 If this provider is a meaningful transition factor. (see instruction		d is not a CAH	(line 105	is "N"),	enter the	9. 9	99169.00
transition ractor. (see instructi	uris)			Re	gi nni 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 ending	date for the r	eporti ng			=: • •	170. 00
					1. 00	2.00	
171.00  f  ine 167 is "Y", does this pro	vider have any days for i	ndi vi dual s enro	olled in		N N		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, Pt umn 1. If column 1 is yes	. I, line 2, co	ol. 6? Ente				

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0037 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/26/2023 1:33 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column  $\hat{\textbf{3}},$  "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 06/15/2023 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper. 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 03/06/2023 03/06/2023 17.00 Υ Υ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CN	IS-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0037	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S Part II	S-2 Prepared:
			iption	Y/N	Y/N	
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:			IV.		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.	IN IN		IN		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)			
22.00	Capital Related Cost	a i natruati ana				22.00
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, so Have changes occurred in the Medicare depreciation expense			ring the cost		22. 00 23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	eporting period?		24.00
25. 00	Have there been new capitalized leases entered into during	g the cost repo	orting period	? If yes, see		25. 00
26. 00	instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	the cost report	ing period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	ne cost reporti	ng period? It	f yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	entered into du	uring the cost	t reporting		28. 00
20.00	period? If yes, see instructions.		g the ees	i i opor irrig		20.00
29. 00	Did the provider have a funded depreciation account and/or		ebt Service F	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 yes	s, see		30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without instructions.	ssuance of new	debt? If yes	s, see		31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	arvicas furnish	and through co	ontractual		32.00
32.00	arrangements with suppliers of services? If yes, see instr		ica trii oagii c	Jirri de tudi		32.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If		33.00
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an	arrangement wi	th provider-l	pased 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	nstructions.		Y/N	Date	
				1. 00	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	orepared 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			f		38.00
39. 00	j '			5,		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	If yes, see			40. 00
	instructions.					
		1.	. 00	2. (	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		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 report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANI	DCO. COM	43. 00
		•		*		

Health Financial S	ystems	HANCOCK REGIO	NAL HOSPITAL			In Lieu	of Form CMS-	2552-10
HOSPITAL AND HOSPI	TAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0037	Peri From To	01/01/2022	Worksheet S-2 Part II Date/Time Pre 5/26/2023 1:3	pared:
				3. 00				
Cost Report	Preparer Contact Information			3.00				
	irst name, last name and the		MANAGER					41.00
held by the respectivel	cost report preparer in colum	mns 1, 2, and 3,						
	y. mployer/company name of the co	ost report						42.00
preparer.	. , . ,	'						
	elephone number and email addi							43.00
report prep	arer in columns 1 and 2, respo	ecti vel y.						l

Heal th Fi nancialSystemsHANCOCKHOSPITALANDHOSPITALHEALTH CARE COMPLEXSTATISTICALDATA | Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0037

						То	12/31/2022	Date/Time Pro 5/26/2023 1:3		
								1/P Days /	Ť	Pili
								0/P Visits /		
								Trips		
	Component	Worksheet A	No	of Beds	Bed Days		CAH Hours	Title V		
		Li ne No.			Avai I abl e					
		1. 00		2.00	3.00		4.00	5. 00		
	PART I - STATISTICAL DATA		•							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		81	29, 56	5	0. 00	0		1.00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days)(see instructions for col. 2									
	for the portion of LDP room available beds)									
2.00	HMO and other (see instructions)									2.00
3.00	HMO IPF Subprovider									3.00
4.00	HMO IRF Subprovider									4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF							0	1	6.00
7.00	Total Adults and Peds. (exclude observation			81	29, 56	5	0. 00	0	1	7.00
	beds) (see instructions)									
8.00	INTENSIVE CARE UNIT	31. 00		24	8, 76	0	0. 00	0		8.00
9. 00	CORONARY CARE UNIT									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11. 00	SURGICAL INTENSIVE CARE UNIT									11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)									12.00
13. 00	NURSERY									13.00
14.00	Total (see instructions)			105	38, 32	5	0. 00	0		14.00
15.00	CAH visits							0		15.00
16. 00	SUBPROVIDER - IPF	40. 00		0		0		0	1 '	16.00
17. 00	SUBPROVIDER - IRF									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	101. 00						0	1 -	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23. 00
24.00	HOSPI CE	116. 00		0		0				24. 00
24. 10	HOSPICE (non-distinct part)	30. 00								24. 10
25. 00	CMHC - CMHC									25.00
26. 00	RURAL HEALTH CLINIC	88. 00						0		26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0		26. 25
27. 00	Total (sum of lines 14-26)			105						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			1 1	32.00
32. 01	Total ancillary labor & delivery room								3	32. 01
	outpatient days (see instructions)								1 -	
33.00	LTCH non-covered days									33.00
33. 01	LTCH site neutral days and discharges	00.00		_						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	l	0	l	0	l	0	1 3	34. 00

Provi der CCN: 15-0037

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/26/2023 1:33 pm

						5/26/2023 1: 3	3 pm
	·	I/P Days	/ O/P Visits	/ Trips	Full Time E	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	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 026	169	4, 782			1.00
1.00	8 exclude Swing Bed, Observation Bed and	1,020	107	1, 702			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	2, 896	1, 749				2.00
3. 00	HMO IPF Subprovider	2,070	1, 747				3.00
4.00	HMO IRF Subprovider		0				4.00
			0	0			5.00
5.00	Hospital Adults & Peds. Swing Bed SNF	U		0			
6.00	Hospital Adults & Peds. Swing Bed NF	4 00/	0	4 700			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 026	169	4, 782			7. 00
	beds) (see instructions)		_				
8. 00	INTENSIVE CARE UNIT	2, 232	0	5, 984			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, 258	169	10, 766	0.00	787. 45	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						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	ol	ol	0	0.00	0.00	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE	0	0	0	0.00	0. 00	
24. 10	HOSPICE (non-distinct part)	١	Ĭ	468		0.00	24. 10
25. 00	CMHC - CMHC			100			25.00
26. 00	RURAL HEALTH CLINIC	115	128	4, 738	0.00	4. 27	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	4, 730		0.00	
27. 00	Total (sum of lines 14-26)	U U	٩	C	0.00	791. 72	
28. 00			0	2 014		191.12	28.00
	Observation Bed Days	o	Ч	3, 014			
29. 00	Ambul ance Trips	U		00			29.00
30.00	Employee discount days (see instruction)			98			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	39	76			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
33. 01	LTCH site neutral days and discharges	0		_			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Heal th Fi nancial SystemsHANCOCKHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0037

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part I | Date/Time | Prepared: | Date/Time | Prepared: | Prepared:

Full Time Equivalents   S/26/2023 1:33 pm
Nonpaid   Title V   Title XVIII   Title XIX   Total All   Patients
Workers   11.00   12.00   13.00   14.00   15.00
PART I - STATISTICAL DATA   11.00   12.00   13.00   14.00   15.00
PART I - STATISTICAL DATA   1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   2.00   HMO IPF Subprovider   0   3.00   HMO IPF Subprovider   0   3.00   Moreover   0   4.00   Moreover   0   Mor
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00   HMO and other (see instructions) 3.00   HMO IPF Subprovider 4.00   HMO IPF Subprovider 5.00   Hospital Adults & Peds. Swing Bed SNF 6.00   Hospital Adults & Peds. Swing Bed NF 7.00   Total Adults and Peds. (exclude observation beds) (see instructions) 8.00   INTENSI VE CARE UNIT 9.00   CORONARY CARE UNI T 10.00   BURN INTENSI VE CARE UNI T 11.00   SUBROICAL INTENSI VE CARE UNI T 12.00   OTHER SPECIAL CARE (SPECI FY) 13.00   NURSERY 15.00   CAH vi sits 16.00   SUBPROVI DER - IPF 17.00   SUBPROVI DER - IPF 17.00   O O O O O O O O O O O O O O O O O O
8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)   2.00
Hospice days) (see instructions for col. 2   for the portion of LDP room available beds)   2.00   HMO and other (see instructions)   565   422   2.00   3.00   HMO IPF Subprovi der   0   3.00   4.00   HMO IRF Subprovi der   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 beds) (see instructions)   8.00   INTENSIVE CARE UNIT   8.00   9.00   CORONARY CARE UNIT   9.00   11.00   SURGICAL INTENSIVE CARE UNIT   10.00   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   0   0   0   0   0   0   15.00   15.00   SUBPROVI DER - IPF   0.00   0   0   0   0   0   0   0   0
For the portion of LDP room available beds   2.00
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovi der 4.00 HM0 IRF Subprovi der 5.00 Hospi tal Adul ts & Peds. Swing Bed SNF 6.00 Hospi tal Adul ts & Peds. Swing Bed NF 7.00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 8.00 INTENSI VE CARE UNI T 10.00 BURN INTENSI VE CARE UNI T 10.00 SURGI CAL INTENSI VE CARE UNI T 11.00 SURGI CAL INTENSI VE CARE UNI T 12.00 OTHER SPECI AL CARE (SPECI FY) 13.00 NURSERY 15.00 CAH visits 16.00 SUBPROVI DER - IPF 17.00 SUBPROVI DER - I RF 17.00 SUBPROVI DER - I RF
3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 13.00 Total (see instructions) 16.00 SUBPROVIDER - IPF 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 10.00 O O O O O O O O O O O O O O O O O O
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 10.00 O O O O O O O O O O O O O O O O O O
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions)  8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)  8.00 INTENSIVE CARE UNIT  9.00 CORONARY CARE UNIT  10.00 BURN INTENSIVE CARE UNIT  11.00 SURGICAL INTENSIVE CARE UNIT  12.00 OTHER SPECIAL CARE (SPECIFY)  13.00 NURSERY  14.00 Total (see instructions)  15.00 CAH visits  16.00 SUBPROVIDER - IPF  0.00 0 0 0 0 0 0 0 16.00  17.00 SUBPROVIDER - IRF
Beds   (see instructions)
8.00   INTENSIVE CARE UNIT
9.00   CORONARY CARE UNIT   9.00   10.00   BURN INTENSIVE CARE UNIT   10.00   11.00   SURGICAL INTENSIVE CARE UNIT   12.00   0THER SPECIAL CARE (SPECIFY)   12.00   13.00   14.00   Total (see instructions)   0.00   0   740   32   2,988   14.00   15.00   CAH visits   15.00   16.00   SUBPROVIDER - IPF   0.00   0   0   0   0   16.00   17.00   SUBPROVIDER - IRF
10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 0.00 0 0 0 0 0 0 16.00 17.00 SUBPROVIDER - IRF
11.00   SURGICAL INTENSIVE CARE UNIT   11.00   12.00   13.00   14.00   15.00   15.00   15.00   16.00   17.00   17.00   17.00   17.00   17.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 12.00 13.00 17.00 O
13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - I PF 17.00 SUBPROVIDER - I RF 13.00 14.00 Total (see instructions) 10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
14.00     Total (see instructions)     0.00     0     740     32     2,988     14.00       15.00     CAH visits     15.00       16.00     SUBPROVI DER - I PF     0.00     0     0     0     0     16.00       17.00     SUBPROVI DER - I RF     17.00
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 0. 00 0 0 0 16. 00 17. 00 SUBPROVIDER - IRF
16. 00   SUBPROVI DER -   PF   0. 00   0   0   16. 00   17. 00   SUBPROVI DER -   I RF   0. 00   17. 00   0   0   0   0   0   0   0   0   0
17. 00   SUBPROVI DER - I RF   17. 00
18. 00   SUBPROVI DER     18. 00
19. 00 SKILLED NURSING FACILITY
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 SURGI CAL CENTER (D. P. )
24. 00 HOSPICE 0. 00 24. 00
24. 10 H0SPI CE (non-distinct part)
25. 00 CMHC - CMHC 25. 00
26. 00 RURAL HEALTH CLINIC 0. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00
27.00   Total (sum of lines 14-26) 0.00   27.00
28. 00 Observation Bed Days
29.00 Ambul ance Trips 29.00
30.00 Employee discount days (see instruction)
31.00 Employee discount days - IRF
32.00 Labor & delivery days (see instructions)
32.01 Total ancillary labor & delivery room 32.01
outpatient days (see instructions)
33.00 LTCH non-covered days 0 33.00
33.01 LTCH site neutral days and discharges 0 33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care 34.00

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	5/26/2023 1:3 Average Hourly Wage (col. 4 ÷ col. 5)	3 pm
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	67, 583, 324	-232, 573	67, 350, 751	1, 574, 157. 00	42. 79	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	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 3, 818, 239	0		0. 00 26, 803. 00	0. 00 142. 46	•
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		122, 712	0	122, 712	5, 864. 00	20. 93	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 15, 170, 088	0 -705, 142	0 14, 464, 946	0. 00 257, 673. 00	0. 00 56. 14	
10.00	instructions) OTHER WAGES & RELATED COSTS		15, 170, 000	-705, 142	14, 404, 940	257, 673.00	30. 14	10.00
11. 00	Contract Labor: Direct Patient Care		3, 820, 956	0	3, 820, 956	32, 030. 00	119. 29	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0. 00	0. 00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		28, 750	0	28, 750	482. 00	59. 65	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	О	0	0. 00	0.00	14.00
14. 01	Home office salaries		0	0	О	0. 00	0.00	14. 01
14. 02	Related organization salaries		0	0	_	0.00	0.00	
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0. 00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		12, 249, 747	0	12, 249, 747			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 564, 462 0	0	2, 564, 462 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21.00
22. 00	B   Physician Part A -   Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		461, 928 43, 360 0	0 0 0	461, 928 43, 360 0			23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
25. 51	(core) Rel ated organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	О	0			25. 52
-	wage-related (core)							l

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0037 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/26/2023 1:33 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 535, 318 -7, 445 527, 873 19, 776. 00 26. 69 26.00 27.00 Administrative & General 5.00 10, 317, 386 -217, 490 10, 099, 896 242, 412. 00 41.66 27.00 28. 00 339, 430 339, 430 1, 514. 00 224. 19 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 1, 294, 859 1, 294, 859 36, 919. 00 35.07 30.00 . Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 32.00 Housekeepi ng 97, 346. 00 9.00 1, 991, 030 -3, 691 1, 987, 339 20.42 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 1, 688, 941 -1, 014, 813 674, 128 30, 361. 00 22. 20 34.00 35.00 Dietary under contract (see 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 1,006,246 1,006,246 90, 848. 00 11.08 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 28, 595. 00 1, 651, 180 57. 74 38.00 38.00 13.00 1, 651, 180 39.00 Central Services and Supply 14.00 325, 965 C 325, 965 8, 820. 00 36. 96 39.00 2, 766, 947 2, 749, 203 56, 219. 00 48. 90 40.00 Pharmacy 15.00 -17, 744 40.00 Medical Records & Medical Records Library 651, 654 -2, 182 26, 269. 00 41.00 16.00 649, 472 24. 72 41.00

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0037	Peri od: From 01/01/2022	Worksheet S-3 Part III

						rom 01/01/2022 o 12/31/2022		
		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		63, 981, 803	-232, 573	63, 749, 230	1, 543, 004. 00	41. 32	1.00
	instructions)							
2.00	Excluded area salaries (see		15, 170, 088	-705, 142	14, 464, 946	257, 673. 00	56. 14	2.00
	instructions)							
3.00	Subtotal salaries (line 1		48, 811, 715	472, 569	49, 284, 284	1, 285, 331. 00	38. 34	3.00
	minus line 2)							
4.00	Subtotal other wages & related		3, 849, 706	0	3, 849, 706	32, 512. 00	118. 41	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		12, 249, 747	0	12, 249, 747	0.00	24. 86	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		64, 911, 168	472, 569	65, 383, 737	1, 317, 843. 00	49. 61	6.00
7.00	Total overhead cost (see		21, 562, 710	-257, 119	21, 305, 591	639, 079. 00	33. 34	7.00
	instructions)							
	,				•	•	•	

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10	
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0037	Period: Worksheet S-3 From 01/01/2022 Part IV	
		To 12/31/2022 Date/Time Prepared	

		2 nm
	5/26/2023 1: 3 Amount	J PIII
	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)	2, 980, 718	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	0	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)	0	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)	6, 992, 890	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	440, 923	10.00
11.00 Life Insurance (If employee is owner or beneficiary)	-31, 261	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)	455, 554	13.00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00 'Workers' Compensation Insurance	0	15.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
Noncumul ati ve portion)		
TAXES		
17.00 FICA-Employers Portion Only	4, 387, 397	17.00
18.00 Medicare Taxes - Employers Portion Only	0	18.00
19.00 Unempl oyment I nsurance	2, 117	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	18, 834	22.00
23. 00 Tuition Reimbursement	72, 324	23.00
24.00 Total Wage Related cost (Sum of lines 1 -23)	15, 319, 496	24.00
Part B - Other than Core Related Cost		25 00
25.00 OTHER WAGE RELATED COSTS (SPECIFY)		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	Peri od: From 01/01/2022	Worksheet S-3 Part V
		To 12/21/2022	Dato/Timo Droparod:

			rom 01/01/2022		
		T	0 12/31/2022	Date/Time Pre 5/26/2023 1:3	pared:
	Cost Center Description		Contract	Benefit Cost	3 pili
	Cost Center Description		Labor	bellett t cost	
			1.00	2. 00	
	PART V - Contract Labor and Benefit Cost		1.00	2.00	
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		4, 160, 386	15, 319, 496	1. 00
2. 00	Hospi tal		4, 160, 386		
3. 00	SUBPROVI DER - I PF		4, 100, 300	13, 317, 470	3.00
4. 00	SUBPROVI DER - I RF		ď	O	4. 00
5. 00	Subprovi der - (Other)			0	5.00
6. 00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	SKILLED NURSING FACILITY		١	U	8.00
9. 00	NURSING FACILITY				9. 00
10. 00	OTHER LONG TERM CARE I				10.00
11. 00	Hospi tal -Based HHA		0	0	
	AMBULATORY SURGICAL CENTER (D. P. ) I		٩	U	12.00
	Hospi tal -Based Hospi ce			0	
	· '		٥	0	
14.00	Hospital Based Health Clinic RHC		۷	U	
15. 00	Hospital -Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
	RENAL DIALYSIS I				17.00
18. 00	lutner		미	0	18. 00

Heal th	n Financial Systems	HANCOCK REGION	IAL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0037	Peri od:	Worksheet S-8	}
			Component	CCN: 15-3987	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 1:3	
					RHC I	Cost	
					1	00	
	Clinic Address and Identification				1.	00	
1.00	Street				224 WEST MAIN		1.00
				00	State 2.00	ZIP Code 3.00	
2. 00	City, State, ZIP Code, County		KNI GHTSTOWN	00		46148	2.00
	1	. 'I'					
2.00	HOCDITAL BACED FOLIO ONLY D. L	IIDII C		.1		1.00	2 00
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds						
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ict)		1	37632	07/01/2015	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o	ate number of o	other operatio	ns in column	N		10.00
	hours.)						
		Sund			londay	Tuesday	
		from 1.00	2. 00	from 3.00	4. 00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
11. 00	CLINIC			08: 00	17: 00	08: 00	11. 00
					1.00	2. 00	
12. 00 13. 00		ed in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y	0	12. 00 13. 00
				Prov	ider name	CCN	
14 00	RHC/FQHC name, CCN				1. 00	2. 00	14. 00
17.00	Titley Lette Halle, Con	Y/N	V	XVIII	XIX	Total Visits	14.00
		1. 00	2. 00	3. 00	4. 00	5. 00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				unty			
2.00	City State 71D Code County		HANCOCK	00			2.00
2. 00	City, State, ZIP Code, County	Tuesday		esday	Thur	sday	2.00
		to	from	to	from	to	
		6. 00	7. 00	8. 00	9. 00	10.00	
11 00	Facility hours of operations (1)	17.00	00.00	17:00	00.00	17, 00	11 00
11.00	CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 15-0037	Peri od:	Worksheet S-8	3
		C	. CON 15 2007	From 01/01/2022		
		Component	CCN: 15-3987	To 12/31/2022	5/26/2023 1:3	epared: 83 pm
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00   CLI NI C	08: 00	14: 00				11. 00

OSPI T	Financial Systems HANCOCK REGIONAL HOTAL UNCOMPENSATED AND INDIGENT CARE DATA P		CN: 15-0037	Peri od:	u of Form CMS-2 Worksheet S-1	
55111	AL GROOMI ENSATED AND THOUGHT GARE DATA	TOVIACI C	ON. 15 0057	From 01/01/2022	WOT KSHEET 5 T	O
				To 12/31/2022	Date/Time Pre 5/26/2023 1:3	
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by I	ine 202 colu	mn 8)	0. 246020	1.
00	Medicaid (see instructions for each line)				7 2/1 0/0	1
00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				7, 361, 069 Y	2. 3.
00	If line 3 is yes, does line 2 include all DSH and/or supplement	al paymer	ts from Medi	cai d?	Ϋ́	4.
00	If line 4 is no, then enter DSH and/or supplemental payments fr				0	
00	Medi cai d charges				65, 193, 224	
00	Medicaid cost (line 1 times line 6)				16, 038, 837	1
00	Difference between net revenue and costs for Medicaid program ( < zero then enter zero)	line 7 mi	nus sum of I	ines 2 and 5; if	8, 677, 768	8.
	Children's Health Insurance Program (CHIP) (see instructions for	r each li	ne)			
00	Net revenue from stand-alone CHIP				0	1
. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	
2. 00		line 11 m	inus line 9	if < zero then	0	1
	enter zero)			20.0		
	Other state or local government indigent care program (see inst					
3. 00	Net revenue from state or local indigent care program (Not incl		•	,	ł	13.
. 00	Charges for patients covered under state or local indigent care 10)	program	(Not include	d in lines 6 or	0	14.
5. 00	State or local indigent care program cost (line 1 times line 14	)			0	15.
6. 00	Difference between net revenue and costs for state or local ind	igent car	e program (I	ine 15 minus line	0	16.
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHII instructions for each line)	P and sta	te/local ind	igent care progra	ams (see	
7. 00	Private grants, donations, or endowment income restricted to fu				0	
	Government grants, appropriations or transfers for support of h				0	
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	i nai gent	care progra	ms (sum of lines	8, 677, 768	19.
	,		Uni nsured		Total (col. 1	
			patients	pati ents	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2. 00	3. 00	
0. 00	Charity care charges and uninsured discounts for the entire fac	ility	4, 194, 4	323, 246	4, 517, 646	20.
1. 00	(see instructions)	nto (coo	1, 031, 9	222 244	1 255 152	21
1.00	Cost of patients approved for charity care and uninsured discoulinstructions)	iits (see	1,031,9	906 323, 246	1, 355, 152	21.
2. 00	Payments received from patients for amounts previously written	off as		0 0	0	22.
	charity care					
3. 00	Cost of charity care (line 21 minus line 22)		1, 031, 9	906 323, 246	1, 355, 152	23.
					1.00	
1. 00	Does the amount on line 20 column 2, include charges for patien		yond a Lengt	h of stay limit	N	24.
5. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		it care progr	am's length of	0	25.
00	stay limit	+			2 200 205	1 2/
6. 00 7. 00	Total bad debt expense for the entire hospital complex (see ins Medicare reimbursable bad debts for the entire hospital complex		•		2, 208, 205 100, 388	
	Medicare allowable bad debts for the entire hospital complex (s	•			154, 443	1
					2, 053, 762	
7. 01	Non-Medicare bad debt expense (see instructions)					
7. 01 8. 00 9. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see	instruction	s)	559, 322	
7. 01 8. 00 9. 00 0. 00	1	·	instruction	s)		29. 30.

	Financial Systems	HANCOCK REGIONA		W 45 0007 D		of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JF EXPENSES	Provi der CC	F	eriod: rom 01/01/2022	Worksheet A	
				1	o 12/31/2022	Date/Time Pre 5/26/2023 1:3	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00	OO100   NEW CAP REL COSTS-BLDG & FIXT   OO400   EMPLOYEE BENEFITS DEPARTMENT	535, 318	17, 836, 043 10, 947, 306	17, 836, 043 11, 482, 624		17, 836, 043 11, 473, 809	
5. 00	00500 ADMI NI STRATI VE & GENERAL	10, 317, 386	27, 402, 359	37, 719, 745		36, 793, 050	
7. 00	00700 OPERATION OF PLANT	1, 294, 859	6, 646, 891	7, 941, 750		7, 943, 127	
9.00	00900 HOUSEKEEPI NG	1, 991, 030	894, 096	2, 885, 126		2, 885, 126	
10. 00 11. 00	01000   DI ETARY   01100   CAFETERI A	1, 688, 941	1, 500, 887	3, 189, 828	-1, 864, 529 1, 864, 529	1, 325, 299 1, 864, 529	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 651, 180	400, 601	2, 051, 781		2, 051, 781	
14.00	01400 CENTRAL SERVICES & SUPPLY	325, 965	85, 725	411, 690		411, 690	1
15.00	01500 PHARMACY	2, 766, 947	20, 359, 697	23, 126, 644		3, 739, 515	
16. 00 23. 00	O1600   MEDICAL RECORDS & LIBRARY   O2300   PARAMED ED PRGM	651, 654 91, 123	352, 272 12, 536	1, 003, 926 103, 659		1, 008, 399 103, 541	1
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	71, 123	12, 330	103, 037	110	103, 341	25.00
30.00	03000 ADULTS & PEDIATRICS	3, 775, 220	2, 049, 264	5, 824, 484		6, 560, 062	1
31.00	03100   NTENSI VE CARE UNIT   04000   SUBPROVI DER -   PF	4, 288, 006	2, 569, 962	6, 857, 968		6, 650, 990	
40. 00	ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	40.00
50.00	05000 OPERATI NG ROOM	4, 517, 310	5, 302, 292	9, 819, 602	-1, 733, 540	8, 086, 062	50.00
51.00	05100 RECOVERY ROOM	617, 411	95, 435	712, 846		686, 759	
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	0 4, 568, 254	0 2, 257, 871	0 6, 826, 125	-	0 6, 354, 527	
60.00	06000 LABORATORY	2, 025, 513	3, 983, 165	6, 008, 678		6, 006, 798	1
65. 00	06500 RESPI RATORY THERAPY	1, 917, 445	425, 295	2, 342, 740		2, 296, 174	
66. 00	06600 PHYSI CAL THERAPY	1, 329, 135	223, 154	1, 552, 289		1, 539, 535	•
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	369, 968 197, 777	36, 352 22, 943	406, 320 220, 720		401, 535 219, 779	•
69. 00	06900 ELECTROCARDI OLOGY	608, 486	781, 772	1, 390, 258		892, 771	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	233	233		3, 476, 857	
72. 00 73. 00	O7200   IMPL. DEV. CHARGED TO PATIENT   O7300   DRUGS CHARGED TO PATIENTS	0	1, 728, 469	1, 728, 469 0	1	1, 728, 469 20, 487, 386	1
76. 00	03020 CARDI AC		o	0	20, 407, 300	20, 407, 300	1
76. 01	03160 CARDI OPULMONARY	67, 699	13, 246	80, 945	-11	80, 934	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	291, 014	274, 468	565, 482	-41, 980	523, 502	88.00
90. 00	09000 CLI NI C	0	0	0		0	1
90. 01	09001 WOUND CLINIC	462, 496	524, 044	986, 540		923, 232	1
90. 02 90. 03	O9002   DI ABETES CLI NI C   O9003   ASTHMA CLI NI C	45, 945	13, 487	59, 432	0	59, 432 0	1
	09004 ANDIS CLINIC	99, 191	42, 182	141, 373	-	141, 066	
	09005 PRIME TIME	0	7, 900	7, 900	0	7, 900	90.05
90. 06 90. 07	O9006   SHELBYVI LLE WOUND CLINIC   O4951   ONCOLOGY	0 2 402 010	71 007	2 7/2 00/	47 073	0 715 023	90.06
90.07	04950 ANDERSON WOMENS CENTER	2, 692, 819 468, 756	71, 087 336, 922	2, 763, 906 805, 678		2, 715, 933 674, 664	
91. 00	09100 EMERGENCY	2, 847, 511	3, 730, 112	6, 577, 623		6, 314, 789	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	ol	0	o	0	101.00
	10200 OPIOID TREATMENT PROGRAM	0	Ö	0			102.00
	SPECIAL PURPOSE COST CENTERS						
116. 00 118. 00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117)	920, 990 53, 425, 349	155, 969 111, 084, 037	1, 076, 959 164, 509, 386		0 164, 265, 065	116.00
110.00	NONREI MBURSABLE COST CENTERS	55, 425, 544	111, 004, 037	104, 507, 300	-244, 321	104, 203, 003	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190. 00
	19001 PROFESSI ONAL BUILDI NG	0	277, 291	277, 291		264, 118	
	19002   PHYSI CI AN BUI LDI NG   19003   PRI VATE DUTY	282, 320	729, 029 877, 235	729, 029 1, 159, 555		729, 029 1, 159, 555	1
	19004 MARKETI NG	0	077, 233	1, 137, 333	1	928, 763	
	19005 SPORTS PHYSI CALS	318, 492	29, 403	347, 895	i i	347, 895	1
	19006 FOUNDATION	243, 521	796, 608	1, 040, 129	i i	1, 040, 129	1
	19007 ASC  19008 GATEWAY LOCATION	0 3, 529, 380	7, 588 1, 417, 541	7, 588 4, 946, 921		2, 323 4, 798, 335	190.07 190.08
	19009 HANCOCK OB	4, 424, 875	2, 347, 319	6, 772, 194	-466, 168	6, 306, 026	1
	19010 HANCOCK WELLNESS	890, 955	279, 600	1, 170, 555		1, 170, 555	
	19011 MORRISTOWN CLINIC  19012 O3PUREMED	0	0	0	0		190. 11 190. 12
	19012  03POREMED   19013  MCCORD WELLNESS	905, 672	460, 680	1, 366, 352		1, 366, 352	1
190. 14	19014 3 WEST UNIT	207, 839	238, 985	446, 824		444, 462	•
	19015 NEUROLOGY PHYSI CI AN	1, 248, 356	392, 688	1, 641, 044		1, 534, 534	•
190. 16	19016 THORACI	77, 464	14, 216	91, 680	0	91, 680	190. 16

Health Financial Systems	HANCOCK REGIONA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der Co		Period: From 01/01/2022 To 12/31/2022	Worksheet A Date/Time Pre	pared:
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	5/26/2023 1:3 Reclassified Trial Balance (col. 3 +- col. 4)	3 pm
	1. 00	2. 00	3.00	4. 00	5. 00	
190. 17 19017 HANCOCK ENDO	834, 071	385, 395	1, 219, 46	6 -48, 879	1, 170, 587	190. 17
190. 18 19018 HANCOCK FOOT & ANKLE	o	0		0	0	190. 18
190. 19 19019 HANCOCK RHEUM	61, 476	29, 603	91, 07	9 0	91, 079	190. 19
194. 00 07950 OTHER NONREI MBURSABLE	320	427	74	7 0	747	194.00
194. 01 07951 SUBURBAN HOSPI CE	o	0		107, 821	107, 821	194. 01
194. 02 07952 HRH HANCOCK GI	768, 891	175, 854	944, 74	5 0	944, 745	194. 02
194. 03 07954 HRH NEPHROLOGY	157, 235	131, 293	288, 52	8 0	288, 528	194. 03
194. 04 07957 HRH SANE	104, 239	64, 304			167, 223	194. 04
194. 05 07955 HRH RI SE	o	379, 942	379, 94	2 0	379, 942	194. 05
194.06 07956 HRH JUSTICE NAVIGATION	102, 869	61, 068			163, 937	1
200.00   TOTAL (SUM OF LINES 118 through 199)	67, 583, 324	120, 180, 106			187, 763, 430	200.00

Provi der CCN: 15-0037

Cost Center Description	1. 00 4. 00 5. 00 7. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
CENERAL SERVICE COST CENTERS	4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 23. 00 30. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
GENERAL SERVI CE COST CENTERS	4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 23. 00 30. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT   -805, 573   17, 030, 470     4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   -6, 455, 180   5, 018, 629     5.00   00500   ADMINISTRATIVE & GENERAL   -15, 164, 786   21, 628, 264     7.00   00700   OPERATI ON OF PLANT   -11, 820   7, 931, 307     9.00   00900   HOUSEKEEPING   -142, 710   2, 742, 416     9.00   01000   DIETARY   -736, 926   588, 373     9.11.00   01100   CAFETERI A   -890, 026   974, 503     9.13.00   01300   NURSI NG ADMINISTRATION   -21, 125   2, 030, 656     9.14.00   01400   CENTRAL SERVI CES & SUPPLY   -3, 752   407, 938     9.15.00   01500   PHARMACY   -1, 901, 299   1, 838, 216     9.16.00   01600   MEDICAL RECORDS & LIBRARY   -61, 206   947, 193     9.23.00   02300   PARAMED ED PRGM   -39, 819   63, 722     9.23.00   O3000   ADULTS & PEDIATRIC S   -914, 959   5, 645, 103     9.10   03000   ADULTS & PEDIATRIC S   -914, 959   5, 645, 103     9.10   03000   ADULTS & PEDIATRIC S   -914, 959   5, 645, 103     9.10   03000   ADULTS & PEDIATRIC S   -914, 959   5, 645, 103     9.10   05100   RECOVERY ROOM   -2, 630, 841   5, 455, 221     9.10   05100   RECOVERY ROOM   -2, 630, 841   5, 455, 221     9.10   05100   RECOVERY ROOM   -703, 719   5, 650, 808     9.10   05100   RECOVERY ROOM   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400   RADIOLOGY -DIAGNOSTIC   -703, 719   5, 650, 808     9.10   05400	4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 23. 00 30. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 23. 00 30. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
5. 00	5. 00 7. 00 9. 00 10. 00 111. 00 13. 00 14. 00 15. 00 16. 00 23. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
9. 00   00900   HOUSEKEEPING	9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 23. 00 30. 00 31. 00 40. 00 50. 00 51. 00 53. 00 60. 00
10. 00 01000 DI ETARY	10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 23. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
11. 00	11. 00 13. 00 14. 00 15. 00 16. 00 23. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
13. 00	13. 00 14. 00 15. 00 16. 00 23. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
14. 00	14. 00 15. 00 16. 00 23. 00 30. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
16. 00	16. 00 23. 00 30. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
23. 00   02300   PARAMED ED PRGM   -39, 819   63, 722     INPATI ENT ROUTI NE SERVI CE COST CENTERS   -914, 959   5, 645, 103     31. 00   03300   ADULTS & PEDI ATRI CS   0 6, 650, 990   04000   SUBPROVI DER - I PF   0   0     ANCI LLARY SERVI CE COST CENTERS   -2, 630, 841   5, 455, 221     51. 00   05100   RECOVERY ROOM   0 686, 759   0   05300   ANESTHESI OLOGY   0   0   0   0   0   0   0   0   0	23. 00 30. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS   -914, 959   5, 645, 103   31. 00   03000   ADULTS & PEDI ATRI CS   -914, 959   5, 645, 103   31. 00   03100   INTENSI VE CARE UNI T   0   6, 650, 990   04000   SUBPROVI DER   IPF   0   0   0   0   0   0   0   0   0	30. 00 31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
30. 00   03000   ADULTS & PEDIATRICS   -914, 959   5, 645, 103   31. 00   03100   INTENSI VE CARE UNIT   0   6, 650, 990   04000   SUBPROVI DER - I PF   0   0   0   0   0   0   0   0   0	31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
31. 00   03100   INTENSI VE CARE UNI T   0   6,650,990   04000   SUBPROVI DER - I PF   0   0   0   0   0   0   0   0   0	31. 00 40. 00 50. 00 51. 00 53. 00 54. 00 60. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00 05000 OPERATI NG ROOM -2, 630, 841 5, 455, 221 51. 00 05100 RECOVERY ROOM 0 686, 759 53. 00 05300 ANESTHESI OLOGY 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C -703, 719 5, 650, 808 60. 00 06000 LABORATORY -634, 720 5, 372, 078 65. 00 06500 RESPI RATORY THERAPY -47, 718 2, 248, 456 66. 00 06600 PHYSI CAL THERAPY -60 1, 539, 475 67. 00 06700 OCCUPATI ONAL THERAPY 0 401, 535 68. 00 06800 SPEECH PATHOLOGY 0 219, 779 69. 00 06900 ELECTROCARDI OLOGY 0 892, 771 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0	50. 00 51. 00 53. 00 54. 00 60. 00
50. 00         05000         OPERATI NG ROOM         -2, 630, 841         5, 455, 221           51. 00         05100         RECOVERY ROOM         0         686, 759           53. 00         05300         ANESTHESI OLOGY         0         0           54. 00         05400         RADI OLOGY-DI AGNOSTI C         -703, 719         5, 650, 808           60. 00         06000         LABORATORY         -634, 720         5, 372, 078           65. 00         06500         RESPI RATORY THERAPY         -47, 718         2, 248, 456           66. 00         06600         PHYSI CAL THERAPY         -60         1, 539, 475           67. 00         06700         OCCUPATI ONAL THERAPY         0         401, 535           68. 00         06800         SPEECH PATHOLOGY         0         219, 779           69. 00         06900         ELECTROCARDI OLOGY         0         892, 771           70. 00         07000         ELECTROENCEPHALOGRAPHY         0         0	51.00 53.00 54.00 60.00
51. 00       05100       RECOVERY ROOM       0       686, 759         53. 00       05300       ANESTHESI OLOGY       0       0         54. 00       05400       RADI OLOGY-DI AGNOSTI C       -703, 719       5, 650, 808         60. 00       06000       LABORATORY       -634, 720       5, 372, 078         65. 00       06500       RESPI RATORY THERAPY       -47, 718       2, 248, 456         66. 00       06600       PHYSI CAL THERAPY       -60       1, 539, 475         67. 00       06700       OCCUPATI ONAL THERAPY       0       401, 535         68. 00       06800       SPEECH PATHOLOGY       0       219, 779         69. 00       06900       ELECTROCARDI OLOGY       0       892, 771         70. 00       07000       ELECTROENCEPHALOGRAPHY       0       0	51.00 53.00 54.00 60.00
53. 00       05300       ANESTHESI OLOGY       0       0         54. 00       05400       RADI OLOGY-DI AGNOSTI C       -703, 719       5, 650, 808         60. 00       06000       LABORATORY       -634, 720       5, 372, 078         65. 00       06500       RESPI RATORY THERAPY       -47, 718       2, 248, 456         66. 00       06600       PHYSI CAL THERAPY       -60       1, 539, 475         67. 00       06700       OCCUPATI ONAL THERAPY       0       401, 535         68. 00       08800       SPEECH PATHOLOGY       0       219, 779         69. 00       06900       ELECTROCARDI OLOGY       0       892, 771         70. 00       07000       ELECTROENCEPHALOGRAPHY       0       0	53. 00 54. 00 60. 00
60. 00   06000   LABORATORY   -634, 720   5, 372, 078   65. 00   06500   RESPI RATORY   THERAPY   -47, 718   2, 248, 456   66. 00   06600   PHYSI CAL THERAPY   -60   1, 539, 475   67. 00   06700   OCCUPATI ONAL THERAPY   0   401, 535   68. 00   06800   SPEECH PATHOLOGY   0   219, 779   69. 00   06900   ELECTROCARDI OLOGY   0   892, 771   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0	60.00
65. 00   06500   RESPI RATORY THERAPY   -47, 718   2, 248, 456	
66. 00   06600   PHYSI CAL THERAPY   -60   1,539,475     67. 00   06700   OCCUPATI ONAL THERAPY   0   401,535     68. 00   06800   SPEECH PATHOLOGY   0   219,779   69. 00   06900   ELECTROCARDI OLOGY   0   892,771   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0	1 65. ()()
67. 00   06700   0CCUPATI ONAL THERAPY   0   401, 535   68. 00   06800   SPEECH PATHOLOGY   0   219, 779   69. 00   06900   ELECTROCARDI OLOGY   0   892, 771   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0	66.00
68. 00   06800   SPEECH PATHOLOGY   0   219, 779   69. 00   06900   ELECTROCARDI OLOGY   0   892, 771   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0	67.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0	68.00
	69. 00
	70.00
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   3, 476, 857   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   0   1, 728, 469	71. 00 72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   20, 487, 386	73.00
76. 00 03020 CARDI AC 0 0	76. 00
76. 01   03160   CARDI OPULMONARY   0   80, 934	76. 01
77. 00   07700  ALLOGENEI C STEM CELL ACQUISITION   0   0    OUTPATIENT SERVICE COST CENTERS	77. 00
88. 00   08800   RURAL HEALTH CLINIC   0   523, 502	88. 00
90. 00   09000   CLI NI C   0   0	90.00
90. 01   09001   WOUND CLINIC   -304, 218   619, 014	90. 01
90. 02   09002   DI ABETES CLI NI C   0   59, 432   90. 03   09003   ASTHMA CLI NI C   0   0	90. 02 90. 03
90. 04   09004   ANDI S   CLI NI C   0   141, 066	90.03
90. 05   09005   PRI ME TI ME -3, 615 4, 285	90.05
90. 06 O9006 SHELBYVI LLE WOUND CLINIC O O	90.06
90. 07   04951   0NCOLOGY   -1, 022, 112   1, 693, 821   90. 08   04950   ANDERSON WOMENS CENTER   -84, 900   589, 764	90. 07 90. 08
91. 00   09100   EMERGENCY   -95, 090   6, 219, 699	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REI MBURSABLE COST CENTERS	l
101.00 10100 HOME HEALTH AGENCY 0 0 101.00 102.00 102.00 102.00 102.00 0 0	101. 00 102. 00
SPECIAL PURPOSE COST CENTERS	102.00
116. 00 11600 H0SPI CE 0 0	116. 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   -32, 676, 174   131, 588, 891	118. 00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0	190. 00
190. 00 19000 GFF, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 01 19001 PROFESSI ONAL BUILDING 0 264, 118	190.00
190. 02 19002 PHYSI CI AN BUI LDI NG 0 729, 029	190. 02
190. 03 19003 PRI VATE DUTY 0 1, 159, 555	190. 03
190. 04 19004 MARKETI NG 0 928, 763	190.04
190. 05 19005 SPORTS PHYSI CALS 0 347, 895 190. 06 19006 FOUNDATI ON 0 1, 040, 129	190. 05 190. 06
190. 07   19007   ASC 0 2, 323	190.00
190. 08 19008 GATEWAY LOCATION 0 4, 798, 335	190. 08
190. 09 19009 HANCOCK OB 0 6, 306, 026	190. 09
190. 10 19010 HANCOCK WELLNESS 0 1, 170, 555	190. 10
190. 11 19011 MORRI STOWN CLINI C 0 0 190. 12 19012 03 PUREMED 0 0	190. 11 190. 12
190. 13 19013 MCCORD WELLNESS 0 1, 366, 352	
190. 14 19014 3 WEST UNIT 0 444, 462	190. 13
190. 15 19015 NEUROLOGY PHYSI CI AN 0 1, 534, 534	190. 14
190. 16 19016 THORACI 0 91, 680 190. 17 19017 HANCOCK ENDO 0 1, 170, 587	190. 14 190. 15
170. 17[17017] NATIONAL ENDO	190. 14

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0037
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0037
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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES PROVIDER CCN: 15-0037
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES PROVIDER CCN: 15-0037
RECLASSIFICATION AND ADJUSTMENT ADJUSTMENT AND ADJUSTMENT AND ADJUSTMENT ADJUSTMENT AND ADJUSTM

			 5/26/2023 1:33 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7. 00	
190. 18 19018 HANCOCK FOOT & ANKLE	0	0	190. 18
190. 19 19019 HANCOCK RHEUM	0	91, 079	190. 19
194.00 07950 OTHER NONREI MBURSABLE	0	747	194. 00
194. 01 07951 SUBURBAN HOSPI CE	0	107, 821	194. 01
194. 02 07952 HRH HANCOCK GI	0	944, 745	194. 02
194. 03 07954 HRH NEPHROLOGY	0	288, 528	194. 03
194. 04 07957 HRH SANE	0	167, 223	194. 04
194. 05 07955 HRH RI SE	0	379, 942	194. 05
194.06 07956 HRH JUSTICE NAVIGATION	0	163, 937	194. 06
200.00   TOTAL (SUM OF LINES 118 through 199)	-32, 676, 174	155, 087, 256	200.00

Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/26/2023 1:33 pm Provider CCN: 15-0037

					5/26/2023	3 1:33 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
1. 00	A - CAFETERIA CAFETERIA	11. 00	1, 006, 246	858, 283		1.00
1.00	TOTALS		1, 006, 246	858, 283		1.00
	B - PLANT		.,,	000, 200		
1.00	OPERATION OF PLANT	7. 00	0	1, 377		1.00
2.00	MEDICAL RECORDS & LIBRARY	16. 00	0	4, 473		2. 00
3.00	ELECTROCARDI OLOGY	69. 00	0	4, 400		3.00
4. 00	RESPIRATORY THERAPY TOTALS	65.00	0	<u>2, 9</u> 23 13, 173		4. 00
	C - MARKETING		U <sub>I</sub>	13, 173		
1. 00	MARKETI NG	190, 04	170, 201	758, 562		1.00
	TOTALS		170, 201	758, 562		
	E - DRUG RECLASS					
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	20, 487, 386		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 218		2.00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5. 00		0.00	Ö	0		5.00
6. 00		0.00	o	0		6.00
7.00		0. 00	O	0		7.00
8. 00		0. 00	0	0		8. 00
9. 00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	Ö	0		13.00
14. 00		0.00	o	0		14.00
15.00		0. 00	o	0		15. 00
16.00		0. 00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	0	0		22.00
23. 00		0.00	o	0		23.00
24.00		0. 00	o	0		24.00
25.00		0. 00	0	0		25. 00
26. 00		0.00	•	0		26. 00
	TOTALS  F - TERM ETO BENEFIT RECLASS		0	20, 489, 604		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	ol	7, 445		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	o	47, 289		2.00
3.00	HOUSEKEEPI NG	9. 00	o	3, 691		3.00
4.00	DI ETARY	10. 00	0	8, 567		4. 00
5.00	PHARMACY	15. 00	0	17, 744		5.00
6.00	MEDICAL RECORDS & LIBRARY ADULTS & PEDIATRICS	16.00	0	2, 182		6.00
7. 00 8. 00	INTENSIVE CARE UNIT	30. 00 31. 00	0	30, 477 9, 680		7. 00 8. 00
9. 00	OPERATING ROOM	50. 00	ő	20, 919		9. 00
10.00	RECOVERY ROOM	51.00	O	2, 584		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	10, 393		11.00
12.00	LABORATORY	60. 00	0	6, 189		12.00
13.00	RESPIRATORY THERAPY	65. 00	0	5, 139		13.00
14. 00 15. 00	WOUND CLINIC ONCOLOGY	90. 01 90. 07	0	3, 807 384		14. 00 15. 00
16. 00	EMERGENCY	91.00	0	7, 543		16.00
18. 00	PRI VATE DUTY	190. 03	ő	801		18. 00
19. 00	SPORTS PHYSI CALS	190. 05	O	6, 073		19. 00
20.00	GATEWAY LOCATION	190. 08	o	24, 610		20.00
21.00	MCCORD WELLNESS	190. 13	0	10, 558		21.00
22. 00	HANCOCK ENDO	190. 17	0	6, 174		22.00
23. 00	SUBURBAN HOSPICE	194. 01	0	<u>324</u> 232, 573		23. 00
	G - TRANSITION UNIT RECLASS		J	232, 373		
1. 00	ADULTS & PEDIATRICS	30.00	826, 803	140, 018		1.00
2.00	SUBURBAN HOSPICE	194. 01	94, 187	15, 951		2. 00
	TOTALS		920, 990	155, 969		
1 00	H - IMPANTABLE SUPPLY RECLASS		51	2 22=1		4 00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	2, 238		1.00
	TOTALS	+				
		ı	9	2, 200		T

Health Financial Systems RECLASSIFICATIONS HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0037

Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/26/2023 1:33 pm

					Ę	5/26/2023 1:33 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4. 00	5.00		
	I - MED SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 474, 532		1.00
	PATI ENTS					
2.00		0. 00	0	0		2.00
3.00		0. 00	0	0		3.00
4.00		0. 00	0	0		4.00
5.00		0. 00	0	0		5.00
6.00		0.00	o	0		6.00
7.00		0.00	o	0		7.00
8.00		0.00	o	0		8.00
9.00		0.00	o	0		9.00
10.00		0.00	o	0		10.00
11.00		0.00	o	0		11.00
12.00		0. 00	o	0		12.00
13.00		0. 00	o	0		13.00
14.00		0.00	ol	0		14.00
15.00		0.00	ol	0		15.00
16.00		0.00	o	0		16.00
17. 00		0.00	o	0		17. 00
18. 00		0.00	o	0		18.00
19.00		0. 00	ol	0		19.00
20. 00		0.00	o	0		20.00
21. 00		0.00	o	0		21.00
23. 00		0.00	o	0		23.00
24.00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0. 00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0. 00	ő	n		28. 00
29. 00		0.00	o o	n		29. 00
30. 00		0.00	0	0		30.00
30.00	TOTALS — — — —			3, 474, 532		33.00
500 00	Grand Total: Increases		2, 097, 437	25, 984, 934		500.00
300.00	Jordina Total. Tilci edses	I	2,091,431	23, 704, 734		500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | Dat Provider CCN: 15-0037

						5	/26/2023 1:33 pm
		Decreases				.,  •	, 20, 2020 TT 00 pm
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00 A - CAFETERI A	7. 00	8. 00	9. 00	10. 00		
1. 00	DI ETARY	10. 00	1, 006, 246	858, 283	0		1.00
1.00	TOTALS — — — —		1, 006, 246	858, 283	— — — 🦞		1.00
	B - PLANT		17 0007 2 10	000, 200			
1.00	PROFESSIONAL BUILDING	190. 01	0	13, 173	0		1.00
2.00		0. 00	0	0	0		2.00
3.00		0. 00	0	0	0		3.00
4. 00		0.00	0	0	0		4.00
	TOTALS  C - MARKETING		0	13, 173			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	170, 201	758, 562	0		1.00
1.00	TOTALS		170, 201	758, 562			1.00
	E - DRUG RECLASS		., 0, 201	700,002			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 815	0		1.00
2.00	PHARMACY	15. 00	O	19, 351, 455	0		2.00
3.00	ADULTS & PEDIATRICS	30. 00	0	13, 616	0		3.00
4.00	INTENSIVE CARE UNIT	31. 00	0	23, 207	0		4.00
5.00	OPERATING ROOM	50.00	0	8, 546	0		5.00
6.00	RECOVERY ROOM	51.00	0	1, 302	0		6.00
7. 00 8. 00	RADI OLOGY-DI AGNOSTI C LABORATORY	54. 00 60. 00	0	339, 179 318	0		7. 00 8. 00
9. 00	RESPI RATORY THERAPY	65. 00	O	195	0		9.00
10.00	PHYSICAL THERAPY	66. 00	0	2, 073	0		10.00
11. 00	ELECTROCARDI OLOGY	69. 00	Ö	27, 887	Ö		11.00
12. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	Ö	146	o		12.00
	PATI ENTS						
13.00	RURAL HEALTH CLINIC	88. 00	0	41, 660	0		13.00
14.00	WOUND CLINIC	90. 01	0	12, 206	0		14.00
15.00	ANDIS CLINIC	90. 04	0	13	0		15. 00
16.00	ONCOLOGY	90. 07	0	8, 631	0		16.00
17. 00 18. 00	ANDERSON WOMENS CENTER EMERGENCY	90. 08 91. 00	0	497 21, 488	0		17. 00 18. 00
20. 00	ASC	190. 07	0	105	0		20.00
21. 00	GATEWAY LOCATION	190. 08	Ö	36, 425	0		21. 00
22. 00	HANCOCK OB	190. 09	ő	449, 591	o		22.00
23. 00	NEUROLOGY PHYSICIAN	190. 15	O	92, 277	O		23.00
24.00	HANCOCK ENDO	190. 17	O	48, 639	0		24.00
25.00	HRH SANE	194. 04	0	1, 102	0		25. 00
26. 00	SUBURBAN HOSPI CE	1 <u>94.</u> 01		231	0		26.00
	TOTALS		0	20, 489, 604			
1. 00	F - TERM ETO BENEFIT RECLASS EMPLOYEE BENEFITS DEPARTMENT	4. 00	7, 445	0	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	47, 289	0	0		2.00
3.00	HOUSEKEEPI NG	9. 00	3, 691	0	Ö		3.00
4.00	DI ETARY	10. 00	8, 567	0	0		4.00
5.00	PHARMACY	15. 00	17, 744	0	0		5. 00
6. 00	MEDICAL RECORDS & LIBRARY	16. 00	2, 182	0	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	30, 477	0	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	9, 680	0	0		8.00
9. 00 10. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	20, 919 2, 584	0	0		9. 00 10. 00
11.00	RADI OLOGY-DI AGNOSTI C	54. 00	10, 393	0	0		11.00
12.00	LABORATORY	60.00	6, 189	0	Ö		12.00
13.00	RESPI RATORY THERAPY	65. 00	5, 139	0	o		13. 00
14.00	WOUND CLINIC	90. 01	3, 807	0	o		14.00
15.00	ONCOLOGY	90. 07	384	0	0		15.00
16.00	EMERGENCY	91. 00	7, 543	0	0		16.00
18.00	PRI VATE DUTY	190. 03	801	0	0		18. 00
19.00	SPORTS PHYSICALS	190. 05	6, 073	0	0		19.00
20.00	GATEWAY LOCATION	190. 08	24, 610	0	0		20.00
21. 00 22. 00	MCCORD WELLNESS HANCOCK ENDO	190. 13 190. 17	10, 558 6, 174	0	0		21. 00 22. 00
23. 00	SUBURBAN HOSPI CE	190. 17	324	0	0		23.00
25.00	TOTALS		232, 573		— — <sup>Ч</sup>		23.00
	G - TRANSITION UNIT RECLASS			<u> </u>			
1.00	HOSPI CE	116. 00	920, 990	155, 969	0		1.00
2.00		000	0	0	0		2. 00
	TOTALS	T	920, 990	155, 969			
1. 00	H - IMPANTABLE SUPPLY RECLASS GATEWAY LOCATION	190. 08		2, 238	0		1.00

Provider CCN: 15-0037

Period: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/26/2023 1:33 pm

						5/26/2023 1: 33 pm
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	I - MED SUPPLY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	150	0	1. C
2.00	PHARMACY	15. 00	0	35, 674	0	2.0
3.00	PARAMED ED PRGM	23. 00	0	118	0	3.0
4.00	ADULTS & PEDIATRICS	30.00	0	217, 627	0	4. C
5.00	INTENSIVE CARE UNIT	31.00	0	183, 771	0	5. C
6.00	OPERATING ROOM	50.00	0	1, 724, 994	0	6.0
7.00	RECOVERY ROOM	51.00	0	24, 785	0	7. C
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	132, 419	0	8.0
9.00	LABORATORY	60.00	0	1, 562	0	9.0
10.00	RESPI RATORY THERAPY	65.00	0	49, 294	0	10.0
11.00	PHYSI CAL THERAPY	66.00	0	10, 681	0	11. C
12.00	OCCUPATIONAL THERAPY	67.00	0	4, 785	0	12.0
13.00	SPEECH PATHOLOGY	68.00	0	941	0	13.0
14.00	ELECTROCARDI OLOGY	69.00	0	474, 000	0	14. C
15.00	CARDI OPULMONARY	76. 01	0	11	0	15. C
16.00	RURAL HEALTH CLINIC	88. 00	0	320	0	16.0
17.00	WOUND CLINIC	90. 01	0	51, 102	0	17. C
18.00	ANDIS CLINIC	90. 04	0	294	0	18.0
19.00	ONCOLOGY	90. 07	0	39, 342	0	19. C
20.00	ANDERSON WOMENS CENTER	90. 08	0	130, 517	0	20.0
21.00	EMERGENCY	91.00	0	241, 346	0	21.0
23.00	ASC	190. 07	0	5, 160	0	23.0
24.00	GATEWAY LOCATION	190. 08	0	109, 923	0	24.0
25.00	HANCOCK OB	190. 09	0	16, 577	0	25.0
26.00	3 WEST UNIT	190. 14	O	2, 362	0	26.0
27.00	NEUROLOGY PHYSICIAN	190. 15	O	14, 233	0	27.0
28.00	HANCOCK ENDO	190. 17	o	240	0	28.0
29.00	HRH SANE	194. 04	o	218	0	29.0
30.00	SUBURBAN HOSPI CE	194. 01	o	2, 086	0	30.0
	TOTALS			3, 474, 532		
500.00	Grand Total: Decreases		2, 330, 010	25, 752, 361		500. 0

					То	12/31/2022	Date/Time Pre 5/26/2023 1:3	pared: 3 nm
				Acqui si ti ons	<u> </u>		072072020 1.0	<u>Б</u>
		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	2, 494, 664	0		0	0	0	1.00
2.00	Land Improvements	26, 217, 818	707, 863		0	707, 863	0	2.00
3.00	Buildings and Fixtures	173, 797, 167	4, 103, 858		0	4, 103, 858	0	3.00
4.00	Building Improvements	235, 570	17, 621		0	17, 621	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	95, 936, 993	4, 025, 651		0	4, 025, 651	43, 155	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	298, 682, 212	8, 854, 993		0	8, 854, 993	43, 155	8. 00
9. 00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	298, 682, 212	8, 854, 993		0	8, 854, 993	43, 155	10.00
		Endi ng	Ful I y					
		Bal ance	Depreci ated					
			Assets					
		6. 00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	2, 494, 664	0					1.00
2.00	Land Improvements	26, 925, 681	0					2.00
3.00	Buildings and Fixtures	177, 901, 025	0					3.00
4.00	Building Improvements	253, 191	0					4. 00
5.00	Fi xed Equi pment	0	0					5. 00
6.00	Movable Equipment	99, 919, 489	0					6. 00
7.00	HIT designated Assets	0	0					7. 00
8.00	Subtotal (sum of lines 1-7)	307, 494, 050	0					8. 00
9. 00	Reconciling Items	0	0					9. 00
10. 00	Total (line 8 minus line 9)	307, 494, 050	0					10.00

Heal th	Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-0037	Peri od: From 01/01/2022 To 12/31/2022		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	RKSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	15, 960, 705	0		0 1, 438, 787	436, 551	1.00
3.00	Total (sum of lines 1-2)	15, 960, 705	0		0 1, 438, 787	436, 551	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOF	RKSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	17, 836, 043				1.00
3. 00	Total (sum of lines 1-2)	0	17, 836, 043				3.00

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 01/01/2022 Fo 12/31/2022		nared.
				12/01/2022	5/26/2023 1: 3	
	COME	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Coat Conton Decemintion	Cross Assets	Conitalized	Gross Assets	Datia (ass	Lnouronoo	
Cost Center Description	Gross Assets	Capi tal i zed Leases	for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col. 1 -	Tristructions)		
			col . 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS (	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	319, 973, 630		319, 973, 630			1.00
3.00 Total (sum of lines 1-2)	319, 973, 630		319, 973, 630			3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
Ocal Ocal of Beautiful	<b>—</b> • • • • •	0.11	T. I. I. ( 6	. D		
Cost Center Description	Taxes	Other	Total (sum of cols. 5	Depreciation	Lease	
		Capital-Relat	through 7)			
	6, 00	7.00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS (		7.00	0.00	7.00	10.00	
1. 00 NEW CAP REL COSTS-BLDG & FLXT	0	0	(	15, 960, 705	-800, 866	1.00
3.00 Total (sum of lines 1-2)	0	0		15, 960, 705	-800, 866	3.00
		SL	JMMARY OF CAPI	TAL		
				+		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
	11. 00	12. 00	13. 00	instructions)	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS (		12.00	13.00	14.00	13.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	-4. 707	1, 438, 787	436, 55	1 0	17, 030, 470	1. 00
3.00 Total (sum of lines 1-2)	-4, 707	,	•		17, 030, 470	

					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 1:3	
			-	Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3. 00	4.00	Ref. 5.00	
1. 00	Investment income - NEW CAP		10	NEW CAP REL COSTS-BLDG &	1. 00	0	1.00
2. 00	REL COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			*** Cost Center Deleted ***	2.00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	
	discounts (chapter 8)						
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	21) Tellevision and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -6, 013, 259		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.	7. 0 2	0,010,207		0.00	0	
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-858, 283 0	CAFETERI A	11. 00 0. 00	0	
	and others						
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17. 00			0		0.00	0	17. 00
18. 00	Sale of medical records and		О		0.00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19.00
20. 00	books, etc.) Vending machines		0		0. 00	0	20.00
	Income from imposition of interest, finance or penalty		o		0.00	0	21. 00
22. 00	charges (chapter 21) 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	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	therapy costs in excess of limitation (chapter 14) Utilization review -		O	*** Cost Center Deleted ***	114. 00		25. 00
25.00	physicians' compensation (chapter 21)			JUST GOITER DEFETED	114.00		25.00
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		I	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00	O	30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99

Peri od: From 01/01/2022

				Fr Tc	om 01/01/2022 12/31/2022	Date/Time Pre	
				Expense Classification on		5/26/2023 1: 3	3 pm
				To/From Which the Amount is t	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4.00	Ref. 5.00	
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32.00
33. 00	PHARMACY - MI SCELLANEOUS REVENUE	В	0		0. 00	0	33.00
33. 01	OTHER NON-DEPARTMENTAL -	В	0		0. 00	0	33. 01
33. 02	MI SCELLANEO I NTERCOMPANY REVENUE	В	0		0. 00	0	33. 02
33. 03	ADMINISTRATION MISCELLANEOUS EXPENSE	А	0		0. 00	0	33. 03
33. 04	DONATI ONS	A	0		0. 00	0	33. 04
33. 05 33. 06	INTEREST EXPENSE LOBBYING % OF DUES	A A	0		0. 00 0. 00	0	33. 05 33. 06
33. 07		A	0		0.00	0	33. 07
33. 08 33. 09	ADMINISTRATION - CONSULTING HRH MMO RENTAL INCOME	A B	-10, 967	NEW CAP REL COSTS-BLDG &	0. 00 1. 00	0 10	33. 08 33. 09
33. 10	HRH HUMAN RESOURCES	В	-175. 440	FIXT EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 10
	MI SCELLANEOUS RE	D	·			0	
33. 11 33. 12	HRH OTHER REVENUE SALES TAX HRH OTHER REVENUE	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 11 33. 12
33. 13	MI SCELLANEOUS REVE HRH MED STAFF SERV QA	В	-15 400	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
	APPLICATION FE						
33. 14	HRH MED STAFF SERV MI SCELLANEOUS REV	В	-516	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	HRH MEDICAL DUES MEDICAL STAFF	В	-33, 900	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	HRH PAT FIN. SERV. BUSINESS	В	-1, 240	ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
33. 17		В	-94, 604	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	MI SCELLANEOUS REVE HRH ACCOUNTING MI SCELLANEOUS	В	-71, 377	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	REVENUE HRH ACCOUNTING MANAGEMENT FEES	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20	HRH EXEC ADMIN MISCELLANEOUS	В		ADMINISTRATIVE & GENERAL	5. 00	Ö	
33. 21	REVENUE HRH PURCHASING MISCELLANEOUS	В	-83, 011	ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 22	REVENUE HRH COMMUNI CATIONS	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
	MI SCELLANEOUS REV						
33. 23	HRH COMMUNICATIONS PHONE LEASE REVEN	В	-98, 304	ADMINISTRATIVE & GENERAL	5. 00	0	33. 23
33. 24	HRH COMM EDUCATION EDUCATION SERVICE	В	-1, 094	ADMINISTRATIVE & GENERAL	5. 00	0	33. 24
33. 25	HRH HEALTHY 365 MI SCELLANEOUS	В	-1, 081	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 26		В	9, 342	ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
33. 27	INVENTO HRH PLANT OFFSITE SERVICES	В	-10, 340	OPERATION OF PLANT	7. 00	0	33. 27
33. 28	HRH HOUSEKEEPING ENVIRONMENTAL	В	· ·	HOUSEKEEPI NG	9. 00	0	
33. 29		В	-106, 796	DI ETARY	10. 00	0	33. 29
33. 30	REVENUE HRH NUTRITIONAL SER	В	-1, 940	DI ETARY	10. 00	0	33. 30
33. 31	MI SCELLANEOUS RE	В		DI ETARY	10. 00	0	
	REBATES/REFUNDS						
33. 32	HRH CLINICAL EDUCAT AHA COURSE REVEN	В	-20, 609	NURSING ADMINISTRATION	13. 00	0	33. 32
33. 33		В	0	NURSING ADMINISTRATION	13. 00	0	33. 33
33. 34	HRH OTHER REVENUE	В	-816	CENTRAL SERVICES & SUPPLY	14. 00	0	33. 34
	REBATES/REFUNDS						I

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 HANCOCK REGIONAL HOSPITAL Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/26/2023 1: 33 pm Provi der CCN: 15-0037

COST CENTER DESCRIPTION BBSIS/COde (2) 2.00 3.00 4.00 5.0  BARNED 0 3.00 4.00 5.0  EARNED 0 3.00 4.00 5.0  BARNED 0 3.00 5.0  BARNED 0 3.00 4.00 5.0  BARNED 0 3.00 5.0  BARNED 0 3.00 6.0  BARNED 0 3.00 6.	off. 00 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3	33. 35 33. 36 33. 37 33. 38 33. 39 33. 40 33. 41 33. 42 33. 43
1.00   2.00   3.00   4.00   5.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   5.00   4.00   5.00   5.00   4.00   5.00	off. 00 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3	33. 36 33. 37 33. 38 33. 39 33. 40 33. 41 33. 42 33. 43
1.00   2.00   3.00   4.00   5.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   3.00   4.00   5.00   5.00   4.00   5.00   5.00   4.00   5.00	off. 00 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3	33. 36 33. 37 33. 38 33. 39 33. 40 33. 41 33. 42
Same	0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3	33. 36 33. 37 33. 38 33. 39 33. 40 33. 41 33. 42 33. 43
EARNED 0	O 3 O 3 O 3 O 3 O 3 O 3 O 3 O 3 O 3 O 3	33. 36 33. 37 33. 38 33. 39 33. 40 33. 41 33. 42 33. 43
33.38   HRI PHARMACY REBATES/REFUNDS   B   -550   PHARMACY   15.00	0 3 0 3 0 3 0 3 0 3 0 3 0 3	33. 38 33. 39 33. 40 33. 41 33. 42 33. 43
PHARMACY	0 3 0 3 0 3 0 3 0 3 0 3	33. 40 33. 41 33. 42 33. 43
33.40   HRH ASSOCIATE PHARM PHARMACY   B   -5,537 PHARMACY   15.00	0 3 0 3 0 3 0 3 0 3	33. 41 33. 42 33. 43
Second   S	0 3 0 3 0 3	33. 42 33. 43
RECORDS	0 3 0 3	33. 43
MI SCELLANEOUS RE	0 3	
SCHOO	0 3	33. 44
MI SCELLANEOUS RE		33. 45
33. 47 HRH SURGERY REBATES/REFUNDS B -420 OPERATING ROOM 50.00 33. 48 HRH LAB WATER TESTING B -68, 110 LABORATORY 60.00 33. 49 HRH LAB DIRECT TESTS B -19, 757 LABORATORY 60.00 33. 50 HRH LAB MISCELLANEOUS REVENUE B -450, 603 LABORATORY 60.00 33. 51 HRH WATER LAB WATER TESTING B OLABORATORY 60.00 33. 52 HRH SLEEP STUDY CLINIC B OLABORATORY 65.00  MANAGMENT 65.00  33. 54 HRH SLEEP STUDY SLEEP STUDY B ORESPIRATORY THERAPY 65.00  33. 55 HRH CATH LAB REBATES/REFUNDS B OELECTROCARDIOLOGY 69.00 33. 55 HRH BED ONCOLOGY MISCELLANEOUS B -185, 734 ONCOLOGY 90.07  REVENU	01.3	33. 45
33. 49 HRH LAB DIRECT TESTS  B	- 1	33. 47
33. 50 HRH LAB MI SCELLANEOUS REVENUE B -450, 603 LABORATORY 60. 00 33. 51 HRH WATER LAB WATER TESTING B OLABORATORY 60. 00 33. 52 HRH SLEEP STUDY CLINIC B -45, 468 RESPIRATORY THERAPY 65. 00 MANAGMENT 65. 00  33. 53 HRH SLEEP STUDY SLEEP STUDY B ORESPIRATORY THERAPY 65. 00  33. 54 HRH CATH LAB REBATES/REFUNDS B OELECTROCARDIOLOGY 69. 00 33. 55 HRH MED ONCOLOGY MI SCELLANEOUS B -185, 734 ONCOLOGY 90. 07  33. 56 HRH E R REBATES/REFUNDS B -90 EMERGENCY 91. 00 33. 57 HRH HOSPICE MI SCELLANEOUS B -178, 338 ADULTS & PEDIATRICS 30. 00  REVENUE 33. 58 MOW A -626, 822 DI ETARY 10. 00 33. 59 CAFETERIA GUEST MEALS A -31, 743 CAFETERIA 11. 00 33. 60 PHYSI CI AN RECRUI TMENT FEES A -44, 121 ADMI NI STRATI VE & GENERAL 5. 00 33. 61 DONATI ONS & SPONSORSHI PS A -217, 054 ADMI NI STRATI VE & GENERAL 5. 00 33. 63 ADVERTI SI NG FEE A -64, 127, 460 ADMI NI STRATI VE & GENERAL 5. 00		33. 48
33. 51 HRH WATER LAB WATER TESTING 33. 52 HRH SLEEP STUDY CLINIC 33. 53 HRH SLEEP STUDY SLEEP STUDY FEES 33. 54 HRH CATH LAB REBATES/REFUNDS 33. 55 HRH E CATH LAB REBATES/REFUNDS 33. 56 HRH E R REBATES/REFUNDS 33. 57 HRH HOSPICE MISCELLANEOUS REVENUE 33. 58 MOW 33. 59 CAFETERIA GUEST MEALS 33. 60 PHYSICIAN RECRUITMENT FEES 33. 61 DONATIONS & SPONSORSHIPS A A CALABORATORY  B OLABORATORY 60. 00  A HRH SLEEP STUDY SLEEP STUDY B ORESPIRATORY THERAPY 65. 00  CRESPIRATORY THERAPY 6		33. 49
33. 52 HRH SLEEP STUDY CLINIC B -45, 468 RESPIRATORY THERAPY 65. 00  33. 53 HRH SLEEP STUDY SLEEP STUDY B ORESPIRATORY THERAPY 65. 00  FEES  33. 54 HRH CATH LAB REBATES/REFUNDS B OELECTROCARDIOLOGY 69. 00  33. 55 HRH ED ONCOLOGY MI SCELLANEOUS B -185, 734 ONCOLOGY 90. 07  REVEN  33. 56 HRH E R REBATES/REFUNDS B -90 EMERGENCY 91. 00  33. 57 HRH HOSPICE MI SCELLANEOUS B -178, 338 ADULTS & PEDIATRICS 30. 00  REVENUE 30. 00  30. 58 MOW A -626, 822 DI ETARY 10. 00  31. 59 CAFETERIA GUEST MEALS A -31, 743 CAFETERIA 11. 00  33. 60 PHYSICIAN RECRUITMENT FEES A -44, 121 ADMINISTRATIVE & GENERAL 5. 00  33. 61 DONATIONS & SPONSORSHIPS A -217, 054 ADMINISTRATIVE & GENERAL 5. 00  33. 62 ADVERTISING FEE A 0EMPLOYEE BENEFITS DEPARTMENT 4. 00  33. 63 ADVERTISING FEE A -4, 127, 460 ADMINISTRATIVE & GENERAL 5. 00		33.50
FEES		33. 51 33. 52
33. 55		33. 53
33. 56 HRH E R REBATES/REFUNDS B -90 EMERGENCY 91. 00 33. 57 HRH HOSPI CE MI SCELLANEOUS B -178, 338 ADULTS & PEDI ATRI CS 30. 00 REVENUE 30. 58 MOW A -626, 822 DI ETARY 10. 00 33. 59 CAFETERI A GUEST MEALS A -31, 743 CAFETERI A 11. 00 33. 60 PHYSI CI AN RECRUI TMENT FEES A -44, 121 ADMI NI STRATI VE & GENERAL 5. 00 33. 61 DONATI ONS & SPONSORSHI PS A -217, 054 ADMI NI STRATI VE & GENERAL 5. 00 33. 62 ADVERTI SI NG FEE A 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 33. 63 ADVERTI SI NG FEE A -4, 127, 460 ADMI NI STRATI VE & GENERAL 5. 00		33. 54 33. 55
33. 58 MOW 33. 59 CAFETERIA GUEST MEALS A -626, 822 DI ETARY 10. 00 33. 60 PHYSI CI AN RECRUI TMENT FEES A -44, 121 ADMI NI STRATI VE & GENERAL 5. 00 33. 61 DONATI ONS & SPONSORSHI PS A -217, 054 ADMI NI STRATI VE & GENERAL 5. 00 33. 62 ADVERTI SI NG FEE A 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 33. 63 ADVERTI SI NG FEE A -4, 127, 460 ADMI NI STRATI VE & GENERAL 5. 00		33. 56 33. 57
33.60       PHYSICIAN RECRUITMENT FEES       A       -44, 121 ADMINISTRATIVE & GENERAL       5.00         33.61       DONATIONS & SPONSORSHIPS       A       -217, 054 ADMINISTRATIVE & GENERAL       5.00         33.62       ADVERTISING FEE       A       0 EMPLOYEE BENEFITS DEPARTMENT       4.00         33.63       ADVERTISING FEE       A       -4, 127, 460 ADMINISTRATIVE & GENERAL       5.00		33. 58
33.61       DONATIONS & SPONSORSHIPS       A       -217,054 ADMINISTRATIVE & GENERAL       5.00         33.62       ADVERTISING FEE       A       0 EMPLOYEE BENEFITS DEPARTMENT       4.00         33.63       ADVERTISING FEE       A       -4,127,460 ADMINISTRATIVE & GENERAL       5.00		33. 59
33. 62         ADVERTISING FEE         A         0 EMPLOYEE BENEFITS DEPARTMENT         4.00           33. 63         ADVERTISING FEE         A         -4, 127, 460 ADMINISTRATIVE & GENERAL         5.00		33. 60 33. 61
33. 63   ADVERTISING FEE A -4, 127, 460   ADMINISTRATIVE & GENERAL 5. 00		33. 62
		33. 63
33.64 ADVERTISING FEE A -444,617 ADMINISTRATIVE & GENERAL 5.00	0 3	33. 64
33. 65   ADVERTISING FEE A -2, 402   ADULTS & PEDIATRICS 30. 00		33. 65
33. 66 ADVERTISING FEE A -7, 000 OPERATING ROOM 50. 00		33.66
33. 67   ADVERTI SI NG FEE A -2, 164   RADI OLOGY-DI AGNOSTI C 54. 00   33. 68   ADVERTI SI NG FEE A OWOUND CLI NI C 90. 01		33. 67 33. 68
33. 69 ADVERTISING FEE A OSHELBYVILLE WOUND CLINIC 90. 06		33. 69
33. 70   I HA LOBBYI NG EXPENSE A -3, 924 ADMI NI STRATI VE & GENERAL 5. 00		33. 70
33.71 AHA LOBBYING EXPENSE A -6,829 ADMINISTRATIVE & GENERAL 5.00	0 3	33. 71
33. 72 PHY OFFICE BLDG DEPR EXPENSE A -699, 890 NEW CAP REL COSTS-BLDG & 1.00 FIXT		33. 72
33. 73 PHY OFFICE BLDG A ORADI OLOGY-DI AGNOSTI C 54. 00		33. 73
33. 74 PHY OFFICE BLDG A ORURAL HEALTH CLINIC 88. 00 33. 75 INTEREST INCOME B -4, 707 NEW CAP REL COSTS-BLDG & 1. 00		33. 74 33. 75
33. 76 RENTAL PROPERTIES EXPENSE A -90, 009 NEW CAP REL COSTS-BLDG & 1.00	10 3	33. 76
33. 77 RENTAL PROPERTIES EXPENSE A -250, 035 ADMINISTRATIVE & GENERAL 5. 00		33. 77
33. 78 RENTAL PROPERTIES EXPENSE A -980 OPERATION OF PLANT 7. 00		33. 78
33. 79 TELEPHONE SERVICES A -50, 426 ADMINISTRATIVE & GENERAL 5. 00	0 3	33. 79
33. 80 HAF EXPENSE A -8, 604, 969 ADMINISTRATIVE & GENERAL 5. 00	0 3	33.80
33. 81   SELF INSURANCE CLAIM EXPENSE   A   -6, 279, 740   EMPLOYEE BENEFITS DEPARTMENT   4. 00   33. 82   HHA MISC REVENUE   B   O  ADMINISTRATIVE & GENERAL   5. 00	0 3 0 3 0 3	33. 81
33. 82   HHA MISC REVENUE B OJADMINISTRATIVE & GENERAL 5.00 33. 83   NUTRI TI ONAL SER CAF SALAD B -1, 368   DI ETARY 10.00	0 3 0 3 0 3	
ROBOT	0 3 0 3 0 3 0 3	33. 82 33. 83

					To 12/31/2022	Date/Time Pre 5/26/2023 1:3	
				Expense Classification	on Worksheet A	1.0	<u>Б рііі</u>
				To/From Which the Amount i			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	Amount	Cost center	LITIC #	Ref.	
		1. 00	2. 00	3.00	4.00	5. 00	
33. 84	PLANT MISCELLANEOUS REVENUE	B		OPERATION OF PLANT	7.00	0.00	33. 84
33. 85	PAT FIN SERV EXPENSE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33.85
33. 03	I and the second	D	-03, 332	ADMINISTRATIVE & GENERAL	3.00	U	33. 65
22.07	REI MBURSEMENT	В	1 207	ADMINISTRATIVE & CENEDAL	F 00	0	33. 86
33. 86	PURCHASING REBATES AND REFUNDS	В		ADMINISTRATIVE & GENERAL	5. 00	_	
33. 87	HIFI MISCELLANEOUS REVENUE			ADMINISTRATIVE & GENERAL	5. 00	0	33.87
33. 88	COMM EDUCATION MISCELLANEOUS	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 88
	REVENUE	_	_			_	
33. 89	ADVERTISING FEE	В		ANDIS CLINIC	90. 04	0	33.89
33. 90	ADVERTISING FEE	В		ANDERSON WOMENS CENTER	90. 08	0	33. 90
33. 91	HRH ACCT ACCRUALS	В	-368, 937	ADMINISTRATIVE & GENERAL	5. 00	0	33. 91
	MI SCELLANEOUS REVE						
33. 92	HRH NURSING ADMIN	В	-516	NURSING ADMINISTRATION	13. 00	0	33. 92
	MI SCELLANEOUS REVE						
33. 93	HRH PHYSICAL THER	В	-60	PHYSI CAL THERAPY	66. 00	0	33. 93
	MI SCELLANEOUS REVE						
33. 94	HRH GATEWAY PROP MISCELLANEOUS	В	-1, 004	ADMINISTRATIVE & GENERAL	5. 00	0	33. 94
	REVEN		·				
33. 95	HRH MC CORDSVILLE P RENTAL	В	-150	ADMINISTRATIVE & GENERAL	5. 00	0	33. 95
	INCOME						
33. 96	HRH IMMED CARE RAD RENTAL	В	-3, 615	PRIME TIME	90. 05	0	33. 96
	INCOME						
33. 97	HRH VACCINE CLINIC CLINIC	В	-547 375	PHARMACY	15. 00	0	33. 97
00. 77	MANAGMENT	5	0177070		10.00	ŭ	00.77
33. 98	HRH PAT FIN. SERV.	Α	-28	ADMINISTRATIVE & GENERAL	5. 00	0	33. 98
00.70	MI SCELLANEOUS REV	• •			0.00	ŭ	00.70
33. 99	HRH 3N MI SCELLANEOUS REVENUE	Α	0	ADULTS & PEDIATRICS	30.00	0	33. 99
34. 00	HRH ANDIS UNIT MISCELLANEOUS	В		ADULTS & PEDIATRICS	30.00	0	34.00
34.00	REVENUE	ь	-200	ADDETS & TEDIATRICS	30.00	O	34.00
34. 01	HRH X-RAY SCHOOL STUDENT	В	1 176	PARAMED ED PRGM	23. 00	0	34. 01
34.01	ACTIVITIES	ь	1, 170	FARAINED ED FROM	23.00	U	34.01
34. 02	1	В	720	PARAMED ED PRGM	23. 00	0	34. 02
34. 02	HRH X-RAY SCHOOL MISCELLANEOUS	ь	-720	PARAWED ED PKGW	23.00	Ü	34.02
24.02	1	Б	2 250	DECDI DATODY THEDADY	/F 00	0	24 02
34. 03	HRH SLEEP STUDY MI SCELLANEOUS	В	-2, 250	RESPI RATORY THERAPY	65. 00	0	34. 03
EO 00	REVENU		22 /7/ 474				E0 00
50. 00	TOTAL (sum of lines 1 thru 49)		-32, 676, 174				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)			1			<u> </u>
(1) De	scription - all chapter referer	ces in this co	lumn pertain t	o CMS Pub. 15-1.			

<sup>(1)</sup> 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.

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

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

Peri od: Worksheet A-8-2 From 01/01/2022 To 12/31/2022 Date/Time Prepared: Provi der CCN: 15-0037

					1	Γο 12/31/2022	Date/Time Pre 5/26/2023 1:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	IIIKSt. 7 EI IIO #	I denti fi er	Remuneration	Component	Component	NOL /IIIIOUTT	ider Component	
		1 40.111 11 01	- Komarior a cr orr	00porrorre	oomponone.		Hours	
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	537, 995	537, 995	0	0	0	1. 00
2.00	30.00	ADULTS & PEDIATRICS	733, 542	733, 542	0	0	0	2.00
3.00	50.00	OPERATING ROOM	2, 623, 421	2, 623, 421	0	0	0	3.00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	701, 555	701, 555	0	0	0	4.00
5.00	60.00	LABORATORY	125, 000	96, 250	28, 750	211, 500	482	5.00
6.00	90. 01	WOUND CLINIC	304, 218	304, 218	0	0	0	6.00
7.00	90. 07	ONCOLOGY	836, 378	836, 378	0	0	0	7. 00
8.00	90. 08	ANDERSON WOMENS CENTER	84, 900	84, 900	0	0	0	8. 00
9.00		EMERGENCY	95, 000	95, 000	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			6, 042, 009		28, 750			200.00
	Wkst. A Line #	J	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	0	0		0	0	1.00
2.00		ADULTS & PEDIATRICS	0	0			0	2.00
3.00		OPERATING ROOM	0	0	0	0	0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	40.011	0	0	0	0	4.00
5.00		LABORATORY	49, 011	2, 451	0	0	0	5.00
6.00		WOUND CLINIC	0	0	0	0	0	6.00
7.00		ONCOLOGY	0	0	0	0	0	7.00
8.00		ANDERSON WOMENS CENTER	0	0	0	0	0	8. 00
9.00	•	EMERGENCY	0	0	0	0	0	9.00
10.00	0. 00		40.011	2 451	0	0	0	10.00
200.00	Wkst. A Line #	Cost Center/Physician	49, 011 Provi der	2, 451 Adjusted RCE	RCE	Adjustment	0	200. 00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Aujustillerrt		
		ruentiffei	Share of col.	Limit	Di Sai i Owance			
			14					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00	5. 00	ADMINISTRATIVE & GENERAL	0	0		537, 995		1. 00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	733, 542		2. 00
3.00		OPERATING ROOM	0	0	0	2, 623, 421		3. 00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	701, 555		4.00
5.00	60.00	LABORATORY	l 0	49, 011	0	96, 250		5. 00
6.00		WOUND CLINIC	0	0	0	304, 218		6. 00
7.00	90. 07	ONCOLOGY	l 0	0	0	836, 378		7. 00
8. 00		ANDERSON WOMENS CENTER	0	0	0	84, 900		8. 00
9. 00		EMERGENCY	0	0	0	95, 000		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	49, 011	0	6, 013, 259		200.00
	•	•	•		•			•

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0037

					То	12/31/2022	Date/Time Pre 5/26/2023 1:3	
				CAPI TAL			1 37 207 2023 1.3	3 piii
				RELATED COSTS				
		Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
			for Cost	FLXT	BENEFITS		E & GENERAL	
			Allocation (from Wkst A		DEPARTMENT			
			col. 7)					
			0	1. 00	4. 00	4A	5. 00	
		AL SERVICE COST CENTERS						
1. 00		NEW CAP REL COSTS-BLDG & FIXT	17, 030, 470	17, 030, 470				1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	5, 018, 629	87, 569		22 05/ 745	22 05/ 745	4.00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	21, 628, 264 7, 931, 307	1, 456, 727 6, 619, 052	771, 754 98, 940	23, 856, 745 14, 649, 299	23, 856, 745 2, 663, 140	5. 00 7. 00
9. 00		HOUSEKEEPI NG	2, 742, 416	35, 999		2, 930, 268	532, 702	9.00
10.00		DI ETARY	588, 373	333, 871	51, 510	973, 754	177, 022	10.00
11.00	01100	CAFETERI A	974, 503	0	76, 887	1, 051, 390	191, 135	11. 00
13.00		NURSING ADMINISTRATION	2, 030, 656	17, 340		2, 174, 163	395, 248	13.00
14.00		CENTRAL SERVICES & SUPPLY	407, 938	133, 729	24, 907	566, 574	102, 999	14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	1, 838, 216 947, 193	260, 625 63, 986		2, 308, 908 1, 060, 805	419, 743 192, 847	15. 00 16. 00
23. 00		PARAMED ED PRGM	63, 722	32, 912		103, 597	18, 833	
20.00		IENT ROUTINE SERVICE COST CENTERS	007.22	02/ 7.2	0,700	100,077	107 000	20.00
30.00		ADULTS & PEDIATRICS	5, 645, 103	1, 073, 402	349, 529	7, 068, 034	1, 284, 919	30. 00
31. 00		INTENSIVE CARE UNIT	6, 650, 990	791, 899		7, 769, 796	1, 412, 495	31.00
40. 00		SUBPROVI DER - I PF	0	0	0	0	0	40. 00
50. 00		LARY SERVICE COST CENTERS  OPERATING ROOM	5, 455, 221	455, 600	343, 569	6, 254, 390	1, 137, 004	50.00
51. 00	1	RECOVERY ROOM	686, 759	120, 481	46, 979	854, 219	155, 291	51.00
53.00		ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	5, 650, 808	887, 167	348, 266	6, 886, 241	1, 251, 870	•
60.00		LABORATORY RESPI RATORY THERAPY	5, 372, 078	188, 177	154, 297	5, 714, 552 2, 590, 798	1, 038, 866	60.00
65. 00 66. 00	1	PHYSICAL THERAPY	2, 248, 456 1, 539, 475	196, 223 167, 750	146, 119 101, 559	2, 590, 798 1, 808, 784	470, 989 328, 824	65. 00 66. 00
67. 00		OCCUPATIONAL THERAPY	401, 535	107, 730	28, 269	429, 804	78, 135	67.00
68. 00		SPEECH PATHOLOGY	219, 779	0	15, 112	234, 891	42, 702	
69. 00		ELECTROCARDI OLOGY	892, 771	160, 329	46, 494	1, 099, 594	199, 898	69. 00
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	3, 476, 857 1, 728, 469	0	0	3, 476, 857 1, 728, 469	632, 068 314, 224	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	20, 487, 386	0		20, 487, 386	3, 724, 420	
76.00		CARDI AC	0	0	О	0	0	76. 00
76. 01		CARDI OPULMONARY	80, 934	43, 247	5, 173	129, 354	23, 516	•
77. 00		ALLOGENEIC STEM CELL ACQUISITION TIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
88. 00		RURAL HEALTH CLINIC	523, 502	0	22, 236	545, 738	99, 211	88. 00
90.00		CLINIC	0	0	0	0	0	90.00
90. 01		WOUND CLINIC	619, 014	116, 215	35, 048	770, 277	140, 031	90. 01
90. 02	1	DI ABETES CLI NI C	59, 432	0	3, 511	62, 943	11, 443	90.02
90. 03 90. 04		ASTHMA CLINIC ANDIS CLINIC	0 141, 066	0 16, 577	7, 579	0 165, 222	0 30, 036	90. 03 90. 04
		PRIME TIME	4, 285	10, 577	7,379	4, 285		90.04
		SHELBYVILLE WOUND CLINIC	0	Ō	Ö	0	0	
		ONCOLOGY	1, 693, 821	511, 783	205, 729	2, 411, 333	438, 363	
		ANDERSON WOMENS CENTER	589, 764	145, 104		770, 686	140, 105	•
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	6, 219, 699	545, 631	217, 002	6, 982, 332 0	1, 269, 339	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS						72.00
101.00		HOME HEALTH AGENCY	0	0	0	0		101. 00
102.00		OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
114 00		AL PURPOSE COST CENTERS	0	0	0	0	0	116. 00
118.00		HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	131, 588, 891	0 14, 461, 395		0 127, 921, 488		
110.00		IMBURSABLE COST CENTERS	131, 300, 071	14, 401, 373	4,007,070	127, 721, 400	10, 710, 177	1110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		PROFESSIONAL BUILDING	264, 118	945, 257		1, 209, 375		
	1	PHYSI CI AN BUI LDI NG	729, 029	15 500	0	729, 029	132, 532	
		PRI VATE DUTY MARKETI NG	1, 159, 555 928, 763	15, 502 0	21, 511 13, 005	1, 196, 568 941, 768	217, 528 171, 207	
		SPORTS PHYSICALS	347, 895	0	23, 872	371, 767	67, 585	•
	1	FOUNDATI ON	1, 040, 129	66, 968		1, 125, 704	204, 645	190. 06
190.07			2, 323	782, 292		784, 615	142, 638	
		GATEWAY LOCATION	4, 798, 335 6, 306, 036	226 152		5, 066, 134	920, 988	
		HANCOCK OB HANCOCK WELLNESS	6, 306, 026 1, 170, 555	226, 153 6, 589		6, 870, 284 1, 245, 222	1, 248, 970 226, 373	
190. 11	19011	MORRISTOWN CLINIC	1, 170, 333	0, 307	00,070	1, 243, 222		190. 10
190. 12	19012	O3PUREMED	О	0	0	0		190. 12
190. 13	19013	MCCORD WELLNESS	1, 366, 352	0	68, 396	1, 434, 748	260, 827	190. 13

					5/26/2023 1: 3	
		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	for Cost	FLXT	BENEFI TS		E & GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1. 00	4. 00	4A	5. 00	
190. 14 19014 3 WEST UNIT	444, 462	428, 896	15, 881	889, 239	161, 657	
190. 15 19015 NEUROLOGY PHYSI CLAN	1, 534, 534	64, 021	95, 387	1, 693, 942	307, 947	190. 15
190. 16 19016 THORACI	91, 680	0	5, 919	97, 599	17, 743	190. 16
190. 17 19017 HANCOCK ENDO	1, 170, 587	0	63, 260	1, 233, 847	224, 305	190. 17
190. 18 19018 HANCOCK FOOT & ANKLE	0	0	0	0	0	190. 18
190. 19 19019 HANCOCK RHEUM	91, 079	0	4, 697	95, 776	17, 411	190. 19
194. 00 07950 OTHER NONREI MBURSABLE	747	0	24	771	140	194.00
194. 01 07951 SUBURBAN HOSPI CE	107, 821	33, 397	7, 197	148, 415	26, 981	194. 01
194. 02 07952 HRH HANCOCK GI	944, 745	0	58, 751	1, 003, 496	182, 429	194. 02
194. 03 07954 HRH NEPHROLOGY	288, 528	0	12, 014	300, 542	54, 636	194. 03
194. 04 07957 HRH SANE	167, 223	0	7, 965	175, 188	31, 848	194.04
194. 05 07955 HRH RI SE	379, 942	o	0	379, 942	69, 071	194. 05
194.06 07956 HRH JUSTICE NAVIGATION	163, 937	o	7, 860	171, 797	31, 231	194. 06
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	155, 087, 256	17, 030, 470	5, 106, 198	155, 087, 256	23, 856, 745	202.00

Provider CCN: 15-0037

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

			1	o 12/31/2022	Date/lime Pre   5/26/2023 1:3	
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMINISTRATIO N	
	7. 00	9. 00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS						1 00
1.00   OO100   NEW CAP REL COSTS-BLDG & FIXT   4.00   OO400   EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00   00700 OPERATION OF PLANT	17, 312, 439					7. 00
9. 00   00900   HOUSEKEEPI NG	79, 030	3, 542, 000				9.00
10. 00   01000   DI ETARY	732, 966	61, 675	1, 945, 417	4 044 457		10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	0	101, 632	0	.,,	2, 614, 155	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	293, 582	154, 164	0	44, 744 13, 660		14.00
15. 00 01500 PHARMACY	572, 165	112, 453	0	87, 539		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	140, 472	135, 265	0	40, 845	101, 438	16.00
23. 00 02300 PARAMED ED PRGM	72, 253	155, 813	0	3, 020	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	2 254 400	1 022 7/2	775 540	157 500	388, 858	20.00
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT	2, 356, 499 1, 738, 500	1, 033, 762 213, 124	775, 568 1, 160, 540		385, 616	30. 00 31. 00
40. 00   04000   SUBPROVI DER -   PF	0	213, 124	1, 100, 340	0	0	40.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	1, 000, 205	413, 806	0	95, 662	237, 573	50.00
51. 00   05100   RECOVERY ROOM	264, 498	152, 373	0	17, 185	42, 678	51.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 947, 647	151, 477	0	147, 971	0 367, 481	53. 00 54. 00
60. 00 06000 LABORATORY	413, 116	144, 549	Ö	· ·	251, 150	60.00
65. 00 06500 RESPIRATORY THERAPY	430, 780	110, 710	0	76, 330	189, 564	65.00
66. 00   06600   PHYSI CAL THERAPY	368, 272	128, 666	0	,	113, 992	66.00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	0	0	15, 192	0	67.00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	351, 979	250, 876	0	7, 103 22, 499	0	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	250, 070	Ö	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00   03020   CARDI AC 76. 01   03160   CARDI OPULMONARY	94, 942	0	0	4, 010	0	76. 00 76. 01
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	Ö	0		ő	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RURAL   HEALTH   CLI NI C	0	0	0	0	0	88.00
90. 00   09000   CLINIC 90. 01   09001   WOUND   CLINIC	0 255, 133	0	0	18, 046	0	90. 00 90. 01
90. 02   09002 DI ABETES CLINIC	255, 155	0	0	1, 902	0	90.01
90. 03   09003   ASTHMA   CLI NI C	0	o	0	· ·	ő	90.03
90. 04   09004   ANDIS CLINIC	341, 396	o	0	4, 045	0	90. 04
90. 05   09005   PRI ME   TI ME	0	0	0	0	0	90.05
90. 06   09006   SHELBYVI LLE WOUND CLINIC 90. 07   04951   ONCOLOGY	1 122 544	0	0	93 71, 464	0	90. 06 90. 07
90. 07   04951 ONCOLOGY 90. 08   04950   ANDERSON WOMENS CENTER	1, 123, 546 6, 776	221, 655	0	18, 859	0	90.07
91. 00   09100   EMERGENCY	1, 197, 855	0	0	95, 069		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				·		92.00
OTHER REIMBURSABLE COST CENTERS	_1	_1		_		
101.00 10100 HOME HEALTH AGENCY 102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0			101. 00 102. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u>U</u>	0	0	0	102.00
116. 00 11600 HOSPI CE	0	0	0		0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 781, 612	3, 542, 000	1, 936, 108	1, 244, 121	2, 565, 773	118.00
NONREI MBURSABLE COST CENTERS		ما		I		1.00.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 PROFESSI ONAL BUILDING	0	0	0	0		190. 00 190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	0	0	0		190.01
190. 03 19003 PRI VATE DUTY	Ö	Ö	0	19, 482		
190. 04 19004 MARKETI NG	0	0	0	5, 899	0	190. 04
190. 05 19005 SPORTS PHYSI CALS	0	0	0	0		190. 05
190. 06 19006 FOUNDATI ON	147, 019	0	0	9, 059		190.06
190. 07 19007 ASC 190. 08 19008 GATEWAY LOCATION	1, 717, 410 0	0	0	0		190. 07 190. 08
190. 09 19009 HANCOCK OB	496, 486	Ö	0	41, 167		190.09
190. 10 19010 HANCOCK WELLNESS	14, 466	ő	Ö	0		190. 10
190. 11 19011 MORRI STOWN CLINIC	0	o	0	0		190. 11
190. 12 19012 03PUREMED	0	0	0	0		190. 12
190. 13 19013 MCCORD WELLNESS 190. 14 19014 3 WEST UNIT	0  941, 579	0	0	0 7, 375		190. 13 190. 14
190. 14 19014 3 WEST UNIT 190. 15 19015 NEUROLOGY PHYSI CLAN	140, 548	O O	0	4, 240		190. 14
190. 16 19016 THORACI	0	ő	Ö	0		190. 16
190. 17 19017 HANCOCK ENDO	0	0	0	5, 983		190. 17

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0037
From 01/01/2022
To 12/31/2022 Date/Time Prepared:

Part I Date/Time Prepared: 5/26/2023 1:33 pm OPERATION OF HOUSEKEEPING CAFETERI A Cost Center Description DI ETARY NURSI NG PLANT ADMI NI STRATI O 13.00 7. 00 9.00 10.00 11.00 190. 18 19018 HANCOCK FOOT & ANKLE 0 190. 18 0 0 0 190. 19 19019 HANCOCK RHEUM 0 190. 19 0 0 0 194.00 07950 OTHER NONREI MBURSABLE 0 194.00 0 26 194. 01 07951 SUBURBAN HOSPI CE 194. 02 07952 HRH HANCOCK GI 0 194. 01 2, 890 73, 319 9, 309 0 0 194. 02 0 0 3, 915 194. 03 07954 HRH NEPHROLOGY 0 0 0 194. 03 194. 04 07957 HRH SANE 194. 05 07955 HRH RI SE 0 0 0 0 0 194.04 0 0 0 194. 05 0 194.06 07956 HRH JUSTICE NAVIGATION o 0 194.06 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 0 TOTAL (sum lines 118 through 201) 1, 945, 417 2, 614, 155 202. 00 202.00 17, 312, 439 3, 542, 000 1, 344, 157

Provider CCN: 15-0037

| Peri od: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared:

CONTROL   SENTICE   DEPTITED				То	12/31/2022	Date/Time Pre 5/26/2023 1:3	
SUPPLY	Cost Center Description		PHARMACY				<b>-</b>
Figure   Separate   Construction   14.00   19.00   16.00   23.90   24.00					PRGM		
1.00   00000   ADMINISTRATION   CONTROL SERVICE   CONTROL SERVIC			15. 00		23. 00	24.00	
0.00   0.0000   DUNCH SERRENT IS DEPARTEMEN					T		1 1 00
2,00							
9.00   00900   DUSENCER INS	· · · · · · · · · · · · · · · · · · ·						1
10.00   DIDOG METARY							
11.00   01100   CAFTERIA	1 1						1
13.00   1300 NURS INC ADMINISTRATION     1,164,903   1,671,672							•
14.00							•
16.00   16.00   MEDICAL RECORDS & LIBRARY   0   0   1.671,70   253,916   23.00   233		1, 164, 903					
23.00		1	3, 718, 207				•
IMPATTENT ROUTINE SERVICE COST CENTERS   0		1			252 547		•
0.000   0.0000   JUNETES IVE CASE UNIT   0   13, 577, 699   0.0   0   0.0000   JUNES IVE CASE UNIT   0   12, 893, 216   31, 00   0.0000   JUNES IVE COST CENTERS   0   0   0   0   0   0   0   0   0		l o	U <sub>I</sub>	U	353, 510		23.00
0.000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		0	0	463, 479	0	13, 527, 699	30.00
ANCILLARY SERVICE COST CENTERS 5.0.00 605000 (PRATINE RODOM 0 0 0 0 0 0 1,486,244 51.00 5.1.00 61000 (PRATINE RODOM 0 0 0 0 0 1,486,244 51.00 5.1.00 61000 (PRATINE RODOM 0 0 0 0 0 0 1,486,244 51.00 5.1.00 61000 (PRATINE RODOM 0 0 0 0 0 1,486,244 51.00 5.1.00 61000 (PRATINE RODOM 0 0 0 0 0 0 1,486,244 51.00 66.00 66.00 66.00 (PRATINE RODOM 0 0 0 0 0 0 0 0 1,776,846 66.00 66.00 66.00 (PRATINE RODOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·	О	57, 871	0	12, 893, 216	31.00
50.00		0	0	0	0	0	40. 00
51 CO   05100   RECOVERY ROOM   0   0   0   0   0   1   4.66, 244   51.00   51.00   53.00   05300   MESTHESI OLOGY   0   0   0   0   0   0   0   0   53.3   10   11, 175, 750   54.00   0   0500   RADI DLOGY-DI AGNOSTI C   0   0   0   0   0   0   0   0   0			٥	600 174	ol	0 7/7 01/	50.00
13.00   0.3300   AMESTHESIOLOGY   0   0   0   0   0   5.5   0.0		1			0		
60.00	· · · · · · · · · · · · · · · · · · ·	- 1	Ö	O	o		
65.00		0	0		353, 516		
66.00   06600 PHYSICAL THERAPY   0 0 0 0 0 2,794,438   66.00 0 0 0 0 0 0 0 0 0 1 253,131   67.00 0 6700   0600 OCUPATIONAL THERAPY   0 0 0 0 0 0 0 1 254,696   68.00 0 0600 DECETROCRAPHY   0 0 0 0 0 0 0 1,294,896   69.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	+ I	0	0	154, 324	0		•
67.00	+ I		0	0	0		1
68.00   066000   SPECEH PATHOLOGY	1 1		o	0	o		1
170 00   07000   ETECTROENCEPHALOGRAPHY   0   0   0   0   0   70 0   70 00   71 00   07100   MEDICALS UDPLIES CHARGED TO PATIENTS   1, 164, 903   0   79, 192   0   5, 533, 020 71 07	• • • • • • • • • • • • • • • • • • •	o	O	0	O		1
17.1 0.0		0	0	0	0		1
17.2 O   07.200   IMPC   DEV. CHARGED TO PATIENT   0	· · · · · · · · · · · · · · · · · · ·	1 164 003	0	70, 103	0		1
13.00   O7300   DRUSS CHARGED TO PATIENTS			0	79, 192	0		1
17.0   03160  CARDI OPULMONARY   0   0   0   0   0   0   0   0   0	· · · · · · · · · · · · · · · · · · ·	١	3, 718, 207	O	ő		1
177.00	76. 00   03020   CARDI AC	o	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS		1		-	0		
88.00   08B00 RURAL HEALTH CLINIC		0	U	U	U	0	77.00
90.01   09001   WOUND CLINIC   0   0   0   1,183,487   90.01   90.02   09002   DIABETES CLINIC   0   0   0   0   0   76,288   90.02   90.03   09003   ASTHMA CLINIC   0   0   0   0   0   0   0   0   0   90.04   09004   ANDIS CLINIC   0   0   0   0   0   0   0   0   0   90.05   09005   PRI ME TIME   0   0   0   0   0   0   0   5,064   90.05   90.06   09005   PRI ME TIME   0   0   0   0   0   0   0   0   0		0	0	0	0	644, 949	88. 00
90. 02   09002   01ABETES CLINIC   0   0   0   76, 288   90. 02   90. 03   09003   ASTHMA CLINIC   0   0   0   0   0   0   0   0   0		O	0	0	0	0	90.00
90.03   09003   ASTHMA CLINIC		0	0	0	0		ł
90. 04   99.004   ADDIS CLINIC   0   0   0   0   540, 699   90. 04   90. 05   O9005   PRIME TIME   0   0   0   0   0   5,064   90. 05   90. 06   O9006   SHELBYVI LLE WOUND CLINIC   0   0   0   0   0   0   93   90. 06   90. 07   04951   ONCOLOGY   0   0   0   0   0   0   4,044,706   90. 07   90. 08   04950   ANDERSON WOMENS CENTER   0   0   0   0   0   1,158,081   90. 08   91. 00   O9200   EMERGENCY   0   0   0   238,085   0   10,018,780   91. 00   92. 00   O9200   DESERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   00   O9200   ODSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0		0	0	0	0		•
90.05   09005   PRIME TIME	· · · · · · · · · · · · · · · · · · ·		0	0	0		•
90. 07   0.4951   0.NOLOLOGY		o	Ö	O	o	•	•
90. 08   04950   ANDERSON WOMENS CENTER   0   0   0   0   1, 158, 081   90. 08   91. 00   99200   BERRECNCY   0   0   0   238, 085   0   10, 018, 780   91. 00   92. 00   99200   OSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0		0	0	0	0		
91.00   09100	· · · · · · · · · · · · · · · · · · ·	0	0	0	0		•
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   101. 00			0	J	0		
OTHER REIMBURSABLE COST CENTERS   0			١	200, 000		.0,0.0,700	
102. 00   10200   OPI OI D TREATMENT PROGRAM   O   O   O   O   O   102. 00	OTHER REIMBURSABLE COST CENTERS						
116. 00   11600   HOSPI CE		1	•		- 1		
116. 00		j Uj	U	U	U <sub>I</sub>	0	102.00
NONREI MBURSABLE COST CENTERS   190.00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0		0	0	0	0	0	116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 01 1900. 01 1900. 01 1900. 01 1900. 01 1900. 01 1900. 01 1900. 01 1900. 02 1900. 02 1900. 02 1900. 02 1900. 02 1900. 02 1900. 02 1900. 02 1900. 03 1900. 03 1900. 03 1900. 03 1900. 03 1900. 03 1900. 04 1900. 04 1900. 04 1900. 04 1900. 04 1900. 05 1900. 05 1900. 05 1900. 05 1900. 05 1900. 05 1900. 05 1900. 05 1900. 06 1900. 06 1900. 06 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 07 1900. 08 1900. 08 1900. 08 1900. 08 1900. 08 1900. 08 1900. 08 1900. 08 1900. 08 1900. 09		1, 164, 903	3, 718, 207	1, 671, 672	353, 516	119, 294, 386	118. 00
190. 01 19001 PROFESSI ONAL BUI LDI NG 190. 02 19002 PHYSI CI AN BUI LDI NG 190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 0 0 0 0 1, 481, 961 190. 02 190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS 0 0 0 0 1, 118, 874 190. 04 190. 06 19006 FOUNDATI ON 190. 07 19007 ASC 0 0 0 0 0 0 1, 486, 427 190. 06 190. 08 19008 GATEWAY LOCATI ON 190. 09 19009 HANCOCK OB 190. 01 19010 HANCOCK WELLNESS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			٥	0		0	100 00
190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 0 0 0 0 0 1, 481, 960 190. 03 190. 04 19004 MARKETI NG 0 0 0 0 0 1, 118, 874 190. 04 190. 05 19005 SPORTS PHYSI CALS 0 0 0 0 0 1, 486, 427 190. 05 190. 06 19006 FOUNDATI ON 0 0 0 0 0 1, 486, 427 190. 06 190. 07 19007 ASC 0 0 0 0 0 0 2, 644, 663 190. 07 190. 08 19008 GATEWAY LOCATI ON 0 0 0 0 0 8, 656, 907 190. 08 190. 09 19009 HANCOCK OB 0 0 0 0 0 8, 656, 907 190. 09 190. 10 19010 HANCOCK WELLNESS 0 0 0 0 0 0 0 1, 486, 061 190. 10 190. 11 19011 MORRI STOWN CLI NI C 0 0 0 0 0 0 0 1, 695, 575 190. 13 190. 13 19013 MCCORD WELLNESS 0 0 0 0 0 0 1, 695, 575 190. 13 190. 14 19014 3 WEST UNI T 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 0 0 0 15, 342 190. 15 190. 16 19016 THORACI		- 1	0	0	0		
190. 04 19004 MARKETING 190. 05 19005 SPORTS PHYSICALS 0 0 0 0 0 439, 352 190. 05 190. 06 19006 FOUNDATION 0 0 0 0 0 1, 486, 427 190. 06 190. 07 19007 ASC 0 0 0 0 0 0 0 2, 644, 663 190. 07 190. 08 19008 GATEWAY LOCATION 0 0 0 0 0 5, 987, 122 190. 08 190. 09 19009 HANCOCK OB 0 0 0 0 0 5, 987, 122 190. 08 190. 10 19010 HANCOCK WELLNESS 0 0 0 0 0 0 1, 486, 061 190. 10 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 0 0 0 190. 11 190. 12 19012 O3PUREMED 0 0 0 0 0 0 1, 695, 575 190. 13 190. 14 19014 3 WEST UNIT 190. 15 19015 NEUROLOGY PHYSICIAN 0 0 0 0 0 0 15, 987, 122 190. 15 190. 16 19016 THORACI		l o	o	Ö	ő		
190. 05 19005 SPORTS PHYSI CALS 190. 06 19006 FOUNDATI ON 190. 07 19007 ASC 190. 08 19008 GATEWAY LOCATI ON 190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS 190. 10 19010 MANCOCK WELLNESS 190. 11 19011 O3PUREMED 190. 12 19012 O3PUREMED 190. 13 19013 MCCORD WELLNESS 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 190. 15 19015 NEUROLOGY PHYSI CI AN 190. 16 19016 THORACI 190. 16 19016 THORACI 190. 16 19016 THORACI 190. 16 19016 THORACI 190. 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		o	0	0	0	1, 481, 960	190. 03
190. 06   19006   FOUNDATION		0	0	0	0		
190. 07   19007   ASC		0	0	0	0		
190. 08   19008   GATEWAY LOCATION		0	0	0	ol Ol		
190. 10   19010   HANCOCK WELLNESS	190.08 19008 GATEWAY LOCATION	o o	ő	ő	ő		
190. 11 19011 MORRISTOWN CLINIC 0 0 0 0 0 190. 11 190. 12 19012 03PUREMED 0 0 0 0 0 190. 12 190. 13 19013 MCCORD WELLNESS 0 0 0 0 0 1, 695, 575 190. 13 190. 14 19014 3 WEST UNIT 0 0 0 0 0 1, 999, 850 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 0 0 2, 146, 677 190. 15 190. 16 19016 THORACI 0 0 0 0 0 115, 342 190. 16		0	О	0	o		
190. 12   19012   03PUREMED     0     0     0     0     190. 12       190. 13   19013   MCCORD WELLNESS     0     0     0     0     1, 695, 575   190. 13       190. 14   19014   3   WEST UNI T     0     0     0     0     1, 999, 850   190. 14       190. 15   19015   NEUROLOGY PHYSI CI AN     0     0     0     0     2, 146, 677   190. 15       190. 16   19016   THORACI     0     0     0     0     115, 342   190. 16		0	O	0	0		
190. 13 19013 MCCORD WELLNESS 0 0 0 0 1, 695, 575 190. 13 190. 14 19014 3 WEST UNIT 0 0 0 0 1, 999, 850 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 0 0 2, 146, 677 190. 15 190. 16 19016 THORACI 0 0 0 0 0 115, 342 190. 16	· · · · · · · · · · · · · · · · · · ·	0	0	0	0		
190. 14 19014 3 WEST UNIT 0 0 0 1, 999, 850 190. 14 190. 15 19015 NEUROLOGY PHYSI CI AN 0 0 0 0 2, 146, 677 190. 15 190. 16 19016 THORACI 0 0 0 0 0 115, 342 190. 16		0	0	0	ol ol		•
190. 16 19016 THORACI 0 0 0 0 115, 342 190. 16		0	o	o	o	1, 999, 850	190. 14
		0	o	0	o		
170. 1/  1701 /  IMMICOCK ENDO   U  U  U  0 U  1,464, 135   190. 17		- 1	0	-	0		
	170. 17 17017 IIMNCOOK LINDO	<u>ı</u>	- U	U <sub>I</sub>	U <sub>I</sub>	1, 404, 135	1170.17

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0037
From 01/01/2022
To 12/31/2022 Date/Time Prepared:

			''	0 12/31/2022	5/26/2023 1: 3	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
	SERVICES &		RECORDS &	PRGM		
	SUPPLY		LI BRARY			
	14. 00	15. 00	16.00	23. 00	24.00	
190. 18 19018 HANCOCK FOOT & ANKLE	0	0	0	0	0	190. 18
190. 19 19019 HANCOCK RHEUM	0	0	0	0	113, 187	190. 19
194. 00 07950 OTHER NONREI MBURSABLE	0	0	0	0	937	194. 00
194. 01 07951 SUBURBAN HOSPI CE	0	0	0	0	260, 914	194. 01
194. 02 07952 HRH HANCOCK GI	0	0	0	0	1, 189, 840	194. 02
194. 03 07954 HRH NEPHROLOGY	0	0	0	0	355, 178	194. 03
194. 04 07957 HRH SANE	0	0	0	0	207, 036	194.04
194. 05 07955 HRH RI SE	0	0	0	0	449, 013	194. 05
194.06 07956 HRH JUSTICE NAVIGATION	0	0	0	0	203, 028	194.06
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00   TOTAL (sum lines 118 through 201)	1, 164, 903	3, 718, 207	1, 671, 672	353, 516	155, 087, 256	202. 00

HANCOCK REGIONAL HOSPITAL

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: 5/26/2023 1:33 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0037

			5/26/2023 1: 3	3 pm
Cost Center Description	Intern &	Total		
	Resi dents			
	Cost & Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	İ			4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	1			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
• • • • • • • • • • • • • • • • • • •	•			1
				13.00
14. 00   01400   CENTRAL SERVICES & SUPPLY				14.00
15. 00   01500   PHARMACY				15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY				16.00
23. 00   02300   PARAMED ED   PRGM				23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00  03000  ADULTS & PEDI ATRI CS	0	13, 527, 699		30.00
31.00  03100 INTENSIVE CARE UNIT	0	12, 893, 216		31.00
40. 00   04000   SUBPROVI DER - 1 PF	0	0		40.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	9, 747, 814		50.00
51.00   05100   RECOVERY   ROOM	0	1, 486, 244		51.00
53. 00 05300 ANESTHESI OLOGY	o	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	11, 175, 750		54.00
60. 00   06000   LABORATORY	o	7, 817, 686		60.00
65. 00 06500 RESPIRATORY THERAPY		3, 869, 171		65.00
66. 00   06600 PHYSI CAL THERAPY	0			66.00
	1 -1	2, 794, 438		1
67. 00 06700 OCCUPATI ONAL THERAPY	0	523, 131		67.00
68. 00   06800   SPEECH PATHOLOGY	0	284, 696		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 924, 846		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00  07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 353, 020		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 042, 693		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	27, 930, 013		73.00
76. 00   03020   CARDI AC	o	o		76.00
76. 01 03160 CARDI OPULMONARY	o	251, 822		76. 01
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	o		77.00
OUTPATIENT SERVICE COST CENTERS	· I	-,		
88. 00 08800 RURAL HEALTH CLINIC	0	644, 949		88. 00
90. 00   09000   CLINIC	o	0 , , , , ,		90.00
90. 01   09001   WOUND   CLINIC	o	1, 183, 487		90.01
90. 02 09002 DI ABETES CLI NI C		76, 288		90.02
90. 03   09003   ASTHMA CLINIC		70, 200		90.03
				1
	0	540, 699		90.04
90. 05   09005   PRI ME   TI ME	0	5, 064		90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	93		90.06
90. 07   04951   0NCOLOGY	0	4, 044, 706		90. 07
90. 08 04950 ANDERSON WOMENS CENTER	0	1, 158, 081		90.08
91. 00   09100   EMERGENCY	0	10, 018, 780		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		101.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0		102.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	o	119, 294, 386		118.00
NONREI MBURSABLE COST CENTERS	· I	, , , , , , , , ,		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190. 01 19001 PROFESSI ONAL BUILDING	o	1, 429, 231		190.01
190. 02 19002 PHYSI CI AN BUI LDI NG		861, 561		190.01
190. 02 19002 PHYSICIAN BUILDING 190. 03 19003 PRI VATE DUTY				190. 02
	1 -1	1, 481, 960		
190. 04 19004 MARKETI NG	0	1, 118, 874		190.04
190. 05 19005 SPORTS PHYSI CALS	0	439, 352		190.05
190. 06 19006 FOUNDATI ON	0	1, 486, 427		190.06
190. 07 19007 ASC	0	2, 644, 663		190. 07
190. 08 19008 GATEWAY LOCATION	0	5, 987, 122		190. 08
190. 09 19009 HANCOCK OB	0	8, 656, 907		190. 09
190. 10 19010 HANCOCK WELLNESS	0	1, 486, 061		190. 10
190. 11 19011 MORRI STOWN CLINIC	l ol	0		190. 11
190. 12 19012 03PUREMED		o		190. 12
190. 13 19013 MCCORD WELLNESS	o	1, 695, 575		190. 13
190. 14 19014 3 WEST UNIT	o	1, 999, 850		190. 14
190. 15 19015 NEUROLOGY PHYSI CI AN	o	2, 146, 677		190. 15
/0  //0.0  // // // // // // // // // // // // //	<u>,                                    </u>	-, 1 10, 017	l .	1.75.15

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0037	Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

190. 17     19017     HANCOCK ENDO     0     1, 464, 135     190.1       190. 18     19018     HANCOCK FOOT & ANKLE     0     0     190.1       190. 19     19019     HANCOCK RHEUM     0     113, 187     190.1       194. 00     07950     OTHER NONREI MBURSABLE     0     937     194.0				5/26/2023 1: 33 pm
Cost & Post   Stepdown   Adj ustments     25.00   26.00	Cost Center Description	Intern &	Total	
Stepdown   Adj ustments   25.00   26.00		Resi dents		
Adjustments   25.00   26.00		Cost & Post		
25. 00   26. 00		Stepdown		
190. 16   19016   THORACI     0     115, 342     190. 1       190. 17   19017   HANCOCK ENDO     0     1, 464, 135     190. 1       190. 18   19018   HANCOCK FOOT & ANKLE     0     0     190. 1       190. 19   19019   HANCOCK RHEUM     0     113, 187     190. 1       194. 00   07950   OTHER NONREI MBURSABLE     0     937     194. 0		Adjustments		
190. 17     19017     HANCOCK ENDO     0     1, 464, 135     190.1       190. 18     19018     HANCOCK FOOT & ANKLE     0     0     190.1       190. 19     19019     HANCOCK RHEUM     0     113, 187     190.1       194. 00     07950     OTHER NONREI MBURSABLE     0     937     194.0		25. 00	26. 00	
190. 18 19018 HANCOCK FOOT & ANKLE 0 0 0 190. 1 190	90. 16 19016 THORACI	0	115, 342	190. 16
190. 19 19019 HANCOCK RHEUM 0 113, 187 194. 00 07950 OTHER NONREI MBURSABLE 0 937 194. 0	90. 17 19017 HANCOCK ENDO	0	1, 464, 135	190. 17
194. 00 07950 OTHER NONREI MBURSABLE 0 937 194. 0	90. 18 19018 HANCOCK FOOT & ANKLE	0	0	190. 18
	90. 19 19019 HANCOCK RHEUM	0	113, 187	190. 19
104 O107051 SUBURDAN HOSPICE 0 240 014	94. 00 07950 OTHER NONREI MBURSABLE	0	937	194. 00
194. U   U/95     SUDUKDAN TUSPI CE   U  200, 914     194. U	194. 01 07951 SUBURBAN HOSPI CE	0	260, 914	194. 01
194. 02 07952 HRH HANCOCK GI 0 1, 189, 840 194. 0	94. 02 07952 HRH HANCOCK GI	0	1, 189, 840	194. 02
194. 03 07954 HRH NEPHROLOGY 0 355, 178 194. 0	94. 03 07954 HRH NEPHROLOGY	0	355, 178	194. 03
194. 04 07957 HRH SANE 0 207, 036 194. 0	94. 04 07957 HRH SANE	0	207, 036	194. 04
194. 05 07955 HRH RI SE 0 449, 013 194. 0	94. 05 07955 HRH RI SE	O	449, 013	194. 05
194. 06 07956  HRH JUSTICE NAVIGATION 0 203, 028  194. 0	94.06 07956 HRH JUSTICE NAVIGATION	O	203, 028	194. 06
200.00   Cross Foot Adjustments   0   0   200.0	200.00 Cross Foot Adjustments	О	o	200. 00
201.00   Negative Cost Centers   0   0	201.00 Negative Cost Centers	О	o	201.00
202.00 TOTAL (sum lines 118 through 201) 0 155,087,256 202.0	202.00 TOTAL (sum lines 118 through 201)	0 15	55, 087, 256	202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0037

			Ť	o 12/31/2022	Date/Time Pre 5/26/2023 1:3	
Cost Center Description	Directly Assigned New Capital	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	5 piii
	Related Costs 0	1.00	2A	4. 00	5. 00	
GENERAL SERVI CE COST CENTERS		ı	ı	1		1
1. 00	0 0 0 0 0 0 0 0	1, 456, 727 6, 619, 052 35, 999 333, 871 0 17, 340 133, 729 260, 625 63, 986	1, 456, 727 6, 619, 052 35, 999 333, 871 0 17, 340 133, 729 260, 625 63, 986	13, 261 1, 696 2, 603 883 1, 318 2, 163 427 3, 601 851	1, 469, 988 164, 101 32, 825 10, 908 11, 778 24, 355 6, 347 25, 864 11, 883 1, 160	1. 00 4. 00 5. 00 7. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 0	1 072 402	1 070 400	F 000	70 17/	1 20 00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF ANCILLARY SERVICE COST CENTERS	0 0 0	791, 899		5, 605	79, 176 87, 037 0	30.00 31.00 40.00
50. 00	0				70, 062	50.00
51. 00   05100   RECOVERY ROOM 53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY 65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	0 0 0 0 0 0 0	0 887, 167 188, 177 196, 223 167, 750 0 0 160, 329	196, 223 167, 750 0	0 5, 971 2, 645 2, 505 1, 741 485 259	9, 569 0 77, 140 64, 014 29, 022 20, 262 4, 815 2, 631 12, 318 0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	38, 948	71.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT 73. 00   07300 DRUGS CHARGED TO PATIENTS 76. 00   03020   CARDI AC 76. 01   03160   CARDI OPULMONARY 77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATIENT SERVI CE COST CENTERS	0 0 0 0 0	43, 247			19, 362 229, 443 0 1, 449	72. 00 73. 00 76. 00 76. 01 77. 00
88. 00   08800   RURAL HEALTH CLINIC 90. 00   09000   CLINIC 90. 01   09001   WOUND CLINIC	0 0 0	0	O	0	6, 113 0 8, 629	88. 00 90. 00 90. 01
90. 02   09002   DI ABETES CLINIC 90. 03   09003   ASTHMA CLINIC	0	0	0	60	705 0	90. 02 90. 03
90. 04 09004 ANDIS CLINIC 90. 05 09005 PRIME TIME 90. 06 09006 SHELBYVILLE WOUND CLINIC 90. 07 04951 ONCOLOGY 90. 08 04950 ANDERSON WOMENS CENTER	0 0 0			130 0 0 3, 527	1, 851 48 0 27, 012 8, 633	90. 04 90. 05 90. 06 90. 07
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	545, 631		3, 720	•	1
OTHER REI MBURSABLE COST CENTERS  101.00 10100 HOME HEALTH AGENCY	0	0			0	101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0					102.00
116. 00 11600 HOSPI CE	0 0					116.00
118.00   SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	14, 461, 393	14, 461, 395	08, 739		
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 PROFESSI ONAL BUILDING	0		945, 257		0 13, 547	190.00
190. 02 19002 PHYSICIAN BUILDING	Ö	0	C	0	8, 167	190. 02
190. 03 19003  PRI VATE DUTY 190. 04 19004  MARKETI NG	0	15, 502 0	15, 502	369 223	13, 404 10, 550	1
190. 05 19005 SPORTS PHYSI CALS	0	0	0	409	4, 165	190. 05
190. 06 19006 FOUNDATI ON 190. 07 19007  ASC	0	66, 968 782, 292			12, 610 8, 789	190. 06 190. 07
190. 08 19008 GATEWAY LOCATION	0	0	C	4, 591	56, 751	190. 08
190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS	0	226, 153 6, 589			76, 961 13, 949	190. 09 190. 10
190. 11 19011 MORRISTOWN CLINIC	0	0	0	0	0	190. 11
190. 12 19012 03PUREMED 190. 13 19013 MCCORD WELLNESS 190. 14 19014 3 WEST UNIT	0 0		0 0 428, 896	1, 173 272	16, 072	190. 12 190. 13 190. 14

Health Financial Systems

HANCOCK REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0037
From 01/01/2022
To 12/31/2022
Date/Time Prepared:

					5/26/2023 1: 3	3 pm
		CAPI TAL				
		RELATED COSTS				
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. 15 19015 NEUROLOGY PHYSI CI AN	0	64, 021	64, 021	1, 635	18, 976	190. 15
190. 16 19016 THORACI	0	0	0	101	1, 093	190. 16
190. 17 19017 HANCOCK ENDO	0	0	0	1, 085	13, 822	190. 17
190. 18 19018 HANCOCK FOOT & ANKLE	0	0	0	0	0	190. 18
190. 19 19019 HANCOCK RHEUM	0	0	0	81	1, 073	190. 19
194.00 07950 OTHER NONREIMBURSABLE	0	0	0	0	9	194.00
194. 01 07951 SUBURBAN HOSPI CE	0	33, 397	33, 397	123	1, 663	194. 01
194. 02 07952 HRH HANCOCK GI	0	0	0	1, 007	11, 241	194. 02
194. 03 07954 HRH NEPHROLOGY	0	0	0	206	3, 367	194. 03
194. 04 07957 HRH SANE	0	0	0	137	1, 962	194. 04
194. 05 07955 HRH RI SE	0	0	0	0	4, 256	194. 05
194.06 07956 HRH JUSTICE NAVIGATION	0	0	0	135	1, 924	194.06
200.00 Cross Foot Adjustments			0			200.00
201.00 Negative Cost Centers		o	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	17, 030, 470	17, 030, 470	87, 569	1, 469, 988	202.00

Provider CCN: 15-0037

				1	0 12/31/2022	Date/lime Pre   5/26/2023 1:3	
	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	piii
		7. 00	9. 00	10. 00	11. 00	N 13. 00	
	GENERAL SERVICE COST CENTERS	7.00	7.00	10.00	11.00	13.00	
1.00 4.00 5.00 7.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 23.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	6, 784, 849 30, 972 287, 254 0 0 115, 057 224, 235 55, 052 28, 317	102, 399 1, 783 2, 938 0 4, 457 3, 251 3, 910 4, 505	634, 699 0 0 0 0 0 0	16, 034 534 163 1, 044 487 36	44, 392 576 3, 692 1, 723 0	14. 00 15. 00 16. 00
30. 00	03000 ADULTS & PEDIATRICS	923, 527	29, 886	253, 032	1, 870	6, 603	30.00
31. 00 40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF ANCILLARY SERVICE COST CENTERS	681, 328	6, 161 0	378, 630 0	1, 852 0	6, 548 0	31. 00 40. 00
50.00	05000 OPERATING ROOM	391, 986	11, 963	0	1, 141	4, 034	50.00
51. 00 53. 00 54. 00 60. 00 65. 00 66. 00 67. 00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	103, 658 0 763, 294 161, 903 168, 825 144, 328	4, 405 0 4, 379 4, 179 3, 201 3, 720	0 0 0 0 0	205 0 1, 765 1, 206 911 548 181	725 0 6, 240 4, 265 3, 219 1, 936	53.00 54.00 60.00 65.00
68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 03020 CARDI AC	0 137, 943 0 0 0 0	0 7, 253 0 0 0 0 0	0 0 0 0 0 0	85 268 0 0 0 0	0 0 0 0 0	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00
76. 01	03160 CARDIOPULMONARY 07700 ALLOGENEIC STEM CELL ACQUISITION	37, 208 0	0	0	48 0	0	76. 01 77. 00
88. 00 90. 00 90. 01 90. 02	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC  09000 CLINIC  09001 WOUND CLINIC  09002 DIABETES CLINIC	0 0 99, 988 0	0 0	0 0 0 0	0 0 215 23	0 0 0 0	90. 00 90. 01
90. 03 90. 04 90. 05 90. 06	09003 ASTHMA CLINIC 09004 ANDIS CLINIC 09005 PRIME TIME 09006 SHELBYVILLE WOUND CLINIC	0 133, 795 0 0 440, 324	0 0 0 0	0 0 0	0 48 0 1	0 0 0	90. 03 90. 04 90. 05 90. 06
	04951 ONCOLOGY 04950 ANDERSON WOMENS CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	2, 656 469, 446	6, 408 0	0	852 225 1, 134	0 0 4,009	
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0		101.00 102.00
116. 00 118. 00	11600 HOSPI CE	0 5, 401, 096	0 102, 399	0 631, 662	0 14, 842		116. 00 118. 00
190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 09 190. 10	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PROFESSIONAL BUILDING 19002 PHYSICIAN BUILDING 19003 PRIVATE DUTY 19004 MARKETING 19005 SPORTS PHYSICALS 19006 FOUNDATION 19007 ASC 19008 GATEWAY LOCATION 19009 HANCOCK OB 19010 HANCOCK WELLNESS 19011 MORRISTOWN CLINIC 19012 OSPURMED	0 0 0 0 0 57, 618 673, 063 0 194, 576 5, 669	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 232 70 0 108 0 0 491 0	0 0 822 0 0 0 0 0 0 0	190. 00 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 08 190. 09 190. 10 190. 11
190. 14 190. 15 190. 16	19013 MCCORD WELLNESS 19014 3 WEST UNIT 19015 NEUROLOGY PHYSICIAN 19016 THORACI 19017 HANCOCK ENDO	369, 011 55, 082 0	0 0 0 0 0	0 0 0 0	0 88 51 0 71	0 0 0	190. 13 190. 14 190. 15 190. 16 190. 17

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS HANCOCK REGIONAL HOSPITAL Provider CCN: 15-0037

					5/26/2023 1:3	3 pm
Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	PLANT				ADMI NI STRATI O	
					N	
	7. 00	9. 00	10.00	11. 00	13. 00	
190. 18 19018 HANCOCK FOOT & ANKLE	0	0	0	0	0	190. 18
190. 19 19019 HANCOCK RHEUM	0	0	0	0	0	190. 19
194. 00 07950 OTHER NONREI MBURSABLE	0	0	0	0	0	194.00
194. 01 07951 SUBURBAN HOSPI CE	28, 734	0	3, 037	34	0	194. 01
194. 02 07952 HRH HANCOCK GI	0	0	0	47	0	194. 02
194. 03 07954 HRH NEPHROLOGY	0	0	0	0	0	194. 03
194. 04 07957 HRH SANE	0	0	0	0	0	194. 04
194. 05 07955 HRH RI SE	0	0	0	0	0	194. 05
194.06 07956 HRH JUSTICE NAVIGATION	0	0	0	0	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 784, 849	102, 399	634, 699	16, 034	44, 392	202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0037

				To	12/31/2022	Date/Time Pre 5/26/2023 1:3	
Cost Center Descript	ti on	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	PARAMED ED PRGM	Subtotal	у ры
		14. 00	15. 00	16. 00	23. 00	24. 00	
GENERAL SERVICE COST CENT							1 00
1.00   00100   NEW CAP REL COSTS-BL 4.00   00400   EMPLOYEE BENEFITS DE							1.00 4.00
5. 00   00500   ADMINISTRATIVE & GEN							5.00
7. 00 00700 OPERATION OF PLANT	VEIVAL						7.00
9. 00   00900   HOUSEKEEPI NG							9.00
10. 00   01000 DI ETARY							10.00
11. 00   01100   CAFETERI A							11.00
13. 00 01300 NURSI NG ADMI NI STRATI	ON						13.00
14.00 01400 CENTRAL SERVICES & S		260, 756					14.00
15. 00 01500 PHARMACY		0	522, 312				15.00
16.00 01600 MEDICAL RECORDS & LI	BRARY	0	0	137, 892			16.00
23. 00 02300 PARAMED ED PRGM		0	0	0	67, 049		23. 00
I NPATI ENT ROUTI NE SERVI CE	COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS		0	0	38, 231		2, 411, 719	1
31. 00   03100   INTENSIVE CARE UNIT		0	0	4, 774		1, 963, 834	1
40. 00 04000 SUBPROVI DER - I PF	NITEDO	0	0	0		0	40.00
ANCILLARY SERVICE COST CEI	NIERS	٥	ol	EO 240		000 025	FO 00
50.00   05000   OPERATING ROOM 51.00   05100   RECOVERY ROOM		0	0	50, 249 0		990, 925 239, 848	
53. 00   05300   ANESTHESI OLOGY		0	0	0		239, 646	1
54. 00   05400   RADI OLOGY-DI AGNOSTI (		0	0	5, 737		1, 751, 693	
60. 00   06000   LABORATORY		0	0	12, 730		439, 119	
65. 00 06500 RESPIRATORY THERAPY		o	ol	0		403, 906	
66. 00 06600 PHYSI CAL THERAPY		0	o	0		340, 285	1
67. 00 06700 OCCUPATI ONAL THERAPY	1	0	o	0		5, 481	67.00
68.00 06800 SPEECH PATHOLOGY		0	O	0		2, 975	68.00
69. 00 06900 ELECTROCARDI OLOGY		0	0	0		318, 908	69. 00
70. 00 07000 ELECTROENCEPHALOGRAF		0	0	0		0	
71.00 07100 MEDICAL SUPPLIES CHA		260, 756	0	6, 532		306, 236	1
72. 00   07200   IMPL. DEV. CHARGED		0	0	0		19, 362	
73. 00 07300 DRUGS CHARGED TO PAT	ITENIS	0	522, 312	0		751, 755	1
76. 00   03020   CARDI AC 76. 01   03160   CARDI OPULMONARY		0	0	0		0	1
77. 00 07700 ALLOGENEIC STEM CELL	ACOULS LITLON	0	0	0		82, 041 0	1
OUTPATIENT SERVICE COST C		U <sub>I</sub>	<u> </u>	U			177.00
88. 00 08800 RURAL HEALTH CLINIC	ENTERO	0	ol	0		6, 494	88. 00
90. 00 09000 CLI NI C		0	O	0		0	1
90. 01 09001 WOUND CLINIC		0	0	0		225, 648	90. 01
90. 02 09002 DIABETES CLINIC		0	o	0		788	90. 02
90.03 09003 ASTHMA CLINIC		0	0	0		0	90. 03
90.04 09004 ANDIS CLINIC		0	0	0		152, 401	1
90. 05   09005   PRI ME TI ME		0	0	0		48	1
90. 06   09006   SHELBYVI LLE WOUND CL	_I NI C	0	0	0		1	
90. 07   04951   ONCOLOGY	TED.	0	0	0		983, 498	1
90. 08   04950   ANDERSON WOMENS CENT 91. 00   09100   EMERGENCY	IEK	0	0	10.620		163, 640	1
92.00 09200 OBSERVATION BEDS (NO	N_DISTINCT PART)	U	٩	19, 639		1, 121, 795	92.00
OTHER REIMBURSABLE COST C							72.00
101.00 10100 HOME HEALTH AGENCY		0	0	0		0	101.00
102.00 10200 OPI OI D TREATMENT PRO		0	0	0		0	102.00
SPECIAL PURPOSE COST CENT	ERS						_
116. 00 11600 HOSPI CE	1150 4 11 1 447)	0	0	0			116.00
118. 00 SUBTOTALS (SUM OF LI		260, 756	522, 312	137, 892	0	12, 682, 400	1118.00
NONREI MBURSABLE COST CENT 190. 00 19000 GIFT, FLOWER, COFFEE		0	ol	0	Ī	0	190. 00
190. 01 19001 PROFESSI ONAL BUILDIN		0	0	0		958. 804	
190. 02 19002 PHYSI CI AN BUI LDI NG	vo	o	Ö	0			190.01
190. 03 19003 PRI VATE DUTY		Ö	Ö	0			190. 03
190. 04 19004 MARKETI NG		o	o	0			190.04
190. 05 19005 SPORTS PHYSI CALS		Ö	Ö	0			190.05
190. 06 19006 FOUNDATI ON		o	o	0		137, 623	
190. 07 19007 ASC		0	o	0		1, 464, 144	190. 07
190.08 19008 GATEWAY LOCATION		0	o	0			190. 08
190. 09 19009 HANCOCK OB		О	o	0		503, 978	
190. 10 19010 HANCOCK WELLNESS		0	o	0			190. 10
190. 11 19011 MORRISTOWN CLINIC		0	0	0			190. 11
190. 12 19012 03PUREMED		0	0	0		0	
190. 13 19013 MCCORD WELLNESS		0	0	0			190. 13
190. 14 19014 3 WEST UNIT		0	0	0		808, 228	
190. 15 19015 NEUROLOGY PHYSI CI AN		0	O	0		139, 765	
190. 16 19016 THORACI 190. 17 19017 HANCOCK ENDO		0	0	0			190. 16 190. 17
170. 17 17017   HANGOOK ENDO		· 이	્ય	U		14, 7/0	1170.17

Health Financial Systems

HANCOCK REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0037
From 01/01/2022
To 12/31/2022
Date/Time Prepared:

					5/26/2023 1: 3	3 pm
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PARAMED ED	Subtotal	
	SERVICES &		RECORDS &	PRGM		
	SUPPLY		LI BRARY			
	14. 00	15. 00	16.00	23.00	24.00	
190. 18 19018 HANCOCK FOOT & ANKLE	0	0	0		0	190. 18
190. 19 19019 HANCOCK RHEUM	0	0	0		1, 154	190. 19
194. 00 07950 OTHER NONREI MBURSABLE	0	0	0		9	194.00
194. 01 07951 SUBURBAN HOSPI CE	0	0	0		66, 988	194. 01
194. 02 07952 HRH HANCOCK GI	0	0	0		12, 295	194. 02
194. 03 07954 HRH NEPHROLOGY	0	0	0		3, 573	194. 03
194. 04 07957 HRH SANE	0	0	0		2, 099	194. 04
194. 05 07955 HRH RI SE	0	0	0		4, 256	194. 05
194.06 07956 HRH JUSTICE NAVIGATION	0	0	0		2, 059	194. 06
200.00 Cross Foot Adjustments				67, 049	67, 049	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	260, 756	522, 312	137, 892	67, 049	17, 030, 470	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0037

				ite/lime Prepared: /26/2023 1:33 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	, , , ,	20,2020 1. 00 pin
CENEDAL SERVICE COST SENTEDS	25. 00	26. 00		
GENERAL SERVICE COST CENTERS  1. 00				1. 00 4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 23. 00
30. 00 03000 ADULTS & PEDI ATRI CS	O	2, 411, 719		30.00
31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF ANCILLARY SERVICE COST CENTERS	0 0	1, 963, 834		31. 00 40. 00
50. 00   05000   OPERATING ROOM 51. 00   05100   RECOVERY ROOM	0	990, 925 239, 848		50. 00 51. 00
53. 00   05300   ANESTHESI OLOGY		237, 848		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 751, 693		54.00
60. 00 06000 LABORATORY	0	439, 119		60.00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY		403, 906 340, 285		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		5, 481		67.00
68.00 06800 SPEECH PATHOLOGY	0	2, 975		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	318, 908		69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 0	0 306, 236		70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		19, 362		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	751, 755		73.00
76. 00   03020   CARDI AC	0	0		76.00
76. 01   03160   CARDI OPULMONARY 77. 00   07700   ALLOGENEI C STEM CELL ACQUI SITION	0	82, 041 0		76. 01 77. 00
OUTPATIENT SERVICE COST CENTERS	J 0	<u> </u>		77.00
88. 00 08800 RURAL HEALTH CLINIC	0	6, 494		88.00
90. 00   09000   CLI NI C	0	0		90.00
90. 01   09001   WOUND CLINIC 90. 02   09002   DIABETES CLINIC	0	225, 648 788		90. 01
90. 03   09003   ASTHMA CLINIC		0		90.02
90. 04   09004   ANDIS CLINIC	o	152, 401		90. 04
90. 05   09005   PRI ME TI ME	0	48		90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0	1		90.06
90. 07   04951   ONCOLOGY 90. 08   04950   ANDERSON WOMENS CENTER	0	983, 498 163, 640		90. 07 90. 08
91. 00   09100   EMERGENCY	o o	1, 121, 795		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
OTHER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY	O	0		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM		o		101.00
SPECIAL PURPOSE COST CENTERS		-		
116. 00 11600 HOSPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	12, 682, 400		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190. 01 19001 PROFESSI ONAL BUILDING	0	958, 804		190. 01
190. 02 19002 PHYSI CI AN BUI LDI NG	0	8, 167		190. 02
190. 03 19003  PRI VATE DUTY 190. 04 19004  MARKETI NG	0	30, 329		190. 03 190. 04
190. 04 19004 MARKETT NG 190. 05 19005 SPORTS PHYSI CALS		10, 843 4, 574		190.04
190. 06 19006 FOUNDATION	o o	137, 623		190. 06
190. 07 19007 ASC	0	1, 464, 144		190. 07
190. 08 19008 GATEWAY LOCATION	0	61, 342		190. 08 190. 09
190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS		503, 978 27, 374		190. 09
190. 11 19011 MORRI STOWN CLINIC		0		190. 11
190. 12 19012 03PUREMED	0	0		190. 12
190. 13 19013 MCCORD WELLNESS	0	17, 245		190. 13
190. 14 19014 3 WEST UNIT 190. 15 19015  NEUROLOGY PHYSI CLAN	0 0	808, 228 139, 765		190. 14 190. 15
,	<u> </u>			1,73,10

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0037	Peri od: Worksheet B
		From 01/01/2022 Part II
		To 12/31/2022 Date/Time Prepared:

				10 1	2/31/2022	5/26/2023	
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
		25. 00	26. 00				
190. 16 19016	THORACI	0	1, 194				190. 16
190. 17 19017 I	HANCOCK ENDO	0	14, 978				190. 17
190. 18 19018 I	HANCOCK FOOT & ANKLE	0	0				190. 18
190. 19 19019 I	HANCOCK RHEUM	0	1, 154				190. 19
194. 00 07950	OTHER NONREI MBURSABLE	0	9				194.00
194. 01 07951	SUBURBAN HOSPICE	0	66, 988				194. 01
194. 02 07952 I	HRH HANCOCK GI	0	12, 295				194. 02
194. 03 07954 I	HRH NEPHROLOGY	0	3, 573				194. 03
194. 04 07957 I	HRH SANE	0	2, 099				194. 04
194. 05 07955 I	HRH RISE	0	4, 256				194. 05
194. 06 07956 I	HRH JUSTICE NAVIGATION	0	2, 059				194. 06
200.00	Cross Foot Adjustments	0	67, 049				200.00
201.00	Negative Cost Centers	0	0				201.00
202. 00	TOTAL (sum lines 118 through 201)	0	17, 030, 470				202. 00

COST /	ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-0037 F	eri od:	Worksheet B-1	
				T	rom 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
		CAPI TAL				5/26/2023 1:3	3 pm
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
		FLXT	BENEFI TS	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS SALARI ES)		COST)	FEET)	
		1. 00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	491, 065					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 525	66, 826, 042		101 000 E11		4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	42, 004 190, 857	10, 099, 896 1, 294, 859			227, 387	5. 00 7. 00
9. 00	00900 HOUSEKEEPI NG	1, 038	1, 987, 339	1			
10.00	01000 DI ETARY	9, 627	674, 128	1	973, 754	9, 627	
11.00	01100 CAFETERI A	O	1, 006, 246	o c	1, 051, 390	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	500	1, 651, 180		2, 174, 163		
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 856	325, 965		,	3, 856	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	7, 515 1, 845	2, 749, 203 649, 472		_,,		15. 00 16. 00
23. 00	02300 PARAMED ED PRGM	949	91, 123				1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		717120	<u> </u>	100/07/		20.00
30.00		30, 951	4, 574, 386	C	7, 068, 034	30, 951	30.00
31.00		22, 834	4, 278, 326				
40. 00		0	0	) C	0	0	40.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	13, 137	4, 496, 391		6, 254, 390	13, 137	50.00
51. 00	05100 RECOVERY ROOM	3, 474	614, 827		1		1
53. 00	05300 ANESTHESI OLOGY	0, 1, 1	011,027	1		0, 1,71	
54.00	05400 RADI OLOGY-DI AGNOSTI C	25, 581	4, 557, 861	C	6, 886, 241	25, 581	54.00
60.00	06000 LABORATORY	5, 426	2, 019, 324		-,,	5, 426	
65. 00	06500 RESPI RATORY THERAPY	5, 658	1, 912, 306		_,		
66.00	06600 PHYSI CAL THERAPY	4, 837	1, 329, 135	1	1, 808, 784	4, 837	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	369, 968 197, 777	1	429, 804 234, 891	0 0	
69. 00	06900 ELECTROCARDI OLOGY	4, 623	608, 486	1		4, 623	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	o c	0	0	1
71. 00		0	0	) c	3, 476, 857	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	1, 728, 469	0	72.00
73.00		0	0		20, 487, 386	0	73.00
76. 00 76. 01	03020 CARDI AC 03160 CARDI OPULMONARY	1, 247	67, 699		129, 354	0 1, 247	
77. 00	1 1	1, 247	07, 077	1		1, 247	
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		,			
88. 00		0	291, 014	1	1		
90.00		0	0	1	_	0	
90. 01	09001 WOUND CLINIC 09002 DIABETES CLINIC	3, 351	458, 689 45, 945			3, 351 0	1
	09003 ASTHMA CLINIC		43, 743		02, 743	0	
	09004 ANDIS CLINIC	478	99, 191		165, 222	-	90.04
	09005 PRIME TIME	o	0	) c	4, 285	0	90. 05
90. 06		0	0	) c	0	0	
	04951 ONCOLOGY	14, 757	2, 692, 435		2, 411, 333		
90. 08 91. 00		4, 184 15, 733	468, 756 2, 839, 968		770, 686 6, 982, 332		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 755	2,037,700		0, 702, 332	15, 733	92.00
	OTHER REIMBURSABLE COST CENTERS			•	1		
	10100 HOME HEALTH AGENCY	0	0				101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	) C	0	0	102. 00
114 0	SPECIAL PURPOSE COST CENTERS 0 11600 HOSPI CE	0		J		0	116. 00
118.00		1 -1	52, 451, 895	) -23, 856, 745			
110.00	NONREI MBURSABLE COST CENTERS	110, 707	02, 101, 070	20,000,710	101,001,710	101,012	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	) C	0	0	190. 00
	1 19001 PROFESSIONAL BUILDING	27, 256	0	) c	, , , , , , , , , , , , , , , , , , , ,		190. 01
	2 19002 PHYSI CI AN BUI LDI NG	0	0	) C	729, 029		190.02
	3 19003 PRI VATE_DUTY 4 19004 MARKETI NG	447	281, 519		1, 196, 568 941, 768		190. 03 190. 04
	19004 MARKETING 19005 SPORTS PHYSICALS		170, 201 312, 419		371, 767		190.04
	19006 FOUNDATION	1, 931	243, 521				190.06
	7 19007 ASC	22, 557	0		784, 615	22, 557	190. 07
	B 19008 GATEWAY LOCATION	0	3, 504, 770		5, 066, 134		190. 08
	9 19009 HANCOCK OB	6, 521	4, 424, 875		6, 870, 284		190.09
	D 19010 HANCOCK WELLNESS 1 19011 MORRI STOWN CLINIC	190	890, 955		1, 245, 222		190. 10 190. 11
	119011 MORRISTOWN CLINIC 219012 03PUREMED	0	0		0		190. 11
	3 19013 MCCORD WELLNESS	0	895, 114				190. 12
		<u>,                                    </u>	2.0, .11		1, 1, 1, 1, 10	<u> </u>	

Provi der CCN: 15-0037

				T	o 12/31/2022	Date/Time Pre 5/26/2023 1:3	pared:
		CAPI TAL				7 07 207 2020 11 0	, p
		RELATED COSTS					
Cost Cer	iter Description	NEW BLDG &	EMPLOYEE	Reconciliatio	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. 14 19014 3 WEST L		12, 367	207, 839	•	007,207		1
190. 15 19015 NEUROLOG	Y PHYSICIAN	1, 846	1, 248, 356		1, 693, 942		190. 15
190. 16 19016 THORACI		0	77, 464	•	97, 599		190. 16
190. 17 19017 HANCOCK		0	827, 897	0	1, 233, 847		190. 17
190. 18 19018 HANCOCK		0	0	0	0		190. 18
190. 19 19019 HANCOCK		0	61, 476		95, 776		190. 19
194.00 07950 OTHER NO		0	320		771		194.00
194. 01 07951 SUBURBAN		963	94, 187		148, 415		194. 01
194. 02 07952 HRH HANC		0	768, 891		1, 003, 496		194. 02
194. 03 07954 HRH NEPH		0	157, 235		300, 542		194. 03
194.04 07957 HRH SANE		0	104, 239	0	175, 188		194. 04
194. 05 07955 HRH RI SE		0	0	0	379, 942		194. 05
194.06 07956 HRH JUST		0	102, 869	0	171, 797	0	194. 06
	ot Adjustments						200. 00
	Cost Centers						201. 00
	be allocated (per Wkst. B,	17, 030, 470	5, 106, 198		23, 856, 745	17, 312, 439	202. 00
Part I)							
	t multiplier (Wkst. B, Part I)	34. 680684	0. 076410		0. 181793		1
	be allocated (per Wkst. B,		87, 569		1, 469, 988	6, 784, 849	204. 00
Part II)							
205.00 Unit cos	t multiplier (Wkst. B, Part		0. 001310		0. 011202	29. 838333	205.00
	ustment amount to be allocated						206. 00
(per Wks							250.00
	t cost multiplier (Wkst. D,						207. 00
Parts II	I and IV)						

COST AL	LOCATION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2022	Worksheet B-1	
					o 12/31/2022		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	5/26/2023 1: 3 CENTRAL	3 pm
	cost center bescription	(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI O	SERVICES &	
		SERVICE)	DAYS)		N	SUPPLY	
					(MANHOURS)	(COSTED REQUIS.)	
		9. 00	10. 00	11. 00	13.00	14. 00	
	SENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
	00700 OPERATION OF PLANT						7.00
	00900 HOUSEKEEPI NG	375, 765					9.00
	01000 DI ETARY	6, 543	10, 031				10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	10, 782	0	867, 895 28, 890			11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	16, 355	o	8, 820		100	ł
15. 00 C	01500 PHARMACY	11, 930	o	56, 522		0	15.00
	01600 MEDICAL RECORDS & LIBRARY	14, 350	0	26, 373		0	16.00
	02300 PARAMED ED PRGM NPATIENT ROUTINE SERVICE COST CENTERS	16, 530	0	1, 950	0	0	23.00
	03000 ADULTS & PEDIATRICS	109, 670	3, 999	101, 100	101, 100	0	30.00
	03100 INTENSIVE CARE UNIT	22, 610	5, 984	100, 257		0	1
	04000 SUBPROVI DER - I PF	0	0	C	0	0	40.00
	NCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM	43, 900	ol	61, 767	61, 767	0	50.00
	05100 RECOVERY ROOM	16, 165	o	11, 096		0	51.00
	D5300 ANESTHESI OLOGY	0	o	C	O	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	16, 070	0	95, 542		0	54.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	15, 335 11, 745	0	65, 297 49, 285		0	60. 00 65. 00
1	06600 PHYSI CAL THERAPY	13, 650	0	29, 637		0	66.00
	06700 OCCUPATI ONAL THERAPY	0	ō	9, 809		0	67.00
	06800 SPEECH PATHOLOGY	0	0	4, 586		0	68.00
	06900  ELECTROCARDI OLOGY 07000  ELECTROENCEPHALOGRAPHY	26, 615	0	14, 527	0	0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		o	C		100	ł
	07200 IMPL. DEV. CHARGED TO PATIENT	o	o	C	o	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.00
	03020  CARDI AC 03160  CARDI OPULMONARY	0	0	2, 589	0	0	76. 00 76. 01
	07700 ALLOGENEIC STEM CELL ACQUISITION		ő	2, 307		0	ł
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	C		0	88.00
	09000  CLI NI C 09001  WOUND   CLI NI C	0	0	11, 652		0	90. 00 90. 01
1	09002 DI ABETES CLINIC	l o	Ö	1, 228		0	90.02
	09003 ASTHMA CLINIC	0	0	C	ή	0	90. 03
	09004 ANDIS CLINIC	0	0	2, 612		0	90.04
	09005 PRIME TIME 09006 SHELBYVILLE WOUND CLINIC		0	60	1 4	0	
90.07	04951 ONCOLOGY	o	Ō	46, 143		0	90.07
	04950 ANDERSON WOMENS CENTER	23, 515	0	12, 177		0	90.08
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	O	61, 384	61, 384	0	91. 00 92. 00
	THER REIMBURSABLE COST CENTERS						92.00
101.00	0100 HOME HEALTH AGENCY	0	0	C	0	0	101.00
	0200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102.00
	SPECIAL PURPOSE COST CENTERS	0	ol	C	ol	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	375, 765	9, 983	803, 303			118.00
	IONRE I MBURSABLE COST CENTERS		·				
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190.00
	9001 PROFESSIONAL BUILDING 19002 PHYSICIAN BUILDING		0	(			190. 01 190. 02
	9003 PRI VATE DUTY	l o	Ö	12, 579	12, 579		190.03
	9004 MARKETI NG	0	o	3, 809	o		190. 04
	9005 SPORTS PHYSI CALS 9006 FOUNDATION	0	0	E 940			190. 05 190. 06
	9007 ASC		0	5, 849 C			190.08
190. 08 1	9008 GATEWAY LOCATION	o	ő	C	o o	0	190. 08
	9009 HANCOCK OB	0	0	26, 581	0		190. 09
	9010   HANCOCK WELLNESS   9011   MORRI STOWN CLINI C	0	0	C			190. 10 190. 11
	19011 MORRISTOWN CLINIC 19012 O3PUREMED		0	C		0	190. 11
190. 13 1	9013 MCCORD WELLNESS	o	ő	C	ol ol	0	190. 13
190. 14 1	9014 3 WEST UNIT	0	O	4, 762			190. 14
190. 15 1	9015 NEUROLOGY PHYSI CI AN	0	이	2, 738	8  0	0	190. 15

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/26/2023 1: 33 pm Provider CCN: 15-0037

						5/26/2023   1:33 pill	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(HOURS OF	(PATI ENT	(MANHOURS)	ADMI NI STRATI O	SERVICES &	
		SERVICE)	DAYS)		N	SUPPLY	
					(MANHOURS)	(COSTED	
						REQUIS.)	
		9. 00	10. 00	11. 00	13. 00	14.00	
190. 16 19016	THORACI	0	0	0	0	0 190.	16
190. 17 19017	HANCOCK ENDO	0	0	3, 863	0	0 190.	17
190. 18 19018	HANCOCK FOOT & ANKLE	0	0	0	0	0 190.	18
190. 19 19019	HANCOCK RHEUM	0	0	0	0	0 190.	19
	OTHER NONREI MBURSABLE	0	0	17	0	0 194. (	00
194. 01 07951	SUBURBAN HOSPI CE	0	48	1, 866	0	0 194. (	01
194. 02 07952	HRH HANCOCK GI	0	0	2, 528	0	0 194. (	02
194. 03 07954	HRH NEPHROLOGY	0	0	0	0	0 194. (	03
194. 04 07957	HRH SANE	0	0	0	0	0 194. (	04
194. 05 07955	HRH RISE	0	0	0	0	0 194. (	05
194. 06 07956	HRH JUSTICE NAVIGATION	0	0	0	0	0 194. (	06
200. 00	Cross Foot Adjustments					200. (	00
201. 00	Negative Cost Centers					201. (	00
202. 00	Cost to be allocated (per Wkst. B,	3, 542, 000	1, 945, 417	1, 344, 157	2, 614, 155	1, 164, 903 202. (	00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	9. 426104	193. 940484	1. 548755	3. 846274	11, 649. 030000 203. (	00
204. 00	Cost to be allocated (per Wkst. B,	102, 399	634, 699	16, 034	44, 392	260, 756 204. (	00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 272508	63. 273751	0. 018475	0. 065315	2, 607. 560000 205. (	00
	[11]						
206. 00	NAHE adjustment amount to be allocated					206. (	00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,					207. (	00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0037

				To	Date/Time Pr 5/26/2023 1:	
	Cost Center Description	PHARMACY	MEDI CAL	PARAMED ED	,, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2	
		(COSTED REQUIS.)	RECORDS & LI BRARY	PRGM (ASSIGNED		
		REQUIS. )	(TIME	TI ME)		
		45.00	SPENT)	22.22		
	GENERAL SERVICE COST CENTERS	15. 00	16. 00	23. 00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
7. 00 9. 00	00700 OPERATION OF PLANT 00900 HOUSEKEEPING					7. 00 9. 00
10. 00	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVI CES & SUPPLY	100				14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	100	3, 293			15. 00 16. 00
	02300 PARAMED ED PRGM		0, 273			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,				
	03000 ADULTS & PEDIATRICS	0	913			30.00
	03100 I NTENSI VE CARE UNI T	0	114			31.00
40.00	04000 SUBPROVIDER - IPF ANCILLARY SERVICE COST CENTERS	0	0	0		40.00
50. 00	05000 OPERATING ROOM	O	1, 200	0		50.00
	05100 RECOVERY ROOM	O	0			51.00
	05300 ANESTHESI OLOGY	0	0	0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	137	100		54.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	304 0			60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		0	0		66.00
	06700 OCCUPATI ONAL THERAPY	Ö	0	Ö		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68. 00
	06900 ELECTROCARDI OLOGY	0	0	0		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00 71.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		156 0	0		71.00
	07300 DRUGS CHARGED TO PATIENTS	100	Ö	Ö		73.00
	03020 CARDI AC	O	0			76. 00
	03160 CARDI OPULMONARY	0	0			76. 01
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0		77. 00
88. 00	08800 RURAL HEALTH CLINIC	O	0	0		88. 00
	09000 CLI NI C	O	0	0		90.00
	09001 WOUND CLINIC	0	0	0		90. 01
	09002 DI ABETES CLI NI C	0	0	0		90.02
	09003 ASTHMA CLINIC 09004 ANDIS CLINIC		0	0		90. 03 90. 04
90. 05	09005 PRIME TIME		0			90.05
90.06	09006 SHELBYVILLE WOUND CLINIC	O	0	0		90. 06
	04951 ONCOLOGY	0	0	0		90. 07
	04950 ANDERSON WOMENS CENTER 09100 EMERGENCY	0	0 469			90. 08 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	ı o	409	l o		92.00
72.00	OTHER REIMBURSABLE COST CENTERS			l .		] /2:00
	10100 HOME HEALTH AGENCY	0	0			101. 00
102. 00	10200 OPI OI D TREATMENT PROGRAM	0	0	0		102.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	l ol	0	l ol		116. 00
118.00		100	3, 293			118.00
	NONREI MBURSABLE COST CENTERS		37 = 1 3			1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
	19001 PROFESSI ONAL BUILDI NG	0	0	0		190. 01
	19002 PHYSICIAN BUILDING 19003 PRIVATE DUTY	0	0	0		190. 02 190. 03
	19004 MARKETI NG	0	0	0		190.03
190. 05	19005 SPORTS PHYSICALS	0	O	0		190. 05
	19006 FOUNDATI ON	0	0	0		190. 06
	19007 ASC	0	0	0		190. 07
	19008 GATEWAY LOCATION 19009 HANCOCK OB		0			190. 08 190. 09
	19010 HANCOCK WELLNESS		0	0		190. 09
	19011 MORRI STOWN CLINIC	0	0	0		190. 11
	19012 03PUREMED	0	0	0		190. 12
	19013 MCCORD WELLNESS	0	0	0		190. 13
	19014 3 WEST UNIT 19015 NEUROLOGY PHYSICIAN	0	0	-		190. 14 190. 15
170.13		<u> </u>	O <sub>1</sub>	ı 0		1170.10

Health FinancialSystemsHANCOCK REGIONALHOSPITALIn Lieu of Form CMS-2552-10COST ALLOCATION - STATISTICAL BASISProvider CCN: 15-0037Period: From 01/01/2022Worksheet B-1

12/31/2022 Date/Time Prepared: 5/26/2023 1:33 pm Cost Center Description PHARMACY MEDI CAL PARAMED ED (COSTED RECORDS & PRGM REQUIS.) LI BRARY (ASSI GNED (TIME TIME) SPENT) 15. 00 23.00 16.00 190. 16 19016 THORACI 190. 16 190. 17 19017 HANCOCK ENDO 190. 17 0 0 0 0 0 0 0 0 0 0 190. 18 190. 18 19018 HANCOCK FOOT & ANKLE 0 190. 19 19019 HANCOCK RHEUM 190. 19 194. 00 07950 OTHER NONREI MBURSABLE 0 0 194. 00 0 194. 01 07951 SUBURBAN HOSPICE 0 194.01 194. 02 07952 HRH HANCOCK GI 194. 02 194. 03 07954 HRH NEPHROLOGY 0 194.03 194. 04 07957 HRH SANE 0 194. 04 194. 05 194. 05 07955 HRH RISE 0 0 194.06 07956 HRH JUSTICE NAVIGATION 0 0 194. 06 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 3, 718, 207 1, 671, 672 353, 516 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 37, 182. 070000 507. 644094 3, 535. 160000 203.00 Cost to be allocated (per Wkst. B, 204.00 522, 312 137, 892 67,049 204.00 Part II) 41. 874279 205.00 Unit cost multiplier (Wkst. B, Part 5, 223. 120000 670.490000 205.00 206.00 NAHE adjustment amount to be allocated 0 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00

Parts III and IV)

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 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

				o 12/31/2022	Date/Time Pre 5/26/2023 1:3	pared:
		Title	xVIII	Hospi tal	PPS	3 piii
		11110	AVIII	Costs	113	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
555t 5511t61 55551   pt. 611	(from Wkst.	Adj.	10141 00010	Di sal I owance	.014. 00010	
	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	13, 527, 699		13, 527, 699	0	13, 527, 699	30.00
31.00 03100 INTENSIVE CARE UNIT	12, 893, 216		12, 893, 216	ol ol	12, 893, 216	31.00
40. 00   04000   SUBPROVI DER - 1 PF	0			ol	0	40.00
ANCILLARY SERVICE COST CENTERS			<u>'</u>	<u>'</u>		ĺ
50. 00 05000 OPERATING ROOM	9, 747, 814		9, 747, 814	0	9, 747, 814	50.00
51.00 05100 RECOVERY ROOM	1, 486, 244		1, 486, 244	ıl ol	1, 486, 244	51.00
53. 00   05300   ANESTHESI OLOGY	0			ol ol	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 175, 750		11, 175, 750	ol	11, 175, 750	54.00
60. 00 06000 LABORATORY	7, 817, 686		7, 817, 686		7, 817, 686	60.00
65. 00 06500 RESPIRATORY THERAPY	3, 869, 171	0	3, 869, 171	o	3, 869, 171	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 794, 438	0			2, 794, 438	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	523, 131	0	523, 131		523, 131	67.00
68. 00 06800 SPEECH PATHOLOGY	284, 696	0	284, 696	ol ol	284, 696	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 924, 846		1, 924, 846		1, 924, 846	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			ol ol	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 353, 020		5, 353, 020	ol ol	5, 353, 020	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 042, 693		2, 042, 693		2, 042, 693	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	27, 930, 013		27, 930, 013		27, 930, 013	1
76. 00 03020 CARDI AC	0		1 (		0	76.00
76. 01 03160 CARDI OPULMONARY	251, 822		251, 822	ol ol	251, 822	76. 01
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		1 (		0	77. 00
OUTPATIENT SERVICE COST CENTERS				-1		
88. 00 08800 RURAL HEALTH CLINIC	644, 949		644, 949	0	644, 949	88.00
90. 00 09000 CLI NI C	0				0	90.00
90. 01   09001   WOUND CLINIC	1, 183, 487		1, 183, 487	ol	1, 183, 487	90. 01
90. 02   09002   DI ABETES   CLINIC	76, 288	•	76, 288		76, 288	•
90. 03   09003   ASTHMA CLINIC	0		(		0	90.03
90. 04   09004   ANDIS CLINIC	540, 699		540, 699	ol ol	540, 699	90.04
90. 05   09005   PRI ME TI ME	5, 064		5, 064		5, 064	90.05
90. 06 09006 SHELBYVI LLE WOUND CLINIC	93		93		93	90.06
90. 07   04951   ONCOLOGY	4, 044, 706		4, 044, 706		4, 044, 706	90.07
90. 08 04950 ANDERSON WOMENS CENTER	1, 158, 081		1, 158, 081		1, 158, 081	90.08
91. 00   09100   EMERGENCY	10, 018, 780		10, 018, 780		10, 018, 780	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 229, 923		5, 229, 923		5, 229, 923	1
OTHER REIMBURSABLE COST CENTERS	0,22,,,20		0,22,7,20	'II	0,22,,,20	72.00
101. 00 10100 HOME HEALTH AGENCY	0				0	101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0					102.00
SPECIAL PURPOSE COST CENTERS				'II		1.02.00
116. 00 11600 HOSPI CE	0				0	116.00
200.00 Subtotal (see instructions)	124, 524, 309	0	1		124, 524, 309	
201.00 Less Observation Beds	5, 229, 923		5, 229, 923		5, 229, 923	
202.00 Total (see instructions)	119, 294, 386	0				
				-1		

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	Peri od:	Worksheet C
		From 01/01/2022	
		To 10/01/0000	Doto/Time Dropored.

						From 01/01/2022 To 12/31/2022	Part I Date/Time Pre 5/26/2023 1:3	pared:
				Title	XVIII	Hospi tal	PPS	<u> </u>
				Charges	<u> </u>	·		
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
			6. 00	7. 00	8. 00	9. 00	10.00	
•	I NPAT	IENT ROUTINE SERVICE COST CENTERS			•	<u>'</u>		
30.00	03000	ADULTS & PEDIATRICS	9, 891, 661		9, 891, 66	1		30.00
31.00	03100	INTENSIVE CARE UNIT	14, 819, 151		14, 819, 15	1		31.00
40.00	04000	SUBPROVI DER - I PF	0					40.00
	ANCI L	LARY SERVICE COST CENTERS	,		•	'		1
50.00		OPERATING ROOM	7, 444, 209	38, 151, 582	45, 595, 79	0. 213788	0.000000	50.00
51.00	05100	RECOVERY ROOM	805, 630	1, 948, 852	2, 754, 48	0. 539573	0.000000	51.00
53.00	05300	ANESTHESI OLOGY	0	0		0. 000000	0.000000	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	3, 764, 721	85, 441, 888	89, 206, 60	9 0. 125279	0.000000	54.00
60.00	06000	LABORATORY	8, 128, 201	53, 544, 211	61, 672, 41	0. 126761	0.000000	60.00
65.00	06500	RESPI RATORY THERAPY	3, 208, 389	1, 876, 097		0. 760976	0.000000	65.00
66.00	06600	PHYSI CAL THERAPY	603, 735	4, 677, 425			0.000000	66.00
67.00	06700	OCCUPATI ONAL THERAPY	498, 621	891, 645	1, 390, 26	0. 376281	0.000000	67.00
68. 00		SPEECH PATHOLOGY	275, 976	509, 007			0. 000000	
69. 00		ELECTROCARDI OLOGY	3, 184, 535	12, 148, 455			0. 000000	1
70.00	1	ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	1
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	400, 869	1, 240, 565	1, 641, 43		0. 000000	
72. 00		IMPL. DEV. CHARGED TO PATIENT	1, 475, 092	7, 437, 449			0. 000000	1
73. 00		DRUGS CHARGED TO PATIENTS	11, 710, 262	104, 777, 546			0. 000000	1
76. 00	1	CARDI AC	0	0		0. 000000	0. 000000	1
76. 01		CARDI OPULMONARY	0	415, 811	415, 81		0. 000000	
	1	ALLOGENEIC STEM CELL ACQUISITION	0	0		0. 000000	0. 000000	1
		TIENT SERVICE COST CENTERS			l.			1
88. 00	08800	RURAL HEALTH CLINIC	0	732, 939	732, 93	9		88.00
90.00		CLINIC	0	0		0. 000000	0.000000	90.00
90. 01	09001	WOUND CLINIC	2, 655	6, 384, 095	6, 386, 75	0. 185303	0.000000	90. 01
90. 02	1	DI ABETES CLINIC	0	15, 274			0.000000	1
90. 03	09003	ASTHMA CLINIC	0	0	1	0. 000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	49, 492	49, 49	2 10. 924978	0.000000	90.04
90.05	09005	PRIME TIME	0	0		0. 000000	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		0. 000000	0.000000	90.06
90. 07		ONCOLOGY	10, 755	5, 587, 801	5, 598, 55	0. 722455	0.000000	90. 07
90.08	04950	ANDERSON WOMENS CENTER	1, 106	4, 041, 590	4, 042, 69	0. 286463	0.000000	
91.00	1	EMERGENCY	6, 079, 286	64, 974, 670			0.000000	1
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	433, 776	17, 312, 952		0. 294698	0.000000	92.00
		REIMBURSABLE COST CENTERS			, , , , ,			
101.00	10100	HOME HEALTH AGENCY	0	0		O		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	O	0		o		102.00
		AL PURPOSE COST CENTERS						
116.00	11600	HOSPI CE	0	0		O		116. 00
200.00	)	Subtotal (see instructions)	72, 738, 630	412, 159, 346	484, 897, 97	6		200.00
201.00	)	Less Observation Beds						201.00
202.00	)	Total (see instructions)	72, 738, 630	412, 159, 346	484, 897, 97	5		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
Feriod:
From 01/01/2022
To 12/31/2022
Date/Time Prepared:
5/26/2023 1: 33 pm

				10 12/31/2022	5/26/2023 1: 3	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
	<b>'</b>	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>				
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
40.00	04000 SUBPROVI DER - I PF					40.00
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				1
50.00	05000 OPERATING ROOM	0. 213788				50.00
51.00	05100 RECOVERY ROOM	0. 539573				51.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 125279				54.00
60.00	06000 LABORATORY	0. 126761				60.00
65. 00	06500 RESPIRATORY THERAPY	0. 760976				65.00
66. 00	06600 PHYSI CAL THERAPY	0. 529133				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 376281				67.00
68. 00	06800 SPEECH PATHOLOGY	0. 362678				68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 125536				69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3. 261185				71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 229193				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 239768				73.00
76. 00	03020 CARDI AC	0. 000000				76.00
76. 00	03160 CARDI OPULMONARY	0. 605616				76.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77.00
77.00	OUTPATIENT SERVICE COST CENTERS	0.000000				17.00
88. 00	08800 RURAL HEALTH CLINIC					88. 00
90.00	09000 CLINIC	0. 000000				90.00
90.00	09001 WOUND CLINIC	1				90.00
90. 01	09001 WOUND CETNIC	0. 185303 4. 994631				90.01
90. 02	09002 DIABETES CLINIC	1				90.02
90. 03		0.000000				
90.04	09004 ANDIS CLINIC 09005 PRIME TIME	10. 924978				90. 04 90. 05
	i i	0. 000000 0. 000000				90.05
90.06	09006 SHELBYVI LLE WOUND CLINIC					
	04951 ONCOLOGY	0. 722455				90. 07 90. 08
	04950 ANDERSON WOMENS CENTER	0. 286463				
	09100 EMERGENCY	0. 141002				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 294698				92.00
101 00	OTHER REIMBURSABLE COST CENTERS					101 00
	10100 HOME HEALTH AGENCY					101.00
102.00	10200 OPI OI D TREATMENT PROGRAM					102.00
114 00	SPECI AL PURPOSE COST CENTERS   11600 HOSPI CE					114 00
						116.00
200.00						200. 00 201. 00
201.00	i i					
202.00	Total (see instructions)					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 01/01/2022 Part I
		To 12/31/2022 Date/Time Prepared

				o 12/31/2022	Date/Time Pre 5/26/2023 1:3	pared:
		Ti +I	e XIX	Hospi tal	Cost	J PIII
		11 61	C XIX	Costs	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 & PEDIATRICS	13, 527, 699		13, 527, 699	0	13, 527, 699	30.00
31.00 03100 INTENSIVE CARE UNIT	12, 893, 216		12, 893, 216	o	12, 893, 216	31.00
40. 00   04000   SUBPROVI DER - 1 PF	o		(	o	0	40.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	9, 747, 814		9, 747, 814	0	9, 747, 814	50.00
51.00   05100   RECOVERY ROOM	1, 486, 244		1, 486, 244	0	1, 486, 244	51.00
53. 00   05300   ANESTHESI OLOGY	0		(	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	11, 175, 750		11, 175, 750	0	11, 175, 750	54.00
60. 00  06000 LABORATORY	7, 817, 686		7, 817, 686	0	7, 817, 686	60.00
65. 00   06500   RESPI RATORY THERAPY	3, 869, 171	0	3, 869, 17	0	3, 869, 171	65.00
66. 00   06600 PHYSI CAL THERAPY	2, 794, 438	0	2, 794, 438	0	2, 794, 438	66.00
67. 00  06700 OCCUPATI ONAL THERAPY	523, 131	0	523, 131	0	523, 131	67.00
68.00 06800 SPEECH PATHOLOGY	284, 696	0	284, 696	0	284, 696	68. 00
69. 00  06900  ELECTROCARDI OLOGY	1, 924, 846		1, 924, 846	0	1, 924, 846	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		(	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 353, 020		5, 353, 020	0	5, 353, 020	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 042, 693		2, 042, 693	0	2, 042, 693	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	27, 930, 013		27, 930, 013	0	27, 930, 013	73.00
76. 00   03020   CARDI AC	0		(		0	76. 00
76. 01 03160 CARDI OPULMONARY	251, 822		251, 822		251, 822	76. 01
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		(	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	644, 949		644, 949		644, 949	88. 00
90. 00   09000   CLI NI C	0		(	ή – – –	0	90.00
90. 01   09001   WOUND   CLINIC	1, 183, 487		1, 183, 487		1, 183, 487	90. 01
90. 02   09002   DI ABETES   CLI NI C	76, 288		76, 288		76, 288	90.02
90. 03   09003   ASTHMA CLINIC	0		(	/I 4	0	90. 03
90. 04   09004   ANDIS CLINIC	540, 699		540, 699		540, 699	90.04
90. 05   09005   PRI ME   TI ME	5, 064		5, 064		5, 064	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	93		93		93	90.06
90. 07   04951   ONCOLOGY	4, 044, 706		4, 044, 706		4, 044, 706	90. 07
90. 08 04950 ANDERSON WOMENS CENTER	1, 158, 081		1, 158, 081		1, 158, 081	90.08
91. 00 09100 EMERGENCY	10, 018, 780		10, 018, 780		10, 018, 780	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 229, 923		5, 229, 923	3	5, 229, 923	92.00
OTHER REIMBURSABLE COST CENTERS				, I	-	101 00
101. 00 10100 HOME HEALTH AGENCY	0		(			101. 00 102. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0				0	102.00
SPECIAL PURPOSE COST CENTERS	0		Ι (	\	^	1 116. 00
116. 00 11600 HOSPI CE	1 "	0		1	124, 524, 309	
200.00 Subtotal (see instructions) 201.00 Less Observation Beds	124, 524, 309 5, 229, 923	U	124, 524, 309 5, 229, 923		5, 229, 923	
202.00 Total (see instructions)	119, 294, 386	0			119, 294, 386	
202.00   10tal (300 1115th ucti 0115)	117, 274, 300	0	1 17, 274, 300	ή	117, 274, 300	1202. UU

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 01/01/2022   Part I
		To 12/31/2022 Date/Time Drenared

						Γο 12/31/2022	Date/Time Pre 5/26/2023 1:3	
				Ti tl	e XIX	Hospi tal	Cost	
		Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
			6. 00	7. 00	8. 00	9, 00	10.00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS				1		
30.00		ADULTS & PEDIATRICS	9, 891, 661		9, 891, 66	1		30.00
31. 00		INTENSIVE CARE UNIT	14, 819, 151		14, 819, 15	1		31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
	ANCI L	LARY SERVICE COST CENTERS						1
50.00	05000	OPERATING ROOM	7, 444, 209	38, 151, 582	45, 595, 79°	0. 213788	0.000000	50.00
51.00	05100	RECOVERY ROOM	805, 630	1, 948, 852	2, 754, 482	0. 539573	0.000000	51.00
53.00	05300	ANESTHESI OLOGY	o	0		0. 000000	0.000000	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	3, 764, 721	85, 441, 888	89, 206, 609	0. 125279	0.000000	54.00
60.00	06000	LABORATORY	8, 128, 201	53, 544, 211	61, 672, 412	0. 126761	0.000000	60.00
65.00	06500	RESPI RATORY THERAPY	3, 208, 389	1, 876, 097	5, 084, 486	0. 760976	0.000000	65.00
66.00	06600	PHYSI CAL THERAPY	603, 735	4, 677, 425	5, 281, 160	0. 529133	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	498, 621	891, 645	1, 390, 26	0. 376281	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	275, 976	509, 007	784, 98	0. 362678	0.000000	68.00
69.00	06900	ELECTROCARDI OLOGY	3, 184, 535	12, 148, 455	15, 332, 990	0. 125536	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	O	0		0. 000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	400, 869	1, 240, 565	1, 641, 43	3. 261185	0.000000	71.00
72.00		IMPL. DEV. CHARGED TO PATIENT	1, 475, 092	7, 437, 449	8, 912, 54 <sup>-</sup>	0. 229193	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11, 710, 262	104, 777, 546	116, 487, 80	0. 239768	0.000000	73.00
76.00		CARDI AC	0	0		0. 000000	0.000000	76.00
76. 01		CARDI OPULMONARY	0	415, 811	415, 81	0. 605616	0.000000	76. 01
77.00		ALLOGENEIC STEM CELL ACQUISITION	0	0	(	0. 000000	0. 000000	77. 00
		TIENT SERVICE COST CENTERS						
		RURAL HEALTH CLINIC	0	732, 939	732, 939		0.000000	
90.00		CLINIC	0	0		0.000000	0.000000	
90. 01	1	WOUND CLINIC	2, 655	6, 384, 095	6, 386, 750		0.000000	1
90. 02		DIABETES CLINIC	0	15, 274	15, 27		0.000000	
90. 03	1	ASTHMA CLINIC	0	0		0.000000	0.000000	1
90. 04		ANDIS CLINIC	0	49, 492	49, 49	1	0. 000000	
90. 05	1	PRIME TIME	0	0		0. 000000	0. 000000	1
90.06		SHELBYVILLE WOUND CLINIC	0	0		0. 000000	0. 000000	
90. 07		ONCOLOGY	10, 755	5, 587, 801		1	0. 000000	
90. 08	1	ANDERSON WOMENS CENTER	1, 106	4, 041, 590			0. 000000	1
91. 00		EMERGENCY	6, 079, 286	64, 974, 670		1	0. 000000	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	433, 776	17, 312, 952	17, 746, 72	0. 294698	0. 000000	92.00
		REIMBURSABLE COST CENTERS						
		HOME HEALTH AGENCY	0	0		)		101.00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	(			102.00
116.00	11600	HOSPI CE	0	0	(			116. 00
200.00	o	Subtotal (see instructions)	72, 738, 630	412, 159, 346	484, 897, 976	6		200.00
201.00	)	Less Observation Beds						201.00
202.00	o	Total (see instructions)	72, 738, 630	412, 159, 346	484, 897, 97	5		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
From 01/01/2022
To 12/31/2022
Date/Time Prepared:

F/26/2023 1: 23 pm

				To 12/31/2022	Date/Time Prepar 5/26/2023 1:33 p
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDIATRICS				30
31. 00	03100 INTENSIVE CARE UNIT				31
40.00	04000 SUBPROVI DER - I PF				40
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 000000			50
51. 00	05100  RECOVERY ROOM	0. 000000			51
53.00	05300 ANESTHESI OLOGY	0. 000000			53
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
60.00	06000 LABORATORY	0. 000000			60
65.00	06500 RESPIRATORY THERAPY	0. 000000			65
66. 00	06600 PHYSI CAL THERAPY	0. 000000			66
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			67
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73
76. 00	03020 CARDI AC	0. 000000			76
76. 01	03160 CARDI OPULMONARY	0. 000000			76
		0. 000000			77
77.00	OUTPATIENT SERVICE COST CENTERS	0. 000000			· · ·
88. 00	08800 RURAL HEALTH CLINIC	0. 000000			88
90.00	09000 CLINIC	0. 000000			90
90. 01	09001 WOUND CLINIC	0. 000000			90
90. 01	09002 DI ABETES CLINIC	0. 000000			90
90. 02	09003 ASTHMA CLINIC	0. 000000			90
90. 03	09004 ANDIS CLINIC	0. 000000			90
90.04	09005 PRIME TIME	0. 000000			90
90.05	09006 SHELBYVILLE WOUND CLINIC	0. 000000			90
90.00	04951 ONCOLOGY	0. 000000			90
90.07	04950 ANDERSON WOMENS CENTER	0. 000000			90
90.08	1 1				
	09100 EMERGENCY	0.000000			91
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92
101 00	OTHER REIMBURSABLE COST CENTERS				101
	10100 HOME HEALTH AGENCY				101
102.00	10200 OPI OI D TREATMENT PROGRAM				102
44/ 5-	SPECIAL PURPOSE COST CENTERS				
	11600 HOSPI CE				116
200.00	,				200
201.00	1 1				201
202.00	Total (see instructions)				202

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL	In Lieu of Form CMS-25			2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		norod.
				Го 12/31/2022	Date/Time Pre 5/26/2023 1:3	
		Title	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						
30. 00 ADULTS & PEDIATRICS	2, 411, 719	0	2, 411, 71	7, 796	309. 35	30.00
31.00 INTENSIVE CARE UNIT	1, 963, 834		1, 963, 83	5, 984	328. 18	31.00
40. 00 SUBPROVI DER - I PF	0	0		0	0.00	40.00
200.00 Total (lines 30 through 199)	4, 375, 553		4, 375, 55	13, 780	I	200.00
Cost Center Description	Inpatient	I npati ent		·		
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 026	317, 393				30.00
31.00 INTENSIVE CARE UNIT	2, 232	732, 498				31.00
40. 00 SUBPROVIDER - IPF	0	0				40.00
200.00 Total (lines 30 through 199)	3, 258	1, 049, 891				200. 00

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co		Period: From 01/01/2022 To 12/31/2022		pared:
		Title	: XVIII	Hospi tal	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	990, 925	45, 595, 791	0. 02173	3 2, 403, 615	52, 238	50.00
51.00   05100   RECOVERY ROOM	239, 848	2, 754, 482	0. 08707	6 218, 498	19, 026	51.00
53. 00   05300   ANESTHESI OLOGY	0	0	0.00000	0	0	53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	1, 751, 693	89, 206, 609	0. 01963	6 2, 999, 366	58, 896	54.00
60. 00   06000   LABORATORY	439, 119		0.00712	0 4, 607, 010	32, 802	60.00
65. 00 06500 RESPIRATORY THERAPY	403, 906	5, 084, 486	0. 07943	9 1, 285, 852	102, 147	65.00
66. 00 06600 PHYSI CAL THERAPY	340, 285	5, 281, 160	0. 06443	4 250, 732	16, 156	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 481	1, 390, 266	0.00394	2 213, 059	840	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 975	784, 983	0.00379	0 127, 598	484	68.00
69. 00 06900 ELECTROCARDI OLOGY	318, 908					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	1	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	306, 236	1, 641, 434			29, 674	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	19, 362			2 698, 544	1, 517	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	751, 755			4, 414, 328	28, 490	73.00
76. 00 03020 CARDI AC	0	0			0	76.00
76. 01 03160 CARDI OPULMONARY	82, 041	415, 811			0	76. 01
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0			0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	6, 494	732, 939	0.00886	0 0	0	88. 00
90. 00 09000 CLI NI C	0	0	0. 00000	0	l 0	90.00
90. 01   09001   WOUND CLINIC	225, 648	6, 386, 750			0	90. 01
90. 02 09002 DI ABETES CLINIC	788	15, 274			0	90.02
90. 03   09003   ASTHMA CLI NI C	0	0			Ō	90.03
90. 04   09004   ANDIS CLINIC	152, 401	49, 492			0	90.04
90. 05   09005   PRI ME TI ME	48	0	1		0	90.05
90. 06 09006 SHELBYVI LLE WOUND CLINIC	1	0	0. 00000		0	90.06
90. 07   04951   0NCOLOGY	983, 498	5, 598, 556			1, 883	
90. 08 04950 ANDERSON WOMENS CENTER	163, 640				l '	90.08
91. 00   09100   EMERGENCY	1, 121, 795					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	932, 391	17, 746, 728				
200.00 Total (lines 50 through 199)	9, 239, 238			22, 835, 478		
	,,23,,200	1 .55, .57, 101	1	22,000,170	1 .52,776	

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/26/2023 1:3	
		Title	2 XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0	0	40.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)	minus col. 4)				
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	7, 79	0.00	1, 026	30.00
31.00 03100 INTENSIVE CARE UNIT		0	5, 98	4 0.00	2, 232	31.00
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0.00	0	40.00
200.00 Total (lines 30 through 199)		0	13, 78	0	3, 258	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
40. 00   04000   SUBPROVI DER - I PF	0					40.00
200.00 Total (lines 30 through 199)	0					200.00
	•					-

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0037	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared:

					10 12/31/2022	5/26/2023 1:3	eparea: 3 nm
			Title	XVIII	Hospi tal	PPS	о р
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	•	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	0		0 0	353, 516	54.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03020 CARDI AC	0	0		0 0	0	76. 00
76. 01	03160 CARDI OPULMONARY	0	0		0 0	0	76. 01
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
90.00	09000  CLI NI C	0	0		0	0	90.00
90. 01	09001 WOUND CLINIC	0	0		0	0	90. 01
	09002 DI ABETES CLINIC	0	0		0	0	90. 02
90. 03	09003 ASTHMA CLINIC	0	0		0	0	90. 03
90. 04	09004 ANDIS CLINIC	0	0		0	0	90. 04
90. 05	09005 PRIME TIME	0	0		0	0	90. 05
90.06	09006 SHELBYVILLE WOUND CLINIC	0	0		0	0	90.06
	O4951 ONCOLOGY	0	0		0	0	90. 07
90. 08	04950 ANDERSON WOMENS CENTER	0	0		0	0	90. 08
91.00	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0 0	353, 516	200.00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provider CCN: 15-0037	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared:

THROUGH GOOTS			Т	o 12/31/2022	Date/Time Prep 5/26/2023 1:3	
		Title	XVIII	Hospi tal	PPS	o piii
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	C	45, 595, 791	0. 000000	1
51.00   05100   RECOVERY ROOM	0	0	C	2, 754, 482		1
53. 00   05300   ANESTHESI OLOGY	0	0	C	0	0. 000000	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	353, 516	353, 516		0. 003963	
60. 00   06000   LABORATORY	0	0	C	0.70727.12	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	[ C	5, 084, 486		
66. 00 06600 PHYSI CAL THERAPY	0	0	[ C	5, 281, 160		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	[ C	1, 390, 266		1
68.00   06800   SPEECH PATHOLOGY	0	0	C	784, 983		
69. 00   06900   ELECTROCARDI OLOGY	0	0	C	15, 332, 990	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	1, 641, 434	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	8, 912, 541	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	116, 487, 808	0.000000	73.00
76. 00   03020   CARDI AC	0	0	C	0	0.000000	76. 00
76. 01   03160   CARDI OPULMONARY	0	0	C	415, 811	0.000000	76. 01
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	0	0.000000	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	C	732, 939	0.000000	88. 00
90. 00  09000  CLI NI C	0	0	C	0	0.000000	90.00
90. 01  09001 WOUND CLINIC	0	0	C	6, 386, 750	0.000000	90. 01
90. 02   09002   DI ABETES CLINIC	0	0	C	15, 274	0.000000	90. 02
90. 03   09003   ASTHMA CLINIC	0	0	C	0	0.000000	90. 03
90. 04   09004   ANDIS CLINIC	0	0	C	49, 492	0.000000	90.04
90.05 09005 PRIME TIME	0	0	C	0	0.000000	90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	0	0	C	0	0.000000	90.06
90. 07   04951   ONCOLOGY	0	0	C	5, 598, 556	0.000000	90.07
90. 08 04950 ANDERSON WOMENS CENTER	0	0	C	4, 042, 696	0.000000	90.08
91. 00 09100 EMERGENCY	0	0	C	71, 053, 956	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C			92.00
200.00 Total (lines 50 through 199)	0	353, 516	353, 516	460, 187, 164		200. 00

Health Financial Systems	HANCOCK REGIONA	L HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der C	CN: 15-0037	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022		
				To 12/31/2022	Date/Time Pre	
					5/26/2023 1: 3	3 pm
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	

Cost Center Description			T: +1 o	VVIII	Hoon: tol	PPS	<u>o p</u>
Rati o of Cost to Charges	Coat Contan Decemintion	Outpoti ont			Hospi tal		
Charges	cost center bescription						
Cost (col   6     Col   7     Cost (col   8   Cost (col   8   Cost (col   9   Cost (col   0					9		
NOTES   NOTE			unarges		Charges		
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS   S0.00   G5000   GFERATI NG ROOM   C.000000   C.403, 615   C.0   S.86, 071   C.0   S.00   S.00   G5000   GFERATI NG ROOM   C.000000   C.403, 615   C.0   S.86, 071   C.0   S.00   S.00   G.000000   C.403, 615   C.0   G.000000   C.403, 618   C.0   S.00   G.000000   C.403, 618   C.0   S.00   G.000000   C.403, 618   C.0   S.00   G.000000   C.403, 618   C.0   G.000000   C.403, 618   C.0   G.000000   C.403, 618   C.0   G.000000   C.403, 618   C.0   G.0000000   C.403, 618   C.0   G.00000000   C.403, 618   C.0   G.00000000   C.403, 618   C.40			10.00		10.00		
50.00	ANOULL ARV. OFRWI OF COOT OFWITTED	9.00	10.00	11.00	12.00	13.00	
51.00		0.00000	0 100 (15		5 00/ 074		
53.00         05300   ANESTHESI OLOGY         0.000000   0.00000         0         0         0         0         53.00           54.00         05400   RADI OLOGY-DI AGNOSTI C         0.000363         2,999,366         11,886         19,766,501         78,335         54.00           65.00         06000   CABORATORY         0.000000         1,872,639         0.60.00         66.00           65.00         06500   RESPI RATORY THERAPY         0.000000         1,285,852         0         1,872,639         0.65.00           66.00         06600   PHYSI CAL THERAPY         0.000000         250,732         0         30,970         0.65.00           68.00         06800   SPECH PATHOLOGY         0.000000         213,059         0         12,717         0         67.00           69.00         06800   SPEECH PATHOLOGY         0.000000         1,333,262         0         2,990,260         0         68.00           70.00         07000   ELECTROEADI LOGY         0.000000         1,333,262         0         2,990,260         0         69.00           71.00         07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.000000         0         0         0         0         70.00           72.00         07200   IMPLL BAL SUPPLIMONARY							
54.00   05400   RADI OLOGY-DI AGNOSTI C   0.003963   2,999,366   11,886   19,766,501   78,335   54,00			218, 498	0	305, 618	l	
60. 00   06000   LABORATORY   0.000000   4,607,010   0   5,803,312   0   60.00   65. 00   06500   06500   RESPIRATORY THERAPY   0.000000   1,285,852   0   1,872,639   0.65.00   66. 00   06600   PHYSI CAL THERAPY   0.000000   250,732   0   30,970   0.66.00   67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   213,059   0   12,717   0   67.00   68. 00   06800   SPEECH PATHOLOGY   0.000000   127,598   0   7,844   0   68.00   69. 00   06900   ELECTROCARDI OLOGY   0.000000   1,333,262   0   2,990,260   0   69.00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   159,051   0   248,639   0   71.00   72. 00   07200   IMPL   DEV   CHARGED TO PATIENTS   0.000000   698,544   0   1,629,436   0   72.00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   698,544   0   1,629,436   0   72.00   76. 01   03160   CARDI AC   0.000000   0   0   0   0   0   0   76. 01   03160   CARDI AC   0.000000   0   0   0   0   0   0   77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0.000000   0   0   0   0   0   77. 00   07000   UNIDATIENT SERVICE COST CENTERS  88. 00   08800   RURAL HEALTH CLINIC   0.000000   0   0   0   0   0   90. 01   90001   WOUND CLINIC   0.000000   0   0   0   0   0   90. 02   09002   DI ABETES CLINIC   0.000000   0   0   0   0   90. 03   09003 ASTHMA CLINIC   0.000000   0   0   0   0   0   90. 04   09004   ANDIS CLINIC   0.000000   0   0   0   0   0   90. 05   09005   PRI ME TI ME   0.000000   0   0   0   0   0   90. 05   09005   PRI ME TI ME   0.000000   0   0   0   0   0   90. 06   09006   SHERBYVILLE WOUND CLINIC   0.000000   0   0   0   138,358   0   90.08   91. 00   09000   00   00   00   00   00			0	0	0		
65. 00   06500   RESPI RATORY THERAPY   0.000000   1, 285, 852   0   1, 872, 639   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0.000000   250, 732   0   30, 970   0   66. 00   67. 00   06700   0500000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000							
66.00   06600   PHYSI CAL THERAPY   0.000000   250,732   0   30,970   0   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0.000000   213,059   0   12,717   0   67.00   68.00   06800   SPEECH PATHOLOGY   0.000000   127,598   0   7,844   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0.000000   1,333,262   0   2,990,260   0   69.00   70.00   07000   ELECTROENCEPHALLOGRAPHY   0.000000   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   159,051   0   248,639   0   71.00   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.000000   698,544   0   1,629,436   0   72.00   73.00   07300   DRIGS CHARGED TO PATI ENTS   0.000000   698,544   0   1,629,436   0   73.00   73.00   07300   DRIGS CHARGED TO PATI ENTS   0.000000   0   0   0   0   76.01   03160   CARDI OPULMONARY   0.000000   0   0   164,049   0   76.01   77.00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0   0   0   0   0   77.00   0UTPATI ENT SERVI CE COST CENTERS  88.00   08800   RURAL HEALTH CLINI C   0.000000   0   0   0   0   0   90.01   09001   WOUND CLI NI C   0.000000   0   0   0   0   0   90.02   09002   DI ABETES CLI NI C   0.000000   0   0   0   0   0   90.03   O9003   ASTHMA CLI NI C   0.000000   0   0   0   0   0   90.04   09004   ANDIS CLI NI C   0.000000   0   0   0   0   0   90.05   09006   SHELBYYI LLE WOUND CLI NI C   0.000000   0   0   0   0   0   90.07   04951   ONCOLOGY   0.000000   0   0   0   0   0   90.08   04950   ANDERSON WOMENS CENTER   0.000000   0   0   138,358   0   90.05   90.09   09000   00   00   00   00   0   0		1 1					
67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   213, 059   0   12,717   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0.000000   127, 598   0   7,844   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0.000000   1,333, 262   0   2,990, 260   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   159, 051   0   248, 639   0   71. 00   72. 00   07200   IMPLD DEV. CHARGED TO PATI ENTS   0.000000   698, 544   0   1, 629, 436   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   4, 414, 328   0   31, 273, 443   0   73. 00   76. 00   03020   CARDI AC   0.000000   0   0   0   0   0   76. 01   03160   CARDI OPULMONARY   0.000000   0   0   0   0   0   76. 01   07700   ALLOGENEIC STEM CELL ACQUISITION   0.000000   0   0   0   0   77. 00   07700   RURAL HEALTH CLINIC   0.000000   0   0   0   0   77. 00   09000   DIABETES CLINIC   0.000000   0   0   0   0   0   79. 01   09001   WOUND CLINIC   0.000000   0   0   0   0   0   79. 02   09002   DIABETES CLINIC   0.000000   0   0   0   0   79. 03   09003   ASTHMA CLINIC   0.000000   0   0   0   0   0   79. 04   09004   ANDIS CLINIC   0.000000   0   0   0   0   79. 05   09005   PRI ME TI ME   0.000000   0   0   0   0   79. 07   0.00000   0   0   0   0   0   79. 08   04950   ANDERSON WOMENS CENTER   0.000000   0   0   138, 358   0   90. 08   79. 09   09000   00000   000000   0   0   0	65. 00  06500 RESPIRATORY THERAPY	0. 000000	1, 285, 852	0	1, 872, 639	0	65.00
68. 00   06800   SPEECH PATHOLOGY   0.000000   127, 598   0   7, 844   0   68. 00   69. 00   0.00000   1, 333, 262   0   2, 990, 260   0   69. 00   0.00000   0   0   0   0   0   0	66. 00  06600 PHYSI CAL THERAPY	0. 000000	250, 732	0	30, 970	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	213, 059	0	12, 717	0	67.00
70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   0   0   0   0   0   0   70. 00	68.00 06800 SPEECH PATHOLOGY	0. 000000	127, 598	0	7, 844	0	68.00
71. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 333, 262	0	2, 990, 260	0	69.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENT   0.000000   698, 544   0   1,629, 436   0   72.00     73.00   07300   DRUGS CHARGED TO PATIENTS   0.000000   4,414,328   0   31,273,443   0   73.00     76.01   03160   CARDI AC   0.000000   0   0   0   0   0     76.01   03160   CARDI OPULMONARY   0.000000   0   0   164,049   0   76.01     77.00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0   0   0   0     77.00   OUTPATI ENT SERVI CE COST CENTERS	70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70.00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	159, 051	0	248, 639	0	71.00
73. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	698, 544	O	1, 629, 436	0	72.00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 414, 328	o		l	73.00
76. 01		1	0	o	0	0	76.00
77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0.000000   0   0   0   0   0   0   0			0	o	164, 049	0	
SECTION   SERVICE COST CENTERS   SERVICE COST COST CENTERS   SERVICE COST COST CENTERS   SERVICE COST COST COST COST COST COST COST COST			0	o o			
88. 00				·			
90. 00		0.000000	0	0	0	0	88.00
90. 01   09001   WOUND CLINIC   0.000000   0   0   476,056   0   90. 01   90. 02   09002   DI ABETES CLINIC   0.000000   0   0   0   0   90. 02   90. 03   09003   ASTHMA CLINIC   0.000000   0   0   0   0   90. 03   90. 04   09004   ANDIS CLINIC   0.000000   0   0   0   0   90. 04   90. 05   09005   PRI ME TI ME   0.000000   0   0   0   0   0   90. 05   90. 06   09006   SHELBYVILLE WOUND CLINIC   0.000000   0   0   0   0   0   90. 05   90. 07   04951   0NCOLOGY   0.000000   10,721   0   1,719,641   0   90. 07   90. 08   04950   ANDERSON WOMENS CENTER   0.000000   0   0   138,358   0   90. 08   91. 00   09100   EMERGENCY   0.000000   3,680,066   0   8,837,944   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.000000   433,776   0   4,630,454   0   92. 00		0. 000000	0	0	0	0	90.00
90. 02			0	o o	476, 056	0	
90. 03			0	0	0	1	
90. 04			0	0	0	0	
90. 05   09005   09005   09006			0		0	ľ	
90. 06   09006   SHELBYVILLE WOUND CLINIC   0. 000000   0   0   0   0   90. 06   90. 07   04951   0NCOLOGY   0. 000000   10, 721   0   1, 719, 641   0   90. 07   90. 08   04950   ANDERSON WOMENS CENTER   0. 000000   0   0   138, 358   0   90. 08   91. 00   09100   EMERGENCY   0. 000000   3, 680, 066   0   8, 837, 944   0   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 000000   433, 776   0   4, 630, 454   0   92. 00			0	١	0	1	
90. 07   04951   ONCOLOGY   0. 000000   10, 721   0   1, 719, 641   0   90. 07   90. 08   04950   ANDERSON WOMENS CENTER   0. 000000   0   138, 358   0   90. 08   91. 00   09100   EMERGENCY   0. 000000   3, 680, 066   0   8, 837, 944   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0. 000000   433, 776   0   4, 630, 454   0   92. 00			0	0	0	· ·	
90. 08   04950   ANDERSON WOMENS CENTER   0. 000000   0   138, 358   0   90. 08   91. 00   09100   EMERGENCY   0. 000000   3, 680, 066   0   8, 837, 944   0   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 000000   433, 776   0   4, 630, 454   0   92. 00			10 721	0	1 710 6/11	1	
91. 00   09100   EMERGENCY   0. 000000   3, 680, 066   0   8, 837, 944   0   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 000000   433, 776   0   4, 630, 454   0   92. 00			10, 721				
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0.000000   433,776   0   4,630,454   0   92.00			2 690 066				
		1 1					
200. 00   Total (Thes 50 through 199)     22, 835, 476  11, 886  85, 793, 952  78, 335 200. 00		0.000000	·				
	200.00   Total (Tries 50 through 199)	1	22, 835, 478	11,886	85, 193, 952	18, 335	1200.00

| Peri od: | Worksheet D | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time Prepared:

				10 12/31/2022	5/26/2023 1: 3	
		Title	XVIII	Hospi tal	PPS	<u>o p</u>
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Servi ces Not	(000 111011)	
	Worksheet C.	inst.)	Subject To	Subject To		
	Part I, col.	11131.)	Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1, 00	2. 00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00		0.00	
50. 00 05000 OPERATING ROOM	0. 213788	5, 886, 071		0	1, 258, 371	50.00
51. 00 05100 RECOVERY ROOM	0. 539573	305, 618		0	164, 903	51.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	303, 010		0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 125279	19, 766, 501			2, 476, 327	54.00
60. 00   06000   LABORATORY	0. 125277	5, 803, 312		-	735, 634	60.00
65. 00   06500   RESPI RATORY   THERAPY	0. 760976	1, 872, 639		0	1, 425, 033	
66. 00   06600   PHYSI CAL THERAPY	0. 760976	30, 970			1, 425, 033	
					-	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 376281	12, 717		-	4, 785	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 362678	7, 844		0	2, 845	
69. 00 06900 ELECTROCARDI OLOGY	0. 125536	2, 990, 260		0	375, 385	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3. 261185	248, 639		0	810, 858	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 229193	1, 629, 436		0	373, 455	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 239768	31, 273, 443		5, 791	7, 498, 371	73.00
76. 00   03020   CARDI AC	0. 000000	0		0	0	76. 00
76. 01 03160 CARDI OPULMONARY	0. 605616	164, 049		0	99, 351	76. 01
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	(	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC						88. 00
90. 00   09000   CLI NI C	0. 000000	0		0	0	90.00
90. 01 09001 WOUND CLINIC	0. 185303	476, 056		0	88, 215	90. 01
90. 02   09002 DI ABETES CLINIC	4. 994631	0		0	0	90. 02
90. 03   09003   ASTHMA   CLI NI C	0. 000000	0		0	0	90. 03
90. 04   09004   ANDIS CLINIC	10. 924978	0		0	0	90.04
90. 05 09005 PRIME TIME	0. 000000	0		0	0	90.05
90. 06 09006 SHELBYVILLE WOUND CLINIC	0. 000000	0		0	0	90.06
90. 07   04951   0NCOLOGY	0. 722455	1, 719, 641	1	0	1, 242, 363	90. 07
90. 08 04950 ANDERSON WOMENS CENTER	0. 286463	138, 358		0	39, 634	90. 08
91. 00   09100   EMERGENCY	0. 141002	8, 837, 944		0	1, 246, 168	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 294698	4, 630, 454		o o	1, 364, 586	
200.00 Subtotal (see instructions)	0.271070	85, 793, 952			19, 222, 671	
201.00 Less PBP Clinic Lab. Services-Program		05, 775, 752		0 0		201.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		85, 793, 952	50	5, 791	19, 222, 671	202 00
202. 00	1	03, 173, 732	1 20	5, 771	17, 222, 071	1202.00

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0037

Period: Period: From 01/01/2022 Part V
To 12/21/2022 Date/Time Prepared:

				To 12/31/2022	Date/Time Pre 5/26/2023 1:3	
		Title	XVIII	Hospi tal	PPS	<u> </u>
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	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   OPERATI NG ROOM	0	0				50.00
51.00  05100 RECOVERY ROOM	0	0	1			51.00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00   06000   LABORATORY	6	0				60.00
65. 00  06500 RESPIRATORY THERAPY	0	0				65.00
66. 00  06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00   06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00   06800   SPEECH PATHOLOGY	0	0				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0				69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00   07300   DRUGS CHARGED TO PATIENTS	0	1, 388				73.00
76. 00   03020   CARDI AC	0	0				76. 00
76. 01 03160 CARDI OPULMONARY	0	0	)			76. 01
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
OUTPATIENT SERVICE COST CENTERS	_					
88. 00 08800 RURAL HEALTH CLINIC						88. 00
90. 00   09000   CLI NI C	0	0				90.00
90. 01   09001   WOUND CLINIC	0	0				90. 01
90. 02   09002   DI ABETES CLINIC	0	0				90. 02
90. 03   09003   ASTHMA CLINIC	0	0				90. 03
90. 04   09004   ANDIS CLINIC	0	0				90. 04
90. 05   09005   PRI ME TI ME	0	0	1			90. 05
90.06 09006 SHELBYVILLE WOUND CLINIC	0	0	1			90.06
90. 07   04951   ONCOLOGY	0	0				90. 07
90.08 04950 ANDERSON WOMENS CENTER	0	0				90. 08
91. 00   09100   EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1			92.00
200.00 Subtotal (see instructions)	6	1, 388				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	,	1 000				202.00
202.00   Net Charges (line 200 - line 201)	6	1, 388	1			202. 00

Heal th Financi	al Systems	HANCOCK REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF	F INPATIENT OPERATING COST		Provi der CCN: 15-0037	Peri od: From 01/01/2022	Worksheet D-1	
				To 12/31/2022	Date/Time Pre 5/26/2023 1:3	
•			Title XVIII	Hospi tal	PPS	
Co	ost Center Description					
					1. 00	
PART I	- ALL PROVIDER COMPONENTS					
I NPATI E	NT DAYS					
1 00 Innatio	ant days (including private room da	ve and swing-had day	s eveluding newhorn)		7 706	1 1 00

		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		7, 796	1.00
2.00	Inpatient days (including private room days, excluding swing-			7, 796	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days	ays). If you have only pr	ivate room days,	0	3.00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation between the complete this line.	and days)		4, 782	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	4, 732	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om daya) +brayab Dagambar	21 of the cost	0	7. 00
7.00	reporting period	on days) thi ough becember	31 OF THE COST	Ü	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 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 t	to the Program (excluding	swing-bed and	1, 026	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		com days)	· ·	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private r	oom days) after	0	11.00
10.00	December 31 of the cost reporting period (if calendar year, e			0	40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	e room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00 16. 00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 c	f the cost	0. 00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19. 00
	reporting period	ğ.			
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instruction	ns)		13, 527, 699	21 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line		22.00
	5 x line 17)	·			
23. 00	J 31	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18)  Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24. 00
2 00	7 x line 19)		g poou (o	Ü	200
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
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		13, 527, 699	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(**************************************		,	
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)		28. 00
	Pri vate room charges (excluding swing-bed charges)			0	1
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)   General inpatient routine service cost/charge ratio (line 27	· lino 20)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	÷ 111le 20)		0.00000	ı
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	1
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ti ons)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (line	0 13, 527, 699	36. 00 37. 00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rielential (IINe	13, 327, 099	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			1, 735. 21	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		1, 780, 325 0	39. 00 40. 00
41.00				1, 780, 325	
		•	'	•	

	Financial Systems TION OF INPATIENT OPERATING COST	HANCOCK REGION	AL HOSPITAL Provider C	CN: 15-0037	Period: From 01/01/2022	u of Form CMS-2 Worksheet D-1	
					To 12/31/2022	Date/Time Pre 5/26/2023 1:3	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	NURSERY (title V & XIX only)						42.
	ntensive Care Type Inpatient Hospital Units	12, 893, 216	5, 984	2, 154. 6	1 2, 232	4, 809, 090	43.
	CORONARY CARE UNIT	12,070,210	0, 701	2, 101. 0	2,202	1,007,070	44.
	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46.
. 00 [0	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.
	·					1. 00	
	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)	5, 388, 186 0	1
	Total Program inpatient costs (sum of lines				, corumin r)	11, 977, 601	
F	PASS THROUGH COST ADJUSTMENTS						
	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	1, 049, 891	50.
. 00	III) Pass through costs applicable to Program inp and IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	464, 661	51.
	Total Program excludable cost (sum of lines	50 and 51)				1, 514, 552	52.
. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-ph	ysician anest	hetist, and	10, 463, 049	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program discharges					0	54.
	Target amount per discharge					0. 00	55.
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor Farget amount (line 54 x sum of lines 55, 55					0.00	55. 56.
	Difference between adjusted inpatient operat			line 56 minus	line 53)	0	57
00 8	Bonus payment (see instructions)	Ü			ŕ	0	58
	Frended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost rep	orting period	endi ng 1996,	0. 00	59
	Expected costs (lesser of line 53 ÷ line 54,		m prior year	cost report,	updated by the	0.00	60.
. 00	market basket) Continuous improvement bonus payment (if lin					0	61.
í	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)						
	Relief payment (see instructions)					0	62.
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of th	e cost renort	ing period (See	0	64.
	nstructions)(title XVIII only)	rts till odgir beec	inder 31 of th	c cost report	ing period (see	Ü	04
	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.
	nstructions)(title XVIII only) Fotal Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	ll only); for	0	66.
	CAH, see instructions					_	
	Fitle V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68.
	(line 13 x line 20) Fotal title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	e 68)		0	69
	ART III - SKILLED NURSING FACILITY, OTHER N						٦.
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				)		70 71
- 1	Program routine service cost (line 9 x line	,	c , o . Trile	-/			72
	Medically necessary private room cost applic	•	•				73
	Fotal Program general inpatient routine serv Capital-related cost allocated to inpatient				Dart II column		74 75
	26, line 45)	TOUTINE SELVICE		WOI KSHEEL D,	rait II, COTUIIII		′°
00	Per diem capital-related costs (line 75 ÷ li						76
	Program capital-related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi den irecon	ds)			78 79
- 1	Total Program routine service costs for comp				nus line 79)		80
00	npatient routine service cost per diem limi	tati on			·		81
	Inpatient routine service cost limitation (I		•				82
1	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		15)				83
	Jtilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 th					86
	PART IV - COMPUTATION OF OBSERVATION BED PAS  Total observation bed days (see instructions					3, 014	87
	Adjusted general inpatient routine cost per	•	line 2)			1, 735. 21	

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			5, 229, 923	89.00
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	2, 411, 719	13, 527, 699	0. 17828	5, 229, 923	932, 391	90.00
91.00 Nursing Program cost	0	13, 527, 699	0. 00000	5, 229, 923	0	91.00
92.00 Allied health cost	0	13, 527, 699	0. 00000	5, 229, 923	0	92.00
93.00 All other Medical Education	0	13, 527, 699	0. 00000	5, 229, 923	0	93.00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0037	Peri od: From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/26/2023 1:3	pared: 3 pm
		Title XIX	Hospi tal	Cost	<u> </u>
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					

		Title XIX	Hospi tal	Cost	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	, excluding newborn)		7, 796	1.00
2. 00	Inpatient days (including private room days, excluding swing-b			7, 796	2.00
3. 00	Private room days (excluding swing-bed and observation bed day	s). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d days)		4, 782	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	4, 782	1
3.00	reporting period	iii days) trii ougri beceiibe	1 31 01 116 6031	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	m 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 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber e	TOT THE COST	· ·	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	169	9. 00
40.00	newborn days) (see instructions)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		oom days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	lv (including private r	noom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, en		days, ares	Ü	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.00
40.00	through December 31 of the cost reporting period			0	40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13.00
14. 00	Medically necessary private room days applicable to the Progra			0	14.00
15. 00	Total nursery days (title V or XIX only)	(energaning energy		0	ł
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 c	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18. 00
.0.00	reporting period	o a. to. Boodinge. o. o.		0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19.00
00.00	reporting period	Clark Branch and Clark		0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions	)		13, 527, 699	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decembe		ing period (line		1
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g 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 reporti	ng period (line	0	24.00
24.00	7 x line 19)	or or the cost reporti	ng perrou (Trie	O	24.00
25.00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25.00
	x line 20)				
26.00	Total swing-bed cost (see instructions)	line 21 minus line 24)		12 527 400	
27.00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	TTHE 21 III HUS TTHE 26)		13, 527, 699	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		,	0	29. 00
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	1
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	ı
34. 00	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x lin			0.00	ı
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 a	nd private room cost di	fferential (line	13, 527, 699	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU-	STMENTS			-
38. 00	Adjusted general inpatient routine service cost per diem (see		T	1, 735. 21	38.00
	Program general inpatient routine service cost (line 9 x line			293, 250	ı
40. 00	Medically necessary private room cost applicable to the Progra			0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		293, 250	41.00

6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room 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 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	169	9. 00
	newborn days) (see instructions)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ĭ	00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
13. 00	through December 31 of the cost reporting period  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	13.00
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	
16. 00	Nursery days (title V or XIX only)	0	16.00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	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
	reporting period		
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
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	13, 527, 699	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	o	23. 00
20.00	x line 18)	ĭ	20.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
25. 00	7 x line 19)   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
23.00	x line 20)	٥	23.00
26.00	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13, 527, 699	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	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi -private room charges (excluding swing-bed charges)	ő	
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
	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	13, 527, 699	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, 735. 21	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	293, 250	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	293, 250	
	·	·	

COMPUTATION OF INPATIENT OPERATING COST		NAL HOSPITAL Provider C		Peri od:	u of Form CMS-2 Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	Cost	э рш
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 Uni		F 004	0.454.7	1	0	40.00
43.00 INTENSIVE CARE UNIT 44.00 CORONARY CARE UNIT	12, 893, 216	5, 984	2, 154. 6	1 0	0	43.00
45. 00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
Cost Center Description						47.00
48.00 Program inpatient ancillary service cost (	Wkst D-3 col	3 line 200)			1. 00 189, 205	48. 00
48.01 Program inpatient cellular therapy acquisi	tion cost (Works	heet D-6, Part		column 1)	0	48. 01
49.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	es 41 through 48.	01)(see instru	ctions)		482, 455	49.00
50.00 Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, sur	n of Parts I and	0	50.00
III)			W D	£ Dt II		F1 00
51.00 Pass through costs applicable to Program i and IV)	npatient ancilia	ry services (r	rom wkst. D, s	sum of Parts II	0	51.00
52.00 Total Program excludable cost (sum of line					0	
53.00 Total Program inpatient operating cost exc medical education costs (line 49 minus lin	9 1	elated, non-ph	ysician anesti	netist, and	0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
<ul><li>54. 00 Program di scharges</li><li>55. 00 Target amount per di scharge</li></ul>					0 0. 00	
55.01 Permanent adjustment amount per discharge					0.00	
55.02 Adjustment amount per discharge (contracto	J.				0.00	
56.00 Target amount (line 54 x sum of lines 55, 57.00 Difference between adjusted inpatient oper		•	line 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)	atting cost and the	arget amount (	Tric 30 iii rid3	11110 33)	0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54		m the cost rep	orting period	endi ng 1996,	0. 00	59.00
updated and compounded by the market baske 60.00 Expected costs (lesser of line 53 ÷ line 5		om prior year	cost report, i	updated by the	0. 00	60.00
market basket) 61.00 Continuous improvement bonus payment (if I 55.01, or line 59, or line 60, enter the I					0	61.00
53) are less than expected costs (lines 54 enter zero. (see instructions)						
<ul><li>62.00   Relief payment (see instructions)</li><li>63.00   Allowable Inpatient cost plus incentive pa</li></ul>	ıvment (see instr	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST		, , , , , , , , , , , , , , , , , , ,			0	,,,,,,
64.00 Medicare swing-bed SNF inpatient routine clinstructions)(title XVIII only)	osts through bec	ember 31 of th	e cost reporti	ng period (see	0	64. 00
65.00 Medicare swing-bed SNF inpatient routine of	osts after Decem	ber 31 of the	cost reportino	g period (See	0	65.00
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient rou	itine costs (line	64 plus line	65)(title XVII	I only); for	0	66. 00
CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient rout	ine costs throug	h December 31	of the cost re	eporting period	0	67. 00
(line 12 x line 19)	-				_	60 00
68.00 Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	THE COSTS AFTER	pecellibet 31 OT	the cost repo	л стпу реггоа	0	68.00
69.00 Total title V or XIX swing-bed NF inpatier					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER 70.00 Skilled nursing facility/other nursing fac						70.00
71.00 Adjusted general inpatient routine service		line 70 ÷ line	2)			71.00
72.00 Program routine service cost (line 9 x lir 73.00 Medically necessary private room cost appl		m (line 14 x l	ine 35)			72.00
74.00 Total Program general inpatient routine se	ervice costs (lin	e 72 + line 73	)			74.00
75.00 Capital-related cost allocated to inpatier 26, line 45)	nt routine servic	e costs (from	Worksheet B, F	Part II, column		75.00
76.00 Per diem capital-related costs (line 75 ÷						76.00
77.00   Program capital-related costs (line 9 x li 78.00   Inpatient routine service cost (line 74 mi						77. 00 78. 00
79.00 Aggregate charges to beneficiaries for exc	ess costs (from					79.00
80.00 Total Program routine service costs for co	•	cost limitatio	n (line 78 mir	nus line 79)		80.00
81.00 Inpatient routine service cost per diem li 82.00 Inpatient routine service cost limitation		1)				81. 00 82. 00
83.00 Reasonable inpatient routine service costs	(see instructio					83.00
84.00 Program inpatient ancillary services (see 85.00 Utilization review - physician compensation	,	ons)				84. 00 85. 00
86. 00 Total Program inpatient operating costs (s						86.00
PART IV - COMPUTATION OF OBSERVATION BED P 87.00 Total observation bed days (see instruction					2.014	07 00
87.00 Total observation bed days (see instruction 88.00 Adjusted general inpatient routine cost pe		1: 2)			1, 735. 21	87.00

Health Financial Systems	HANCOCK REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 3 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			5, 229, 923	89.00
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	2, 411, 719	13, 527, 699	0. 17828	5, 229, 923	932, 391	90.00
91.00 Nursing Program cost	0	13, 527, 699	0.00000	5, 229, 923	0	91.00
92.00 Allied health cost	0	13, 527, 699	0.00000	5, 229, 923	0	92.00
93.00 All other Medical Education	0	13, 527, 699	0.00000			93.00

<del></del>	REGIONAL HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0037	Peri od: From 01/01/2022	Worksheet D-3	3
			To 12/31/2022		epared:
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description	<u> </u>	Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	col . 2)	
INDATIENT DOUTINE CEDVICE COCT CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS			943, 223		30.00
31. 00   03100   NTENSIVE CARE UNIT			5, 770, 851		31.00
40. 00   04000   SUBPROVI DER -   PF			3, 770, 831		40.00
ANCILLARY SERVICE COST CENTERS					1 40.00
50. 00 OPERATING ROOM		0. 21378	2, 403, 615	513, 864	50.00
51. 00   05100   RECOVERY ROOM		0. 5395			
53. 00   05300   ANESTHESI OLOGY		0.00000	00 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1252	79 2, 999, 366	375, 758	54.0
50. 00 06000 LABORATORY		0. 1267	4, 607, 010	583, 989	60.0
55. 00 06500 RESPIRATORY THERAPY		0. 7609	76 1, 285, 852	978, 503	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 5291	33 250, 732	132, 671	66.0
57. 00 06700 OCCUPATI ONAL THERAPY		0. 37628	213, 059	80, 170	67.00
58. 00   06800   SPEECH PATHOLOGY		0. 3626			
59. 00 06900 ELECTROCARDI OLOGY		0. 1255		167, 372	
O. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3. 26118		518, 695	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT		0. 2291			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2397			
76. 00   03020   CARDI AC		0.00000		1	
76. 01   03160  CARDI OPULMONARY 77. 00   07700  ALLOGENEI C STEM CELL ACQUISITION		0. 6056 0. 00000			
OUTPATIENT SERVICE COST CENTERS		0.0000	50  0		17.0
88. 00   08800   RURAL HEALTH CLINIC		0.0000	00	0	88.00
20. 00   09000   CLI NI C		0. 00000			90.0
00. 01   09001   WOUND CLINIC		0. 18530		Ō	
00. 02 09002 DI ABETES CLINIC		4. 9946		0	1
00.03 09003 ASTHMA CLINIC		0. 00000		0	90.0
0. 04   09004   ANDIS CLINIC		10. 9249	78 0	0	90.0
00.05 09005 PRIME TIME		0. 00000	00	0	90.0
00.06 09006 SHELBYVILLE WOUND CLINIC		0.00000	00	0	90.0
00. 07   04951   ONCOLOGY		0. 7224!		7, 745	90.0
PO. 08 04950 ANDERSON WOMENS CENTER		0. 2864			
91. 00   09100   EMERGENCY		0. 14100			
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2946	-		
200 00 Total (sum of lines 50 through 94 and 96 through	1 98)		22 835 478	5 388 186	1200 0

5, 388, 186 200. 00 201. 00

202.00

22, 835, 478

22, 835, 478

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

200. 00 201. 00

202.00

Health Financial Systems HANCOCK REGIONAL	UOSDI TAI		In Lio	u of Form CMS-:	2552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0037	Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022		pared:
	Ti tl	e XIX	Hospi tal	Cost	о рііі
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x	
		1.00	2.00	col . 2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			289, 560		30.00
31.00 03100 INTENSIVE CARE UNIT			227, 038		31.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM		0. 21378			
51. 00   05100   RECOVERY ROOM		0. 5395			1
53. 00   05300  ANESTHESI OLOGY		0.0000		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1252		7, 127	1
60. 00   06000   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY		0. 1267 0. 7609		19, 256	1
66. 00   06600   PHYSI CAL THERAPY		0. 7609		28, 638 2, 842	1
67. 00   06700   OCCUPATI ONAL THERAPY		0. 37628			1
68. 00   06800   SPEECH   PATHOLOGY		0. 3626			
69. 00   06900   ELECTROCARDI OLOGY		0. 1255			1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3. 26118		20, 885	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 2291		0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 2397	58 194, 939	46, 740	73.00
76. 00   03020   CARDI AC		0. 00000		0	
76. 01 03160 CARDI OPULMONARY		0. 6056		0	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS		0.0700	40		00.00
88. 00   08800   RURAL HEALTH CLINIC 90. 00   09000   CLINIC		0. 8799 0. 0000		0	
90. 01   09001   WOUND   CLINIC		0. 00000		34	
90. 02   09002   DI ABETES   CLI NI C		4. 9946		0	1
90. 03   09003   ASTHMA   CLINIC		0. 00000		0	
90. 04   09004   ANDIS CLINIC		10. 9249		l ő	1
90. 05   09005   PRI ME TI ME		0. 00000		Ö	1
90. 06 O9006 SHELBYVILLE WOUND CLINIC		0.0000		Ō	1
90. 07   04951   ONCOLOGY		0. 7224!		7	90. 07
90.08 04950 ANDERSON WOMENS CENTER		0. 2864	53 0	0	90. 08
91. 00   09100   EMERGENCY		0. 14100	125, 380	17, 679	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2946		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			777, 020	189, 205	1
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00   Net charges (line 200 minus line 201)			777, 020		202. 00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0037	From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/26/2023 1:33 pm

1.01   RPC amounts other than outlier payments for discharges occurring on or after October 1 (see   1,772,58   1.02		Title XVIII Ho	ospi tal	5/26/2023 1: 3 PPS	3 pm
Next   Next   Text   Insert				1 00	
1.00   Biol amounts other than outlier payments for discharges occurring on or after October 1 (see   1.772,584   1.01				1. 00	
1.02   Mick amounts other than outlier payments for discharges occurring on or after October 1 (see   1,772,565   1.02		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see			1. 00 1. 01
1.03   DRG for Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)   1.03	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	ا د	1, 772, 584	1. 02
Dictaber 1 (see instructions)   2.00   Dutilier record listing substrages, (see instructions)   2.00   Dutilier record listing substrages, (see instructions)   3.01   Dutilier record listing substrages, (see instructions)   3.02   Dutilier payments for discharges occurring on or after October 1 (see instructions)   4.781   2.02   Dutilier payments for discharges occurring on or after October 1 (see instructions)   0.02   Dutilier payments for discharges occurring on or after October 1 (see instructions)   0.02   Dutilier payments for discharges occurring on or after October 1 (see instructions)   0.02   Dutilier Payments for discharges occurring on or after October 1 (see instructions)   0.03   Dutilier Payments for discharges occurring on or after October 1 (see instructions)   0.05   Dutilier Payments for discharges occurring on or after October 1 (see instructions)   0.05   Dutilier Payments for discharges occurring on or after October 1 (see instructions)   0.05   Dutilier Payments for discharges occurring on or after October 1 (see instructions)   0.05   Dutilier Payments for Million (see instructions)   0.05   Dutilier Payments for discharges (see instructions)   0.05   Dutilier Payments for discharges (see instructions)   0.00   Substrate 1 (see instructions)   0.00   Substrate 2 (see instructions)   0.00   Substrate 2 (see instructions)   0.00   Substrate 2 (see instructions)   0.00   Substrate 3 (see instruction	1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior	to October	0	1.03
2.01         Duttler reconcilitation amount         0         2.07           2.02         Quitter payment for discharges for Model 4 BPCI (see instructions)         0         2.02           2.03         Duttler payments for discharges coccurring prior to October 1 (see Instructions)         0         2.02           2.04         Duttler payments for discharges coccurring prior to October 1 (see Instructions)         0         2.00           2.05         Duttler payments for discharges coccurring prior to October 1 (see Instructions)         0         2.00           2.00         Duttler payments for discharges coccurring prior to October 1 (see Instructions)         0         2.00           3.00         Electron 1 (see Instructions)         95.46         4.00           4.00         Bed days awail abile divided by number of days in the cost reporting period (see Instructions)         95.46           5.01         FEE count for all opathic and osteopathic programs for the most recent cost reporting period dedice on the cop of the control of the cost of the co		October 1 (see instructions)	after	0	1.04
2.03   Outlier payments for discharges occurring prior to October 1 (see Instructions)   6.4,81   2.03   2.04   Outlier payments for discharges occurring on or after October 1 (see Instructions)   0.2   3.00   Managed Care Simulated Payments   0.3   0.0   8.01   Open days available of wide by number of days in the cost reporting period (see Instructions)   9.4   4.00   9.50   Open days available of wide by number of days in the cost reporting period ending of   0.00   5.00   FIFE cap adjustment for qualifying and extensive programs for the most recent cost reporting period ending of   0.00   6.26   Open days available of wide by number of days in the cAA 2021 (see Instructions)   0.00   6.00   6.26   Open days available of the cap as specified under at 2 CR 5412.105(f) (1)(iv)(8)(1)   0.00   6.00   6.27   Open days available of the cap as specified under at 2 CR 5412.105(f)(iv)(8)(1)   0.00   6.00   6.28   Rural track programs FIE cap Init lation adjustment after the cap-building window closed under 5127 of   0.00   6.26   6.29   Rural track programs FIE cap Init lation (s) Expression and the cap as specified under at 2 CR 5412.105(f)(iv)(8)(2) If the cost report straidles July 1, 2011 then see instructions   0.00   0.00   0.00   0.00   6.20   Adjustment (increase or decrease) to the hospital 'is rural track programs FIE initiation(s) For rural track programs with a rural track for Medicare QMS affiliated programs in accordance with 413.75(b) and 91 ft 490% (August 1), 2022 (See Instructions)   0.00	2. 01	Outlier reconciliation amount		_	2. 01
	2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)		64, 781	2. 03
Indirect Medical Education Adjustment	3.00	Managed Care Simulated Payments	-)	0	3.00
or Defore 12/31/1996. (see Instructions)  1. 07 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 433.79(e)  2. 08 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 433.79(e)  3. 08 FTE count for all opathic and osteopathic and justment after the cap-building window closed under \$127 or new programs in accordance with 412.79(e)  3. 09 Mas Section 42? reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) if the cost part of the cost propert straddles July 1, 2011 then see instructions.  3. 01 FTE count for all opathic and the image as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) if the cost propert straddles July 1, 2011 then see instructions.  3. 02 FTE 4975 (August 10, 2022) (see instructions)  3. 03 Aljustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for a few properts straddles July 1, 2011, see instructions.  4. 01 The amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  4. 02 The amount of increase if the hospital was awarded FTE cap slots under \$5506 of ACA. (see instructions)  4. 03 The amount of increase if the hospital was awarded FTE cap slots under \$506 of ACA. (see instructions)  5. 04 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see 1) instructions and substance in the sopital was awarded FTE cap slots under \$126 of the CAA 2021 (see 1) instructions and substance in the sopital was awarded FTE cap slots under \$126 of the CAA 2021 (see 1) instructions and substance in the sopital was awarded FTE cap slots under \$126 of the CAA 2021 (see 1) instructions and substance in the su	4.00		,)	75. 40	4.00
FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		or before 12/31/1996. (see instructions)	l ending or		
6.26   Rural track program FTE cap Ilmitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions)   1.00		FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to	the cap for		
	6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under	er §127 of	0. 00	6. 26
Adjustment (Increase or decrease) to the hospital's rural track programs IFI Limitation(s) for rural track for Medicare GNE affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)  8.00 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) (2) (iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradidle sluly 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  8.21 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA 2021 (see instructions)  8.22 The amount of increase if the hospital was awarded FTE cap slots under § 526 of the CAA 2021 (see instructions)  9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus lines 8.01 through 8.27 (see instructions)  9.00 FTE count for all opathic and osteopathic programs in the current year from your records  10.00 FTE count for all opathic and osteopathic programs in the current year from your records  11.00 FTE count for the promultimate year if that year ended on or after September 30, 1997.  12.00 Current year all owable FTE count for the promultimate year if that year ended on or after September 30, 1997.  12.00 Current year residents in initial years of the program (see instructions)  12.00 Total allowable FTE count for the promultimate year if that year ended on or after September 30, 1997.  12.00 Current year residents on initial years of the program (see instructions)  12.00 Current year residents of year year year if that year ended on or after September 30, 1997.  12.00 Current year residents of year year year if that year ended on or after September 3		ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)			7. 00 7. 01
Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1. 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots slots deaching hospital under § 5506 of ACA. (see instructions)  8.21 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)  9.00 Disposition of the first of the CAA 2021 (see instructions)  10.00 FTE count for all opathic and osteopathic programs in the current year from your records  10.00 FTE count for all opathic and osteopathic programs in the current year from your records  10.00 Current year all owable FTE (see instructions)  10.00 Total allowable FTE count for the prenul timate year if that year ended on or after September 30, 1997, otherwise enter zero.  10.00 Sum of lines 12 through 14 divided by 3.  10.00 Adjustment for residents in initial years of the program (see instructions)  10.00 Adjustment for residents displaced by program or hospital closure  10.00 Adjustment for residents displaced by program or hospital closure  10.00 Adjustment for residents displaced by program or hospital closure  10.00 Adjustment for residents in initial years of the program (see instructions)  10.00 Current year resident to bed ratio (see instructions)  10.00 Current year resident to bed ratio (see instructions)  10.00 Opinical Medical program or hospital closure  10.00 Adjustment for residents in initial years of the program (see instructions)  10.00 Opinical Medical Additional allopathic and osteopathic IME FTE resident	7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) is track programs with a rural track for Medicare GME affiliated programs in accordance with		0.00	7. 02
8.01   The amount of Increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May		0. 00	8. 00
under § 5506 of ACA. (see instructions)  1 memount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  2 under § 5506 of ACA. (see instructions)  3 um of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)  5 FTE count for allopathic and osteopathic programs in the current year from your records  6 under 1.00 (current year allowable FTE (see instructions)  7 under allowable FTE count for the prior year.  8 under allowable FTE count for the penul timate year if that year ended on after September 30, 1997, and 13.00 (and allowable FTE count for the penul timate year if that year ended on after September 30, 1997, and 14.00 (and allowable FTE count for the penul timate year if that year ended on after September 30, 1997, and 15.00 (and allowable FTE count for the penul timate year if that year ended on after September 30, 1997, and 15.00 (and allowable FTE count for the penul timate year if that year ended on after September 30, 1997, and 15.00 (and allowable FTE count for residents in initial years of the program (see instructions)  8 und file ines 12 through 14 divided by 3.  8 und file ines 12 through 14 divided by 3.  8 und dijustment for residents displaced by program or hospital closure  9 und dijustment for residents of line 18 divided by line 4).  9 und dijustment for residents of see instructions)  9 und or under the disease of lines 19 or 20 (see instructions)  10 under file payment adjustment (see instructions)  10 under file payment adjustment (see instructions)  10 under file payment adjustment for the Add-on for § 422 of the IMMA  10 under of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  10 under file payment adjustment factor. (see instructions)  10 under file add-on adjustment amount - Managed Care (see instructions)  10 under file add-on adjustment amount file file file file file file f	8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. I	f the cost	0. 00	8. 01
Instructions   Instructions   O.00	8. 02	under § 5506 of ACA. (see instructions)		0. 00	
minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)   FTE count for allopathic and osteopathic programs in the current year from your records   0.00   10.00     The count for residents in dental and podiatric programs.   0.00   11.00     Current year allowable FTE (see instructions)   0.00   12.00     Total allowable FTE count for the prior year.   0.00   13.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   15.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   15.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   16.00     Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   17.00     Total penultimate year if that year ended on or after September 30, 1997,   0.00   17.00   18.00     Total penultimate year if that year ended on or after September 30, 1997,   0.00   1997,   0.00   1997,   0.00   1997,   0.00   1997,   0.00   1997,   0.00   1997,   0.00   1997,   0.00   1997,   0.00   1997,   0		instructions)			
11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   12.00   12.00   13.00   10.00   12.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   10.00   10.00   13.00   10.00   1		minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	plus or		
13.00   Total allowable FTE count for the prior year.   0.00   13.00   14.00   15.00	11.00	FTE count for residents in dental and podiatric programs.		0. 00	11.00
Otherwise enter zero.   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   Adjustment for residents in initial years of the program (see instructions)   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   18.00   Adjusted rolling average FTE count   0.00   18.00	13.00	Total allowable FTE count for the prior year.		0. 00	13.00
16.00		otherwise enter zero.	30, 1997,		
18. 00					1
19.00   Current year resident to bed ratio (line 18 divided by line 4).   0.000000   19.00   20.00					1
21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  1 Me payment adjustment - Managed Care (see instructions)  1 Minder of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  23.00 (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.01 IME add-on adjustment amount (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (see instructions)  20.02 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  19.00 Sum of lines 30 and 31  19.34 32.00					
22.00   IME payment adjustment (see instructions)   0   22.00     IME payment adjustment - Managed Care (see instructions)   0   22.01     Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA     Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00     (f)(1)(iv)(C)   .					1
22.01 IME payment adjustment - Managed Care (see instructions)  Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  17.89 31.00  32.00 Sum of lines 30 and 31  19.34 32.00			ļ		1
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days (see instructions)  10.00 23.00  24.00  25.00  26.00  27.00  28.00  28.01  29.00  29.01  20.01  20.02  20.03  20.03  20.04  20.04  20.05  20.05  20.06  20.06  20.07  20.07  20.08  20.08  20.09  20.09  20.00  2		IME payment adjustment - Managed Care (see instructions)			
24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  10.00 24.00  25.00  26.00 0.000000 26.00  0.000000 27.00  0.0000000 27.00  0.0000000 27.00  0.0000000000000000000000000000000	23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412	2. 105	0. 00	23. 00
26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.00       IME add-on adjustment amount (see instructions)       0.000000       28.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.000000       28.01         29.01       Total IME payment (sum of lines 22 and 28)       0.000000       29.00         29.01       Disproportionate Share Adjustment       0.000000       29.01         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       1.45       30.00         31.00       Percentage of Medicaid patient days (see instructions)       17.89       31.00         32.00       Sum of lines 30 and 31       19.34       32.00		IME FTE Resident Count Over Cap (see instructions)	see		
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  28.00  28.00  29.01  2		Resident to bed ratio (divide line 25 by line 4)			
28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  29. 01 Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  19. 34  32. 00					
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 17.89 31.00  31.00 Percentage of Medicaid patient days (see instructions) 19.34 32.00		· · · · · · · · · · · · · · · · · · ·	ļ		
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  1. 45 30.00 31.00 Percentage of Medicaid patient days (see instructions)  1. 45 30.00 31.00 Sum of lines 30 and 31	29. 00	Total IME payment ( sum of lines 22 and 28)  Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29. 00 29. 01
31.00 Percentage of Medicaid patient days (see instructions)       17.89 31.00         32.00 Sum of lines 30 and 31       19.34 32.00	30 00		1	1 /5	30 00
32.00 Sum of lines 30 and 31 19.34 32.00					
33.00   Allowable disproportionate share percentage (see instructions) 5.32   33.00	32.00	Sum of Lines 30 and 31		19. 34	32.00
	33. 00	Allowable disproportionate share percentage (see instructions)		5. 32 	33.00

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	Financial Systems HANCOCK REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0037	Period: From 01/01/2022			
			To 12/31/2022	Date/Time Pre 5/26/2023 1:3		
		Title XVIII	Hospi tal	PPS		
				1. 00		
34. 00	Disproportionate share adjustment (see instructions)			87, 751	34.00	
			Prior to 10/1			
	Uncompensated Care Payment Adjustment		1.00	2. 00		
35. 00	Total uncompensated care amount (see instructions)		0	0	35.00	
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	35. 01	
35. 02	Hospital UCP, including supplemental UCP (If line 34 is zero, (see instructions)	, enter zero on this line	1, 311, 318	891, 326	35. 02	
35. 03	1.	CP (see instructions)	980, 794	224, 663	35. 03	
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1, 205, 457		36.00	
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges (see instructions)	scharges (lines 40 throu	gn 46)   0		40. 00	
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00	
41. 01	Total ESRD Medicare covered and paid discharges (see instruc-		o		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 44. 00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		43. 00 44. 00	
00	days)	zy mie m an maea zy m	0.00000			
45. 00	Average weekly cost for dialysis treatments (see instructions	•	0.00		45.00	
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 47 Subtotal (see instructions)	1.01)	7, 955, 821		46. 00 47. 00	
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00	
	only. (see instructions)	<u> </u>		Amount		
49. 00	Total payment for inpatient operating costs (see instructions	s)		1. 00 7, 955, 821	49. 00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I am			510, 925	50.00	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			_	l	
				0	51.00	
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment			0 0 11, 071	51. 00 52. 00 53. 00	
52. 00 53. 00 54. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 11, 071 139, 240	52. 00 53. 00 54. 00	
52. 00 53. 00 54. 00 54. 01	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment	ine 49 see instructions).		0 11, 071 139, 240 0	52. 00 53. 00 54. 00 54. 01	
52. 00 53. 00 54. 00 54. 01 55. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of	ine 49 see instructions).		0 11, 071 139, 240 0 0	52. 00 53. 00 54. 00 54. 01 55. 00	
52. 00 53. 00 54. 00 54. 01	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into	ine 49 see instructions). 69) ructions)		0 11, 071 139, 240 0	52. 00 53. 00 54. 00 54. 01	
52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. III)	ine 49 see instructions). 59) ructions) III, column 9, lines 30 t	hrough 35).	0 11, 071 139, 240 0 0 0 0	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00	
52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. I	ine 49 see instructions). 59) ructions) III, column 9, lines 30 t	hrough 35).	0 11, 071 139, 240 0 0 0 0 11, 886	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00	
52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. III)	ine 49 see instructions). 59) ructions) III, column 9, lines 30 t	hrough 35).	0 11, 071 139, 240 0 0 0 0	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00	
52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intractions acquisition cost of physicians' services in a teaching hospital (see intractions) Ancillary service other pass through costs (from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 11, 071 139, 240 0 0 0 11, 886 8, 628, 943 0 8, 628, 943	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00	
52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. IA Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 11, 071 139, 240 0 0 0 11, 886 8, 628, 943 0 8, 628, 943 867, 096	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00	
52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. In Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 11, 071 139, 240 0 0 0 11, 886 8, 628, 943 0 8, 628, 943 867, 096 5, 057	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	
52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intr. Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 11, 071 139, 240 0 0 0 11, 886 8, 628, 943 0 8, 628, 943 867, 096	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	
52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. Indicilarly service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60)	hrough 35).	0 11, 071 139, 240 0 0 0 0 11, 886 8, 628, 943 0 8, 628, 943 867, 096 5, 057 51, 626 33, 557 36, 620	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00	
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52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 61. 00 62. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intractional Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) (Line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ine 49 see instructions).  59)  ructions)  III, column 9, lines 30 t  IV, col. 11 line 200)  s line 60)  tructions)  applicable to MS-DRGs (s  (For SCH see instruction	ee instructions) s)	0 11, 071 139, 240 0 0 0 0 11, 886 8, 628, 943 0 8, 628, 943 867, 096 5, 057 51, 626 33, 557 36, 620 7, 790, 347 0	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	
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52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 55 70. 75	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs (from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions)	ine 49 see instructions).  59)  ructions)  III, column 9, lines 30 t  IV, col. 11 line 200)  s line 60)  tructions)  applicable to MS-DRGs (s  (For SCH see instruction	ee instructions) s)	0 11, 071 139, 240 0 0 0 0 11, 886 8, 628, 943 0 8, 628, 943 867, 096 5, 057 51, 626 33, 557 36, 620 7, 790, 347 0 0	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 75	
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52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 75 70. 88 70. 89	Direct graduate medical education payment (from Wkst. E-4, linkursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs (from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries (line 59 minus Deductibles bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) (Inne 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount (see instructions) Demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	ine 49 see instructions).  59)  ructions)  III, column 9, lines 30 t  IV, col. 11 line 200)  s line 60)  tructions)  applicable to MS-DRGs (s. (For SCH see instruction)  tration) adjustment (see	ee instructions) s)	0 11, 071 139, 240 0 0 0 0 11, 886 8, 628, 943 867, 096 5, 057 51, 626 33, 557 36, 620 7, 790, 347 0 0	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 75 70. 87 70. 88 70. 90 70. 91	
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	Financial Systems HANCOCK REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0037	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	
		Title	xVIII	Hospi tal	5/26/2023 1: 3 PPS	3 piii
		11 11 0		Y (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		2022	718, 442	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			2023	126, 175	70. 97
70.00	the corresponding federal year for the period ending on or af	ter 10/1)				70.00
	Low Volume Payment-3 HAC adjustment amount (see instructions)				0	1
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			8, 605, 967	
	Sequestration adjustment (see instructions)	o, a ,o,			108, 435	1
	Demonstration payment adjustment amount after sequestration				0	1
	Sequestration adjustment-PARHM or CHART pass-throughs					71.03
	Interim payments				8, 037, 570	72.00
72. 01	Interim payments-PARHM or CHART					72. 01
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM or CHART (for contractor use only				450.040	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			459, 962	74.00
74. 01	73) Balance due provider/program-PARHM or CHART (see instructions	`				74. 01
	Protested amounts (nonallowable cost report items) in accorda				102, 764	
73.00	CMS Pub. 15-2, chapter 1, §115.2	nee with			102, 704	75.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)		'			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
	plus 2.04 (see instructions)					
	Capital outlier from Wkst. L, Pt. I, line 2				0	
	Operating outlier reconciliation adjustment amount (see instr				0	
	Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instr Time value of money for operating expenses (see instructions)	uctions)			0.00	
1	Time value of money for capital related expenses (see instructions)	tions)			0	
70.00	Trine varies of morey for capital related expenses (see mistrue	11 0113)		Prior to 10/1		70.00
				1.00	2. 00	
	HSP Bonus Payment Amount			<u> </u>		
	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					4
	HVBP adjustment factor (see instructions)	`		0. 0000000000		
	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0.0000	0.0000	102 00
	HRR adjustment amount for HSP bonus payment (see instructions	)		0.0000		104.00
	Rural Community Hospital Demonstration Project (§410A Demonst		ustment			1104.00
	Is this the first year of the current 5-year demonstration pe					200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
Ì	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	e 49)				201.00
1	Medicare discharges (see instructions)					202.00
	Case-mix adjustment factor (see instructions)	6'	. 6 11			203.00
	Computation of Demonstration Target Amount Limitation (N/A in period)	iirst year	or the curr	ent 5-year demons	stration	
	Medicare target amount					204.00
	Case-mix adjusted target amount (line 203 times line 204)					205.00
1	Medicare inpatient routine cost cap (line 202 times line 205)					206.00
	Adjustment to Medicare Part A Inpatient Reimbursement					1
	Program reimbursement under the §410A Demonstration (see inst	ructi ons)				207. 00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	line 59)				208.00
	Adjustment to Medicare LPPS payments (see instructions)					200 00

209. 00

210.00

211. 00

212. 00 213. 00 218. 00

210.00 Reserved for future use

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2022 Part A Exhi bit 4 To 12/31/2022 Date/Time Prepared: Provider CCN: 15-0037

					10	5 12/31/2022	Date/lime Pre 5/26/2023 1:3	
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	4, 825, 248	0	4, 825, 248		4, 825, 248	1.01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 772, 584	0		1, 772, 584	1, 772, 584	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1.03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1.04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2.00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
2. 02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	64, 781	0	64, 781		64, 781	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	0	0		0	0	2.03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adj	ustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adj	ustmont for the	a Add on for Sa	oction 122 of	the MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	O	0	0	O	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
	8.01) Disproportionate Share Adjustm	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0532	0. 0532	0. 0532	0. 0532		10.00
11. 00	instructions) Disproportionate share	34. 00	87, 751	0	64, 176	23, 575	87, 751	11.00
11. 01	adjustment (see instructions) Uncompensated care payments	36. 00	1, 205, 457	0	980, 794	224, 663	1, 205, 457	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment	rcentage of ESI 46.00	RD beneficiary 0	dí scharges 0	0	0	0	12. 00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	7, 955, 821 0	0	5, 934, 999 0	2, 020, 822 0	7, 955, 821 0	13. 00 14. 00
15. 00	(completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient	49. 00	7, 955, 821	0	5, 934, 999	2, 020, 822	7, 955, 821	15. 00
	operating costs (see instructions)							

						From 01/01/2022 To 12/31/2022		pared:
				Title	xVIII	Hospi tal	5/26/2023 1: 3 PPS	3 pm
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	510, 925	0	379, 25	131, 670	510, 925	16. 00
17. 00	Special add-on payments for new technologies	54. 00	139, 240	0	137, 09	7 2, 143	139, 240	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	'	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0	,	0	0	18. 00
19.00	SUBTOTAL			0	6, 451, 35	1 2, 154, 635	8, 605, 986	19.00
		W/S L, line	(Amounts from L)		-, ,	, , , , , , , ,	2, 222,	
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	491, 371 0	0		1 131, 670 0 0	491, 371 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	19, 554 0	0	19, 55	4 O O	19, 554 0	21. 00 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	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	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	510, 925	0	379, 25	5 131, 670	510, 925	26. 00
		W/S E, Part A	(Amounts to					
		line 0	E, Part A) 1.00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	0	1.00	2.00	0. 11136		3.00	27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			718, 44.		718, 442	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				126, 175	126, 175	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0037 Period: From 01/01/2022 To 12/31/2022 Part A Exhibit 5 Date/Time Prepared: 5/26/2023 1: 33 pm

Title XVIII Hospital PPS

Wkst. E, Pt. Amt. from Period to A, line Wkst. E, Pt. 10/01 after 10/01 2 and 3)

						5/26/2023 1: 3	3 pm
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		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 discharges occurring prior to October 1	1. 01	4, 825, 248	4, 825, 248		4, 825, 248	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	1, 772, 584		1, 772, 584	1, 772, 584	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	64, 781	64, 781		64, 781	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	0		0	0	2. 03
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	3.00
4.00	Managed care simulated payments	3. 00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	· -	-	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)		0	0	0	0	6. 01
7 00	Indirect Medical Education Adjustment for the				0.000000		7.00
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000				7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0	0	0	0	8. 00 8. 01
	care (see instructions)				0		
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0		0	0	9. 00 9. 01
9.01	lines 6.01 and 8.01) Disproportionate Share Adjustment	29.01	0		0	0	9.01
10.00	Allowable disproportionate share percentage	33. 00	0. 0532	0. 0532	0. 0532		10.00
	(see instructions)	33. 33	0.0002	0.0002	0.0002		
11. 00	Disproportionate share adjustment (see instructions)	34. 00	87, 751	64, 176	23, 575	87, 751	11. 00
11. 01	Uncompensated care payments	36. 00	1, 205, 457	980, 794	224, 663	1, 205, 457	11. 01
12. 00	Additional payment for high percentage of ESI Total ESRD additional payment (see	RD beneficiary 46.00	di scharges 0	0	0	0	12. 00
	instructions)						
	Subtotal (see instructions)	47. 00	7, 955, 821			7, 955, 821	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	0	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	7, 955, 821	5, 934, 999	2, 020, 822	7, 955, 821	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	510, 925	379, 255	131, 670	510, 925	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	139, 240	137, 097	2, 143	139, 240	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			6, 451, 351	2, 154, 635	8, 605, 986	19. 00

Hool +b	Financial Systems	HANCOCK REGIO	MAI HOSDITAI		In Lio	u of Form CMS-:	neen 10
	HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0037 Period: From 01, To 12,					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	491, 371	359, 70°	131, 670	491, 371	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	19, 554	19, 554	1 0	19, 554	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	510, 925	379, 25	131, 670	510, 925	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	718, 442	718, 442	2	718, 442	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	126, 175		126, 175	126, 175	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	0	(	0	0	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	-28, 997	-1, 489	-27, 508	-28, 997	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(	0	0	31. 01
						(Amt to	

0 70. 99

1.00

Υ

2.00

0

3.00

0

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

32.00

100.00

32.00 HAC Reduction Program adjustment (see

instructions)

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

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	-	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	- CCN: 15-0037		Worksheet E Part B Date/Time Prepared: 5/26/2023 1:33 pm

		7 3 17 2022	5/26/2023 1: 3	
	Title XVIII Hosp	oi tal	PPS	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1. 00	Medical and other services (see instructions)		1, 394	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	19, 144, 336	2.00	
3.00	OPPS payments		13, 185, 669	3.00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)		67, 387 0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)		0. 000	1
6. 00	Line 2 times line 5		0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	1
8. 00	Transitional corridor payment (see instructions)		0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200		78, 335	ł
10.00	Organ acqui si ti ons		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1, 394	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
	Ancillary service charges			12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)		5, 841	14.00
15 00	Customary charges		0	1 1 00
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge		0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a char had such payment been made in accordance with 42 CFR §413.13(e)	gebasis	U	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	ŀ	0. 000000	17. 00
	Total customary charges (see instructions)		5, 841	ı
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (	(see	4, 447	ı
	instructions)			
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (	(see	0	20.00
	instructions)			
	Lesser of cost or charges (see instructions)		1, 394	
	Interns and residents (see instructions)		0	
	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		13, 331, 391	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	25.00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions)  Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	,	0 2, 280, 246	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23]		11, 052, 539	•
27.00	instructions)	(366	11,032,339	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	l	0	1
	Subtotal (sum of lines 27 through 29)		11, 052, 539	30.00
31.00	Pri mary payer payments	ļ	2, 939	31.00
32.00	Subtotal (line 30 minus line 31)		11, 049, 600	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
	Composite rate ESRD (from Wkst. I-5, line 11)		0	
	Allowable bad debts (see instructions)		102, 817	•
	Adjusted reimbursable bad debts (see instructions)		66, 831	1
	Allowable bad debts for dual eligible beneficiaries (see instructions)		65, 194	1
	Subtotal (see instructions)		11, 116, 431	ı
39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ŀ	-180 0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		U	39.50
	N95 respirator payment adjustment amount (see instructions)		0	
39. 97	Demonstration payment adjustment amount before sequestration	ŀ	0	ı
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	ľ	0	39. 99
40.00	Subtotal (see instructions)	ľ	11, 116, 611	40.00
40.01	Sequestration adjustment (see instructions)		140, 070	40. 01
40. 02	Demonstration payment adjustment amount after sequestration		0	40. 02
	Sequestration adjustment-PARHM or CHART pass-throughs			40. 03
	Interim payments		10, 952, 263	1
	Interim payments-PARHM or CHART		_	41.01
42.00	Tentative settlement (for contractors use only)		0	
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)		04.070	42.01
43.00	Balance due provider/program (see instructions)		24, 278	•
43. 01	Balance due provider/program-PARHM (see instructions)	1	0	43. 01 44. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter §115.2	1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR			1
90. 00	Original outlier amount (see instructions)		0	90.00
	Outlier reconciliation adjustment amount (see instructions)		0	
	The rate used to calculate the Time Value of Money		0.00	
	Time Value of Money (see instructions)		0	•
	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022		
				5/26/2023 1:	33 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(	200.00

| Peri od: | Worksheet E-1 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0037

				10 12/31/2022	5/26/2023 1: 3	
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	T	1. 00	2.00	3.00	4. 00	
1.00	Total interim payments paid to provider		8, 037, 57		10, 833, 664	1.00
2. 00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0 12/31/2022	118, 599	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
2 50	Provi der to Program					2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0	0	3. 50 3. 51
3. 51				0		3. 51
3. 52				0		3. 52
3. 54				Ö		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	118, 599	3. 99
0. 77	3. 50-3. 98)				110,077	0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 037, 57	o	10, 952, 263	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 Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02	TENTATIVE TO PROVIDER			0		5. 02
5. 03				Ö		5. 02
0.00	Provider to Program			<u> </u>		0.00
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				O	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		450.07		04.070	, 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		459, 96		24, 278	6. 01
6. 02	Total Medicare program liability (see instructions)		8, 497, 53	0	10, 976, 541	6. 02 7. 00
7. 00	Trotal medicale program frability (see Instructions)		0, 497, 53	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	,			•	. '	

Heal th	Financial Systems HANCOCK REGIONA	L HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0037	Peri od:	Worksheet E-1	
			From 01/01/2022		
			To 12/31/2022		
		Title XVIII	Hospi tal	5/26/2023 1: 3 PPS	is pili
		THE AVITE	1103pi tai	113	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	N			1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst		e 14		1.00
2. 00	Medicare days (see instructions)				2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of		Wkst. S-2, Pt. I		7.00
	line 168	-			
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

Health Financial Systems	HANCOCK REGIONAL HOSPITAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CCN: 15-0037	From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2023 1:33 pm

			10 12/31/2022	5/26/2023 1: 3	3 pm
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		482, 455		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		482, 455	0	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		482, 455	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				1
8.00	Routi ne servi ce charges		516, 598		8.00
9.00	Ancillary service charges		777, 020	0	9.00
10.00	Organ acquisition charges, net of revenue		O		10.00
11.00	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 293, 618	0	12.00
	CUSTOMARY CHARGES				1
13.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
	basis	-			
14.00	Amounts that would have been realized from patients liable fo	r payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1, 293, 618	0	16.00
17.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	811, 163	0	17.00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line	0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line		482, 455	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.		
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
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)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		482, 455	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	)	482, 455	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	482, 455	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		482, 455	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		482, 455	0	
	Interim payments		588, 298	0	
42.00	Balance due provider/program (line 40 minus line 41)		-105, 843	0	
43.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Heal th	Financial Systems HANCOCK F	REGI ONAL	HOSPI TAL	In Lie	u of Form CMS-2	552-10
			Worksheet E-5			
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/26/2023 1:33	pared: B_pm
			Title XVIII		PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2,	or sum	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00	Operating outlier reconciliation adjustment amount (se	ee instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see	instruc	tions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)					0.00	5.00
6.00	Time value of money for operating expenses (see instru	uctions)			0	6.00
7.00	Time value of money for capital related expenses (see	instruc	tions)		0	7.00

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

Health Financial Systems

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

Provider CCN: 15-0037

oni y)				12/01/2022	5/26/2023 1: 3	3 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1. 00	
1.00	Cash on hand in banks	9, 859, 312	1	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	10 242 240	0	0	0	3. 00 4. 00
5. 00	Other receivable	18, 262, 348 19, 342, 089	1	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7. 00	Inventory	6, 046, 112	0	0	0	7. 00
8.00	Prepai d expenses	2, 541, 080	0	0	0	8. 00
9. 00	Other current assets	112, 023, 032	1	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	168, 073, 973	0	0	0	11.00
12. 00	Land	29, 420, 345	0	0	0	12.00
13. 00	Land improvements	0	ő	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15. 00	Bui I di ngs	189, 252, 280	1	0	0	15.00
16. 00	Accumulated depreciation	-197, 881, 721	1	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	0	0	0	0	18. 00 19. 00
20. 00	Accumulated depreciation		0	0	0	20.00
21. 00	Automobiles and trucks	Ö	ő	0	Ö	21.00
22. 00	Accumul ated depreciation	0	0	0	0	22.00
23. 00	Major movable equipment	100, 005, 799	0	0	0	23. 00
24. 00	Accumulated depreciation	0	0	0	0	24.00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0		0	0	26. 00 27. 00
28.00	Accumulated depreciation		0	0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e		0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	120, 796, 703	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	37, 967, 002	0	0	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	37, 967, 002	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	326, 837, 678	1	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10, 585, 826	1	0	0	37.00
38. 00	Salaries, wages, and fees payable	7, 715, 544	1	0	0	38.00
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	0	0	0	0	39. 00 40. 00
41. 00	Deferred income		0	0	0	41.00
42. 00	Accel erated payments	0		O		42.00
43. 00	Due to other funds	Ö	О	0	0	43.00
44.00	Other current liabilities	6, 521, 160	0	0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	24, 822, 530	0	0	0	45. 00
	LONG TERM LIABILITIES	_		_	_	
46. 00	Mortgage payable	0	0	0	0	46.00
47. 00 48. 00	Notes payable Unsecured Loans	0	0	0	0	47. 00 48. 00
49. 00	Other long term liabilities	802, 091	_	0	0	49.00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	802, 091	1	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25, 624, 621	1	0	0	51.00
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	301, 213, 057	1			52.00
53.00	Specific purpose fund		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	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			O	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	301, 213, 057	1	0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	326, 837, 678	0	0	0	60.00
	[59]	I	ı l	ļ	l	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

Provi der CCN: 15-0037

					То	12/31/2022	Date/Time Pre 5/26/2023 1:3	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	·
		1. 00	2.00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	1.00	339, 225, 123 -38, 012, 066			0	3.00	1.00
3. 00 4. 00 5. 00 6. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	301, 213, 057		0	0	0 0 0	3. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00		0			0		0	7. 00 8. 00 9. 00
10. 00 11. 00 12. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 301, 213, 057		0	0 0	0	10. 00 11. 00 12. 00
13. 00 14. 00 15. 00	(11111111111111111111111111111111111111	0			0		0 0	13. 00 14. 00 15. 00
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0	0 301, 213, 057		0	0	0	16. 00 17. 00 18. 00 19. 00
	sheet (line 11 minus line 18)							17.00
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0	0		0			1. 00 2. 00 3. 00
4. 00 5. 00 6. 00 7. 00 8. 00	Additions (credit adjustments) (specify)		0 0 0 0					4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0		0			9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0		0			16. 00 17. 00 18. 00 19. 00

Health Financial Systems HA Provi der CCN: 15-0037

			Γο 12/31/2022	Date/Time Pre 5/26/2023 1:3	
	Cost Center Description	I npati ent	Outpati ent	Total	3 pili
	oust defited beset per on	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	1100	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	8, 435, 21	1	8, 435, 211	1.00
2.00	SUBPROVIDER - IPF			0	2.00
3.00	SUBPROVI DER - I RF				3.00
4. 00	SUBPROVI DER				4. 00
5. 00	Swing bed - SNF			0	5. 00
6. 00	Swing bed - NF			0	6. 00
7. 00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	8, 435, 21	1	8, 435, 211	
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	14, 798, 340		14, 798, 340	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	14, 798, 340		14, 798, 340	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	23, 233, 55	1	23, 233, 551	17.00
18.00	Ancillary services	48, 100, 020	430, 259, 615	478, 359, 635	18.00
19. 00	Outpati ent servi ces		27, 422	27, 422	19.00
20.00	RURAL HEALTH CLINIC		739, 513	739, 513	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )				25.00
26.00	HOSPI CE	991, 280	1, 227, 818	2, 219, 098	26.00
27. 00	OTHER PROFESSIONAL FEES	8, 450		2, 855, 799	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	. 72, 333, 30	1 435, 101, 717	507, 435, 018	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		107 7/0 /00		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		187, 763, 430		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33.00					33.00
34.00					34.00
35. 00	Talah a 1818 a 40 a 4				35.00
36. 00 37. 00	Total additions (sum of lines 30-35)		0		36. 00 37. 00
38.00	DEDUCT (SPECIFY)				
39.00					38. 00 39. 00
40.00					40.00
41. 00					40.00
41.00	Total deductions (sum of lines 37-41)	,			41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer	187, 763, 430		43.00
43.00	to Wkst. G-3, line 4)	101	107, 703, 430		45.00
	10 mot. 0 0, 11110 T)	ı	1		

Heal th	Financial Systems HANCOCK REGIO	NAL HOSPITAL	In lie	u of Form CMS-2	2552_10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0037	Peri od:	Worksheet G-3	
	From 01/01/2022 To 12/31/2022 Da 5/				
4 00	Table and a second of the seco	11,		1.00	1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			507, 435, 018	
2.00	Less contractual allowances and discounts on patients' acc	ounts		358, 558, 001	
3. 00 4. 00	Net patient revenues (line 1 minus line 2) Less total operating expenses (from Wkst. G-2, Part II, li	no 42)		148, 877, 017	
4. 00 5. 00	Net income from service to patients (line 3 minus line 4)	ne 43)		187, 763, 430 -38, 886, 413	
5.00	OTHER INCOME			-30, 000, 413	5.00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			-16, 384, 612	
8. 00	Revenues from telephone and other miscellaneous communicat	ion services		0,001,012	
9. 00	Revenue from television and radio service			0	
	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to othe	r than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and canteen			0	
	Rental of vending machines			0	
	Rental of hospital space			0	
	Governmental appropriations			0	
	OTHER OPERATING INCOME			15, 021, 943	
	OTHER NON-OPERATING INCOME			2, 660, 503	
	COVI D-19 PHE Funding			145, 186	
	Total other income (sum of lines 6-24)			1, 443, 020	
	Total (line 5 plus line 25)			-37, 443, 393	
	OTHER EXPENSES			568, 673	
	Total other expenses (sum of line 27 and subscripts)	`		568, 673	
29.00	Net income (or loss) for the period (line 26 minus line 28	)	l	-38, 012, 066	29.00

	F1	55010111	UOODI TII		6.5. 0110.4	
		REGI ONAL			u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT		Provider CCN: 15-0037	Peri od:	Worksheet L	
				From 01/01/2022 To 12/31/2022	Parts I-III Date/Time Pre	narod:
				10 12/31/2022	5/26/2023 1: 3	
			Title XVIII	Hospi tal	PPS	J pili
			THE XVIII	nospi tui	110	
					1. 00	
	PART I - FULLY PROSPECTIVE METHOD					
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier				491, 371	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier				0	1. 01
2.00	Capital DRG outlier payments				19, 554	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments				0	2. 01
3.00	Total inpatient days divided by number of days in the	e cost rep	porting period (see ins	tructions)	29. 97	3.00
4.00	Number of interns & residents (see instructions)				0. 00	4.00
5.00	Indirect medical education percentage (see instruction				0. 00	
6.00	Indirect medical education adjustment (multiply line	5 by 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	Part A pa	atient days (Worksheet	E, part A line	0. 00	7. 00
0.00	30) (see instructions)		ati ana)		0. 00	8. 00
8. 00 9. 00	Percentage of Medicaid patient days to total days (se Sum of lines 7 and 8	ee mstrud	etions)		0.00	
10.00		+======================================				10.00
	Allowable disproportionate share percentage (see inst	tructions,	)		0.00	
11.00		`			-	
12.00	Total prospective capital payments (see instructions)	)			510, 925	12.00
					1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				1.00	
1. 00	Program inpatient routine capital cost (see instructi	i ons)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instruc				0	2.00
3. 00	Total inpatient program capital cost (line 1 plus lin				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	4)			0	5. 00
					1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
1.00	Program inpatient capital costs (see instructions)				0	1.00
2. 00	Program inpatient capital costs for extraordinary cir		es (see instructions)		0	2.00
3. 00	Net program inpatient capital costs (line 1 minus lin	ne 2)			0	3.00
4. 00	Applicable exception percentage (see instructions)				0.00	
5. 00	Capital cost for comparison to payments (line 3 x lin	,			0	5.00
6. 00	Percentage adjustment for extraordinary circumstances	•			0.00	
7. 00	Adjustment to capital minimum payment level for extra	aordi nary	circumstances (line 2	x line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)				0	8. 00
9. 00	Current year capital payments (from Part I, line 12,				0	9. 00
10. 00	Current year comparison of capital minimum payment le				0	10.00
11. 00	Carryover of accumulated capital minimum payment leve	el over ca	apital payment (from pr	ior year	0	11. 00
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to ca	anital nav	ments (line 10 nlue li	ne 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive				0	13.00
14. 00	Carryover of accumulated capital minimum payment leve				0	
14.00	(if line 12 is negative, enter the amount on this lin		apitai payillent roi the	iorrowing perrou	Ü	14.00
15. 00	,		tructions)		0	15. 00
16. 00		•	11 4011 0113)		0	16.00
	Current year exception offset amount (see instruction				-	17.00
17.00	Tourism your onception or set amount (see instruction			ı	O	1 17.00

111 41-	Financial Contant	HANCOCK DECLON	IAL HOCDITAL		1-1:-		2552 40
	Financial Systems IS OF HOSPITAL-BASED RHC/FOHC COSTS	HANCOCK REGION	Provider C	°N: 15_0037	In Lie Period:	u of Form CMS-2 Worksheet M-1	
ANALIS	NO THOSE FIRE-BASED KHO/FQHC COSTS		110videi C		From 01/01/2022	WOI KSHEET WI-1	
			Component	CCN: 15-3987	To 12/31/2022	5/26/2023 1: 3	
					RHC I	Cost	
		Compensation	Other Costs		Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 + col. 4)	
		1. 00	2. 00	3. 00	4.00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2.00	0.00	1. 00	0.00	
1.00	Physi ci an	7, 076	0	7, 07	6 0	7, 076	1.00
2.00	Physician Assistant	0	0		0 0	0	1
3.00	Nurse Practitioner	161, 225	0	161, 22	5 0	161, 225	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	29, 345	0	29, 34	5 0	29, 345	5.00
6.00	Clinical Psychologist	0	0		0	0	6.00
7. 00	Clinical Social Worker	0	0		0	0	
8. 00	Laboratory Techni ci an	0	0		0	0	
9. 00	Other Facility Health Care Staff Costs	93, 368	0	93, 36		93, 368	
10.00	Subtotal (sum of lines 1 through 9)	291, 014	0	291, 01		291, 014	
11.00	Physician Services Under Agreement	0	0		0	0	
12.00	Physician Supervision Under Agreement Other Costs Under Agreement	0	0		0 0	0	
13. 00 14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15. 00	Medical Supplies	0	58. 566	58. 56	٥	58, 246	
16. 00	Transportation (Health Care Staff)	0	30, 300 N	30, 30	0 -320	0 30, 240	16.00
17. 00	Depreciation-Medical Equipment	0	0		0 0	Ö	
18. 00	Professional Liability Insurance	0	0		o o	l o	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	58, 566	58, 56	6 -320	58, 246	21.00
22. 00	Total Cost of Health Care Services (sum of	291, 014	58, 566	349, 58	0 -320	349, 260	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	41, 660	41, 66	·	0	
24. 00	Dental	0	0		0	0	
25. 00 25. 01	Optometry Tel eheal th	0	0		0	0	25. 00 25. 01
25. 01	Chronic Care Management	0	0		0 0	0	25.01
26. 00	All other nonreimbursable costs	0	0		0 0	0	
27. 00	Nonallowable GME costs	U	U		0	U	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	41, 660	41, 66	0 -41, 660	0	
20.00	through 27)	Ö	11,000	11,00	11,000	Ĭ	20.00
	FACILITY OVERHEAD				<u>'</u>		1
29. 00	Facility Costs	0	0		0 0	0	29. 00
30.00	Administrative Costs	0	174, 242	174, 24	2 0	174, 242	30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	174, 242	174, 24	2 0	174, 242	31.00
	30)						I

291, 014

274, 468

565, 482

-41, 980

523, 502

32.00

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	HANCOCK REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-00	037 Period: From 01/01/2022	Worksheet M-1
	Component CCN: 15-3	3987 To 12/31/2022	Date/Time Prepared: 5/26/2023 1:33 pm
		RHC I	Cost

						5/26/2023 1: 3	33 pm
					RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00	1			
1.00	Physi ci an	0	7, 076	,			1.00
2. 00	Physician Assistant	0	7,070	1			2.00
3. 00	Nurse Practitioner	0	161, 225	1			3.00
4. 00	1	0	101, 225				4.00
	Visiting Nurse	0	20 245				
5.00	Other Nurse	U O	29, 345	1			5.00
6.00	Clinical Psychologist	U	C	•			6.00
7.00	Clinical Social Worker	0	C	1			7.00
8. 00	Laboratory Techni ci an	0	C	1			8. 00
9. 00	Other Facility Health Care Staff Costs	0	93, 368				9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	291, 014	ļ.			10.00
11. 00	Physician Services Under Agreement	0	C	)			11.00
12.00	Physician Supervision Under Agreement	0	C	)			12.00
13.00	Other Costs Under Agreement	0	C				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	C				14.00
15.00	Medical Supplies	o	58, 246				15.00
16.00	Transportation (Health Care Staff)	o	C				16.00
17.00	Depreciation-Medical Equipment	o	C				17.00
18.00	1 ' ' '	0	Ċ				18.00
19.00	Other Health Care Costs	0	Ċ				19.00
20.00	Allowable GME Costs	_	_				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	58, 246				21.00
22. 00	Total Cost of Health Care Services (sum of	o o	349, 260				22.00
22.00	lines 10, 14, and 21)	٥	347, 200	1			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	l					
22 00	Pharmacy	0	C	N .			23. 00
24. 00	Dental	0	(	1			24.00
25.00	1	0					25.00
	Optometry	0					25.00
25. 01	Tel eheal th	U	(				
25. 02	Chronic Care Management	U	(				25. 02
26.00	All other nonreimbursable costs	U	C	)			26.00
27. 00	Nonallowable GME costs	_	_				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C	)			28. 00
	through 27)						1
	FACILITY OVERHEAD	ı					
	Facility Costs	0	C	1			29. 00
30.00	Administrative Costs	0	174, 242	1			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	174, 242	2			31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	523, 502	2			32.00
	and 31)						

Heal th	Financial Systems	HANCOCK REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 15-3987	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 1:3	
					RHC I	Cost	<u> </u>
		Number of FTE	Total Visits	Producti vi ty	Minimum	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						
	Posi ti ons						
1. 00	Physi ci an	0.00		l .	1 0		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3. 00	Nurse Practitioner	1. 19		1	1 1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 19		1	1	4, 738	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0.00				0	0.00
7.00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FOHC only)	0.00		1		0	7. 01 7. 02
7. 02	Diabetes Self Management Training (FQHC only)	0.00	·	1		Ü	7.02
8. 00	Total FTEs and Visits (sum of lines 4	1. 19	4, 738			4, 738	8.00
0.00	through 7)	1. 17	4, 730			4, 730	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
71.00	Triger or air cer vi eee criaer vigi cemente						71.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			349, 260	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			349, 260	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, I	ine 31)		174, 242	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			121, 447	15. 00
16. 00	Total overhead (sum of lines 14 and 15)					295, 689	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					295, 689	
	Overhead applicable to hospital-based RHC/FC					295, 689	
20. 00	Total allowable cost of hospital-based RHC/F	·QHC services (	sum of lines 1	0 and 19)		644, 949	20.00

ealth Financial Systems HANCOCK REGIONAL			u of Form CMS-2	
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 15-0037	Peri od: From 01/01/2022	Worksheet M-3	
ERVI CES	Component CCN: 15-3987	To 12/31/2022	Date/Time Pre	pared:
	·		5/26/2023 1: 3	
	Title XVIII	RHC I	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		644, 949	1.00
.00 Cost of injections/infusions and their administration (from W			16, 313	2.00
.00 Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		628, 636	3.00
.00 Total Visits (from Wkst. M-2, column 5, line 8)			4, 738	
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
.00 Total adjusted visits (line 4 plus line 5)			4, 738	l
.00 Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	132.68	7.00
		Carcuration	OI LIIIII (I)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2022	
			through	
		1. 00	12/31/2022) 2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	0.00	113. 00	8.00
.00 Rate for Program covered visits (see instructions)	. o or your contractor)	0.00	113. 00	9.00
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from	contractor records)	0	115	10.00
1.00 Program cost excluding costs for mental health services (line	•	0	12, 995	
2.00 Program covered visits for mental health services (from contr	•	0	0	12.00
3.00 Program covered cost from mental health services (line 9 x li	•	0	0	13.00
4.00 Limit adjustment for mental health services (see instructions	•	0	0	14.00
5.00   Graduate Medical Education Pass Through Cost (see instruction 6.00   Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	12, 995	15. 00 16. 00
6.01 Total program charges (see instructions)(from contractor's re	*		14, 455	
6.02 Total program preventive charges (see instructions)(from prov			1, 788	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	•		1, 607	
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		4, 431	16.04
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	6, 038	1
7.00   Primary payer amounts 8.00   Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 5, 849	17. 00 18. 00
records)	(Troil contractor		5, 649	10.00
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		1, 364	19.00
records)				
0.00 Net Medicare cost excluding vaccines (see instructions)			6, 038	
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		5, 166	
2.00 Total reimbursable Program cost (line 20 plus line 21)			11, 204	
3.00   Allowable bad debts (see instructions) 3.01   Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
5. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 40 11 0113)		0	25.00
5.50 Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
5.99 Demonstration payment adjustment amount before sequestration	0			
6.00 Net reimbursable amount (see instructions)	Net reimbursable amount (see instructions)			
, , , , , , , , , , , , , , , , , , , ,	Sequestration adjustment (see instructions)			
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00  Interim payments 8.00  Tentative settlement (for contractor use only)			5, 595 0	27. 00 28. 00
9.00 Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		5, 468	
0.00 Protested amounts (nonallowable cost report items) in accorda		.	0,400	30.00
chapter I, §115.2		.	Ŭ	

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od:	Worksheet M-4	
		Component (		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 1:3	
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	291, 014 0. 004108	291, 01 0. 01535		291, 014 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	1, 195	4, 46	2, 998	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	145	2	0	0	4. 00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 340 349, 260	4, 49 349, 26		0 349, 260	5. 00 6. 00
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	295, 689 0. 003837	295, 68 0. 01287		295, 689 0. 000000	7. 00 8. 00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1, 135 2, 475	3, 80 8, 30		0	9. 00 10. 00
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	61 40, 57	22 36. <sup>4</sup>		0 0. 00	
13. 00	Number of injection/infusion administered to Program beneficiaries	20		52 58	0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	811	2, 25	2, 098	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	f columns 1,		16, 313	15. 00
16. 00	Total Program cost of injections/infusions and their admin	istration costs	s (sum of		5, 166	16.00

Health Financial Systems	HANCOCK REGIONAL	HOSPI TAL		In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI			CCN: 15-0037 CCN: 15-3987	From 01/01/2022	Worksheet M-5 Date/Time Prepared:
		•			5/26/2023 1:33 pm
				RHC I	Cost

		Component CCN: 15-3987	To 12/31/2022	5/26/2023 1:3	
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
	<u> </u>		1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			5, 595	1.00
2.00	Interim payments payable on individual bills, either submit			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 amount				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)				
	Program to Provider				
3. 01				0	3.0
3.02				0	3. 02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program		<u>"</u>		1
3.50				0	3.50
3. 51				l o	3.5
3. 52				0	3. 5.
3. 53				0	3. 53
3. 54				l o	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		l o	3.99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		9	5, 595	4.00
00	27)			0,0,0	
	TO BE COMPLETED BY CONTRACTOR		<u> </u>		İ
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	nf		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		<u> </u>		İ
5. 01	<del> </del>			0	5.01
5. 02				l o	
5. 03				0	
0.00	Provider to Program				1 0.00
5. 50	Trovidor to rrogium			0	5.50
5. 51				0	5.5
5. 52					5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the				6. 00
6. 01	SETTLEMENT TO PROVIDER	, 5551 report. (1)		5, 468	6.0
6. 02	SETTLEMENT TO PROGRAM			3, 400	6.02
7. 00	Total Medicare program liability (see instructions)			11, 063	
7.00	Total medicale program traditity (see thistructions)		Contractor	NPR Date	/.00
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8. 00	Name of Contractor	U	1.00	2.00	8.00
0.00	Name of Contractor		1	1	1 0.00