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 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/31/2024 7:01 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/31/2024 7: 01 am ] 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.

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

(4) Reopened(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 01/01/2023 and ending 12/31/2023 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 |   |   |  |  |
|---|-------------------------|-----------------------------------|----------|---|---|--|--|
|   | 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       | 197, 540 | -22, 982 | 0     | -329, 828 | 1.00   |
| 2. 00 SUBPROVI D | ER - IPF             | 0       | 0        | 0        |       | 0         | 2.00   |
| 3. 00 SUBPROVI D | ER - 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 HEAL   | TH AGENCY I          | 0       | 0        | 0        |       | 0         | 9.00   |
| 10.00 RURAL HEA  | LTH CLINIC I         | 0       |          | 4, 267   |       | 0         | 10.00  |
| 200. 00 TOTAL    |                      | 0       | 197, 540 | -18, 715 | 0     | -329, 828 | 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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 7:01 am 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)
/ 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 Hospi tal -Based NF 10.00 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) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) Q 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 N 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

for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 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? In column 2, enter "Y" for yes or "N" for no.

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

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 7:01 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d 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 160 49 1, 740 34 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 2.00 1.00 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 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 N Ν 48.00 Teachi ng Hospi tal s 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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 7:01 am 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 23.00 60.01 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. 0.00 61.20 61.20 Of the FTEs in line 61.05, specify each expanded 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 N

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

| Health Financial Systems   | HANCOCK  | REGIONAL HOSPITAL   |  | In lie                            | u of Form CMS-2                                   | 2552-10 |
|--|--|---|--|-----------------------------------|---|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMP   |  |   |  | eriod:<br>com 01/01/2023          | Worksheet S-2<br>Part I<br>Date/Time Pre          | pared:  |
|  |  |   | Unweighted   | Unweighted                        | 5/31/2024 7:0<br>Ratio (col.                      | ı am    |
|  |  |   | FTEs<br>Nonprovider                                  | FTEs in<br>Hospital               | 1/ (col . 1 + col . 2))                           |         |
|  |  |   | Si te<br>1.00  | 2. 00                             | 3. 00   |         |
| Section 5504 of the ACA Base Yea   | r FTE Residents in N   | onprovider Settings   |  |                                   |   |         |
| period that begins on or after J   | uly 1, 2009 and befo   | re June 30, 2010.   |  |                                   |   |         |
| 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column  | ber of unweighted non<br>tations occurring in<br>number of unweighten<br>ur hospital. Enter in | n-primary care<br>all nonprovider<br>d non-primary care<br>n column 3 the ratio | 0.00   | 0.00                              | 0. 000000   | 64.00   |
| or (cordinir r dr vr ded by (cordinir  | Program Name   | Program Code  | Unwei ghted  | Unwei ghted                       | Ratio (col.                                       |         |
|  | 3  | 3   | FTEs<br>Nonprovi der<br>Si te                        | FTEs in<br>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) | Year FTE Residents i   |   | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te<br>1.00 | Unwei ghted FTEs in Hospi tal     | 0.000000  Ratio (col. 1/ (col. 1 + col. 2))  3.00 | 65. 00  |
| beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit   | unweighted non-priman<br>ccurring in all nonpo<br>unweighted non-priman                        | rovider settings.<br>ry care resident   | 0.00   | 0. 00                             | 0. 000000   | 66. 00  |
| (column 1 divided by (column 1 +   | column 2)). (see ins   | structions)   |  |                                   |   |         |
|  | Program Name   | Program Code  | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te         | Unweighted<br>FTEs in<br>Hospital | Ratio (col.<br>3/ (col. 3 +<br>col. 4))           |         |
|  | 1. 00  | 2. 00   | 3. 00  | 4. 00                             | 5. 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)  | 30   | 2.00  | 0.00   | 0.00                              |   | 67.00   |

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0037 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 7:01 am 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 0 76.00 Ν Ν 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 "Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adiustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved Date Permanent No. Adjustment Amount Per Di scharge 3. 00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 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 di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90.00 Ν Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91.00 Υ 91.00 Ν Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 0.00 0.00

| Health Financial Systems HANCOCK REGION   |   |   |  | u of Form CMS        |                               |
|---|---|---|--|----------------------|-------------------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA   | Provi der C   | F                                       | eriod:<br>rom 01/01/2023<br>o 12/31/2023 | Date/Time Pr         | epared:                       |
|   |   |   | V  | 5/31/2024 7:<br>XI X | UT am                         |
| 00.00 Dags title V on VIV follow Medicans (title VVIII) for the   | intonno and ros   | i danta naat                            | 1.00                                     | 2. 00<br>Y           | 98.00                         |
| 98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.   | for yes or "N"  | for no in                               | Y  |                      |                               |
| 98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.  |   |   | Y  | Y                    | 98. 01                        |
| 98.02 Does title V or XIX follow Medicare (title XVIII) for the composition bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.  |   |   | Y  | Y                    | 98. 02                        |
| 98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.   |   | N                                       | N  | 98. 03               |                               |
| 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAP outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.  |   |   | N  | N                    | 98. 04                        |
| 98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.  |   |   | Y  | Y                    | 98. 05                        |
| 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.   |   |   | Y  | Y                    | 98. 06                        |
| Rural Providers   |   |   |  |                      |                               |
| 105.00 Does this hospital qualify as a CAH? 106.00 of this facility qualifies as a CAH, has it elected the all  | l-inclusive met   | hod of payment                          | N<br>N                                   |                      | 105. 00<br>106. 00            |
| for outpatient services? (see instructions)  107.00 Column 1: If line 105 is Y, is this facility eligible for outpatient in the services? (see instructions)  training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do   | mn 1. (see ins  | structions)                             | N  |                      | 107. 00                       |
| approved medical education program in the CAH's excluded I<br>Enter "Y" for yes or "N" for no in column 2. (see instruct<br>107.01 f this facility is a REH (line 3, column 4, is "12"), is i   | IPF and/or IRF<br>tions)  | uni t(s)?                               |  |                      | 107. 01                       |
| reimbursement for I&R training programs? Enter "Y" for yes instructions)  |   |   |  |                      | 107.01                        |
| 108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.   |   |   | N  |                      | 108. 00                       |
|   | Physi cal<br>1.00   | Occupational<br>2.00                    | Speech<br>3.00                           | Respiratory<br>4.00  | _                             |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.   |   | N N                                     | N N                                      | N N                  | 109. 00                       |
|   |   |   |  | 1.00                 | _                             |
| 110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  | "Y" for yes or  | "N" for no. I                           | f yes,                                   | N                    | 110.00                        |
| аррт годы с.  |   |   |  |                      |                               |
| 111.00  f this facility qualifies as a CAH, did it participate in   | the Frantier (  | `ammuni +v                              | 1. 00<br>N                               | 2. 00                | 111.00                        |
| Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is particularly that apply: "A" for Ambulance services; "B" for a for tele-health services.   | cost reporting<br>column 1 is Y,<br>articipating ir                           | period? Enter<br>enter the<br>column 2. | IV                                       |                      | 111.00                        |
| not tere hearth services.   |   | 1.00                                    | 2. 00                                    | 3. 00                |                               |
| 112.00 Did this hospital participate in the Pennsylvania Rural Heat (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable. | reporting<br>column 1 is<br>ipating in the                                    | N                                       |  |                      | 112.00                        |
| Miscellaneous Cost Reporting Information  | UNII C  |   |  |                      | 0115 05                       |
| 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of   | or "N" for no   | N                                       |  |                      | 0 115. 00                     |
| in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub 15-1, chapter 22, \$2208.1   | B, or E only)<br>"93" percent<br>(i ncl udes                                  |   |  |                      |                               |
| in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care   | B, or E only) "93" percent (includes ers) based on                            | N                                       |  |                      | 116. 00                       |
| in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.  116.00 Is this facility classified as a referral center? Enter "Y"   | B, or E only) "93" percent (includes ers) based on " for yes or urance? Enter | N<br>Y                                  |  |                      | 116. 00<br>117. 00<br>118. 00 |

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CCN: 15-0037   Period: From 01/01/ To 12/31/  |                              |
|---|------------------------------|
|   |                              |
| Premi ums Losse   | 5/31/2024 7: 01 am Insurance |
|   |                              |
|   |                              |
| 11.00 2.00 118.01 List amounts of malpractice premiums and paid losses: 320,190   | 3. 00<br>0 0118. 01          |
|   |                              |
| 11.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the   | 2. 00                        |
| Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119.00D0 NOT USE THIS LINE  | 119.00                       |
| 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. | N 120.00                     |
| 121.00 Did this facility incur and report costs for high cost implantable devices charged to Y  | 121.00                       |
| patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2  | 5. 00 122. 00                |
| the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/combitting services, from an unrelated organization? In column 1, enter "Y"  | N 123.00                     |
| for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.   |                              |
| Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N  | 125.00                       |
| and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.   |                              |
| 126.00  f this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  | 126.00                       |
| 127.00 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.   | 127. 00                      |
| 128.00   f this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  | 128.00                       |
| 129.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  | 129. 00                      |
| 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification   | 130. 00                      |
| date in column 1 and termination date, if applicable, in column 2.  131.00 f this is a Medicare-certified intestinal transplant program, enter the certification  | 131.00                       |
| date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.   | 132.00                       |
| 133.00 Removed and reserved   | 133. 00                      |
| 134.00  If this is a hospital-based organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2.  All Providers   | 134.00                       |
| 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, N chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  | 140. 00                      |
| 1.00 2.00 3.  If this facility is part of a chain organization, enter on lines 141 through 143 the name and ad office and enter the home office contractor name and contractor number.  |                              |
| 141.00 Name: Contractor's Name: Contractor's Number 142.00 Street: PO Box:  | 141. 00<br>142. 00           |
| 143. 00 Ci ty: State: Zi p Code:  | 143. 00                      |
|   | 1.00                         |
| 144.00 Are provider based physicians' costs included in Worksheet A?  | Y 144.00                     |
| 1.00  | 2.00                         |
| 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.   | 145.00                       |
| 146.00 Has the cost allocation methodology changed from the previously filed cost report?  Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.  | 146.00                       |

| Health Financial Systems  | HANCOCK RI                                      | EGI ONAL  | HOSPI TAL    |             |       | In Lie                               | u of Form CMS. | -2552-10           |
|---|---|-----------|--------------|-------------|-------|--------------------------------------|----------------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE  | EX IDENTIFICATION DATA                          | A         | Provi der CC | CN: 15-0037 |       | riod:<br>om 01/01/2023<br>12/31/2023 |                | epared:            |
|   |   |           |              |             |       |                                      | 1.00           | +                  |
| 147.00Was there a change in the statist   | ical hasis? Enter "V"                           | for yes   | s or "N" for | · no        |       |                                      | 1.00<br>N      | 147. 00            |
| 148.00 Was there a change in the order of   |   |           |              |             |       |                                      | N N            | 148. 00            |
| 149.00 Was there a change to the simplif  |   |           |              |             | for n | 0                                    | N              | 149. 00            |
| The column that a change to the chimpiri  | i sa seet i i i ai i g iii stii e               |           | Part A       | Part        |       | Title V                              | Title XIX      | 1177.00            |
|   |   |           | 1.00         | 2. 00       |       | 3. 00                                | 4. 00          | 1                  |
| Does this facility contain a prov<br>or charges? Enter "Y" for yes or   |   |           |              |             |       |                                      |                |                    |
| 155. 00 Hospi tal   |   |           | N            | N N         |       | N                                    | N              | 155. 00            |
| 156.00 Subprovi der - IPF   |   |           | N            | l N         |       | N                                    | N              | 156. 00            |
| 157. 00 Subprovi der - I RF   |   |           | N            | N N         |       | N                                    | N              | 157. 00            |
| 158. 00 SUBPROVI DER  |   |           |              |             |       |                                      |                | 158.00             |
| 159. 00 SNF   |   |           | N            | N N         |       | N                                    | N              | 159.00             |
| 160.00 HOME HEALTH AGENCY   |   |           | N            | N N         |       | N                                    | N              | 160.00             |
| 161. 00 CMHC  |   |           |              | N N         |       | N                                    | N              | 161.00             |
| h   |   |           |              |             |       |                                      | 1. 00          |                    |
| Multicampus  165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.   | ampus hospital that ha                          | as one o  | or more camp | uses in di  | ffere | nt CBSAs?                            | N              | 165. 00            |
| Effect 1 for yes of in for his.   | Name  |           | County       | State       | Zip C | Code CBSA                            | FTE/Campus     |                    |
|   | 0   |           | 1. 00        | 2.00        | 3.0   |                                      | 5. 00          |                    |
| 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) |   |           |              |             |       |                                      | 0.0            | 0 166. 00          |
|   |   |           |              |             |       |                                      | 1.00           | -                  |
| Health Information Technology (HI   |   |           |              |             |       | Act                                  |                |                    |
| 167.00 s this provider a meaningful use<br>168.00 of this provider is a CAH (line 10<br>reasonable cost incurred for the  | 05 is "Y") and is a me                          | eani ngfi | ul user (lin |             |       | enter the                            | Y              | 167. 00<br>168. 00 |
| 168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)   | not a meaningful user,                          | , does f  | this provide |             |       | hardshi p                            |                | 168. 01            |
| 169.00 If this provider is a meaningful transition factor. (see instruction   |   | ) and is  | s not a CAH  | (line 105   | is "N | "), enter the                        | 9. 9           | 9169. 00           |
|   |   |           |              |             |       | Begi 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 end                          | ding da   | te for the r | eporti ng   |       |                                      |                | 170. 00            |
|   |   |           |              |             |       | 1. 00                                | 2.00           |                    |
| 171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2.  | reported on Wkst. S-3,<br>umn 1. If column 1 is | , Pt. I,  | , line 2, co | I. 6? Ente  |       | N                                    |                | 0171.00            |

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 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 7:01 am 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 Has the provider terminated participation in the Medicare Program? If 2.00 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 07/30/2024 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 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 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? Ν 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 04/02/2024 04/02/2024 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  |                  | CN: 15-0037   | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet S<br>Part II | S-2<br>Prepared: |
|                  |  |                  | i pti on      | Y/N  | Y/N                    |                  |
| 20. 00           | If line 16 or 17 is yes, were adjustments made to PS&R   |                  | 0             | 1. 00<br>N                                   | 3. 00<br>N             | 20.00            |
| 20.00            | Report data for Other? Describe the other adjustments:   |                  |               | IN IN  | IN                     | 20.00            |
|                  |  | Y/N              | Date          | Y/N  | Date                   |                  |
| 04.00            | lw   | 1.00             | 2. 00         | 3.00   | 4. 00                  | 01.00            |
| 21. 00           | Was the cost report prepared only using the provider's records? If yes, see instructions.  | N                |               | N  |                        | 21.00            |
|                  |  |                  |               |  | 1.00                   |                  |
|                  | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC   | EPT CHILDRENS    | HOSPI TALS)   |  |                        |                  |
| 22.00            | Capital Related Cost   | a i patruati ana |               |  |                        | 22.00            |
| 22. 00<br>23. 00 | Have assets been relifed for Medicare purposes? If yes, se<br>Have changes occurred in the Medicare depreciation expense                       |                  |               | ring the cost                                |                        | 22. 00<br>23. 00 |
| 20.00            | reporting period? If yes, see instructions.  | due to apprai    | Jar J made ad | Tring the cost                               |                        | 20.00            |
| 24. 00           | Were new leases and/or amendments to existing leases enter If yes, see instructions  | red into during  | this cost r   | eporting period?                             |                        | 24.00            |
| 25. 00           | Have there been new capitalized leases entered into during   | the cost repo    | rting period  | ? If yes, see                                |                        | 25. 00           |
| 26. 00           | instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t  | he cost report   | ing period?   | If yes, see                                  |                        | 26. 00           |
| 27. 00           | instructions.<br>Has the provider's capitalization policy changed during th  | ne cost reporti  | ng period? I  | f yes, submit                                |                        | 27. 00           |
|                  | Copy. Interest Expense   |                  |               |  |                        | 28. 00           |
|                  | period? If yes, see instructions.  |                  |               |  |                        |                  |
| 29. 00           |  |                  |               |  |                        |                  |
| 30. 00           |  |                  |               |  |                        |                  |
| 31. 00           | instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.                  |                  |               |  |                        |                  |
| 32. 00           | Purchased Services Have changes or new agreements occurred in patient care se  | ervices furnish  | ed through c  | ontractual                                   |                        | 32.00            |
| 33. 00           | arrangements with suppliers of services? If yes, see instr<br>If line 32 is yes, were the requirements of Sec. 2135.2 ap                       |                  | ng to compet  | itive bidding? If                            | -                      | 33. 00           |
|                  | no, see instructions. Provider-Based Physicians  |                  |               |  |                        |                  |
| 34.00            | Were services furnished at the provider facility under an  | arrangement wi   | th provider-  | based physicians?                            | •                      | 34.00            |
|                  | If yes, see instructions.  |                  |               |  |                        |                  |
| 35. 00           | If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i                           |                  | ents with the | provi der-based                              |                        | 35. 00           |
|                  | physicians during the cost reporting period: 11 yes, see i   | nstructions.     |               | Y/N  | Date                   |                  |
|                  |  |                  |               | 1.00   | 2. 00                  |                  |
| 24 00            | Home Office Costs  |                  |               |  |                        | 26.00            |
|                  | Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been purposes see instructions.        | prepared by the  | home office   | ?  |                        | 36. 00<br>37. 00 |
| 38. 00           | If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en |                  |               | f  |                        | 38.00            |
| 39. 00           |  |                  |               | S,   |                        | 39. 00           |
| 40. 00           | If line 36 is yes, did the provider render services to the instructions.   | home office?     | If yes, see   |  |                        | 40. 00           |
|                  | THE GOLD OILS.   |                  |               |  |                        |                  |
|                  |  | 1.               | 00            | 2.   | 00                     |                  |
| 41 00            | Cost Report Preparer Contact Information   | ITI NIA          |               | CEVEDO                                       |                        | 41.00            |
| 41. 00           | Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.                  | TINA             |               | SEVERS                                       |                        | 41.00            |
| 42. 00           | Enter the employer/company name of the cost report preparer.   | BLUE & CO., LI   | _C            |  |                        | 42.00            |
| 43. 00           | 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 Finan   | cial Systems   |  | HANCOCK REGI                              | ONAL | HOSPI TAL |      |         |    | In Lie                               | u of Form | CMS-2 | 2552-10 |
|--|--|--|---|------|-----------|------|---------|----|--------------------------------------|-----------|-------|---------|
| HOSPI TAL AND  | ) HOSPITAL HEALTH CARE R   | EI MBURSEMENT  | QUESTI ONNAI RE                           |      | Provi der | CCN: | 15-0037 |    | riod:<br>om 01/01/2023<br>12/31/2023 | Date/Time | e Pre | pared:  |
|  |  |  |   |      |           |      |         | Ц, |                                      | 5/31/2024 | 7:0   | 1 am    |
|  |  |  |   |      |           |      |         |    |                                      |           |       |         |
|  |  |  |   |      |           | 3.00 |         |    |                                      |           |       |         |
| Cost F   | Report Preparer Contact  | Information  |   |      |           |      |         |    |                                      |           |       |         |
| 41.00 Enter  | the first name, last na  | ame and the t  | itle/position                             | MAN  | NAGER     |      |         |    |                                      |           |       | 41.00   |
|  | by the cost report prepa   | arer in colum  | ns 1, 2, and 3,                           |      |           |      |         |    |                                      |           |       |         |
|  |  |  |   | l    |           |      |         |    |                                      |           |       |         |
| 42.00 Enter  | the employer/company na  | ame of the co  | st report                                 |      |           |      |         |    |                                      |           |       | 42.00   |
| prepa  |  |  |   |      |           |      |         |    |                                      |           |       |         |
| 43.00 Enter  | the telephone number ar  | nd email addr  | ess of the cost                           |      |           |      |         |    |                                      |           |       | 43.00   |
| repor  | t preparer in columns 1  | and 2, respe   | cti vel y.                                |      |           |      |         |    |                                      |           |       |         |
| 41.00 Enter held respective enter prepared as 00 Enter | the first name, last name, the cost report prepactively. the employer/company namer. the telephone number an | ame and the t<br>arer in colum<br>ame of the co<br>nd email addr | ns 1, 2, and 3, st report ess of the cost | MAN  | NAGER     |      |         |    |                                      |           |       | 42. 00  |

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

|                  |   |                         |             |                       | o 12/31/2023  | Date/Time Prep<br>5/31/2024 7:0 |                  |
|------------------|---|-------------------------|-------------|-----------------------|---------------|---------------------------------|------------------|
|                  |   |                         |             |                       |               | 1/P Days /                      | ı aiii           |
|                  |   |                         |             |                       |               | 0/P Vi si ts /                  |                  |
|                  |   |                         |             |                       |               | Trips                           |                  |
|                  | Component   | Worksheet A<br>Line No. | No. of Beds | Bed Days<br>Available | CAH/REH Hours | Title V                         |                  |
|                  |   | 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                  | 87          | 31, 755               | 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 Subprovi der  |                         |             |                       |               |                                 | 3.00             |
| 4.00             | HMO IRF Subprovider   |                         |             |                       |               | o                               | 4. 00<br>5. 00   |
| 5. 00<br>6. 00   | Hospital Adults & Peds. Swing Bed SNF<br>Hospital Adults & Peds. Swing Bed NF |                         |             |                       |               | 0                               | 6. 00            |
| 7. 00            | Total Adults and Peds. (exclude observation                                   |                         | 87          | 31, 755               | 0.00          | 0                               | 7. 00            |
| 7.00             | beds) (see instructions)  |                         | 07          | 31,755                | 0.00          | ۷                               | 7.00             |
| 8. 00            | INTENSIVE CARE UNIT   | 31.00                   | 26          | 9, 490                | 0.00          | 0                               | 8.00             |
| 9. 00            | CORONARY CARE UNIT  | 01.00                   | 20          | 7, 170                | 0.00          | ĭ                               | 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)  |                         | 113         | 41, 245               | 0.00          | 0                               | 14.00            |
| 15.00            | CAH visits  |                         |             |                       |               | 0                               | 15.00            |
| 15. 10           | REH hours and visits  |                         |             |                       | 0.00          | 0                               | 15. 10           |
| 16. 00           | SUBPROVIDER - IPF   | 40. 00                  | 0           | 0                     |               | 0                               | 16.00            |
| 17. 00           | SUBPROVI DER - I RF   |                         |             |                       |               |                                 | 17.00            |
| 18. 00           | SUBPROVI DER  |                         |             |                       |               |                                 | 18.00            |
| 19. 00           | SKILLED NURSING FACILITY  |                         |             |                       |               |                                 | 19. 00           |
| 20.00            | NURSING FACILITY  |                         |             |                       |               |                                 | 20.00            |
| 21. 00           | OTHER LONG TERM CARE  | 101 00                  |             |                       |               |                                 | 21.00            |
| 22. 00           | HOME HEALTH AGENCY  | 101. 00                 |             |                       |               | 0                               | 22. 00           |
| 23. 00<br>24. 00 | AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE                                   | 114 00                  | 7           | 2, 555                |               |                                 | 23. 00<br>24. 00 |
| 24. 00           | HOSPICE (non-distinct part)   | 116. 00<br>30. 00       | /           | 2, 555                |               |                                 | 24. 00           |
| 25. 00           | CMHC - CMHC   | 30.00                   |             |                       |               |                                 | 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)  | 67.00                   | 120         |                       |               | ĭ                               | 27. 00           |
| 28. 00           | Observation Bed Days  |                         | .20         |                       |               | 0                               | 28. 00           |
| 29. 00           | Ambulance Trips   |                         |             |                       |               | -                               | 29. 00           |
| 30.00            | Employee discount days (see instruction)                                      |                         |             |                       |               |                                 | 30.00            |
| 31.00            | Employee discount days - IRF  |                         |             |                       |               |                                 | 31.00            |
| 32.00            | Labor & delivery days (see instructions)                                      |                         | 0           | 0                     |               |                                 | 32.00            |
| 32.01            | Total ancillary labor & delivery room   |                         |             |                       |               |                                 | 32.01            |
|                  | outpatient days (see instructions)  |                         |             |                       |               |                                 |                  |
| 33.00            | LTCH non-covered days   |                         |             |                       |               |                                 | 33.00            |
| 33. 01           | LTCH site neutral days and discharges   |                         |             |                       |               |                                 | 33. 01           |
| 34. 00           | Temporary Expansion COVID-19 PHE Acute Care                                   | 30. 00                  | 0           | 0                     |               | 0                               | 34.00            |

Provider CCN: 15-0037

Peri od: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/31/2024 7:01 am

|         |  |             |              |           |               | 5/31/2024 7:0 | 1 am   |
|---------|--|-------------|--------------|-----------|---------------|---------------|--------|
|         |  | I/P Days    | / O/P Visits | / Tri ps  | Full Time I   | Equi val ents |        |
|         |  |             |              |           |               |               |        |
|         |  |             |              |           |               |               |        |
|         | Component                                    | Title XVIII | Title XIX    | Total All | Total Interns | Employees On  |        |
|         |  |             |              | Pati ents | & Residents   | Payrol I      |        |
|         |  | 6. 00       | 7. 00        | 8. 00     | 9. 00         | 10.00         |        |
| <u></u> | PART I - STATISTICAL DATA                    |             |              |           |               |               |        |
| 1.00    | Hospital Adults & Peds. (columns 5, 6, 7 and | 935         | 160          | 5, 011    |               |               | 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)             | 3, 895      | 1, 796       |           |               |               | 2.00   |
| 3.00    | HMO IPF Subprovider                          | o           | 0            |           |               |               | 3.00   |
| 4.00    | HMO IRF Subprovider                          | o           | 0            |           |               |               | 4.00   |
| 5.00    | Hospital Adults & Peds. Swing Bed SNF        | o           | 0            | 0         |               |               | 5.00   |
| 6.00    | Hospital Adults & Peds. Swing Bed NF         |             | 0            | 0         |               |               | 6.00   |
| 7.00    | Total Adults and Peds. (exclude observation  | 935         | 160          | 5, 011    |               |               | 7.00   |
|         | beds) (see instructions)                     |             |              |           |               |               |        |
| 8.00    | INTENSIVE CARE UNIT                          | 1, 858      | 0            | 6, 140    |               |               | 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)                     | 2, 793      | 160          | 11, 151   | 0.00          | 812. 43       |        |
| 15. 00  | CAH visits                                   | 2,7,0       | 0            | 11, 101   |               | 012.10        | 15.00  |
| 15. 10  | REH hours and visits                         | o           | 0            | 0         |               |               | 15. 10 |
| 16. 00  | SUBPROVIDER - IPF                            | o o         | 0            |           |               | 0.00          |        |
| 17. 00  | SUBPROVIDER - IRF                            |             | J            |           | 0.00          | 0.00          | 17.00  |
| 18. 00  | SUBPROVI DER                                 |             |              |           |               |               | 18.00  |
| 19. 00  | SKILLED NURSING FACILITY                     |             |              |           |               |               | 19.00  |
| 20.00   | NURSING FACILITY                             |             |              |           |               |               | 20.00  |
| 21. 00  | OTHER LONG TERM CARE                         |             |              |           |               |               | 21.00  |
| 22. 00  | HOME HEALTH AGENCY                           | 0           | 0            | 0         | 0.00          | 0.00          | •      |
| 23. 00  | AMBULATORY SURGICAL CENTER (D. P.)           | ۷           | U            | U         | 0.00          | 0.00          | 23.00  |
| 24. 00  | HOSPICE                                      | 0           | 0            | 314       | 0.00          | 7. 81         |        |
| 24. 00  | HOSPICE (non-distinct part)                  | ۷           | U            | 314       |               | 7.01          | 24.00  |
| 25. 00  | CMHC - CMHC                                  |             |              | 0         |               |               | 25.00  |
|         | 1  | 275         | 0            | 4 015     | 0.00          | 4 00          |        |
| 26. 00  | RURAL HEALTH CLINIC                          | 375         | 0            | 4, 015    |               |               |        |
| 26. 25  | FEDERALLY QUALIFIED HEALTH CENTER            | 0           | 0            | 0         |               |               | 26. 25 |
| 27. 00  | Total (sum of lines 14-26)                   |             |              | 0 //0     | 0. 00         | 824. 24       |        |
| 28. 00  | Observation Bed Days                         |             | 0            | 3, 662    |               |               | 28. 00 |
| 29. 00  | Ambul ance Tri ps                            | 0           |              |           |               |               | 29. 00 |
| 30.00   | Employee discount days (see instruction)     |             |              | 74        |               |               | 30.00  |
| 31.00   | Employee discount days - IRF                 | _           |              | 0         |               |               | 31.00  |
| 32.00   | Labor & delivery days (see instructions)     | 0           | 34           | 72        |               |               | 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  |

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-0037

| Full Time Equivalents  |        |   |               |         | To          | 12/31/2023 | Date/Time Pre 5/31/2024 7:0 |       |
|--|--------|---|---------------|---------|-------------|------------|-----------------------------|-------|
| Component  |        |   | Full Time     |         | Di sch      | arges      |                             |       |
| PART I - STATISTICAL DATA   11.00   12.00   13.00   14.00   15.00      |        |   | Equi val ents |         |             |            |                             |       |
| PART I - STATISTICAL DATA  |        | Component                               |               | Title V | Title XVIII | Title XIX  |                             |       |
| PART I - STATISTICAL DATA   1.00      |        |   |               |         |             |            |                             |       |
| 1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8   8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2   7 or the portion of LDP room available beds)   |        |   | 11. 00        | 12. 00  | 13. 00      | 14. 00     | 15. 00                      |       |
| 8 exclude \$wing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP roon available beds)   |        |   |               |         |             |            |                             |       |
| Hospice days)(see instructions for col. 2  | 1. 00  | ,                                       |               | 0       | 734         | 52         | 2, 817                      | 1.00  |
| Tor the portion of LDP room available beds)   3.00   3.00   3.00   466   2.00   3.00   4.00   |        |   |               |         |             |            |                             |       |
| 2.00   |        |   |               |         |             |            |                             |       |
| 3.00 HMU IPF Subprovi der 4.00 HMU IPF Subprovi der 4.00 HMU IPF Subprovi der 5.00 Hospi tal Adult s & Peds. Swing Bed NIF 7.00 Hospi tal Adult s & Peds. Swing Bed NIF 7.00 Total Adult s & Peds. Swing Bed NIF 7.00 Total Adult s & Peds. Swing Bed NIF 7.00 Total Adult s & Peds. Swing Bed NIF 7.00 Total Adult s & Peds. Swing Bed NIF 8.00 INTENSIVE CARE UNIT 9.00 COROMARY CARE UNIT 9.00 COROMARY CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 THER SPECIAL CARE (SPECIFY) 13.00 NURSERY 10.00 CAH visits 15.10 Ret hours and visits 15.10 Ret hours and visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER SACILITY 19.00 SKILLED NURSING FACILITY 20.00 OHMER HEALTH AGENCY 20.00 DAYLOR OF SCHOOL OF SCH | 2 00   |   |               |         | 000         |            |                             | 2 00  |
| 4. 00   HMO I RF Subprovi der  |        |   |               |         | 820         |            |                             |       |
| 5.00   |        |   |               |         |             | - 1        |                             |       |
| 6.00   Hospital Adults & Peds. Swing Bed NF   Total Adults and Peds. (exclude observation beds) (see Instructions)   Notes     |        |   |               |         |             | ٩          |                             | •     |
| 7.00   Total Adul ts and Peds. (exclude observation beds) (see instructions)   8.00   INTENSIVE CARE UNIT   9.00   10.00   IUNITENSIVE CARE UNIT   10.00   11.00   1   |        | , ,                                     |               |         |             |            |                             | •     |
| beds) (see instructions)   8.00  |        |   |               |         |             |            |                             | •     |
| 8. 00   INTENSIVE CARE UNIT  | 7.00   |   |               |         |             |            |                             | 7.00  |
| 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 TOTHER SPECIAL CARE (SPECIFY) 13.00 INNSERY 13.00 TOTAL (see instructions) 15.10 REH hours and visits 15.10 REH HOURS REH LIFE 15.00 REH HOURS REH LIFE 15.00 REH HOURS REH LIFE 17.00 REH LIFE REH CARE 19.00 SUBPROVI DER 19.00 SUBPROVI DER 19.00 SUBPROVI DER 19.00 SUBPROVI DER 19.00 REH LIFE REH CARE 19.00 ROW NURSI NG FACI LITY 20.00 NURSI NG FACI LITY 20.00 ROW NURSI NG FACI LITY 20.00 ROW NURSI NG FACI LITY 20.00 ROW NURSI NG FACI LITY 20.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPI CE 24.00 HOSPI CE 24.00 ROW CE (non-distinct part) 25.00 CMR - CMMC - CMMC 25.00 ROW CE (non-distinct part) 26.05 ROW ROW CE (non-distinct part) 27.00 ROW ROW CENTRE REHALTH CLINIC 28.00 ROW ROW CENTRE REHALTH CLINIC 29.00 ROW ROW CENTRE REHALTH CLINIC 29.00 ROW ROW CENTRE REHALTH CLINIC 29.00 ROW CENTRE REHALTH CLINIC 29.0 | 0.00   |   |               |         |             |            |                             | 0.00  |
| 10.00   BURN INTENSIVE CARE UNIT   |        |   |               |         |             |            |                             | •     |
| 11.00   SURGI CAL INTENSIVE CARE UNIT   12.00   OTHER SPECIAL CARE (SPECIFY)   OTOTAL (see instructions)   O.00   O   O   O   O   O   O   O   O   O   |        |   |               |         |             |            |                             | 1     |
| 12. 00 13. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10 |        |   |               |         |             |            |                             |       |
| 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 15. 00 CAH visits 15. 00 CAH visits 15. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMRAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 20. 00 Labor & delivery days (see instructions) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 30. 00 End - Crowded Cays 30. 00 LTCH site neutral days and discharges  |        |   |               |         |             |            |                             |       |
| 14. 00 Total (see instructions)  |        |   |               |         |             |            |                             | 1     |
| 15. 00 CAH visits 15. 10 REH hours and visits 16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 19. 00 SKI LLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH site neutral days and discharges  15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |        | 4                                       | 0.00          | 0       | 704         | F.2        | 2 017                       |       |
| 15. 10 REH hours and visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER AGE INF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOWE HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Empl oyee discount days (see instruction) 31. 00 Empl oyee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days and discharges  15. 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |        | 1                                       | 0.00          | U       | /34         | 52         | 2,817                       | •     |
| 16. 00 SUBPROVIDER - IPF   |        | 4                                       |               |         |             |            |                             |       |
| 17. 00   SUBPROVIDER - IRF   17. 00   18. 00   SUBPROVIDER     18. 00   SKILLED NURSING FACILITY   19. 00   SKILLED NURSING FACILITY   20. 00   NURSING FACILITY   20. 00   21. 00   21. 00   21. 00   21. 00   22. 00   22. 00   23. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 10   40. 40   25. 00   26. 20   26 |        | 4                                       | 0.00          | 0       |             | 0          | 0                           | •     |
| 18.00 SUBPROVI DER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGI CAL CENTER (D. P.) 24.00 HOSPI CE 40.00 HOSPI CE 40.00 CMHC - CMHC 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 27.00 Observation Bed Days 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee di scount days (see instruction) 31.00 Employee di scount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 30.00 LTCH non-covered days 30.00 LTCH non-covered days 30.00 LTCH site neutral days and discharges  |        | 4                                       | 0.00          | U       | ٥           | ٩          | Ü                           | 1     |
| 19. 00   |        | 1                                       |               |         |             |            |                             |       |
| 20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   22.00   22.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   24.00   40.00   40.00   24.00   24.10   40.00   24.10   40.00   24.10   40.00   24.10   40.00   24.10   40.00   24.10   40.00   24.10   40.00   24.10   25.00   24.10   25.00   26.25   26.00   26.25   26.00   26.25   27.00   26.25   27.00   26.25   27.00   27.00   27.00   28.00   27.00   28.00   29.00   |        | 4                                       | +             |         |             |            |                             | 1     |
| 21.00 OTHER LONG TERM CARE  22.00 HOME HEALTH AGENCY  23.00 AMBULATORY SURGICAL CENTER (D.P.)  24.00 HOSPICE  0.00  24.10 HOSPICE (non-distinct part)  25.00 CMHC - CMHC  26.00 RURAL HEALTH CLINIC  26.25 FEDERALLY QUALIFIED HEALTH CENTER  27.00 Observation Bed Days  28.00 Observation Bed Days  29.00 Ambulance Trips  30.00 Employee discount days (see instruction)  31.00 Employee discount days - IRF  31.00  32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  LTCH site neutral days and discharges  21.00  22.00  22.00  22.00  23.00  24.10  24.10  25.00  26.00  27.00  26.00  27.00  26.00  27.00  28.00  29.00  30.00  30.00 Employee discount days (see instruction)  31.00 LTCH non-covered days  COMPACTOR AGENTALY OF ACTUAL AGENCY ASSETTION ASSETTIO |        | 4                                       | +             |         |             |            |                             |       |
| 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.00 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges   |        | 4                                       | +             |         |             |            |                             |       |
| 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE  |        | 4                                       | 0.00          |         |             |            |                             |       |
| 24.00 HOSPICE  |        |   | 0.00          |         |             |            |                             |       |
| 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance 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 outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 33. 01 LTCH site neutral days and discharges  |        |   | 0.00          |         |             |            |                             |       |
| 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 31. 00 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges   |        | 4                                       | 0.00          |         |             |            |                             | •     |
| 26. 00 RURAL HEALTH CLINIC   |        |   |               |         |             |            |                             |       |
| 26. 25   FEDERALLY QUALIFIED HEALTH CENTER   0.00   26. 25   27. 00   70tal (sum of lines 14-26)   0.00   27. 00   28. 00   0bservation Bed Days   28. 00   29. 00   Ambulance Trips   29. 00    |        | 1                                       | 0.00          |         |             |            |                             | 1     |
| 27.00   Total (sum of lines 14-26)   0.00   27.00   28.00   0bservation Bed Days   28.00   29.00   Ambulance Trips   29.00   30.00   Employee discount days (see instruction)   30.00   Employee discount days - IRF   31.00   32.00   Labor & delivery days (see instructions)   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   UTCH non-covered days   0   33.00   UTCH site neutral days and discharges   0   33.01   3 |        |   |               |         |             |            |                             |       |
| 28.00 Observation Bed Days 29.00 Ambulance Trips 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 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges  28.00 29.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 31.00 32.01 33.00 33.01  |        |   |               |         |             |            |                             | 1     |
| 29.00 Ambulance Trips 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 outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  29.00 30.00 31.00 31.00 32.00 33.00 33.00   |        | 1                                       | 0.00          |         |             |            |                             | 1     |
| 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 outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  30.00 31.00 3 |        | 1                                       |               |         |             |            |                             |       |
| 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  31.00 32.00 32.01 33.00 33.01 LTCH site neutral days and discharges  |        | •                                       |               |         |             |            |                             |       |
| 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges  32.00 32.01 0 32.01 0 32.01 0 33.00   |        | 1 . 3                                   |               |         |             |            |                             |       |
| 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  32.01 Outpatient days (see instructions) 33.00 Outpatient days (see instructions)  |        | , , ,                                   |               |         |             |            |                             |       |
| outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01   |        |   | 1             |         |             |            |                             | 1     |
| 33.00       LTCH non-covered days       0       33.00         33.01       LTCH site neutral days and discharges       0       33.01  | 52. 51 |   |               |         |             |            |                             | 32.01 |
| 33.01 LTCH site neutral days and discharges 0 33.01  | 33.00  | , |               |         | 0           |            |                             | 33.00 |
|  |        | ,                                       |               |         | - 1         |            |                             | •     |
|  |        | ,                                       |               |         |             |            |                             | 34.00 |

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0037 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 7:01 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to 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 PART II - WAGE DATA SALARI ES 200 00 73, 306, 400 -242, 411 1.00 Total salaries (see 73. 063. 989 1, 609, 053. 00 45.41 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3 00 O 3 00 Non-physician anesthetist Part 0 00 0 00 0 4.00 Physician-Part A -0 0.00 0.00 4.00 Administrative 4. 01 Physicians - Part A - Teaching 0.00 0.00 4.01 3, 795, 733 3, 795, 733 5.00 Physician and Non 26, 653. 00 142.41 5.00 Physician-Part B 6.00 Non-physician-Part B for 115, 241 115, 241 6, 337. 00 18.19 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 21.00 7.00 7.00 0 0.00 0.00 0 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9 00 44 00 SNF 0.00 0 00 9 00 10.00 Excluded area salaries (see 18, 420, 246 -503, 679 17, 916, 567 292, 375. 00 61. 28 10.00 instructions) OTHER WAGES & RELATED COSTS 2, 947, 108 2, 947, 108 11.00 Contract labor: Direct Patient 30, 505.00 96.61 11.00 Contract Labor: Top Level 0.00 12.00 0 0 0.00 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 32, 695 0 32, 695 467.00 70.01 13.00 A - Administrative 14.00 Home office and/or related 0 0 0.00 14.00 0.00 organization salaries and wage-related costs 14.01 Home office salaries 0 0.00 0.00 14.01 Related organization salaries 0.00 14.02 14.02 0 0.00 15.00 Home office: Physician Part A 0 0.00 0.00 15.00 - Administrative 0 16.00 Home office and Contract 0.00 0.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A О 0.00 0.00 16.01 - Teachi ng Home office contract 16.02 0 0.00 0.00 16.02 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 12, 172, 351 12, 172, 351 17.00 instructions) 18.00 Wage-related costs (other) 18 00 (see instructions) 19.00 Excluded areas 3, 055, 082 3, 055, 082 19.00 20.00 Non-physician anesthetist Part 0 20.00 21.00 Non-physician anesthetist Part 21.00 0 0 22.00 Physician Part A -0 22.00 Administrative 22.01 Physician Part A - Teaching 22.01 Physician Part B 453, 228 453, 228 23.00 23 00 24.00 Wage-related costs (RHC/FQHC) 42, 792 42, 792 24.00 25.00 Interns & residents (in an 25.00 approved program) 25.50 C Home office wage-related 0 0 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) Home office: Physician Part A 25.52 0 25.52 - Administrative wage-related (core)

Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 7:01 am 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 4.00 642, 288 -8, 577 633, 711 20, 059. 00 31. 59 26.00 27.00 Administrative & General 5.00 11, 141, 428 -316, 038 10, 825, 390 252, 445. 00 42.88 27.00 28. 00 283, 468 283, 468 1, 186. 00 239. 01 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, 234, 551 -34, 071 1, 200, 480 30, 353.00 39. 55 30.00 Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 32.00 Housekeepi ng -1, 949 94, 474. 00 9.00 2,004,405 2,002,456 21. 20 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 1, 722, 956 -1, 065, 903 657, 053 30, 194. 00 21. 76 34.00 35.00 Dietary under contract (see 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 1, 059, 492 1, 059, 492 41, 010. 00 25. 83 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 60. 48 38.00 38.00 13.00 1, 461, 219 1, 461, 219 24, 159. 00 39.00 Central Services and Supply 14.00 325, 761 -6, 417 319, 344 8, 314. 00 38. 41 39.00 2, 685, 772 2, 682, 936 55, 621. 00 48. 24 40. 00 40.00 Pharmacy 15.00 -2,836 Medical Records & Medical Records Library 733, 457 41.00 16.00 733, 457 C 27, 311. 00 26. 86 41. 00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00

0

0

0

0.00

0.00 43.00

18.00

43.00 Other General Service

| Health Financial Systems        | HANCOCK REGIONAL HOSPITAL | In Lieu of Form CMS-2552-10 |
|---------------------------------|---------------------------|-----------------------------|
| HOSPITAL WAGE INDEX INFORMATION | Provi der CCN: 15-0037    | Peri od: Worksheet S-3      |
|                                 |                           | From 01/01/2023   Part III  |

|       |                                |             |              |                  | Т             | o 12/31/2023    | Date/Time Pre<br>5/31/2024 7:0 |      |
|-------|--------------------------------|-------------|--------------|------------------|---------------|-----------------|--------------------------------|------|
|       |                                | 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              |             | 69, 678, 894 | -242, 411        | 69, 436, 483  | 1, 577, 249. 00 | 44. 02                         | 1.00 |
|       | instructions)                  |             |              |                  |               |                 |                                |      |
| 2. 00 | Excluded area salaries (see    |             | 18, 420, 246 | -503, 679        | 17, 916, 567  | 292, 375. 00    | 61. 28                         | 2.00 |
|       | instructions)                  |             |              |                  |               |                 |                                |      |
| 3. 00 | Subtotal salaries (line 1      |             | 51, 258, 648 | 261, 268         | 51, 519, 916  | 1, 284, 874. 00 | 40. 10                         | 3.00 |
|       | minus line 2)                  |             |              |                  |               |                 |                                |      |
| 4.00  | Subtotal other wages & related |             | 2, 979, 803  | 0                | 2, 979, 803   | 30, 972. 00     | 96. 21                         | 4.00 |
|       | costs (see inst.)              |             |              |                  |               |                 |                                |      |
| 5.00  | Subtotal wage-related costs    |             | 12, 172, 351 | 0                | 12, 172, 351  | 0.00            | 23. 63                         | 5.00 |
|       | (see inst.)                    |             |              |                  |               |                 |                                |      |
| 6.00  | Total (sum of lines 3 thru 5)  |             | 66, 410, 802 | 261, 268         | 66, 672, 070  | 1, 315, 846. 00 | 50. 67                         | 6.00 |
| 7.00  | Total overhead cost (see       |             | 22, 235, 305 | -376, 299        | 21, 859, 006  | 585, 126. 00    | 37. 36                         | 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 Per | ri od: W<br>om 01/01/2023 F | Worksheet S-3<br>Part IV |
|                             |                           | То               |                             | Date/Time Prepared:      |

|        | To 12/31/2023   | Date/Time Prep 5/31/2024 7:0 |        |
|--------|---|------------------------------|--------|
|        |   | Amount                       |        |
|        |   | Reported                     |        |
|        |   | 1.00                         |        |
|        | PART IV - WAGE RELATED COSTS  |                              |        |
|        | Part A - Core List  |                              |        |
|        | RETI REMENT COST  |                              |        |
| 1.00   | 401K Employer Contributions   | 0                            | 1.00   |
| 2.00   | Tax Sheltered Annuity (TSA) Employer Contribution   | 0                            | 2.00   |
| 3.00   | Nonqualified Defined Benefit Plan Cost (see instructions)   | 3, 027, 052                  | 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   | 655                          | 6.00   |
| 7.00   | Employee Managed Care Program Administration Fees   | 0                            | 7. 00  |
|        | HEALTH AND INSURANCE COST   |                              | l      |
| 8.00   | Health Insurance (Purchased or Self Funded)   | 0                            |        |
| 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, 547, 722                  |        |
| 8. 03  | Health Insurance (Purchased)  | 0                            | 1 0.00 |
| 9. 00  | Prescription Drug Plan  | 0                            |        |
| 10.00  | Dental, Hearing and Vision Plan   | 513, 300                     |        |
| 11. 00 | Life Insurance (If employee is owner or beneficiary)  | 273, 916                     | 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)  | 425, 165                     |        |
| 14.00  | Long-Term Care Insurance (If employee is owner or beneficiary)  | -1, 608                      |        |
| 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  |
|        | Noncumulative portion)  |                              |        |
|        | TAXES   |                              |        |
| 17. 00 | FICA-Employers Portion Only   | 4, 805, 789                  | 1      |
| 18. 00 | Medicare Taxes - Employers Portion Only   | 0                            |        |
| 19. 00 | Unempl oyment Insurance   |                              | 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 | -6                           | 21.00  |
|        | instructions))  |                              |        |
| 22. 00 | Day Care Cost and Allowances  | 28, 600                      |        |
|        |   | 100, 918                     |        |
| 24. 00 | Total Wage Related cost (Sum of lines 1 -23)  | 15, 723, 453                 | 24.00  |
| 05.00  | Part B - Other than Core Related Cost   |                              | 05.00  |
| 25.00  | OTHER WAGE RELATED COSTS (SPECIFY)  | l l                          | 25.00  |
|        |   |                              |        |

| Health Financial Systems                 | HANCOCK REGIONAL HOSPITAL | In Lieu of Form CMS-2552-10   |
|--|---------------------------|---|
| HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provi der CCN: 15-0037    | Peri od: Worksheet S-3<br>From 01/01/2023 Part V<br>To 12/31/2023 Date/Time Prepared: |

|        |   | To | 12/31/2023  | Date/Time Pre 5/31/2024 7:0 |        |
|--------|---|----|-------------|-----------------------------|--------|
|        | Cost Center Description                               |    | Contract    | Benefit Cost                |        |
|        |   |    | Labor       |                             |        |
|        |   |    | 1.00        | 2. 00                       |        |
|        | PART V - Contract Labor and Benefit Cost              |    |             |                             |        |
|        | Hospital and Hospital-Based Component Identification: |    |             |                             |        |
| 1. 00  | Total facility's contract labor and benefit cost      |    | 2, 947, 108 | 15, 723, 453                | 1.00   |
| 2. 00  | Hospi tal   |    | 2, 947, 108 | 15, 723, 453                | 2.00   |
| 3.00   | SUBPROVI DER - I PF                                   |    | 0           | 0                           | 3.00   |
| 4. 00  | SUBPROVI DER - I RF                                   |    |             |                             | 4.00   |
| 5. 00  | Subprovider - (Other)                                 |    | 0           | 0                           | 5.00   |
| 6.00   | Swing Beds - SNF                                      |    | 0           | 0                           | 6.00   |
| 7. 00  | Swing Beds - NF                                       |    | 0           | 0                           | 7.00   |
| 8. 00  | SKILLED NURSING FACILITY                              |    |             |                             | 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                           | 11.00  |
| 12. 00 | AMBULATORY SURGICAL CENTER (D. P.) I                  |    |             |                             | 12.00  |
| 13.00  | Hospi tal -Based Hospi ce                             |    | 0           | 0                           | 13.00  |
| 14.00  | Hospital-Based Health Clinic RHC                      |    | 0           | 0                           | 14.00  |
| 15.00  | Hospital-Based Health Clinic FQHC                     |    |             |                             | 15.00  |
| 16.00  | Hospi tal -Based-CMHC                                 |    |             |                             | 16.00  |
| 17.00  | RENAL DIALYSIS I                                      |    |             |                             | 17.00  |
| 18. 00 | Other Other   |    | O           | 0                           | 18. 00 |

| Health Financial Systems   | HANCOCK REGIO   | NAL HOSPITAL  |   | In Li  | eu of Form CMS-                               | 2552-10                    |
|--|---|---|---|--|---|----------------------------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA   |   | Provi der Co  | CN: 15-0037   | Peri od:   | Worksheet S-8                                 |                            |
|  |   | Component (   | CCN: 15-3987  | From 01/01/202<br>To 12/31/202                   |   | narod:                     |
|  |   | Component   | JCN. 13-3907  | 10 12/31/202                                     | 5/31/2024 7:0                                 |                            |
|  |   |   |   | RHC I  | Cost  |                            |
|  |   |   |   |  |   | -                          |
| Clinic Address and Identification  |   |   |   |  | 1. 00   |                            |
| 1. 00 Street   |   |   |   | 224 WEST MAIN                                    | L STREET                                      | 1.00                       |
|  |   | Ci  | ty  | State  | ZIP Code                                      |                            |
|  |   | 1.  | 00  | 2. 00  | 3. 00   |                            |
| 2.00 City, State, ZIP Code, County   |   | KNI GHTSTOWN  |   | I  | N 46146                                       | 2.00                       |
|  |   |   |   |  | 1.00  |                            |
| 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent  | er "R" for rur  | al or "U" for u   | urban   |  | 1.00  | 3.00                       |
|  |   |   |   | nt Award   | Date  | 0.00                       |
|  |   |   |   | 1. 00  | 2. 00   |                            |
| Source of Federal Funds  |   |   | Г -   | 27/22  | 07/04/0045                                    |                            |
| 4.00 Community Health Center (Section 330(d), PHS 8.00 Migrant Health Center (Section 329(d), PHS 8.00 Migrant Health Center (Section 320(d), PHS 8.00 Migran Health Center (Section 320(d), PHS 8.00 Migran Health Center (Se |   |   | 1   | 37632  | 07/01/2015                                    | 4. 00<br>5. 00             |
| 6.00 Health Services for the Homeless (Section 34  |   |   |   |  |   | 6.00                       |
| 7.00 Appal achi an Regional Commission   | 10(4)/ 1110 7101/   |   |   |  |   | 7.00                       |
| 8. 00 Look-Alikes  |   |   |   |  |   | 8. 00                      |
| 9.00 OTHER (SPECIFY)   |   |   |   |  |   | 9.00                       |
|  |   |   |   | 1.00   | 2.00  |                            |
| 10.00 Does this facility operate as other than a h   | ospi tal -based   | RHC or FOHC? Fi   | nter "Y" for  | 1.00<br>N  |   | 10.00                      |
| yes or "N" for no in column 1. If yes, indic   | •   |   |   | ***  |   | 10.00                      |
| 2. (Enter in subscripts of line 11 the type of   | of other operat   | ion(s) and the  | operati ng  |  |   |                            |
| hours.)  |   | T.  |   | L. L.  | T I.  |                            |
|  | from  | day<br>to   | from  | londay<br>to                                     | Tuesday<br>from                               |                            |
|  | 110111  |   |   |  |   |                            |
|  | 1, 00   | 2.00  | 3.00  | 4.00   | _   |                            |
| Facility hours of operations (1)   | 1. 00   |   |   |  | 5. 00   |                            |
| Facility hours of operations (1) 11.00 CLINIC  | 1.00  | 2.00  |   |  | _   | 11.00                      |
|  | 1.00  | 2.00  | 3. 00   | 4. 00  | 5. 00   | 11.00                      |
| 11. 00 CLINIC  |   | 2.00  | 3. 00   | 4. 00<br>17: 00<br>1. 00                         | 5. 00   |                            |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti   | on to the prod  | 2.00<br>uctivity standa   | 3.00<br>08:00<br>ard?   | 4. 00  | 5. 00   | 12.00                      |
| 11. 00 CLINIC  | on to the prod  | 2.00<br>uctivity standa<br>100-04, chapter  | 3.00<br>08:00<br>ard?<br>r 9, section   | 4. 00<br>17: 00<br>1. 00<br>N                    | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.  | on to the proded in CMS Pub.  | 2.00<br>uctivity standa<br>100-04, chapter  | 3.00<br>08:00<br>ard?<br>r 9, section<br>nn 2 the   | 4. 00<br>17: 00<br>1. 00<br>N                    | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.   | on to the prod<br>ed in CMS Pub.<br>umn 1. If yes,<br>List the name   | 2.00<br>uctivity standa<br>100-04, chapter<br>enter in colur<br>s of all provid   | 3.00  08:00  ard?  r 9, section mn 2 the ders and   | 4. 00<br>17: 00<br>1. 00<br>N                    | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report.  | on to the proded in CMS Pub. umn 1. If yes, List the name   | 2.00  uctivity standa 100-04, chapter enter in colur s of all provio  | 3.00 08:00 ard? f 9, section mn 2 the ders and Cs (as define  | 4. 00<br>17: 00<br>1. 00<br>N<br>N               | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.   | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c  | 2.00  uctivity standa 100-04, chapter enter in colur s of all provide consolidated RHG for yes or "N"   | 3.00  08:00  ard? r 9, section nn 2 the ders and  Cs (as define for no. If                                  | 4. 00<br>17: 00<br>1. 00<br>N<br>N               | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated.   | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c ?)? Enter "Y" dated RHC grouping.  | 2.00  uctivity standa 100-04, chaptel enter in colur s of all provious consolidated RHG for yes or "N" pings and complings and complicated                | 3.00  08:00  ard? r 9, section nn 2 the ders and  Cs (as define for no. If ete a RHC groupine               | 4. 00<br>17: 00<br>1. 00<br>N<br>N               | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered consolidated.  | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c ?)? Enter "Y" dated RHC group I RHC grouping.  | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group       | 3.00  08:00  ard? r 9, section nn 2 the ders and  Cs (as define for no. If ete a RHC groupine               | 4. 00<br>17: 00<br>1. 00<br>N<br>N               | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated.   | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c ?)? Enter "Y" dated RHC group I RHC grouping.  | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group       | 3.00  08:00  ard? r 9, section mn 2 the ders and  Cs (as define for no. If ete a RHC grouping oing or       | 4. 00<br>17: 00<br>1. 00<br>N<br>N<br>ed N       | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered consolidates.  | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c ?)? Enter "Y" dated RHC group I RHC grouping.  | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group       | 3.00  08:00  ard? r 9, section nn 2 the ders and  Cs (as define for no. If ete a RHC grouping oing or       | 4. 00<br>17: 00<br>1. 00<br>N<br>N               | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered consolidates.  | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c ?)? Enter "Y" dated RHC group I RHC grouping.  | 2.00  uctivity standa 100-04, chapter enter in colur s of all provid  consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group        | 3.00  08:00  ard? r 9, section nn 2 the ders and  Cs (as define for no. If ete a RHC grouping oing or       | 4.00  17:00  1.00  N N N ed N                    | 5. 00<br>08: 00<br>2. 00                      | 12.00                      |
| 12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RF   | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c ?)? Enter "Y" dated RHC grouping. consolidated RH Cs in the grou                     | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group ping. | 3.00  08:00  ard? r 9, section mn 2 the ders and  Cs (as define for no. If ete a RHC groupine ping or  Prov | 4.00  17:00  1.00  N N N ed N  gs ider name 1.00 | 5. 00  08: 00  2. 00  CCN 2. 00  Total Visits | 12. 00<br>13. 00           |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RF  | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH ICs in the grou                    | 2.00  uctivity standa 100-04, chapter enter in colur s of all provid  consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group        | 3.00  08:00  ard? r 9, section mn 2 the ders and  Cs (as define for no. If ete a RHC groupine oing or       | 4.00  17:00  1.00  N N N Sed N                   | 5. 00<br>08: 00<br>2. 00                      | 12. 00<br>13. 00<br>13. 01 |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH.  | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c ?? Enter "Y" dated RHC group RHC grouping. consolidated RH ICs in the grou  Y/N 1.00 | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group ping. | 3.00  08:00  ard? r 9, section mn 2 the ders and  Cs (as define for no. If ete a RHC groupine ping or  Prov | 4.00  17:00  1.00  N N N ed N  gs ider name 1.00 | 5. 00  08: 00  2. 00  CCN 2. 00  Total Visits | 12. 00<br>13. 00           |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH.  14.00 RHC/FOHC name, CCN   | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the grou  Y/N 1.00           | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group ping. | 3.00  08:00  ard? r 9, section mn 2 the ders and  Cs (as define for no. If ete a RHC groupine ping or  Prov | 4.00  17:00  1.00  N N N ed N  gs ider name 1.00 | 5. 00  08: 00  2. 00  CCN 2. 00  Total Visits | 12. 00<br>13. 00<br>13. 01 |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH.  14.00 RHC/FOHC name, CCN  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  | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the grou  Y/N 1.00           | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group ping. | 3.00  08:00  ard? r 9, section mn 2 the ders and  Cs (as define for no. If ete a RHC groupine ping or  Prov | 4.00  17:00  1.00  N N N ed N  gs ider name 1.00 | 5. 00  08: 00  2. 00  CCN 2. 00  Total Visits | 12. 00<br>13. 00<br>13. 01 |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RF.  14.00 RHC/FOHC name, CCN  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  | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the grou  Y/N 1.00           | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group ping. | 3.00  08:00  ard? r 9, section mn 2 the ders and  Cs (as define for no. If ete a RHC groupine ping or  Prov | 4.00  17:00  1.00  N N N ed N  gs ider name 1.00 | 5. 00  08: 00  2. 00  CCN 2. 00  Total Visits | 12. 00<br>13. 00<br>13. 01 |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RF  14.00 RHC/FOHC name, CCN  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 column 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   | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the grou  Y/N 1.00           | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group ping. | 3.00  08:00  ard? r 9, section mn 2 the ders and  Cs (as define for no. If ete a RHC groupine ping or  Prov | 4.00  17:00  1.00  N N N ed N  gs ider name 1.00 | 5. 00  08: 00  2. 00  CCN 2. 00  Total Visits | 12. 00<br>13. 00<br>13. 01 |
| 11.00 CLINIC  12.00 Have you received an approval for an excepti 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RF.  14.00 RHC/FOHC name, CCN  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  | on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the grou  Y/N 1.00           | 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RHG for yes or "N" pings and compl Consolidated Cs in the group ping. | 3.00  08:00  ard? r 9, section mn 2 the ders and  Cs (as define for no. If ete a RHC groupine ping or  Prov | 4.00  17:00  1.00  N N N ed N  gs ider name 1.00 | 5. 00  08: 00  2. 00  CCN 2. 00  Total Visits | 12. 00<br>13. 00<br>13. 01 |

| Health Financial Systems                 | HANCOCK REGIO | NAL HOSPITAL |              | In Lie                           | u of Form CMS- | 2552-10 |
|--|---------------|--------------|--------------|----------------------------------|----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |               | Provi der C  | CN: 15-0037  | Peri od:                         | Worksheet S-8  | 3       |
|  |               | Component    | CCN: 15-3987 | From 01/01/2023<br>To 12/31/2023 |                |         |
|  |               |              |              | RHC I                            | Cost           |         |
|  |               | Cou          | inty         |                                  |                |         |
|  |               | 4.           | 00           |                                  |                |         |
| 2.00 City, State, ZIP Code, County       |               | HANCOCK      |              |                                  |                | 2.00    |
|  | Tuesday       | Wedne        | esday        | Thur                             | sday           |         |
|  | to            | from         | to           | from                             | to             |         |
|  | 6. 00         | 7.00         | 8. 00        | 9. 00                            | 10.00          |         |
| Facility hours of operations (1)         |               |              |              |                                  |                |         |
| 11. 00 CLINIC                            | 17: 00        | 08: 00       | 17: 00       | 08: 00                           | 17: 00         | 11.00   |
|  | Fri           | day          | Sa           | turday                           |                |         |
|  | from          | to           | from         | to                               |                |         |
|  | 11. 00        | 12. 00       | 13.00        | 14.00                            |                |         |
| Facility hours of operations (1)         |               |              |              |                                  |                |         |
| 11. 00 CLINIC                            | 08: 00        | 14: 00       |              |                                  |                | 11.00   |

|               | Financial Systems HANCOCK REGIONAL I AL UNCOMPENSATED AND INDIGENT CARE DATA  | Provider CC  | N: 15_0037            | Peri od:         | u of Form CMS-2<br>Worksheet S-1 |        |
|---------------|---|--------------|-----------------------|------------------|----------------------------------|--------|
| HUSFII        | AL UNCOMPENSATED AND THUTGENT CARE DATA   | riovidei cc  | 1. 15-0037            | From 01/01/2023  |                                  | U      |
|               |   |              |                       | To 12/31/2023    |                                  |        |
|               |   |              |                       |                  | 5/31/2024 7.0                    | ı allı |
|               | DADT I WOOD TALL AND WOOD TALL COMPLEY DATA   |              |                       |                  | 1. 00                            |        |
|               | PART I - HOSPITAL AND HOSPITAL COMPLEX DATA Uncompensated and Indigent Care Cost-to-Charge Ratio                              |              |                       |                  |                                  |        |
| 1. 00         | Cost to charge ratio (see instructions)   |              |                       |                  | 0. 224900                        | 1.00   |
| 1.00          | Medicaid (see instructions for each line)   |              |                       |                  | 0.224700                         | 1.00   |
| 2. 00         | Net revenue from Medicaid   |              |                       |                  | 9, 602, 644                      | 2.00   |
| 3.00          | Did you receive DSH or supplemental payments from Medicaid?   |              |                       |                  | Υ                                | 3.00   |
| 4.00          | If line 3 is yes, does line 2 include all DSH and/or supplemen  | tal payment  | s from Medic          | ai d?            | Υ                                | 4.00   |
| 5.00          | If line 4 is no, then enter DSH and/or supplemental payments f  | rom Medicai  | b                     |                  | 0                                | 5.00   |
| 6.00          | Medi cai d charges  |              |                       |                  | 70, 672, 903                     | 6.00   |
| 7.00          | Medicaid cost (line 1 times line 6)   |              |                       |                  | 15, 894, 336                     | 7.00   |
| 8.00          | Difference between net revenue and costs for Medicaid program   |              |                       |                  | 6, 291, 692                      | 8.00   |
|               | Children's Health Insurance Program (CHIP) (see instructions for  | or each line | e)                    |                  | _                                |        |
| 9.00          | Net revenue from stand-alone CHIP   |              |                       |                  | 0                                |        |
| 10.00         | Stand-allone CHIP charges   |              |                       |                  | 0                                |        |
| 11.00         | Stand-alone CHIP cost (line 1 times line 10)  | (000   notru | ationa)               |                  | 0                                | 11.00  |
| 12.00         | Difference between net revenue and costs for stand-alone CHIP Other state or local government indigent care program (see ins  |              |                       | `                | U                                | 12.00  |
| 13. 00        | Net revenue from state or local indigent care program (Not inc  |              |                       |                  | 0                                | 13.00  |
| 14. 00        | Charges for patients covered under state or local indigent care   |              |                       |                  | 0                                |        |
| 14.00         | 10)   | c program (  | iot incruded          | 111 111103 0 01  | O                                | 14.00  |
| 15.00         | State or local indigent care program cost (line 1 times line 1  | 4)           |                       |                  | 0                                | 15.00  |
| 16.00         | Difference between net revenue and costs for state or local in  |              | program (se           | e instructions)  | 0                                | 16.00  |
|               | Grants, donations and total unreimbursed cost for Medicaid, CH  | IP and state | e/Local indi          | gent care progra | ms (see                          |        |
|               | instructions for each line)   |              |                       |                  |                                  |        |
| 17. 00        | Private grants, donations, or endowment income restricted to f  |              |                       |                  | 0                                |        |
| 18.00         | Government grants, appropriations or transfers for support of   |              |                       |                  | 0                                | 18.00  |
| 19. 00        | Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)  | i indigent   | care program          | s (sum or lines  | 6, 291, 692                      | 19. 00 |
|               | 10, 12 and 10)  |              | Uni nsured            | Insured          | Total (col. 1                    |        |
|               |   |              | pati ents             | pati ents        | + col . 2)                       |        |
|               |   |              | 1.00                  | 2. 00            | 3. 00                            |        |
| 20.00         | Uncompensated care cost (see instructions for each line)  | , I          | 2 702 (/              | 0 1 510 001      | E 221 400                        | 20.00  |
| 20. 00 21. 00 | Charity care charges and uninsured discounts (see instructions Cost of patients approved for charity care and uninsured disco |              | 3, 702, 66<br>832, 73 |                  | 5, 221, 490<br>2, 351, 551       |        |
| 21.00         | instructions)   | uiits (see   | 032, 73               | 1,310,621        | 2, 331, 331                      | 21.00  |
| 22. 00        | Payments received from patients for amounts previously written  | off as       |                       | 0 0              | 0                                | 22.00  |
| 22.00         | charity care  | 011 45       |                       |                  | o l                              | 22.00  |
| 23.00         |   |              | 832, 73               | 1, 518, 821      | 2, 351, 551                      | 23.00  |
|               |   |              |                       |                  |                                  |        |
| 24.00         | Dana the amount on live 20 and 20 include the great for   |              |                       | £ -4   !! 4      | 1. 00                            | 24.00  |
| 24.00         | Does the amount on line 20 col. 2, include charges for patient imposed on patients covered by Medicaid or other indigent care |              | a a rength o          | r Stay IImit     | N                                | 24.00  |
| 25. 00        | If line 24 is yes, enter the charges for patient days beyond t  |              | care progra           | m's Lanath of    | 0                                | 25. 00 |
| 20.00         | stay limit  | ne murgent   | care progra           | ııı ə renytii ui |                                  | 25.00  |
| 25. 01        | Charges for insured patients' liability (see instructions)  |              |                       |                  | 0                                | 25. 01 |
|               | Bad debt amount (see instructions)  |              |                       |                  | 10, 726, 482                     |        |
| 27. 00        | ,   |              |                       |                  | 49, 954                          | •      |
|               | Medicare allowable bad debts (see instructions)   |              |                       |                  | 76, 853                          |        |
|               |   |              |                       |                  |                                  | 28 00  |

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

10, 649, 629 28. 00 2, 422, 001 29. 00 4, 773, 552 30. 00 11, 065, 244 31. 00

| Hool +b | Financial Systems HANCOCK REGIONAL   | HOSDI TAI     |               | In Lio            | u of Form CMS-2 | DEE2 10 |
|---------|--|---------------|---------------|-------------------|-----------------|---------|
|         | AL UNCOMPENSATED AND INDIGENT CARE DATA  | Provi der CO  | N. 15 0027    | Peri od:          | Worksheet S-1   |         |
| позы    | AL UNCOMPENSATED AND THUTGENT CARE DATA  | Provider Co   | JN. 13-0037   | From 01/01/2023   |                 | U       |
|         |  |               |               | To 12/31/2023     |                 | nared:  |
|         |  |               |               | 10 12/01/2020     | 5/31/2024 7:0   |         |
|         |  |               |               |                   |                 |         |
|         |  |               |               |                   | 1. 00           |         |
|         | PART II - HOSPITAL DATA  |               |               |                   |                 |         |
|         | Uncompensated and Indigent Care Cost-to-Charge Ratio   |               |               |                   |                 |         |
| 1.00    | Cost to charge ratio (see instructions)  |               |               |                   | 0. 224263       | 1.00    |
|         | Medicaid (see instructions for each line)  |               |               |                   |                 |         |
| 2.00    | Net revenue from Medicaid  |               |               |                   |                 | 2.00    |
| 3.00    | Did you receive DSH or supplemental payments from Medicaid?  |               |               |                   |                 | 3.00    |
| 4.00    | If line 3 is yes, does line 2 include all DSH and/or suppleme  | ental payment | ts from Medio | ai d?             |                 | 4.00    |
| 5.00    | If line 4 is no, then enter DSH and/or supplemental payments   | from Medicai  | d             |                   |                 | 5.00    |
| 6.00    | Medi cai d charges   |               |               |                   |                 | 6.00    |
| 7.00    | Medicaid cost (line 1 times line 6)  |               |               |                   |                 | 7.00    |
| 8.00    | Difference between net revenue and costs for Medicaid program  | n (see instru | uctions)      |                   |                 | 8.00    |
|         | Children's Health Insurance Program (CHIP) (see instructions   |               |               |                   |                 |         |
| 9.00    | Net revenue from stand-alone CHIP  |               | ,             |                   |                 | 9.00    |
| 10.00   | Stand-alone CHIP charges   |               |               |                   |                 | 10.00   |
| 11.00   |  |               |               |                   |                 | 11.00   |
| 12. 00  | ,  | (see instru   | uctions)      |                   |                 | 12.00   |
|         | Other state or local government indigent care program (see in  |               |               | e)                |                 |         |
| 13.00   | Net revenue from state or local indigent care program (Not in  |               |               |                   |                 | 13.00   |
| 14. 00  | Charges for patients covered under state or local indigent ca  |               |               |                   |                 | 14.00   |
|         | 10)  | 13            | (             |                   |                 |         |
| 15.00   | State or local indigent care program cost (line 1 times line   | 14)           |               |                   |                 | 15.00   |
| 16.00   | Difference between net revenue and costs for state or local i  | ndigent care  | e program (se | e instructions)   |                 | 16.00   |
|         | Grants, donations and total unreimbursed cost for Medicaid, (  |               |               |                   | ıms (see        |         |
|         | instructions for each line)  |               |               |                   | `               |         |
| 17.00   | Private grants, donations, or endowment income restricted to   | fundi ng char | rity care     |                   |                 | 17.00   |
| 18.00   | Government grants, appropriations or transfers for support of  | hospital or   | perati ons    |                   |                 | 18.00   |
| 19.00   | Total unreimbursed cost for Medicaid, CHIP and state and loc   | cal indigent  | care program  | ns (sum of lines  |                 | 19.00   |
|         | 8, 12 and 16)  | •             |               |                   |                 |         |
|         |  |               | Uni nsured    | Insured           | Total (col. 1   |         |
|         |  |               | pati ents     | pati ents         | + col . 2)      |         |
|         |  |               | 1.00          | 2. 00             | 3. 00           |         |
|         | Uncompensated care cost (see instructions for each line)   |               |               |                   |                 |         |
| 20.00   | ,  | ,             | 3, 702, 6     |                   | 5, 221, 490     |         |
| 21. 00  | Cost of patients approved for charity care and uninsured disc  | counts (see   | 830, 3        | 72 1, 518, 821    | 2, 349, 193     | 21. 00  |
|         | instructions)  |               |               |                   | _               |         |
| 22. 00  | ,  | en off as     |               | 0 0               | 0               | 22. 00  |
|         | charity care   |               |               | 4 540 004         |                 |         |
| 23. 00  | Cost of charity care (see instructions)  |               | 830, 3        | 72 1, 518, 821    | 2, 349, 193     | 23.00   |
|         |  |               |               |                   | 4 00            |         |
| 0.4.00  | Described to the control of the latest terms o |               |               | 6 . 1 . 1 . 1 . 1 | 1. 00           | 0.4.00  |
| 24. 00  | Does the amount on line 20 col. 2, include charges for patier  |               | nd a length o | of stay limit     | N               | 24. 00  |
| 05 00   | imposed on patients covered by Medicaid or other indigent car  |               |               |                   |                 | 05.00   |
| 25. 00  |  | the Indigen   | t care progra | ım's length or    | 0               | 25. 00  |
| 05 04   | stay limit   |               |               |                   |                 | 05.04   |
| 25. 01  | Charges for insured patients' liability (see instructions)   |               |               |                   | 10 724 402      |         |
|         | Bad debt amount (see instructions)   |               |               |                   | 10, 726, 482    |         |
| 27. 00  | Medicare reimbursable bad debts (see instructions)   |               |               |                   | 49, 954         |         |
| 27. 01  | Medicare allowable bad debts (see instructions)  |               |               |                   | 76, 853         |         |
| 28.00   | Non-Medicare bad debt amount (see instructions)  |               |               | `                 | 10, 649, 629    |         |
| 29. 00  |  | amounts (see  | instructions  | 5)                | 2, 415, 217     |         |
| 30.00   |  | line 20)      |               |                   | 4, 764, 410     |         |
| 31.00   | Total unreimbursed and uncompensated care cost (line 19 plus   | 1111e 30)     |               |                   | 4, 764, 410     | 31.00   |
|         |  |               |               |                   |                 |         |

|                  | Financial Systems  | HANCOCK REGIONAL           |                            |               |                            | u of Form CMS-2                 | 2552-10          |
|------------------|--|----------------------------|----------------------------|---------------|----------------------------|---------------------------------|------------------|
| RECLAS           | SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE                                | OF EXPENSES                | Provi der C                |               | Period:<br>From 01/01/2023 | Worksheet A                     |                  |
|                  |  |                            |                            |               | To 12/31/2023              | Date/Time Pre                   |                  |
|                  | Cost Center Description  | Sal ari es                 | Other                      | Total (col. 1 | Reclassi fi cat            | 5/31/2024 7:0<br>Reclassi fi ed | 1 am             |
|                  | Cost Center Description  | Sararres                   | Other                      | + col . 2)    | i ons (See                 | Tri al Bal ance                 |                  |
|                  |  |                            |                            | <u> </u>      | A-6)                       | (col. 3 +-                      |                  |
|                  |  | 1.00                       |                            | 0.00          | 1.00                       | col . 4)                        |                  |
|                  | GENERAL SERVICE COST CENTERS   | 1.00                       | 2. 00                      | 3. 00         | 4. 00                      | 5. 00                           |                  |
| 1.00             | 00100 NEW CAP REL COSTS-BLDG & FLXT  |                            | 17, 980, 420               | 17, 980, 42   | 0 0                        | 17, 980, 420                    | 1.00             |
| 4. 00            | 00400 EMPLOYEE BENEFITS DEPARTMENT   | 642, 288                   | 11, 392, 123               |               |                            | 11, 981, 057                    | 4. 00            |
| 5.00             | 00500 ADMINISTRATIVE & GENERAL   | 11, 141, 428               | 27, 738, 792               | 38, 880, 22   | 0 -1, 100, 482             | 37, 779, 738                    | 5.00             |
| 7. 00            | 00700 OPERATION OF PLANT   | 1, 234, 551                | 6, 379, 801                |               |                            | 7, 616, 412                     |                  |
| 9. 00<br>10. 00  | 00900 HOUSEKEEPI NG<br>01000 DI ETARY                                      | 2, 004, 405<br>1, 722, 956 | 1, 016, 726<br>1, 629, 366 |               |                            | 3, 021, 131<br>1, 432, 447      |                  |
| 11. 00           | 01100 CAFETERI A   | 1, 722, 930                | 1, 029, 300                |               | 0 1, 919, 875              | 1, 432, 447                     |                  |
| 13. 00           | 01300 NURSI NG ADMI NI STRATI ON   | 1, 461, 219                | 366, 434                   |               |                            | 1, 827, 600                     |                  |
| 14.00            | 01400 CENTRAL SERVICES & SUPPLY  | 325, 761                   | 104, 140                   | 429, 90       | 1 -1, 845                  | 428, 056                        |                  |
| 15.00            | 01500 PHARMACY   | 2, 685, 772                | 22, 191, 596               |               |                            | 3, 775, 902                     |                  |
| 16.00            | 01600 MEDICAL RECORDS & LIBRARY  | 733, 457                   | 557, 386                   |               |                            | 1, 297, 536                     |                  |
| 23. 00           | 02300   PARAMED ED PRGM<br>  INPATI ENT ROUTI NE SERVI CE COST CENTERS     | 98, 083                    | 18, 797                    | 116, 88       | 0 0                        | 116, 880                        | 23.00            |
| 30.00            | 03000 ADULTS & PEDIATRICS  | 3, 685, 952                | 1, 924, 433                | 5, 610, 38    | 5 644, 273                 | 6, 254, 658                     | 30.00            |
| 31.00            | 03100 INTENSIVE CARE UNIT  | 4, 511, 505                | 2, 521, 990                |               | 5 -197, 090                |                                 |                  |
| 40.00            | 04000 SUBPROVI DER - I PF  | 0                          | 0                          |               | 0 0                        | 0                               | 40.00            |
| FO 00            | ANCILLARY SERVICE COST CENTERS   | 4 050 070                  | F 2/4 100                  | 10 215 07     | 0 1 077 007                | 0 227 242                       | F0 00            |
| 50. 00<br>51. 00 | 05000 OPERATING ROOM<br>05100 RECOVERY ROOM                                | 4, 850, 968<br>533, 627    | 5, 364, 100<br>94, 397     |               |                            | 8, 237, 242<br>595, 628         |                  |
| 53. 00           | 05300 ANESTHESI OLOGY  | 0                          | 0                          |               | 0 02,070                   | 0                               |                  |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C  | 4, 750, 794                | 2, 342, 435                | 7, 093, 22    | 9 -465, 276                | 6, 627, 953                     | 54.00            |
| 60.00            | 06000 LABORATORY   | 2, 109, 876                | 4, 351, 362                |               |                            | 6, 459, 678                     | 1                |
| 65.00            | 06500 RESPIRATORY THERAPY  | 1, 898, 995                | 493, 373                   |               |                            | 2, 345, 301                     | 1                |
| 66. 00<br>67. 00 | 06600  PHYSI CAL THERAPY<br>  06700  0CCUPATI ONAL THERAPY                 | 1, 188, 750<br>353, 780    | 184, 747<br>31, 703        |               |                            | 1, 361, 186<br>382, 473         | 1                |
| 68. 00           | 06800 SPEECH PATHOLOGY   | 220, 287                   | 24, 101                    |               |                            | 243, 188                        | 1                |
| 69. 00           | 06900 ELECTROCARDI OLOGY   | 750, 269                   | 577, 327                   |               |                            | 1, 013, 856                     |                  |
| 70.00            | 07000 ELECTROENCEPHALOGRAPHY   | 0                          | 0                          |               | 0 0                        | 0                               | 70.00            |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                 | 0                          | 143                        |               |                            | 3, 588, 967                     | 1                |
| 72.00            | 07200 IMPL. DEV. CHARGED TO PATIENT  | 0                          | 1, 110, 614                |               |                            | 1, 127, 171                     | 1                |
| 73. 00<br>76. 00 | 07300 DRUGS CHARGED TO PATIENTS<br>03020 CARDI AC                          | 0                          | 0                          |               | 0 22, 613, 096<br>0 0      | 22, 613, 096<br>0               | 1                |
| 76. 01           | 03160 CARDI OPULMONARY   | 71, 811                    | 6, 824                     | 78, 63        | -                          | 78, 609                         |                  |
| 77. 00           | 07700 ALLOGENEIC STEM CELL ACQUISITION                                     | 0                          | 0                          | 1             | 0 0                        | 0                               | 1                |
| 78. 00           | 07800 CAR T-CELL IMMUNOTHERAPY   | 0                          | 0                          |               | 0 0                        | 0                               | 78. 00           |
| 88. 00           | OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC                 | 283, 543                   | 222, 282                   | 505, 82       | 5 -31, 684                 | 474, 141                        | 88.00            |
| 90.00            | 09000 CLINIC   | 203, 343                   | 222, 202                   | 505, 62       | 0 -31,004                  | 474, 141                        | 1                |
| 90. 01           | 09001 WOUND CLINIC   | 589, 680                   | 551, 284                   | 1, 140, 96    | 4 -100, 844                | 1, 040, 120                     |                  |
| 90. 02           | 09002 DI ABETES CLINIC   | 39, 698                    | 32, 693                    | 72, 39        | 1 0                        | 72, 391                         |                  |
|                  | 09003 ASTHMA CLINIC  | 0                          | 71 0(4                     |               | 0                          | 0                               |                  |
|                  | 09004 ANDIS CLINIC<br>09005 PRIME TIME                                     | 123, 264                   | 71, 364<br>3, 268          | 1             |                            | 194, 525                        | 90.04            |
| 90.06            | 09006 SHELBYVILLE WOUND CLINIC   | o o                        | 0, 200                     | 3, 20         | 0 0                        | 0, 200                          | 90.06            |
| 90. 07           | 04951 ONCOLOGY   | 3, 008, 089                | 407, 840                   | 3, 415, 92    | 9 -54, 737                 | 3, 361, 192                     | 90. 07           |
| 90. 08           | 04950 ANDERSON WOMENS CENTER   | 648, 897                   | 749, 163                   |               |                            | 1, 264, 657                     | 1                |
| 91.00            | 09100 EMERGENCY  | 3, 314, 532                | 1, 667, 665                | 4, 982, 19    | 7 -220, 792                | 4, 761, 405                     | 91. 00<br>92. 00 |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS |                            |                            |               |                            |                                 | 92.00            |
| 101.00           | 10100 HOME HEALTH AGENCY   | 0                          | 0                          |               | 0 0                        | 0                               | 101.00           |
| 102.00           | 10200 OPIOID TREATMENT PROGRAM   | 0                          | 0                          |               | 0 0                        | 0                               | 102.00           |
| 444.00           | SPECIAL PURPOSE COST CENTERS   | 000 705                    | 040.040                    | 1 440 70      | 1 110 700                  |                                 |                  |
| 116.00           | 11600 HOSPICE<br>  SUBTOTALS (SUM OF LINES 1 through 117)                  | 930, 705<br>55, 914, 942   | 218, 018<br>112, 326, 707  |               |                            |                                 | 116.00           |
| 110.00           | NONREI MBURSABLE COST CENTERS  | 55, 914, 942               | 112, 320, 707              | 100, 241, 04  | 9 -127, 400                | 100, 114, 104                   | 1116.00          |
| 190.00           | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                  | 0                          | 0                          |               | 0 0                        | 0                               | 190.00           |
|                  | 19001 PROFESSI ONAL BUI LDI NG   | 0                          | 487, 091                   |               |                            | 467, 381                        | 190. 01          |
|                  | 19002 PHYSI CI AN BUI LDI NG   | 0                          | 624, 351                   |               |                            | 624, 351                        |                  |
|                  | 19003  PRI VATE DUTY<br>  19004  MARKETI NG                                | 342, 763                   | 1, 373, 897<br>0           |               | 0<br>0 1, 099, 210         | 1, 716, 660<br>1, 099, 210      |                  |
|                  | 19005 SPORTS PHYSI CALS  | 358, 719                   | 32, 689                    |               |                            | 391, 408                        |                  |
|                  | 19006 FOUNDATION   | 283, 345                   | 1, 353, 229                |               |                            | 1, 636, 574                     |                  |
|                  | 19007 ASC  | 0                          | 12, 878                    | 12, 87        | -2, 066                    | 10, 812                         | 190. 07          |
|                  | 19008 GATEWAY LOCATION   | 3, 959, 651                | 866, 003                   |               |                            | 4, 599, 193                     |                  |
|                  | 19009 HANCOCK OB<br> 19010 HANCOCK WELLNESS                                | 2, 620, 699<br>922, 849    | 1, 595, 634                |               |                            | 3, 780, 169                     |                  |
|                  | 19010 HANCOCK WELLINESS<br> 19011 MORRI STOWN CLINI C                      | 722, 049                   | 286, 173<br>0              |               | 2 0<br>0 0                 | 1, 209, 022<br>0                | 190. 10          |
|                  | 19012 03PUREMED  | j ő                        | Ö                          |               | o o                        |                                 | 190. 12          |
| 190. 13          | 19013 MCCORD WELLNESS  | 1, 069, 446                | 590, 150                   |               |                            | 1, 659, 596                     | 190. 13          |
|                  | 19014 3 WEST UNIT  | 215, 595                   | 232, 496                   |               |                            | 442, 954                        |                  |
| 190. 15          | 19015  NEUROLOGY PHYSI CI AN   | 1, 224, 425                | 430, 726                   | 1, 655, 15    | 1 -133, 380                | 1, 521, 771                     | 1190. 15         |
|                  |  |                            |                            |               |                            |                                 |                  |

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0037 Peri od: Worksheet A From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 7:01 am Cost Center Description Sal ari es 0ther Total (col. 1 Reclassi fi cat Recl assi fi ed Trial Balance + col. 2) ions (See (col. 3 +-col. 4) A-6) 4. 00 5.00 1.00 2.00 3.00 190. 16 19016 THORACI 1, 000 1, 951 2, 951 2, 951 190. 16 190. 17 19017 HANCOCK ENDO 1, 205, 257 190. 17 894, 094 375, 849 1, 269, 943 -64, 686 0 190. 18 190. 18 19018 HANCOCK FOOT & ANKLE 0 0 190. 19 19019 HANCOCK RHEUM 5, 788 11, 564 17, 352 0 17, 352 190. 19 194. 00 07950 OTHER NONREI MBURSABLE 254 194.00 180 74 254 194. 01 07951 SUBURBAN HOSPI CE 0 259, 593 259, 593 194. 01 194. 02 07952 HRH HANCOCK GI 1, 497, 791 194. 02 1, 497, 796 1, 268, 442 229, 354 -5 194. 03 07954 HRH NEPHROLOGY 102, 829 82, 675 185, 504 185, 504 194. 03 194. 04 07957 HRH SANE 148, 839 39, 669 188, 508 -1, 185 187, 323 194. 04 194. 05 07955 HRH RISE 164, 702 194. 05 9,081 155, 621 164, 702 194.06 07956 HRH JUSTICE NAVIGATION 245, 036 245, 036 194. 06 177, 074 67, 962 194. 07 07953 HPN PHYSICIAN 94, 262 16,650 110, 912 -150 110, 762 194. 07 194. 08 07958 HOSPI TALI ST 512, 217 512, 217 512, 217 194. 08 5, 010 194. 09 07959 HPN HANCOCK COUNSEL 67, 160 194. 09 62, 150 67, 160 194. 10 07960 HPN HFM MCKENZIE 118, 889 118, 892 237, 781 -106, 214 131, 567 194. 10 194. 11 07961 HPN HIM GREENFIELD 97, 195 29, 314 126, 509 126, 509 194. 11 194. 12 07962 HPN HFM BOYD 161, 770 36, 976 198, 746 198, 746 194. 12 194. 13 07963 HPN HIM MCCORD 102, 269 194. 13 81.912 158, 055 -55. 786 76, 143 194. 14 07964 HPN WELL BEING 45, 641 28,067 73, 708 -8, 940 64, 768 194. 14 194. 15 07965 PHYSICIAN BILLING SERVICE 204, 054 70, 356 274, 410 274, 410 194. 15 194. 16 07966 CLINI CAL MANAGEMENT 148, 119 12,078 160, 197 160, 197 194. 16 0 194. 17 07967 HANCOCK ORTHO 2, 488, 110 793, 436 3, 281, 546 -61, 329 3, 220, 217 194. 17 194. 18 07968 HANCOCK PEDIATRICS 95, 835 37, 404 133, 239 -35 133, 204 194. 18 194. 19 07969 HRN HFM NEW 127, 794 -67, 060 205, 496 194. 19 144, 762 272, 556 66, 888 194. 20 60, 189 194. 20 07970 HRH HFM CLEARVIEW 49 709 109, 898 -43, 010

73, 306, 400

123, 107, 038

196, 413, 438

196, 413, 438 200. 00

TOTAL (SUM OF LINES 118 through 199)

200.00

Provi der CCN: 15-0037

Peri od: Worksheet A From 01/01/2023 Date/Ti me Prepared: 5/21/2024 7:01 am

| Control Center Research   Line   Long Service   L   |                              |               |   | 5/31/2024 7:   |          |
|--|------------------------------|---------------|---|--|----------|
| PATRICIAL SERVICE COST CENTERS   0.00  | Cost Center Description      | Adjustments   | Net Expenses                            | 07017232171  | <u> </u> |
|  |                              | (See A-8)     |   |  |          |
| FIGURE AL SERVICE COST CENTERS   1, 100   USD CAPE ALC AL FLAT   -819, 395   17, 161, 025   1, 100     |                              |               |   |  |          |
| 1.00   | CENEDAL SEDVICE COST CENTEDS | 6.00          | 7.00                                    |  |          |
| 4. 00 00000 PURP OVER PROFETTS OFFACTIVETY   |                              | -819 395      | 17 161 025                              |  | 1 100    |
| 5.00   000000 ARMINISTRATIVE SCREENAL   15, 561, 467   22, 218, 271   7, 700   000000 PREPARTION OF PLANT   7, 740   7, 760   7,  |                              |               |   | 1  | •        |
| 2.00   0.0000   DOUGNESTED NO OF PLANT   -7.251   7.609, 151   7.00   10000   DIESKEEPI NG   -1.56.695   2.884, 388   9.00   10.00   DIESKEEPI NG   -1.56.695   2.884, 388   9.00   10.00   DIESKEEPI NG   -1.79   509   1.622, 589   1.00   10.00   DIESKEEPI NG   -1.79   509   1.622, 589   1.00   DIESKEEPI NG   -1.79   509   1.00   DIESKEEPI NG   -1.79   DIE   |                              |               | 1                                       | 1  | 1        |
| 10.00   01000   DETARY   -7-79, 809  |                              |               | 1                                       | l e e e e e e e e e e e e e e e e e e e  |          |
| 11.00   10100   DATE THEN A  | 9. 00 00900 HOUSEKEEPI NG    | -156, 695     | 2, 864, 436                             |  | 9. 00    |
| 13.00   01300   MURSINES ADMINISTRATION  | 10. 00  01000 DI ETARY       | -749, 809     | 682, 638                                |  | 10.00    |
| 14.00   01400   CENTRAL SERVICES & SUPPLY   -2.501   425, 466   14.00   16.00   10100   MEDICAL RECORDS & LIBRARY   -7.7 518   1.220, 016   1.60   10.00   10100   MEDICAL RECORDS & LIBRARY   -7.7 518   1.220, 016   1.60   10.00   10.00   MEDICAL RECORDS & LIBRARY   -7.7 518   1.220, 016   1.60   10.00   10.00   MEDICAL RECORDS & LIBRARY   -7.7 518   1.220, 016   1.60   10.00   10.00   MEDICAL RECORDS & LIBRARY   -7.7 518   1.220, 016   1.60   10.00   10.00   MEDICAL RESONANCE RES   | 11. 00   01100   CAFETERI A  | -899, 073     | 1, 020, 802                             |  | 11. 00   |
| 15.00   OISCO  PHABIMACY   -1, 813, 889   1, 962, 013   15.00   16.00   OISCO  PHABIMACY   -7, 75   18   1, 220, 018   23.00   0.0320  PARAMED ED PROM   -1, 27, 75   18   1, 270, 018   31.00   0.0320  PARAMED ED PROM   -1, 27, 75   18   1, 270, 018   31.00   0.0320  PARAMED ED PROM   -1, 27, 75   18   1, 270, 018   31.00   0.0320  PARAMED ED PROM   -1, 27, 75   31.00   0.0320  PARAMED ED PROM   -1, 27, 75   31.00   0.0320  PARAMED ED PROM   -1, 27, 752, 324   -1, 28, 28, 28, 28, 28, 28, 28, 28, 28, 28   |                              |               | 1, 812, 773                             |  |          |
| 1.0   0.0    |                              |               |   |  |          |
| 0.300   OADAQ   DARANED ED PORCH   IPATEUR ROUTINE SERVICE COST CENTERS  |                              |               |   |  |          |
| IMPART IN TROUTH SERVICE COST CENTERS   3.0 00   |                              |               |   |  |          |
| 30.00  |                              | -42, 319      | /4, 561                                 |  | 23.00    |
| 31.00   0100   INTERSIVE CARE UNIT   0   6.88, 405   31.00   40.00   A00.00   A00.00 |                              | 700 642       | 5 464 015                               |  | 20.00    |
| 40, 00   |                              |               | 1                                       |  |          |
| MICHELARY SERVICE COST CENTERS   50.00   |                              |               |   |  |          |
| 51 00   05100   RECOVERY ROOM   0   595, 628   51.00   53.00   53.00   05300   MESTHESI OLOSY   0   0   53.00   53.00   05300   MESTHESI OLOSY   0   0   53.00   0500   MESTHESI OLOSY   0   5.00      |                              | _             |   |  |          |
| 53.00   0.5300   AMESTHESIOLOGY   0   0   55.00  | 50. 00 05000 OPERATING ROOM  | -2, 752, 334  | 5, 484, 908                             |  | 50.00    |
| 54. 00   0s400  RADIOLON-DIAGNOSTIC   -707, 789   5, 920, 164   60.00   0s600  LABORATORY   -723, 692   5, 735, 986   60.00   0s600  RESPIRATORY THERAPY   -2, 338   2, 342, 96.3   65.00   0s600  RESPIRATORY THERAPY   0   324, 783   65.00   0s600  RESPIRATIONAL THERAPY   0   322, 473   67.00   68.00   0s600  SPECEH PATHOLOGY   0   243, 188   68.00   0s600  SPECEH PATHOLOGY   0   243, 188   68.00   0s600  ELECTROCAGNIOLOGY   0   70.00   |                              | 0             | 595, 628                                |  | 51.00    |
| 0.0   0.0000   0.0000   LABDRATORY   FIRAPY   -7.23, 802   5.735, 986   0.0   0.00     |                              | _             | · -                                     | I .  |          |
| 65.00   06500   RESPIRATORY THERAPY   -2,338   2,342,963   66.00   666.00   666.00   670.00   |                              |               |   |  | •        |
| 66.00  |                              |               | 1                                       | 1  | •        |
| 67. 00   60-700   COLUPATI ONAL THERAPY   0   382, 473   66. 00   69-80   69-800   69-800   69-800   69-800   69-800   69-800   69-800   69-800   69-800   61-801   69-800   70. 00   7 | · •                          |               | 1                                       | 1  | •        |
| 68. 00   06500   SPEECH PATHOLOGY   0   243, 188   66. 00  |                              |               |   |  | •        |
| 99. 00   060000   ELECTROCAEDIOLOGY  |                              |               | i .                                     | 1  |          |
| 17.0. 0   07000   07000   07000   07000   070. 00   07   |                              | _             | ,                                       | 1  | •        |
| 71.00  |                              |               | 1                                       |  | •        |
| 172.00   07200   IMPL. DEV. CHARGED TO PATIENT   0   1, 127, 171   72, 00   73, 00   730, 00     |                              | _             | · -                                     | 1  | •        |
| 173.00   07300   DRUSS CHARGED TO PATIENTS   0   22,613,096   73.00   76.00   76.00   76.00   76.00   76.00   76.00   77.00    |                              |               |   | l e e e e e e e e e e e e e e e e e e e  | •        |
| 17.0   03160   CARDI OPULMONARY   0   78, 609   76, 01   77. 00   77. 00   07.00   0   |                              | 0             | 1                                       | l e e e e e e e e e e e e e e e e e e e  | 73.00    |
| 177.00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0   0   0   0  | 76. 00 03020 CARDI AC        | 0             | 0                                       |  | 76. 00   |
| 78. 00   ORSO CAR T-CELL IMMUNTHERAPY   0   0   0   0   0   0   0   0   0  |                              | _             | l .                                     | l e e e e e e e e e e e e e e e e e e e  | •        |
| OUTPATIENT SERVICE COST CENTERS  |                              |               |   | l .  |          |
| 88. 00   |                              | 0             | 0                                       |  | 78.00    |
| 90.00   09000   CLINIC   0   0   0   0   0   0   0   0   0   |                              | _47_050       | 126 101                                 |  | 98 00    |
| 99.01   09001   09001   0010ND CLINIC   -302,013   738,107   99.01   99.02   09002   DIABETES CLINIC   -26,975   45,416   90.02   90.03   90.03   90.03   90.03   90.03   90.04   09004   ANDIS CLINIC   0   194,525   90.04   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.06   90.05   90.05   90.05   90.06   90.05   90.06   90.05   90.06   90.05   90.06   90.05   90.06   90.05   90.06   |                              | -47, 750      |   |  |          |
| 90. 02   09002   DI ABETES CLINIC   -26, 975   45, 416   90, 02   09003   ASTHMA CLINIC   0   0   0   0   0   0   0   0   0  |                              | -302 013      |   | 1  |          |
| 90. 03   09003   ASTHMA CLINIC   0   194, 525   99. 03   90. 04   09004   ANDIS CLINIC   0   194, 525   99. 04   90. 05   09005   PRI IME   TI IME   -8, 236   -4, 968   90. 05   90. 06   09006   SHELBYYI LLE WOUND CLINIC   0   0   0   90. 07   04951   ONCOLOGY   -1, 360, 692   2, 000, 500   99. 07   90. 08   04950   ANDERSON WOMENS CENTER   -333, 300   931, 357   99. 08   91. 00   09100   EMERGENCY   -1, 35, 000   4, 626, 405   99. 07   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   07HER REI MBURSABLE COST CENTERS   99. 08   99. 09   9 |                              |               | 1                                       |  | •        |
| 90. 04   990.04   ADDIS CLINI C   0   194, 525   90.05   PRIME TIME   -8, 236   -4, 968   90.05   90.05   PRIME TIME   -8, 236   -4, 968   90.05   90.05   PRIME TIME   -8, 236   -4, 968   90.05   90.06   90.06   90.07   04951   NOKOLOGY   -1, 360, 969   2, 0.00, 500   90.07   90.07   90.08   94950   ANDERSON WOMENS CENTER   -333, 300   931, 357   90.08   91.00   9 |                              |               | 0                                       |  | 90. 03   |
| 99. 06   990.06   90006   SHELBYVILLE WOUND CLINIC   0   0   90.07   90. 07   04951   ONCOLOGY   -1,360,692   2,000,500   90.07   90. 08   04950   ANDERSON WOMENS CENTER   -333,300   931,357   90.08   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92.00   | 90. 04 09004 ANDIS CLINIC    | 0             | 194, 525                                |  |          |
| 90. 07   04951   0NCOLLOGY   -1, 360, 692   2, 000, 500   90. 07   90. 08   94. 065   0   09100   EMERGENCY   -135, 000   4, 626, 405   91. 00   92.00   0   0   0   EMERGENCY   -135, 000   4, 626, 405   92. 00   92.00   0   0   0   0   0   0   0   0   0  |                              | -8, 236       | -4, 968                                 |  | 90.05    |
| 90. 08   04950   ANDERSON WOMENS CENTER   -333, 300   931, 357   99. 08   91. 00   9900   EMERGENCY   91. 00   99. 00    |                              | _             | 0                                       |  | 90. 06   |
| 91. 00   09100   EMERGENCY   -135,000   4,626,405   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   07   07   07   07   07   07   07  |                              |               | 1                                       | l control of the cont |          |
| 92. 00   09200  0BSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   OTHER REIMBURSABLE COST CENTERS   101. 00   10200  OPI OID TREATMENT PROGRAM   0   0   0   0   10200  OPI OID TREATMENT PROGRAM   0   0   0   116. 00   116. 00   116. 00   116. 00   116. 00   118. 00   116. 00   118. 00   116. 00   118. 00   116. 00   118. 00   |                              |               |   |  |          |
| OTHER REIMBURSABLE COST CENTERS   101.00   101.00   1000   11600   100   |                              | -135, 000     | 4, 626, 405                             |  | •        |
| 101. 00   10100   HOME   HEALTH   AGENCY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |                              |               |   |  | 92.00    |
| 102. 00   10200   OPI OI D TREATMENT PROGRAM   50   50   50   50   50   50   50   5  |                              | n             | n                                       |  | 101 00   |
| 116. 00   11600   HOSPI CE   0 0 0   0   0   0   0   0   0   0   |                              |               |   |  |          |
| 116. 00 118. 00  |                              |               |   | •  | 1        |
| NONREI MBURSABLE COST CENTERS   190  | 116. 00 11600 H0SPI CE       |               |   |  |          |
| 190. 00  |                              | -32, 126, 675 | 135, 987, 489                           |  | 118. 00  |
| 190. 01 19001  |                              | T .           |   |  | 4.00     |
| 190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 0 1,716, 660 190. 04 19004 MARKETI NG 0 1,099, 210 190. 05 19005 PORTS PHYSI CALS 0 391, 408 190. 06 19006 FOUNDATI ON 0 1, 636, 574 190. 07 19007 ASC 0 10, 812 190. 08 19008 GATEWAY LOCATI ON 0 4, 599, 193 190. 09 19009 HANCOCK OB 0 3, 780, 169 190. 10 19010 HANCOCK WELLNESS 0 1, 209, 022 190. 11 19011 MORRI STOWN CLI NI C 0 0 190. 12 19012 O3PUREMED 190. 13 19013 MCCORD WELLNESS 0 1, 659, 596 190. 15 19015 NEUROLOGY PHYSI CI AN   |                              | 0             |   | l .  |          |
| 190. 03 19003 PRI VATE DUTY 190. 04 19004 MARKETI NG 190. 05 19005 SPORTS PHYSI CALS 190. 06 19006 FOUNDATI ON 190. 07 19007 ASC 190. 08 19008 GATEWAY LOCATI ON 190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS 190. 10 19010 MORRI STOWN CLI NI C 190. 13 19013 MCCORD WELLNESS 190. 13 19013 MCCORD WELLNESS 190. 15 19015 NEUROLOGY PHYSI CI AN 190. 15 19015 NEUROLOGY PHYSI CI AN 190. 03 1, 716, 660 1, 650, 510 1, 636, 574 1, 636, 57 |                              |               |   | l e e e e e e e e e e e e e e e e e e e  |          |
| 190. 04 19004 MARKETI NG 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. 11 19011 MORRI STOWN CLI NI C 190. 12 19012 03PUREMED 190. 14 19014 3 WEST UNI T 190. 15 19015 NEUROLOGY PHYSI CI AN 190. 05 391, 408 190. 391, 408 190. 06 190. 06 190. 10, 636, 574 190. 06 190. 10, 812 190. 07 190. 10, 812 190. 08 190. 08 190. 09 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 10 190. 11 190. 10 190. |                              | _             |   |  |          |
| 190. 05  |                              |               | , |  |          |
| 190. 06   19006   FOUNDATION   0   1, 636, 574   190. 06   190.07   19007   ASC   0   10, 812   190. 07   190.08   190.08   190.08   190.08   190.09   190.09   140.00ck   OB   OB   OB   OB   OB   OB   OB   O  |                              |               |   |  |          |
| 190. 07   19007   ASC  |                              | 0             |   |  |          |
| 190. 08 19008 GATEWAY LOCATION 0 4, 599, 193 190. 08 190. 09 19009 HANCOCK 0B 0 3, 780, 169 190. 09 19010 HANCOCK WELLNESS 0 1, 209, 022 190. 11 19011 MORRI STOWN CLINI C 0 0 190. 11 19012 03 PUREMED 0 0 190. 13 19013 MCCORD WELLNESS 0 1, 659, 596 190. 14 190. 14 19014 3 WEST UNI T 0 442, 954 190. 15 19015 NEUROLOGY PHYSI CI AN 0 1, 521, 771 190. 15  |                              | l 0           | 1                                       |  | 1        |
| 190. 09   19009   HANCOCK OB   |                              | l n           |   |  |          |
| 190. 10   19010   HANCOCK WELLNESS   |                              | 0             | 1                                       |  | •        |
| 190. 11     19011     MORRI STOWN CLINI C     0     0     190. 11       190. 12     19012     03PUREMED     0     0     190. 12       190. 13     19013     MCCORD WELLNESS     0     1,659,596     190. 13       190. 14     19014     3 WEST UNIT     0     442,954     190. 14       190. 15     19015     NEUROLOGY PHYSI CI AN     0     1,521,771     190. 15  |                              | 0             | 1                                       |  | •        |
| 190. 13   19013   MCCORD WELLNESS 0 1,659,596 190. 13   190. 14   19014   3   WEST UNI T 0 442,954 190. 15   19015   NEUROLOGY PHYSI CI AN 0 1,521,771 190. 15   |                              | 0             | 1                                       |  |          |
| 190. 14   19014   3 WEST UNIT 0 442, 954 190. 15   19015   NEUROLOGY PHYSI CI AN 0 1, 521, 771 190. 15   |                              | 0             | 0                                       |  |          |
| 190. 15 19015 NEUROLOGY PHYSI CI AN 0 1, 521, 771 190. 15  |                              |               | 1                                       | l control of the cont |          |
|  |                              |               |   |  |          |
| 190. TO 1901 TO 1 THUKACI   0   2, 951   190. 16   |                              |               |   |  |          |
|  | 190. TO TOUTO THUKACT        | 1 0           | 2, 951                                  | 1  | 1190. 16 |

 
 Health Financial
 Systems
 HANCOCK REC

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-0037

Peri od: Worksheet A From 01/01/2023 Date/Time Prepared:

|   |               |               | 5/31/2024 7:01 am |
|---|---------------|---------------|-------------------|
| Cost Center Description                       | Adjustments   | Net Expenses  |                   |
|   | (See A-8)     | For           |                   |
|   |               | Allocation    |                   |
|   | 6. 00         | 7. 00         |                   |
| 190. 17 19017 HANCOCK ENDO                    | 0             | 1, 205, 257   |                   |
| 190. 18 19018 HANCOCK FOOT & ANKLE            | 0             | 0             | 190. 18           |
| 190. 19 19019 HANCOCK RHEUM                   | 0             | 17, 352       |                   |
| 194.00 07950 OTHER NONREI MBURSABLE           | 0             | 254           | 194.00            |
| 194. 01 07951 SUBURBAN HOSPI CE               | 0             | 259, 593      | 194. 01           |
| 194. 02 07952 HRH HANCOCK GI                  | 0             | 1, 497, 791   | 194. 02           |
| 194. 03 07954 HRH NEPHROLOGY                  | 0             | 185, 504      | 194. 03           |
| 194. 04 07957 HRH SANE                        | 0             | 187, 323      | 194. 04           |
| 194. 05 07955 HRH RI SE                       | 0             | 164, 702      | 194. 05           |
| 194.06 07956 HRH JUSTICE NAVIGATION           | 0             | 245, 036      | 194. 06           |
| 194.07 07953 HPN PHYSICIAN                    | 0             | 110, 762      | 194. 07           |
| 194. 08 07958 HOSPI TALI ST                   | 0             | 512, 217      | 194. 08           |
| 194.09 07959 HPN HANCOCK COUNSEL              | 0             | 67, 160       | 194. 09           |
| 194.10 07960 HPN HFM MCKENZIE                 | 0             | 131, 567      | 194. 10           |
| 194.11 07961 HPN HIM GREENFIELD               | 0             | 126, 509      | 194. 11           |
| 194.12 07962 HPN HFM BOYD                     | 0             | 198, 746      | 194. 12           |
| 194.13 07963 HPN HIM MCCORD                   | 0             | 102, 269      | 194. 13           |
| 194.14 07964 HPN WELL BEING                   | 0             | 64, 768       | 194. 14           |
| 194.15 07965 PHYSICIAN BILLING SERVICE        | 0             | 274, 410      | 194. 15           |
| 194. 16 07966 CLINICAL MANAGEMENT             | 0             | 160, 197      | 194. 16           |
| 194. 17 07967 HANCOCK ORTHO                   | 0             | 3, 220, 217   | 194. 17           |
| 194. 18 07968 HANCOCK PEDI ATRI CS            | 0             | 133, 204      | 194. 18           |
| 194. 19 07969 HRN HFM NEW                     | 0             | 205, 496      | 194. 19           |
| 194. 20 07970 HRH HFM CLEARVIEW               | 0             | 66, 888       | 194. 20           |
| 200.00   TOTAL (SUM OF LINES 118 through 199) | -32, 126, 675 | 164, 286, 763 | 200. 00           |

Provider CCN: 15-0037

|                  |   |                    |              |                              | 2024 7:01 am     |
|------------------|---|--------------------|--------------|------------------------------|------------------|
|                  |   | Increases          |              |                              |                  |
|                  | Cost Center                             | Li ne #            | Sal ary      | Other                        |                  |
|                  | 2. 00<br>A - CAFETERI A RECLASS         | 3. 00              | 4. 00        | 5. 00                        |                  |
| 1. 00            | CAFETERIA RECLASS                       | 11. 00             | 1, 059, 492  | 860, 383                     | 1.00             |
| 1.00             | TOTALS                                  |                    | 1, 059, 492  | 860, 383                     | 1.00             |
|                  | B - PLANT RECLASS                       |                    | 1,007,172    | 2007 2007                    |                  |
| 1.00             | OPERATION OF PLANT                      | 7. 00              | 0            | 2, 060                       | 1.00             |
| 2.00             | MEDICAL RECORDS & LIBRARY               | 16. 00             | 0            | 6, 693                       | 2.00             |
| 3.00             | ELECTROCARDI OLOGY                      | 69. 00             | 0            | 6, 583                       | 3.00             |
| 4. 00            | RESPI RATORY THERAPY                    | 65.00              | 0_           | 4, 374                       | 4.00             |
|                  | TOTALS                                  |                    | 0            | 19, 710                      |                  |
| 1 00             | C - MARKETING RECLASS                   | 190, 04            | 226, 588     | 072 (22                      | 1 00             |
| 1. 00            | MARKETING                               | 190.04             | 226, 588     | 87 <u>2, 622</u><br>872, 622 | 1.00             |
|                  | E - DRUG RECLASS                        |                    | 220, 300     | 072, 022                     |                  |
| 1. 00            | DRUGS CHARGED TO PATIENTS               | 73. 00             | 0            | 22, 613, 096                 | 1.00             |
| 2. 00            |   | 0.00               | O            | 0                            | 2. 00            |
| 3.00             |   | 0. 00              | O            | 0                            | 3.00             |
| 4.00             |   | 0.00               | 0            | 0                            | 4. 00            |
| 5. 00            |   | 0. 00              | 0            | 0                            | 5. 00            |
| 6. 00            |   | 0.00               | 0            | 0                            | 6.00             |
| 7. 00            |   | 0.00               | 0            | 0                            | 7.00             |
| 8. 00            |   | 0.00               | 0            | 0                            | 8.00             |
| 9. 00<br>10. 00  |   | 0. 00<br>0. 00     | 0            | 0                            | 9. 00<br>10. 00  |
| 11. 00           |   | 0.00               | o            | 0                            | 11.00            |
| 12. 00           |   | 0.00               | o            | ő                            | 12.00            |
| 13. 00           |   | 0.00               | o            | 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           |
| 19. 00           |   | 0.00               | 0            | 0                            | 19.00            |
| 20.00            |   | 0.00               | 0            | 0                            | 20.00            |
| 21. 00<br>22. 00 |   | 0. 00<br>0. 00     | 0            | 0                            | 21. 00<br>22. 00 |
| 24. 00           |   | 0.00               | 0            | 0                            | 24.00            |
| 25. 00           |   | 0.00               | 0            | 0                            | 25. 00           |
| 26. 00           |   | 0.00               | o            | Ö                            | 26.00            |
| 27. 00           |   | 0.00               | o            | 0                            | 27. 00           |
| 28. 00           |   | 0.00               | O            | 0                            | 28. 00           |
| 29.00            |   | 0.00               | О            | 0                            | 29. 00           |
| 30.00            |   | 0. 00              | 0            | 0                            | 30.00            |
| 31.00            |   | 0. 00              | 0            | 0                            | 31.00            |
| 32.00            |   | 0. 00              | 0            | 0                            | 32.00            |
| 33.00            |   | 0.00               | 0            | 0                            | 33.00            |
| 34.00            |   | 0.00               | 0            | 0                            | 34.00            |
| 35. 00           |   | 0.00               | 0            | 0                            | 35.00            |
| 36. 00<br>37. 00 |   | 0. 00<br>0. 00     | 0            | 0                            | 36. 00<br>37. 00 |
| 38. 00           |   | 0.00               | 0            | 0                            | 38.00            |
| 30.00            | TOTALS — — — —                          |                    | <del>ŏ</del> | 22, 613, 096                 | 30.00            |
|                  | F - TERM ETO BENEFIT RECLASS            |                    |              | , ,                          |                  |
| 1.00             | EMPLOYEE BENEFITS DEPARTMENT            | 4. 00              | 0            | 8, 577                       | 1.00             |
| 2.00             | ADMINISTRATIVE & GENERAL                | 5. 00              | O            | 89, 450                      | 2.00             |
| 3. 00            | OPERATION OF PLANT                      | 7. 00              | 0            | 34, 071                      | 3. 00            |
| 4. 00            | HOUSEKEEPI NG                           | 9. 00              | 0            | 1, 949                       | 4. 00            |
| 5. 00            | DI ETARY                                | 10.00              | 0            | 6, 411                       | 5. 00            |
| 6. 00            | CENTRAL SERVICES & SUPPLY               | 14. 00             | 0            | 6, 417                       | 6.00             |
| 7.00             | PHARMACY                                | 15. 00             | 0            | 2, 836                       | 7.00             |
| 8. 00<br>9. 00   | ADULTS & PEDIATRICS INTENSIVE CARE UNIT | 30. 00<br>31. 00   | 0            | 23, 759<br>983               | 8. 00<br>9. 00   |
| 9. 00<br>10. 00  | OPERATING ROOM                          | 50.00              | o            | 6, 168                       | 10.00            |
| 11. 00           | RECOVERY ROOM                           | 51. 00             | o            | 4, 961                       | 11.00            |
| 12. 00           | LABORATORY                              | 60. 00             | o            | 8, 672                       | 12.00            |
| 13. 00           | RESPI RATORY THERAPY                    | 65. 00             | Ö            | 15, 792                      | 13.00            |
| 14.00            | PHYSI CAL THERAPY                       | 66. 00             | O            | 726                          | 14.00            |
| 15.00            | OCCUPATIONAL THERAPY                    | 67. 00             | 0            | 7, 227                       | 15. 00           |
| 16.00            | WOUND CLINIC                            | 90. 01             | 0            | 2, 520                       | 16. 00           |
| 17.00            | ONCOLOGY                                | 90. 07             | 0            | 2, 469                       | 17. 00           |
| 18. 00           | EMERGENCY                               | 91. 00             | 0            | 4, 707                       | 18.00            |
| 19.00            | SUBURBAN HOSPI CE                       | 194. 01            | 0            | 835                          | 19.00            |
| 20.00            | PRI VATE DUTY                           | 190. 03            | 0            | 648                          | 20.00            |
| 21. 00           | GATEWAY LOCATION                        | 190. 08<br>190. 09 | 0            | 9, 456<br>1, 288             | 21.00            |
| 22. 00           | HANCOCK OB                              | 190.09             | υļ           | 1, 200                       | 22. 00           |

Heal th Financial Systems

HANCOCK REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0037
From 01/01/2023
To 12/31/2023 Date/Time Prepared:

|        |                               |           |             |              | To 12/31/2023 Date/Time F 5/31/2024 7 | repared:  |
|--------|-------------------------------|-----------|-------------|--------------|---------------------------------------|-----------|
|        |                               | Increases |             |              | 373172024 7                           | . OT alli |
|        | Cost Center                   | Li ne #   | Sal ary     | Other        |                                       |           |
|        | 2.00                          | 3.00      | 4. 00       | 5. 00        |                                       |           |
| 23. 00 | HANCOCK WELLNESS              | 190. 10   | 0           | 908          |                                       | 23. 00    |
| 24.00  | MCCORD WELLNESS               | 190. 13   | o           | 722          |                                       | 24.00     |
| 25. 00 | HRH HANCOCK GI                | 194. 02   | o           | 859          |                                       | 25. 00    |
|        | TOTALS                        |           |             | 242, 411     |                                       |           |
|        | G - TRANSITIONS UNIT RECLASS  | <u>'</u>  | <u> </u>    | · · · · · ·  |                                       |           |
| 1.00   | ADULTS & PEDIATRICS           | 30.00     | 715, 551    | 167, 618     |                                       | 1.00      |
| 2.00   | SUBURBAN HOSPICE              | 194. 01   | 215, 154    | 50, 400      |                                       | 2.00      |
|        | TOTALS — — — — —              |           | 930, 705    | 218, 018     |                                       | 1         |
|        | H - IMPLANTABLE SUPPLY RECLAS | SS        |             |              |                                       |           |
| 1.00   | IMPL. DEV. CHARGED TO         | 72. 00    | 0           | 16, 557      |                                       | 1.00      |
|        | PATI ENT                      |           |             |              |                                       |           |
|        | TOTALS                        |           | 0           | 16, 557      |                                       |           |
|        | I - MED SUPPLY RECLASS        |           |             |              |                                       |           |
| 1.00   | MEDICAL SUPPLIES CHARGED TO   | 71.00     | 0           | 3, 588, 967  |                                       | 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      | 0           | 0            |                                       | 6. 00     |
| 7. 00  |                               | 0.00      | 0           | 0            |                                       | 7. 00     |
| 8.00   |                               | 0.00      | 0           | 0            |                                       | 8. 00     |
| 9. 00  |                               | 0.00      | 0           | 0            |                                       | 9. 00     |
| 10.00  |                               | 0.00      | 0           | 0            |                                       | 10.00     |
| 11. 00 |                               | 0. 00     | 0           | 0            |                                       | 11.00     |
| 12.00  |                               | 0. 00     | 0           | 0            |                                       | 12. 00    |
| 13.00  |                               | 0.00      | 0           | 0            |                                       | 13. 00    |
| 14.00  |                               | 0.00      | 0           | 0            |                                       | 14.00     |
| 15. 00 |                               | 0. 00     | 0           | 0            |                                       | 15. 00    |
| 16. 00 |                               | 0.00      | 0           | 0            |                                       | 16. 00    |
| 17. 00 |                               | 0.00      | 0           | 0            |                                       | 17. 00    |
| 18.00  |                               | 0.00      | 0           | 0            |                                       | 18.00     |
| 19.00  |                               | 0.00      | 0           | 0            |                                       | 19.00     |
| 20.00  |                               | 0.00      | 0           | 0            |                                       | 20.00     |
| 21.00  |                               | 0.00      | 0           | 0            |                                       | 21.00     |
| 22. 00 |                               | 0.00      | 0           | 0            |                                       | 22.00     |
| 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      | 0           | 0            |                                       | 28.00     |
| 29. 00 |                               | 0.00      | 0           | 0            |                                       | 29.00     |
| 30. 00 |                               | 0.00      | 0           | 0            |                                       | 30. 00    |
| E00 00 | TOTALS                        |           | <u> </u>    | 3, 588, 967  |                                       | F00 00    |
| 500.00 | Grand Total: Increases        | ı l       | 2, 216, 785 | 28, 431, 764 |                                       | 500.00    |

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0037

| Cost Conter  |        |         |         |              |          | To                                    | Date/Time P<br>5/31/2024 7 |        |
|--|--------|---------|---------|--------------|----------|---------------------------------------|----------------------------|--------|
| CO   A   |        |         |         | Callan       | 011      | W                                     |                            |        |
| A CAPTERIA RECLASS   |        |         |         |              |          |                                       |                            |        |
| DIALS  |        |         | 7100    | 0.00         | 7. 00    | 10.00                                 |                            |        |
| 1  | 1. 00  |         | 1000    |              |          |                                       |                            | 1. 00  |
| 1.00   |        |         |         | 1, 059, 492  | 860, 383 |                                       |                            |        |
| 2.00   0.00   0.00   0   0   0   0   0   | 1. 00  |         | 190, 01 | O            | 19, 710  | 0                                     |                            | 1.00   |
| 1.00   CTALS   CTALS |        |         |         | 0            |          |                                       |                            | 1      |
| TOTALS     0   19,710  |        |         |         | 0            | 0        | l l                                   |                            | 1      |
| 1.00   AMENINFERATIVE & CREENAL   5.00   226.588   572.622   0   1.00  | 4. 00  | TOTAL C |         |              | 0        |                                       |                            | 4.00   |
| DO   |        |         |         | UU           | 19, 710  |                                       |                            |        |
| - DRUG RECLASS   | 1.00   |         | 5. 00   | 226, 588     | 872, 622 | 0                                     |                            | 1.00   |
| DATE   DATE   DEPARTMENT   |        |         |         | 226, 588     | 872, 622 |                                       |                            |        |
| 2.00   DAMIN STRATIVE & GENERAL   5.00   0   166   0   2.00   4.00   PHARMACY PI ATTICES   3.00   0   21.074,877   0   4.00   5.00   ADUIL SERVICES & SUPPLY   15.00   0   21.074,877   0   4.00   5.00   ADUIL SERVICES & SUPPLY   15.00   0   21.074,877   0   4.00   7.00   DEPART IN SERVICES & SUPPLY   15.00   0   10.028   0   7.00   9.00   RECOVERY ROOM   5.100   0   10.028   0   7.00   9.00   RECOVERY ROOM   5.100   0   10.028   0   9.00   9.00   RECOVERY ROOM   5.100   0   10.028   0   9.00   9.10   RESPIRATION THERAPY   6.500   0   30.00   0   11.00   11.00   LABRORATORY   6.500   0   30.00   0   11.00   11.00   LABRORATORY   6.500   0   30.00   0   11.00   14.10   RESPIRATION THERAPY   6.500   0   30.00   0   11.00   14.10   RESPIRATION THERAPY   6.500   0   30.00   0   11.00   14.10   RESPIRATION THERAPY   6.500   0   34.454   0   11.00   14.10   RESPIRATION THERAPY   77.00   0   34.454   0   11.00   14.10   RESPIRATION THERAPY   77.00   0   34.554   0   11.00   14.10   RUSHING THERAPY   77.00   0   34.500   34.500   34.500   14.10   RUSHING THERAPY   6.500   0   34.500   34.500   34.500   34.500   34.500   34.500   34.500   34.500   34.500   34.500   34.500   34.500   34.500   34.500   34.500   34.500  | 1 00   |         | 4 00    | O            | E2 2E4   | 0                                     |                            | 1 00   |
| CATION   STRING STRING S SUPPLY   14.00  |        | •       | l I     | - 1          |          |                                       |                            | 1      |
| Description   Color   Color  |        | •       | l I     | - 1          |          | I                                     |                            | 1      |
| NITERSIVE CARE UNIT   31.00   0   15.623   0   6.00  |        | 1       |         | 0            |          | - 1                                   |                            | 1      |
| 7.00         OPERATI NG ROOM         50.00         0         10.028         0         7.00         8.00           9.00         RADI OLOCY-DI AGNOSTI C         54.00         0         29,613         0         9.00           9.00         RADI OLOCY-DI AGNOSTI C         54.00         0         29,613         0         9.00           9.00         RESPI RATORY THERAPY         65.00         0         300         0         111.00           11.00         RESPI RATORY THERAPY         65.00         0         1.268         0         112.00           14.00         DELECTROLAGIO LOCY         69.00         0         3.4454         0         114.00           14.00         ELECTROLAGIO LOCY         69.00         0         34.454         0         115.00           15.00         MEDICAL SUPPLIES CHARGED TO         71.00         16.00         0         16.00           16.00         CARDI OPULLIONIARY         76.01         0         16.00         0         16.00           17.00         RURAL HEALTH CLINIC         88.00         0         31.632         0         17.00           18.00         MINIS CLINIC         90.04         0         3.01         0         18.00  |        |         | l I     | 0            |          | -1                                    |                            |        |
| B. OD   RECOVERY ROOM   51.00   0   1.278   0   9.00   0 |        |         | l I     | 0            |          | - 1                                   |                            |        |
| 10.00   ABORATORY   65.00   0   300   0   11.10   11.00   RESPERATORY THERAPY   66.00   0   0   300   0   11.10   11.00   RESPERATORY THERAPY   66.00   0   1.2.00   12.00   14.30   0   15.00   12.00   14.30   0   14.30   0   15.00   14.30   0   14.30   0   14.30   0   14.30   0   14.30   0   14.30   0   14.30   0   14.30   0   15.00   MEDICAL SUPPLIES CHARGED TO   71.00   0   14.30   0   15.00   MEDICAL SUPPLIES CHARGED TO   71.00   0   14.30   0   15.00   16.00   0   16.00   0   16.00   0   17.00   0   17.00   0   18.30   0   17.00   0   18.00   0   |        |         | l I     | Ö            |          |                                       |                            |        |
| 11.00 RESPI RATIORY THERAPY 66.00 0 1.208 0 112.00 13.00 SPEECH PATHOLOGY 66.00 0 1.208 0 112.00 13.00 SPEECH PATHOLOGY 66.00 0 1.208 0 113.00 15.00 REDICAL SUPPLIES CHARGED TO 71.00 0 143 0 15.00 16.00 REDICAL SUPPLIES CHARGED TO 71.00 0 143 0 15.00 16.00 REDICAL SUPPLIES CHARGED TO 71.00 0 143 0 15.00 16.00 REDICAL SUPPLIES CHARGED TO 71.00 0 143 0 15.00 16.00 REDICAL SUPPLIES CHARGED TO 71.00 0 143 0 15.00 16.00 REDICAL SUPPLIES CHARGED TO 71.00 0 143 0 15.00 17.00 REDICAL SUPPLIES CHARGED TO 71.00 0 143 0 15.00 18.00 ROUND CHARGED TO 71.00 0 143 0 15.00 19.00 RADIO CHARGED TO 71.00 0 10.01 10.01 19.00 RADIO CHARGED TO 71.00 0 10.01 11 0 0 16.00 19.00 RADIO CHARGED TO 71.00 0 10.01 11 0 0 16.00 19.00 RADIO CHARGED TO 71.00 0 10.01 11 0 0 16.00 19.00 RADIO CHARGED TO 71.00 0 10.01 11 0 0 16.00 19.00 RADIO CHARGED TO 71.00 0 10.01 11 0 0 16.00 19.00 RADIO CHARGED TO 71.00 0 10.01 11 0 0 16.00 19.00 RADIO CHARGED TO 71.00 0 10.01 11 0 0 16.00 19.00 RADIO CHARGED TO 71.00 0 10.01 11 0 0 10.01 11 0 0 10.01 11 0 0 10.01 11 0 0 10.01 11 0 1 0   |        |         | 1       | 0            |          |                                       |                            | 1      |
| 12.00   PHYSI CAL THERAPY  |        |         | l I     | ĭ            |          |                                       |                            | 1      |
| 13.00   SPEECH PATHOLOGY   |        |         | l I     | ĭ            |          | - 1                                   |                            | 1      |
| 14. 00   LECTROCARDIOLOGY   69. 00   0   34. 454   0   15. 00   PATI ENTS   0   0   16. 00   16. 00   16. 00   16. 00   16. 00   17. 00   0   18. 00   17. 00   18. 00   17. 00   18. 00   18. 00   19. |        |         |         | o            |          | · · · · · · · · · · · · · · · · · · · |                            | 4      |
| PATI ENTS  | 14.00  | I       |         | 0            | 34, 454  | 0                                     |                            | 14.00  |
| 16. 00   CARDI OPULINOMARY   76. 01   0   16. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   19.  | 15. 00 |         | 71. 00  | 0            | 143      | 0                                     |                            | 15. 00 |
| 17. 00   RURAL HEALTH CLINIC   88. 00   0   31. 632   0   18. 00     18. 00   WOUND CLINIC   90. 01   0   10. 211   0   18. 00     19. 00   ANDIS CLINIC   90. 04   0   32   0   19. 00     20. 00   ANDIS CLINIC   90. 07   0   13. 191   0   20. 00     21. 00   ANDERSON WOMENS CENTER   90. 08   0   774   0   21. 00     22. 00   SUBIRRAH HOSPIC E   194. 01   0   773   0   22. 00     24. 00   GATEWAY LOCATION   190. 08   0   37. 287   0   24. 00     25. 00   ANDROCK OB   190. 09   0   43. 64. 64   0   25. 00     26. 00   3   WEST UNIT   190. 14   0   139   0   26. 00     26. 00   3   WEST UNIT   190. 14   0   139   0   26. 00     28. 00   HANGOCK FEID   190. 17   0   64. 686   0   27. 00     29. 00   HANGOCK FEID   190. 17   0   64. 686   0   28. 00     29. 00   HANGOCK FEID   190. 17   0   64. 686   0   29. 00     30. 00   HRN HFM NEW   194. 19   0   67. 060   0   30. 00     40. 00   HRN HFM NEW   194. 19   0   67. 060   0   30. 00     30. 00   HRN HFM NEW   194. 19   0   67. 060   0   31. 00     30. 00   HRN HFM NEW   194. 19   0   67. 060   0   33. 00     30. 00   HRN HFM NEW   194. 10   0   1. 185   0   32. 00     30. 00   HRN HFM NEW   194. 10   0   1. 185   0   33. 00     30. 00   HRN HFM NEW   194. 10   0   0   1. 185   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 0. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   33. 00     30. 00   HRN HFM NECENZIE   194. 10   0   10. 214   0   0   10. 00     30. 00   HRN HFM NECENZIE   194. 10   0   1 | 16 00  | I       | 76.01   |              | 16       | 0                                     |                            | 16 00  |
| 18. 00   WOUND CLI NI C  |        | •       | 1       | -            |          |                                       |                            | 1      |
| 20.00   ONCOLOGY   90.07   0   13,191   0   20.00  |        | I       | 1       | 0            |          | 0                                     |                            | 4      |
| 21 00   ANDERSON WOMENS CENTER   90 08   0   774   0   22 00   0   0   0   0   0   0   22 00   0   |        |         |         | 0            |          | - 1                                   |                            | 4      |
| 22.00   SUBURBAN HOSPICE   194.01   0   773   0   22.00     24.00   CATEWAY LOCATION   190.08   0   73.287   0   24.00     25.00   HANCOCK OB   190.09   0   436.164   0   25.00     26.00   SWEST UNIT   190.14   0   139   0   26.00     27.00   NEUROLOGY PHYSICIAN   190.15   0   126.794   0   27.00     28.00   HANCOCK ENDO   190.17   0   64.686   0   28.00     29.00   HANCOCK PEDIATRICS   194.18   0   35   0   29.00     30.00   HRN HFH MEW   194.19   0   67.060   0   30.00     31.00   HRN HFH MEW   194.19   0   67.060   0   31.00     32.00   HRN SANE   194.04   0   1,185   0   32.00     33.00   HRN HFM KCENZIE   194.10   0   160.214   0   33.00     33.00   HPN HFM MCKENZIE   194.10   0   106.214   0   34.00     36.00   HPN HIM MCCOKO   194.13   0   55.786   0   35.00     36.00   HPN HIM MCCOKO   194.13   0   55.786   0   36.00     37.00   ANCOCK FEDIATRICS   191.00   0   28.237   0     38.00   EMERGENCY   91.00   0   28.237   0     57.00   ADMINISTRATIVE & GENERAL   5.00   89.450   0   0   0     4.00   HOUSEKEEPING   9.00   1,949   0   0   0     4.00   HOUSEKEEPING   9.00   1,949   0   0   0     5.00   CENTRAL SERVICES & SUPPLY   14.00   6.417   0   0   0     6.00   CENTRAL SERVICES & SUPPLY   14.00   6.417   0   0   0     6.00   ADMINISTRATIVE & GENERAL   5.00   89.450   0   0   0     6.00   CENTRAL SERVICES & SUPPLY   14.00   6.417   0   0   0     6.00   CENTRAL SERVICES & SUPPLY   14.00   6.417   0   0   0     7.00   ADMINISTRATIVE & GENERAL   5.00   89.450   0   0   0     8.00   ADULTS & PEDIATRICS   30.00   2.759   0   0   0     9.00   ADMINISTRATIVE & GENERAL   5.00   89.450   0   0     9.00   ADMINISTRATIVE & GENERAL   5.00   89.450   0   0     9.00   CENTRAL SERVICES & SUPPLY   14.00   6.417   0   0   0     9.00   ADMINISTRATIVE & GENERAL   5.00   6.416   0   0     9.00   ADMINISTRATIVE & GENERAL   5.00   6.411   0   0   0     9.00   ADMINISTRATIVE & GENERAL   5.00   6.410   0   0     9.00   ADMINISTRATIVE & GENERAL   5.00   6.410   0   0     9.00   ADMINISTRATIVE & GENERAL   5.00   6.410   0   0     9. |        | •       |         | 0            |          |                                       |                            | 1      |
| 24. 00   CATEWAY LOCATION   190. 08   0   73, 287   0   24. 00   |        |         | l l     | o            |          | - 1                                   |                            | 1      |
| 26. 00 3 WEST UNIT 190, 14 0 139 0 26. 00 27. 00 NEUROLOCY PHYSICIAN 190, 15 0 126,794 0 27. 00 28. 00 HANCOCK ENDO 190, 17 0 64, 686 0 28. 00 29. 00 HANCOCK EDIATRICS 194, 18 0 35 0 29. 00 30. 00 HAN HEM NEW 194, 19 0 67, 660 0 30. 00 31. 00 HRH HEM CLEARVIEW 194, 20 0 43, 010 0 31. 00 32. 00 HRH SANE 194, 04 0 1, 185 0 32. 00 33. 00 HPN PHYSICIAN 194, 07 0 150 0 33. 00 33. 00 HPN PHYSICIAN 194, 10 0 160, 214 0 34. 00 35. 00 HPN HEM MCKEZIE 194, 10 0 106, 214 0 34. 00 35. 00 HPN HEM MCKEZIE 194, 11 0 8, 940 0 36. 00 36. 00 HPN WELL BEING 194, 14 0 8, 940 0 36. 00 37. 00 HANCOCK ORTHO 194, 17 0 47, 830 0 37. 00 38. 00 HPN WELL BEING 194, 17 0 47, 830 0 37. 00 38. 00 HPN WELL BEING 194, 17 0 47, 830 0 37. 00 38. 00 EMERGENCY 91.00 0 22, 613, 096  F - TERM ETO BENEFIT RECLASS  F - TERM ETO BENEFIT S DEPARTMENT 1. 00 1, 949 0 0 4. 00 3. 00 OPERATION OF PLANT 7. 00 34, 071 0 0 3. 00 3. 00 OPERATION OF PLANT 7. 00 34, 071 0 0 0 4. 00 5. 00 DI ETARY 1. 00 6, 411 0 0 6, 411 0 0 6. 00 7. 00 PLARMACY 15. 00 2, 836 0 0 0 9. 00 9. 00 I TETRY 15. 00 2, 836 0 0 0 9. 00 9. 00 I TETRY 15. 00 2, 836 0 0 0 0 0 0 0 0 0 0 0 9. 00 I TETRY 15. 00 0 0, 8, 572 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |        | •       | 1       | O            |          |                                       |                            | 1      |
| 27. 00   NEUROLOGY PHYSICIAN   190. 15   0   126, 794   0   27. 00   28. 00   28. 00   28. 00   28. 00   29.  |        | •       | l I     | 0            |          | - 1                                   |                            |        |
| 28. 00   |        | 1       | l l     | ~            |          |                                       |                            | 4      |
| 29. 00   HANCOCK PEDIATRICS  |        |         |         | 0            |          | - 1                                   |                            | 4      |
| 31.00   HRH HFH CLEARVIEW  |        |         |         | O            |          |                                       |                            | 4      |
| 32.00   HRI SANE   194.04   0   1,185   0   32.00     33.00   HRI SANE   194.07   0   150   0   33.00     33.00   HPN HFM MCKENZI E  |        | 1       |         | 0            |          | 0                                     |                            | 1      |
| 33.00   HPN PHYSICIAN   194.07   0   150   0   33.00   150   0   34.00   HPN HFM MCKENZIE   194.10   0   106.214   0   34.00   35.00   HPN HIM MCCORD   194.13   0   8,940   0   35.00   35.00   HPN WELL BEING   194.14   0   8,940   0   37.00   38.00   HPN WELL BEING   194.17   0   47,830   0   37.00   38.00   HEN WELL BEING   91.00   0   28,237   0   38.00   HEN WELL BEING   91.00   0   22,613,096   1   1   1   1   1   1   1   1   1  |        | •       |         | 0            |          | 0                                     |                            | 1      |
| 34.00   HPN HFM MCKENZIE   |        | •       | 1       | 0            |          | 0                                     |                            | 1      |
| A6. 00   HPN WELL BEING  |        |         | 194. 10 | Ö            |          | I                                     |                            | 1      |
| 37. 00   |        |         |         | 0            |          | 0                                     |                            |        |
| Section   Sect |        |         |         | - 1          |          |                                       |                            |        |
| TOTALS   |        |         |         | 0            |          |                                       |                            | 1      |
| F - TERM ETO BENEFIT RECLASS   | 30.00  |         |         | <del> </del> |          |                                       |                            | 30.00  |
| 2. 00 ADMI NI STRATI VE & GENERAL 5. 00 89, 450 0 0 0 3.00 OPERATI ON OF PLANT 7. 00 34, 071 0 0 0 3.00 OPERATION OF PLANT 7. 00 34, 071 0 0 0 3.00 OPERATION OF PLANT 7. 00 34, 071 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |        |         |         |              |          |                                       |                            |        |
| 3. 00 OPERATI ON OF PLANT 7. 00 34, 071 0 0 0 4. 00 4. 00 4. 00 4. 00 5. 00 DI ETARY 9. 00 10. 00 6. 411 0 0 0 5. 00 DI ETARY 14. 00 6. 417 0 0 0 6. 00 7. 00 PHARMACY 15. 00 2. 836 0 0 0 7. 00 8. 00 ADULTS & PEDI ATRI CS 30. 00 23, 759 0 0 0 8. 00 9. 00 INTENSI VE CARE UNIT 31. 00 983 0 0 0 9. 00 INTENSI VE CARE UNIT 31. 00 983 0 0 0 10. 00 OPERATI NG ROOM 50. 00 6. 168 0 0 0 10. 00 11. 00 RECOVERY ROOM 51. 00 4. 961 0 0 0 11. 00 12. 00 LABORATORY 65. 00 15. 792 0 0 0 13. 00 RESPI RATORY THERAPY 65. 00 15. 792 0 0 14. 00 PHYSI CAL THERAPY 66. 00 7. 227 0 0 15. 00 CCUPATI ONAL THERAPY 67. 00 7. 227 0 0 16. 00 WOUND CLI NI C 90. 01 2. 520 0 0 16. 00 17. 00 18. 00 EMERGENCY 91. 00 4, 961 0 0 17. 00 18. 00 EMERGENCY 91. 00 4, 90. 07 2. 469 0 0 0 17. 00 18. 00 EMERGENCY 91. 00 4, 90. 07 2. 469 0 0 0 19. 00 19. 00 19. 00 19. 00 19. 00 PRI VATE DUTY 190. 03 648 0 0 0 0 0 19. 00  |        |         |         |              |          |                                       |                            |        |
| 4. 00 HOUSEKEEPING 9. 00 1, 949 0 0 0 0 4. 00 5. 00 1 1, 949 0 0 0 0 5. 00 0 5. 00 0 5. 00 0 0 0 0 0   |        | I       | 1       |              |          | · · · · · · · · · · · · · · · · · · · |                            | 1      |
| 6.00 CENTRAL SERVICES & SUPPLY 14.00 6, 417 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |        | •       |         |              | -        |                                       |                            | 1      |
| 7. 00         PHARMACY         15. 00         2,836         0         0         0         7. 00           8. 00         ADULTS & PEDI ATRI CS         30. 00         23,759         0         0         0         8. 00           9. 00         I NTENSI VE CARE UNI T         31. 00         983         0         0         9. 00           10. 00         OPERATI NG ROOM         50. 00         6. 168         0         0         0         10. 00           11. 00         RECOVERY ROOM         51. 00         4, 961         0         0         11. 00         11. 00         12. 00         13. 00         12. 00         12. 00         13. 00         12. 00         13. 00         12. 00         13. 00         12. 00         13. 00         13. 00         13. 00         14. 00         0         0         13. 00         14. 00         14. 00         0         14. 00         14. 00         14. 00         14. 00         14. 00         14. 00         15. 00         0         0         15. 00         15. 00         15. 00         15. 00         15. 00         15. 00         15. 00         16. 00         17. 00         16. 00         17. 00         17. 00         17. 00         17. 00         17. 00         17. 00   |        |         |         |              | 0        | 0                                     |                            | 5. 00  |
| 8.00   ADULTS & PEDI ATRI CS   30.00   23,759   0   0   0   0   0   0   0   0   0  |        | •       |         |              |          |                                       |                            | 1      |
| 9.00 INTENSIVE CARE UNIT 31.00 983 0 0 0 10.00 10.00 10.00 10.00 11.00 PERATING ROOM 50.00 6, 168 0 0 0 10.00 11.00 RECOVERY ROOM 51.00 4, 961 0 0 11.00 12.00 LABORATORY 60.00 8, 672 0 0 0 12.00 13.00 RESPIRATORY THERAPY 65.00 15, 792 0 0 13.00 PHYSI CAL THERAPY 66.00 726 0 0 14.00 15.00 OCCUPATIONAL THERAPY 67.00 7, 227 0 0 15.00 WOUND CLINIC 90.01 2, 520 0 0 15.00 16.00 WOUND CLINIC 90.01 2, 520 0 0 16.00 17.00 NCOLOGY 90.07 2, 469 0 0 0 17.00 18.00 EMERGENCY 91.00 4, 707 0 0 18.00 19.00 SUBURBAN HOSPI CE 194.01 835 0 0 0 19.00 20.00 PRI VATE DUTY 190.03 648 0 0 0 0 0 20.00   |        | 1       |         |              |          | - 1                                   |                            |        |
| 10. 00       OPERATI NG ROOM       50. 00       6, 168       0       0       10. 00         11. 00       RECOVERY ROOM       51. 00       4, 961       0       0       0       11. 00         12. 00       LABORATORY       60. 00       8, 672       0       0       0       12. 00         13. 00       RESPI RATORY THERAPY       65. 00       15, 792       0       0       0       13. 00         14. 00       PHYSI CAL THERAPY       66. 00       726       0       0       0       14. 00         15. 00       OCCUPATI ONAL THERAPY       67. 00       7, 227       0       0       15. 00         16. 00       WOUND CLI NI C       90. 01       2, 520       0       0       15. 00         17. 00       ONCOLOGY       90. 07       2, 469       0       0       0       17. 00         18. 00       EMERGENCY       91. 00       4, 707       0       0       18. 00         19. 00       PRI VATE DUTY       190. 03       648       0       0       0       20. 00  |        |         |         |              | -        |                                       |                            | 4      |
| 12. 00     LABORATORY     60. 00     8, 672     0     0     12. 00       13. 00     RESPI RATORY THERAPY     65. 00     15, 792     0     0     0     13. 00       14. 00     PHYSI CAL THERAPY     66. 00     726     0     0     14. 00       15. 00     OCCUPATI ONAL THERAPY     67. 00     7, 227     0     0     15. 00       16. 00     WOUND CLINIC     90. 01     2, 520     0     0     16. 00       17. 00     ONCOLOGY     90. 07     2, 469     0     0     17. 00       18. 00     EMERGENCY     91. 00     4, 707     0     0     18. 00       19. 00     SUBURBAN HOSPI CE     194. 01     835     0     0     0     19. 00       20. 00     PRI VATE DUTY     190. 03     648     0     0     0     20. 00  |        |         |         | 1            |          |                                       |                            |        |
| 13. 00     RESPIRATORY THERAPY     65. 00     15. 792     0     0     13. 00       14. 00     PHYSI CAL THERAPY     66. 00     726     0     0     14. 00       15. 00     OCCUPATI ONAL THERAPY     67. 00     7, 227     0     0     15. 00       16. 00     WOUND CLI NI C     90. 01     2, 520     0     0     16. 00       17. 00     ONCOLOGY     90. 07     2, 469     0     0     17. 00       18. 00     EMERGENCY     91. 00     4, 707     0     0     18. 00       19. 00     SUBURBAN HOSPI CE     194. 01     835     0     0     19. 00       20. 00     PRI VATE DUTY     190. 03     648     0     0     0     20. 00  |        |         |         |              |          |                                       |                            |        |
| 14. 00     PHYSI CAL THERAPY     66. 00     726     0     0     14. 00       15. 00     OCCUPATI ONAL THERAPY     67. 00     7, 227     0     0     15. 00       16. 00     WOUND CLI NI C     90. 01     2, 520     0     0     0     16. 00       17. 00     ONCOLOGY     90. 07     2, 469     0     0     17. 00       18. 00     EMERGENCY     91. 00     4, 707     0     0     18. 00       19. 00     SUBURBAN HOSPI CE     194. 01     835     0     0     19. 00       20. 00     PRI VATE DUTY     190. 03     648     0     0     20. 00   |        |         |         |              | -        | - 1                                   |                            |        |
| 15. 00     OCCUPATI ONAL THERAPY     67. 00     7, 227     0     0     15. 00       16. 00     WOUND CLI NI C     90. 01     2, 520     0     0     0     16. 00       17. 00     ONCOLOGY     90. 07     2, 469     0     0     0     17. 00       18. 00     EMERGENCY     91. 00     4, 707     0     0     18. 00       19. 00     SUBURBAN HOSPI CE     194. 01     835     0     0     0     19. 00       20. 00     PRI VATE DUTY     190. 03     648     0     0     0     20. 00  |        |         |         |              |          |                                       |                            |        |
| 16. 00     WOUND CLINIC     90. 01     2,520     0     0     16. 00       17. 00     ONCOLOGY     90. 07     2,469     0     0     0     17. 00       18. 00     EMERGENCY     91. 00     4,707     0     0     0     18. 00       19. 00     SUBURBAN HOSPI CE     194. 01     835     0     0     0     19. 00       20. 00     PRI VATE DUTY     190. 03     648     0     0     0     20. 00   |        | 1       |         |              |          | - 1                                   |                            |        |
| 18. 00     EMERGENCY     91. 00     4, 707     0     0     18. 00       19. 00     SUBURBAN HOSPI CE     194. 01     835     0     0     0     19. 00       20. 00     PRI VATE DUTY     190. 03     648     0     0     0     20. 00  |        |         |         | 2, 520       |          | О                                     |                            |        |
| 19. 00     SUBURBAN HOSPI CE     194. 01     835     0     0     0     19. 00       20. 00     PRI VATE DUTY     190. 03     648     0     0     0     20. 00  |        |         | l I     |              | -        | 0                                     |                            |        |
| 20. 00 PRI VATE DUTY 190. 03 648 0 0 0 20. 00  |        |         |         |              |          |                                       |                            |        |
|  |        |         |         |              |          | - 1                                   |                            |        |
|  |        |         |         |              |          |                                       |                            |        |

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

|        |                               |  |             |              | 1              | To 12/31/202 |           |            |
|--------|-------------------------------|--|-------------|--------------|----------------|--------------|-----------|------------|
|        |                               | Decreases  |             |              |                |              | 5/31/2024 | 7: 01 alli |
|        | Cost Center                   | Li ne #  | Sal ary     | Other        | Wkst. A-7 Ref. |              |           |            |
|        | 6. 00                         | 7.00   | 8. 00       | 9. 00        | 10.00          |              |           |            |
| 22. 00 | HANCOCK OB                    | 190. 09  | 1, 288      | 0            | 0              |              |           | 22.00      |
| 23.00  | HANCOCK WELLNESS              | 190. 10  | 908         | 0            | 0              |              |           | 23.00      |
| 24.00  | MCCORD WELLNESS               | 190. 13  | 722         | 0            | 0              | •            |           | 24.00      |
| 25. 00 | HRH HANCOCK GI                | 194. 02  | 859         | 0            | 0              |              |           | 25. 00     |
|        | TOTALS                        |  | 242, 411    |              |                | •            |           |            |
|        | G - TRANSITIONS UNIT RECLASS  | <u>'</u>   | · · · · · · |              | <u>'</u>       |              |           |            |
| 1.00   | HOSPI CE                      | 116. 00  | 930, 705    | 218, 018     | 0              |              |           | 1.00       |
| 2.00   |                               | 0.00   | 0           | 0            | 0              |              |           | 2.00       |
|        | TOTALS                        |  | 930, 705    | 218, 018     |                | •            |           |            |
|        | H - IMPLANTABLE SUPPLY RECLAS | SS   |             |              |                |              |           |            |
| 1.00   | GATEWAY LOCATION              | 190. 08  | 0           | 16, 557      | 0              |              |           | 1.00       |
|        | TOTALS                        |  |             | 16, 557      |                | •            |           |            |
|        | I - MED SUPPLY RECLASS        |  | - 1         |              |                |              |           |            |
| 1.00   | ADMINISTRATIVE & GENERAL      | 5. 00  | 0           | 1, 106       | 0              |              |           | 1.00       |
| 2.00   | NURSING ADMINISTRATION        | 13. 00   | o           | 53           |                |              |           | 2.00       |
| 3.00   | CENTRAL SERVICES & SUPPLY     | 14. 00   | o           | 1, 818       | 0              |              |           | 3.00       |
| 4.00   | PHARMACY                      | 15. 00   | o           | 26, 589      |                |              |           | 4.00       |
| 5. 00  | ADULTS & PEDIATRICS           | 30.00  | o           | 223, 594     |                |              |           | 5.00       |
| 6.00   | INTENSIVE CARE UNIT           | 31.00  | 0           | 181, 467     |                |              |           | 6.00       |
| 7. 00  | OPERATING ROOM                | 50.00  | 0           | 1, 967, 798  |                |              |           | 7.00       |
| 8.00   | RECOVERY ROOM                 | 51.00  | 0           | 31, 118      |                |              |           | 8.00       |
| 9. 00  | RADI OLOGY-DI AGNOSTI C       | 54. 00   | 0           | 175, 663     |                |              |           | 9. 00      |
| 10.00  | LABORATORY                    | 60.00  | 0           | 1, 102       |                |              |           | 10.00      |
| 11. 00 | RESPIRATORY THERAPY           | 65. 00   | 0           | 51, 141      | 0              |              |           | 11.00      |
| 12. 00 | PHYSI CAL THERAPY             | 66.00  | 0           | 11, 043      | 0              |              |           | 12.00      |
| 13. 00 | OCCUPATI ONAL THERAPY         | 67. 00   | 0           | 3, 010       |                |              |           | 13.00      |
| 14. 00 | SPEECH PATHOLOGY              | 68.00  | o           | 1, 141       | 0              |              |           | 14.00      |
| 15. 00 | ELECTROCARDI OLOGY            | 69. 00   | 0           | 285, 869     | 0              |              |           | 15. 00     |
| 16. 00 | CARDI OPULMONARY              | 76. 01   | 0           | 10           |                |              |           | 16.00      |
| 17. 00 | RURAL HEALTH CLINIC           | 88. 00   | 0           | 52           | 0              |              |           | 17. 00     |
| 18. 00 | WOUND CLINIC                  | 90. 01   | 0           | 90, 633      | 0              |              |           | 18.00      |
| 19. 00 | ANDIS CLINIC                  | 90. 04   | 0           | 70, 000      | 0              |              |           | 19.00      |
| 20. 00 | ONCOLOGY                      | 90. 07   | 0           | 41, 546      | 0              |              |           | 20.00      |
| 21. 00 | ANDERSON WOMENS CENTER        | 90. 08   | 0           | 132, 629     |                |              |           | 21.00      |
| 22.00  | EMERGENCY                     | 91.00  | 0           | 192, 555     |                |              |           | 22.00      |
| 24. 00 | ASC                           | 190. 07  | 0           | 2, 066       |                |              |           | 24.00      |
| 25. 00 | GATEWAY LOCATION              | 190. 08  | 0           | 136, 617     |                |              |           | 25. 00     |
| 26. 00 | 3 WEST UNIT                   | 190. 08  | 0           | 4, 998       |                |              |           | 26.00      |
| 27. 00 | NEUROLOGY PHYSICIAN           | 190. 14  | 0           | 6, 586       |                |              |           | 27. 00     |
| 28. 00 | HRH HANCOCK GI                | 194. 02  | 0           | 5, 500       | 0              |              |           | 28.00      |
| 29. 00 | HANCOCK ORTHO                 | 194. 02  | 0           | 13, 499      | 0              |              |           | 29.00      |
| 30.00  | SUBURBAN HOSPI CE             | 194. 17  | 0           | 5, 188       |                |              |           | 30.00      |
| 30.00  | TOTALS                        | <del>                                     </del> | — — — #     | 3, 588, 967  |                |              |           | 30.00      |
| 500 00 | Grand Total: Decreases        |  | 2, 459, 196 | 28, 189, 353 |                |              |           | 500.00     |
| 500.00 | pi ana rotar. Decreases       | 1  | 2,407,190   | 20, 107, 333 | l              | l            |           | 500.00     |

|        |  |               |              |                 | To 12/31 | 1/2023  | Date/Time Pre 5/31/2024 7:0 | pared:<br>1 am |
|--------|--|---------------|--------------|-----------------|----------|---------|-----------------------------|----------------|
|        |  |               |              | Acqui si ti ons |          |         |                             |                |
|        |  | Begi nni ng   | Purchases    | Donati on       | Tota     | ıl      | 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        | C       | 0                           | 1.00           |
| 2.00   | Land Improvements                            | 26, 925, 681  | 0            | (               | 0        | C       | 0                           | 2.00           |
| 3.00   | Buildings and Fixtures                       | 69, 916, 832  | 0            | (               | 0        | C       | 517, 415                    | 3.00           |
| 4.00   | Building Improvements                        | 108, 237, 385 | 9, 139, 278  | (               | 9, 13    | 39, 278 | 0                           | 4.00           |
| 5.00   | Fixed Equipment                              | 0             | 0            | (               | 0        | C       | 0                           | 5.00           |
| 6.00   | Movable Equipment                            | 100, 005, 799 | 6, 845, 172  | (               | 0 6, 84  | 45, 172 | 2 0                         | 6.00           |
| 7.00   | HIT designated Assets                        | 0             | 0            | (               | 0        | C       | 0                           | 7.00           |
| 8.00   | Subtotal (sum of lines 1-7)                  | 307, 580, 361 | 15, 984, 450 | (               | 0 15, 98 | 34, 450 | 517, 415                    | 8.00           |
| 9.00   | Reconciling Items                            | 0             | 0            | (               | 0        | C       | 0                           | 9.00           |
| 10.00  | Total (line 8 minus line 9)                  | 307, 580, 361 | 15, 984, 450 | (               | 0 15, 98 | 34, 450 | 517, 415                    | 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                       | 69, 399, 417  | 0            |                 |          |         |                             | 3.00           |
| 4. 00  | Building Improvements                        | 117, 376, 663 | 0            |                 |          |         |                             | 4.00           |
| 5.00   | Fixed Equipment                              | 0             | 0            |                 |          |         |                             | 5.00           |
| 6.00   | Movable Equipment                            | 106, 850, 971 | 0            |                 |          |         |                             | 6.00           |
| 7.00   | HIT designated Assets                        | 0             | 0            |                 |          |         |                             | 7.00           |
| 8.00   | Subtotal (sum of lines 1-7)                  | 323, 047, 396 | 0            |                 |          |         |                             | 8.00           |
| 9.00   | Reconciling Items                            | 0             | 0            |                 |          |         |                             | 9.00           |
| 10. 00 | Total (line 8 minus line 9)                  | 323, 047, 396 | 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:<br>From 01/01/2023<br>To 12/31/2023 |                          | pared:  |
|         |  |                  | SU              | JMMARY OF CAP | ITAL   |                          |         |
|         | Cost Center Description                      | Depreciation     | Lease           | Interest      | Insurance<br>(see<br>instructions)           | Taxes (see instructions) |         |
|         |  | 9. 00            | 10. 00          | 11.00         | 12. 00                                       | 13.00                    |         |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WOR | RKSHEET A, COLU  | MN 2, LINES 1 a | and 2         |  |                          |         |
| 1.00    | NEW CAP REL COSTS-BLDG & FLXT                | 17, 980, 420     | 0               |               | 0  | 0                        | 1.00    |
| 3.00    | Total (sum of lines 1-2)                     | 17, 980, 420     | 0               |               | 0 0  | 0                        | 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, 980, 420    |               | ·  | ·                        | 1.00    |
| 3. 00   | Total (sum of lines 1-2)                     | 0                | 17, 980, 420    |               |  |                          | 3.00    |

| Heal th | Financial Systems                            | HANCOCK REGION      | NAL HOSPITAL             |                          | In Lie                           | u of Form CMS-2 | 552-10 |
|---------|--|---------------------|--------------------------|--------------------------|----------------------------------|-----------------|--------|
| RECONC  | CILIATION OF CAPITAL COSTS CENTERS           |                     | Provi der C              |                          | Peri od:                         | Worksheet A-7   |        |
|         |  |                     |                          | 1 -                      | From 01/01/2023<br>Fo 12/31/2023 |                 | nared: |
|         |  |                     |                          |                          | 12/01/2020                       | 5/31/2024 7: 0  |        |
|         |  | COME                | PUTATION OF RAT          | TI 0S                    | ALLOCATION OF                    | OTHER CAPITAL   |        |
|         | Coot Conton Decemintion                      | Cross Assets        | Conitalized              | Gross Assets             | Datia (ass                       | Lnouronoo       |        |
|         | Cost Center Description                      | Gross Assets        | Capi tal i zed<br>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 C |                     |                          |                          |                                  |                 |        |
| 1.00    | NEW CAP REL COSTS-BLDG & FIXT                | 17, 980, 420        |                          | 17, 980, 420             |                                  |                 | 1.00   |
| 3. 00   | Total (sum of lines 1-2)                     | 17, 980, 420        |                          | 17, 980, 420             |                                  |                 | 3.00   |
|         |  | ALLOCA <sup>-</sup> | TION OF OTHER (          | CAPI TAL                 | SUMMARY O                        | F CAPITAL       |        |
|         | Cost Center Description                      | Taxes               | Other                    | Total (sum of            | Depreciation                     | Lease           |        |
|         | cost center bescription                      | Taxes               | Capi tal -Rel at         |                          | Depi eci ati on                  | Lease           |        |
|         |  |                     | ed Costs                 | through 7)               |                                  |                 |        |
|         |  | 6. 00               | 7. 00                    | 8. 00                    | 9. 00                            | 10.00           |        |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C | ENTERS              |                          | •                        |                                  |                 |        |
| 1.00    | NEW CAP REL COSTS-BLDG & FIXT                | 0                   | 0                        | (                        | 17, 262, 578                     | -100, 209       | 1.00   |
| 3.00    | Total (sum of lines 1-2)                     | 0                   | 0                        | (                        | 17, 262, 578                     | -100, 209       | 3.00   |
|         |  |                     | SL                       | JMMARY OF CAPI           | TAL                              |                 |        |
|         | Cook Cooker December of                      | 1 4 4               | 1                        | T (                      | 0+1                              | T-+-1 (2)       |        |
|         | Cost Center Description                      | Interest            | Insurance<br>(see        | Taxes (see instructions) | Other<br>Capital-Relat           | Total (2)       |        |
|         |  |                     | instructions)            | I IIS LI UC LI UIIS)     | ed Costs (see                    |                 |        |
|         |  |                     | instructions)            |                          | instructions)                    | / till ough 14) |        |
|         |  | 11. 00              | 12. 00                   | 13.00                    | 14. 00                           | 15.00           |        |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C |                     |                          |                          |                                  |                 |        |
| 1.00    | NEW CAP REL COSTS-BLDG & FIXT                | -1, 344             | 0                        | (                        | 0                                | 17, 161, 025    | 1.00   |
| 3.00    | Total (sum of lines 1-2)                     | -1, 344             | 0                        | (                        | 0                                | 17, 161, 025    | 3.00   |

| ADJUST           | MENTS TO EXPENSES  |              |                   |  | Period:<br>From 01/01/2023 | Worksheet A-8                  |                  |
|------------------|--|--------------|-------------------|--|----------------------------|--------------------------------|------------------|
|                  |  |              |                   |  |                            | Date/Time Pre<br>5/31/2024 7:0 |                  |
|                  |  |              | To                | Expense Classification of<br>/From Which the Amount is |                            |                                |                  |
|                  |  |              |                   | 711 OIII WITTELL THE AMOUNT 13                         | s to be Aujusteu           |                                |                  |
|                  |  |              |                   |  |                            |                                |                  |
|                  |  |              |                   |  |                            |                                |                  |
|                  |  |              |                   |  |                            |                                |                  |
|                  | Cost Center Description                                      | Basi s/Code  | Amount            | Cost Center  | Li ne #                    | Wkst. A-7                      |                  |
|                  |  | (2)<br>1. 00 | 2. 00             | 3. 00  | 4. 00                      | Ref.<br>5.00                   |                  |
| 1. 00            | Investment income - NEW CAP                                  |              |                   | W CAP REL COSTS-BLDG &                                 | 1. 00                      | 0                              | 1.00             |
|                  | REL COSTS-BLDG & FIXT (chapter 2)                            |              | FI                | A I  |                            |                                |                  |
| 2. 00            | Investment income - CAP REL<br>COSTS-MVBLE EQUIP (chapter 2) |              | 0 **              | * Cost Center Deleted ***                              | 2.00                       | 0                              | 2. 00            |
| 3.00             | Investment income - other                                    |              | О                 |  | 0. 00                      | 0                              | 3.00             |
| 4. 00            | (chapter 2)<br>Trade, quantity, and time                     |              | 0                 |  | 0.00                       | 0                              | 4.00             |
|                  | 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            | Tel ephone servi ces (pay                                    |              | О                 |  | 0.00                       | 0                              | 7. 00            |
|                  | stations excluded) (chapter 21)                              |              |                   |  |                            |                                |                  |
| 8. 00            | Television and radio service                                 |              | О                 |  | 0.00                       | 0                              | 8. 00            |
| 9. 00            | (chapter 21)<br>Parking Lot (chapter 21)                     |              | o                 |  | 0.00                       | 0                              | 9. 00            |
| 10.00            | Provi der-based physi ci an                                  | A-8-2        | -6, 664, 835      |  |                            | 0                              | 10.00            |
| 11. 00           | adjustment<br>Sale of scrap, waste, etc.                     |              | 0                 |  | 0. 00                      | 0                              | 11.00            |
| 12. 00           | (chapter 23)<br>Related organization                         | A-8-1        | 0                 |  |                            | 0                              | 12.00            |
|                  | transactions (chapter 10)                                    | A-0-1        |                   |  |                            | 0                              |                  |
| 13. 00<br>14. 00 | Laundry and linen service<br>Cafeteria-employees and guests  | В            | 0<br>-860, 383 CA | FETERI A   | 0. 00<br>11. 00            | 0                              |                  |
| 15. 00           | Rental of quarters to employee                               |              | 0                 | . 2.12   | 0.00                       | 0                              |                  |
| 16. 00           | and others Sale of medical and surgical                      |              | O                 |  | 0.00                       | 0                              | 16. 00           |
|                  | supplies to other than                                       |              |                   |  |                            |                                |                  |
| 17. 00           | patients<br>Sale of drugs to other than                      |              | О                 |  | 0.00                       | 0                              | 17.00            |
| 18. 00           | patients Sale of medical records and                         |              | 0                 |  | 0.00                       | 0                              | 18. 00           |
|                  | abstracts  |              |                   |  |                            | _                              |                  |
| 19. 00           | Nursing and allied health education (tuition, fees,          |              | 0                 |  | 0.00                       | 0                              | 19. 00           |
| 20.00            | books, etc.)   |              |                   |  | 0.00                       | 0                              | 20.00            |
|                  | Vending machines Income from imposition of                   |              | 0<br>0            |  | 0. 00<br>0. 00             | 0                              |                  |
|                  | interest, finance or penalty charges (chapter 21)            |              |                   |  |                            |                                |                  |
| 22. 00           | Interest expense on Medicare                                 |              | О                 |  | 0.00                       | 0                              | 22. 00           |
|                  | overpayments and borrowings to repay Medicare overpayments   |              |                   |  |                            |                                |                  |
| 23. 00           | Adjustment for respiratory                                   | A-8-3        | 0 RE              | SPI RATORY THERAPY                                     | 65. 00                     |                                | 23. 00           |
|                  | therapy costs in excess of limitation (chapter 14)           |              |                   |  |                            |                                |                  |
| 24. 00           | Adjustment for physical therapy costs in excess of           | A-8-3        | ОРН               | YSI CAL THERAPY  | 66. 00                     |                                | 24. 00           |
|                  | limitation (chapter 14)                                      |              |                   |  |                            |                                |                  |
| 25. 00           | Utilization review -<br>physicians' compensation             |              | 0 **              | * Cost Center Deleted ***                              | 114. 00                    |                                | 25.00            |
|                  | (chapter 21)   |              |                   |  |                            | _                              |                  |
| 26. 00           | Depreciation - NEW CAP REL<br>COSTS-BLDG & FIXT              |              | ONE<br>FI         | W CAP REL COSTS-BLDG &<br>XT                           | 1. 00                      | 0                              | 26. 00           |
| 27. 00           | Depreciation - CAP REL                                       |              |                   | * Cost Center Deleted ***                              | 2. 00                      | 0                              | 27. 00           |
| 28. 00           | COSTS-MVBLE EQUIP<br>Non-physician Anesthetist               |              | 0 **              | * Cost Center Deleted ***                              | 19.00                      |                                | 28. 00           |
| 29. 00<br>30. 00 | Physicians' assistant<br>Adjustment for occupational         | A-8-3        | 0                 | CUPATI ONAL THERAPY                                    | 0. 00<br>67. 00            | 0                              | 29. 00<br>30. 00 |
| 30.00            | therapy costs in excess of                                   | 7 0-0        |                   | OSTATIONAL ITEMALI                                     | 37.00                      |                                | 30.00            |
| 30. 99           | limitation (chapter 14)<br>Hospice (non-distinct) (see       |              | OAD               | ULTS & PEDIATRICS                                      | 30. 00                     |                                | 30. 99           |
|                  | instructions)  |              |                   |  |                            |                                |                  |
|                  |  |              |                   |  |                            |                                |                  |

Provi der CCN: 15-0037

| 7.5000           | INICITIS TO EXICINOES                                      |                    |           |  | From 01/01/2023<br>Fo 12/31/2023 | Date/Time Pre     | pared:           |
|------------------|--|--------------------|-----------|--|----------------------------------|-------------------|------------------|
|                  |  |                    |           | Expense Classification on                            |                                  | 5/31/2024 7:0     | 1 am             |
|                  |  |                    |           | To/From Which the Amount is                          | to be Adjusted                   |                   |                  |
|                  |  |                    |           |  |                                  |                   |                  |
|                  |  |                    |           |  |                                  |                   |                  |
|                  |  |                    |           |  |                                  |                   |                  |
|                  | Cost Center Description                                    | Basi s/Code<br>(2) | Amount    | Cost Center  | Li ne #                          | Wkst. A-7<br>Ref. |                  |
| 31 00            | Adjustment for speech                                      | 1. 00<br>A-8-3     | 2. 00     | 3.00<br>SPEECH PATHOLOGY                             | 4. 00                            | 5. 00             | 31.00            |
| 31.00            | pathology costs in excess of                               | K 0 3              | J         | SI LEGII I ATTIOLOGI                                 | 00.00                            |                   | 31.00            |
| 32. 00           | limitation (chapter 14)<br>CAH HIT Adjustment for          |                    | 0         |  | 0.00                             | 0                 | 32.00            |
| 33. 00           | Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY)      |                    | 0         |  | 0.00                             | 0                 | 33.00            |
| 33. 01           | (3)<br>OTHER ADJUSTMENTS (SPECIFY)                         |                    | 0         |  | 0.00                             | 0                 | 33. 01           |
|                  | (3)  |                    |           |  |                                  |                   |                  |
| 33. 02           | OTHER ADJUSTMENTS (SPECIFY) (3)                            |                    | o o       |  | 0.00                             | 0                 |                  |
| 33. 03           | OTHER ADJUSTMENTS (SPECIFY) (3)                            |                    | O         |  | 0.00                             | 0                 | 33. 03           |
| 33. 04           | OTHER ADJUSTMENTS (SPECIFY) (3)                            |                    | 0         |  | 0.00                             | 0                 | 33. 04           |
| 33. 05           | OTHER ADJUSTMENTS (SPECIFY) (3)                            |                    | 0         |  | 0.00                             | 0                 | 33. 05           |
| 33. 06           | OTHER ADJUSTMENTS (SPECIFY)                                |                    | 0         |  | 0.00                             | 0                 | 33.06            |
| 33. 07           | (3)<br>OTHER ADJUSTMENTS (SPECIFY)                         |                    | 0         |  | 0. 00                            | 0                 | 33. 07           |
| 33. 08           | (3)<br>OTHER ADJUSTMENTS (SPECIFY)                         |                    | 0         |  | 0.00                             | 0                 | 33. 08           |
| 33. 09           | (3)<br>HRH MMO RENTAL INCOME                               | В                  | -150      | NEW CAP REL COSTS-BLDG &                             | 1.00                             | 10                | 33. 09           |
| 33. 10           | HRH HUMAN RESSOURCES MISC REV                              | В                  |           | FIXT<br>EMPLOYEE BENEFITS DEPARTMEN                  | T 4.00                           | 0                 | 33. 10           |
| 33. 11<br>33. 12 | HRH OTHER ADR REV SALES TAX<br>HRH OTHER REVENUE MISC REV  | B<br>B             | 1, 540    | ADMINISTRATIVE & GENERAL<br>ADMINISTRATIVE & GENERAL | 5. 00<br>5. 00                   | 0                 |                  |
| 33. 12           | HRH MED STAFF SERV QA                                      | В                  |           | ADMINISTRATIVE & GENERAL                             | 5. 00                            | 0                 |                  |
| 33. 14           | APPLICATION FE<br>HRH MED STAFF SERV MISC REV              | В                  | -2, 190   | ADMINISTRATIVE & GENERAL                             | 5. 00                            | 0                 | 33. 14           |
| 33. 15           | HRH MEDICAL DUES MEDICAL STAFF DUES                        | В                  | -29, 700  | ADMINISTRATIVE & GENERAL                             | 5. 00                            | 0                 | 33. 15           |
| 33. 16           | HRH PAT FIN SEV BUS SVC COPY FEES                          | В                  | -1, 130   | ADMINISTRATIVE & GENERAL                             | 5. 00                            | 0                 | 33. 16           |
| 33. 17<br>33. 18 | HRH INFO SERVICES MISC REVENUE<br>HRH ACCOUINTING MISC REV | B<br>B             |           | ADMINISTRATIVE & GENERAL<br>ADMINISTRATIVE & GENERAL | 5. 00<br>5. 00                   | 0                 | 33. 17<br>33. 18 |
| 33. 19           | HRH ACCOUNTING MANAGEMENT FEES                             |                    | 0         |  | 0.00                             | 0                 | 33. 19           |
| 33. 20<br>33. 21 | HRH EXEC ADMIN MISC REVENUE HRH PURCHASING MISC REV        | B<br>B             | i         | ADMINISTRATIVE & GENERAL<br>ADMINISTRATIVE & GENERAL | 5. 00<br>5. 00                   | 0                 |                  |
| 33. 22           | HRH COMMUINCATIONS MISC REV                                | В                  | 0         |  | 0.00                             | 0                 | 33. 22           |
| 33. 23           | HRH COMMUNICATIONS PHONE LEASE<br>REV                      |                    |           | ADMINISTRATIVE & GENERAL                             | 5. 00                            | 0                 |                  |
| 33. 24<br>33. 25 | HRH COMM EDUCATION SERVICE REV                             | B<br>B             |           | ADMINISTRATIVE & GENERAL<br>ADMINISTRATIVE & GENERAL | 5. 00<br>5. 00                   | 0                 |                  |
| 33. 26           | HRH GAIN/LOSS GROSS VARIANCE                               | В                  | 13, 102   | ADMINISTRATIVE & GENERAL                             | 5. 00                            | 0                 | 33. 26           |
| 33. 27           | OTHER ADJUSTMENTS (SPECIFY)                                |                    | 0         |  | 0.00                             | 0                 | 33. 27           |
| 33. 28           | (3)<br>HRH CARDIO SERV MISC REV                            | В                  |           | ELECTROCARDI OLOGY                                   | 69. 00                           | 0                 |                  |
| 33. 29<br>33. 30 | HRH DIAG IMAGING MISC REV<br>HRH PLANT OFFSITE SERV        | B<br>B             | l .       | RADI OLOGY-DI AGNOSTI C<br>OPERATI ON OF PLANT       | 54. 00<br>7. 00                  | 0                 |                  |
| 33. 31           | HRH HOUSEKEEPING ENVIRON SERVICES                          | В                  |           | HOUSEKEEPI NG  | 9. 00                            | 0                 | 1                |
| 33. 32           | HRH NUTRITIONAL SER LTACH REV                              | В                  | -122, 046 |  | 10. 00                           | 0                 |                  |
| 33. 33<br>33. 34 | HRH NUTRITIONAL SER MISC REV HRH NUTRITIONAL SER           | B<br>B             |           | DI ETARY<br>DI ETARY                                 | 10. 00<br>10. 00                 | 0                 |                  |
| 33. 35           | REBATES/REFUNDS<br>HRH CLINICAL EDUCAT AHA COURSE          | В                  | -14, 740  | NURSING ADMINISTRATION                               | 13. 00                           | 0                 | 33. 35           |
| 33. 36           | REV<br>HRH CLINICAL ECUATION SERVICE                       | В                  | 0         |  | 0.00                             | 0                 |                  |
|                  | REV  |                    |           |  |                                  |                   |                  |
| 33. 37           | HRH OTHER REVENUE REBATES/REFUNDS                          | В                  |           | CENTRAL SERVICES & SUPPLY                            | 14.00                            | 0                 |                  |
| 33. 38           | HRH OTHER REV DISCOUNTS EARNED<br>ON IN                    |                    |           | CENTRAL SERVICES & SUPPLY                            | 14. 00                           | 0                 |                  |
| 33. 39           | HRH PHARMACY MISC REV                                      | В                  | -192      | PHARMACY   | 15. 00                           | 0                 | 33. 39           |

Heal th Financial Systems

ADJUSTMENTS TO EXPENSES

HANCOCK REGIONAL HOSPITAL

Provider CCN: 15-0037

Period:
From 01/01/2023
To 12/31/2023

Period:
From 01/01/2023
To 12/31/2023

Date/Time Prepared:
5/31/2024 7: 01 am

Expense Classification on Worksheet A
To/From Which the Amount is to be Adjusted

|                  |  |             |              |   |                | 5/31/2024 7: 0 |          |
|------------------|--|-------------|--------------|---|----------------|----------------|----------|
|                  |  |             |              | Expense Classification on V                       |                |                |          |
|                  |  |             |              | To/From Which the Amount is t                     | o be Adjusted  |                |          |
|                  |  |             |              |   |                |                |          |
|                  |  |             |              |   |                |                |          |
|                  |  |             |              |   |                |                |          |
|                  |  |             |              |   |                |                |          |
|                  |  |             |              |   |                |                |          |
|                  | Coot Contor Decerintian  | Basi s/Code | Amount       | Coot Conton                                       | Li ne #        | Wkst. A-7      |          |
|                  | Cost Center Description  | (2)         | Amount       | Cost Center                                       | Little #       | Ref.           |          |
|                  |  | 1. 00       | 2. 00        | 3.00  | 4. 00          | 5. 00          |          |
| 33. 40           | HRH PHARMACY REBATES/REFUNDS   | В           |              | PHARMACY  | 15. 00         | 0.00           | 33. 40   |
| 33. 41           | HRH ASSOC PHARM RETAIL PHARM   | В           | -1, 318, 079 |   | 15. 00         | 0              | 1        |
| 00               | REV  | 5           | 1,0.0,0,     |   | .0.00          | · ·            | 00       |
| 33. 42           | HRH ASSOC PHARM HOSPICE  | В           | -227, 427    | PHARMACY  | 15. 00         | 0              | 33. 42   |
|                  | PHARMACY REV   |             | ,            |   |                |                |          |
| 33. 43           | HRH ASSOC PHARM PHARMACY MED   | В           | -4, 694      | PHARMACY  | 15. 00         | 0              | 33. 43   |
|                  | TO BED   |             |              |   |                |                |          |
| 33.44            | HRH ASSOC PHARM MISC REV   | В           | -89, 298     | PHARMACY  | 15. 00         | 0              | 33.44    |
| 33. 45           | HRH HEALTH INFO SER MED REC  | В           | -216         | MEDICAL RECORDS & LIBRARY                         | 16. 00         | 0              | 33. 45   |
|                  | COPY FEE   |             |              |   |                |                |          |
| 33. 46           | HRH HEALTH INFO SER MISC REV   | В           |              | MEDICAL RECORDS & LIBRARY                         | 16. 00         | 0              |          |
| 33. 47           | HRH XRAY SCHOOL TUITION  | В           | -40, 335     | PARAMED ED PRGM                                   | 23. 00         | 0              | 33. 47   |
| 33. 48           | HRH MED/SURG 2 EAST MISC REV   | В           | 0            |   | 0. 00          | 0              | 33. 48   |
| 33. 49           | HRH ANDIS UNIT REBATES/REFUND  | В           | 0            |   | 0. 00          | 0              | 33. 49   |
| 33. 50           | HRH SURGERY REBATES/REFUNDS  | В           |              | OPERATING ROOM                                    | 50.00          | 0              | 33.50    |
| 33. 51           | HRH LAB WATER TESETING   | В           |              | LABORATORY  | 60.00          | 0              |          |
| 33. 52           | HRH LAB DI RECT TESTS  | В           | · ·          | LABORATORY  | 60.00          | 0              | 33. 52   |
| 33. 53           | HRH LAB MISC REV   | В           | -528, 760    | LABORATORY  | 60.00          | 0              | 1        |
| 33. 54           | HRH LAB WATER LAB WATER  | В           | 0            |   | 0. 00          | 0              | 33.54    |
| 22 EE            | TESTING HRH SLEEP STUDY CLINIC   | В           | 2 250        | DECDI DATODY THEDADY                              | 4F 00          | 0              | 22 55    |
| 33. 55           | MANAGEMENT   | В           | -2, 250      | RESPI RATORY THERAPY                              | 65. 00         | 0              | 33. 55   |
| 33. 56           | HRH SLEEP STUDY FEES   | В           | 0            | RESPI RATORY THERAPY                              | 65. 00         | 0              | 33.56    |
| 33. 57           | HRH CATH LAB REBATES/REFUNDS   | В           |              | ELECTROCARDI OLOGY                                | 69. 00         | 0              | 33.50    |
| 33. 58           | HRH MED ONCOLOGY MISC REV  | В           |              | ONCOLOGY  | 90. 07         | 0              | 1        |
| 33. 59           | HRH ER REBATES/REFUNDS   | В           |              | EMERGENCY   | 91. 00         | 0              | 33.59    |
| 33. 60           | HRH HOSPICE MISC REV   | В           |              | ADULTS & PEDIATRICS                               | 30. 00         | 0              |          |
| 33. 61           | MOW  | A           | -632, 611    |   | 10. 00         | 0              | 33.61    |
| 33. 62           | CAFETERIA GUEST MEALS  | A           |              | CAFETERI A  | 11. 00         | 0              | 33.62    |
| 33. 63           | PHYSICIAN RECRUITMENT FEES   | A           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              | 1        |
| 33. 64           | DONATIONS & SPONSORSHIPS   | A           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              | 33.64    |
| 33. 65           | ADVERTISING FEE  | A           |              | EMPLOYEE BENEFITS DEPARTMENT                      | 4. 00          | 0              | 33.65    |
| 33. 66           | ADVERTISING FEE  | A           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              | 33.66    |
| 33. 67           | ADVERTISING FEE  | В           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              | 1        |
| 33. 68           | ADVERTISING FEE  | В           |              | ADULTS & PEDIATRICS                               | 30.00          | 0              | 33. 68   |
| 33. 69           | ADVERTISING FEE  | В           |              | OPERATI NG ROOM                                   | 50.00          | 0              | 33. 69   |
| 33. 70           | ADVERTI SING FEE   | В           |              | RADI OLOGY-DI AGNOSTI C                           | 54. 00         | 0              | 33. 70   |
| 33. 71           | ADVERTI SI NG FEE  | В           |              | RURAL HEALTH CLINIC                               | 88. 00         | 0              | 33. 71   |
| 33. 72           | ADVERTISING FEE  | Α           |              | SHELBYVILLE WOUND CLINIC                          | 90. 06         | 0              | 1        |
| 33. 73           | I HA LOBBYING EXPENSE  | Α           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              | 33. 73   |
| 33.74            | AHA LOBBYING EXPENSE   | Α           | -6, 829      | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              | 33. 74   |
| 33. 75           | PHYS OFFICE BLDG DEPR EXP  | Α           | -717, 842    | NEW CAP REL COSTS-BLDG &                          | 1.00           | 9              | 33. 75   |
|                  |  |             |              | FLXT  |                |                |          |
| 33. 76           | PHY OFFICE BLDG  | Α           |              | RADI OLOGY-DI AGNOSTI C                           | 54.00          | 0              | 33. 76   |
| 33. 77           | PHY OFFICE BLDG  | Α           |              | RURAL HEALTH CLINIC                               | 88. 00         | 0              | 33. 77   |
| 33. 78           | INTEREST INCOME  | В           |              | NEW CAP REL COSTS-BLDG &                          | 1. 00          | 11             | 33. 78   |
|                  |  |             |              | FLXT  |                |                |          |
| 33. 79           | RENTAL PROPERTIES EXPENSE  | Α           | -100, 059    | NEW CAP REL COSTS-BLDG &                          | 1. 00          | 10             | 33. 79   |
| 00               | DENTAL PROPERTY SO STITLING  |             | 04= =        | FIXT  |                | _              | 00.5-    |
| 33. 80           | RENTAL PROPERTIES EXPENSE  | A           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              |          |
| 33. 81           | RENTAL PROPERTIES EXPENSE  | A           |              | OPERATION OF PLANT                                | 7.00           | 0              |          |
| 33. 82           | 1  | A           |              | OPERATION OF PLANT                                | 7. 00          | 0              |          |
| 33. 83           | TELEPHONE SERVICES   | A           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              |          |
| 33. 84           | 1  | A           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              |          |
| 33. 85           | SELF INSURANCE CLAIM EXPENSE   | A           |              | EMPLOYEE BENEFITS DEPARTMENT                      | 4. 00          | 0              |          |
| 33. 86           | HHA MISC REV   | В           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              |          |
| 33. 87           | HRH NUTRITIONAL SER CAFE SALAD   | В           | - /42        | DI ETARY  | 10. 00         | 0              | 33. 87   |
| 22 00            | ROBOT  | D           | 2 400        | ODERATION OF DIANT                                | 7 00           | 0              | 33.88    |
| 33.88            | HRH PLANT MISC REV   | В           |              | OPERATION OF PLANT                                | 7. 00          | 0              | 1        |
| 33. 89<br>33. 90 | HRH PAT FIN SERV EXPENSE REIMB   | B<br>B      |              | ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL | 5. 00<br>5. 00 | 0              |          |
| 33. 90           | HRH PURCHASING REBATES/REFUNDS HRH HIFI MISC REV   | В           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              |          |
| 33. 91           |  | A           |              | ANDIS CLINIC                                      | 90. 04         | 0              | 1        |
| 33. 92           | ADVERTISING FEE  | A           |              | ANDERSON WOMENS CENTER                            | 90. 08         | 0              | 1        |
| 33. 94           | ADVERTISING FEE  | A           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          | 0              | 1        |
|                  | HRH ACCT ACCRUALS MISC REV   | В           |              | ADMINISTRATIVE & GENERAL                          | 5. 00          |                | 33. 95   |
| 55. 75           | The state of the s | 5           |              | ,   | 3. 30          | O              | , 55. 75 |
|                  |  |             |              |   |                |                |          |

|        |                                |            |               |                             | 0 12/31/2023 | Date/IIme Pre<br>  5/31/2024 7:0 |        |
|--------|--------------------------------|------------|---------------|-----------------------------|--------------|----------------------------------|--------|
|        |                                |            |               | Expense Classification on   | Worksheet A  | 0,01,2021 ,10                    |        |
|        |                                |            |               | To/From Which the Amount is |              |                                  |        |
|        |                                |            |               |                             |              |                                  |        |
|        |                                |            |               |                             |              |                                  |        |
|        |                                |            |               |                             |              |                                  |        |
|        |                                |            |               |                             |              |                                  |        |
|        |                                |            |               |                             |              |                                  |        |
|        |                                |            |               |                             |              |                                  |        |
|        | Cost Center Description        | Basis/Code | Amount        | Cost Center                 | Li ne #      | Wkst. A-7                        |        |
|        |                                | (2)        |               |                             |              | Ref.                             |        |
|        |                                | 1. 00      | 2. 00         | 3. 00                       | 4. 00        | 5. 00                            |        |
| 33. 96 | HRH NURSING ADMIN MISC REV     | В          |               | NURSING ADMINISTRATION      | 13. 00       | 0                                |        |
| 33. 97 | HRH PHYSICAL THER MISC REV     | В          |               | PHYSI CAL THERAPY           | 66. 00       | 0                                |        |
| 33. 98 | HRH GATEWAY PROP MISC REV      | В          | 0             | ADMINISTRATIVE & GENERAL    | 5. 00        | 0                                | 33. 98 |
| 33. 99 | HRH MCCORDSVILLE P RENTAL INC  | В          |               | ADMINISTRATIVE & GENERAL    | 5. 00        | 0                                | 33. 99 |
| 34.00  | HRH IMMED CARE RAD RENTAL      | В          | -8, 236       | PRIME TIME                  | 90. 05       | 0                                | 34.00  |
|        | INCOME                         |            |               |                             |              |                                  |        |
| 34.01  | HRH VACCINE CLINIC MANAGEMENT  | В          | ·             | PHARMACY                    | 15. 00       | 0                                |        |
| 34.02  | HRH PAT FIN SERV MISC REV      | В          |               | ADMINISTRATIVE & GENERAL    | 5. 00        | 0                                | 34. 02 |
| 34.03  |                                | В          |               | ADULTS & PEDIATRICS         | 30.00        | 0                                | 34.03  |
| 34.04  | HRH ANDIS UNIT MISC REV        | В          |               | ADULTS & PEDIATRICS         | 30.00        | 0                                | 34.04  |
| 34.05  | HRH XRAY SCHOOL STUDENT        | В          | 468           | PARAMED ED PRGM             | 23. 00       | 0                                | 34.05  |
|        | ACTI VI TI ES                  |            |               |                             |              |                                  |        |
| 34.06  | HRH XRAY SCHOOL MISC REV       | В          |               | PARAMED ED PRGM             | 23. 00       | 0                                |        |
| 34.07  | HRH SLEEP STUDY MISC REV       | В          |               | RESPI RATORY THERAPY        | 65. 00       | 0                                |        |
| 34.08  | HRH OTHRE REVENUE FOOD & BEV   | В          | 6, 919        | DI ETARY                    | 10. 00       | 0                                | 34. 08 |
|        | TAX                            |            |               |                             |              |                                  |        |
| 34.09  | HRH OB ANEST INCOME            | В          |               | OPERATING ROOM              | 50. 00       | 0                                | 34. 09 |
| 34. 10 | HRH KNIGHTSTOWN OFF MISC REV   | В          | ·             | RURAL HEALTH CLINIC         | 88. 00       | 0                                | 34. 10 |
| 34. 11 | HRH VOLUNTEERS                 | В          | -22           | ADMINISTRATIVE & GENERAL    | 5. 00        | 0                                | 0      |
| 50.00  | TOTAL (sum of lines 1 thru 49) |            | -32, 126, 675 |                             |              |                                  | 50.00  |
|        | (Transfer to Worksheet A,      |            |               |                             |              |                                  |        |
|        | column 6, line 200.)           |            |               |                             |              |                                  |        |

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-0037

|        |                |                                     |                       |                       | 1                      | To 12/31/2023 | B Date/Time Pro<br>5/31/2024 7:0 |        |
|--------|----------------|-------------------------------------|-----------------------|-----------------------|------------------------|---------------|----------------------------------|--------|
|        | Wkst. A Line # | Cost Center/Physician               | Total                 | Professi onal         | Provi der              | RCE Amount    | Physi ci an/Prov                 |        |
|        |                | l denti fi er                       | Remuneration          | Component             | Component              |               | ider Component                   |        |
|        |                |                                     |                       |                       |                        |               | Hours                            |        |
|        | 1. 00          | 2. 00                               | 3. 00                 | 4. 00                 | 5. 00                  | 6. 00         | 7. 00                            |        |
| 1.00   |                | ADMINISTRATIVE & GENERAL            | 452, 639              |                       | 0                      | 211, 500      | 0                                | 1.00   |
| 2.00   |                | ADULTS & PEDIATRICS                 | 603, 449              | 603, 449              | 0                      | 211, 500      | 0                                | 2.00   |
| 3.00   |                | OPERATING ROOM                      | 2, 744, 727           |                       | 0                      | 246, 400      |                                  | 0.00   |
| 4.00   |                | RADI OLOGY-DI AGNOSTI C             | 706, 141              |                       |                        | 211, 500      |                                  | 1      |
| 5.00   |                | LABORATORY                          | 142, 154              | 109, 459              | 32, 695                | 211, 500      | 482                              |        |
| 6.00   |                | WOUND CLINIC                        | 302, 013              |                       |                        | 211, 500      | 0                                |        |
| 7.00   |                | DIABETES CLINIC                     | 26, 975               | 26, 975               | 0                      | 211, 500      | 0                                | 1      |
| 8.00   | 90. 04         | ANDIS CLINIC                        | 0                     | 0                     | 0                      | 211, 500      | 0                                | 8.00   |
| 9.00   | 90. 07         | ONCOLOGY                            | 1, 251, 132           | 1, 251, 132           | 0                      | 211, 500      | 0                                | 9.00   |
| 10.00  | 90. 08         | ANDERSON WOMENS CENTER              | 333, 300              | 333, 300              | 0                      | 211, 500      |                                  | 10.00  |
| 11.00  | 91. 00         | EMERGENCY                           | 135, 000              | 135, 000              | 0                      | 211, 500      | 0                                | 11.00  |
| 200.00 |                |                                     | 6, 697, 530           | 6, 664, 835           | 32, 695                |               | 482                              |        |
|        | Wkst. A Line # | Cost Center/Physician               | Unadjusted RCE        | 5 Percent of          | Cost of                | Provi der     | Physician Cost                   |        |
|        |                | l denti fi er                       | Limit                 |                       | Memberships &          | 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  |                | ADMI NI STRATI VE & GENERAL         | 0                     |                       | _                      | 0             |                                  |        |
| 2. 00  |                | ADULTS & PEDIATRICS                 | 0                     | 1                     | J                      | 0             |                                  |        |
| 3. 00  |                | OPERATING ROOM                      | 0                     | 0                     | J                      | 0             | 0                                |        |
| 4. 00  |                | RADI OLOGY-DI AGNOSTI C             | 0                     | 0                     | -                      | 0             | 0                                |        |
| 5. 00  |                | LABORATORY                          | 49, 011               | 1                     |                        | 0             | 0                                |        |
| 6. 00  |                | WOUND CLINIC                        | 0                     | 0                     | 0                      | 0             | 0                                |        |
| 7. 00  |                | DI ABETES CLINIC                    | 0                     | 0                     | 0                      | 0             | 0                                | 7.00   |
| 8. 00  |                | ANDIS CLINIC                        | 0                     | 0                     | 0                      | 0             | 0                                |        |
| 9. 00  |                | ONCOLOGY                            | 0                     | 0                     | 0                      | 0             | 0                                | 7.00   |
| 10.00  |                | ANDERSON WOMENS CENTER              | 0                     | 0                     | 0                      | 0             | 0                                |        |
| 11.00  | 91.00          | EMERGENCY                           | 0                     | 0                     | 0                      | 0             | 0                                | 1      |
| 200.00 | MII - 1 A 1 "  | 01.01/Dl                            | 49, 011               |                       |                        | 0             | 0                                | 200.00 |
|        | Wkst. A Line # | Cost Center/Physician<br>Identifier | Provider<br>Component | Adjusted RCE<br>Limit | RCE<br>Di sal I owance | Adjustment    |                                  |        |
|        |                | rdentrirei                          | Share of col.         | LIMIL                 | Di Sai i Owance        |               |                                  |        |
|        |                |                                     | 14                    |                       |                        |               |                                  |        |
|        | 1. 00          | 2.00                                | 15. 00                | 16. 00                | 17. 00                 | 18. 00        |                                  |        |
| 1. 00  |                | ADMINISTRATIVE & GENERAL            | 0                     |                       |                        | 452, 639      |                                  | 1.00   |
| 2. 00  |                | ADULTS & PEDIATRICS                 | 0                     |                       |                        | 603, 449      | •                                | 2.00   |
| 3. 00  |                | OPERATING ROOM                      | 0                     |                       |                        | 2, 744, 727   |                                  | 3.00   |
| 4. 00  |                | RADI OLOGY-DI AGNOSTI C             | 0                     | _                     |                        | 706, 141      |                                  | 4.00   |
| 5. 00  |                | LABORATORY                          | 0                     | _                     | _                      | 109, 459      |                                  | 5.00   |
| 6. 00  |                | WOUND CLINIC                        | 0                     | 17,011                |                        | 302, 013      | •                                | 6.00   |
| 7. 00  |                | DI ABETES CLINIC                    | l n                   | i o                   | -                      | 26, 975       | •                                | 7.00   |
| 8. 00  |                | ANDIS CLINIC                        | Ö                     | _                     | -                      | 25,776        |                                  | 8.00   |
| 9. 00  |                | ONCOLOGY                            | 0                     | l o                   | 0                      | 1, 251, 132   |                                  | 9.00   |
| 10.00  |                | ANDERSON WOMENS CENTER              | l ő                   | Ö                     | 0                      | 333, 300      | •                                | 10.00  |
| 11. 00 |                | EMERGENCY                           | l ő                   | · ·                   | _                      | 135, 000      | •                                | 11.00  |
| 200.00 |                |                                     | Ö                     | 49, 011               | -                      |               | •                                | 200.00 |
|        | 1              |                                     | '                     |                       | 1                      |               | 1                                |        |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0037

| Cost   Center   Description  |                             |  |              | То          | 12/31/2023    | Date/Time Pre 5/31/2024 7:0 |         |
|--|-----------------------------|--|--------------|-------------|---------------|-----------------------------|---------|
| Cost Center Description  |                             |  | CAPI TAL     |             |               | 7 37 3 17 2024 7.0          | i diii  |
| PRINCE   P   |                             | _  |              |             |               |                             |         |
| BANKERS   A   DEPARTMENT   DE   | Cost Center Description     |  |              |             | Subtotal      |                             |         |
| Column   C   |                             |  | FIXI         |             |               | E & GENERAL                 |         |
|  |                             |  |              | DEPARTMENT  |               |                             |         |
| D  |                             |  |              |             |               |                             |         |
| 1.00   |                             |  | 1. 00        | 4.00        | 4A            | 5. 00                       |         |
| 4.00 DOOOD EMPLOYEE ERREIT TO DEPARTMENT 7, 190, 190 S8, 250 7, 278, 490 C 24, 745, 184 C 24, 745, 184 C 5, 00 DOOD OWN HISTATIVE & GENERAL 22, 227 1, 14, 00 77 1, 00 77 1, 00 235 C 24, 745, 184 C 5, 00 DOOD OWN HISTATIVE & GENERAL 22, 227 1, 14, 00 77 1, 120, 635 C 3, 13, 902, 805 C 25, 522, 27 9, 70 0 DOOD OWN HISTATIVE & GENERAL 22, 281 B, 280, 290 C 10, 467 1, 120, 635 C 3, 13, 902, 805 C 25, 522, 290 7, 70 0 DOOD OWN HISTATIVE & GENERAL 24, 281 B, 280, 290 C 10, 467 1, 127, 290 C 199, 944 1, 10 0 DOOD OWN HISTATIVE & GENERAL 24, 281 B, 280, 290 C 10, 467 C 1, 127, 290 C 199, 944 1, 10 0 DOOD OWN HISTATIVE & GENERAL 24, 281 B,  |                             |  |              |             |               | Г                           |         |
| 5.00   0.0000 ADM IN STRATTIVE & CENERAL   22, 218, 271   1, 439, 077   1, 097, 836   24, 745, 184   24, 745, 184   2, 70, 00   0.0000 (PREATION OF PLATEY   7, 609, 151   6, 665, 019   12, 025   13, 030, 005   1, 000   10, 0   |                             |  |              |             |               |                             | 1       |
| 7.00 DOTOOD DEFIRATION OF PLANT  |                             |  |              |             | 24 745 184    | 24 745 184                  | 1       |
| 9.00   00000   00000     00000     00000     00000     00000     00000     00000     00000     00000     00000     00000     00000     00000   00000     00000     00000     00000     00000     00000     000000  |                             |  |              |             |               |                             | 1       |
| 11.00   01100  CAFETERIA   1.000, 802   0   104, 467   1,127, 266   33, 083   13, 00   130, 00   |                             |  |              |             |               |                             | •       |
| 13.00   01300   NIRSI NE ADMINISTRATION   1.812_772   34,955   146,830   1,994,502   333,688   13.00   15.00   10500   PHARMACY   1.962_013   262_6767   260_600   2,494_250   412_302   15.00   10500   PHARMACY   1.962_013   262_6767   260_600   2,494_250   412_302   15.00   10500   PHARMACY   1.962_013   262_6767   260_600   2,494_250   412_302   15.00   15.00   10500   PHARMACY   1.962_013   43.170   2.865   17.570   41.265   2.065   |                             | 682, 638                                       | 336, 491     | 66, 027     | 1, 085, 156   | 192, 426                    | 10.00   |
| 14.00   014000  CNTRML SERVICES & SUPPLY   |                             |  | _            |             |               |                             | 1       |
| 15.00   01500   PHARBACY   1, 962   015   262   670   269, 600   2, 494, 289   442, 302   15.00   23.00   02300   PARAMED LD PIGUI NESS   74.60   33.170   9,955   17.591   20,951   20,051      |                             |  |              |             |               | 1                           | ł       |
| 16.00   01-000  MEDICAL RECORDS & LIBRARY   1,220,018   64,733   73,704   1,388,458   240,889   16.00   30.00   01-000  MEDICAL RECORDS   74,561   33,170   9,856   111,587   20,851   23.00   33.00   01-000  MEDICAL RECORDS   74,561   30,170   449,915   6,96,604   1,233,587   30.00   33.00   01-0000  MEDICAL RECORDS   1,434,173   31.00   01-0000  MEDICAL RECORDS   1,443,173   30.00   31.00   3   |                             |  |              |             |               | 1                           | 1       |
| 13.00   10.0   |                             |  |              |             |               | 1                           | ł       |
| 30.00   30300   ADULTS & PEDIATRICS   5, 464, 015   1,052, 674   439, 915   6, 956, 604   1,233, 587   30.00   310.00   310.00   310.00   0   0   0   0   0   0   0   0   0  |                             |  |              |             |               |                             | 1       |
| 31.00     OSTOD    INTERSIVE CARE UNIT     6,88,405   798,112   453,258   8,087,775   1,434,173   31.00   0.00     |                             |  |              | ,           |               |                             |         |
| 40,00   0.0000   SUBPROVIDER - I PF  |                             |  |              |             |               |                             | •       |
| MACILLARY SERVICE COST CENTERS   5, 484, 908   459, 175   486, 849   6, 430, 932   1, 140, 371   50  |                             |  |              |             |               |                             | •       |
| 50.00  |                             |  |              | 0           |               |                             | 1 40.00 |
| 53.00  |                             | 5, 484, 908                                    | 459, 175     | 486, 849    | 6, 430, 932   | 1, 140, 371                 | 50.00   |
| 54. 00 0 64000 RADIOLOGY-DIAGNOSTIC 5 9,920,164 894,128 477, 403 7, 291,695 1,293,007 54, 00 0.0 6000 LABORATION** 5. 735,986 19,654 211,148 6,136,788 1,088,212 60.00 650.00 66500 RESPIRATORY THERAPY 2,242,963 197,763 189,241 2,729,967 484,094 65.00 60.00 6000 PhySICAL THERAPY 1,361,186 169,07 119,383 1,649,63 292,523 66.00 67.00 6700 0CUPATIONAL THERAPY 382,473 0 34,825 417,298 73,998 67.00 6700 0CUPATIONAL THERAPY 382,473 0 34,825 417,298 73,998 67.00 6900 ELECTROCARDIOLOGY 1,013,851 161,587 75,394 1,250,832 221,805 69.00 70.00 1000 ELECTROCARDIOLOGY 1,013,851 161,587 75,394 1,250,832 221,805 69.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |                             | 595, 628                                       |              |             |               | 1                           | •       |
| 0.000   0.0000   LABORATORY   1,088, 212   0.00   0.000   0.6000   RESPIRATORY THERAPY   2,342,963   197,65   191,965   211,148   0,136,788   1,089,212   0.00   0.6600   PHYSICAL THERAPY   1,361,186   169,067   119,383   1,649,636   292,523   66.00   0.00   0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.0000000   0.00000000   |                             | 0  | ·            | 1           | -             |                             | 1       |
| 65.00  |                             |  |              |             |               |                             | •       |
| 66.0 0   66600   PHYSICAL THERAPY   1,361,186   169,067   119,385   1.649,636   292,523   66.00   68.0 0   66900   CEUPATIONAL THERAPY   382,473   0   348,825   417,298   73,998   67,00   68.0 0   66900   SPEECH PATHOLOGY   243,188   0   22,136   265,324   47,049   68.00   67.0 0   67000   ELECTROCRABIOLOGY   1,013,851   161,587   75,394   1,256,832   221,805   69,00   67.0 0   07000   ELECTROCRABIOLOGY   1,013,851   161,587   75,394   1,256,832   221,805   69,00   67.0 0   07000   ELECTROCRAGEPHALOGRAPHY   0   0   0   0   0   0   0   0   67.0 0   07000   ELECTROCRAGED TO PATIENTS   3,588,967   665,417   71,00   72.0 0   07200   IMPL. DEV. CHARGED TO PATIENTS   22,613,996   0   0   0   0   22,613,996   0   0   0   0   0   0   0   0   0  |                             |  |              |             |               |                             | 1       |
| 67.00   06/7000   06/7000   06/7000   06/7000   06/7000   06/7000   06/7000   06/7000   06/7000   06/70000      |                             |  |              |             |               | l                           | ł       |
| 69.00   06900   ELECTROCARDIOLOGY   1.013,851   161,587   75,994   1.250,832   221,805   69.00   71.00   07100   ELECTROCARDIOLOGY   1.00   0   0   0   0   0   0   0   0   0  |                             |  |              |             |               | l                           | 1       |
| 0   0   0   0   0   0   0   0   0   0  |                             | 243, 188                                       | 0            |             | 265, 324      | 47, 049                     | 68. 00  |
| 17.00   O7100   MEDICAL SUPPLIES CHARGED TO PATIENTS   3,588,967   0   0   3,588,967   636,417   71.00   |                             | 1, 013, 851                                    |              |             |               | 1                           | 1       |
| 1.   1.   1.   1.   1.   1.   1.   1.  |                             | 2 500 067                                      | _            | 1           | ū             |                             | •       |
| 73.00   07300   07300   0740   |                             |  | 0            | _           |               |                             | •       |
| 76. 01   03160   CARDI OPULIMONARY   78,600   43,586   7,216   129,411   22,948   76. 01   77. 00   0700   0.0     |                             |  | 0            | - 1         |               |                             | •       |
| 77.00  | 76. 00 03020 CARDI AC       | 0  | 0            | 0           | 0             |                             | 1       |
| 18.00  |                             | 78, 609  | 43, 586      |             |               | 1                           | 1       |
| OUTPATLENT SERVICE COST CENTERS  |                             | 0  | 0            |             |               |                             | 1       |
| 90. 00   09000   CLI NI C  |                             |  |              | <u> </u>    |               |                             | 70.00   |
| 90. 01   09001   09001   09001   000IND CLINIC   738, 107   117, 127   59, 003   914, 237   162, 118   90. 01   90. 02   09002   DI ABETES CLINIC   45, 416   0   3, 989   49, 405   8, 761   90. 02   90. 03   09003   ASTHMA CLINIC   0   0   0   0   0   0   0   90. 04   09004   ANDIS CLINIC   194, 525   16, 707   12, 387   223, 619   39, 653   90. 04   90. 05   09005   PRI ME T IME   -4, 968   0   0   -4, 968   0   0   -4, 968   0   90. 06   09006   SHELBYVI LLE WOUND CLINIC   0   0   0   0   0   0   0   0   90. 07   04951   ONCOLOGY   2, 000, 500   515, 799   302, 032   28, 183, 331   499, 763   90. 07   90. 08   04950   ANDERSON WOMENS CENTER   931, 357   143, 132   65, 207   1, 139, 696   202, 098   90. 88   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   90. 07   07   07   07   07   07   07   07   |                             | 426, 191                                       | -            |             | 454, 684      |                             | 1       |
| 90. 02   09002   DI ABETES CLINIC  |                             | 720 107  | _            | -           | -             |                             | ł       |
| 90. 03   |                             |  |              |             |               | l                           | 1       |
| 90. 04   09004   ANDIS CLINIC   194, 525   16, 707   12, 387   223, 619   39, 653   90. 04   90. 05   09005   PRIME TIME   -4, 968   0   0   -4, 968   0   90. 05   09006   09006   O   0   0   0   0   0   0   0   0   0  |                             | 0  | 0            |             |               | l                           | 1       |
| 90. 06   09006   SHELBYVI LLE WOUND CLI NI C   | 90. 04 09004 ANDIS CLINIC   | 194, 525                                       | 16, 707      | 12, 387     | 223, 619      | 39, 653                     | 90. 04  |
| 90. 07   04951   ONCOLOGY   04951   ONCOLOGY   2,000,500   515,799   302,032   2,818,331   499,763   90.07   90.08   04950   ADRERSON WOMENS CENTER   931,357   143,132   65,207   1,139,696   202,098   90.08   91.00   91.00   09100   EMERGENCY   4,626,405   549,913   332,601   5,508,919   976,875   91.00   92.00   000 |                             | -4, 968  | 0            | 0           |               | l                           |         |
| 90. 08   04950   ANDERSON WOMENS CENTER   931, 357   143, 132   65, 207   1, 139, 696   202, 098   90. 08   91. 00   09100   EMERGENCY   4, 626, 405   549, 913   332, 601   5, 508, 919   976, 875   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   OTHER REI MBURSABLE COST CENTERS   91. 00   OTHER REI MBURSABLE COST CENTERS   92. 00   OTHER REI MBURSABLE COST CENTERS   92. 00   OTHER REI MBURSABLE COST CENTERS   93. 00   OTHER REI MBURSABLE COST CENTERS   94. 00   0. 00    |                             | 0  | 0            | 0           | -             |                             | 1       |
| 91. 00   09100   EMERGENCY   4, 626, 405   549, 913   332, 601   5, 508, 919   976, 875   91. 00   92. 00   08SERVATI ON BEDS (NON-DISTINCT PART)   92. 00   0   0   0   0   0   0   0   101. 00   101. 00   1000    |                             |  |              |             |               |                             | 1       |
| 92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   0THER REI MBURSABLE COST CENTERS   92. 00   0   0   0   0   0   0   0   0   0  |                             |  |              |             |               |                             | •       |
| 101. 00  |                             |  |              |             | 0             |                             | 92.00   |
| 102.00   102.00   010   D TREATMENT PROGRAM   0   0   0   0   0   0   102.00   |                             |  |              | 1           |               |                             |         |
| SPECIAL PURPOSE COST CENTERS   116.00   11600   HOSPI CE   SUBTOLALS (SUM OF LINES 1 through 117)   135,987,489   14,523,278   5,487,888   131,559,181   18,941,733   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190.00   190.00   190.01   190.01   19001   PROFESSI ONAL BUI LDI NG   467,381   962,321   0   1,429,702   253,523   190.01   190.02   19002   PHYSI CI AN BUI LDI NG   624,351   0   0   624,351   110,714   190.02   190.03   190.03   PRI VATE DUTY   1,716,660   15,624   34,379   1,766,663   313,275   190.03   190.04   19004   MARKETI NG   1,099,210   0   22,770   1,121,980   198,956   190.04   190.05   190.05   190.05   190.05   190.05   190.05   190.06   190.06   190.06   10,636,574   56,693   28,473   1,721,740   305,309   190.06   190.07     |                             |  |              |             |               | l e                         | ł       |
| 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) SUBTOTALS (SUM OF LINES 1 through 118, 941, 733 SUBTOTALS (SUM OF LINES 1 18, 941, 733 SUBTOTALS (SUM OF LINES 1 through 118, 941, 733 SUBTOTALS (SUM OF LINES 1 18, 941, 733 SUBTOTAL SUBTOR (SUBTOR COLOR SUBTOR |                             | 0  | 0            | 0           | 0             | 0                           | 102.00  |
| NONREI MBURSABLE COST CENTERS   NONREI MBURSABLE COST CENTERS   NONREI MBURSABLE COST CENTERS   NONREI MBURSABLE COST CENTERS   NO   NO   NO   NO   NO   NO   NO   N   | 116. 00 11600 HOSPI CE      | 0  | 0            | 0           | 0             | 0                           | 116. 00 |
| 190. 00  |                             | 135, 987, 489                                  | 14, 523, 278 | 5, 487, 888 | 131, 559, 181 | 18, 941, 733                | 118. 00 |
| 190. 01 19001 PROFESSIONAL BUILDING 467, 381 962, 321 0 1, 429, 702 253, 523 190. 01 190. 02 19002 PHYSICIAN BUILDING 624, 351 0 0 624, 351 110, 714 190. 02 190. 03 19003 PRI VATE DUTY 1,716, 660 15, 624 34, 379 1, 766, 663 313, 275 190. 03 190. 04 19004 MARKETING 1,099, 210 0 22, 770 1, 121, 980 198, 956 190. 04 190. 05 19005 PORTS PHYSICALS 391, 408 0 36, 047 427, 455 75, 799 190. 05 190. 06 19006 FOUNDATION 1,636, 574 56, 693 28, 473 1,721, 740 305, 309 190. 06 190. 07 19007 ASC 10, 812 788, 430 0 799, 242 141, 726 190. 07 190. 08 190. 08 190. 08 19008 GATEWAY LOCATION 4,599, 193 0 396, 951 4, 996, 144 885, 946 190. 08 190. 09 19009 HANCOCK OB 3,780, 169 227, 927 263, 222 4, 271, 318 757, 416 190. 09 190. 10 19010 HANCOCK WELLNESS 1,209, 022 6, 641 92, 645 1, 308, 308 231, 997 190. 10 190. 11 190. 10 |                             | 0  | 0            |             | 0             | 0                           | 100 00  |
| 190. 02 19002 PHYSI CI AN BUI LDI NG 190. 03 19003 PRI VATE DUTY 1,716, 660 15, 624 34, 379 1, 766, 663 313, 275 190. 03 190. 04 19004 MARKETI NG 1,099, 210 0 22,770 1,121, 980 198, 956 190. 04 190. 05 19005 PORTS PHYSI CALS 391, 408 0 36, 047 427, 455 75, 799 190. 05 190. 07 19007 ASC 10, 812 190. 08 19008 GATEWAY LOCATI ON 190. 08 19008 GATEWAY LOCATI ON 190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS 1, 209, 022 190. 11 19011 MORRI STOWN CLI NI C  |                             |  |              |             |               | l e                         |         |
| 190. 03 19003 PRI VATE DUTY 1, 716, 660 15, 624 34, 379 1, 766, 663 313, 275 190. 03 190. 04 19004 MARKETI NG 1, 099, 210 0 22, 770 1, 121, 980 198, 956 190. 04 190. 05 19005 SPORTS PHYSI CALS 391, 408 0 36, 047 427, 455 75, 799 190. 05 190. 06 19006 FOUNDATI ON 1, 636, 574 190. 07 1907 ASC 10, 812 190. 08 19008 GATEWAY LOCATI ON 190. 09 19009 HANCOCK OB 190. 10 19010 HANCOCK WELLNESS 1, 209, 022 6, 641 92, 645 1, 308, 308 231, 977 190. 03 1, 766, 663 313, 275 190. 03 190. 04 190. 04 190. 05 1, 636, 574 56, 693 28, 473 1, 721, 740 305, 309 190. 06 396, 951 4, 996, 144 885, 946 190. 08 190. 09 190. 10 19010 HANCOCK WELLNESS 1, 209, 022 6, 641 92, 645 1, 308, 308 231, 997 190. 10 190. 11   |                             |  | 0            |             |               |                             | 1       |
| 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. 09 19010 HANCOCK WELLNESS 170. 00 190. 10 19011 MORRI STOWN CLINIC 180. 00 36, 047 427, 455 75, 799 190. 05 1, 636, 574 56, 693 28, 473 1, 721, 740 305, 309 190. 06 10, 812 788, 430 0 799, 242 141, 726 190. 07 1927, 927 263, 222 4, 271, 318 757, 416 190. 08 1, 209, 022 6, 641 92, 645 1, 308, 308 231, 997 190. 10 190. 11 19011 MORRI STOWN CLINIC   | 190. 03 19003 PRI VATE DUTY | 1, 716, 660                                    |              |             | 1, 766, 663   | 313, 275                    | 190. 03 |
| 190. 06 19006 FOUNDATION 1, 636, 574 56, 693 28, 473 1, 721, 740 305, 309 190. 06 190. 07 19007 ASC 10, 812 788, 430 0 799, 242 141, 726 190. 07 190. 08 19008 GATEWAY LOCATION 4, 599, 193 0 396, 951 4, 996, 144 885, 946 190. 08 190. 09 19009 HANCOCK 0B 3, 780, 169 227, 927 263, 222 4, 271, 318 757, 416 190. 09 190. 10 19010 HANCOCK WELLNESS 1, 209, 022 6, 641 92, 645 1, 308, 308 231, 997 190. 10 190. 11 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 0 190. 11  |                             |  |              |             |               |                             | 1       |
| 190. 07 19007 ASC 10,812 788, 430 0 799, 242 141, 726 190. 07 190. 08 19008 GATEWAY LOCATION 4,599, 193 0 396, 951 4, 996, 144 885, 946 190. 08 190. 09 19009 HANCOCK 0B 3,780, 169 227, 927 263, 222 4, 271, 318 757, 416 190. 09 190. 10 190. 10 19010 HANCOCK WELLNESS 1, 209, 022 6, 641 92, 645 1, 308, 308 231, 997 190. 10 190. 11 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 0 190. 11   |                             |  |              | ,           |               |                             |         |
| 190. 08 19008 GATEWAY LOCATION 4, 599, 193 0 396, 951 4, 996, 144 885, 946 190. 08 190. 09 19009 HANCOCK 0B 3, 780, 169 227, 927 263, 222 4, 271, 318 757, 416 190. 09 190. 10 190. 10 190. 10 19010 HANCOCK WELLNESS 1, 209, 022 6, 641 92, 645 1, 308, 308 231, 997 190. 10 190. 11 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 0 190. 11   |                             |  |              |             |               |                             |         |
| 190. 10 19010 HANCOCK WELLNESS 1, 209, 022 6, 641 92, 645 1, 308, 308 231, 997 190. 10 190. 11 19011 MORRI STOWN CLINIC 0 0 0 0 190. 11  |                             |  | · ·          |             |               | 885, 946                    | 190. 08 |
| 190. 11   19011   MORRISTOWN CLINIC   0   0   0   0   190. 11  |                             |  |              |             |               |                             |         |
|  |                             |  | · ·          |             |               |                             |         |
| O  O  O  O  O  170. 12   |                             | _  |              |             |               |                             |         |
|  |                             | <u>.                                      </u> |              | , 0         |               |                             |         |

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0037

|               |                                   |               |               | 10          | o 12/31/2023  | Date/lime Pre<br>5/31/2024 7:0 |         |
|---------------|-----------------------------------|---------------|---------------|-------------|---------------|--------------------------------|---------|
|               |                                   |               | CAPI TAL      |             |               | 3/31/2024 7.0                  | i aiii  |
|               |                                   |               | RELATED COSTS |             |               |                                |         |
|               | Cost Center Description           | Net Expenses  | NEW BLDG &    | EMPLOYEE    | Subtotal      | ADMINISTRATIV                  |         |
|               |                                   | for Cost      | FLXT          | BENEFITS    |               | E & GENERAL                    |         |
|               |                                   | Allocation    |               | DEPARTMENT  |               | 2 4 02.12.012                  |         |
|               |                                   | (from Wkst A  |               |             |               |                                |         |
|               |                                   | col. 7)       |               |             |               |                                |         |
|               |                                   | 0             | 1.00          | 4. 00       | 4A            | 5. 00                          |         |
| 190. 13 19013 | MCCORD WELLNESS                   | 1, 659, 596   | 0             | 107, 395    | 1, 766, 991   | 313, 333                       | 190. 13 |
| 190. 14 19014 | 3 WEST UNIT                       | 442, 954      | 432, 261      | 21, 665     | 896, 880      | 159, 040                       | 190. 14 |
| 190. 15 19015 | NEUROLOGY PHYSICIAN               | 1, 521, 771   | 64, 523       | 123, 041    | 1, 709, 335   | 303, 110                       | 190. 15 |
| 190. 16 19016 | THORACI                           | 2, 951        | 0             | 100         | 3, 051        | 541                            | 190. 16 |
| 190. 17 19017 | HANCOCK ENDO                      | 1, 205, 257   | 0             | 89, 847     | 1, 295, 104   | 229, 656                       | 190. 17 |
| 190. 18 19018 | HANCOCK FOOT & ANKLE              | 0             | 0             | 0           | 0             | 0                              | 190. 18 |
| 190. 19 19019 | HANCOCK RHEUM                     | 17, 352       | 0             | 582         | 17, 934       | 3, 180                         | 190. 19 |
| 194. 00 07950 | OTHER NONREIMBURSABLE             | 254           | 0             | 18          | 272           | 48                             | 194. 00 |
| 194. 01 07951 | SUBURBAN HOSPICE                  | 259, 593      | 62, 810       | 21, 537     | 343, 940      | 60, 990                        | 194. 01 |
| 194. 02 07952 | HRH HANCOCK GI                    | 1, 497, 791   | 0             | 127, 378    | 1, 625, 169   | 288, 185                       | 194. 02 |
| 194. 03 07954 | HRH NEPHROLOGY                    | 185, 504      | 0             | 10, 333     | 195, 837      | 34, 727                        | 194. 03 |
| 194. 04 07957 | HRH SANE                          | 187, 323      | 0             | 14, 957     | 202, 280      | 35, 870                        | 194. 04 |
| 194. 05 07955 | HRH RISE                          | 164, 702      | 0             | 913         | 165, 615      | 29, 368                        | 194. 05 |
| 194. 06 07956 | HRH JUSTICE NAVIGATION            | 245, 036      | 0             | 17, 794     | 262, 830      | 46, 607                        | 194. 06 |
| 194. 07 07953 | HPN PHYSICIAN                     | 110, 762      | 0             | 9, 472      | 120, 234      | 21, 321                        | 194. 07 |
| 194. 08 07958 | HOSPI TALI ST                     | 512, 217      | 0             | 0           | 512, 217      | 90, 829                        | 194. 08 |
| 194. 09 07959 | HPN HANCOCK COUNSEL               | 67, 160       | 0             | 6, 245      | 73, 405       | 13, 017                        | 194. 09 |
| 194. 10 07960 | HPN HFM MCKENZIE                  | 131, 567      | 0             | 11, 947     | 143, 514      | 25, 449                        | 194. 10 |
| 194. 11 07961 | HPN HIM GREENFIELD                | 126, 509      | 0             | 9, 767      | 136, 276      | 24, 165                        | 194. 11 |
| 194. 12 07962 | HPN HFM BOYD                      | 198, 746      | 0             | 16, 256     | 215, 002      | 38, 125                        | 194. 12 |
| 194. 13 07963 | HPN HIM MCCORD                    | 102, 269      | 0             | 7, 652      | 109, 921      | 19, 492                        | 194. 13 |
| 194. 14 07964 | HPN WELL BEING                    | 64, 768       | 0             | 4, 586      | 69, 354       | 12, 298                        | 194. 14 |
| 194. 15 07965 | PHYSICIAN BILLING SERVICE         | 274, 410      | 20, 517       | 20, 505     | 315, 432      | 55, 934                        | 194. 15 |
| 194. 16 07966 | CLINICAL MANAGEMENT               | 160, 197      | 0             | 14, 884     | 175, 081      | 31, 046                        | 194. 16 |
| 194. 17 07967 | HANCOCK ORTHO                     | 3, 220, 217   | 0             | 250, 028    | 3, 470, 245   | 615, 365                       | 194. 17 |
| 194. 18 07968 | HANCOCK PEDIATRICS                | 133, 204      | 0             | 9, 630      | 142, 834      | 25, 328                        | 194. 18 |
| 194. 19 07969 | HRN HFM NEW                       | 205, 496      | 0             | 14, 547     | 220, 043      | 39, 019                        | 194. 19 |
| 194. 20 07970 | HRH HFM CLEARVIEW                 | 66, 888       | 0             | 4, 995      | 71, 883       | 12, 747                        | 194. 20 |
| 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) | 164, 286, 763 | 17, 161, 025  | 7, 278, 449 | 164, 286, 763 | 24, 745, 184                   | 202. 00 |

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In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/31/2024 7:01 am

|  |                         |                      | 10          | 12/31/2023         | 5/31/2024 7:0        |                    |
|--|-------------------------|----------------------|-------------|--------------------|----------------------|--------------------|
| Cost Center Description  | OPERATION OF            | HOUSEKEEPI NG        | DI ETARY    | CAFETERI A         | NURSI NG             |                    |
|  | PLANT                   |                      |             |                    | ADMINISTRATIO<br>N   |                    |
|  | 7. 00                   | 9. 00                | 10.00       | 11. 00             | 13.00                |                    |
| GENERAL SERVICE COST CENTERS   |                         |                      |             |                    |                      |                    |
| 1. 00   00100   NEW CAP REL COSTS-BLDG & FIXT                                  |                         |                      |             |                    |                      | 1.00               |
| 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT                                   |                         |                      |             |                    |                      | 4.00               |
| 5.00   00500   ADMINISTRATIVE & GENERAL<br>7.00   00700   OPERATION OF PLANT   | 14 045 024              |                      |             |                    |                      | 5. 00<br>7. 00     |
| 9. 00   00900   HOUSEKEEPI NG  | 16, 945, 024<br>76, 918 | 3, 728, 915          |             |                    |                      | 9.00               |
| 10. 00   01000 DI ETARY  | 713, 379                |                      | 2, 055, 891 |                    |                      | 10.00              |
| 11. 00 01100 CAFETERI A  | 0                       | 106, 995             | 0           | 1, 434, 158        |                      | 11.00              |
| 13.00 01300 NURSING ADMINISTRATION   | 74, 102                 | 0                    | 0           | 37, 185            | 2, 459, 537          | 13.00              |
| 14.00 01400 CENTRAL SERVICES & SUPPLY  | 285, 737                | 162, 299             | 0           | 12, 977            | 30, 050              | 14.00              |
| 15. 00   01500   PHARMACY  | 556, 876                | 118, 388             | 0           | 80, 691            | 186, 844             | 15.00              |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY                                       | 137, 237                | 142, 403             | 0           | 41, 707            | 96, 574              | 16. 00             |
| 23. 00 02300 PARAMED ED PRGM   | 70, 323                 | 164, 036             | 0           | 2, 895             | 0                    | 23. 00             |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS | 2, 231, 726             | 1, 088, 313          | 812, 730    | 151, 129           | 349, 947             | 30.00              |
| 31. 00   03100   NTENSI VE CARE UNI T  | 1, 692, 042             | 224, 371             | 1, 201, 292 | 151, 129           |                      | 31.00              |
| 40. 00   04000   SUBPROVI DER -   PF   | 0                       | 0                    | 0           | 0                  | 0                    | 40.00              |
| ANCILLARY SERVICE COST CENTERS   |                         |                      | -           |                    |                      |                    |
| 50.00 O5000 OPERATING ROOM   | 973, 476                | 435, 643             | 0           | 108, 795           | 251, 919             | 50.00              |
| 51.00   05100   RECOVERY ROOM  | 257, 430                | 160, 414             | 0           | 14, 237            | 32, 967              | 51.00              |
| 53. 00   05300   ANESTHESI OLOGY   | 0                       | 0                    | 0           | 0                  | 0                    | 53.00              |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 1, 895, 600             | 159, 471             | 0           | 145, 496           | 336, 902             | 54.00              |
| 60. 00   06000   LABORATORY<br>65. 00   06500   RESPI RATORY   THERAPY         | 402, 077<br>419, 268    | 152, 177<br>116, 552 | 0           | 96, 847<br>69, 258 | 224, 252<br>160, 369 | 60. 00<br>65. 00   |
| 66. 00   06600   PHYSI CAL THERAPY   | 358, 431                | 135, 456             | 0           | 38, 341            | 88, 781              | 66.00              |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 0                       | 133, 430             | 0           | 13, 665            | 00,701               | 67.00              |
| 68. 00 06800 SPEECH PATHOLOGY  | 0                       | 0                    | 0           | 7, 272             | 0                    | 68.00              |
| 69. 00 06900 ELECTROCARDI OLOGY  | 342, 573                | 264, 115             | 0           | 23, 189            | 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 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<br>76. 01   03160  CARDI OPULMONARY                   | 92, 405                 | 0                    | 0           | 3, 635             | 0                    | 76. 00<br>76. 01   |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION                                  | 72, 403                 | 0                    | 0           | 3, 033             | 0                    | 77. 00             |
| 78. 00 07800 CAR T-CELL IMMUNOTHERAPY  | o o                     | ő                    | 0           | 0                  | Ö                    | 78. 00             |
| OUTPATIENT SERVICE COST CENTERS  |                         |                      |             |                    |                      |                    |
| 88.00 08800 RURAL HEALTH CLINIC  | 0                       | 0                    | 0           | 1, 715             | 0                    | 88. 00             |
| 90. 00  09000  CLI NI C  | 0                       | 0                    | 0           | 0                  | 0                    | 90.00              |
| 90. 01   09001   WOUND   CLINIC  | 248, 315                | 0                    | 0           | 20, 647            | 0                    | 90. 01             |
| 90. 02   09002   DI ABETES CLI NI C<br>90. 03   09003   ASTHMA CLI NI C        | 0                       | 0                    | 0           | 1, 553             | 0                    | 90. 02<br>90. 03   |
| 90. 03   09003   ASTHMA   CLINIC<br>90. 04   09004   ANDIS   CLINIC            | 35, 421                 | 0                    | 0           | 4, 395             | 0                    | 90.03              |
| 90. 05   09005   PRI ME   TI ME  | 0 0                     | 0                    | 0           | 4, 373             | 0                    | 90.05              |
| 90. 06 09006 SHELBYVILLE WOUND CLINIC  | 0                       | Ö                    | 0           | 0                  | Ö                    | 90.06              |
| 90. 07   04951   ONCOLOGY  | 1, 093, 521             | 0                    | 0           | 73, 883            | 0                    | 90. 07             |
| 90.08 04950 ANDERSON WOMENS CENTER   | 303, 447                | 233, 352             | 0           | 24, 128            |                      | 90. 08             |
| 91. 00   09100   EMERGENCY   | 1, 165, 845             | 0                    | 0           | 114, 799           | 265, 823             |                    |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                              |                         |                      |             |                    |                      | 92.00              |
| OTHER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY              | 0                       | 0                    | 0           | 0                  | 0                    | 101. 00            |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM                                       | 0                       |                      | 0           | 0                  |                      | 101.00             |
| SPECIAL PURPOSE COST CENTERS   | <u> </u>                | <u> </u>             | 3           |                    |                      | 102.00             |
| 116. 00 11600 HOSPI CE   | 0                       |                      | 0           | 0                  | 0                    | 116.00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                                  | 13, 426, 149            | 3, 728, 915          | 2, 014, 022 | 1, 247, 817        | 2, 393, 472          | 118. 00            |
| NONREI MBURSABLE COST CENTERS  |                         |                      |             |                    |                      |                    |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                               | 0                       | 0                    | 0           | 0                  |                      | 190.00             |
| 190. 01 19001 PROFESSI ONAL BUI LDI NG<br>190. 02 19002 PHYSI CI AN BUI LDI NG | 0                       | 0                    | 0           | 0                  |                      | 190. 01            |
| 190. 03 19003 PRI VATE DUTY  | 0                       | 0                    | 0           | 21, 696            |                      | 190. 02            |
| 190. 04 19004 MARKETI NG   | 0                       | 0                    | 0           | 5, 817             |                      | 190. 03            |
| 190. 05 19005 SPORTS PHYSI CALS  | 0                       | 0                    | 0           | 0,017              |                      | 190.05             |
| 190. 06 19006 FOUNDATION   | 120, 193                | 0                    | 0           | 8, 590             |                      | 190. 06            |
| 190. 07 19007 ASC  | 1, 671, 516             | 0                    | 0           | 0                  |                      | 190. 07            |
| 190. 08 19008 GATEWAY LOCATION   | 0                       | o                    | 0           | 0                  |                      | 190. 08            |
| 190. 09 19009 HANCOCK OB   | 483, 218                | 0                    | 0           | 47, 860            |                      | 190. 09            |
| 190. 10 19010 HANCOCK WELLNESS   | 14, 079                 | 0                    | 0           | 0                  |                      | 190. 10            |
| 190. 11 19011 MORRI STOWN CLINIC   | 0                       |                      | 0           | 0                  |                      | 190. 11            |
| 190. 12 19012 03PUREMED<br>190. 13 19013 MCCORD_WELLNESS                       |                         | 0                    | 0           | 0                  |                      | 190. 12<br>190. 13 |
| 190. 13 19013 MCCORD WELLNESS<br>190. 14 19014 3 WEST UNIT                     | 916, 418                | 0                    | 0           | 7, 057             |                      | 190. 13            |
| 190. 15 19015 NEUROLOGY PHYSI CI AN  | 136, 792                | ő                    | o           | 8, 619             |                      | 190. 15            |
| 190. 16 19016 THORACI  | 0                       | o                    | 0           | 0                  |                      | 190. 16            |
|  | '                       |                      | ·           |                    |                      |                    |

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|  |              |               |             |             | 5/31/2024 7:0    | 1 am    |
|--|--------------|---------------|-------------|-------------|------------------|---------|
| 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. 17 19017 HANCOCK ENDO               | 0            | 0             | 0           | 8, 654      |                  | 190. 17 |
| 190. 18 19018 HANCOCK FOOT & ANKLE       | 0            | 0             | 0           | 0           |                  | 190. 18 |
| 190. 19 19019 HANCOCK RHEUM              | 0            | 0             | 0           | 0           |                  | 190. 19 |
| 194.00 07950 OTHER NONREIMBURSABLE       | 0            | 0             | 0           | 11          |                  | 194. 00 |
| 194. 01 07951 SUBURBAN HOSPI CE          | 133, 161     | 0             | 41, 869     | 6, 835      | •                |         |
| 194. 02 07952 HRH HANCOCK GI             | 0            | 0             | 0           | 6, 544      |                  | 194. 02 |
| 194. 03 07954 HRH NEPHROLOGY             | 0            | 0             | 0           | 208         |                  | 194. 03 |
| 194. 04 07957  HRH SANE                  | 0            | 0             | 0           | 803         |                  | 194. 04 |
| 194. 05 07955 HRH RI SE                  | 0            | 0             | 0           | 1, 156      |                  | 194. 05 |
| 194.06 07956 HRH JUSTICE NAVIGATION      | 0            | 0             | 0           | 7, 872      |                  | 194. 06 |
| 194. 07 07953 HPN PHYSICIAN              | 0            | 0             | 0           | 3, 587      |                  | 194. 07 |
| 194. 08 07958  HOSPI TALI ST             | 0            | 0             | 0           | 0           |                  | 194. 08 |
| 194.09 07959 HPN HANCOCK COUNSEL         | 0            | 0             | 0           | 3, 184      |                  | 194. 09 |
| 194. 10 07960 HPN HFM MCKENZIE           | 0            | 0             | 0           | 5, 609      |                  | 194. 10 |
| 194. 11 07961 HPN HIM GREENFIELD         | 0            | 0             | 0           | 4, 655      |                  | 194. 11 |
| 194.12 07962 HPN HFM BOYD                | 0            | 0             | 0           | 8, 303      |                  | 194. 12 |
| 194.13 07963 HPN HIM MCCORD              | 0            | 0             | 0           | 3, 509      |                  | 194. 13 |
| 194.14 07964 HPN WELL BEING              | 0            | 0             | 0           | 0           |                  | 194. 14 |
| 194. 15 07965 PHYSICIAN BILLING SERVICE  | 43, 498      | 0             | 0           | 11, 724     |                  | 194. 15 |
| 194. 16 07966 CLI NI CAL MANAGEMENT      | 0            | 0             | 0           | 0           |                  | 194. 16 |
| 194. 17 07967 HANCOCK ORTHO              | 0            | 0             | 0           | 0           |                  | 194. 17 |
| 194. 18 07968 HANCOCK PEDIATRICS         | 0            | 0             | 0           | 4, 438      |                  | 194. 18 |
| 194.19 07969 HRN HFM NEW                 | 0            | 0             | 0           | 7, 037      |                  | 194. 19 |
| 194. 20 07970 HRH HFM CLEARVIEW          | 0            | 0             | 0           | 2, 573      |                  | 194. 20 |
| 200.00 Cross Foot Adjustments            |              |               |             |             |                  | 200. 00 |
| 201.00 Negative Cost Centers             | 0            | 0             | 0           | 0           |                  | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 16, 945, 024 | 3, 728, 915   | 2, 055, 891 | 1, 434, 158 | 2, 459, 537      | 202.00  |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0037 

|  |                    |             | То                    | 12/31/2023     | Date/Time Pre<br>5/31/2024 7:0 |                    |
|--|--------------------|-------------|-----------------------|----------------|--------------------------------|--------------------|
| Cost Center Description  | CENTRAL            | PHARMACY    | MEDI CAL              | PARAMED ED     | Subtotal                       |                    |
|  | SERVI CES & SUPPLY |             | RECORDS &<br>LI BRARY | PRGM           |                                |                    |
|  | 14. 00             | 15. 00      | 16. 00                | 23. 00         | 24. 00                         |                    |
| GENERAL SERVICE COST CENTERS   | T T                |             |                       |                |                                |                    |
| 1.00   O0100   NEW CAP REL COSTS-BLDG & FIXT 4.00   O0400   EMPLOYEE BENEFITS DEPARTMENT |                    |             |                       |                |                                | 1.00<br>4.00       |
| 5. 00 00500 ADMINISTRATIVE & GENERAL   |                    |             |                       |                |                                | 5.00               |
| 7. 00   00700   OPERATION OF PLANT   |                    |             |                       |                |                                | 7.00               |
| 9. 00   00900   HOUSEKEEPI NG  |                    |             |                       |                |                                | 9.00               |
| 10. 00 01000 DI ETARY  |                    |             |                       |                |                                | 10.00              |
| 11. 00  01100 CAFETERI A   |                    |             |                       |                |                                | 11.00              |
| 13.00 01300 NURSING ADMINISTRATION   |                    |             |                       |                |                                | 13.00              |
| 14.00 01400 CENTRAL SERVICES & SUPPLY  | 1, 188, 433        |             |                       |                |                                | 14.00              |
| 15. 00   01500   PHARMACY  | 0                  | 3, 879, 390 | 0.017.0/5             |                |                                | 15.00              |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY   | 0                  | 0           | 2, 017, 265           | 275 402        |                                | 16.00              |
| 23. 00   O2300   PARAMED ED PRGM   I NPATI ENT ROUTI NE SERVI CE COST CENTERS            | 0                  | υĮ          | 0                     | 375, 692       |                                | 23.00              |
| 30. 00 03000 ADULTS & PEDI ATRI CS   | 0                  | o           | 559, 296              | 0              | 13, 383, 332                   | 30.00              |
| 31. 00   03100   NTENSI VE CARE UNI T  |                    | ő           | 69, 835               | ő              | 13, 237, 910                   |                    |
| 40. 00   04000   SUBPROVI DER - I PF   | Ö                  | Ö           | 0                     | 0              | 0                              | 40.00              |
| ANCILLARY SERVICE COST CENTERS   |                    |             |                       |                |                                |                    |
| 50.00 05000 OPERATING ROOM   | 0                  | 0           | 735, 111              | 0              | 10, 076, 247                   | 50.00              |
| 51.00  05100   RECOVERY ROOM   | 0                  | 0           | 0                     | 0              | 1, 371, 800                    |                    |
| 53. 00   05300   ANESTHESI OLOGY   | 0                  | 0           | 0                     | 0              | 0                              | 53.00              |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 0                  | 0           | 83, 925               | 375, 692       | 11, 581, 788                   |                    |
| 60. 00   06000   LABORATORY<br>65. 00   06500   RESPI RATORY   THERAPY                   | 0                  | 0           | 186, 228              | 0              | 8, 286, 581<br>3, 979, 508     |                    |
| 66. 00   06600 PHYSI CAL THERAPY   |                    | 0           | 0                     | 0              | 2, 563, 168                    |                    |
| 67. 00 06700 OCCUPATI ONAL THERAPY   |                    | Ö           | 0                     | o              | 504, 961                       |                    |
| 68. 00 06800 SPEECH PATHOLOGY  | o                  | o           | O                     | o              | 319, 645                       | ı                  |
| 69. 00 06900 ELECTROCARDI OLOGY  | 0                  | o           | 0                     | О              | 2, 102, 514                    |                    |
| 70.00 07000 ELECTROENCEPHALOGRAPHY   | 0                  | 0           | 0                     | O              | 0                              | 70.00              |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   | 1, 188, 433        | 0           | 95, 564               | 0              | 5, 509, 381                    |                    |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT  | 0                  | 0           | 0                     | 0              | 1, 327, 048                    |                    |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS   | 0                  | 3, 879, 390 | 0                     | 0              | 30, 502, 330                   |                    |
| 76. 00   03020   CARDI AC  | 0                  | 0           | 0                     | 0              | 0                              | 76.00              |
| 76. 01   03160  CARDI OPULMONARY 77. 00   07700  ALLOGENEI C STEM CELL ACQUI SITION      | 0                  | 0           | 0                     | 0              | 248, 399<br>0                  | 1                  |
| 78.00 07800 CAR T-CELL IMMUNOTHERAPY   |                    | 0           | 0                     | 0              | 0                              | 77. 00<br>78. 00   |
| OUTPATIENT SERVICE COST CENTERS  | <u> </u>           | <u> </u>    | O <sub>I</sub>        | O <sub>I</sub> |                                | 70.00              |
| 88. 00 08800 RURAL HEALTH CLINIC   | 0                  | 0           | 0                     | 0              | 537, 026                       | 88. 00             |
| 90. 00 09000 CLI NI C  | 0                  | 0           | 0                     | 0              | 0                              | 90.00              |
| 90. 01  09001   WOUND CLINIC   | 0                  | 0           | 0                     | 0              | 1, 345, 317                    | 90. 01             |
| 90. 02   09002   DI ABETES CLINIC  | 0                  | 0           | 0                     | 0              | 59, 719                        |                    |
| 90. 03   09003   ASTHMA CLINIC   | 0                  | 0           | 0                     | 0              | 0                              | 90. 03             |
| 90. 04   09004   ANDIS CLINIC  | 0                  | 0           | 0                     | 0              | 303, 088                       |                    |
| 90. 05   09005   PRI ME TI ME<br>90. 06   09006   SHELBYVI LLE WOUND CLI NI C            | 0                  | 0           | 0                     | 0              | -4, 968                        | 1                  |
| 90. 06   09006   SHELBYVI LLE WOUND CLINIC<br>90. 07   04951   ONCOLOGY                  |                    | 0           | 0                     | 0              | 0<br>4, 485, 498               | 90. 06<br>90. 07   |
| 90. 08   04950   ANDERSON WOMENS CENTER  |                    | 0           | 0                     | 0              | 1, 902, 721                    |                    |
| 91. 00   09100   EMERGENCY   |                    | ő           | 287, 306              | ő              | 8, 319, 567                    |                    |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)   |                    |             | , , , , ,             |                | .,,                            | 92.00              |
| OTHER REIMBURSABLE COST CENTERS  |                    |             |                       |                |                                |                    |
| 101.00 10100 HOME HEALTH AGENCY  | 0                  | 0           | 0                     | 0              |                                | 101.00             |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM   | 0                  | 0           | 0                     | 0              | 0                              | 102.00             |
| SPECIAL PURPOSE COST CENTERS   |                    | ما          |                       | ما             |                                | 11/ 00             |
| 116.00 11600 HOSPICE<br>118.00  SUBTOTALS (SUM OF LINES 1 through 117)                   | 1 100 422          | 2 970 200   | 2 017 245             | 0<br>375, 692  | 0<br>121, 942, 580             | 116.00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS               | 1, 188, 433        | 3, 879, 390 | 2, 017, 265           | 375, 692       | 121, 942, 580                  | 1118.00            |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 0                  | 0           | 0                     | O              | 0                              | 190. 00            |
| 190. 01 19001 PROFESSI ONAL BUI LDI NG   |                    | Ö           | 0                     | Ö              | 1, 683, 225                    |                    |
| 190. 02 19002 PHYSI CI AN BUI LDI NG   | o                  | Ö           | Ö                     | o              | 735, 065                       |                    |
| 190. 03 19003 PRI VATE DUTY  | 0                  | O           | 0                     | О              | 2, 151, 871                    | 190. 03            |
| 190. 04 19004 MARKETI NG   | 0                  | 0           | 0                     | 0              | 1, 326, 753                    | 190. 04            |
| 190. 05 19005 SPORTS PHYSI CALS  | 0                  | 0           | 0                     | 0              | 503, 254                       |                    |
| 190. 06 19006 FOUNDATI ON  | 0                  | 0           | 0                     | 0              | 2, 155, 832                    |                    |
| 190. 07 19007 ASC  | 0                  | 0           | 0                     | 0              | 2, 612, 484                    |                    |
| 190. 08 19008 GATEWAY LOCATION   | 0                  | 0           | 0                     | 0              | 5, 882, 090                    |                    |
| 190. 09 19009 HANCOCK OB   | 0                  | 0           | 0                     | 0              | 5, 559, 812                    |                    |
| 190. 10 19010 HANCOCK WELLNESS   | 0                  | O           | 0                     | 0              | 1, 554, 384                    | 1                  |
| 190. 11 19011 MORRI STOWN CLINI C  | 0                  | 0           | 0                     | O              |                                | 190. 11<br>190. 12 |
| 190. 12 19012 03PUREMED<br>190. 13 19013 MCCORD WELLNESS                                 |                    |             | 0                     |                | 2, 080, 324                    | 1                  |
| 190. 14 19014 3 WEST UNIT  |                    | 0           | 0                     | 0              | 1, 979, 395                    |                    |
| 190. 15 19015 NEUROLOGY PHYSI CI AN  | o                  | ől          | Ö                     | ől             | 2, 157, 856                    |                    |
| 190. 16 19016 THORACI  | Ö                  | o           | 0                     | o              |                                | 190. 16            |
|  |                    |             |                       |                |                                |                    |

| Peri od: | Worksheet B | From 01/01/2023 | Part | To | 12/31/2023 | Date/Time Prepared:

|  |             |             | 10          | 12/31/2023 | Date/lime Pre<br>  5/31/2024 7:0 |         |
|--|-------------|-------------|-------------|------------|----------------------------------|---------|
| 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. 17 19017 HANCOCK ENDO               | 0           | 0           | 0           | 0          | 1, 533, 414                      | 190. 17 |
| 190. 18 19018 HANCOCK FOOT & ANKLE       | 0           | 0           | 0           | 0          | 0                                | 190. 18 |
| 190. 19 19019 HANCOCK RHEUM              | 0           | 0           | 0           | 0          | 21, 114                          | 190. 19 |
| 194. 00 07950 OTHER NONREI MBURSABLE     | 0           | 0           | 0           | 0          | 331                              | 194. 00 |
| 194. 01 07951 SUBURBAN HOSPI CE          | 0           | 0           | 0           | 0          | 602, 623                         | 194. 01 |
| 194. 02 07952 HRH HANCOCK GI             | 0           | 0           | 0           | 0          | 1, 919, 898                      | 194. 02 |
| 194. 03 07954 HRH NEPHROLOGY             | 0           | 0           | 0           | 0          | 230, 772                         | 194. 03 |
| 194. 04 07957 HRH SANE                   | 0           | 0           | 0           | 0          | 238, 953                         | 194. 04 |
| 194. 05 07955 HRH RI SE                  | 0           | 0           | 0           | 0          | 196, 139                         | 194. 05 |
| 194.06 07956 HRH JUSTICE NAVIGATION      | 0           | 0           | 0           | 0          | 317, 309                         | 194. 06 |
| 194. 07 07953 HPN PHYSICIAN              | 0           | 0           | 0           | 0          | 145, 142                         | 194. 07 |
| 194. 08 07958 HOSPI TALI ST              | 0           | 0           | 0           | 0          | 603, 046                         | 194. 08 |
| 194.09 07959 HPN HANCOCK COUNSEL         | 0           | 0           | 0           | 0          | 89, 606                          | 194. 09 |
| 194.10 07960 HPN HFM MCKENZIE            | 0           | 0           | 0           | 0          | 174, 572                         | 194. 10 |
| 194. 11 07961 HPN HIM GREENFIELD         | 0           | 0           | 0           | 0          | 165, 096                         | 194. 11 |
| 194.12 07962 HPN HFM BOYD                | 0           | 0           | 0           | 0          | 261, 430                         | 194. 12 |
| 194. 13 07963 HPN HIM MCCORD             | 0           | 0           | 0           | 0          | 132, 922                         | 194. 13 |
| 194.14 07964 HPN WELL BEING              | 0           | 0           | 0           | 0          | 81, 652                          | 194. 14 |
| 194. 15 07965 PHYSICIAN BILLING SERVICE  | 0           | 0           | 0           | 0          | 426, 588                         | 194. 15 |
| 194. 16 07966 CLINICAL MANAGEMENT        | 0           | 0           | 0           | 0          | 206, 127                         | 194. 16 |
| 194. 17 07967 HANCOCK ORTHO              | 0           | 0           | 0           | 0          | 4, 085, 610                      | 194. 17 |
| 194. 18 07968 HANCOCK PEDI ATRI CS       | 0           | 0           | 0           | 0          | 172, 600                         | 194. 18 |
| 194.19 07969  HRN HFM NEW                | 0           | 0           | 0           | 0          | 266, 099                         | 194. 19 |
| 194. 20 07970 HRH HFM CLEARVIEW          | 0           | 0           | 0           | 0          | 87, 203                          | 194. 20 |
| 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, 188, 433 | 3, 879, 390 | 2, 017, 265 | 375, 692   | 164, 286, 763                    | 202. 00 |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/31/2024 7:01 am Provi der CCN: 15-0037 Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adiustment

|                  |  | Adjustments |                  |                    |
|------------------|--|-------------|------------------|--------------------|
|                  | I  | 25. 00      | 26. 00           |                    |
| 1 00             | GENERAL SERVICE COST CENTERS   |             |                  | 4 00               |
| 1.00             | 00100 NEW CAP REL COSTS-BLDG & FLXT                                  |             |                  | 1.00               |
| 4. 00<br>5. 00   | 00400 EMPLOYEE BENEFITS DEPARTMENT<br>00500 ADMINISTRATIVE & GENERAL |             |                  | 4. 00<br>5. 00     |
| 7. 00            | 00700 OPERATION OF PLANT   |             |                  | 7.00               |
| 9. 00            | 00900 HOUSEKEEPI NG  |             |                  | 9.00               |
| 10. 00           | 01000 DI ETARY   |             |                  | 10.00              |
| 11. 00           | 01100 CAFETERI A   |             |                  | 11.00              |
| 13. 00           | 01300 NURSI NG ADMI NI STRATI ON                                     |             |                  | 13.00              |
|                  | 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, 383, 332     | 30.00              |
| 31. 00           | 03100 I NTENSI VE CARE UNI T   | 0           | 13, 237, 910     | 31.00              |
| 40.00            | 04000 SUBPROVI DER - I PF  | 0           | 0                | 40. 00             |
| F0 00            | ANCI LLARY SERVI CE COST CENTERS                                     |             | 10 07/ 047       |                    |
| 50. 00<br>51. 00 | 05000 OPERATING ROOM<br>05100 RECOVERY ROOM                          | 0           | 10, 076, 247     | 50.00              |
| 53.00            | 05300 ANESTHESI OLOGY  |             | 1, 371, 800<br>0 | 51.00<br>53.00     |
| 54. 00           | 05400 RADI OLOGY-DI AGNOSTI C  |             | 11, 581, 788     | 54.00              |
| 60. 00           | 06000 LABORATORY   |             | 8, 286, 581      | 60.00              |
| 65. 00           | 06500 RESPI RATORY THERAPY   | o o         | 3, 979, 508      | 65.00              |
| 66. 00           | 06600 PHYSI CAL THERAPY  | o           | 2, 563, 168      | 66.00              |
| 67.00            |  | 0           | 504, 961         | 67.00              |
| 68.00            | 06800 SPEECH PATHOLOGY   | o           | 319, 645         | 68. 00             |
| 69.00            | 06900 ELECTROCARDI OLOGY   | 0           | 2, 102, 514      | 69. 00             |
| 70.00            | 07000 ELECTROENCEPHALOGRAPHY   | 0           | 0                | 70.00              |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                           | 0           | 5, 509, 381      | 71.00              |
|                  | 07200 IMPL. DEV. CHARGED TO PATIENT                                  | 0           | 1, 327, 048      | 72. 00             |
| 73. 00           | 07300 DRUGS CHARGED TO PATIENTS                                      | 0           | 30, 502, 330     | 73. 00             |
|                  | 03020 CARDI AC   | 0           | 0                | 76. 00             |
| 76. 01           | 03160 CARDI OPULMONARY   | 0           | 248, 399         | 76. 01             |
| 77. 00           | 07700 ALLOGENEIC STEM CELL ACQUISITION                               | 0           | 0                | 77.00              |
| 78. 00           | O7800   CAR T-CELL   IMMUNOTHERAPY   OUTPATIENT SERVICE COST CENTERS | 0           | 0                | 78. 00             |
| 88 00            | 08800 RURAL HEALTH CLINIC  | n           | 537, 026         | 88. 00             |
| 90.00            | 09000 CLINIC   | 0           | 0                | 90.00              |
| 90. 01           | 09001 WOUND CLINIC   | o           | 1, 345, 317      | 90. 01             |
| 90. 02           | 09002 DI ABETES CLINIC   | o           | 59, 719          | 90. 02             |
| 90. 03           | 09003 ASTHMA CLINIC  | O           | 0                | 90. 03             |
| 90.04            | 09004 ANDIS CLINIC   | 0           | 303, 088         | 90. 04             |
| 90. 05           | 09005 PRI ME TI ME   | 0           | -4, 968          | 90. 05             |
| 90.06            | 09006 SHELBYVILLE WOUND CLINIC                                       | 0           | 0                | 90. 06             |
| 90. 07           | 04951 ONCOLOGY   | 0           | 4, 485, 498      | 90. 07             |
| 90. 08           | 04950 ANDERSON WOMENS CENTER   | 0           | 1, 902, 721      | 90. 08             |
| 91.00            | 09100 EMERGENCY  | 0           | 8, 319, 567      | 91.00              |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                           | 0           |                  | 92.00              |
| 101 00           | OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY             | O           | 0                | 101.00             |
|                  | 10100 NOME HEALTH AGENCY<br>10200 OPI OID TREATMENT PROGRAM          |             | 0                | 101.00             |
| 102.00           | SPECIAL PURPOSE COST CENTERS   | J           | <u> </u>         | 1102.00            |
| 116.00           | 11600 HOSPI CE   | 0           | 0                | 116. 00            |
| 118.00           | i i  | o           | 121, 942, 580    | 118.00             |
|                  | NONREI MBURSABLE COST CENTERS  | <u>'</u>    |                  |                    |
| 190.00           | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                            | 0           | 0                | 190. 00            |
| 190. 01          | 19001 PROFESSIONAL BUILDING  | 0           | 1, 683, 225      | 190. 01            |
| 190. 02          | 19002 PHYSICIAN BUILDING   | 0           | 735, 065         | 190. 02            |
|                  | 19003 PRI VATE DUTY  | 0           | 2, 151, 871      | 190. 03            |
|                  | 19004 MARKETI NG   | 0           | 1, 326, 753      | 190. 04            |
|                  | 19005 SPORTS PHYSI CALS  | 0           | 503, 254         | 190. 05            |
|                  | 19006 FOUNDATI ON  | 0           | 2, 155, 832      | 190.06             |
|                  | 7 19007 ASC  | 0           | 2, 612, 484      | 190.07             |
|                  | 19008 GATEWAY LOCATION   | 0           | 5, 882, 090      | 190. 08            |
|                  | 1909 HANCOCK OB  | 0           | 5, 559, 812      | 190. 09            |
|                  | 19010 HANCOCK WELLNESS   | 0           | 1, 554, 384      | 190. 10            |
|                  | 19011   MORRISTOWN CLINIC<br>  19012   03PUREMED                     |             | 0                | 190. 11<br>190. 12 |
|                  | 19012 OSPOREMED<br>19013 MCCORD WELLNESS                             |             | 2, 080, 324      | 190. 12            |
|                  | 19014 3 WEST UNIT  |             | 1, 979, 395      | 190. 13            |
|                  | 1  | , 91        | , ,,,,,,,,       | · · · · · ·        |
|                  |  |             |                  |                    |

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0037 Period: From 01/01/2023 Part I

|  |             |               | To 12/31/2023   Part 1   To 12/31/2023   Date/Time Prepared: |
|--|-------------|---------------|--|
|  |             |               | 5/31/2024 7: 01 am   |
| Cost Center Description                  | Intern &    | Total         |  |
|  | Resi dents  |               |  |
|  | Cost & Post |               |  |
|  | Stepdown    |               |  |
|  | Adjustments |               |  |
|  | 25. 00      | 26. 00        |  |
| 190. 15 19015 NEUROLOGY PHYSI CI AN      | 0           | 2, 157, 856   | 190. 15  |
| 190. 16 19016 THORACI                    | 0           | 3, 592        | 190. 16  |
| 190. 17 19017 HANCOCK ENDO               | 0           | 1, 533, 414   | 190. 17  |
| 190. 18 19018 HANCOCK FOOT & ANKLE       | 0           | 0             | 190. 18  |
| 190. 19 19019 HANCOCK RHEUM              | 0           | 21, 114       | 190. 19  |
| 194. 00 07950 OTHER NONREI MBURSABLE     | 0           | 331           | 194. 00  |
| 194. 01 07951 SUBURBAN HOSPI CE          | 0           | 602, 623      | 194. 01  |
| 194. 02 07952 HRH HANCOCK GI             | 0           | 1, 919, 898   | 194. 02  |
| 194. 03 07954 HRH NEPHROLOGY             | 0           | 230, 772      | 194. 03  |
| 194. 04 07957 HRH SANE                   | 0           | 238, 953      | 194. 04  |
| 194. 05 07955 HRH RI SE                  | 0           | 196, 139      | 194. 05  |
| 194.06 07956 HRH JUSTICE NAVIGATION      | 0           | 317, 309      | 194. 06  |
| 194. 07 07953 HPN PHYSICIAN              | 0           | 145, 142      | 194. 07  |
| 194. 08 07958 HOSPI TALI ST              | 0           | 603, 046      | 194. 08  |
| 194.09 07959 HPN HANCOCK COUNSEL         | 0           | 89, 606       | 194. 09  |
| 194.10 07960 HPN HFM MCKENZIE            | 0           | 174, 572      | 194. 10  |
| 194. 11 07961 HPN HIM GREENFIELD         | 0           | 165, 096      | 194. 11  |
| 194.12 07962 HPN HFM BOYD                | 0           | 261, 430      | 194. 12  |
| 194. 13 07963 HPN HIM MCCORD             | 0           | 132, 922      | 194. 13  |
| 194. 14 07964 HPN WELL BEING             | 0           | 81, 652       | 194. 14  |
| 194.15 07965 PHYSICIAN BILLING SERVICE   | 0           | 426, 588      | 194. 15  |
| 194. 16 07966 CLI NI CAL MANAGEMENT      | 0           | 206, 127      | 194. 16  |
| 194. 17 07967 HANCOCK ORTHO              | 0           | 4, 085, 610   | 194. 17  |
| 194. 18 07968 HANCOCK PEDI ATRI CS       | 0           | 172, 600      | 194. 18  |
| 194.19 07969 HRN HFM NEW                 | 0           | 266, 099      | 194. 19  |
| 194.20 07970 HRH HFM CLEARVIEW           | 0           | 87, 203       | 194. 20  |
| 200.00 Cross Foot Adjustments            | 0           | 0             | 200.00   |
| 201.00 Negative Cost Centers             | 0           | 0             | 201. 00  |
| 202.00 TOTAL (sum lines 118 through 201) | 0           | 164, 286, 763 | 202. 00  |

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | Total 2014 | Prepared: | Pr Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0037

|   |  |  |  |                      | o 12/31/2023                       | Date/lime Pre<br>5/31/2024 7:0     |                                      |
|---|--|--|--|----------------------|------------------------------------|------------------------------------|--------------------------------------|
|   | Cost Center Description  | Directly<br>Assigned New<br>Capital<br>Related Costs | CAPITAL<br>RELATED COSTS<br>NEW BLDG &<br>FIXT               | Subtotal             | EMPLOYEE<br>BENEFITS<br>DEPARTMENT | ADMINISTRATIV<br>E & GENERAL       | T Gill                               |
|   |  | 0  | 1.00   | 2A                   | 4. 00                              | 5. 00                              |                                      |
| 4 00  | GENERAL SERVICE COST CENTERS   | 1  |  |                      | T                                  | T                                  | 1 00                                 |
| 1. 00<br>4. 00<br>5. 00<br>7. 00<br>9. 00<br>10. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00900 HOUSEKEEPING 01000 DI ETARY   | 0 0 0  | 88, 256<br>1, 439, 077<br>6, 663, 019<br>36, 281<br>336, 491 | 1, 439, 077          | 13, 224                            | 1, 452, 301<br>149, 786<br>32, 282 | 1.00<br>4.00<br>5.00<br>7.00<br>9.00 |
| 11. 00  | 01100 CAFETERI A   | 0  | 0  | 0                    | 1, 290                             |                                    | 1                                    |
| 13. 00<br>14. 00<br>15. 00<br>16. 00                | 01300 NURSING ADMINISTRATION<br>01400 CENTRAL SERVICES & SUPPLY<br>01500 PHARMACY<br>01600 MEDICAL RECORDS & LIBRARY   | 0 0  | 34, 953<br>134, 778<br>262, 670<br>64, 733                   | 134, 778<br>262, 670 | 389<br>3, 268                      | 6, 164<br>25, 958                  | 13. 00<br>14. 00<br>15. 00<br>16. 00 |
| 23. 00  | 02300 PARAMED ED PRGM  | 0  | 33, 170  |                      |                                    |                                    | 23. 00                               |
|   | INPATIENT ROUTINE SERVICE COST CENTERS   |  | ·  |                      |                                    |                                    |                                      |
| 30. 00<br>31. 00<br>40. 00                          | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF ANCILLARY SERVICE COST CENTERS   | 0 0  | 1, 052, 674<br>798, 112<br>0                                 | 798, 112             | 5, 494                             | 84, 169                            | ı                                    |
| 50. 00  | 05000 OPERATING ROOM   | 0  | 459, 175   | 459, 175             | 5, 901                             | 66, 927                            | 50.00                                |
| 51.00   | 05100 RECOVERY ROOM  | o  | 121, 426   | 121, 426             |                                    | 1                                  |                                      |
| 53. 00<br>54. 00                                    | 05300  ANESTHESI OLOGY<br>  05400  RADI OLOGY-DI AGNOSTI C   | 0  | 0<br>894, 128  | 894, 128             | 0<br>5, 786                        | _                                  | 53. 00<br>54. 00                     |
| 60. 00  | 06000 LABORATORY   | 0  | 189, 654   | 189, 654             | 2, 559                             |                                    | 60.00                                |
| 65. 00  | 06500 RESPI RATORY THERAPY   | o  | 197, 763   |                      |                                    |                                    | 1                                    |
| 66. 00<br>67. 00                                    | 06600  PHYSI CAL THERAPY<br>  06700  OCCUPATI ONAL THERAPY   | 0  | 169, 067<br>0  | 169, 067             | 1, 447<br>422                      |                                    |                                      |
| 68. 00  | 06800 SPEECH PATHOLOGY   |  | 0  |                      | 268                                |                                    | 1                                    |
| 69. 00  | 06900 ELECTROCARDI OLOGY   | 0  | 161, 587   | 161, 587             | 914                                | · ·                                | 69.00                                |
| 70. 00  | 07000 ELECTROENCEPHALOGRAPHY   | 0  | 0  | 0                    | 1                                  | _                                  | 70.00                                |
| 71. 00<br>72. 00                                    | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   | 0  | 0  | 0                    | 0                                  | ,                                  | 1                                    |
| 72.00   | 07200 IMPL. DEV. CHARGED TO PATIENT<br>07300 DRUGS CHARGED TO PATIENTS   | 0  | 0  | 1 0                  | 0                                  |                                    | 73.00                                |
| 76. 00  | 03020 CARDI AC   | Ö  | 0  | Ö                    | 0                                  |                                    | 1                                    |
| 76. 01  | 03160 CARDI OPULMONARY   | 0  | 43, 586  |                      |                                    |                                    | 76. 01                               |
| 77. 00  | 07700 ALLOGENEIC STEM CELL ACQUISITION   | 0  | 0  |                      |                                    |                                    |                                      |
| 78. 00  | 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS   | 0  | 0  | 0                    | 0                                  | 0                                  | 78. 00                               |
| 88. 00  | 08800 RURAL HEALTH CLINIC  | 0  | 0  | C                    | 345                                | 4, 732                             | 88. 00                               |
| 90.00   | 09000 CLI NI C   | 0  | 0  | 0                    | -                                  | _                                  | 90.00                                |
| 90. 01<br>90. 02                                    | 09001   WOUND CLINIC<br>  09002   DIABETES CLINIC  | 0  | 117, 127<br>0  | 117, 127<br>0        | 715                                | 1                                  | 90. 01<br>90. 02                     |
| 90. 02  | 09003 ASTHMA CLINIC  | 0  | 0  |                      | 48                                 | l .                                | 90.02                                |
| 90. 04  | 09004 ANDIS CLINIC   | 0  | 16, 707  | 16, 707              | 150                                | 2, 327                             | 1                                    |
|   | 09005 PRIME TIME   | 0  | 0  | 0                    | 0                                  | 1                                  |                                      |
|   | O9006   SHELBYVI LLE WOUND CLINI C<br>  O4951   ONCOLOGY   | 0  | 0<br>515, 799  | 515, 799             | 3, 661                             | 0<br>29, 330                       |                                      |
|   | 04950 ANDERSON WOMENS CENTER   |  | 143, 132   |                      |                                    |                                    |                                      |
|   | 09100 EMERGENCY  | 0  | 549, 913   |                      |                                    | 57, 331                            |                                      |
| 92. 00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART)   |  |  | 0                    |                                    |                                    | 92.00                                |
| 101 00  | OTHER REIMBURSABLE COST CENTERS  10100 HOME HEALTH AGENCY  | 0  | 0  | С                    | 0                                  | 0                                  | 101. 00                              |
|   | 10200 OPI OI D TREATMENT PROGRAM   | Ö  | 0  |                      |                                    |                                    | 102.00                               |
|   | SPECIAL PURPOSE COST CENTERS   |  |  |                      |                                    |                                    |                                      |
| 116. 00<br>118. 00                                  | 11600 HOSPICE<br>SUBTOTALS (SUM OF LINES 1 through 117)<br>NONREIMBURSABLE COST CENTERS  | 0  | 0<br>14, 523, 278  |                      | _                                  |                                    | 116. 00<br>118. 00                   |
|   | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 0  | 0  | C                    | 0                                  | l .                                | 190. 00                              |
|   | 19001 PROFESSI ONAL BUILDI NG  | 0  | 962, 321   | 962, 321             | 0                                  | 14, 879                            |                                      |
|   | 19002  PHYSI CI AN BUI LDI NG<br> 19003  PRI VATE DUTY   | 0  | 15, 624  | 15, 624              | 417                                |                                    | 190. 02<br>190. 03                   |
|   | 19004 MARKETI NG   |  | 13, 024  | 13, 024              |                                    |                                    | 190.03                               |
| 190. 05   | 19005 SPORTS PHYSI CALS  | 0  | 0  | 0                    | 437                                | 4, 449                             | 190. 05                              |
|   | 19006 FOUNDATI ON  | 0  | 56, 693  |                      |                                    |                                    | 190.06                               |
|   | 19007 ASC<br> 19008 GATEWAY LOCATION   |  | 788, 430<br>0  | 788, 430             |                                    |                                    | 190. 07<br>190. 08                   |
|   | 19009 HANCOCK OB   |  | 227, 927   | 1                    |                                    |                                    | 190.09                               |
| 190. 10   | 19010 HANCOCK WELLNESS   | 0  | 6, 641   | 6, 641               | 1, 123                             | 13, 616                            | 190. 10                              |
|   | 19011 MORRISTOWN CLINIC<br> 19012 O3PUREMED  | 0  | 0  |                      | _                                  | l .                                | 190. 11<br>190. 12                   |
|   | 19012   03POREMED<br>  19013   MCCORD   WELLNESS   | 0  | 0  |                      |                                    | l .                                | 190. 12                              |
|   | t transfer to the second of th | <u> </u>   |  | 1                    | ., 302                             |                                    |                                      |

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time | Prepared: | To 12/31/2023 | Date/Time | Prepared: | To 12/31/2024 | Prepared: | To 12/

|  |               |               | 10           | 12/31/2023 | 5/31/2024 7:0    |         |
|--|---------------|---------------|--------------|------------|------------------|---------|
|  |               | CAPI TAL      |              |            |                  |         |
|  |               | RELATED COSTS |              |            |                  |         |
| Cost Center Description                  | Di rectl y    | NEW BLDG &    | Subtotal     | EMPLOYEE   | ADMI NI STRATI V |         |
|  | Assigned New  | FLXT          |              | BENEFI TS  | E & GENERAL      |         |
|  | Capi tal      |               |              | DEPARTMENT |                  |         |
|  | Related Costs |               |              |            |                  |         |
| 100 4 4 4 00 4 4 0 1950 T 1991 T         | 0             | 1.00          | 2A           | 4. 00      | 5. 00            | 100.11  |
| 190. 14 19014 3 WEST UNIT                | 0             | 432, 261      | 432, 261     | 263        |                  | 190. 14 |
| 190. 15 19015 NEUROLOGY PHYSI CI AN      | 0             | 64, 523       | 64, 523      | 1, 491     | 17, 789          |         |
| 190. 16 19016 THORACI                    | 0             | 0             | 0            | 1          |                  | 190. 16 |
| 190. 17 19017 HANCOCK ENDO               | 0             | 0             | 0            | 1, 089     | 13, 478          |         |
| 190. 18 19018 HANCOCK FOOT & ANKLE       | 0             | 0             | 0            | 0          |                  | 190. 18 |
| 190. 19 19019 HANCOCK RHEUM              | 0             | 0             | 0            | 7          |                  | 190. 19 |
| 194.00 07950 OTHER NONREI MBURSABLE      | 0             | 0             | 0            | 0          |                  | 194. 00 |
| 194. 01 07951 SUBURBAN HOSPICE           | 0             | 62, 810       | 62, 810      | 261        |                  | 194. 01 |
| 194. 02 07952 HRH HANCOCK GI             | 0             | 0             | 0            | 1, 544     | 16, 913          |         |
| 194. 03 07954 HRH NEPHROLOGY             | 0             | 0             | 0            | 125        | •                | 194. 03 |
| 194. 04 07957 HRH SANE                   | 0             | 0             | 0            | 181        | •                | 194. 04 |
| 194. 05 07955 HRH RI SE                  | 0             | 0             | 0            | 11         | •                | 194. 05 |
| 194.06 07956 HRH JUSTICE NAVIGATION      | 0             | 0             | 0            | 216        | •                | 194. 06 |
| 194. 07 07953 HPN PHYSICIAN              | 0             | 0             | 0            | 115        |                  | 194. 07 |
| 194. 08 07958 H0SPI TALI ST              | 0             | 0             | 0            | 0          |                  | 194. 08 |
| 194.09 07959 HPN HANCOCK COUNSEL         | 0             | 0             | 0            | 76         |                  | 194. 09 |
| 194.10 07960 HPN HFM MCKENZIE            | 0             | 0             | 0            | 145        | •                | 194. 10 |
| 194. 11 07961 HPN HIM GREENFIELD         | 0             | 0             | 0            | 118        | •                | 194. 11 |
| 194.12 07962 HPN HFM BOYD                | 0             | 0             | 0            | 197        | 2, 238           | 194. 12 |
| 194. 13 07963 HPN HIM MCCORD             | 0             | 0             | 0            | 93         | 1, 144           | 194. 13 |
| 194.14 07964 HPN WELL BEING              | 0             | 0             | 0            | 56         | 722              | 194. 14 |
| 194. 15 07965 PHYSICIAN BILLING SERVICE  | 0             | 20, 517       | 20, 517      | 249        | 3, 283           | 194. 15 |
| 194. 16 07966 CLINICAL MANAGEMENT        | 0             | 0             | 0            | 180        | 1, 822           | 194. 16 |
| 194. 17 07967 HANCOCK ORTHO              | 0             | 0             | 0            | 3, 031     | 36, 115          | 194. 17 |
| 194. 18 07968 HANCOCK PEDI ATRI CS       | 0             | 0             | 0            | 117        | 1, 486           | 194. 18 |
| 194.19 07969 HRN HFM NEW                 | 0             | 0             | 0            | 176        | 2, 290           | 194. 19 |
| 194. 20 07970 HRH HFM CLEARVIEW          | 0             | 0             | 0            | 61         | 748              | 194. 20 |
| 200.00 Cross Foot Adjustments            |               |               | 0            |            |                  | 200. 00 |
| 201.00 Negative Cost Centers             |               | 0             | 0            | 0          | 0                | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 0             | 17, 161, 025  | 17, 161, 025 | 88, 256    | 1, 452, 301      | 202. 00 |

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| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | Total 2014 | Prepared: | Pr

|   |  |   |   | '  | o 12/31/2023  | Date/lime Pre<br>  5/31/2024 7:0  |  |
|---|--|---|---|--|---|---|--|
|   | Cost Center Description  | OPERATION OF PLANT  | HOUSEKEEPI NG   | DI ETARY   | CAFETERI A  | NURSI NG<br>ADMI NI STRATI O  |  |
|   |  | 7. 00   | 9. 00   | 10.00  | 11.00   | N<br>13.00  |  |
|   | GENERAL SERVICE COST CENTERS   |   |   |  |   |   |  |
| 1. 00<br>4. 00<br>5. 00<br>7. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>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, 814, 267<br>30, 932<br>286, 878<br>0<br>29, 799<br>114, 906<br>223, 942<br>55, 188<br>28, 280              | 101, 934<br>1, 775<br>2, 925<br>0<br>4, 437<br>3, 236<br>3, 893<br>4, 484 | 637, 237<br>0<br>0<br>0<br>0<br>0<br>0                   | 15, 946<br>413<br>144<br>897<br>464                                       | 87, 702<br>1, 072<br>6, 662<br>3, 444   | 14. 00<br>15. 00<br>16. 00   |
| 30. 00  | 03000 ADULTS & PEDI ATRI CS  | 897, 469  | 29, 750   | 251, 911   | 1, 680  | 12, 478   | 30.00  |
| 31. 00<br>40. 00  | 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF ANCILLARY SERVICE COST CENTERS   | 680, 437<br>0   | 6, 133<br>0   | 372, 348<br>0  | 1, 774<br>0   | 13, 160   | 31. 00<br>40. 00   |
| 50.00   | 05000 OPERATING ROOM   | 391, 473  | 11, 909   | 0  | 1, 210  |   |  |
| 51. 00<br>53. 00<br>54. 00<br>60. 00<br>65. 00<br>66. 00<br>67. 00  | 05100 RECOVERY ROOM<br>05300 ANESTHESI OLOGY<br>05400 RADI OLOGY-DI AGNOSTI C<br>06000 LABORATORY<br>06500 RESPI RATORY THERAPY<br>06600 PHYSI CAL THERAPY<br>06700 OCCUPATI ONAL THERAPY  | 103, 523<br>0<br>762, 296<br>161, 691<br>168, 604<br>144, 139   | 4, 385<br>0<br>4, 359<br>4, 160<br>3, 186<br>3, 703<br>0                  | 0<br>0<br>0<br>0<br>0                                    | 770<br>426<br>152   | 0<br>12, 013<br>7, 996<br>5, 718<br>3, 166  | 53. 00<br>54. 00<br>60. 00<br>65. 00<br>66. 00<br>67. 00   |
| 68. 00<br>69. 00<br>70. 00<br>71. 00<br>72. 00<br>73. 00<br>76. 00<br>76. 01                                    | O6800   SPEECH PATHOLOGY   | 0<br>137, 762<br>0<br>0<br>0<br>0<br>0<br>0<br>37, 160  | 0<br>7, 220<br>0<br>0<br>0<br>0<br>0                                      | 0<br>0<br>0<br>0<br>0<br>0                               | 81<br>258<br>0<br>0<br>0<br>0<br>0  | 0<br>0<br>0<br>0<br>0   | 69. 00<br>70. 00<br>71. 00<br>72. 00<br>73. 00<br>76. 00   |
| 77. 00  | 07700 ALLOGENEIC STEM CELL ACQUISITION   | 0   | О   | 0  | 0   | 0   | 77. 00   |
| 91. 00<br>92. 00  | 07800 CAR T-CELL IMMUNOTHERAPY  OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC  09000 CLINIC  09001 WOUND CLINIC  09002 DIABETES CLINIC  09003 ASTHMA CLINIC  09005 PRIME TIME  09006 SHELBYVILLE WOUND CLINIC  04951 ONCOLOGY  04950 ANDERSON WOMENS CENTER  09100 EMERGENCY  07100 HOME HEALTH AGENCY  | 0<br>0<br>99, 857<br>0<br>14, 244<br>0<br>0<br>439, 748<br>122, 028<br>468, 832                               | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>6, 379                  | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0      | 19<br>0<br>230<br>17<br>0<br>49<br>0<br>0<br>822<br>268<br>1, 276         | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 88. 00<br>90. 00<br>90. 01<br>90. 02<br>90. 03<br>90. 04<br>90. 05<br>90. 06<br>90. 07   |
|   | 10200 OPIOID TREATMENT PROGRAM   | 0   | 0   | 0  |   |   | 101.00   |
| 116. 00<br>118. 00  | SPECIAL PURPOSE COST CENTERS   11600 HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS   | 0<br>5, 399, 188  | 0<br>101, 934   | 0<br>624, 259  |   |   | 116. 00<br>118. 00   |
| 190. 01 190. 02 190. 03 190. 04 190. 05 190. 06 190. 07 190. 10 190. 11 190. 12 190. 13                         | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PROFESSI ONAL BUI LDI NG 19002 PHYSI CI AN BUI LDI NG 19003 PRI VATE DUTY 19004 MARKETI NG 19005 SPORTS PHYSI CALS 19006 FOUNDATI ON 19007 ASC 19008 GATEWAY LOCATI ON 19009 HANCOCK OB 19010 HANCOCK WELLNESS 19011 MORRI STOWN CLI NI C 19012 O3PUREMED 19013 MCCORD WELLNESS 19014 3 WEST UNI T 19015 NEUROLOGY PHYSI CI AN 19016 THORACI | 0<br>0<br>0<br>0<br>0<br>0<br>48, 334<br>672, 183<br>0<br>194, 321<br>5, 662<br>0<br>0<br>368, 528<br>55, 010 | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                            | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 0<br>0<br>241<br>65<br>0<br>96<br>0<br>0<br>532<br>0<br>0<br>0<br>0<br>78 | 0<br>0<br>1,791<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                                     | 190. 00<br>190. 01<br>190. 02<br>190. 03<br>190. 04<br>190. 05<br>190. 06<br>190. 07<br>190. 08<br>190. 09<br>190. 10<br>190. 11<br>190. 12<br>190. 13<br>190. 14<br>190. 15 |

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| Peri od: | Worksheet B | From 01/01/2023 | Part I I | To | 12/31/2023 | Date/Time | Prepared: |

|  |              |               |          |            | 5/31/2024 7:0    |         |
|--|--------------|---------------|----------|------------|------------------|---------|
| 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. 17 19017 HANCOCK ENDO                 | 0            | 0             | 0        | 96         |                  | 190. 17 |
| 190. 18 19018 HANCOCK FOOT & ANKLE         | 0            | 0             | 0        | 0          |                  | 190. 18 |
| 190. 19 19019 HANCOCK RHEUM                | 0            | 0             | 0        | 0          |                  | 190. 19 |
| 194.00 07950 OTHER NONREIMBURSABLE         | 0            | 0             | 0        | 0          |                  | 194. 00 |
| 194. 01 07951  SUBURBAN HOSPI CE           | 53, 549      | 0             | 12, 978  | 76         |                  | 194. 01 |
| 194. 02 07952 HRH HANCOCK GI               | 0            | 0             | 0        | 73         |                  | 194. 02 |
| 194. 03 07954 HRH_NEPHROLOGY               | 0            | 0             | 0        | 2          |                  | 194. 03 |
| 194. 04 07957 HRH_SANE                     | 0            | 0             | 0        | 9          |                  | 194. 04 |
| 194. 05 07955 HRH_RLSE                     | 0            | 0             | 0        | 13         | -                | 194. 05 |
| 194.06 07956 HRH JUSTICE NAVIGATION        | 0            | 0             | 0        | 88         | -                | 194. 06 |
| 194. 07 07953 HPN PHYSICIAN                | 0            | 0             | 0        | 40         | -                | 194. 07 |
| 194. 08 07958 H0SPI TALI ST                | 0            | 0             | 0        | 0          |                  | 194. 08 |
| 194. 09 07959 HPN HANCOCK COUNSEL          | 0            | 0             | 0        | 35         | -                | 194. 09 |
| 194. 10 07960 HPN HFM MCKENZIE             | 0            | 0             | 0        | 62         | _                | 194. 10 |
| 194. 11 07961 HPN HIM GREENFIELD           | 0            | 0             | 0        | 52         |                  | 194. 11 |
| 194.12 07962 HPN HFM BOYD                  | 0            | 0             | 0        | 92         | 0                | 194. 12 |
| 194.13 07963 HPN HIM MCCORD                | 0            | 0             | 0        | 39         | 0                | 194. 13 |
| 194.14 07964 HPN WELL BEING                | 0            | 0             | 0        | 0          | 0                | 194. 14 |
| 194. 15 07965 PHYSICIAN BILLING SERVICE    | 17, 492      | 0             | 0        | 130        |                  | 194. 15 |
| 194. 16 07966 CLI NI CAL MANAGEMENT        | 0            | 0             | 0        | 0          |                  | 194. 16 |
| 194. 17 07967 HANCOCK ORTHO                | 0            | 0             | 0        | 0          |                  | 194. 17 |
| 194. 18 07968 HANCOCK PEDIATRICS           | 0            | 0             | 0        | 49         |                  | 194. 18 |
| 194.19 07969 HRN HFM NEW                   | 0            | 0             | 0        | 78         |                  | 194. 19 |
| 194. 20 07970 HRH HFM CLEARVIEW            | 0            | 0             | 0        | 29         |                  | 194. 20 |
| 200.00 Cross Foot Adjustments              |              |               |          |            |                  | 200.00  |
| 201.00 Negative Cost Centers               | 0            | 0             | 0        | 0          |                  | 201.00  |
| 202.00   TOTAL (sum lines 118 through 201) | 6, 814, 267  | 101, 934      | 637, 237 | 15, 946    | 87, 702          | 202.00  |

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | Total 2014 | Prepared: | Pr Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0037

|                  |   |                    |               | 10                    | ) 12/31/2023 | Date/lime Pre<br>  5/31/2024 7:0 |                    |
|------------------|---|--------------------|---------------|-----------------------|--------------|----------------------------------|--------------------|
|                  | Cost Center Description   | CENTRAL            | PHARMACY      | MEDI CAL              | PARAMED ED   | Subtotal                         |                    |
|                  |   | SERVI CES & SUPPLY |               | RECORDS &<br>LI BRARY | PRGM         |                                  |                    |
|                  |   | 14. 00             | 15. 00        | 16. 00                | 23. 00       | 24. 00                           |                    |
|                  | GENERAL SERVICE COST CENTERS  |                    |               |                       |              |                                  |                    |
| 1.00             | 00100 NEW CAP REL COSTS-BLDG & FLXT   |                    |               |                       |              |                                  | 1.00               |
| 4. 00<br>5. 00   | OO400   |                    |               |                       |              |                                  | 4. 00<br>5. 00     |
| 7. 00            | 00700 OPERATION OF PLANT  |                    |               |                       |              |                                  | 7.00               |
| 9. 00            | 00900 HOUSEKEEPI NG   |                    |               |                       |              |                                  | 9. 00              |
| 10.00            | 01000 DI ETARY  |                    |               |                       |              |                                  | 10.00              |
| 11.00            | 01100 CAFETERI A  |                    |               |                       |              |                                  | 11.00              |
| 13. 00<br>14. 00 | O1300   NURSI NG ADMI NI STRATI ON   O1400   CENTRAL SERVI CES & SUPPLY       | 261, 890           |               |                       |              |                                  | 13.00<br>14.00     |
| 15. 00           | 01500 PHARMACY  | 201, 070           | 526, 633      |                       |              |                                  | 15.00              |
| 16.00            | 01600 MEDICAL RECORDS & LIBRARY   | 0                  | 0             | 142, 752              |              |                                  | 16. 00             |
| 23. 00           | 02300 PARAMED ED PRGM   | 0                  | 0             | 0                     | 67, 309      |                                  | 23. 00             |
| 20.00            | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS              | O                  | ol            | 20 570                |              | 2 2/2 270                        | 20.00              |
| 30. 00<br>31. 00 | 03100 INTENSIVE CARE UNIT   | 0                  | 0             | 39, 579<br>4, 942     |              | 2, 363, 270<br>1, 966, 569       | 30.00<br>31.00     |
| 40. 00           | 04000 SUBPROVI DER - I PF   | Ö                  | o             | 0                     |              | 0                                | 1                  |
|                  | ANCILLARY SERVICE COST CENTERS  |                    |               |                       |              |                                  |                    |
| 50.00            | 05000 OPERATING ROOM  | 0                  | 0             | 52, 020               |              | 997, 598                         | 50.00              |
| 51. 00<br>53. 00 | 05100   RECOVERY ROOM   05300   ANESTHESI OLOGY                               | 0                  | 0             | 0                     |              | 239, 327<br>0                    | 51. 00<br>53. 00   |
| 54. 00           | 05400 RADI OLOGY-DI AGNOSTI C   | 0                  | 0             | 5, 939                |              | 1, 762, 024                      | 54.00              |
| 60.00            | 06000 LABORATORY  | 0                  | 0             | 13, 178               |              | 444, 181                         | 60.00              |
| 65.00            | 06500 RESPI RATORY THERAPY  | 0                  | 0             | 0                     |              | 406, 746                         | 1                  |
| 66. 00<br>67. 00 | 06600 PHYSI CAL THERAPY   | 0                  | 0             | 0                     |              | 339, 116                         | 1                  |
| 68. 00           | O6700   OCCUPATI ONAL THERAPY<br>  O6800   SPEECH PATHOLOGY                   |                    | 0             | 0                     |              | 4, 917<br>3, 110                 | 67.00<br>68.00     |
| 69. 00           | 06900 ELECTROCARDI OLOGY  | Ö                  | o             | 0                     |              | 320, 758                         |                    |
| 70.00            | 07000 ELECTROENCEPHALOGRAPHY  | 0                  | 0             | 0                     |              | 0                                | 70.00              |
| 71.00            | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                    | 261, 890           | 0             | 6, 763                |              | 306, 003                         | ı                  |
| 72. 00<br>73. 00 | O7200   I MPL. DEV. CHARGED TO PATIENT<br>  O7300   DRUGS CHARGED TO PATIENTS | 0                  | 0<br>526, 633 | 0                     |              | 11, 730<br>762, 008              |                    |
| 76. 00           | 03020 CARDI AC  | 0                  | 020, 033      | 0                     |              | 702,008                          | 76.00              |
| 76. 01           | 03160 CARDI OPULMONARY  | o                  | O             | 0                     |              | 82, 220                          | 1                  |
| 77. 00           | 07700 ALLOGENEIC STEM CELL ACQUISITION  | 0                  | 0             | 0                     |              | 0                                | 77. 00             |
| 78. 00           | 07800 CAR T-CELL IMMUNOTHERAPY  | 0                  | 0             | 0                     |              | 0                                | 78.00              |
| 88. 00           | OUTPATIENT SERVICE COST CENTERS  O8800 RURAL HEALTH CLINIC                    | 0                  | ol            | 0                     |              | 5, 096                           | 88. 00             |
| 90.00            | 09000 CLINIC  | o o                | o             | 0                     |              | 0, 0,0                           | 90.00              |
| 90. 01           | 09001 WOUND CLINIC  | 0                  | 0             | 0                     |              | 227, 443                         | 90. 01             |
| 90. 02           | 09002 DI ABETES CLI NI C  | 0                  | 0             | 0                     |              | 579                              | 90.02              |
| 90. 03<br>90. 04 | 09003 ASTHMA CLINIC<br>09004 ANDIS CLINIC                                     | 0                  | 0             | 0                     |              | 22 477                           | 90. 03<br>90. 04   |
| 90.04            | 09005 PRIME TIME  | 0                  | 0             | 0                     |              | 33, 477<br>0                     | 90.04              |
| 90. 06           | 09006 SHELBYVILLE WOUND CLINIC  | o                  | Ö             | 0                     |              | 0                                | 90.06              |
| 90. 07           | 04951 ONCOLOGY  | 0                  | 0             | 0                     |              | 989, 360                         |                    |
|                  | 04950 ANDERSON WOMENS CENTER  | 0                  | 0             | 0                     |              | 284, 458                         | 90.08              |
|                  | O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)            | 0                  | 0             | 20, 331               |              | 1, 111, 193                      | 91.00              |
| 72.00            | OTHER REIMBURSABLE COST CENTERS   |                    |               |                       |              |                                  | 72.00              |
|                  | 10100 HOME HEALTH AGENCY  | 0                  | 0             | 0                     |              |                                  | 101.00             |
| 102.00           | 10200 OPI OI D TREATMENT PROGRAM  | 0                  | 0             | 0                     |              | 0                                | 102. 00            |
| 116 00           | SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE                                   | 0                  | ol            | 0                     |              | 0                                | ]<br>116. 00       |
| 118.00           |   | 261, 890           | 526, 633      | 142, 752              | o            | 12, 661, 183                     |                    |
|                  | NONREI MBURSABLE COST CENTERS   | ·                  |               | ·                     |              |                                  |                    |
|                  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                     | 0                  | 0             | 0                     |              |                                  | 190.00             |
|                  | 19001 PROFESSI ONAL BUILDI NG   | 0                  | 0             | 0                     |              | 977, 200                         |                    |
|                  | 19002 PHYSICIAN BUILDING<br>19003 PRIVATE DUTY                                | 0                  | 0             | 0                     |              |                                  | 190. 02<br>190. 03 |
|                  | 19004 MARKETI NG  | o                  | o             | 0                     |              |                                  | 190. 04            |
|                  | 19005 SPORTS PHYSI CALS   | 0                  | 0             | 0                     |              | 4, 886                           | 190. 05            |
|                  | 19006 FOUNDATI ON   | 0                  | 0             | 0                     |              | 123, 386                         |                    |
|                  | 19007 ASC   | 0                  | 0             | 0                     |              | 1, 468, 931                      | 1                  |
|                  | 19008 GATEWAY LOCATION<br>  19009 HANCOCK OB                                  |                    | 0             | 0                     |              | 56, 806<br>470, 422              | 190. 08<br>190. 09 |
|                  | 19010 HANCOCK WELLNESS  |                    | ol            | 0.                    |              |                                  | 190. 09            |
| 190. 11          | 19011 MORRI STOWN CLINIC  | o                  | o             | 0                     |              | 0                                | 190. 11            |
|                  | 19012 O3PUREMED   | 0                  | 0             | 0                     |              |                                  | 190. 12            |
|                  | 19013 MCCORD WELLNESS   | 0                  | 0             | 0                     |              | 19, 691<br>810, 464              | 1                  |
|                  | 19014  3 WEST UNIT<br>  19015  NEUROLOGY PHYSICIAN                            | 0                  | 0             | 0                     |              | 810, 464<br>138, 909             |                    |
|                  | 19016 THORACI   | 0                  | o             | 0                     |              |                                  | 190. 16            |
|                  | •   |                    |               |                       |              |                                  |                    |

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time | Prepared: | To 12/31/2023 | Date/Time | Prepared: | To 12/31/2024 | Prepared: | To 12/

|  |            |          | ''        | 0 12/31/2023 | 5/31/2024 7:0 |          |
|--|------------|----------|-----------|--------------|---------------|----------|
| Cost Center Description                    | CENTRAL    | PHARMACY | MEDI CAL  | PARAMED ED   | Subtotal      |          |
|  | SERVICES & |          | RECORDS & | PRGM         |               |          |
|  | SUPPLY     | 45.00    | LI BRARY  | 00.00        | 04.00         |          |
| 400 47 40047 HANGOOK ENDO                  | 14. 00     | 15. 00   | 16.00     | 23. 00       | 24.00         | 100 17   |
| 190. 17 19017 HANCOCK ENDO                 | 0          | 0        | 0         |              | 14, 663       | 1        |
| 190. 18 19018 HANCOCK FOOT & ANKLE         | 0          | 0        | 0         |              |               | 190. 18  |
| 190. 19 19019 HANCOCK RHEUM                | 0          | 0        | 0         |              |               | 190. 19  |
| 194. 00 07950 OTHER NONREI MBURSABLE       | 0          | 0        | 0         |              |               | 194.00   |
| 194. 01 07951 SUBURBAN HOSPI CE            | 0          | 0        | 0         |              | 133, 817      |          |
| 194. 02 07952 HRH HANCOCK GI               | 0          | 0        | 0         |              | 18, 530       |          |
| 194. 03 07954 HRH NEPHROLOGY               | 0          | 0        | 0         |              |               | 194. 03  |
| 194. 04 07957 HRH SANE                     | 0          | 0        | 0         |              | •             | 194.04   |
| 194. 05 07955 HRH RI SE                    | 0          | 0        | 0         |              |               | 194. 05  |
| 194. 06 07956 HRH JUSTI CE NAVI GATI ON    | 0          | 0        | 0         |              |               | 194.06   |
| 194. 07 07953 HPN PHYSI CI AN              | 0          | 0        | 0         |              |               | 194. 07  |
| 194. 08 07958 HOSPI TALI ST                | 0          | 0        | 0         |              | •             | 194. 08  |
| 194. 09 07959 HPN HANCOCK COUNSEL          | 0          | 0        | 0         |              |               | 194. 09  |
| 194. 10 07960 HPN HFM MCKENZI E            | 0          | 0        | 0         |              |               | 194. 10  |
| 194. 11 07961 HPN HIM GREENFIELD           | 0          | 0        | 0         |              | •             | 194. 11  |
| 194. 12 07962 HPN HFM BOYD                 | 0          | 0        | 0         |              | •             | 194. 12  |
| 194. 13 07963 HPN HIM MCCORD               | 0          | 0        | 0         |              |               | 194. 13  |
| 194. 14 07964 HPN WELL BEING               | 0          | 0        | 0         |              |               | 194. 14  |
| 194. 15 07965 PHYSI CI AN BILLING SERVI CE | 0          | 0        | 0         |              | 41, 671       |          |
| 194. 16 07966 CLI NI CAL MANAGEMENT        | 0          | 0        | 0         |              |               | 194. 16  |
| 194. 17 07967 HANCOCK ORTHO                | 0          | 0        | 0         |              | 39, 146       |          |
| 194. 18 07968 HANCOCK PEDI ATRI CS         | 0          | 0        | 0         |              | •             | 194. 18  |
| 194. 19 07969 HRN HFM NEW                  | 0          | 0        | 0         |              | •             | 194. 19  |
| 194. 20 07970 HRH HFM CLEARVI EW           | O          | 0        | 0         |              |               | 194. 20  |
| 200.00 Cross Foot Adjustments              | _          | _        | _         | 67, 309      |               | 1        |
| 201.00 Negative Cost Centers               | 0          | 0        | 0         | 0            |               | 201.00   |
| 202.00   TOTAL (sum lines 118 through 201) | 261, 890   | 526, 633 | 142, 752  | 67, 309      | 17, 161, 025  | J202. 00 |

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

From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 7:01 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 23.00 02300 PARAMED ED PRGM 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 2, 363, 270 30.00 03100 INTENSIVE CARE UNIT 31.00 0 1, 966, 569 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 997, 598 50.00 0 05100 RECOVERY ROOM 51.00 239, 327 51.00 05300 ANESTHESI OLOGY 0 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0000000000000 1, 762, 024 54.00 06000 LABORATORY 60.00 444, 181 60.00 65 00 06500 RESPIRATORY THERAPY 406, 746 65 00 06600 PHYSI CAL THERAPY 66.00 339, 116 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 917 67.00 06800 SPEECH PATHOLOGY 68.00 3, 110 68.00 06900 ELECTROCARDI OLOGY 69 00 320, 758 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 306,003 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 11, 730 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 762,008 73 00 76.00 03020 CARDI AC 76.00 03160 CARDI OPULMONARY 76.01 82, 220 76.01 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 C 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 5,096 88.00 09000 CLI NI C 0 90.00 90.00 0 09001 WOUND CLINIC 227, 443 90.01 90.01 90.02 09002 DIABETES CLINIC 0 579 90.02 09003 ASTHMA CLINIC 0 0 0 90.03 90.03  $\mathcal{C}$ 09004 ANDIS CLINIC 90.04 90 04 33.477 90.05 09005 PRIME TIME 0 90.05 90 06 09006 SHELBYVILLE WOUND CLINIC 90.06 0 04951 ONCOLOGY 90.07 989, 360 90.07 04950 ANDERSON WOMENS CENTER 90.08 284, 458 90.08 09100 EMERGENCY 0 1, 111, 193 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 12, 661, 183 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 190. 01 19001 PROFESSI ONAL BUILDING 0 977, 200 l190. 01 6, 498 0 190. 02 19002 PHYSICIAN BUILDING 190.02 190. 03 19003 PRI VATE DUTY 0000000000 36, 459 190.03 190. 04 19004 MARKETING 12 017 190. 04 190. 05 19005 SPORTS PHYSI CALS 4,886 190.05 190. 06 19006 FOUNDATI ON 123, 386 190.06 190. 07 19007 ASC 1, 468, 931 190.07 190. 08 19008 GATEWAY LOCATION 56, 806 190 08 190. 09 19009 HANCOCK OB 470, 422 190.09 190. 10 19010 HANCOCK WELLNESS 27, 042 190.10 190. 11 19011 MORRI STOWN CLINIC 190. 11 Ω 190. 12 19012 03PUREMED C 190. 12 190. 13 19013 MCCORD WELLNESS 19, 691 190. 13 190. 14 19014 3 WEST UNIT 810, 464 190. 14

|  |                      |                    | To 12/31/2023   Part 11   To 12/31/2023   Date/Time Prepared: |
|--|----------------------|--------------------|---|
|  |                      | T                  | 5/31/2024 7:01 am   |
| Cost Center Description  | Intern &             | Total              |   |
|  | Residents            |                    |   |
|  | Cost & Post          |                    |   |
|  | Stepdown             |                    |   |
|  | Adjustments<br>25.00 | 24.00              |   |
| 190. 15 19015 NEUROLOGY PHYSI CLAN                               | 25.00                | 26. 00<br>138, 909 | 190. 15   |
| 190. 15 19015 NEUROLOGY PHYSICIAN<br>190. 16 19016  THORACI      |                      | 33                 | 190. 15   |
| 190. 16 19016 THORACT<br>190. 17 19017 HANCOCK ENDO              |                      | •                  | 190. 16   |
| 190. 17 19017 HANCOCK ENDO<br>190. 18 19018 HANCOCK FOOT & ANKLE |                      | 14, 663            | 190. 17   |
| 190. 19 19018 HANCOCK FOOT & ANKLE                               |                      | ٩                  | 190. 18   |
| 194. 00 07950 OTHER_NONRELMBURSABLE                              |                      | 194                | 194.00  |
| 194. 01 07950 0THER NONRETMBURSABLE                              |                      | 122 017            | 194.00  |
|  |                      | 133, 817           |   |
| 194. 02 07952 HRH HANCOCK GI                                     | 0                    | 18, 530            | 194. 02   |
| 194. 03 07954 HRH NEPHROLOGY<br>194. 04 07957 HRH SANE           | 0                    | 2, 165             | 194. 03   |
|  | 0                    | 2, 295             | 194. 04   |
| 194. 05 07955 HRH RISE   | 0                    | 1, 748             | 194. 05   |
| 194. 06 07956 HRH JUSTI CE NAVI GATI ON                          | 0                    | 3, 039             | 194.06  |
| 194. 07 07953 HPN PHYSI CI AN                                    | 0                    | 1, 406             | 194. 07   |
| 194. 08 07958 HOSPI TALI ST                                      | 0                    | 5, 331             | 194. 08   |
| 194. 09 07959 HPN HANCOCK COUNSEL                                | 0                    | 875                | 194. 09   |
| 194. 10 07960 HPN HFM MCKENZI E                                  | 0                    | 1, 701             | 194. 10   |
| 194. 11 07961 HPN HIM GREENFIELD                                 | 0                    | 1, 588             | 194. 11   |
| 194. 12 07962 HPN HFM BOYD                                       | 0                    | 2, 527             | 194. 12   |
| 194. 13 07963 HPN HI M MCCORD                                    | 0                    | 1, 276             | 194. 13   |
| 194. 14 07964 HPN WELL BEING                                     | 0                    | 778                | 194. 14   |
| 194. 15 07965 PHYSI CI AN BILLING SERVI CE                       | 0                    | 41, 671            | 194. 15   |
| 194. 16 07966 CLI NI CAL MANAGEMENT                              | 0                    | 2, 002             | 194. 16   |
| 194. 17 07967 HANCOCK ORTHO                                      | 0                    | 39, 146            | 194. 17   |
| 194. 18 07968 HANCOCK PEDI ATRI CS                               | 0                    | 1, 652             | 194. 18   |
| 194. 19 07969 HRN HFM NEW  | 0                    | 2, 544             | 194. 19   |
| 194. 20 07970 HRH HFM CLEARVIEW                                  | 0                    | 838                | 194. 20   |
| 200.00 Cross Foot Adjustments                                    | 0                    | 67, 309            | 200.00  |
| 201.00 Negative Cost Centers                                     | 0                    | 0                  | 201.00  |
| 202.00   TOTAL (sum lines 118 through 201)                       | 0                    | 17, 161, 025       | 202.00  |

|   | Financial Systems  | HANCOCK REGION  |  |   |  | u or Form CMS-2                           |  |
|---|--|---|--|---|--|---|--|
| COST A  | LLOCATION - STATISTICAL BASIS  |   | Provi der C  | F   | eriod:<br>rom 01/01/2023<br>o 12/31/2023   | Worksheet B-1 Date/Time Pre 5/31/2024 7:0 | pared:   |
|   | Cost Center Description  | CAPI TAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)  | EMPLOYEE<br>BENEFITS<br>DEPARTMENT<br>(GROSS<br>SALARIES)  | Reconciliatio<br>n                                    | ADMINISTRATIVE & GENERAL (ACCUM. COST)   | OPERATION OF<br>PLANT<br>(SQUARE<br>FEET) |  |
|   |  | 1. 00   | 4. 00  | 5A  | 5. 00  | 7. 00                                     |  |
|   | GENERAL SERVICE COST CENTERS   |   |  |   | 1  |   |  |
| 1. 00<br>4. 00<br>5. 00<br>7. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>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 | 490, 977<br>2, 525<br>41, 172<br>190, 629<br>1, 038<br>9, 627<br>0<br>1, 000<br>3, 856<br>7, 515<br>1, 852<br>949 | 72, 430, 278 10, 825, 390 1, 200, 480 2, 002, 456 657, 053 1, 059, 492 1, 461, 219 319, 344 2, 682, 936 733, 457 98, 083 | -24, 745, 184<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 14, 392, 805<br>3, 101, 942<br>1, 085, 156<br>1, 127, 269<br>1, 994, 562<br>592, 334<br>2, 494, 289<br>1, 358, 455 |   | 10.00<br>11.00<br>13.00<br>14.00<br>15.00<br>16.00 |
| 30.00   | 03000 ADULTS & PEDIATRICS  | 30, 117   | 4, 377, 744  | 0   | 6, 956, 604  | 30, 117                                   | 30.00  |
| 31.00   | 03100 INTENSIVE CARE UNIT  | 22, 834   | 4, 510, 522  | 0   | 8, 087, 775  | 22, 834                                   |  |
| 40.00   | 04000 SUBPROVI DER - I PF  | 0   | 0  | 0   | 0  | 0   | 40.00  |
| FO 00   | ANCILLARY SERVICE COST CENTERS   | 12 127  | 4 044 000  |   | / 420 022  | 10 107                                    |  |
| 50. 00<br>51. 00  | 05000   OPERATI NG ROOM   05100   RECOVERY ROOM  | 13, 137<br>3, 474   | 4, 844, 800<br>528, 666  | 1   |  | 13, 137<br>3, 474                         | 1  |
| 53. 00  | 05300 ANESTHESI OLOGY  | 3, 474  | 320, 000   | 1   | ·  | 0,474                                     | 53.00  |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C  | 25, 581   | 4, 750, 794  |   |  | 25, 581                                   |  |
| 60.00   | 06000 LABORATORY   | 5, 426  | 2, 101, 204  |   | 6, 136, 788  | 5, 426                                    | 60.00  |
| 65.00   | 06500 RESPI RATORY THERAPY   | 5, 658  | 1, 883, 203  |   | 2, 729, 967  | 5, 658                                    | •  |
| 66.00   | 06600 PHYSI CAL THERAPY  | 4, 837  | 1, 188, 024  | 1   | 1, 649, 636  | 4, 837                                    | 1  |
| 67. 00<br>68. 00  | O6700   OCCUPATI ONAL THERAPY<br>  O6800   SPEECH PATHOLOGY  | 0   | 346, 553<br>220, 287   | 1   | 417, 298<br>265, 324   | 0<br>0                                    | 67. 00<br>68. 00                                   |
| 69. 00  | 06900 ELECTROCARDI OLOGY   | 4, 623  | 750, 269   | 1   |  | _   | 1  |
| 70.00   | 07000 ELECTROENCEPHALOGRAPHY   | 0   | 0  | Ō   |  | 0   | ı  |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   | 0   | 0  | 0   | -,,  | 0   | 71.00  |
| 72.00   | 07200 I MPL. DEV. CHARGED TO PATIENT   | 0   | 0  | 0   | .,,  | 0   | 72.00  |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS  | 0   | 0  | 0   | 22, 613, 096   | 0   | 73.00  |
| 76. 00<br>76. 01  | 03020   CARDI AC<br>  03160   CARDI OPULMONARY   | 1, 247  | 71, 811  |   | 129, 411   | 0<br>1, 247                               | 76. 00<br>76. 01                                   |
| 77. 00  | 07700 ALLOGENEIC STEM CELL ACQUISITION   | 1, 247  | 71, 011  |   | · ·  | 1, 247                                    | ı  |
| 78. 00  | 07800 CAR T-CELL IMMUNOTHERAPY   | 0   | 0  |   | -  | 0   | ı  |
|   | OUTPATIENT SERVICE COST CENTERS  |   |  |   | ,  |   |  |
| 88. 00  | 08800 RURAL HEALTH CLINIC  | 0   | 283, 543   | l .   |  | 0   |  |
| 90.00   | 09000   CLINIC   09001   WOUND   CLINIC  | 3, 351  | 587, 160   | 0   | _  | 0   | 90. 00<br>90. 01                                   |
|   | 09002 DI ABETES CLI NI C   | 3, 331  | 39, 698  |   | 49, 405  | 0   |  |
|   | 09003 ASTHMA CLINIC  | O   | 0  | Ō   |  | 0   | ı  |
| 90.04   | 09004 ANDIS CLINIC   | 478   | 123, 264   | 0   | 223, 619   | 478                                       |  |
| 90. 05  | 09005 PRIME TIME   | 0   | 0  | 4, 968  |  | 0   |  |
| 90. 06<br>90. 07  | O9006   SHELBYVI LLE WOUND CLINIC<br>  O4951   ONCOLOGY  | 14, 757   | 3, 005, 620  | 0   | _  | 0<br>14, 757                              |  |
| 90. 07  | 04950 ANDERSON WOMENS CENTER   | 4, 095  | 648, 897   |   |  | 4, 095                                    | •  |
| 91.00   | 09100 EMERGENCY  | 15, 733   | 3, 309, 825  | 1   | 5, 508, 919  |   | •  |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART)   |   |  |   |  |   | 92.00  |
| 404 00  | OTHER REIMBURSABLE COST CENTERS  |   |  |   | 1  |   | 101 00   |
|   | 10100 HOME HEALTH AGENCY<br>10200 OPIOID TREATMENT PROGRAM   | 0   | 0  |   |  |   | 101. 00<br>102. 00                                 |
| 102.00  | SPECIAL PURPOSE COST CENTERS   | J   |  | · · · · · · ·   | 0  |   | 1102.00  |
| 116.00  | 11600 HOSPI CE   | 0   | 0  | 0   | 0  | 0   | 116.00   |
| 118.00  | 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2  | 415, 511  | 54, 611, 794   | -24, 740, 216   | 106, 818, 965  | 181, 185                                  | 118.00   |
|   | NONREI MBURSABLE COST CENTERS  | TT  |  | T   | _  |   |  |
|   | 1900  GIFT, FLOWER, COFFEE SHOP & CANTEEN<br> 1900  PROFESSIONAL BUILDING  | 27, 532   | 0  | 0   |  |   | 190. 00<br>190. 01                                 |
|   | 19001 PROFESSIONAL BUILDING  | 27, 532   | 0  | 0   |  |   | 190.01   |
|   | 19003 PRI VATE DUTY  | 447   | 342, 115   | _   |  |   | 190.03   |
|   | 19004 MARKETI NG   | 0   | 226, 588   | 0   | 1, 121, 980  |   | 190. 04  |
|   | 19005 SPORTS PHYSI CALS  | 0   | 358, 719   |   | 427, 455   |   | 190. 05  |
|   | 19006  FOUNDATI ON<br> 19007  ASC  | 1, 622  | 283, 345   | 0   | ., . = . ,   |   | 190.06   |
|   | 19007  ASC<br>  19008  GATEWAY LOCATION  | 22, 557   | 3, 950, 195  |   | 799, 242<br>4, 996, 144  |   | 190. 07<br>190. 08                                 |
|   | 19009 HANCOCK OB   | 6, 521  | 2, 619, 411  | l .   | 4, 271, 318  |   | 190.09   |
| 190. 10   | 19010 HANCOCK WELLNESS   | 190   | 921, 941   | l .   | 1, 308, 308  |   | 190. 10  |
|   | 19011 MORRISTOWN CLINIC  | O   | 0  | _   | _  |   | 190. 11  |
| 190. 12   | 19012 03PUREMED  | 0   | 0  | 0   | 0  | 0   | 190. 12  |
|   |  |   |  |   |  |   |  |

Provi der CCN: 15-0037

|               |  |               |             | Т             | o 12/31/2023     | Date/Time Pre 5/31/2024 7:0 |         |
|---------------|--|---------------|-------------|---------------|------------------|-----------------------------|---------|
|               |  | CAPI TAL      |             |               |                  | 3/31/2024 /.0               | I dili  |
|               |  | RELATED COSTS |             |               |                  |                             |         |
|               | Cost Center Description                  | NEW BLDG &    | EMPLOYEE    | Reconciliatio | ADMI NI STRATI V | OPERATION OF                |         |
|               | oost contor bescription                  | FLXT          | BENEFITS    | n             | E & GENERAL      | PLANT                       |         |
|               |  | (SQUARE       | DEPARTMENT  |               | (ACCUM.          | (SQUARE                     |         |
|               |  | FEET)         | (GROSS      |               | COST)            | FEET)                       |         |
|               |  | ''''          | SALARI ES)  |               | (031)            | 1 [[]                       |         |
|               |  | 1. 00         | 4. 00       | 5A            | 5. 00            | 7. 00                       |         |
| 190. 13 19013 | MCCORD WELLNESS                          | 0             | 1, 068, 724 |               |                  |                             | 190. 13 |
| 190, 14 19014 | 3 WEST UNIT                              | 12, 367       | 215, 595    | 0             | 896, 880         | 12, 367                     | 190. 14 |
| 1             | NEUROLOGY PHYSICIAN                      | 1, 846        | 1, 224, 425 | 1             |                  | •                           | 190. 15 |
| 190. 16 19016 |  | 0             | 1, 000      | 1             |                  |                             | 190. 16 |
| 1             | HANCOCK ENDO                             | 0             | 894, 094    | 1             |                  |                             | 190. 17 |
|               | HANCOCK FOOT & ANKLE                     | 0             | 0           | 1             |                  |                             | 190. 18 |
|               | HANCOCK RHEUM                            | 0             | 5, 788      |               |                  |                             | 190. 19 |
|               | OTHER NONREI MBURSABLE                   | 0             | 180         | 1             | ,                |                             | 194.00  |
| 4             | SUBURBAN HOSPICE                         | 1, 797        | 214, 319    |               |                  |                             | 194. 01 |
|               | HRH HANCOCK GI                           | 0             | 1, 267, 583 | 1             | ,                |                             | 194. 02 |
|               | HRH NEPHROLOGY                           | o o           | 102, 829    | 1             | ·                |                             | 194. 03 |
| 194. 04 07957 |  |               | 148, 839    | l .           | ,                |                             | 194. 04 |
| 194. 05 07955 |  |               | 9, 081      | 1             |                  |                             | 194. 05 |
|               | HRH JUSTICE NAVIGATION                   | 0             | 177, 074    | 1             |                  |                             | 194. 06 |
|               | HPN PHYSICIAN                            | 0             | 94, 262     | 1             |                  |                             | 194. 07 |
|               | HOSPI TALI ST                            | 0             | 94, 202     | 1             |                  |                             | 194. 07 |
|               | HPN HANCOCK COUNSEL                      | 0             | 62, 150     | l .           | ·                |                             | 194. 06 |
|               | HPN HFM MCKENZIE                         | 0             |             | 1             | ,                |                             | 194. 09 |
| 1             |  | 0             | 118, 889    |               |                  |                             | 194. 10 |
|               | HPN HIM GREENFIELD<br>HPN HFM BOYD       | 0             | 97, 195     | 1             |                  |                             | 194. 11 |
|               |  | 0             | 161, 770    | 1             |                  |                             | 194. 12 |
| 4             | HPN HIM MCCORD                           | 0             | 76, 143     |               | ,                |                             | 194. 13 |
|               | HPN WELL BEING                           | 507           | 45, 641     |               | ,                |                             |         |
|               | PHYSICIAN BILLING SERVICE                | 587           | 204, 054    |               |                  |                             | 194. 15 |
| 4             | CLINICAL MANAGEMENT                      | 0             | 148, 119    |               |                  |                             | 194. 16 |
|               | HANCOCK ORTHO                            | 0             | 2, 488, 110 | 1             | -,,              |                             | 194. 17 |
|               | HANCOCK PEDI ATRI CS                     | 0             | 95, 835     | 1             |                  |                             | 194. 18 |
| 1             | HRN HFM NEW                              | 0             | 144, 762    | 1             | ,                |                             | 194. 19 |
|               | HRH HFM CLEARVIEW                        | 0             | 49, 709     | 0             | 71, 883          | 0                           | 194. 20 |
| 200.00        | Cross Foot Adjustments                   |               |             |               |                  |                             | 200.00  |
| 201. 00       | Negative Cost Centers                    |               |             |               |                  |                             | 201.00  |
| 202. 00       | Cost to be allocated (per Wkst. B,       | 17, 161, 025  | 7, 278, 449 |               | 24, 745, 184     | 16, 945, 024                | 202.00  |
|               | Part I)                                  | 0.4.050000    | 0.400400    |               | 0.47700/         | 7. 101075                   |         |
| 203. 00       | Unit cost multiplier (Wkst. B, Part I)   | 34. 952808    | 0. 100489   |               | 0. 177326        |                             |         |
| 204. 00       | Cost to be allocated (per Wkst. B,       |               | 88, 256     | 1             | 1, 452, 301      | 6, 814, 267                 | 204.00  |
|               | Part II)                                 |               | 0 004040    |               | 0.040407         |                             |         |
| 205. 00       | Unit cost multiplier (Wkst. B, Part      |               | 0. 001218   |               | 0. 010407        | 29. 799306                  | 205.00  |
| 204 00        | NAUE adjustment amount to be all control |               |             |               |                  |                             | 20/ 00  |
| 206. 00       | NAHE adjustment amount to be allocated   |               |             |               |                  |                             | 206. 00 |
| 207 00        | (per Wkst. B-2)                          |               |             |               |                  |                             | 207.00  |
| 207. 00       | NAHE unit cost multiplier (Wkst. D,      |               |             |               |                  |                             | 207. 00 |
|               | Parts III and IV)                        | 1             |             | I             |                  |                             | I       |

| COST ALLOCATION - STATISTICAL BASIS  |                       | Provi der CC       | CN: 15-0037 P      | eri od:                        | Worksheet B-1             |                    |
|--|-----------------------|--------------------|--------------------|--------------------------------|---------------------------|--------------------|
|  |                       |                    | T                  | rom 01/01/2023<br>o 12/31/2023 | Date/Time Pre             |                    |
| Cost Center Description  | HOUSEKEEPI NG         | DI ETARY           | CAFETERI A         | NURSI NG                       | 5/31/2024 7: 0<br>CENTRAL | 1 am               |
|  | (HOURS OF<br>SERVICE) | (PATI ENT<br>DAYS) | (MANHOURS)         | ADMI NI STRATI O<br>N          | SERVI CES & SUPPLY        |                    |
|  | SLKVI CL)             | DATS)              |                    | (MANHOURS)                     | (COSTED                   |                    |
|  | 9. 00                 | 10. 00             | 11. 00             | 13. 00                         | REQUIS.)<br>14.00         |                    |
| GENERAL SERVICE COST CENTERS   | 9.00                  | 10.00              | 11.00              | 13.00                          | 14.00                     |                    |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT               |                       |                    |                    |                                |                           | 1.00<br>4.00       |
| 5. 00   00500   ADMI NI STRATI VE & GENERAL  |                       |                    |                    |                                |                           | 5.00               |
| 7.00 00700 OPERATION OF PLANT  | 075 745               |                    |                    |                                |                           | 7. 00              |
| 9. 00   00900   HOUSEKEEPI NG<br>10. 00   01000   DI ETARY                                     | 375, 765<br>6, 543    | 10, 508            |                    |                                |                           | 9.00               |
| 11. 00   01100   CAFETERI A  | 10, 782               | 0                  | 939, 129           |                                |                           | 11.00              |
| 13. 00   01300   NURSI NG   ADMI NI STRATI ON<br>14. 00   01400   CENTRAL   SERVI CES & SUPPLY | 0<br>16, 355          | 0                  | 24, 350<br>8, 498  |                                | 100                       | 13. 00<br>14. 00   |
| 15. 00   01500   PHARMACY  | 11, 930               | 0                  | 52, 839            |                                | 0                         | 15.00              |
| 16.00 01600 MEDICAL RECORDS & LIBRARY  | 14, 350               | 0                  | 27, 311            |                                | 0                         | 16.00              |
| 23. 00   02300   PARAMED ED PRGM   I NPATI ENT ROUTI NE SERVI CE COST CENTERS                  | 16, 530               | 0                  | 1, 896             | 0                              | 0                         | 23. 00             |
| 30. 00 03000 ADULTS & PEDIATRICS   | 109, 670              | 4, 154             | 98, 964            |                                | 0                         |                    |
| 31. 00   03100   I NTENSI VE CARE UNI T<br>40. 00   04000   SUBPROVI DER -   I PF              | 22, 610               | 6, 140<br>0        | 104, 365           |                                | 0                         |                    |
| ANCI LLARY SERVI CE COST CENTERS   | l d                   | O                  |                    | 0                              | 0                         | 40.00              |
| 50. 00 05000 OPERATI NG ROOM   | 43, 900               | 0                  | 71, 242            |                                | 0                         |                    |
| 51. 00   05100   RECOVERY ROOM<br>53. 00   05300   ANESTHESI OLOGY                             | 16, 165               | 0                  | 9, 323             |                                | 0                         | 51. 00<br>53. 00   |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 16, 070               | o                  | 95, 275            | 95, 275                        | 0                         | 54.00              |
| 60. 00   06000   LABORATORY<br>65. 00   06500   RESPI RATORY   THERAPY                         | 15, 335               | 0                  | 63, 418            |                                | 0                         | 60. 00<br>65. 00   |
| 66. 00   06600   PHYSI CAL THERAPY   | 11, 745<br>13, 650    | o                  | 45, 352<br>25, 107 |                                | 0                         | 66.00              |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 0                     | 0                  | 8, 948             | 0                              | 0                         | 67.00              |
| 68. 00   06800   SPEECH PATHOLOGY<br>69. 00   06900   ELECTROCARDI OLOGY                       | 0<br>26, 615          | 0                  | 4, 762<br>15, 185  |                                | 0                         | 68. 00<br>69. 00   |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY  | 20,013                | ő                  | 13, 103            |                                | 0                         | 70.00              |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 0                     | 0                  | 0                  | 0                              | 100                       |                    |
| 72.00   07200   IMPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS        | 0                     | 0                  | 0                  | 0                              | 0                         | 72. 00<br>73. 00   |
| 76. 00   03020   CARDI AC  | 0                     | 0                  | O                  |                                | 0                         | 76. 00             |
| 76. 01   03160   CARDI OPULMONARY<br>77. 00   07700   ALLOGENEI C   STEM   CELL   ACQUI SITION | 0                     | 0                  | 2, 380             | 0                              | 0                         | 76. 01<br>77. 00   |
| 78. 00 O7800 CAR T-CELL IMMUNOTHERAPY  | Ö                     | ő                  | Ö                  |                                | 0                         |                    |
| 0UTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC                              | 0                     | O                  | 1, 123             | O                              | 0                         | 88. 00             |
| 90. 00   09000   CLINIC  |                       | 0                  | 1, 123             |                                | 0                         | 90.00              |
| 90. 01   09001   WOUND CLINIC  | 0                     | 0                  | 13, 520            |                                | 0                         | 90. 01             |
| 90. 02   09002   DI ABETES   CLINIC<br>90. 03   09003   ASTHMA   CLINIC                        | 0                     | 0                  | 1, 017<br>0        |                                | 0                         | 90. 02<br>90. 03   |
| 90. 04   09004   ANDIS CLINIC  | 0                     | ő                  | 2, 878             |                                | 0                         | 90.04              |
| 90. 05   09005   PRIME TIME<br>90. 06   09006   SHELBYVILLE WOUND CLINIC                       | 0                     | 0                  | 0                  | 0                              | 0                         | 90. 05<br>90. 06   |
| 90. 07   04951   0NCOLOGY  | 0                     | 0                  | 48, 381            | 0                              | 0                         | 90.06              |
| 90. 08 04950 ANDERSON WOMENS CENTER  | 23, 515               | 0                  | 15, 800            |                                | 0                         | 90.08              |
| 91.00   09100   EMERGENCY<br>92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)              | 0                     | O                  | 75, 174            | 75, 174                        | 0                         | 91. 00<br>92. 00   |
| OTHER REIMBURSABLE COST CENTERS  |                       |                    |                    |                                |                           |                    |
| 101.00 10100 HOME HEALTH AGENCY<br>102.00 10200 0PI0ID TREATMENT PROGRAM                       | 0                     | 0                  | 0                  |                                |                           | 101. 00<br>102. 00 |
| SPECIAL PURPOSE COST CENTERS   | j d                   | <u> </u>           |                    | ı v                            | 0                         | 102.00             |
| 116. 00 11600 HOSPI CE   | 0                     | 0                  | 017.100            |                                |                           | 116.00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS                     | 375, 765              | 10, 294            | 817, 108           | 676, 868                       | 100                       | 118. 00            |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 0                     | 0                  | C                  | 0                              |                           | 190. 00            |
| 190. 01 19001  PROFESSI ONAL BUI LDI NG<br>190. 02 19002  PHYSI CI AN BUI LDI NG               | 0                     | 0                  | 0                  | 0                              |                           | 190. 01<br>190. 02 |
| 190. 03 19003 PRI VATE DUTY  |                       | o                  | 14, 207            | 14, 207                        |                           | 190. 02            |
| 190. 04 19004 MARKETI NG   | 0                     | 0                  | 3, 809             | 0                              |                           | 190.04             |
| 190. 05 19005  SPORTS PHYSI CALS<br>190. 06 19006  FOUNDATI ON                                 | 0                     | 0                  | 5, 625             |                                |                           | 190. 05<br>190. 06 |
| 190. 07 19007 ASC  | 0                     | ő                  | 0, 525             | o                              | 0                         | 190. 07            |
| 190. 08 19008  GATEWAY LOCATION<br>190. 09 19009  HANCOCK OB                                   | 0                     | 0                  | 31, 340            | 0                              |                           | 190. 08<br>190. 09 |
| 190. 10 19010 HANCOCK WELLNESS   |                       | 0                  | 31, 340            | 0                              |                           | 190. 09            |
| 190. 11 19011 MORRI STOWN CLINIC   | 0                     | o                  | 0                  | 0                              |                           | 190. 11            |
| 190. 12 19012  03PUREMED<br>190. 13 19013  MCCORD WELLNESS                                     |                       | 0 <br>0            | 0                  |                                |                           | 190. 12<br>190. 13 |
| 190. 14 19014 3 WEST UNIT  | 0                     | o                  | 4, 621             | o                              |                           | 190. 14            |
|  |                       |                    |                    |                                |                           |                    |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0037

|  |               |             |             | rom 01/01/2023<br>o 12/31/2023 |                         |
|--|---------------|-------------|-------------|--------------------------------|-------------------------|
|  |               |             |             |                                | 5/31/2024 7:01 am       |
| Cost Center Description  | HOUSEKEEPI NG | DI ETARY    | CAFETERI A  | NURSI NG                       | CENTRAL                 |
|  | (HOURS OF     | (PATI ENT   | (MANHOURS)  | ADMI NI STRATI O               | SERVI CES &             |
|  | SERVICE)      | DAYS)       |             | N                              | SUPPLY                  |
|  |               |             |             | (MANHOURS)                     | (COSTED                 |
|  |               |             |             |                                | REQUIS.)                |
|  | 9. 00         | 10. 00      | 11. 00      | 13. 00                         | 14. 00                  |
| 190. 15 19015 NEUROLOGY PHYSICIAN                              | 0             | 0           | 5, 644      | 0                              | 0 190. 15               |
| 190. 16 19016 THORACI  | 0             | 0           | 0           | 0                              | 0 190. 16               |
| 190. 17 19017 HANCOCK ENDO                                     | 0             | 0           | 5, 667      | 0                              | 0 190. 17               |
| 190. 18 19018 HANCOCK FOOT & ANKLE                             | O             | 0           | 0           | 0                              | 0 190. 18               |
| 190. 19 19019 HANCOCK RHEUM                                    | o             | 0           | 0           | 0                              | 0 190. 19               |
| 194. 00 07950 OTHER NONREI MBURSABLE                           | o             | 0           | 7           | 0                              | 0 194. 00               |
| 194. 01 07951 SUBURBAN HOSPI CE                                | o             | 214         | 4, 476      | 4, 476                         | 0 194. 01               |
| 194. 02 07952 HRH HANCOCK GI                                   | l ol          | 0           | 4, 285      | o                              | 0 194. 02               |
| 194. 03 07954 HRH NEPHROLOGY                                   | l ol          | 0           | 136         |                                | 0 194. 03               |
| 194. 04 07957 HRH SANE   | ام            | 0           | 526         |                                | 0 194. 04               |
| 194. 05 07955 HRH RI SE  |               | 0           | 757         |                                | 0 194. 05               |
| 194. 06 07956 HRH JUSTICE NAVIGATION                           |               | 0           | 5, 155      |                                | 0 194. 06               |
| 194. 07 07953 HPN PHYSI CI AN                                  |               | 0           | 2, 349      |                                | 0 194. 07               |
| 194. 08 07958 HOSPI TALI ST                                    |               | 0           | 2, 347      |                                | 0 194. 08               |
| 194. 09 07959 HPN HANCOCK COUNSEL                              |               | 0           | 2, 085      |                                | 0 194. 09               |
| 194. 10 07960  HPN   HFM   MCKENZI E                           |               | 0           | 3, 673      |                                | 0 194.10                |
| 194. 11 07961 HPN HIM GREENFIELD                               |               | 0           | 3, 048      |                                | 0 194.10                |
| 194. 11 07961 HPN HTM GREENFIELD<br>194. 12 07962 HPN HFM BOYD |               | 0           |             |                                | 0 194.11                |
|  |               | 0           | 5, 437      |                                | - 1                     |
| 194. 13 07963 HPN HIM MCCORD                                   |               | 0           | 2, 298      |                                | 0 194. 13               |
| 194. 14 07964 HPN WELL BEING                                   | 0             | 0           | 0           |                                | 0 194. 14               |
| 194. 15 07965 PHYSI CI AN BILLING SERVI CE                     | 0             | 0           | 7, 677      | 0                              | 0 194. 15               |
| 194. 16 07966 CLI NI CAL MANAGEMENT                            | 0             | 0           | 0           | 0                              | 0 194. 16               |
| 194. 17 07967 HANCOCK ORTHO                                    | 0             | 0           | 0           | 0                              | 0 194. 17               |
| 194. 18 07968 HANCOCK PEDI ATRI CS                             | 0             | 0           | 2, 906      |                                | 0 194. 18               |
| 194. 19 07969 HRN HFM NEW                                      | O             | 0           | 4, 608      |                                | 0 194. 19               |
| 194. 20 07970 HRH HFM CLEARVI EW                               | 0             | 0           | 1, 685      | 0                              | 0 194. 20               |
| 200.00 Cross Foot Adjustments                                  |               |             |             |                                | 200. 00                 |
| 201.00 Negative Cost Centers                                   |               |             |             |                                | 201. 00                 |
| 202.00 Cost to be allocated (per Wkst. B, Part I)              | 3, 728, 915   | 2, 055, 891 | 1, 434, 158 | 2, 459, 537                    | 1, 188, 433 202. 00     |
| 203.00 Unit cost multiplier (Wkst. B, Part                     | 1) 9. 923529  | 195. 650076 | 1. 527115   | 3. 536099                      | 11, 884. 330000 203. 00 |
| 204.00 Cost to be allocated (per Wkst. B,                      | 101, 934      | 637, 237    | 15, 946     | 87, 702                        | 261, 890 204. 00        |
| Part II)   | 0.071071      |             | 0.01/000    | 0.12/000                       | 2 /10 000000 205 00     |
| 205.00 Unit cost multiplier (Wkst. B, Part                     |               | 60. 643034  | 0. 016980   | 0. 126090                      | 2, 618. 900000 205. 00  |
| 206.00 NAHE adjustment amount to be alloca (per Wkst. B-2)     | ted           |             |             |                                | 206. 00                 |
| 207.00 NAHE unit cost multiplier (Wkst. D,                     |               |             |             |                                | 207. 00                 |
| Parts III and IV)  |               |             |             |                                |                         |
|  |               |             | •           |                                | •                       |

HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0037 Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

|   |  |  |   | 10  | o 12/31/2023 Date/lime Pr<br>  5/31/2024 7: |  |
|---|--|--|---|---|---|--|
|   | Cost Center Description  | PHARMACY<br>(COSTED<br>REQUIS.)                | MEDI CAL<br>RECORDS &<br>LI BRARY<br>(TI ME<br>SPENT) | PARAMED ED<br>PRGM<br>(ASSI GNED<br>TIME) | 373172024 7.                                | OT AIII  |
|   | OFNEDAL CEDIUSE COCT OFNEDO  | 15. 00   | 16. 00  | 23. 00                                    |   |  |
| 1. 00<br>4. 00<br>5. 00<br>7. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>23. 00       | 01400 CENTRAL SERVICES & SUPPLY<br>01500 PHARMACY<br>01600 MEDICAL RECORDS & LIBRARY   | 100<br>0<br>0                                  | 3, 293<br>0   | 100                                       |   | 1. 00<br>4. 00<br>5. 00<br>7. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>23. 00  |
|   | INPATIENT ROUTINE SERVICE COST CENTERS   | - ,  |   |   |   |  |
| 30. 00<br>31. 00<br>40. 00  |  | 0<br>0<br>0                                    | 913<br>114<br>0                                       | 0<br>0<br>0                               |   | 30. 00<br>31. 00<br>40. 00   |
| 50. 00<br>51. 00<br>53. 00<br>54. 00<br>60. 00<br>65. 00<br>66. 00<br>67. 00  | 05300 ANESTHESI OLOGY<br>05400 RADI OLOGY-DI AGNOSTI C<br>06000 LABORATORY<br>06500 RESPI RATORY THERAPY   | 0<br>0<br>0<br>0<br>0<br>0                     | 1, 200<br>0<br>0<br>137<br>304<br>0<br>0              | 0<br>0<br>100<br>0<br>0<br>0              |   | 50. 00<br>51. 00<br>53. 00<br>54. 00<br>60. 00<br>65. 00<br>66. 00<br>67. 00   |
| 71. 00<br>72. 00<br>73. 00<br>76. 00<br>76. 01<br>77. 00  | 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 03020 CARDI AC 03160 CARDI OPULMONARY 07700 ALLOGENEI C STEM CELL ACQUI SITION  | 0<br>0<br>0<br>0<br>100<br>0                   | 0<br>0<br>156<br>0<br>0<br>0                          | 0<br>0<br>0<br>0<br>0                     |   | 68. 00<br>69. 00<br>70. 00<br>71. 00<br>72. 00<br>73. 00<br>76. 01<br>77. 00   |
| 78. 00<br>88. 00  | OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC  | 0  | 0   | 0   |   | 78.00  |
| 90. 07<br>90. 08  | 09001   WOUND CLINIC   09002   DIABETES CLINIC   09003   ASTHMA CLINIC   09004   ANDIS CLINIC   09005   PRIME TIME   09006   SHELBYVILLE WOUND CLINIC   04951   ONCOLOGY   04950   ANDERSON WOMENS CENTER  | 0<br>0<br>0<br>0<br>0<br>0                     | 0<br>0<br>0<br>0<br>0<br>0                            | 0<br>0<br>0<br>0<br>0<br>0                |   | 90. 00<br>90. 01<br>90. 02<br>90. 03<br>90. 04<br>90. 05<br>90. 06<br>90. 07<br>90. 08   |
|   | 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS   | 0  | 469   | 0   |   | 91. 00<br>92. 00   |
|   | 0 10100 HOME HEALTH AGENCY<br>0 10200 OPIOID TREATMENT PROGRAM<br>SPECIAL PURPOSE COST CENTERS   | 0  | 0   | 0   |   | 101. 00<br>102. 00   |
| 116. 00<br>118. 00  | 0 11600 HOSPICE<br>SUBTOTALS (SUM OF LINES 1 through 117)<br>NONREI MBURSABLE COST CENTERS   | 0<br>100                                       | 0<br>3, 293   | 0<br>100                                  |   | 116. 00<br>118. 00   |
| 190. 01<br>190. 02<br>190. 03<br>190. 04<br>190. 05<br>190. 06<br>190. 06<br>190. 10<br>190. 11<br>190. 12<br>190. 12 | NONREL MBURSABLE COST CENTERS   19000   GLIFT, FLOWER, COFFEE SHOP & CANTEEN   19001   PROFESSIONAL BUILDING   219002   PHYSICIAN BUILDING   319003   PRIVATE DUTY   419004   MARKETING   519005   SPORTS PHYSICALS   519006   FOUNDATION   719007   ASC   319008   GATEWAY LOCATION   719009   HANCOCK OB   719009   HANCOCK OB   719010   HANCOCK WELLNESS   719011   MORRISTOWN CLINIC   719012   O3PUREMED   719013   MCCORD WELLNESS   719014   3 WEST UNIT | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 |   | 190. 00<br>190. 01<br>190. 02<br>190. 03<br>190. 04<br>190. 05<br>190. 06<br>190. 07<br>190. 08<br>190. 09<br>190. 10<br>190. 11<br>190. 12<br>190. 13 |

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

|   |                 |             | ''             | '31/2024 7:01 am         |
|---|-----------------|-------------|----------------|--------------------------|
| Cost Center Description                       | PHARMACY        | MEDI CAL    | PARAMED ED     | <br>017 202 1 71 01 0111 |
| '   | (COSTED         | RECORDS &   | PRGM           |                          |
|   | REQUIS.)        | LI BRARY    | (ASSI GNED     |                          |
|   |                 | (TIME       | TIME)          |                          |
|   |                 | SPENT)      |                |                          |
|   | 15. 00          | 16. 00      | 23. 00         |                          |
| 190. 15 19015 NEUROLOGY PHYSICIAN             | 0               | 0           | 0              | 190. 15                  |
| 190. 16 19016 THORACI                         | 0               | 0           | 0              | 190. 16                  |
| 190. 17 19017 HANCOCK ENDO                    | 0               | 0           | 0              | 190. 17                  |
| 190. 18 19018 HANCOCK FOOT & ANKLE            | 0               | 0           | 0              | 190. 18                  |
| 190. 19 19019 HANCOCK RHEUM                   | 0               | 0           | 0              | 190. 19                  |
| 194. 00 07950 OTHER NONREI MBURSABLE          | 0               | 0           | 0              | 194. 00                  |
| 194. 01 07951 SUBURBAN HOSPI CE               | 0               | 0           | 0              | 194. 01                  |
| 194. 02 07952 HRH HANCOCK GI                  | 0               | 0           | 0              | 194. 02                  |
| 194. 03 07954 HRH NEPHROLOGY                  | 0               | 0           | 0              | 194. 03                  |
| 194. 04 07957 HRH SANE                        | 0               | 0           | 0              | 194. 04                  |
| 194. 05 07955 HRH RI SE                       | 0               | 0           | 0              | 194. 05                  |
| 194.06 07956 HRH JUSTICE NAVIGATION           | 0               | 0           | 0              | 194. 06                  |
| 194.07 07953 HPN PHYSICIAN                    | 0               | 0           | 0              | 194. 07                  |
| 194. 08 07958 HOSPI TALI ST                   | 0               | 0           | 0              | 194. 08                  |
| 194.0907959 HPN HANCOCK COUNSEL               | 0               | 0           | 0              | 194. 09                  |
| 194. 10 07960 HPN HFM MCKENZIE                | 0               | 0           | 0              | 194. 10                  |
| 194. 11 07961 HPN HIM GREENFI ELD             | 0               | o o         | ٥              | 194. 11                  |
| 194. 12 07962 HPN HFM BOYD                    | 0               | o o         | 0              | 194. 12                  |
| 194. 13 07963 HPN HI M MCCORD                 | 0               | o o         | ٥              | 194. 13                  |
| 194. 14 07964 HPN WELL BEING                  | 0               | o o         | ٥              | 194. 14                  |
| 194. 15 07965 PHYSI CI AN BILLING SERVI CE    | 0               | o o         | ٥              | 194. 15                  |
| 194. 16 07966 CLI NI CAL MANAGEMENT           | 0               | l ő         | ٥              | 194, 16                  |
| 194. 17 07967 HANCOCK ORTHO                   | 0               | l ő         | ٥              | 194. 17                  |
| 194. 18 07968 HANCOCK PEDI ATRI CS            | 0               | o o         | o o            | 194. 18                  |
| 194. 19 07969 HRN HFM NEW                     | 0               | l o         | 0              | 194. 19                  |
| 194. 20 07970 HRH HFM CLEARVI EW              | 0               | l o         | 0              | 194. 20                  |
| 200.00 Cross Foot Adjustments                 |                 | 0           | ٥              | 200.00                   |
| 201.00 Negative Cost Centers                  |                 |             |                | 201.00                   |
| 202.00 Cost to be allocated (per Wkst. B,     | 3, 879, 390     | 2, 017, 265 | 375, 692       | 202.00                   |
| Part I)                                       | 3,077,370       | 2,017,203   | 373,092        | 202.00                   |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 38, 793. 900000 | 612. 591862 | 3, 756. 920000 | 203. 00                  |
| 204.00 Cost to be allocated (per Wkst. B,     | 526, 633        |             |                | 204. 00                  |
| Part II)                                      |                 | ,           |                |                          |
| 205.00 Unit cost multiplier (Wkst. B, Part    | 5, 266. 330000  | 43. 350137  | 673. 090000    | 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 Lie          | u of Form CMS-2552-10   |
|--|---------------------------|-----------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0037    | From 01/01/2023 | Worksheet C<br>Part I<br>Date/Time Prepared:<br>5/31/2024 7:01 am |

|         |  |                                       |               |             | To 12/31/2023   | Date/Time Pre<br>5/31/2024 7:0 | pared:<br>1 am |
|---------|--|---------------------------------------|---------------|-------------|-----------------|--------------------------------|----------------|
|         |  |                                       | Title         | XVIII       | Hospi tal       | PPS                            |                |
|         |  |                                       | <u> </u>      |             | Costs           |                                |                |
|         | Cost Center Description                    | Total Cost                            | Therapy Limit | Total Costs | RCE             | Total Costs                    |                |
|         | <b>'</b>                                   | (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     | <u> </u>                              |               |             |                 |                                |                |
| 30.00   | 03000 ADULTS & PEDIATRICS                  | 13, 383, 332                          |               | 13, 383, 33 | 2 0             | 13, 383, 332                   | 30.00          |
| 31.00   | 03100 INTENSIVE CARE UNIT                  | 13, 237, 910                          |               | 13, 237, 91 |                 | 13, 237, 910                   |                |
| 40.00   | 04000 SUBPROVI DER - I PF                  | 0                                     |               |             | ol ol           | 0                              | 40.00          |
|         | ANCILLARY SERVICE COST CENTERS             | · · · · · · · · · · · · · · · · · · · |               | •           | -,              |                                |                |
| 50.00   | 05000 OPERATING ROOM                       | 10, 076, 247                          |               | 10, 076, 24 | 7 0             | 10, 076, 247                   | 50.00          |
| 51.00   | 05100 RECOVERY ROOM                        | 1, 371, 800                           |               | 1, 371, 80  | ol ol           | 1, 371, 800                    | 51.00          |
| 53.00   | 05300 ANESTHESI OLOGY                      | 0                                     |               |             | ol ol           | 0                              | 53.00          |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C              | 11, 581, 788                          |               | 11, 581, 78 | 8 0             | 11, 581, 788                   | 54.00          |
| 60.00   | 06000 LABORATORY                           | 8, 286, 581                           |               | 8, 286, 58  |                 | 8, 286, 581                    | 60.00          |
| 65.00   | 06500 RESPIRATORY THERAPY                  | 3, 979, 508                           | 0             |             |                 | 3, 979, 508                    |                |
| 66. 00  | 06600 PHYSI CAL THERAPY                    | 2, 563, 168                           | 0             |             |                 | 2, 563, 168                    |                |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY                | 504, 961                              | 0             | 504, 96     |                 | 504, 961                       | 67.00          |
| 68. 00  | 06800 SPEECH PATHOLOGY                     | 319, 645                              | 0             | 319, 64     |                 | 319, 645                       |                |
| 69. 00  | 06900 ELECTROCARDI OLOGY                   | 2, 102, 514                           | ŭ             | 2, 102, 51  |                 | 2, 102, 514                    |                |
| 70.00   | 07000 ELECTROENCEPHALOGRAPHY               | 2, 102, 011                           |               |             |                 | 0                              | 70.00          |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 5, 509, 381                           |               | 5, 509, 38  | -               | 5, 509, 381                    | 71.00          |
| 72.00   | 07200 I MPL. DEV. CHARGED TO PATIENT       | 1, 327, 048                           |               | 1, 327, 04  |                 | 1, 327, 048                    |                |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS            | 30, 502, 330                          |               | 30, 502, 33 |                 | 30, 502, 330                   |                |
| 76.00   | 03020 CARDI AC                             | 00,002,000                            |               |             |                 | 00,002,000                     | 1              |
| 76. 01  | 03160 CARDI OPULMONARY                     | 248, 399                              |               | 248, 39     | -               | 248, 399                       |                |
|         | 07700 ALLOGENEIC STEM CELL ACQUISITION     | 2.0,077                               |               | 1           |                 | 0                              | 77. 00         |
|         | 07800 CAR T-CELL IMMUNOTHERAPY             | 0                                     |               |             | o o             | 0                              | 78.00          |
| 70.00   | OUTPATIENT SERVICE COST CENTERS            | 9                                     |               |             | 5               |                                | 70.00          |
| 88. 00  | 08800 RURAL HEALTH CLINIC                  | 537, 026                              |               | 537, 02     | 6 0             | 537, 026                       | 88. 00         |
| 90.00   | 09000 CLI NI C                             | 0                                     |               |             |                 | 0                              | 90.00          |
| 90. 01  | 09001 WOUND CLINIC                         | 1, 345, 317                           |               | 1, 345, 31  |                 | 1, 345, 317                    | 90. 01         |
| 90. 02  | 09002 DI ABETES CLINIC                     | 59, 719                               |               | 59, 71      |                 | 59, 719                        | 90.02          |
| 90. 03  | 09003 ASTHMA CLINIC                        | 0,7,7.7                               |               |             |                 | 0                              | 90.03          |
| 90. 04  | 09004 ANDIS CLINIC                         | 303, 088                              |               | 303, 08     |                 | 303, 088                       |                |
| 90. 05  | 09005 PRIME TIME                           | 000,000                               |               |             |                 | 0                              | 90.05          |
| 90.06   | 09006 SHELBYVILLE WOUND CLINIC             |                                       |               |             |                 | 0                              | 90.06          |
| 90. 07  | 04951 ONCOLOGY                             | 4, 485, 498                           |               | 4, 485, 49  | ۷۱              | 4, 485, 498                    |                |
|         | 04950 ANDERSON WOMENS CENTER               | 1, 902, 721                           |               | 1, 902, 72  |                 | 1, 902, 721                    |                |
| 91.00   | 09100 EMERGENCY                            | 8, 319, 567                           |               | 8, 319, 56  |                 | 8, 319, 567                    | 1              |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 5, 650, 832                           |               | 5, 650, 83  |                 | 5, 650, 832                    |                |
| 72.00   | OTHER REIMBURSABLE COST CENTERS            | 0,000,002                             |               | 0,000,00    | _               | 0,000,002                      | 72.00          |
| 101 00  | 10100 HOME HEALTH AGENCY                   | 0                                     |               |             | O               | 0                              | 101.00         |
|         | 10200 OPIOID TREATMENT PROGRAM             | 0                                     |               |             | o               |                                | 102.00         |
|         | SPECIAL PURPOSE COST CENTERS               | ·                                     |               |             | -               |                                | 1              |
| 116. 00 | 11600 HOSPI CE                             | 0                                     |               |             | O               | 0                              | 116. 00        |
| 200.00  |  | 127, 598, 380                         | 0             |             |                 |                                |                |
| 201.00  |  | 5, 650, 832                           | _             | 5, 650, 83  |                 | 5, 650, 832                    |                |
| 202.00  | 1  | 121, 947, 548                         | 0             |             |                 |                                |                |
|         |  |                                       | _             |             | ,               | ,                              |                |

| 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 01/01/2023   Part I          |   |
|  |                           | To 12/21/2022 Doto/Time Dropered. |   |

|         |  |                                       |               |               | o 12/31/2023                          | Date/Time Pre<br>5/31/2024 7:0 | pared:  |
|---------|--|---------------------------------------|---------------|---------------|---------------------------------------|--------------------------------|---------|
|         |  |                                       | Title         | XVIII         | Hospi tal                             | PPS                            | ı aiii  |
|         |  |                                       | Charges       |               | 1100 21 tui                           |                                |         |
|         | Cost Center Description                    | Inpati ent                            | Outpati ent   | Total (col. 6 | Cost or Other                         | TEFRA                          |         |
|         |  | ,                                     |               | + col . 7)    | Ratio                                 | Inpatient                      |         |
|         |  |                                       |               | ' ' ' ' ' ' ' |                                       | Ratio                          |         |
|         |  | 6. 00                                 | 7. 00         | 8, 00         | 9. 00                                 | 10.00                          |         |
|         | INPATIENT ROUTINE SERVICE COST CENTERS     |                                       |               |               |                                       |                                |         |
| 30.00   | 03000 ADULTS & PEDIATRICS                  | 10, 913, 945                          |               | 10, 913, 945  |                                       |                                | 30.00   |
| 31.00   | 03100 INTENSIVE CARE UNIT                  | 15, 418, 087                          |               | 15, 418, 087  |                                       |                                | 31.00   |
| 40.00   | 04000 SUBPROVI DER - I PF                  | 0                                     |               | 0             |                                       |                                | 40.00   |
|         | ANCILLARY SERVICE COST CENTERS             | · · · · · · · · · · · · · · · · · · · |               |               | '                                     |                                |         |
| 50.00   | 05000 OPERATING ROOM                       | 9, 557, 227                           | 37, 883, 957  | 47, 441, 184  | 0. 212395                             | 0.000000                       | 50.00   |
| 51.00   | 05100 RECOVERY ROOM                        | 904, 624                              | 2, 316, 081   | 3, 220, 705   |                                       | 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              | 4, 107, 776                           | 98, 580, 189  | 102, 687, 965 | 0. 112786                             | 0.000000                       | 54.00   |
| 60.00   | 06000 LABORATORY                           | 8, 540, 959                           | 56, 167, 236  |               |                                       | 0.000000                       | 60.00   |
| 65.00   | 06500 RESPI RATORY THERAPY                 | 2, 234, 949                           | 8, 584, 240   | 10, 819, 189  | 0. 367819                             | 0.000000                       | 65.00   |
| 66. 00  | 06600 PHYSI CAL THERAPY                    | 573, 634                              | 4, 859, 989   |               |                                       | 0.000000                       |         |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY                | 471, 110                              | 882, 253      |               |                                       | 0.000000                       | 1       |
| 68. 00  | 06800 SPEECH PATHOLOGY                     | 240, 205                              | 792, 904      | 1, 033, 109   |                                       | 0. 000000                      |         |
| 69. 00  | 06900 ELECTROCARDI OLOGY                   | 3, 398, 217                           | 13, 877, 995  |               |                                       | 0. 000000                      |         |
| 70.00   | 07000 ELECTROENCEPHALOGRAPHY               | 0                                     | 0             | 0             | 0. 000000                             | 0. 000000                      |         |
|         | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 428, 553                              | 1, 136, 209   | 1, 564, 762   |                                       | 0. 000000                      |         |
| 72. 00  | 07200 IMPL. DEV. CHARGED TO PATIENT        | 1, 440, 224                           | 8, 982, 603   |               |                                       | 0. 000000                      | 1       |
|         | 07300 DRUGS CHARGED TO PATIENTS            | 9, 910, 224                           | 121, 367, 759 |               |                                       | 0. 000000                      |         |
|         | 03020 CARDI AC                             | 0                                     | 0             | 0             |                                       | 0. 000000                      |         |
|         | 03160 CARDI OPULMONARY                     | o                                     | 486, 642      | 486, 642      |                                       | 0.000000                       |         |
| 77. 00  | 07700 ALLOGENEIC STEM CELL ACQUISITION     | 0                                     | 0             | 0             |                                       | 0. 000000                      |         |
|         | 07800 CAR T-CELL IMMUNOTHERAPY             | 0                                     | 0             |               | 1                                     | 0. 000000                      |         |
|         | OUTPATIENT SERVICE COST CENTERS            |                                       | -             | <u>-</u>      |                                       |                                |         |
| 88. 00  | 08800 RURAL HEALTH CLINIC                  | 0                                     | 853, 313      | 853, 313      |                                       |                                | 88.00   |
| 90.00   | 09000 CLI NI C                             | o                                     | 0             | 0             |                                       | 0.000000                       | 90.00   |
|         | 09001 WOUND CLINIC                         | 9, 400                                | 5, 827, 910   | 5, 837, 310   | l l                                   | 0.000000                       |         |
| 90. 02  | 09002 DI ABETES CLINIC                     | 0                                     | 5, 441        | 5, 441        | 10. 975740                            | 0.000000                       |         |
| 90. 03  | 09003 ASTHMA CLINIC                        | o                                     | 0             | 0             |                                       | 0.000000                       | 90. 03  |
| 90. 04  | 09004 ANDIS CLINIC                         | o                                     | 48, 801       | 48, 801       | 6. 210692                             | 0.000000                       | 1       |
| 90. 05  | 09005 PRIME TIME                           | 0                                     | 0             | 0             |                                       | 0.000000                       |         |
| 90.06   | 09006 SHELBYVILLE WOUND CLINIC             | o                                     | 0             |               | 0. 000000                             | 0.000000                       | 90.06   |
| 90. 07  | 04951 ONCOLOGY                             | 19, 798                               | 8, 405, 777   | 8, 425, 575   |                                       | 0.000000                       | 90. 07  |
| 90. 08  | 04950 ANDERSON WOMENS CENTER               | 0                                     | 5, 206, 148   | 5, 206, 148   | 0. 365476                             | 0.000000                       | 90.08   |
|         | 09100 EMERGENCY                            | 8, 549, 181                           | 71, 411, 281  | 79, 960, 462  |                                       | 0.000000                       |         |
|         | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 438, 106                              | 17, 396, 387  | 17, 834, 493  |                                       | 0.000000                       |         |
|         | OTHER REIMBURSABLE COST CENTERS            | · · · ·                               |               |               | ·                                     |                                |         |
| 101.00  | 10100 HOME HEALTH AGENCY                   | 0                                     | 0             | 0             |                                       |                                | 101.00  |
|         | 10200 OPI OI D TREATMENT PROGRAM           | o                                     | 0             |               |                                       |                                | 102.00  |
|         | SPECIAL PURPOSE COST CENTERS               |                                       |               |               | · · · · · · · · · · · · · · · · · · · |                                |         |
| 116. 00 | 11600 H0SPI CE                             | 0                                     | 0             | C             |                                       |                                | 116. 00 |
| 200.00  | l l  | 77, 156, 219                          | 465, 073, 115 | 542, 229, 334 | .                                     |                                | 200.00  |
| 201.00  |  | ' ' ' ' '                             |               |               |                                       |                                | 201.00  |
| 202.00  | l l  | 77, 156, 219                          | 465, 073, 115 | 542, 229, 334 |                                       |                                | 202.00  |
|         |  |                                       |               |               | '                                     |                                |         |

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0037 Period: From 01/01/2023 To 12/31/2024 7:01 am 5/31/2024 7:01 am

| Sy31/2024 7: 01 am  |
|---|
| NPATI ENT ROUTINE SERVICE COST CENTERS   30.00   03000 ADULTS & PEDI ATRI CS   31.00   03000 ADULTS & PEDI ATRI CS   31.00   04000 SUBBROVI DER = 1 PF   40.00   04000 SUBBROVI DER = 1 PF   40.00   04000 SUBBROVI DER = 1 PF   40.00   05000   0PERATI NG ROOM   0.212395   50.00   05000   0PERATI NG ROOM   0.425932   51.00   05100 RECOVERY ROOM   0.425932   51.00   05300   0AUESTHESI OLOGY   0.000000   53.00   05300   0AUESTHESI OLOGY   0.000000   53.00   05300   0AUESTHESI OLOGY   0.000000   55.000   06500   RESPI RATORY THERAPY   0.12786   60.00   06500   RESPI RATORY THERAPY   0.367819   65.00   06500   06600   PHASI CAL THERAPY   0.373116   66.00   06600   04600 CAL DERORATORY   0.373116   66.00   06600   06600   PHASI CAL THERAPY   0.373116   67.00   06700   0CCUPATI ONAL THERAPY   0.373116   67.00   068.00   06800   SPEECH PATHOLOGY   0.309401   68.00   06900   ELECTROCARDI OLOGY   0.121700   0.9000   ELECTROCARDI OLOGY   0.121700   0.7000   0.7000   ELECTROCARDI OLOGY   0.121700   0.7000   0.7000   ELECTROECEPHALOGRAPHY   0.000000   70.00   70.00   07000   ELECTROENCEPHALOGRAPHY   0.000000   70.00   70.00   07000   CARDIA C   0.000000   70.00   0.33940   70.00   70.00   70.00   07000   CARDIA C   0.000000   70.00   |
| INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30.00   3000   ADULTS & PEDIATRICS   30.00   31.00  |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00     |
| 30. 00   3000   ADULTS & PEDIATRICS   30. 00   30100   INTENSIVE CARE UNIT   31. 00   40. 00   40. 00   40. 00   50. 0  |
| 31.00   03100   INTENSIVE CARE UNIT   |
| 40. 00   04000   SUBPROVIDER - IPF  |
| ANCILLARY SERVICE COST CENTERS  |
| 50. 00   05000   OPERATI NG ROOM   0. 212395   50. 00   |
| 51.00   05100   RECOVERY ROOM   0.425932   51.00   53.00   05300   AMESTHESI OLOGY   0.000000   53.00   05400   RADI OLOGY-DI AGNOSTI C   0.112786   54.00   06000   LABDRATORY   0.128061   66.00   06500   RESPIRATORY THERAPY   0.367819   66.00   06500   RESPIRATORY THERAPY   0.471724   66.00   06000   CLUPATI ONAL THERAPY   0.471724   66.00   06000   RESPIRATORY THERAPY   0.373116   67.00   06700   0CCUPATI ONAL THERAPY   0.373116   67.00   06800   SPEECH PATHOLOGY   0.309401   68.00   06900   ELECTROCARDI OLOGY   0.121700   69.00   07000   ELECTROENCEPHALOGRAPHY   0.000000   70.00   07000   ELECTROENCEPHALOGRAPHY   0.000000   70.00   07200   IMPL DEV. CHARGED TO PATI ENTS   3.520907   71.00   07300   DRUGS CHARGED TO PATI ENTS   0.232349   73.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0.232349   76.01   03160   CARDI OPULMONARY   0.510435   76.01   77.00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0.000000   0.00000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000   |
| 53. 00       05300   ANESTHESI OLOGY       0.000000       53. 00         54. 00       05400   RADI OLOGY-DI AGNOSTI C       0.112786       54. 00         60. 00   06000   LABORATORY       0.128061       66. 00         65. 00   06500   RESPI RATORY THERAPY       0.367819       65. 00         66. 00   06600   PHYSI CAL THERAPY       0.471724       66. 00         68. 00   06600   PHYSI CAL THERAPY       0.373116       67. 00         68. 00   06800   SPEECH PATHOLOGY       0.373116       68. 00         69. 00   06900   ELECTROCARDI OLOGY       0.121700       69. 00         70. 00   07000   DELECTROENCEPHALOGRAPHY       0.000000       70. 00         71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS       3.520907       71. 00         72. 00   07200   IMPL   DEV   CHARGED TO PATIENTS       3.520907       72. 00         73. 00   07300   DRUGS CHARGED TO PATIENTS       0.232349       73. 00         76. 01   03160   CARDI AC       0.000000       76. 01         77. 00   07700   ALLOGENEIC STEM CELL ACQUI SI TI ON       0.00000       77. 00         78. 00   07700   ALLOGENEIC STEM CELL ACQUI SI TI ON       0.000000       77. 00         00   0900   CAR T - CELL IMMUNOTHERAPY       0.000000       77. 00         00   0900   CAR T - CELL IMMUNOTHERAPY       0.000000  |
| 54. 00       05400 RADI OLOGY-DI AGNOSTI C       0. 112786       54. 00         60. 00       06000 LABORATORY       0. 128061       60. 00         65. 00       06500 RESPI RATORY THERAPY       0. 367819       65. 00         66. 00       06600 PHYSI CAL THERAPY       0. 471724       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0. 373116       67. 00         68. 00       06800 SPEECH PATHOLOGY       0. 309401       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0. 121700       69. 00         70. 00       07000 ELECTROENCEPHALOGRAPHY       0. 000000       70. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       3. 520907       71. 00         72. 00       07200 I IMPL. DEV. CHARGED TO PATI ENTS       3. 520907       71. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0. 232349       73. 00         76. 01       03020 CARDI AC       0. 000000       76. 01         77. 00       0700 ALLOGENEI C STEM CELL ACQUI SI TI ON       0. 000000       76. 01         78. 00       07800 CARDI AC       0. 000000       77. 00         77. 00       0700 ALLOGENEI C STEM CELL ACQUI SI TI ON       0. 000000       77. 00         0700 Ognot Linic       0.  |
| 60. 00   06000   LABORATORY   0. 128061   60. 00   65. 00   RESPI RATORY THERAPY   0. 367819   65. 00   66. 00   66. 00   66. 00   66. 00   66. 00   67. 00   67. 00   67. 00   67. 00   67. 00   67. 00   67. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   68. 00   69. 00 |
| 65. 00  |
| 66. 00  |
| 67. 00  |
| 68. 00  |
| 69. 00  |
| 70. 00  |
| 71. 00  |
| 72. 00  |
| 73. 00  |
| 76. 00  |
| 76. 01  |
| 77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0.000000   78. 00   00000   CI NI C   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000   |
| 78. 00   07800   CAR T-CELL I MMUNOTHERAPY   0. 000000   78. 00   |
| SERVICE COST CENTERS   SERVICE COST CENTERS  |
| 88. 00   08800   RURAL HEALTH CLINIC   90. 00   09000   CLINIC   0. 000000   90. 01   09001   WOUND CLINIC   0. 230469   90. 02   09002   DIABETES CLINIC   10. 975740   90. 02   |
| 90. 00     09000 CLINIC     0. 000000       90. 01     09001 WOUND CLINIC     0. 230469       90. 02     09002 DI ABETES CLINIC     10. 975740  |
| 90. 01   09001   WOUND CLINIC   0. 230469   90. 02   09002   DI ABETES CLINIC   0. 975740   90. 02  |
| 90. 02 09002 DI ABETES CLINI C 10. 975740 90. 02  |
|   |
| 90. 03   09003   ASTHMA CLINIC   0. 000000   90. 03   |
|   |
| 90. 04   09004   ANDIS CLINIC   6. 210692   90. 04  |
| 90. 05   09005   PRI ME TI ME   0. 000000   90. 05  |
| 90. 06   09006   SHELBYVI LLE WOUND CLINI C 0. 000000 90. 06  |
| 90. 07   04951   0NCOLOGY   0. 532367   90. 07  |
| 90. 08   04950  ANDERSON WOMENS CENTER   0. 365476   90. 08   |
| 91. 00   09100   EMERGENCY   0. 104046   91. 00   |
| 92. 00   09200  OBSERVATI ON BEDS (NON-DI STI NCT PART)   0. 316848   92. 00  |
| OTHER REIMBURSABLE COST CENTERS   |
| 101. 00 10100 HOME HEALTH AGENCY 101. 00  |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM 102. 00  |
| SPECIAL PURPOSE COST CENTERS  |
| 116. 00 11600 HOSPI CE 116. 00  |
| 200.00 Subtotal (see instructions) 200.00   |
| 201.00 Less Observation Beds 201.00   |
| 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                        |

|         |  |               |               |              | To 12/31/2023   | Date/Time Pre 5/31/2024 7:0 | pared:<br>1 am |
|---------|--|---------------|---------------|--------------|-----------------|-----------------------------|----------------|
|         |  |               | Ti tl         | e XIX        | Hospi tal       | Cost                        |                |
|         |  |               | <u>'</u>      |              | Costs           |                             |                |
|         | Cost Center Description  | Total Cost    | Therapy Limit | Total Costs  | RCE             | Total Costs                 |                |
|         |  | (from Wkst.   | Adj .         |              | Di sal I owance |                             |                |
|         |  | B, Part I,    |               |              |                 |                             |                |
|         |  | col. 26)      |               |              |                 |                             |                |
|         |  | 1. 00         | 2. 00         | 3. 00        | 4. 00           | 5. 00                       |                |
|         | INPATIENT ROUTINE SERVICE COST CENTERS                               |               |               |              |                 |                             |                |
| 30.00   | 03000 ADULTS & PEDI ATRI CS  | 13, 383, 332  |               | 13, 383, 33  |                 | 13, 383, 332                | 30.00          |
| 31.00   | 03100 INTENSIVE CARE UNIT  | 13, 237, 910  |               | 13, 237, 91  |                 | 13, 237, 910                | 31.00          |
| 40.00   | 04000 SUBPROVI DER - I PF  | 0             |               |              | 0 0             | 0                           | 40. 00         |
|         | ANCILLARY SERVICE COST CENTERS                                       |               |               |              |                 |                             |                |
| 50. 00  | 05000 OPERATING ROOM   | 10, 076, 247  |               | 10, 076, 24  |                 |                             | 50.00          |
| 51. 00  | 05100 RECOVERY ROOM  | 1, 371, 800   |               | 1, 371, 80   |                 | 1, 371, 800                 | 51.00          |
| 53.00   | 05300 ANESTHESI OLOGY  | 0             |               |              | 0               | 0                           | 53.00          |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C  | 11, 581, 788  |               | 11, 581, 78  |                 | 11, 581, 788                | 54.00          |
| 60.00   | 06000 LABORATORY   | 8, 286, 581   |               | 8, 286, 58   |                 | 8, 286, 581                 | 60.00          |
| 65.00   | 06500 RESPI RATORY THERAPY   | 3, 979, 508   | 0             |              |                 | 3, 979, 508                 | 65.00          |
| 66. 00  | 06600 PHYSI CAL THERAPY  | 2, 563, 168   | 0             | 2,000,.0     |                 | 2, 563, 168                 | 1              |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY  | 504, 961      | 0             | 504, 96      |                 | 504, 961                    | 67.00          |
| 68. 00  | 06800 SPEECH PATHOLOGY   | 319, 645      | 0             | 319, 64      |                 | 319, 645                    | 68.00          |
| 69. 00  | 06900 ELECTROCARDI OLOGY   | 2, 102, 514   |               | 2, 102, 51   |                 | 2, 102, 514                 | ł              |
| 70.00   | 07000 ELECTROENCEPHALOGRAPHY   | 0             |               |              | 0               | 0                           | 70.00          |
| 71.00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                           | 5, 509, 381   |               | 5, 509, 38   |                 | 5, 509, 381                 | 71.00          |
| 72.00   | 07200 I MPL. DEV. CHARGED TO PATIENT                                 | 1, 327, 048   |               | 1, 327, 04   |                 | 1, 327, 048                 |                |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS                                      | 30, 502, 330  |               | 30, 502, 33  |                 | 30, 502, 330                | 73.00          |
| 76.00   | 03020 CARDI AC   | 0             |               |              | 0               | 0                           | 76.00          |
| 76. 01  | 03160 CARDI OPULMONARY   | 248, 399      |               | 248, 39      |                 | 248, 399                    | 76. 01         |
| 77.00   | 07700 ALLOGENEIC STEM CELL ACQUISITION                               | 0             |               |              | 0 0             | 0                           | 77.00          |
| 78. 00  | O7800   CAR T-CELL   IMMUNOTHERAPY   OUTPATIENT SERVICE COST CENTERS | U             |               |              | 0               | 0                           | 78. 00         |
| 88. 00  | 08800 RURAL HEALTH CLINIC  | 537, 026      |               | 537, 02      | 6 0             | 537, 026                    | 88. 00         |
| 90.00   | 09000 CLINIC   | 537, 026      |               |              | 0 0             | 537,026                     | 90.00          |
| 90.00   | 09000 CLINIC   | 1, 345, 317   |               | 1, 345, 31   |                 | 1, 345, 317                 | 90.00          |
| 90.01   | 09001 WOUND CLINIC   | 1, 345, 317   |               | 1, 345, 31   |                 | 1, 345, 317                 |                |
| 90. 02  | 09002 DIABETES CLINIC  | 39, /19       |               |              | 0 0             | 0 59,719                    | 90.02          |
| 90.03   | 09004 ANDIS CLINIC   | 303, 088      |               | 303, 08      | -               | 303, 088                    | 90.03          |
| 90.04   | 09005 PRIME TIME   | 303,000       |               |              | 0 0             | 303, 000                    | 90.04          |
| 90.06   | 09006 SHELBYVILLE WOUND CLINIC                                       | 0             |               |              |                 | 0                           | 90.06          |
| 90. 07  | 04951 ONCOLOGY   | 4, 485, 498   |               | 4, 485, 49   | 8 0             | 4, 485, 498                 | 90.00          |
| 90. 08  | 04950 ANDERSON WOMENS CENTER   | 1, 902, 721   |               | 1, 902, 72   |                 | 1, 902, 721                 | 90.08          |
| 91. 00  | 09100 EMERGENCY  | 8, 319, 567   |               | 8, 319, 56   |                 | 8, 319, 567                 | 91.00          |
| 92. 00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                           | 5, 650, 832   |               | 5, 650, 83   |                 | 5, 650, 832                 |                |
| 72.00   | OTHER REIMBURSABLE COST CENTERS                                      | 3,030,032     |               | 3, 050, 05   | ۷               | 3, 030, 032                 | 72.00          |
| 101 00  | 10100 HOME HEALTH AGENCY   | 0             |               |              | 0               | 0                           | 101.00         |
|         | 10200 OPI OI D TREATMENT PROGRAM                                     | 0             |               |              | o<br>O          |                             | 102.00         |
| .02.00  | SPECIAL PURPOSE COST CENTERS   |               |               |              | <u> </u>        |                             |                |
| 116. 00 | 11600 HOSPI CE   | 0             |               |              | 0               | 0                           | 116. 00        |
| 200.00  |  | 127, 598, 380 | 0             | 127, 598, 38 | 0               |                             |                |
| 201.00  |  | 5, 650, 832   |               | 5, 650, 83   |                 | 5, 650, 832                 |                |
| 202.00  | Total (see instructions)   | 121, 947, 548 | 0             | 121, 947, 54 | 8 0             | 121, 947, 548               | 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<br>From 01/01/2023 Part I |
|  |                           | To 12/31/2023 Date/Time Prepared              |

|   |                |               |              | To 12/31/2023 | Date/Time Pre<br>5/31/2024 7:0 | pared:  |
|---|----------------|---------------|--------------|---------------|--------------------------------|---------|
|   |                | Ti +I         | e XIX        | Hospi tal     | Cost                           | i aiii  |
|   |                | Charges       | CAIA         | 1103pi tai    | 0031                           |         |
| Cost Center Description   | Inpatient      | Outpati ent   | Total (col 6 | Cost or Other | TEFRA                          |         |
| oost center bescription   | Tripatricit    | outpatrent    | + col . 7)   | Ratio         | I npati ent                    |         |
|   |                |               | 1 001. 7)    | Ratio         | Ratio                          |         |
|   | 6. 00          | 7. 00         | 8.00         | 9. 00         | 10.00                          |         |
| INPATIENT ROUTINE SERVICE COST CENTERS  | 0.00           | 7.00          | 0.00         | 7.00          | 10.00                          |         |
| 30. 00 03000 ADULTS & PEDIATRICS  | 10, 913, 945   |               | 10, 913, 94  | 5             |                                | 30.00   |
| 31. 00 03100   NTENSI VE CARE UNI T   | 15, 418, 087   |               | 15, 418, 08  |               |                                | 31.00   |
| 40. 00   04000   SUBPROVI DER -   PF  | 0              |               |              | Ó             |                                | 40.00   |
| ANCI LLARY SERVICE COST CENTERS   | <u> </u>       |               |              | ١             |                                | 10.00   |
| 50. 00   05000   OPERATING ROOM   | 9, 557, 227    | 37, 883, 957  | 47, 441, 18  | 4 0. 212395   | 0.000000                       | 50.00   |
| 51. 00   05100   RECOVERY   ROOM  | 904, 624       | 2, 316, 081   | 3, 220, 70   |               | 0. 000000                      |         |
| 53. 00 05300 ANESTHESI OLOGY  | 0              | 2,0.0,001     |              | 0. 000000     | 0. 000000                      | 1       |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  | 4, 107, 776    | 98, 580, 189  |              |               | 0. 000000                      |         |
| 60. 00   06000   LABORATORY   | 8, 540, 959    | 56, 167, 236  |              |               | 0. 000000                      | 1       |
| 65. 00 06500 RESPIRATORY THERAPY  | 2, 234, 949    | 8, 584, 240   |              |               | 0. 000000                      | 1       |
| 66. 00   06600 PHYSI CAL THERAPY  | 573, 634       | 4, 859, 989   |              |               | 0. 000000                      |         |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 471, 110       | 882, 253      | 1, 353, 36   |               | 0. 000000                      | 1       |
| 68. 00 06800 SPEECH PATHOLOGY   | 240, 205       | 792, 904      | 1, 033, 10   |               | 0. 000000                      | 1       |
| 69. 00   06900   ELECTROCARDI OLOGY   | 3, 398, 217    | 13, 877, 995  |              |               | 0. 000000                      |         |
| 70. 00 07000 ELECTROCARDI OLOGI<br>70. 00 07000 ELECTROENCEPHALOGRAPHY                      | 3, 370, 217    | 13,077,773    |              | 0. 121700     | 0. 000000                      | 1       |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   | 428, 553       | 1, 136, 209   |              |               | 0. 000000                      | 1       |
| 72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS   | 1, 440, 224    | 8, 982, 603   |              |               | 0. 000000                      | 1       |
| 73. 00 07300 DRUGS CHARGED TO PATTENTS  | 9, 910, 224    | 121, 367, 759 |              |               | 0. 000000                      | 1       |
| 75. 00 07500 DROGS CHARGED TO PATTENTS  76. 00 03020 CARDI AC                               | 9, 910, 224    | 121, 307, 739 |              | 0. 232349     | 0. 000000                      | 1       |
| 76. 00   03020 CARDI AC<br>76. 01   03160 CARDI OPULMONARY                                  |                | 486, 642      | 486, 64      |               | 0. 000000                      |         |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION   |                | 460, 642      |              | 0. 510433     | 0. 000000                      | 1       |
| 78. 00   07/00 ALLOGENETC STEW CELL ACQUISITION 78. 00   07800   CAR T-CELL   IMMUNOTHERAPY |                | 0             |              | 0.000000      | 0. 000000                      | 1       |
| OUTPATIENT SERVICE COST CENTERS   | U U            |               |              | 0. 000000     | 0.000000                       | 78.00   |
| 88. 00 08800 RURAL HEALTH CLINIC  | O              | 853, 313      | 853, 31      | 3 0. 629342   | 0. 000000                      | 88. 00  |
| 90. 00   09000   CLI NI C   |                | 033, 313      |              | 0.000000      | 0. 000000                      |         |
| 90. 01 09001 WOUND CLINIC   | 9, 400         | 5, 827, 910   |              |               | 0. 000000                      | 1       |
| 90. 02   09002 DI ABETES CLI NI C   | 7, 400         | 5, 627, 910   | 5, 657, 31   |               | 0.000000                       | 1       |
| 90. 03   09003   ASTHMA CLINIC  |                | J, 441        |              | 0.000000      | 0. 000000                      |         |
| 90. 04   09004 ANDIS CLINIC   |                | 48, 801       | 48, 80       |               | 0. 000000                      | 1       |
| 90. 05   09005   PRI ME   TI ME   |                | 40,001        |              | 0. 210072     | 0.000000                       |         |
| 90. 06 09006 SHELBYVILLE WOUND CLINIC   |                | 0             |              | 0. 000000     | 0. 000000                      |         |
| 90. 07 04951 ONCOLOGY   | 19, 798        | 8, 405, 777   | 8, 425, 57   |               | 0. 000000                      | 1       |
| 90. 08 04950 ANDERSON WOMENS CENTER   | 17, 770        | 5, 206, 148   |              |               | 0. 000000                      |         |
| 91. 00   09100   EMERGENCY  | 8, 549, 181    | 71, 411, 281  | 79, 960, 46  |               | 0. 000000                      |         |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)   | 438, 106       | 17, 396, 387  | 17, 834, 49  |               | 0. 000000                      | 1       |
| OTHER REIMBURSABLE COST CENTERS   | 430, 100       | 17, 370, 307  | 17,034,47    | 0. 310040     | 0.000000                       | 72.00   |
| 101. 00 10100 HOME HEALTH AGENCY  | O              | 0             |              | 0             |                                | 101.00  |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM  |                | 0             |              | 0             |                                | 102.00  |
| SPECIAL PURPOSE COST CENTERS  | <u> </u>       |               |              | <u> </u>      |                                | 102.00  |
| 116. 00 11600 HOSPI CE  | 0              | 0             |              | 0             |                                | 116.00  |
| 200.00 Subtotal (see instructions)  | 77, 156, 219   | 465, 073, 115 |              | ~             |                                | 200.00  |
| 201.00 Less Observation Beds  | 77, 130, 219   | 400,070,110   | 572, 227, 33 | 1             |                                | 201.00  |
| 202.00 Total (see instructions)   | 77, 156, 219   | 465, 073, 115 | 542, 229, 33 | 4             |                                | 202.00  |
| 202.00    10141 (300 1/1311 4011 0113)  | , , , 100, 217 | 100, 070, 110 | 1 512,227,33 | .1            |                                | 1-02.00 |

Health Financial Systems HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0037 Period: From 01/01/2023 To 12/31/2024 7:01 am 5/31/2024 7:01 am

|        |  |               |           | 12, 01, 2020 | 5/31/2024 7: | 01 am  |
|--------|--|---------------|-----------|--------------|--------------|--------|
|        |  |               | Title XIX | Hospi tal    | Cost         |        |
|        | Cost Center Description                    | PPS Inpatient |           |              |              |        |
|        |  | Ratio         |           |              |              |        |
|        |  | 11. 00        |           |              |              |        |
|        | INPATIENT ROUTINE SERVICE COST CENTERS     |               |           |              |              |        |
| 30.00  | 03000 ADULTS & PEDI ATRI CS                |               |           |              |              | 30.00  |
| 31.00  | 03100 INTENSIVE CARE UNIT                  |               |           |              |              | 31.00  |
| 40.00  | 04000 SUBPROVI DER - I PF                  |               |           |              |              | 40.00  |
|        | ANCILLARY SERVICE COST CENTERS             |               |           |              |              |        |
| 50.00  | 05000 OPERATING ROOM                       | 0. 000000     |           |              |              | 50.00  |
| 51.00  | 05100 RECOVERY ROOM                        | 0. 000000     |           |              |              | 51.00  |
| 53.00  | 05300 ANESTHESI OLOGY                      | 0. 000000     |           |              |              | 53.00  |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | 0. 000000     |           |              |              | 54.00  |
| 60.00  | 06000 LABORATORY                           | 0. 000000     |           |              |              | 60.00  |
| 65.00  | 06500 RESPIRATORY THERAPY                  | 0. 000000     |           |              |              | 65.00  |
| 66.00  | 06600 PHYSI CAL THERAPY                    | 0. 000000     |           |              |              | 66.00  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 0. 000000     |           |              |              | 67.00  |
| 68.00  | 06800 SPEECH PATHOLOGY                     | 0. 000000     |           |              |              | 68. 00 |
| 69.00  | 06900 ELECTROCARDI OLOGY                   | 0. 000000     |           |              |              | 69.00  |
| 70.00  | 07000 ELECTROENCEPHALOGRAPHY               | 0. 000000     |           |              |              | 70.00  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000     |           |              |              | 71.00  |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENT       | 0. 000000     |           |              |              | 72.00  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 0. 000000     |           |              |              | 73.00  |
| 76.00  | 03020 CARDI AC                             | 0. 000000     |           |              |              | 76.00  |
| 76. 01 | 03160 CARDI OPULMONARY                     | 0. 000000     |           |              |              | 76. 01 |
| 77.00  | 07700 ALLOGENEIC STEM CELL ACQUISITION     | 0. 000000     |           |              |              | 77. 00 |
| 78.00  | 07800 CAR T-CELL IMMUNOTHERAPY             | 0. 000000     |           |              |              | 78. 00 |
|        | OUTPATIENT SERVICE COST CENTERS            | <u> </u>      |           |              |              |        |
| 88. 00 | 08800 RURAL HEALTH CLINIC                  | 0. 000000     |           |              |              | 88. 00 |
| 90.00  | 09000 CLI NI C                             | 0. 000000     |           |              |              | 90.00  |
| 90. 01 | 09001 WOUND CLINIC                         | 0. 000000     |           |              |              | 90. 01 |
| 90. 02 | 09002 DI ABETES CLINIC                     | 0. 000000     |           |              |              | 90. 02 |
| 90. 03 | 09003 ASTHMA CLINIC                        | 0. 000000     |           |              |              | 90. 03 |
| 90.04  | 09004 ANDIS CLINIC                         | 0. 000000     |           |              |              | 90. 04 |
| 90.05  | 09005 PRIME TIME                           | 0. 000000     |           |              |              | 90.05  |
| 90.06  | 09006 SHELBYVILLE WOUND CLINIC             | 0. 000000     |           |              |              | 90.06  |
| 90. 07 | 04951 ONCOLOGY                             | 0. 000000     |           |              |              | 90. 07 |
| 90.08  | 04950 ANDERSON WOMENS CENTER               | 0. 000000     |           |              |              | 90. 08 |
|        | 09100 EMERGENCY                            | 0. 000000     |           |              |              | 91.00  |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000     |           |              |              | 92.00  |
|        | OTHER REIMBURSABLE COST CENTERS            | <u> </u>      |           |              |              |        |
| 101.00 | 10100 HOME HEALTH AGENCY                   |               |           |              |              | 101.00 |
| 102.00 | 10200 OPIOID TREATMENT PROGRAM             |               |           |              |              | 102.00 |
|        | SPECIAL PURPOSE COST CENTERS               |               |           |              |              |        |
| 116.00 | 11600 H0SPI CE                             |               |           |              |              | 116.00 |
| 200.00 | 1  |               |           |              |              | 200.00 |
| 201.00 | ,  |               |           |              |              | 201.00 |
| 202.00 |  |               |           |              |              | 202.00 |
|        |  |               |           |              |              | •      |

| Health Financial Systems                           | HANCOCK REGION | NAL HOSPITAL    |              | In Lie                           | u of Form CMS-2 | 2552-10 |
|--|----------------|-----------------|--------------|----------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS          | Provi der C     |              | Peri od:                         | Worksheet D     |         |
|  |                |                 |              | From 01/01/2023<br>To 12/31/2023 |                 | nared:  |
|  |                |                 |              | 10 12/31/2023                    | 5/31/2024 7: 0  |         |
|  |                |                 | XVIII        | Hospi tal                        | PPS             |         |
| Cost Center Description                            | Capi tal       | Swing Bed       | Reduced      | Total Patient                    | Per Diem        |         |
|  | Related Cost   | Adjustment      | Capi tal     | Days                             | (col. 3 /       |         |
|  | (from Wkst.    |                 | Related Cost |                                  | col. 4)         |         |
|  | B, Part II,    |                 | (col. 1 -    |                                  |                 |         |
|  | col. 26)       |                 | col. 2)      |                                  |                 |         |
|  | 1. 00          | 2. 00           | 3. 00        | 4. 00                            | 5. 00           |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             |                | _               |              |                                  |                 |         |
| 30. 00 ADULTS & PEDIATRICS                         | 2, 363, 270    |                 | 2, 363, 27   |                                  |                 | 1       |
| 31. 00   INTENSIVE CARE UNIT                       | 1, 966, 569    | _               | 1, 966, 56   | 9 6, 140                         |                 | 1       |
| 40. 00 SUBPROVI DER – I PF                         | 0              | 0               |              | 0                                | 0. 00           | 1       |
| 200.00 Total (lines 30 through 199)                | 4, 329, 839    |                 | 4, 329, 83   | 9 14, 813                        |                 | 200.00  |
| Cost Center Description                            | I npati ent    | I npati ent     |              |                                  |                 |         |
|  | Program days   | Program         |              |                                  |                 |         |
|  |                | Capital Cost    |              |                                  |                 |         |
|  |                | (col. 5 x       |              |                                  |                 |         |
|  | 6, 00          | col. 6)<br>7.00 |              |                                  |                 |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             | 6.00           | 7.00            |              |                                  |                 |         |
| 30.00 ADULTS & PEDIATRICS                          | 935            | 254, 778        |              |                                  |                 | 30.00   |
| 31. 00 INTENSIVE CARE UNIT                         | 1, 858         |                 |              |                                  |                 | 31.00   |
| 40. 00   SUBPROVI DER - I PF                       | 1, 838         | 090, 099        |              |                                  |                 | 40.00   |
| 200.00 Total (lines 30 through 199)                | 2 702          | 040.077         |              |                                  |                 | •       |
| 200.00 Total (Titles 30 till ough 199)             | 2, 793         | 849, 877        | I            |                                  |                 | 200. 00 |

| Health Financial Systems   |                           | HANCOCK REGIO | NAL HOSPITAL  |              | In Lie          | u of Form CMS-2 | 2552-10 |
|----------------------------|---------------------------|---------------|---------------|--------------|-----------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT | T ANCILLARY SERVICE CAPIT | AL COSTS      | Provi der C   |              | Peri od:        | Worksheet D     |         |
|                            |                           |               |               |              | From 01/01/2023 |                 |         |
|                            |                           |               |               |              | To 12/31/2023   | Date/Time Pre   | pared:  |
|                            |                           |               |               |              |                 | 5/31/2024 7:0   | 1 am    |
|                            |                           |               | Ti tl e       | e XVIII      | Hospi tal       | PPS             |         |
| Cost Center D              | escri pti on              | 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           |         |

|  |              | Title         | XVIII         | Hospi tal    | PPS           |         |
|--|--------------|---------------|---------------|--------------|---------------|---------|
| Cost Center Description                          | Capi tal     | Total Charges | Ratio of Cost | I npati ent  | Capital Costs |         |
|  | Related Cost | (from Wkst.   | to Charges    | Program      | (column 3 x   |         |
|  | (from Wkst.  | C, Part I,    | (col. 1 ÷     | Charges      | column 4)     |         |
|  | B, Part II,  | col. 8)       | col . 2)      | •            |               |         |
|  | col. 26)     |               |               |              |               |         |
|  | 1. 00        | 2. 00         | 3.00          | 4. 00        | 5. 00         |         |
| ANCILLARY SERVICE COST CENTERS                   |              |               |               |              |               |         |
| 50.00   05000   OPERATING ROOM                   | 997, 598     | 47, 441, 184  | 0. 021028     | 2, 490, 478  | 52, 370       | 50.00   |
| 51.00   05100   RECOVERY ROOM                    | 239, 327     | 3, 220, 705   | 0. 074309     | 207, 889     | 15, 448       | 51.00   |
| 53. 00   05300   ANESTHESI OLOGY                 | 0            | 0             | 0.000000      | 0            | 0             | 53.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 1, 762, 024  | 102, 687, 965 | 0. 017159     | 3, 096, 219  | 53, 128       | 54.00   |
| 60. 00  06000 LABORATORY                         | 444, 181     | 64, 708, 195  | 0. 006864     | 4, 401, 330  | 30, 211       | 60.00   |
| 65. 00 06500 RESPIRATORY THERAPY                 | 406, 746     | 10, 819, 189  | 0. 037595     | 789, 309     | 29, 674       | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                   | 339, 116     | 5, 433, 623   | 0. 062411     | 219, 623     | 13, 707       | 66.00   |
| 67. 00  06700 OCCUPATI ONAL THERAPY              | 4, 917       | 1, 353, 363   | 0. 003633     | 174, 241     | 633           | 67.00   |
| 68.00   06800   SPEECH PATHOLOGY                 | 3, 110       | 1, 033, 109   | 0. 003010     | 83, 245      | 251           | 68.00   |
| 69. 00   06900   ELECTROCARDI OLOGY              | 320, 758     | 17, 276, 212  | 0. 018566     | 1, 506, 407  | 27, 968       | 69. 00  |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY              | 0            | 0             | 0.000000      | 0            | 0             | 70.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 306, 003     | 1, 564, 762   | 0. 195559     | 153, 377     | 29, 994       | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT        | 11, 730      | 10, 422, 827  | 0. 001125     | 695, 522     | 782           | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 762, 008     | 131, 277, 983 | 0. 005805     | 3, 876, 940  | 22, 506       | 73.00   |
| 76. 00   03020   CARDI AC                        | 0            | 0             | 0.000000      | 0            | 0             | 76.00   |
| 76. 01   03160   CARDI OPULMONARY                | 82, 220      | 486, 642      | 0. 168954     | 0            | 0             | 76. 01  |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION     | 0            | 0             | 0. 000000     | 0            | 0             | 77. 00  |
| 78.00 07800 CAR T-CELL IMMUNOTHERAPY             | 0            | 0             | 0.000000      | 0            | 0             | 78. 00  |
| OUTPATIENT SERVICE COST CENTERS                  |              |               |               |              |               |         |
| 88.00   08800   RURAL HEALTH CLINIC              | 5, 096       | 853, 313      | 0. 005972     | 0            | 0             | 88. 00  |
| 90. 00  09000 CLI NI C                           | 0            | 0             | 0.000000      | 0            | 0             | 90.00   |
| 90. 01   09001   WOUND CLINIC                    | 227, 443     | 5, 837, 310   | 0. 038964     | 0            | 0             | 90. 01  |
| 90. 02   09002 DI ABETES CLINIC                  | 579          | 5, 441        | 0. 106414     | 0            | 0             | 90. 02  |
| 90. 03 09003 ASTHMA CLINIC                       | 0            | 0             | 0.000000      | 0            | 0             | 90. 03  |
| 90. 04   09004   ANDIS CLINIC                    | 33, 477      | 48, 801       | 0. 685990     | 0            | 0             | 90.04   |
| 90.05 09005 PRIME TIME                           | 0            | 0             | 0.000000      | 0            | 0             | 90.05   |
| 90.06 09006 SHELBYVILLE WOUND CLINIC             | 0            | 0             | 0. 000000     | 0            | 0             | 90.06   |
| 90. 07   04951   ONCOLOGY                        | 989, 360     | 8, 425, 575   | 0. 117423     | 19, 798      | 2, 325        | 90. 07  |
| 90.08 04950 ANDERSON WOMENS CENTER               | 284, 458     | 5, 206, 148   | 0. 054639     | 0            | 0             | 90. 08  |
| 91. 00 09100 EMERGENCY                           | 1, 111, 193  | 79, 960, 462  | 0. 013897     | 3, 961, 191  | 55, 049       | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 997, 841     | 17, 834, 493  | 0. 055950     | 438, 106     | 24, 512       | 92.00   |
| 200.00   Total (lines 50 through 199)            | 9, 329, 185  | 515, 897, 302 |               | 22, 113, 675 | 358, 558      | 200. 00 |

| 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:<br>From 01/01/2023<br>To 12/31/2023 |                | epared: |
|   |                 | Title         | : 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             | (             | 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                                    | Inpatient      |         |
| ·   | 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             | 8, 67         | 0.00  | 935            | 30.00   |
| 31.00 03100 INTENSIVE CARE UNIT                     |                 | 0             | 6, 14         | 0.00  | 1, 858         | 31.00   |
| 40. 00   04000   SUBPROVI DER - 1 PF                | 0               | 0             |               | 0.00  | 0              | 40.00   |
| 200.00 Total (lines 30 through 199)                 |                 | 0             | 14, 81        | 3   | 2, 793         | 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                                      | u of Form CMS-2552-10                         |
|---|--------------------------------|-----------------------|--|---|
| APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS | ANCI LLARY SERVI CE OTHER PASS | Provider CCN: 15-0037 | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet D<br>Part IV<br>Date/Time Prepared: |

|        |  |               |               |          | To 12/31/2023 | Date/Time Pre 5/31/2024 7:0 |         |
|--------|--|---------------|---------------|----------|---------------|-----------------------------|---------|
|        |  |               | Title         | xVIII    | Hospi tal     | PPS                         | i alli  |
|        | Cost Center Description                    | Non Physician | Nursi ng      | Nursi ng | Allied Health |                             |         |
|        | 5051 501101 50501 Pt. 611                  | Anesthetist   | Program       | Program  | Post-Stepdown | , oa oa                     |         |
|        |  | Cost          | Post-Stepdown |          | Adjustments   |                             |         |
|        |  |               | Adjustments   |          | ,             |                             |         |
|        |  | 1. 00         | 2A            | 2.00     | 3A            | 3. 00                       |         |
|        | ANCILLARY SERVICE COST CENTERS             |               |               | •        | <u> </u>      |                             |         |
| 50.00  | 05000 OPERATING ROOM                       | 0             | 0             |          | 0 0           | 0                           | 50.00   |
| 51.00  | 05100 RECOVERY ROOM                        | o             | 0             |          | 0 0           | 0                           | 51.00   |
| 53.00  | 05300 ANESTHESI OLOGY                      | o             | 0             | 1        | 0 0           | 0                           | 53.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | o             | 0             | 1        | 0 0           | 375, 692                    | 54.00   |
| 60.00  | 06000 LABORATORY                           | o             | 0             |          | 0 0           | 0                           | 60.00   |
| 65.00  | 06500 RESPIRATORY THERAPY                  | o             | 0             | 1        | 0 0           | 0                           | 65.00   |
| 66.00  | 06600 PHYSI CAL THERAPY                    | o             | 0             |          | 0 0           | 0                           | 66.00   |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | o             | 0             | 1        | 0 0           | 0                           | 67.00   |
| 68.00  | 06800 SPEECH PATHOLOGY                     | o             | 0             | 1        | 0 0           | 0                           | 68.00   |
| 69.00  | 06900 ELECTROCARDI OLOGY                   | o             | 0             | 1        | 0 0           | 0                           | 69.00   |
| 70.00  | 07000 ELECTROENCEPHALOGRAPHY               | o             | 0             |          | 0 0           | 0                           | 70.00   |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | o             | 0             |          | 0 0           | 0                           | 71.00   |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENT       | o             | 0             |          | 0 0           | 0                           | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | o             | 0             |          | 0 0           | 0                           | 73.00   |
| 76.00  | 03020 CARDI AC                             | o             | 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   |
| 78.00  | 07800 CAR T-CELL IMMUNOTHERAPY             | 0             | 0             |          | 0 0           | 0                           | 78. 00  |
|        | OUTPATIENT SERVICE COST CENTERS            |               |               |          |               |                             |         |
| 88. 00 | 08800 RURAL HEALTH CLINIC                  | 0             | 0             |          | 0 0           | 0                           | 88. 00  |
| 90.00  | 09000 CLI NI C                             | 0             | 0             |          | 0 0           | 0                           | 90.00   |
| 90. 01 | 09001 WOUND CLINIC                         | 0             | 0             |          | 0 0           | 0                           | 90. 01  |
| 90. 02 | 09002 DI ABETES CLINIC                     | 0             | 0             |          | 0 0           | 0                           | 90.02   |
| 90. 03 | 09003 ASTHMA CLINIC                        | 0             | 0             |          | 0 0           | 0                           | 90. 03  |
| 90. 04 | 09004 ANDIS CLINIC                         | 0             | 0             |          | 0 0           | 0                           | 90.04   |
| 90. 05 | 09005 PRIME TIME                           | 0             | 0             |          | 0 0           | 0                           | 90.05   |
| 90.06  | 09006 SHELBYVILLE WOUND CLINIC             | 0             | 0             |          | 0 0           | 0                           | 90.06   |
| 90. 07 | 04951 ONCOLOGY                             | 0             | 0             |          | 0 0           | 0                           | 90. 07  |
| 90.08  | 04950 ANDERSON WOMENS CENTER               | 0             | 0             |          | 0             | 0                           | 90.08   |
| 91.00  | 09100 EMERGENCY                            | o             | 0             |          | 0             | 0                           | 91.00   |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0             |               |          | 0             | 0                           | 1 /2:00 |
| 200.00 | Total (lines 50 through 199)               | 0             | 0             | 1        | 0             | 375, 692                    | 200.00  |

| Health Financial Systems              | HANCOCK REGIONAL             | HOSPI TAL             | In Lie          | u of Form CMS-2552-10 |
|---------------------------------------|------------------------------|-----------------------|-----------------|-----------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS | Provider CCN: 15-0037 | Peri od:        | Worksheet D           |
| THROUGH COSTS                         |                              |                       | From 01/01/2023 | Part   V              |

| THROUGH COSTS                                    |            |               |              | Fo 12/31/2023   | Date/Time Pre<br>5/31/2024 7:0 | pared:<br>1 am |
|--|------------|---------------|--------------|-----------------|--------------------------------|----------------|
|  |            | Title         | : XVIII      | Hospi tal       | PPS                            |                |
| Cost Center Description                          | All Other  | Total Cost    | Total        | Total Charges   | Ratio of Cost                  |                |
| · ·  | Medi cal   | (sum of cols. | Outpati ent  | (from Wkst.     | to Charges                     |                |
|  | Educati on | 1, 2, 3, and  | Cost (sum of | 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   OPERATI NG ROOM                 | 0          | 0             | (            | ,,              | 0. 000000                      |                |
| 51.00   05100   RECOVERY ROOM                    | 0          | 0             | (            | 3, 220, 705     | 0. 000000                      | 1              |
| 53. 00 05300 ANESTHESI OLOGY                     | 0          | 0             | (            | -               | 0. 000000                      | 1              |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 0          | 375, 692      | 375, 692     | 102, 687, 965   | 0. 003659                      | 54.00          |
| 60. 00   06000   LABORATORY                      | 0          | 0             | (            | 64, 708, 195    | 0.000000                       | 60.00          |
| 65. 00   06500   RESPI RATORY THERAPY            | 0          | 0             | (            | 10, 819, 189    | 0.000000                       | 65.00          |
| 66. 00   06600 PHYSI CAL THERAPY                 | 0          | 0             | (            | 5, 433, 623     | 0.000000                       |                |
| 67. 00  06700 OCCUPATI ONAL THERAPY              | 0          | 0             | (            | 1, 353, 363     | 0.000000                       | 67.00          |
| 68.00 06800 SPEECH PATHOLOGY                     | 0          | 0             | (            | 1, 033, 109     | 0.000000                       |                |
| 69. 00   06900   ELECTROCARDI OLOGY              | 0          | 0             | (            | 17, 276, 212    | 0.000000                       | 69.00          |
| 70. 00   07000   ELECTROENCEPHALOGRAPHY          | 0          | 0             | (            | 0               | 0.000000                       | 70.00          |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0          | 0             | (            | 1, 564, 762     | 0.000000                       |                |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT        | 0          | 0             | (            | 10, 422, 827    | 0.000000                       | 72.00          |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 0          | 0             | (            | 131, 277, 983   | 0.000000                       |                |
| 76. 00   03020   CARDI AC                        | 0          | 0             | (            | 0               | 0.000000                       |                |
| 76. 01  03160  CARDI OPULMONARY                  | 0          | 0             | (            | 486, 642        | 0.000000                       |                |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION     | 0          | 0             | (            | 0               | 0.000000                       | 77. 00         |
| 78.00 07800 CAR T-CELL IMMUNOTHERAPY             | 0          | 0             | (            | 0               | 0.000000                       | 78. 00         |
| OUTPATIENT SERVICE COST CENTERS                  |            |               |              |                 |                                |                |
| 88.00 08800 RURAL HEALTH CLINIC                  | 0          |               |              |                 | 0. 000000                      |                |
| 90. 00  09000  CLI NI C                          | 0          | 0             | ,            | -               | 0. 000000                      |                |
| 90. 01   09001   WOUND CLINIC                    | 0          | 0             | `            | -,,             | 0. 000000                      |                |
| 90. 02   09002   DI ABETES CLINIC                | 0          | 0             | (            | 5, 441          | 0. 000000                      | 1              |
| 90. 03   09003   ASTHMA CLINIC                   | 0          | 0             | (            | 0               | 0. 000000                      |                |
| 90. 04   09004   ANDIS CLINIC                    | 0          | 0             | (            | 48, 801         | 0. 000000                      | 1              |
| 90. 05   09005   PRI ME TI ME                    | 0          | 0             | (            | 0               | 0. 000000                      | 90. 05         |
| 90.06 09006 SHELBYVILLE WOUND CLINIC             | 0          | 0             | (            | 0               | 0. 000000                      | •              |
| 90. 07   04951   0NCOLOGY                        | 0          | 0             | (            | 8, 425, 575     | 0. 000000                      |                |
| 90.08 04950 ANDERSON WOMENS CENTER               | 0          | 0             | (            | 5, 206, 148     | 0. 000000                      |                |
| 91. 00   09100   EMERGENCY                       | 0          | 0             | `            | ,               | 0. 000000                      | 1              |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0          | 0             | (            | ,               |                                | 1              |
| 200.00   Total (lines 50 through 199)            | 0          | 375, 692      | 375, 692     | 2 515, 897, 302 |                                | 200. 00        |
|  |            |               |              |                 |                                |                |

|        | Figure 1 Control  | HANGOOK BEGLONA                     | I HOCDI TAI |              | 1 - 12 -                                    | . C. F OHC .                | 2550 40 |
|--------|---|-------------------------------------|-------------|--------------|---|-----------------------------|---------|
| APP0R1 | Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THE COSTS | HANCOCK REGIONA<br>RVICE OTHER PASS | Provi der C |              | Period:<br>From 01/01/2023<br>To 12/31/2023 | Date/Time Pre 5/31/2024 7:0 | pared:  |
|        |   |                                     |             | XVIII        | Hospi tal                                   | PPS                         |         |
|        | Cost Center Description   | Outpati ent                         | I npati ent | I npati ent  | Outpati ent                                 | Outpati ent                 |         |
|        |   | Ratio of Cost                       | Program     | Program      | Program                                     | Program                     |         |
|        |   | to Charges                          | Charges     | Pass-Through |   | Pass-Through                |         |
|        |   | (col. 6 ÷                           |             | Costs (col.  | 8   | Costs (col. 9               |         |
|        |   | col. 7)                             |             | x col. 10)   |   | x col . 12)                 |         |
|        |   | 9. 00                               | 10. 00      | 11. 00       | 12.00                                       | 13. 00                      |         |
|        | ANCILLARY SERVICE COST CENTERS  | 0.000000                            | 0 100 170   | ı            |   |                             |         |
| 50.00  | 05000 OPERATI NG ROOM   | 0. 000000                           | 2, 490, 478 |              | 0 6, 801, 082                               | 0                           | 50.00   |
| 51.00  | 05100 RECOVERY ROOM   | 0. 000000                           | 207, 889    |              | 0 316, 386                                  | 0                           | 51.00   |
| 53. 00 | 05300 ANESTHESI OLOGY   | 0. 000000                           | 0           |              | 0   | 0                           | 53.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C   | 0. 003659                           | 3, 096, 219 |              |   | 86, 346                     |         |
| 60.00  | 06000 LABORATORY  | 0. 000000                           | 4, 401, 330 |              | 0 5, 443, 081                               | 0                           | 60.00   |
| 65.00  | 06500 RESPI RATORY THERAPY  | 0. 000000                           | 789, 309    |              | 0 1, 507, 466                               | 0                           | 65.00   |
| 66.00  | 06600 PHYSI CAL THERAPY   | 0. 000000                           | 219, 623    |              | 0 23, 201                                   | 0                           | 66.00   |
| 67.00  | 06700 OCCUPATI ONAL THERAPY   | 0. 000000                           | 174, 241    |              | 0 8, 764                                    | 0                           | 67.00   |
| 68. 00 | 06800 SPEECH PATHOLOGY  | 0. 000000                           | 83, 245     |              | 0 4, 896                                    | 0                           |         |
| 69. 00 | 06900 ELECTROCARDI OLOGY  | 0. 000000                           | 1, 506, 407 |              | 0 3, 467, 552                               | 0                           |         |
| 70.00  | 07000 ELECTROENCEPHALOGRAPHY  | 0. 000000                           | 0           |              | 0   | 0                           |         |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                | 0. 000000                           | 153, 377    |              | 0 265, 052                                  | 0                           | 71.00   |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENT                                      | 0. 000000                           | 695, 522    |              | 0 1, 959, 811                               | 0                           | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS   | 0. 000000                           | 3, 876, 940 |              | 0 38, 733, 869                              | 0                           | 73.00   |
| 76. 00 | 03020 CARDI AC  | 0. 000000                           | 0           |              | 0   | 0                           | 76.00   |
| 76. 01 | 03160 CARDI OPULMONARY  | 0. 000000                           | 0           |              | 0 186, 803                                  | 0                           | 76. 01  |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION                                    | 0. 000000                           | 0           |              | 0   | 0                           | 77.00   |
| 78. 00 | 07800 CAR T-CELL IMMUNOTHERAPY  | 0. 000000                           | 0           |              | 0 0   | 0                           | 78. 00  |
|        | OUTPAȚI ENT SERVI CE COST CENTERS   |                                     |             |              |   |                             |         |
| 88. 00 | 08800 RURAL HEALTH CLINIC   | 0. 000000                           | 0           |              | 0   | 0                           | 88. 00  |
| 90.00  | 09000 CLI NI C  | 0. 000000                           | 0           |              | 0   | 0                           | 90.00   |
| 90. 01 | 09001 WOUND CLINIC  | 0. 000000                           | 0           |              | 0 399, 040                                  | 0                           |         |
| 90. 02 | 09002 DI ABETES CLINIC  | 0. 000000                           | 0           |              | 0   | 0                           |         |
|        | 09003 ASTHMA CLINIC   | 0. 000000                           | 0           |              | 0   | 0                           |         |
| 00 04  | 00004 ANDLS CLINIC  | 0 000000                            | 0           | 1            | ΛΙ Λ  | Ι                           | 00 04   |

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4, 479, 694

98, 482, 683

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86, 346 200. 00

09004 ANDIS CLINIC 09005 PRIME TIME

04951 ONCOLOGY

91. 00 09100 EMERGENCY

90.06 09006 SHELBYVILLE WOUND CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (lines 50 through 199)

90. 08 04950 ANDERSON WOMENS CENTER

90.04

90. 05

90.07

| Period: | Worksheet D | From 01/01/2023 | Part V | To | 12/31/2023 | Date/Time Prepared:

|        |  |              |               | Τ             | o 12/31/2023  | Date/Time Pre 5/31/2024 7:0 |         |
|--------|--|--------------|---------------|---------------|---------------|-----------------------------|---------|
|        |  |              | Title         | : XVIII       | Hospi tal     | PPS                         |         |
|        |  |              |               | 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     | Services Not  | ,                           |         |
|        |  | Worksheet C, | inst.)        | Subject To    | Subject To    |                             |         |
|        |  | Part I, col. |               | Ded. & Coins. | Ded. & Coins. |                             |         |
|        |  | 9            |               | (see inst.)   | (see inst.)   |                             |         |
|        |  | 1. 00        | 2. 00         | 3.00          | 4. 00         | 5. 00                       |         |
|        | ANCILLARY SERVICE COST CENTERS             |              |               |               |               |                             |         |
| 50.00  | 05000 OPERATING ROOM                       | 0. 212395    |               |               | 0             | 1, 444, 516                 | 1       |
| 51.00  | 05100 RECOVERY ROOM                        | 0. 425932    | 316, 386      | (             | 0             | 134, 759                    |         |
| 53.00  | 05300 ANESTHESI OLOGY                      | 0. 000000    |               | (             |               | 0                           | 53.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | 0. 112786    |               |               |               | 2, 661, 568                 |         |
| 60.00  | 06000 LABORATORY                           | 0. 128061    | 5, 443, 081   | 1, 084        | 0             | 697, 046                    | 60.00   |
| 65.00  | 06500 RESPI RATORY THERAPY                 | 0. 367819    | 1, 507, 466   | c             | 0             | 554, 475                    | 65.00   |
| 66.00  | 06600 PHYSI CAL THERAPY                    | 0. 471724    | 23, 201       |               | 0             | 10, 944                     | 66.00   |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 0. 373116    | 8, 764        |               | 0             | 3, 270                      | 67.00   |
| 68. 00 | 06800 SPEECH PATHOLOGY                     | 0. 309401    | 4, 896        |               | 0             | 1, 515                      | 68. 00  |
| 69. 00 | 06900 ELECTROCARDI OLOGY                   | 0. 121700    | 3, 467, 552   |               | 0             | 422, 001                    | 69.00   |
| 70.00  | 07000 ELECTROENCEPHALOGRAPHY               | 0. 000000    | 0             | C             | 0             | 0                           | 70.00   |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 3. 520907    | 265, 052      |               | 0             | 933, 223                    | 71.00   |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENT       | 0. 127321    | 1, 959, 811   |               | 0             | 249, 525                    | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 0. 232349    | 38, 733, 869  | 53            | 5, 742        | 8, 999, 776                 | 73.00   |
| 76.00  | 03020 CARDI AC                             | 0. 000000    | 0             | C             | 0             | 0                           | 76.00   |
| 76. 01 | 03160 CARDI OPULMONARY                     | 0. 510435    | 186, 803      |               | 0             | 95, 351                     | 76. 01  |
| 77.00  | 07700 ALLOGENEIC STEM CELL ACQUISITION     | 0. 000000    | 0             | C             | 0             | 0                           | 77. 00  |
| 78.00  | 07800 CAR T-CELL IMMUNOTHERAPY             | 0. 000000    | 0             | C             | 0             | 0                           | 78. 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. 230469    | 399, 040      | (             | 0             | 91, 966                     | 90. 01  |
| 90. 02 | 09002 DI ABETES CLINIC                     | 10. 975740   | 0             | (             | 0             | 0                           | 90. 02  |
| 90. 03 | 09003 ASTHMA CLINIC                        | 0. 000000    | 0             | (             | 0             | 0                           | 90. 03  |
| 90. 04 | 09004 ANDIS CLINIC                         | 6. 210692    | 0             | (             | 0             | 0                           | 90. 04  |
| 90. 05 | 09005 PRIME TIME                           | 0. 000000    | 0             | C             | 0             | 0                           | 90.05   |
| 90.06  | 09006 SHELBYVILLE WOUND CLINIC             | 0. 000000    | 0             | C             | 0             | 0                           | 90.06   |
| 90. 07 | 04951 ONCOLOGY                             | 0. 532367    | 2, 482, 370   | (             | 0             | 1, 321, 532                 | 90.07   |
| 90.08  | 04950 ANDERSON WOMENS CENTER               | 0. 365476    | 97, 768       | (             | 0             | 35, 732                     | 90.08   |
| 91.00  | 09100 EMERGENCY                            | 0. 104046    | 8, 707, 461   |               | 0             | 905, 976                    | 91.00   |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 316848    | 4, 479, 694   | (             | 0             | 1, 419, 382                 | 92.00   |
| 200.00 |  |              | 98, 482, 683  | 7, 641        | 5, 742        | 19, 982, 557                | 200.00  |
| 201.00 |  |              |               | (             | 0             |                             | 201. 00 |
|        | Only Charges                               |              |               |               |               |                             |         |
| 202.00 | Net Charges (line 200 - line 201)          |              | 98, 482, 683  | 7, 641        | 5, 742        | 19, 982, 557                | 202.00  |

| Health Financial Systems   | HANCOCK REGIONAL                       | HOSPI TAL             | In Lieu         | of Form CMS-2552-10 |
|----------------------------|--|-----------------------|-----------------|---------------------|
| APPORTI ONMENT OF MEDICAL, | OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0037 |                 | Worksheet D         |
|                            |  |                       | From 01/01/2023 | Part V              |

|             |  |               |               |       | To 12/31/2023 | Date/Time Pre<br>5/31/2024 7:0 |        |
|-------------|--|---------------|---------------|-------|---------------|--------------------------------|--------|
|             |  |               | Title         | XVIII | Hospi tal     | PPS                            |        |
|             |  | Cos           | sts           |       |               |                                |        |
|             | Cost Center Description                  | Cost          | Cost          |       |               |                                |        |
|             |  | Rei mbursed   | Rei mbursed   |       |               |                                |        |
|             |  | Servi ces     | Services Not  |       |               |                                |        |
|             |  | Subject To    | Subject To    |       |               |                                |        |
|             |  | Ded. & Coins. | Ded. & Coins. |       |               |                                |        |
|             |  | (see inst.)   | (see inst.)   |       |               |                                |        |
|             |  | 6. 00         | 7. 00         |       |               |                                |        |
|             | CILLARY SERVICE COST CENTERS             |               |               |       |               |                                |        |
|             | OOO OPERATING ROOM                       | 0             | 0             |       |               |                                | 50.00  |
|             | 100 RECOVERY ROOM                        | 0             | 0             | 1     |               |                                | 51.00  |
|             | 300 ANESTHESI OLOGY                      | 0             | 0             |       |               |                                | 53.00  |
|             | 400 RADI OLOGY-DI AGNOSTI C              | 734           | 0             |       |               |                                | 54.00  |
|             | 000 LABORATORY                           | 139           | 0             |       |               |                                | 60.00  |
|             | 500 RESPI RATORY THERAPY                 | 0             | 0             |       |               |                                | 65. 00 |
|             | 600 PHYSI CAL THERAPY                    | 0             | 0             |       |               |                                | 66. 00 |
|             | 700 OCCUPATI ONAL THERAPY                | 0             | 0             |       |               |                                | 67.00  |
| 68.00 06    | 800 SPEECH PATHOLOGY                     | 0             | 0             |       |               |                                | 68. 00 |
|             | 900 ELECTROCARDI OLOGY                   | 0             | 0             |       |               |                                | 69. 00 |
|             | 000 ELECTROENCEPHALOGRAPHY               | 0             | 0             |       |               |                                | 70.00  |
| 71.00 07    | 100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0             | 0             |       |               |                                | 71.00  |
|             | 200 IMPL. DEV. CHARGED TO PATIENT        | 0             | 0             |       |               |                                | 72.00  |
|             | 300 DRUGS CHARGED TO PATIENTS            | 12            | 1, 334        |       |               |                                | 73.00  |
|             | 020 CARDI AC                             | 0             | 0             |       |               |                                | 76. 00 |
|             | 160 CARDI OPULMONARY                     | 0             | 0             |       |               |                                | 76. 01 |
| 77. 00   07 | 700 ALLOGENEIC STEM CELL ACQUISITION     | 0             | 0             | 1     |               |                                | 77. 00 |
|             | 800 CAR T-CELL IMMUNOTHERAPY             | 0             | 0             |       |               |                                | 78. 00 |
|             | TPATIENT SERVICE COST CENTERS            |               |               |       |               |                                |        |
|             | 800 RURAL HEALTH CLINIC                  |               |               |       |               |                                | 88. 00 |
|             | 000 CLI NI C                             | 0             | 0             |       |               |                                | 90.00  |
|             | 001 WOUND CLINIC                         | 0             | 0             |       |               |                                | 90. 01 |
|             | 002 DI ABETES CLI NI C                   | 0             | 0             |       |               |                                | 90. 02 |
|             | 003 ASTHMA CLINIC                        | 0             | 0             |       |               |                                | 90. 03 |
|             | 004 ANDIS CLINIC                         | 0             | 0             |       |               |                                | 90.04  |
|             | 005 PRIME TIME                           | 0             | 0             |       |               |                                | 90.05  |
|             | 006 SHELBYVILLE WOUND CLINIC             | 0             | 0             |       |               |                                | 90.06  |
|             | 951 ONCOLOGY                             | 0             | 0             |       |               |                                | 90. 07 |
|             | 950 ANDERSON WOMENS CENTER               | 0             | 0             |       |               |                                | 90. 08 |
|             | 100 EMERGENCY                            | 0             | 0             |       |               |                                | 91.00  |
|             | 200 OBSERVATION BEDS (NON-DISTINCT PART) | 0             | 0             |       |               |                                | 92.00  |
| 200.00      | Subtotal (see instructions)              | 885           | 1, 334        |       |               |                                | 200.00 |
| 201. 00     | Less PBP Clinic Lab. Services-Program    | 0             |               |       |               |                                | 201.00 |
|             | Only Charges                             |               |               |       |               |                                |        |
| 202. 00     | Net Charges (line 200 - line 201)        | 885           | 1, 334        |       |               |                                | 202.00 |

| Heal th | Financial Systems   | HANCOCK REGIONAL  | HOSPI TAL               | In Lie                           | u of Form CMS-2                 | 552-10         |
|---------|---|-------------------|-------------------------|----------------------------------|---------------------------------|----------------|
| COMPUT  | ATION OF INPATIENT OPERATING COST   |                   | Provi der CCN: 15-0037  | Peri od:                         | Worksheet D-1                   |                |
|         |   |                   |                         | From 01/01/2023<br>To 12/31/2023 | Doto/Timo Dros                  | oorod:         |
|         |   |                   |                         | 10 12/31/2023                    | Date/Time Prep<br>5/31/2024 7:0 | oareu:<br>1 am |
|         |   |                   | Title XVIII             | Hospi tal                        | PPS                             |                |
|         | Cost Center Description   |                   |                         |                                  |                                 |                |
|         |   |                   |                         |                                  | 1. 00                           |                |
|         | PART I - ALL PROVIDER COMPONENTS  |                   |                         |                                  |                                 |                |
|         | I NPATI ENT DAYS  |                   |                         |                                  |                                 |                |
| 1.00    | Inpatient days (including private room days   | and swing-bed day | s, excluding newborn)   |                                  | 8, 673                          | 1.00           |
| 2.00    | 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) |                   |                         |                                  |                                 | 2.00           |
| 3. 00   | Private room days (excluding swing-bed and c<br>do not complete this line.              | bservation bed da | ys). If you have only p | rivate room days,                | 0                               | 3.00           |
| 4.00    | Semi -pri vate room days (excluding swing-bed   | and observation b | ed days)                |                                  | 5, 011                          | 4.00           |

|                  | 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 days, excluding newborn)   | 8, 673            | •                |
| 2.00             | Inpatient days (including private room days, excluding swing-bed and newborn days)   | 8, 673            |                  |
| 3. 00            | Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.                                   | 0                 | 3.00             |
| 4.00             | Semi-private room days (excluding swing-bed and observation bed days)  | 5, 011            | 4.00             |
| 5. 00            | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost  | 0,011             | •                |
|                  | reporting period   |                   |                  |
| 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             |
| 7. 00            | reporting period   | U                 | 7. 00            |
| 8. 00            | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   | 0                 | 8.00             |
|                  | reporting period (if calendar year, enter 0 on this line)  |                   |                  |
| 9. 00            | Total inpatient days including private room days applicable to the Program (excluding swing-bed and  | 935               | 9. 00            |
| 10. 00           | newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)                                    | 0                 | 10.00            |
| 10.00            | through December 31 of the cost reporting period (see instructions)  | U                 | 10.00            |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after   | 0                 | 11.00            |
|                  | December 31 of the cost reporting period (if calendar year, enter 0 on this line)  |                   |                  |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  | 0                 | 12.00            |
| 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)  | O                 | 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   | 0. 00             | 19. 00           |
| 20. 00           | reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  | 0.00              | 20.00            |
| 20.00            | reporting period   | 0.00              | 20.00            |
| 21.00            | Total general inpatient routine service cost (see instructions)  | 13, 383, 332      | 21.00            |
| 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 had cost applicable to SNE type corvices after December 21 of the cost reporting period (Line 4)  | 0                 | 23.00            |
| 23.00            | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   | 0                 | 23.00            |
| 24.00            | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line   | 0                 | 24.00            |
|                  | 7 x line 19)   |                   |                  |
| 25. 00           | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8   | 0                 | 25. 00           |
| 26. 00           | x line 20) Total swing-bed cost (see instructions)   | 0                 | 26.00            |
|                  | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   | 13, 383, 332      | •                |
|                  | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   |                   |                  |
|                  | General inpatient routine service charges (excluding swing-bed and observation bed charges)  | 0                 |                  |
|                  | Pri vate room charges (excluding swing-bed charges) Semi-pri vate 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           | Average private room per diem charge (line 29 ÷ line 3)  | 0. 00             | ı                |
| 33. 00           | Average semi-private room per diem charge (line 30 ÷ line 4)   | 0. 00             | ı                |
|                  | Average per diem private room charge differential (line 32 minus line 33)(see instructions)  | 0. 00             | 1                |
| 35.00            | Average per diem private room cost differential (line 34 x line 31)  | 0.00              | 1                |
| 36. 00<br>37. 00 | Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line | 0<br>13, 383, 332 | 36. 00<br>37. 00 |
| 37.00            | 27 minus line 36)  | 13, 303, 332      | 37.00            |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                   |                  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  |                   |                  |
|                  | Adjusted general inpatient routine service cost per diem (see instructions)  | 1, 543. 10        | 1                |
| 39. 00<br>40. 00 | Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)              | 1, 442, 799<br>0  | 1                |
|                  | Total Program general inpatient routine service cost (line 39 + line 40)   | 1, 442, 799       |                  |
| 55               | 1.1.1  | ., 112, 177       |                  |

| 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, 383, 332 | 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, 543. 10   | 38.00 |
| 39.00 | Program general inpatient routine service cost (line 9 x line 38)                                     | 1, 442, 799  | 39.00 |
| 40.00 | Medically necessary private room cost applicable to the Program (line 14 x line 35)                   | 0            | 40.00 |
| 41.00 | Total Program general inpatient routine service cost (line 39 + line 40)                              | 1, 442, 799  | 41.00 |
|       |   |              |       |
|       |   |              |       |
|       |   |              |       |

| COMPUTATION OF INPATIENT OPERATING COST   |                              | NAL HOSPITAL Provider C    |  | Peri od:                         | Worksheet D-1                        | 2552-10          |
|---|------------------------------|----------------------------|--|----------------------------------|--------------------------------------|------------------|
|   |                              |                            |  | From 01/01/2023<br>To 12/31/2023 |                                      |                  |
|   |                              | Title                      | e XVIII                                  | Hospi tal                        | 5/31/2024 7: 0<br>PPS                | n alli           |
| Cost Center Description   | Total<br>I npati ent<br>Cost | Total<br>Inpatient<br>Days | Average Per<br>Diem (col. 1<br>÷ col. 2) | Program Days                     | Program Cost<br>(col. 3 x<br>col. 4) |                  |
| 42.00 NUDCEDY (+:+  c \ / 0 \ V  \ cm  v)   | 1. 00                        | 2. 00                      | 3. 00                                    | 4. 00                            | 5. 00                                | 42.00            |
| 42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni   | ts                           |                            |  |                                  |                                      | 42.00            |
| 43. 00 I NTENSI VE CARE UNIT  | 13, 237, 910                 | 6, 140                     | 2, 156. 0                                | 1 1, 858                         | 4, 005, 867                          |                  |
| 44. 00 CORONARY CARE UNIT   |                              |                            |  |                                  |                                      | 44.00            |
| 45. 00 BURN INTENSIVE CARE UNIT<br>46. 00 SURGICAL INTENSIVE CARE UNIT  |                              |                            |  |                                  |                                      | 45. 00<br>46. 00 |
| 47. 00 OTHER SPECIAL CARE (SPECIFY)   |                              |                            |  |                                  |                                      | 47. 00           |
| Cost Center Description   |                              |                            |  |                                  | 1. 00                                |                  |
| 48.00 Program inpatient ancillary service cost  | (Wkst. D-3, col. 3           | 3, line 200)               |  |                                  | 4, 289, 266                          | 48. 00           |
| 48.01 Program inpatient cellular therapy acquisi  |                              |                            |  | column 1)                        | 0                                    | 48. 01           |
| 49.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS  | es 41 through 48.0           | JI)(see Instru             | ctions)                                  |                                  | 9, 737, 932                          | 49. 00           |
| 50.00 Pass through costs applicable to Program i  | npatient routine             | services (fro              | m Wkst. D, sun                           | of Parts I and                   | 849, 877                             | 50.00            |
| III)  |                              |                            | W D                                      | £ Dt II                          | 2/0 007                              | F1 00            |
| 51.00 Pass through costs applicable to Program i and IV)  | npatient anciliar            | ry services (r             | rom WKSt. D, S                           | sum of Parts II                  | 369, 887                             | 51.00            |
| 52.00 Total Program excludable cost (sum of line  |                              |                            |  |                                  | 1, 219, 764                          | 1                |
| 53.00 Total Program inpatient operating cost exc  |                              | elated, non-ph             | ysician anesth                           | etist, and                       | 8, 518, 168                          | 53.00            |
| medical education costs (line 49 minus lir<br>TARGET AMOUNT AND LIMIT COMPUTATION   | IE 32)                       |                            |  |                                  |                                      | 1                |
| 54.00 Program di scharges   |                              |                            |  |                                  | 0                                    |                  |
| <ul><li>55.00   Target amount per discharge</li><li>55.01   Permanent adjustment amount per discharge</li></ul>                         |                              |                            |  |                                  | 0. 00<br>0. 00                       | 1                |
| 55.02 Adjustment amount per discharge (contracto  | or use only)                 |                            |  |                                  | 0.00                                 | 1                |
| 56.00 Target amount (line 54 x sum of lines 55,   | <b>J</b> ,                   | )                          |  |                                  | 0                                    | 56.00            |
| 57.00 Difference between adjusted inpatient oper  | rating cost and ta           | arget amount (             | line 56 minus                            | line 53)                         | 0                                    |                  |
| 58.00 Bonus payment (see instructions) 59.00 Trended costs (lesser of line 53 ÷ line 54   | L or line 55 from            | m the cost rep             | orting period                            | endi na 1996.                    | 0<br>0. 00                           | 58. 00<br>59. 00 |
| updated and compounded by the market basks  | et)                          | ·                          | 0 .                                      | 0                                |                                      |                  |
| 60.00 Expected costs (lesser of line 53 ÷ line 5 market basket)   | 54, or line 55 fro           | om prior year              | cost report, ι                           | pdated by the                    | 0.00                                 | 60.00            |
| 61.00 Continuous improvement bonus payment (if I 55.01, or line 59, or line 60, enter the I 53) are less than expected costs (lines 54) | esser of 50% of              | the amount by              | which operatir                           | ng costs (line                   | 0                                    | 61.00            |
| enter zero. (see instructions)  |                              |                            |  |                                  |                                      | ,,,,,,,          |
| 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive pa  | yment (see instr             | uctions)                   |  |                                  | 0<br>0                               |                  |
| PROGRAM INPATIENT ROUTINE SWING BED COST  |                              | ,                          |  |                                  |                                      |                  |
| 64.00 Medicare swing-bed SNF inpatient routine of instructions) (title XVIII only)  | costs through Dece           | ember 31 of th             | e cost reporti                           | ng period (See                   | 0                                    | 64.00            |
| 65.00 Medicare swing-bed SNF inpatient routine of   | costs after Decemb           | ber 31 of the              | cost reporting                           | period (See                      | 0                                    | 65.00            |
| instructions)(title XVIII only)   |                              |                            |  |                                  |                                      |                  |
| 66.00 Total Medicare swing-bed SNF inpatient rou<br>CAH, see instructions   | itine costs (line            | 64 plus line               | 65)(TITIE XVII                           | i only); for                     | 0                                    | 66.00            |
| 67.00 Title V or XIX swing-bed NF inpatient rout  | ine costs through            | h December 31              | of the cost re                           | porting period                   | 0                                    | 67.00            |
| (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient rout  | ine costs after [            | Necember 31 of             | the cost reno                            | orting period                    | 0                                    | 68. 00           |
| (line 13 x line 20)   |                              |                            | •  | a tring period                   |                                      |                  |
| 69.00 Total title V or XIX swing-bed NF inpatier PART III - SKILLED NURSING FACILITY, OTHER   |                              |                            |  |                                  | 0                                    | 69.00            |
| 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 lin<br>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  | 5                            | •                          | ,  |                                  |                                      | 74.00            |
| 75.00 Capital-related cost allocated to inpatier  | nt routine service           | e costs (from              | Worksheet B, F                           | Part II, column                  |                                      | 75.00            |
| 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷  | line 2)                      |                            |  |                                  |                                      | 76.00            |
| 77.00 Program capital-related costs (line 9 x li  | ne 76)                       |                            |  |                                  |                                      | 77. 00           |
| 78.00   Inpatient routine service cost (line 74 mi 79.00   Aggregate charges to beneficiaries for exc                                   |                              | nrovi der recor            | de)                                      |                                  |                                      | 78. 00<br>79. 00 |
| 80.00 Total Program routine service costs for co  |                              |                            |  | nus line 79)                     |                                      | 80.00            |
| 81.00 Inpatient routine service cost per diem li  |                              | 4.                         |  | •                                |                                      | 81.00            |
| 82.00   Inpatient routine service cost limitation 83.00   Reasonable inpatient routine service costs                                    |                              |                            |  |                                  |                                      | 82. 00<br>83. 00 |
| 84.00 Program inpatient ancillary services (see   |                              | 10)                        |  |                                  |                                      | 84.00            |
| 85.00 Utilization review - physician compensation   | on (see instructio           |                            |  |                                  |                                      | 85.00            |
| 86.00 Total Program inpatient operating costs (SPART IV - COMPUTATION OF OBSERVATION BED F  |                              | nrough 85)                 |  |                                  |                                      | 86.00            |
| 87.00 Total observation bed days (see instruction   |                              |                            |  |                                  | 3, 662                               | 87. 00           |
| 88.00 Adjusted general inpatient routine cost pe  | r diam (lina 27 -            | iline 2)                   |  |                                  | 1, 543. 10                           | 1 88 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 01/01/2023<br>To 12/31/2023 |                 |         |
|  |                | Title        | XVIII      | Hospi tal                        | PPS             |         |
| Cost Center Description                            |                |              |            |                                  |                 |         |
|  |                |              |            |                                  | 1. 00           |         |
| 89.00 Observation bed cost (line 87 x line 88) (se | e instructions | )            |            |                                  | 5, 650, 832     | 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    |         |
|  |                | ŕ            |            | (from line                       | (col. 3 x       |         |
|  |                |              |            | 89)                              | col. 4) (see    |         |
|  |                |              |            | ŕ                                | instructions)   |         |
|  | 1. 00          | 2.00         | 3.00       | 4. 00                            | 5. 00           |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH        | COST           |              |            |                                  |                 |         |
| 90.00 Capital -related cost                        | 2, 363, 270    | 13, 383, 332 | 0. 17658   | 5, 650, 832                      | 997, 841        | 90.00   |
| 91.00 Nursing Program cost                         | 0              | 13, 383, 332 | 0. 00000   | 0 5, 650, 832                    | 0               | 91.00   |
| 92.00 Allied health cost                           | 0              | 13, 383, 332 | 0. 00000   | 0 5, 650, 832                    | 0               | 92.00   |
| 93.00 All other Medical Education                  | 0              | 13, 383, 332 | 0. 00000   | 0 5, 650, 832                    | 0               | 93.00   |

| Heal th | Financial Systems  | HANCOCK REGIONAL   | HOSPI TAL               | In Lie                      | u of Form CMS-2                 | 552-10       |
|---------|--|--------------------|-------------------------|-----------------------------|---------------------------------|--------------|
| COMPUT  | ATION OF INPATIENT OPERATING COST  |                    | Provi der CCN: 15-0037  | Peri od:<br>From 01/01/2023 | Worksheet D-1                   |              |
|         |  |                    |                         | To 12/31/2023               | Date/Time Prep<br>5/31/2024 7:0 | oared:<br>am |
|         |  |                    | Title XIX               | Hospi tal                   | Cost                            |              |
|         | Cost Center Description  |                    |                         |                             |                                 |              |
|         |  |                    |                         |                             | 1. 00                           |              |
|         | PART I - ALL PROVIDER COMPONENTS   |                    |                         |                             |                                 |              |
|         | I NPATI ENT DAYS   |                    |                         |                             |                                 |              |
| 1.00    | Inpatient days (including private room days                                | and swing-bed day  | s, excluding newborn)   |                             | 8, 673                          | 1.00         |
| 2.00    |  |                    |                         |                             |                                 | 2.00         |
| 3. 00   | Private room days (excluding swing-bed and c<br>do not complete this line. | observation bed da | ys). If you have only p | rivate room days,           | 0                               | 3. 00        |
| 4.00    | Semi-private room days (excluding swing-bed                                | and observation b  | ed days)                |                             | 5, 011                          | 4.00         |

|                  | Cost Center Description  |               |                  |
|------------------|--|---------------|------------------|
|                  | PART I - ALL PROVIDER COMPONENTS   | 1. 00         |                  |
|                  | I NPATI ENT DAYS   |               |                  |
| 1.00             | Inpatient days (including private room days and swing-bed days, excluding newborn)   | 8, 673        | 1.00             |
| 2.00             | Inpatient days (including private room days, excluding swing-bed and newborn days)   | 8, 673        | 2.00             |
| 3. 00            | Private room days (excluding swing-bed and observation bed days). If you have only private room days,  | 0             | 3.00             |
| 4 00             | do not complete this line.   | 5, 011        | 4. 00            |
| 4. 00<br>5. 00   | Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost            |               | 5. 00            |
| 3.00             | reporting period   | ĭ             | 3.00             |
| 6.00             | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  | 0             | 6.00             |
|                  | reporting period (if calendar year, enter 0 on this line)  |               |                  |
| 7. 00            | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost   | 0             | 7. 00            |
| 8. 00            | reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost  | o             | 8. 00            |
| 8.00             | reporting period (if calendar year, enter 0 on this line)  | ١             | 8.00             |
| 9. 00            | Total inpatient days including private room days applicable to the Program (excluding swing-bed and  | 160           | 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            |
| 44.00            | through December 31 of the cost reporting period (see instructions)  |               | 44.00            |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | 0             | 11. 00           |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  | 0             | 12. 00           |
| 12.00            | through December 31 of the cost reporting period   |               | .2.00            |
| 13.00            | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  | 0             | 13.00            |
|                  | after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  |               |                  |
| 14.00            | Medically necessary private room days applicable to the Program (excluding swing-bed days)   | 0             |                  |
| 15.00            | Total nursery days (title V or XIX only)   | 0             | 15. 00<br>16. 00 |
| 16. 00           | Nursery days (title V or XIX only) SWING BED ADJUSTMENT  | U             | 16.00            |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  | 0.00          | 17. 00           |
| 00               | report in a peri od  | 1             | .,, 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   | 0.00          | 19. 00           |
| 20. 00           | reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  | 0.00          | 20. 00           |
| 20.00            | report in a peri od  | 0.00          | 20.00            |
| 21.00            | Total general inpatient routine service cost (see instructions)  | 13, 383, 332  | 21.00            |
| 22. 00           | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line  | 0             | 22. 00           |
|                  | 5 x line 17)   |               |                  |
| 23. 00           | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6  | 0             | 23. 00           |
| 24. 00           | x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line  | o             | 24. 00           |
| 24.00            | 7 x line 19)   | ĭ             | 24.00            |
| 25.00            | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8   | 0             | 25.00            |
|                  | x line 20)   |               |                  |
| 26.00            | Total swing-bed cost (see instructions)  | 0             | 26.00            |
| 27. 00           | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  | 13, 383, 332  | 27.00            |
| 28 00            | General inpatient routine service charges (excluding swing-bed and observation bed charges)  | 0             | 28. 00           |
|                  | Pri vate room charges (excluding swing-bed charges)  | ő             |                  |
| 30.00            | Semi-private room charges (excluding swing-bed charges)  | o             |                  |
| 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          |                  |
| 33.00            | 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<br>36. 00 | Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  | 0.00          | 35. 00<br>36. 00 |
| 37. 00           | General inpatient routine service cost net of swing-bed cost and private room cost differential (line  |               | 37.00            |
| 00               | 27 minus line 36)  | 12, 300, 002  |                  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |               |                  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  |               |                  |
| 38.00            |  | 1, 543. 10    |                  |
| 39.00            | Program general inpatient routine service cost (line 9 x line 38)  | 246, 896      |                  |
| 40. 00<br>41. 00 | Medically necessary private room cost applicable to the Program (line 14 x line 35)  Total Program general inpatient routine service cost (line 39 + line 40)                          | 0<br>246, 896 | 40. 00<br>41. 00 |
| 41.00            | Total Trogram general impatrent routine service cost (Tine 37 + Tine 40)   | 240, 090      | 41.00            |

|                  | do not complete this line.   |              |                  |
|------------------|--|--------------|------------------|
| 4.00             | Semi-private room days (excluding swing-bed and observation bed days)  | 5, 011       | 4.00             |
| 5.00             | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost  | 0            | 5.00             |
|                  | reporting period   | _            |                  |
| 6. 00            | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  | 0            | 6. 00            |
| 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            |
| 7.00             | reporting period   | , of         | 7.00             |
| 8. 00            | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   | 0            | 8. 00            |
|                  | reporting period (if calendar year, enter 0 on this line)  |              |                  |
| 9. 00            | Total inpatient days including private room days applicable to the Program (excluding swing-bed and  | 160          | 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 | o            | 11. 00           |
| 11.00            | December 31 of the cost reporting period (if calendar year, enter 0 on this line)  | ,            | 11.00            |
| 12.00            | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  | ol           | 12.00            |
|                  | through December 31 of the cost reporting period   |              |                  |
| 13.00            |  | 0            | 13.00            |
| 44.00            | after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  |              |                  |
| 14.00            | Medically necessary private room days applicable to the Program (excluding swing-bed days)   |              | 14.00            |
| 15. 00<br>16. 00 | Total nursery days (title V or XIX only) Nursery days (title V or XIX only)  | 0            |                  |
| 10.00            | SWING BED ADJUSTMENT   | - 0          | 10.00            |
| 17. 00           |  | 0.00         | 17. 00           |
|                  | reporting period   |              |                  |
| 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           |  | 0. 00        | 19. 00           |
| 20. 00           | reporting period   | 0.00         | 20. 00           |
| 20.00            | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  | 0.00         | 20.00            |
| 21. 00           |  | 13, 383, 332 | 21. 00           |
| 22. 00           | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line  |              |                  |
|                  | 5 x line 17)   |              |                  |
| 23. 00           |  | 0            | 23.00            |
| 24.00            | x line 18)   |              | 24.00            |
| 24. 00           | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  | ا            | 24. 00           |
| 25. 00           | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8   | 0            | 25. 00           |
| 20.00            | In line 20)  | ĭ            | 20.00            |
| 26.00            | Total swing-bed cost (see instructions)  | 0            | 26.00            |
| 27. 00           | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   | 13, 383, 332 | 27.00            |
|                  | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   | _            |                  |
| 28. 00           |  | 0            |                  |
| 29. 00<br>30. 00 | Pri vate room charges (excluding swing-bed charges) Semi-pri vate room charges (excluding swing-bed charges)   | 0            | 29. 00<br>30. 00 |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  | 0. 000000    |                  |
|                  | Average private room per diem charge (line 29 ÷ line 3)  |              | 32. 00           |
| 33. 00           | Average semi-private room per diem charge (line 30 + line 4)   |              | 33.00            |
| 34.00            |  | 0.00         | 34.00            |
| 35.00            | Average per diem private room cost differential (line 34 x line 31)  | 0. 00        | 35.00            |
| 36.00            | Private room cost differential adjustment (line 3 x line 35)   |              | 36.00            |
| 37. 00           | General inpatient routine service cost net of swing-bed cost and private room cost differential (line  | 13, 383, 332 | 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, 543. 10   | 38 00            |
|                  | Program general inpatient routine service cost (line 9 x line 38)  | 246, 896     |                  |
|                  | Medically necessary private room cost applicable to the Program (line 14 x line 35)  | 0            |                  |
| 41.00            | Total Program general inpatient routine service cost (line 39 + line 40)   | 246, 896     | 41.00            |
|                  |  |              |                  |
|                  |  |              |                  |

| COMPUTATION OF INPATIENT OPERATION   | NG COST              | THE WOOD IN THE OTHER      | NAL HOSPITAL Provider C    |  | Peri od:                         | u of Form CMS-2<br>Worksheet D-1     |                  |
|--|----------------------|----------------------------|----------------------------|--|----------------------------------|--------------------------------------|------------------|
|  |                      |                            |                            |  | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre<br>5/31/2024 7:0       |                  |
|  |                      |                            | Ti tl                      | e XIX                                    | Hospi tal                        | Cost                                 | i aiii           |
| Cost Center Descript   | i on                 | Total<br>Inpatient<br>Cost | Total<br>Inpatient<br>Days | Average Per<br>Diem (col. 1<br>÷ col. 2) |                                  | Program Cost<br>(col. 3 x<br>col. 4) |                  |
| 42.00 NURSERY (title V & XIX onl   | у)                   | 1. 00                      | 2. 00                      | 3.00                                     | 4. 00                            | 5. 00                                | 42.00            |
| Intensive Care Type Inpati   | ent Hospital Units   |                            |                            | 2.15/.0                                  | 1                                |                                      | 42.00            |
| 43. 00   I NTENSI VE CARE UNI T 44. 00   CORONARY CARE UNI T                         |                      | 13, 237, 910               | 6, 140<br>                 | 2, 156. 0                                | 1 0                              | 0                                    | 43.00<br>44.00   |
| 45.00 BURN INTENSIVE CARE UNIT   |                      |                            |                            |  |                                  |                                      | 45.00            |
| 46.00 SURGICAL INTENSIVE CARE UN<br>47.00 OTHER SPECIAL CARE (SPECIF                 |                      |                            |                            |  |                                  |                                      | 46. 00<br>47. 00 |
| Cost Center Descript   |                      | . <b>L</b>                 |                            |  |                                  | 4.00                                 | 47.00            |
| 48.00 Program inpatient ancillar   | y service cost (W    | kst. D-3, col.             | 3, line 200)               |  |                                  | 1. 00<br>147, 940                    | 48. 00           |
| 48.01 Program inpatient cellular   | therapy acquisiti    | on cost (Works             | heet D-6, Part             |  | column 1)                        | 0                                    | 48. 01           |
| 49.00 Total Program inpatient co   |                      | 41 through 48.             | 01)(see instru             | ctions)                                  |                                  | 394, 836                             | 49.00            |
| 50.00 Pass through costs applica   |                      | patient routine            | services (fro              | m Wkst. D, sur                           | n of Parts I and                 | 0                                    | 50.00            |
| III) 51.00 Pass through costs applica  | ublo to Drogram in   | nationt ancilla            | ry coryl coc (f            | rom Wkst D                               | sum of Dorts II                  | 0                                    | 51.00            |
| and IV)  | ibie to Program iii  | Datreil alicitra           | ry services (i             | TOIII WKSt. D, S                         | Suiii Of Parts II                |                                      | 31.00            |
| 52.00 Total Program excludable of  |                      |                            | alatad - · ·               | vol al · · · · · ·                       | antint!                          | 0                                    |                  |
| 53.00 Total Program inpatient or medical education costs (I                          |                      |                            | erated, non-pn             | ysician anesti                           | netist, and                      | 0                                    | 53.00            |
| TARGET AMOUNT AND LIMIT CO   |                      | •                          |                            |  |                                  |                                      |                  |
| <ul><li>54.00 Program discharges</li><li>55.00 Target amount per discharge</li></ul> | ie                   |                            |                            |  |                                  | 0.00                                 |                  |
| 55. 01 Permanent adjustment amour  |                      |                            |                            |  |                                  | 0.00                                 |                  |
| 55. 02 Adjustment amount per disc  |                      | <b>J</b> ,                 | `                          |  |                                  | 0.00                                 |                  |
| 56.00 Target amount (line 54 x s 57.00 Difference between adjuste                    |                      |                            | •                          | line 56 minus                            | line 53)                         | 0                                    | 56. 00<br>57. 00 |
| 58.00 Bonus payment (see instruc   | ctions)              | · ·                        |                            |  | ,                                | 0                                    | 58. 00           |
| 59.00 Trended costs (lesser of lupdated and compounded by                            |                      |                            | m the cost rep             | orting period                            | endi ng 1996,                    | 0.00                                 | 59.00            |
| 60.00 Expected costs (lesser of  |                      |                            | om prior year              | cost report, ι                           | updated by the                   | 0.00                                 | 60.00            |
| 61.00 (Continuous improvement bor 55.01, or line 59, or line                         | e 60, enter the Les  | sser of 50% of             | the amount by              | which operatio                           | ng costs (line                   | 0                                    | 61.00            |
| 53) are less than expected enter zero. (see instructi                                |                      | (60), or 1 % o             | f the target a             | mount (line 50                           | b), otherwise                    |                                      |                  |
| 62.00 Relief payment (see instru   | ıctions)             |                            |                            |  |                                  | 0                                    |                  |
| 63.00 Allowable Inpatient cost p PROGRAM INPATIENT ROUTINE                           |                      | ment (see instr            | uctions)                   |  |                                  | 0                                    | 63.00            |
| 64.00 Medicare swing-bed SNF inp   |                      | sts through Dec            | ember 31 of th             | e cost reporti                           | ng period (See                   | 0                                    | 64.00            |
| instructions)(title XVIII 65.00 Medicare swing-bed SNF inp                           |                      | ets after Decem            | har 31 of the              | cost reporting                           | neriod (See                      | 0                                    | 65. 00           |
| instructions)(title XVIII  |                      | sts after becein           | bei 31 01 the              | cost reporting                           | g perrou (see                    |                                      | 05.00            |
| 66.00 Total Medicare swing-bed S   | SNF inpatient routi  | ne costs (line             | 64 plus line               | 65)(title XVII                           | l only); for                     | 0                                    | 66.00            |
| CAH, see instructions 67.00 Title V or XIX swing-bed N                               | IF inpatient routir  | ne costs throug            | h December 31              | of the cost re                           | eporting period                  | О                                    | 67.00            |
| (line 12 x line 19) 68.00 Title V or XIX swing-bed M                                 | I i nnati ant mautir | o costo often              | Dagambar 21 of             | the east ron                             | neting ported                    |                                      | 40.00            |
| 68.00 Title V or XIX swing-bed N (line 13 x line 20)                                 | ir impatrem routii   | le costs arter             | becember 31 or             | the cost repo                            | of tring period                  | 0                                    | 68. 00           |
| 69.00 Total title V or XIX swing   |                      |                            |                            |  |                                  | 0                                    | 69.00            |
| 70.00 Skilled nursing facility/o   |                      |                            |                            |  | )                                |                                      | 70.00            |
| 71.00 Adjusted general inpatient   |                      |                            | line 70 ÷ line             | 2)                                       |                                  |                                      | 71.00            |
| 72.00 Program routine service co<br>73.00 Medically necessary privat                 | •                    |                            | m (line 14 x l             | ine 35)                                  |                                  |                                      | 72. 00<br>73. 00 |
| 74.00 Total Program general inpa   | ntient routine serv  | vice costs (l̃in           | e 72 + line 73             | )  |                                  |                                      | 74.00            |
| 75.00 Capital-related cost allocation 26, line 45)                                   | cated to inpatient   | routine servic             | e costs (from              | Worksheet B, F                           | Part II, column                  |                                      | 75.00            |
| 76.00 Per diem capital-related o   | costs (line 75 ÷ li  | ne 2)                      |                            |  |                                  |                                      | 76. 00           |
| 77.00 Program capital-related co<br>78.00 Inpatient routine service                  |                      |                            |                            |  |                                  |                                      | 77. 00<br>78. 00 |
| 79. 00 Aggregate charges to benef  |                      |                            | provi der recor            | ds)                                      |                                  |                                      | 79.00            |
| 80.00 Total Program routine serv   | vice costs for comp  | parison to the             |                            |  | nus line 79)                     |                                      | 80.00            |
| 81.00 Inpatient routine service<br>82.00 Inpatient routine service                   | •                    |                            | 1)                         |  |                                  |                                      | 81. 00<br>82. 00 |
| 83.00 Reasonable inpatient routi   | ne service costs (   | (see instructio            |                            |  |                                  |                                      | 83. 00           |
| 84.00 Program inpatient ancillar   | ,                    | ,                          | one)                       |  |                                  |                                      | 84. 00<br>85. 00 |
| 85.00 Utilization review - physi<br>86.00 Total Program inpatient op                 |                      |                            |                            |  |                                  |                                      | 86.00            |
| PART IV - COMPUTATION OF C   | BSERVATION BED PAS   | S THROUGH COST             |                            |  |                                  |                                      |                  |
| 87.00 Total observation bed days   | s (see instructions  | s)                         |                            |  |                                  | 3, 662                               | 87.00            |

| Health Financial Systems                           | HANCOCK REGIO  | NAL HOSPITAL |             | In Lie                           | u of Form CMS-2 | 2552-10 |
|--|----------------|--------------|-------------|----------------------------------|-----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST            |                | Provi der CO | CN: 15-0037 | Peri od:                         | Worksheet D-1   |         |
|  |                |              |             | From 01/01/2023<br>To 12/31/2023 |                 |         |
|  |                | 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, 650, 832     | 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, 363, 270    | 13, 383, 332 | 0. 17658    | 5, 650, 832                      | 997, 841        | 90.00   |
| 91.00 Nursing Program cost                         | 0              | 13, 383, 332 | 0. 00000    | 5, 650, 832                      | 0               | 91.00   |
| 92.00 Allied health cost                           | 0              | 13, 383, 332 | 0. 00000    | 5, 650, 832                      | 0               | 92.00   |
| 93.00 All other Medical Education                  | 0              | 13, 383, 332 | 0. 00000    | 5, 650, 832                      | 0               | 93.00   |

| Health Financial Systems  | HANCOCK REGIONAL                    | HOSPI TAL    |                      | In Lie          | u of Form CMS-        | 2552-10          |
|---|-------------------------------------|--------------|----------------------|-----------------|-----------------------|------------------|
| INPATIENT ANCILLARY SERVICE COST A                                      | APPORTI ONMENT                      | Provi der C  | CN: 15-0037          | Peri od:        | Worksheet D-3         |                  |
|   |                                     |              |                      | From 01/01/2023 |                       |                  |
|   |                                     |              |                      | To 12/31/2023   |                       |                  |
|   |                                     | Ti +Lo       | e XVIII              | Hospi tal       | 5/31/2024 7: 0<br>PPS | ı allı           |
| Cost Center Description   |                                     | 11110        | Ratio of Cos         |                 | Inpati ent            |                  |
| cost center bescriptive   | 110                                 |              | To Charges           | Program         | Program Costs         |                  |
|   |                                     |              | 10 charges           | Charges         | (col. 1 x             |                  |
|   |                                     |              |                      | onal ges        | col . 2)              |                  |
|   |                                     |              | 1.00                 | 2. 00           | 3.00                  |                  |
| INPATIENT ROUTINE SERVICE C   | OST CENTERS                         |              |                      |                 |                       |                  |
| 30. 00 03000 ADULTS & PEDIATRICS  |                                     |              |                      | 917, 877        |                       | 30.00            |
| 31.00 03100 INTENSIVE CARE UNIT   |                                     |              |                      | 5, 113, 125     |                       | 31.00            |
| 40. 00   04000   SUBPROVI DER - 1 PF                                    |                                     |              |                      | 0               |                       | 40.00            |
| ANCILLARY SERVICE COST CENT   | ERS                                 |              |                      |                 |                       |                  |
| 50. 00 05000 OPERATING ROOM   |                                     |              | 0. 21239             | 95 2, 490, 478  | 528, 965              | 50.00            |
| 51.00   05100   RECOVERY ROOM   |                                     |              | 0. 42593             | 32 207, 889     | 88, 547               | 51.00            |
| 53. 00   05300   ANESTHESI OLOGY  |                                     |              | 0. 00000             | 00              | 0                     | 53.00            |
| 54. 00   05400 RADI OLOGY-DI AGNOSTI C                                  |                                     |              | 0. 11278             | 3, 096, 219     | 349, 210              | 54.00            |
| 60. 00   06000   LABORATORY   |                                     |              | 0. 1280              | 4, 401, 330     | 563, 639              | 60.00            |
| 65. 00 06500 RESPIRATORY THERAPY  |                                     |              | 0. 3678              | 19 789, 309     | 290, 323              | 65.00            |
| 66. 00 06600 PHYSI CAL THERAPY  |                                     |              | 0. 47172             | 24 219, 623     | 103, 601              | 66.00            |
| 67. 00 06700 OCCUPATI ONAL THERAPY                                      |                                     |              | 0. 3731              | 16 174, 241     | 65, 012               | 67.00            |
| 68.00 06800 SPEECH PATHOLOGY  |                                     |              | 0. 30940             | 01 83, 245      | 25, 756               | 68.00            |
| 69. 00  06900   ELECTROCARDI OLOGY                                      |                                     |              | 0. 12170             | 00 1, 506, 407  | 183, 330              | 69.00            |
| 70. 00 07000 ELECTROENCEPHALOGRAPH                                      |                                     |              | 0.00000              |                 | 0                     |                  |
| 71.00 07100 MEDICAL SUPPLIES CHARG                                      |                                     |              | 3. 52090             |                 | 540, 026              |                  |
| 72.00 07200 I MPL. DEV. CHARGED TO                                      |                                     |              | 0. 12732             |                 | 88, 555               |                  |
| 73.00 07300 DRUGS CHARGED TO PATIE                                      | ENTS                                |              | 0. 23234             |                 | 900, 803              |                  |
| 76. 00   03020   CARDI AC   |                                     |              | 0. 00000             |                 | 0                     |                  |
| 76. 01 03160 CARDI OPULMONARY   |                                     |              | 0. 51043             |                 | 0                     | 1                |
| 77.00 07700 ALLOGENEIC STEM CELL  |                                     |              | 0.00000              |                 | 0                     | 77. 00           |
| 78. 00 07800 CAR T-CELL IMMUNOTHER                                      |                                     |              | 0.00000              | 00 0            | 0                     | 78. 00           |
| OUTPATIENT SERVICE COST CEN   | TERS                                |              | 0.0000               | 20              |                       | 00.00            |
| 88. 00 08800 RURAL HEALTH CLINIC  |                                     |              | 0.00000              |                 | 0                     |                  |
| 90. 00   09000   CLI NI C   |                                     |              | 0.00000              |                 | 0                     | 90.00            |
| 90. 01   09001   WOUND CLINIC   |                                     |              | 0. 23046             |                 | 0                     | 90. 01           |
| 90. 02 09002 DI ABETES CLINIC   |                                     |              | 10. 97574            |                 | 0                     | 90.02            |
| 90. 03   09003   ASTHMA CLINIC  |                                     |              | 0.00000              |                 | 0                     | 90.03            |
| 90. 04   09004   ANDIS CLINIC   |                                     |              | 6. 21069             |                 | 0                     | 90.04            |
| 90. 05   09005   PRIME TIME   | 11.0                                |              | 0.00000              |                 | 0                     | 90.05            |
| 90. 06   09006   SHELBYVILLE WOUND CLII<br>90. 07   04951   ONCOLOGY    | VI C                                |              | 0.00000              |                 | -                     | 90. 06<br>90. 07 |
|   | 1                                   |              | 0. 53236             |                 | 10, 540               |                  |
| 90. 08 04950 ANDERSON WOMENS CENTER<br>91. 00 09100 EMERGENCY           | \                                   |              | 0. 3654              |                 | 0                     | 90. 08<br>91. 00 |
| 91. 00   09100   EMERGENCY<br>92. 00   09200   OBSERVATION   BEDS (NON- | DISTINCT DADT)                      |              | 0. 10404<br>0. 31684 |                 | 412, 146<br>138, 813  |                  |
|   | ) through 94 and 96 through 98)     |              | 0.31004              | 22, 113, 675    | 4, 289, 266           |                  |
|   | atory Services-Program only charge: | s (line 61)  |                      | 22, 113, 0/3    | 4, 207, 200           | 201.00           |
| 202.00 Net charges (line 200  |                                     | 3 (11116 01) |                      | 22, 113, 675    |                       | 202.00           |
| 202. 00   Not that ges (Title 200                                       | 11110 201)                          |              | I                    | 22, 115, 075    | I                     | 1202.00          |

| Health Financial Systems  INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | HANCOCK REGIONAL HOSPITAL Provider | CCN: 15-0037                 | Peri od:        | u of Form CMS-2<br>Worksheet D-3 |        |
|--|------------------------------------|------------------------------|-----------------|----------------------------------|--------|
|  |                                    |                              | From 01/01/2023 |                                  |        |
|  |                                    |                              | To 12/31/2023   | Date/Time Pre 5/31/2024 7:0      |        |
|  | Ti                                 | tle XIX                      | Hospi tal       | Cost                             | 71 am  |
| Cost Center Description  |                                    | Ratio of Cos                 |                 | I npati ent                      |        |
| , , , , , , , , , , , , , , , , , , ,                                    |                                    | To Charges                   | Program         | Program Costs                    |        |
|  |                                    |                              | Charges         | (col. 1 x                        |        |
|  |                                    |                              | ŭ               | col . 2)                         |        |
|  |                                    | 1.00                         | 2. 00           | 3. 00                            |        |
| INPATIENT ROUTINE SERVICE COST CENTERS                                   |                                    |                              |                 |                                  |        |
| 30. 00   03000   ADULTS & PEDI ATRI CS                                   |                                    |                              | 314, 158        |                                  | 30.00  |
| 31. 00 03100 INTENSIVE CARE UNIT   |                                    |                              | 163, 057        |                                  | 31.00  |
| 40. 00   04000   SUBPROVI DER -   PF                                     |                                    |                              | 0               |                                  | 40.00  |
| ANCILLARY SERVICE COST CENTERS   |                                    | 0.01000                      |                 | 10.5(1                           |        |
| 50. 00   05000   OPERATING ROOM  |                                    | 0. 21239                     |                 | 42, 564                          |        |
| 51. 00   05100   RECOVERY ROOM   |                                    | 0. 42593                     |                 | 7, 818                           |        |
| 53. 00   05300   ANESTHESI OLOGY   |                                    | 0.00000                      |                 | 0                                |        |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C<br>60. 00   06000   LABORATORY  |                                    | 0. 11278                     |                 | 4, 743                           |        |
| 60. 00   06000   LABORATORY<br>65. 00   06500   RESPI RATORY   THERAPY   |                                    | 0. 1280 <i>6</i><br>0. 36781 |                 | 16, 957                          | 1      |
| 66. 00   06600   PHYSI CAL THERAPY                                       |                                    | 0. 36761                     |                 | 10, 634<br>1, 549                | 1      |
| 67. 00 06700 OCCUPATI ONAL THERAPY                                       |                                    | 0. 47172                     | · ·             | 1, 072                           |        |
| 68. 00   06800   SPEECH PATHOLOGY  |                                    | 0. 30940                     |                 | 657                              |        |
| 69. 00   06900   ELECTROCARDI OLOGY                                      |                                    | 0. 12170                     |                 | 2, 679                           |        |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY                                      |                                    | 0.00000                      |                 | 0                                | 1      |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                        |                                    | 3. 52090                     |                 | 15, 267                          | 1      |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT                               |                                    | 0. 12732                     | · ·             | 0                                | 1      |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                                    |                                    | 0. 23234                     |                 | 30, 987                          | 73.00  |
| 76. 00 03020 CARDI AC  |                                    | 0.00000                      |                 | 0                                | 76.00  |
| 76. 01   03160   CARDI OPULMONARY  |                                    | 0. 51043                     | 35 0            | 0                                | 76. 01 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION                             |                                    | 0.00000                      | 00              | 0                                | 77.00  |
| 78. 00 07800 CAR T-CELL IMMUNOTHERAPY                                    |                                    | 0.00000                      | 00              | 0                                | 78. 00 |
| OUTPATIENT SERVICE COST CENTERS  |                                    |                              |                 |                                  |        |
| 88. 00 08800 RURAL HEALTH CLINIC   |                                    | 0. 62934                     |                 | 0                                |        |
| 90. 00 09000 CLI NI C  |                                    | 0.00000                      |                 | 0                                | 1      |
| 90. 01   09001   WOUND CLINIC  |                                    | 0. 23046                     |                 | 29                               |        |
| 90. 02   09002   DI ABETES   CLI NI C                                    |                                    | 10. 97574                    |                 | 0                                |        |
| 90. 03   09003   ASTHMA   CLI NI C                                       |                                    | 0.00000                      |                 | 0                                |        |
| 90. 04   09004   ANDIS CLINIC  |                                    | 6. 21069                     |                 | 0                                |        |
| 90. 05   09005   PRI ME TI ME  |                                    | 0.00000                      |                 | 0                                | 1      |
| 90. 06 O9006 SHELBYVILLE WOUND CLINIC                                    |                                    | 0.00000                      |                 | 0                                |        |
| 90. 07   04951   0NCOLOGY<br>90. 08   04950   ANDERSON WOMENS CENTER     |                                    | 0. 5323 <i>6</i><br>0. 36547 |                 | 0                                | 1      |
| 91 ON 109100 EMERGENCY   |                                    | 0.30547                      |                 | 12 984                           |        |

0. 365476 0. 104046 0. 316848

201. 00 202. 00

12, 984 91. 00 0 92. 00 147, 940 200. 00

91. 00 09100 EMERGENCY

200.00 201. 00 202. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

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)

| Health Financial Systems                | HANCOCK REGIONAL HOSPITAL | -              | In Lieu                                      | u of Form CMS-2552-10   |
|---|---------------------------|----------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi de                  | r CCN: 15-0037 | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E<br>Part A<br>Date/Time Prepared:<br>5/31/2024 7:01 am |

| MAX Associate Other Than Cutil or Replacets   0.00   |          | Title WILL Hearit  |         | 5/31/2024 7: 0 | <u>1 am</u>    |
|--|----------|--|---------|----------------|----------------|
| MARICA - INVAILED HIGHER HISPOTIAL SERVICES DUBBER HIPPS   |          |  | ai      | PPS            |                |
| 1.00   Dick Amounts Other than Outilier payments for discharges occurring prior to October 1 (see   1,724,623   1.01   1.02   1.02   1.02   1.02   1.03        |          |  |         | 1. 00          |                |
| 1.00   DRG anounts other than outlier payments for discharges occurring prior to October 1 (see   4,74,623   1.01   Instruction other than outlier payments for discharges occurring on or after October 1 (see   1.734,504   1.02   1.03   1.03   1.03   1.03   1.03   1.04   1.05   1.04   1.05   1.03   1.03   1.03   1.03   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.04   1.05   1.     | 4 00     |  |         |                | 4 00           |
| 1.02   Rick and control with the noutlier payments for discharges occurring on or after October 1 (see Instructions)   |          | DRG amounts other than outlier payments for discharges occurring prior to October 1 (see   |         | -              |                |
| 1.03   Note for Federal specific operating payment for Model 4 BPCI for discharges accurring prior to October 1   1.03   | 1. 02    | DRG amounts other than outlier payments for discharges occurring on or after October 1 (see  |         | 1, 734, 504    | 1. 02          |
| October 1 (see instructions)   2.00   Outlifer payments for discharges. (see instructions)   2.00   Outlifer payments for discharges. (see instructions)   2.00   Outlifer payments for discharges occurring or for took of cottober 1 (see Instructions)   2.00   Outlifer payments for discharges occurring prior to October 1 (see Instructions)   3.8   3.8   2.04   Outlifer payments for discharges occurring or or after October 1 (see Instructions)   3.8   3.8   3.9   3     | 1. 03    | DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to 0  | ctober  | 0              | 1. 03          |
| 2.01 Outlier reconciliation amount         0         2.01           2.02 Outlier payment for discharges for Model 4 BPCI (see instructions)         0         2.02           2.03 Dutilier payments for discharges occurring prior to 6ctober 1 (see instructions)         41,695         2.02           2.04 Dutilier payments for discharges occurring prior to 6ctober 1 (see instructions)         8.184         2.04           4.00         Bed days awail able divided by number of days in the cost reporting period (see instructions)         102.97           5.00         Fife count for all opathic and asteopathic programs for the most researt cost reporting period ending or or before 12/31/196. (see instructions)         10.00         5.00           5.00         Fife count for all opathic and asteopathic programs for the most researt cost reporting period ending or or before 12/31/196. (see instructions)         0.00         5.00           6.00         Fife count for all opathic and asteopathic programs for the most researt cost reporting period ending or   | 1. 04    |  | r       | 0              | 1. 04          |
| 2.03   Outlier payments for discharges occurring prior to October 1 (see Instructions)   8.184   2.04  |          |  |         | 0              | 2. 00<br>2. 01 |
| 2.04   Outslier payments for discharges occurring on or after October 1 (see instructions)   0.300   |          |  |         | ŭ              | 2. 02          |
| Managed Care Simulated Payments  |          |  |         |                |                |
| Indirect   Medical   Education Adjustment  |          |  |         |                | 3.00           |
| Fife count for all opathic and osteopathic programs for the most recent cost reporting period ending or or before 12/31/19/69 (see instructions)   0.00   5.01   | 4. 00    |  |         | 102. 97        | 4. 00          |
| or before 12/3/1799 (see Instructions)  or before 12/3/1799 (see Instructions)  5. 01 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for 0.00 6.00 new programs in accordance with 42 CTR 413.79(c)  6. 26 Rural track program FTE cap I initiation adjustment after the cap-building window closed under \$127 or 0.00 6.00 new programs in accordance with 42 CTR 413.79(c)  7. 01 MAS Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(1) 0.00 7.00 cost report straddies July 1, 2011 then see instructions in a struction of track program FTE Limitation (S) for rural track programs in accordance with 413.75(b) and 87 FR 4075 (August 10. 2022) (see instructions) 1.00 Aljustment (increase or decrease) to the hospital's rural track program FTE Limitation(s) for rural track programs in accordance with 413.75(b) and 87 FR 4075 (August 10. 2022) (see instructions) 1.00 Aljustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 0.00 Aljustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 0.00 Aljustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 0.00 R.00 17998), and 67 FR 5009 (August 1. 2002)  8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5506 of fACA. (see instructions) 1.00 17999, and 67 FR 5009 (August 1. 2002)  8. 02 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see 1. Instructions) 1.00 1799 (august 10. 10. 10. 10. 10. 10. 10. 10. 10. 10.  | 5 00     |  | i na on | 0.00           | 5 00           |
| 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 413.79(e)  | 3.00     |  | Ting on | 0.00           | 3.00           |
| new programs in accordance with 42 CFR 413.79(e)   6.26  |          |  | _       |                |                |
| 6.2 b         Rural track program FTE cap IImitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see Instructions)         0.00         0.00         0.00         0.00         0.00         7.00           7.00 In ACA \$2021 (see Instructions)         0.00         7.00         0.00         7.00         0.00         7.00         0.00         7.00         7.00         0.00         7.00         0.00         7.00         7.00         7.01         0.00         7.00         0.00         7.00         7.00         7.01         0.00         7.01         0.00         7.01         0.00         7.02   | 6. 00    |  | ap for  | 0. 00          | 6. 00          |
| MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f(1)(1)(1)(8)(2) If the 0.00   7.01  | 6. 26    | Rural track program FTE cap limitation adjustment after the cap-building window closed under §1  | 27 of   | 0. 00          | 6. 26          |
| cost report straddles July 1, 2011 then see Instructions.  7.02 Adjustment (increase or decrease) to the hospital's rural track programs FTE limitation(s) for rural track programs with a rural track for Medicare GME 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 FCF 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 from a closed teaching hospital under \$ 5506 of ACA. (see instructions)  8.03 under \$ 5506 of ACA. (see instructions)  8.04 Instructions)  8.05 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)  8.04 Districtions)  8.05 Of Tecount for all opathic and osteopathic programs in the current year from your records  8.06 Current year allowable FTE count for the prior year.  8.07 Of total allowable FTE count for the prior year.  8.08 Of total allowable FTE count for the prior year.  8.09 Of total allowable FTE count for the prior year.  8.00 Of total allowable FTE count for the prior year.  8.00 Of total allowable FTE count for the prior year.  8.00 Of total allowable FTE count for the prior year.  8.00 Of total allowable FTE count for the prior year.  8.00 Of total allowable FTE count for the prior year.  8.00 Of total allowable FTE count for the prior year.  8.01 Of total allowable FTE count for the prior year.  8.02 Of total allowable FTE count for the prior year.  8.03 Of total allowable FTE count for the prior year.  8.04 Of Wittenson of the year year year.  8.05 Of total allowable FTE count for the prior year. | 7. 00    |  | (1)     | 0. 00          | 7. 00          |
| Track programs with a rural track for Medicare GNE affiliated programs in accordance with 413.75(b) and 87 FR 40075 (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 straddles July 1, 2011, see instructions.   8.02   The amount of increase if the hospital was awarded FTE cap slots under \$ 126 of the CAA 2021 (see 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   Instructions   9.00   I | 7. 01    |  | f the   | 0.00           | 7. 01          |
| affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 2634Ö (May 12, 1998), and 67 FR 50009 (August 1, 2002).   | 7. 02    | track programs with a rural track for Medicare GME affiliated programs in accordance with 413.7  |         | 0. 00          | 7. 02          |
| report straddles July 1, 2011, see instructions.   | 8. 00    | affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,  |         | 0. 00          | 8. 00          |
| 8.02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 or ACA. (see instructions)   | 8. 01    | · · · · · · · · · · · · · · · · · · ·  | e cost  | 0. 00          | 8. 01          |
| 8.21   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  | 8. 02    | The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospita  | ı       | 0. 00          | 8. 02          |
| 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   1.00   TEC count for residents in dental and podiatric programs.   0.00   11.00     12.00   Current year allowable FTE (see instructions)   0.00   12.00     13.00   Total allowable FTE count for the prior year.   0.00   13.00     14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00     15.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   0.00   14.00     16.00   Adjustment for residents in initial years of the program (see instructions)   0.00   16.00     16.00   Adjustment for residents displaced by program or hospital closure   0.00   16.00     18.00   Adjustment for residents to bed ratio (line 18 divided by line 4).   0.000000     18.00   O.00   O.00   O.00   O.00   O.00   O.00   O.00   O.00     19.00   O.00     19.00   O.00   O.     | 8. 21    | · · · · · · · · · · · · · · · · · · ·  | е       | 0. 00          | 8. 21          |
| 11. 00   FTE count for residents in dental and podiatric programs.   0.00   11. 00   12. 00   12. 00   13. 00   14. 00   14. 00   14. 00   14. 00   15. 00   14. 00   14. 00   14. 00   15. 00   15. 00   14. 00   15. 00     | 9. 00    |  | s or    | 0.00           | 9. 00          |
| 12.00   Current year allowable FTE (see instructions)   Total allowable FTE count for the prior year.   O.00   12.00   13.00   13.00   14.00   O.00   13.00   14.00   O.00   14.00   O.00   14.00   O.00   14.00   O.00   O.00   14.00   O.00      |          |  |         |                |                |
| 13.00   Total allowable FTE count for the prior year.   0.00   13.00   14.00   15.00   14.00   15.00     |          | ' ' '  | ŀ       |                |                |
| 14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.   0.00   14.00 otherwise enter zero.   0.00   15.00   15.00   20     |          | ,  | l       |                |                |
| 15.00       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       Adjusted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (see instructions)       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       19.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.000000       22.00         22.01       Image:   |          | Total allowable FTE count for the penultimate year if that year ended on or after September 30,  | 1997,   | 0. 00          | 14.00          |
| 16. 00       Adjustment for residents in initial years of the program (see instructions)       0. 00       16. 00       Adjustment for residents displaced by program or hospital closure       0. 00       17. 00       0. 00       18. 00       17. 00       0. 00       18. 00       0. 00       18. 00       0. 00       18. 00       0. 00       18. 00       0. 00       0. 00       18. 00       0. 00       0. 00       19. 00       0. 00       2. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00       0. 00   | 15 00    |  |         | 0.00           | 15 00          |
| 17. 00       Adjustment for residents displaced by program or hospital closure       0. 00       17. 00         18. 00       Adjusted rolling average FTE count       0. 00       18. 00         19. 00       Current year resident to bed ratio (line 18 divided by line 4).       0. 0000000       19. 00         20. 00       Prior year resident to bed ratio (see instructions)       0. 0000000       20. 00         21. 00       IME payment adjustment (see instructions)       0. 0000000       21. 00         1ME payment adjustment - Managed Care (see instructions)       0. 22. 01       22. 01         1ndirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0. 00       23. 00         23. 00       IME FTE Resident Count Over Cap (see instructions)       0. 00       24. 00         24. 00       IME FTE Resident Count Over Cap (see instructions)       0. 00       25. 00         25. 00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0. 000000       27. 00         26. 00       Resident to bed ratio (divide line 25 by line 4)       0. 0000000       28. 00       28. 00         27. 00       IME payments adjustment amount (see instructions)       0. 000000       27. 00       28. 01         28. 01       IME payment (sum of lines 22 and 28)       0. 28. 00       <   |          |  |         |                |                |
| 19.00   Current year resident to bed ratio (line 18 divided by line 4).   0.000000   19.00   20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   20.00   20.00   20.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00   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  |          |  | l       |                |                |
| 20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   21.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00   22.00   IME payment adjustment (see instructions)   0   22.00   IME payment adjustment - Managed Care (see instructions)   0   22.00   IME payment adjustment - Managed Care (see instructions)   0   22.00   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   0.00   23.00   (f)(1)(iv)(c).   0.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000   0.00     |          |  |         |                |                |
| 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 23.00 IME payment adjustment - Managed Care (see instructions) 24.00 IME payment adjustment - Managed Care (see instructions) 25.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  26.00 IME FTE Resident Count Over Cap (see instructions) 27.00 IME FTE Resident Count Over Cap (see instructions) 28.00 IME FTE Resident Count Over Cap (see instructions) 29.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment amount (see instructions) 20.00 IME payments adjustment amount (see instructions) 20.00 IME payments adjustment amount - Managed Care (see instructions) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 INTOtal IME payment (sum of lines 22 and 28) 20.00 INTOTAL IME payment - Managed Care (sum of lines 22.01 and 28.01) 20.00 Disproportionate Share Adjustment 20.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20.00 Sum of lines 30 and 31 20.00 Sum of lines 30 and 31  |          |  |         |                |                |
| 22.00 IME payment adjustment (see instructions)  1   |          |  |         |                |                |
| 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 0.00 (f) (1) (iv) (C).  24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 1 IME FTE Resident count on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 1 IME payments adjustment factor. (see instructions) 0.000000 27.00 1 IME payments adjustment amount (see instructions) 0.000000 27.00 1 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 28.01 1 IME payment (sum of lines 22 and 28) 0.00 1 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 17.62 31.00 32.00 Sum of lines 30 and 31 19.30 32.00  |          |  |         | 0              | 22.00          |
| 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   | 22. 01   |  |         | 0              | 22. 01         |
| 24.00   IME FTE Resident Count Over Cap (see instructions)   | 23. 00   |  |         | 0.00           | 23. 00         |
| 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   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)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  1.68 30.00  31.00 Sum of lines 30 and 31  19.30 32.00  | 24.00    |  |         | 0.00           | 24.00          |
| 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       28.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0       28.01         29.00       Total IME payment (sum of lines 22 and 28)       0       29.00         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0       29.01         Disproportionate Share Adjustment       9ercentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       1.68       30.00         31.00       Percentage of Medicaid patient days (see instructions)       17.62       31.00         32.00       Sum of lines 30 and 31       19.30       32.00   |          | If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see  |         |                |                |
| 27. 00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28. 00       IME add-on adjustment amount (see instructions)       0       28.00         28. 01       IME add-on adjustment amount - Managed Care (see instructions)       0       28.01         29. 00       Total IME payment (sum of lines 22 and 28)       0       29.00         29. 01       Disproportionate Share Adjustment       0       29.01         30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       1.68       30.00         31. 00       Percentage of Medicaid patient days (see instructions)       17.62       31.00         32. 00       Sum of lines 30 and 31       19.30       32.00   | 26. 00   |  |         | 0. 000000      | 26. 00         |
| 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)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Sum of lines 30 and 31  28.01 29.00 29   |          | IME payments adjustment factor. (see instructions)   |         | 0. 000000      | 27. 00         |
| 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)  1.68 30.00  31.00 Percentage of Medicaid patient days (see instructions)  17.62 31.00  32.00 Sum of lines 30 and 31   |          |  |         | -              |                |
| 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)  1. 68 30. 00  31. 00 Percentage of Medicaid patient days (see instructions)  17. 62 31. 00  32. 00 Sum of lines 30 and 31   |          |  |         |                |                |
| Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  1. 68 30.00  31.00 Percentage of Medicaid patient days (see instructions)  17. 62 31.00  32.00 Sum of lines 30 and 31  19. 30 32.00  |          |  |         | -              |                |
| 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  1.68 30.00 31.00 Percentage of Medicaid patient days (see instructions)  17.62 31.00 32.00 Sum of lines 30 and 31   | _ /. 0 ! |  |         |                |                |
| 32.00 Sum of lines 30 and 31 19.30 32.00   |          | Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  |         |                |                |
|  |          |  |         |                |                |
| 50. 50 principles at appropriate and 6 per centrage (500 finational)   |          |  |         |                |                |
|  |          | The second of th |         | 5. 27          |                |

| Hoal th          | Financial Systems HANCOCK REGIONA   | I HOSDITAI                | In Lio                                       | u of Form CMS-2          | )552 10          |  |  |  |
|------------------|---|---------------------------|--|--------------------------|------------------|--|--|--|
|                  | Financial Systems HANCOCK REGIONA ATION OF REIMBURSEMENT SETTLEMENT   | Provi der CCN: 15-0037    | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E              |                  |  |  |  |
|                  |   |                           |  | 5/31/2024 7: 0           |                  |  |  |  |
|                  |   | Title XVIII               | Hospi tal                                    | PPS                      |                  |  |  |  |
|                  | 1. 00   |                           |  |                          |                  |  |  |  |
| 34.00            | Disproportionate share adjustment (see instructions)  |                           | D  | 85, 422                  | 34.00            |  |  |  |
|                  | Pri or to 10/1 1.00   |                           |  |                          |                  |  |  |  |
|                  | Uncompensated Care Payment Adjustment   |                           | 1.00   | 2. 00                    |                  |  |  |  |
| 35. 00           | Total uncompensated care amount (see instructions)  |                           | 0  | 0                        |                  |  |  |  |
| 35. 01<br>35. 02 | Factor 3 (see instructions) Hospital UCP, including supplemental UCP (see instructions)   |                           | 0. 000000000<br>891, 326                     | 0. 000000000<br>692, 931 | 35. 01<br>35. 02 |  |  |  |
| 35. 02           | Pro rata share of the hospital UCP, including supplemental U  | ICP (see instructions)    | 666, 663                                     | 174, 179                 |                  |  |  |  |
| 36.00            | Total UCP adjustment (sum of columns 1 and 2 on line 35.03)   |                           | 840, 842                                     | ·                        | 36.00            |  |  |  |
| 40. 00           | Additional payment for high percentage of ESRD beneficiary d<br>Total Medicare discharges (see instructions)  | ischarges (lines 40 thro  | ugh 46)<br>0                                 |                          | 40.00            |  |  |  |
| 41. 00           | Total ESRD Medicare discharges (see instructions)   |                           | 0  |                          | 40. 00<br>41. 00 |  |  |  |
| 41. 01           | Total ESRD Medicare covered and paid discharges (see instruc  |                           | 0  |                          | 41. 01           |  |  |  |
| 42.00            | Divide line 41 by line 40 (if less than 10%, you do not qual  | ify for adjustment)       | 0.00   |                          | 42.00            |  |  |  |
| 43. 00<br>44. 00 | Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided                                  | lby line 41 divided by 7  | 0.000000                                     |                          | 43. 00<br>44. 00 |  |  |  |
| 44.00            | days)   | by Time 41 divided by 7   | 0.000000                                     |                          | 44.00            |  |  |  |
| 45. 00           | Average weekly cost for dialysis treatments (see instruction  |                           | 0.00   |                          | 45.00            |  |  |  |
| 46. 00<br>47. 00 | Total additional payment (line 45 times line 44 times line 4  | 1. 01)                    | 7 425 270                                    |                          | 46. 00<br>47. 00 |  |  |  |
| 48. 00           |   |                           |  |                          |                  |  |  |  |
|                  | only. (see instructions)  | <u> </u>                  |  |                          |                  |  |  |  |
|                  |   |                           |  | Amount<br>1.00           |                  |  |  |  |
| 49. 00           | Total payment for inpatient operating costs (see instruction  | is)                       |  | 7, 435, 270              | 49. 00           |  |  |  |
| 50.00            | Payment for inpatient program capital (from Wkst. L, Pt. I a  | nd Pt. II, as applicable  | )  | 524, 244                 |                  |  |  |  |
| 51.00            | Exception payment for inpatient program capital (Wkst. L, Pt Direct graduate medical education payment (from Wkst. E-4, I                           |                           |  | 0                        | 51. 00<br>52. 00 |  |  |  |
| 52. 00<br>53. 00 | Nursing and Allied Health Managed Care payment  | The 49 See Thistructions) |  | 12, 916                  |                  |  |  |  |
| 54. 00           | Special add-on payments for new technologies  |                           |  | 39, 320                  |                  |  |  |  |
| 54. 01           | Islet isolation add-on payment  | >                         |  | 0                        | 54. 01           |  |  |  |
| 55. 00<br>55. 01 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions)                                    | 69)                       |  | 0                        | 55. 00<br>55. 01 |  |  |  |
| 56. 00           | Cost of physicians' services in a teaching hospital (see int  | ructions)                 |  | 0                        | 56.00            |  |  |  |
| 57.00            | Routine service other pass through costs (from Wkst. D, Pt.   |                           | through 35).                                 | 0                        | 57.00            |  |  |  |
| 58. 00           | Ancillary service other pass through costs from Wkst. D, Pt.  | IV, col. 11 line 200)     |  | 11, 329                  |                  |  |  |  |
| 59. 00<br>60. 00 | Total (sum of amounts on lines 49 through 58) Primary payer payments  |                           |  | 8, 023, 079<br>3, 400    |                  |  |  |  |
| 61. 00           | Total amount payable for program beneficiaries (line 59 minu  | s line 60)                |  | 8, 019, 679              |                  |  |  |  |
| 62. 00           | Deductibles billed to program beneficiaries   |                           |  | 916, 055                 |                  |  |  |  |
|                  | Coinsurance billed to program beneficiaries   |                           |  | 25, 200                  |                  |  |  |  |
|                  | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)   |                           |  | 22, 860<br>14, 859       |                  |  |  |  |
|                  | Allowable bad debts for dual eligible beneficiaries (see ins  | tructi ons)               |  | 22, 860                  |                  |  |  |  |
| 67.00            | Subtotal (line 61 plus line 65 minus lines 62 and 63)   |                           |  | 7, 093, 283              |                  |  |  |  |
| 68.00            | Credits received from manufacturers for replaced devices for  |                           |  | 0                        | 68. 00<br>69. 00 |  |  |  |
|                  | 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) |                           |  |                          |                  |  |  |  |
| 70. 50           | Rural Community Hospital Demonstration Project (§410A Demons  | tration) adjustment (see  | instructions)                                | 0                        | 70. 50           |  |  |  |
| 70. 75           | ,   |                           |  |                          |                  |  |  |  |
| 70. 87<br>70. 88 |   |                           |  |                          |                  |  |  |  |
| 70. 89           | · · · · · · · · · · · · · · · · · · ·   |                           |  |                          | 70. 88<br>70. 89 |  |  |  |
| 70. 90           | HSP bonus payment HVBP adjustment amount (see instructions)   | 0                         | 70. 90<br>70. 91                             |                          |                  |  |  |  |
| 70. 91           | 91 HSP bonus payment HRR adjustment amount (see instructions)   |                           |  |                          |                  |  |  |  |
| 70. 92<br>70. 93 | Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)  |                           |  | 0<br>-9, 175             | 70. 92<br>70. 93 |  |  |  |
|                  | HRR adjustment amount (see instructions)  |                           |  | -79, 217                 |                  |  |  |  |
| 70. 95           | Recovery of accelerated depreciation  |                           | l  | 0                        | 70. 95           |  |  |  |

| Health Financial Systems   | HANCOCK REGIONAL              | HOSPI TAL    |              | In Lie                                      | u of Form CMS-2   | 2552-10        |
|--|-------------------------------|--------------|--------------|---|---|----------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT  |                               | Provi der CC |              | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E<br>Part A<br>Date/Time Pre<br>5/31/2024 7:0 |                |
|  |                               | Title        | XVIII        | Hospi tal                                   | PPS   | ri aiii        |
|  |                               |              |              | (уууу)                                      | Amount  |                |
|  |                               |              |              | 0   | 1. 00   |                |
| 70.96 Low volume adjustment for federal the corresponding federal year fo                                    |                               | n column 0   | 2            | 2023  | 346, 451  | 70. 96         |
| 70.97 Low volume adjustment for federal the corresponding federal year fo                                    |                               |              | 2            | 2024  | 128, 115  | 70. 97         |
| 70.98 Low Volume Payment-3   |                               |              |              | 0   | 0   | 70. 98         |
| 70.99   HAC adjustment amount (see instru  | ctions)                       |              |              |   | 0   | 70. 9          |
| 71.00 Amount due provider (line 67 minu  |                               | 69 & 70)     |              |   | 7, 479, 457   |                |
| 71.01 Sequestration adjustment (see ins  |                               |              |              |   | 149, 589  |                |
| 71.02 Demonstration payment adjustment   |                               |              |              |   | 0   | 1              |
| 71.03  Sequestration adjustment-PARHM pa<br>72.00  Interim payments  | ss-throughs                   |              |              |   | 7 122 220   | 71.03          |
| 72.00  Interim payments<br>72.01  Interim payments-PARHM   |                               |              |              |   | 7, 132, 328   | 72.00<br>72.01 |
| 73.00 Tentative settlement (for contrac  | tor use only)                 |              |              |   | 0   |                |
| 73.01 Tentative settlement-PARHM (for c  |                               |              |              |   | O   | 73.00          |
| 74.00 Balance due provider/program (lin  |                               | 2, 72, and   |              |   | 197, 540  |                |
| 74.01 Balance due provider/program-PARH  | M (see instructions)          |              |              |   |   | 74.0           |
| 75.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 |                               |              |              |   | 124, 483  | 75.00          |
| TO BE COMPLETED BY CONTRACTOR (III   |                               |              |              |   |   |                |
| 90.00 Operating outlier amount from Wks plus 2.04 (see instructions)   |                               | of 2.03      |              |   | 0   |                |
| 91.00 Capital outlier from Wkst. L, Pt.  |                               |              |              |   | 0   |                |
| 92.00 Operating outlier reconciliation   |                               |              |              |   | 0   | 1 /2.0         |
| 93.00 Capital outlier reconciliation ad  |                               |              |              |   | 0   |                |
| 94.00 The rate used to calculate the ti  |                               | uctions)     |              |   | 0.00  |                |
| 95.00 Time value of money for operating  |                               | +: 000)      |              |   | 0   |                |
| 96.00 Time value of money for capital r  | erated expenses (see firstruc | LI ONS)      |              | Prior to 10/1                               | 0n/After 10/1   | 96.00          |
|  |                               |              |              | 1.00  | 2.00  |                |
| HSP Bonus Payment Amount   |                               |              |              |   |   |                |
| 100.00 HSP bonus amount (see instruction   |                               |              |              | 0   | 0   | 100.00         |
| HVBP Adjustment for HSP Bonus Pay  |                               |              |              |   |   | ļ              |
| 101.00 HVBP adjustment factor (see instr   |                               |              |              | 0. 0000000000                               | 0. 0000000000   |                |
| 102.00 HVBP adjustment amount for HSP bo   |                               | S)           |              | 0   | 0   | 102.00         |
| HRR Adjustment for HSP Bonus Paym<br>103.00 HRR adjustment factor (see instru                                |                               |              |              | 0.0000                                      | 0. 0000   | 102 00         |
| 104.00 HRR adjustment amount for HSP bon   |                               | )            |              | 0.0000                                      |   | 104.00         |
| Rural Community Hospital Demonstra   |                               |              | istment      | <u> </u>                                    |   | 1104.00        |
| 200.00 Is this the first year of the cur<br>Century Cures Act? Enter "Y" for                                 | rent 5-year demonstration pe  |              |              |   |   | 200. 00        |
| Cost Reimbursement   |                               |              |              |   |   | 1              |
| 201.00 Medicare inpatient service costs  | (from Wkst. D-1, Pt. II, lin  | e 49)        |              |   |   | 201.00         |
| 202.00 Medicare discharges (see instruct   |                               |              |              |   |   | 202.00         |
| 203.00 Case-mix adjustment factor (see i   |                               |              |              |   |   | 203.00         |
| Computation of Demonstration Targo<br>period)  | et Amount Limitation (N/A in  | first year   | of the curre | nt 5-year demons                            |   |                |
| 204.00 Medicare target amount  |                               |              |              |   |   | 204.00         |
| 205 00 Caso mix adjusted target amount (   | lino 202 timos lino 204)      |              |              | 1   |   | DOE OF         |

206.00

207. 00

208. 00

209. 00 210. 00

211. 00

212. 00 213. 00 218. 00

210.00 Reserved for future use

205.00 Case-mix adjusted target amount (line 203 times line 204)

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

206.00 Medicare inpatient routine cost cap (line 202 times line 205)

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)

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Adjustment to Medicare Part A Inpatient Reimbursement

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 | Peri od: | Worksheet E | From 01/01/2023 | Part A Exhi bit 4 | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0037

|                  |   |                          |                          |                         | Ic                       | 12/31/2023                   | Date/lime Prep<br>  5/31/2024 7:0 |        |
|------------------|---|--------------------------|--------------------------|-------------------------|--------------------------|------------------------------|-----------------------------------|--------|
|                  |   |                          |                          |                         | XVIII                    | Hospi tal                    | PPS                               |        |
|                  |   | W/S E, Part A<br>line    | Amounts (from E, Part A) | Pre/Post<br>Entitlement | Period Prior<br>to 10/01 | Peri od<br>On/After<br>10/01 | Total (Col 2<br>through 4)        |        |
|                  |   | 0                        | 1. 00                    | 2. 00                   | 3. 00                    | 4. 00                        | 5. 00                             |        |
| 1. 00            | DRG amounts other than outlier payments   | 1. 00                    | 0                        | 0                       |                          | 0                            | 0                                 | 1. 00  |
| 1. 01            | DRG amounts other than outlier<br>payments for discharges<br>occurring prior to October 1                       | 1. 01                    | 4, 724, 623              | 0                       | 4, 724, 623              |                              | 4, 724, 623                       | 1. 01  |
| 1. 02            | DRG amounts other than outlier<br>payments for discharges<br>occurring on or after October                      | 1. 02                    | 1, 734, 504              | 0                       |                          | 1, 734, 504                  | 1, 734, 504                       | 1. 02  |
| 1. 03            | DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1                        | 1. 03                    | 0                        | 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                            | 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                            | 0                                 | 2. 01  |
| 2. 02            | Outlier payments for discharges occurring prior to  | 2. 03                    | 41, 695                  | 0                       | 41, 695                  |                              | 41, 695                           | 2. 02  |
| 2. 03            | October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see               | 2. 04                    | 8, 184                   | 0                       |                          | 8, 184                       | 8, 184                            | 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 instructions)  | 22. 01                   | 0                        | 0                       | 0                        | 0                            | O                                 | 6. 01  |
|                  | Indirect Medical Education Adj  | ustment for the          | e Add-on for Se          | ection 422 of t         | the MMA                  |                              |                                   |        |
| 7. 00            | IME payment adjustment factor (see instructions)  | 27. 00                   | 0. 000000                | 0. 000000               | 0. 000000                | 0. 000000                    |                                   | 7. 00  |
| 8. 00            | IME adjustment (see instructions)   | 28. 00                   | 0                        | 0                       | 0                        | 0                            | 0                                 | 8. 00  |
| 8. 01            | IME payment adjustment add on for managed care (see instructions)   | 28. 01                   | O                        | 0                       | 0                        | 0                            | O                                 | 8. 01  |
| 9. 00            | Total IME payment (sum of lines 6 and 8)  | 29. 00                   | 0                        | 0                       | 0                        | 0                            | 0                                 | 9. 00  |
| 9. 01            | Total IME payment for managed care (sum of lines 6.01 and 8.01)   | 29. 01                   | 0                        | 0                       | 0                        | 0                            | 0                                 | 9. 01  |
| 10. 00           | Disproportionate Share Adjustm<br>Allowable disproportionate<br>share percentage (see<br>instructions)          | a33. 00                  | 0. 0529                  | 0. 0529                 | 0. 0529                  | 0. 0529                      |                                   | 10.00  |
| 11. 00           | Di sproporti onate share  | 34. 00                   | 85, 422                  | 0                       | 62, 483                  | 22, 939                      | 85, 422                           | 11. 00 |
| 11. 01           | adjustment (see instructions) Uncompensated care payments Additional payment for high pe                        | 36.00                    | 840, 842                 | di scharges             | 666, 663                 | 174, 179                     | 840, 842                          | 11. 01 |
| 12. 00           | Total ESRD additional payment   | rcentage of ESI<br>46.00 | 0 beneficiary            | discharges<br>0         | 0                        | 0                            | 0                                 | 12.00  |
| 13. 00<br>14. 00 | (see instructions) Subtotal (see instructions) Hospital specific payments                                       | 47. 00<br>48. 00         | 7, 435, 270<br>0         | 0                       | 5, 495, 464<br>0         | 1, 939, 806<br>0             | 7, 435, 270<br>0                  |        |
| 15. 00           | (completed by SCH and MDH,<br>small rural hospitals only.)<br>(see instructions)<br>Total payment for inpatient | 49. 00                   | 7, 435, 270              | 0                       | 5, 495, 464              | 1, 939, 806                  | 7, 435, 270                       | 15. 00 |
|                  | operating costs (see instructions)  |                          |                          |                         |                          |                              |                                   |        |

|                  |   |                       |                           |                         |                          | From 01/01/2023<br>Fo 12/31/2023 |                            | pared:           |
|------------------|---|-----------------------|---------------------------|-------------------------|--------------------------|----------------------------------|----------------------------|------------------|
|                  |   |                       |                           |                         | XVIII                    | Hospi tal                        | PPS                        |                  |
|                  |   | W/S E, Part A<br>line | Amounts (from E, Part A)  | Pre/Post<br>Entitlement | Period Prior<br>to 10/01 | Peri od<br>On/After<br>10/01     | Total (Col 2<br>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                | 524, 244                  | 0                       | 381, 38                  | 142, 862                         | 524, 244                   | 16.00            |
| 17. 00<br>17. 01 | Special add-on payments for<br>new technologies<br>Net organ aquisition cost                          | 54. 00                | 39, 320                   | 0                       | 39, 32                   | 0                                | 39, 320                    | 17. 00<br>17. 01 |
| 17. 02           | Credits received from<br>manufacturers for replaced<br>devices for applicable MS-DRGs                 | 68. 00                | 0                         | 0                       | (                        | 0                                | 0                          |                  |
| 18. 00           | Capital outlier reconciliation adjustment amount (see instructions)                                   | 93. 00                | O                         | 0                       |                          | 0                                | 0                          | 18. 00           |
| 19. 00           | SUBTOTAL  |                       |                           | 0                       | 5, 916, 16               | 2, 082, 668                      | 7, 998, 834                | 19.00            |
|                  |   | W/S L, line           | (Amounts from L)          |                         |                          |                                  |                            |                  |
|                  | I   | 0                     | 1. 00                     | 2. 00                   | 3.00                     | 4.00                             | 5. 00                      |                  |
| 20. 00<br>20. 01 | Capital DRG other than outlier<br>Model 4 BPCI Capital DRG other<br>than outlier                      | 1. 00<br>1. 01        | 489, 221<br>0             | 0                       | 355, 34                  | 1 133, 880                       | 489, 221<br>0              | 20. 00 20. 01    |
| 21. 00<br>21. 01 | Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments                                | 2. 00<br>2. 01        | 15, 503<br>0              | 0                       | 11, 86                   | 3, 640                           | 15, 503<br>0               | 21. 00<br>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                          |                  |
| 24. 00           | Allowable disproportionate share percentage (see instructions)  | 10. 00                | 0. 0399                   | 0. 0399                 | 0. 039                   | 0. 0399                          |                            | 24.00            |
| 25. 00           | Disproportionate share adjustment (see instructions)  | 11. 00                | 19, 520                   | 0                       | 14, 17                   | 5, 342                           | 19, 520                    | 25. 00           |
| 26. 00           | Total prospective capital payments (see instructions)   | 12. 00                | 524, 244                  | 0                       | 381, 38                  | 142, 862                         | 524, 244                   | 26. 00           |
|                  |   | W/S E, Part A<br>line | (Amounts to<br>E, Part A) |                         |                          |                                  |                            |                  |
|                  | I   | 0                     | 1. 00                     | 2. 00                   | 3.00                     | 4.00                             | 5. 00                      |                  |
| 27. 00<br>28. 00 | Low volume adjustment factor<br>Low volume adjustment<br>(transfer amount to Wkst. E,<br>Pt. A, line) | 70. 96                |                           |                         | 0. 05856<br>346, 45      |                                  | 346, 451                   | 27. 00<br>28. 00 |
| 29. 00           | Low volume adjustment<br>(transfer amount to Wkst. E,<br>Pt. A, line)                                 | 70. 97                |                           |                         |                          | 128, 115                         | 128, 115                   | 29. 00           |
| 100.00           | Transfer Iow volume<br>adjustments to Wkst. E, Pt. A.   |                       | Y                         |                         |                          |                                  |                            | 100.00           |

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0037 Peri od: Worksheet E From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 12/31/2023 5/31/2024 7:01 am Hospi tal Title XVIII PPS Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 4.724.623 4, 724, 623 4, 724, 623 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 1, 734, 504 1, 734, 504 1, 734, 504 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 2.02 41, 695 41, 695 41, 695 2.02 Outlier payments for discharges occurring 2.03 prior to October 1 (see instructions) . Outlier payments for discharges occurring on 2.03 2.04 8, 184 8, 184 8, 184 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 C 0 0 3.00 Managed care simulated payments 0 4.00 4.00 3.00 Indirect Medical Education Adjustment 0.000000 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 6.00 C 6.01 IME payment adjustment for managed care (see 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 0 8.00 0 IME payment adjustment add on for managed 0 28 01 r 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 10.00 Allowable disproportionate share percentage 33.00 0.0529 0.0529 0.0529 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 85, 422 62, 483 22, 939 85, 422 11.00 instructions) Uncompensa<u>ted care payments</u> 11.01 36 00 840.842 666, 663 174, 179 840, 842 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 46.00 12.00 instructions) 5, 495, 464 47.00 13.00 Subtotal (see instructions) 7, 435, 270 1, 939, 806 7, 435, 270 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions)

49 00

50.00

54.00

68.00

93.00

7 435 270

524, 244

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5 495 464

381, 382

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5, 916, 166

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7, 435, 270

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7, 998, 834 19.00

15 00

16.00

17.00

17.01

15 00

16.00

17.00

17.01

17.02

18.00

19.00 SUBTOTAL

Total payment for inpatient operating costs

Payment for inpatient program capital (from

Special add-on payments for new technologies

Credits received from manufacturers for

replaced devices for applicable MS-DRGs

Capital outlier reconciliation adjustment

Wkst. L, Pt. I, if applicable)

Net organ acquisition cost

amount (see instructions)

(see instructions)

| Heal th | Financial Systems  | HANCOCK REGIO | NAI HOSPITAI           |         | Inlie                                       | u of Form CMS-2  | 2552_10       |
|---------|--|---------------|------------------------|---------|---|--|---------------|
|         | AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA                    |               | Provider C             | !       | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E<br>Part A Exhibi<br>Date/Time Pre<br>5/31/2024 7:0 | t 5<br>pared: |
|         |  |               |                        | XVIII   | Hospi tal                                   | PPS  |               |
|         |  | Wkst. L, line | (Amt. from<br>Wkst. L) |         |   |  |               |
|         |  | 0             | 1.00                   | 2. 00   | 3. 00                                       | 4. 00  |               |
| 20.00   | Capital DRG other than outlier                                   | 1. 00         | 489, 221               | 355, 34 | 1 133, 880                                  | 489, 221   | 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         | 15, 503                | 11, 86  | 3, 640                                      | 15, 503  | 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                 | 0.000   | 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. 0399                | 0. 039  | 0. 0399                                     |  | 24. 00        |
| 25. 00  | Disproportionate share adjustment (see instructions)             | 11. 00        | 19, 520                | 14, 17  | 5, 342                                      | 19, 520  | 25. 00        |
| 26. 00  | Total prospective capital payments (see instructions)            | 12. 00        | 524, 244               | 381, 38 | 142, 862                                    | 524, 244   | 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        | 346, 451               | 346, 45 | 1   | 346, 451   |               |
| 29. 00  | Low volume adjustment on or after October 1                      | 70. 97        | 128, 115               |         | 128, 115                                    | 128, 115   |               |
| 30.00   | HVBP payment adjustment (see instructions)                       | 70. 93        | -9, 175                | (       | 9, 175                                      | -9, 175  | 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        | -79, 217               | -73, 84 | 5, 377                                      | -79, 217   | 31.00         |
| 31. 01  | HRR adjustment for HSP bonus payment (see instructions)          | 70. 91        | 0                      | (       | 0   | 0  | 31. 01        |
|         |  |               |                        |         |   | (Amt to  |               |

1.00

Ν

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    | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E<br>Part B<br>Date/Time Prepared:<br>5/31/2024 7:01 am |
|   |                           |  |   |

|                  |  | Title XVIII                  | Hospi tal         | 5/31/2024 /: 0<br>PPS  | 1 am             |
|------------------|--|------------------------------|-------------------|------------------------|------------------|
|                  |  |                              |                   | 1. 00                  |                  |
|                  | PART B - MEDICAL AND OTHER HEALTH SERVICES   |                              |                   | 1. 00                  |                  |
| 1.00             | Medical and other services (see instructions)  | 12                           |                   | 2, 219                 | 1.00             |
| 2. 00<br>3. 00   | Medical and other services reimbursed under OPPS (see instruc<br>OPPS or REH payments  | 19, 896, 211<br>14, 535, 055 | 2. 00<br>3. 00    |                        |                  |
| 4. 00            | Outlier payment (see instructions)   |                              | 81, 873           | 4. 00                  |                  |
| 4. 01            | Outlier reconciliation amount (see instructions)   | . 12                         |                   | 0                      | 4. 01            |
| 5. 00<br>6. 00   | Enter the hospital specific payment to cost ratio (see instru<br>Line 2 times line 5   | ctions)                      |                   | 0.000                  | 5. 00<br>6. 00   |
| 7. 00            | Sum of lines 3, 4, and 4.01, divided by line 6   |                              | 0.00              | 7. 00                  |                  |
| 8.00             | Transitional corridor payment (see instructions)   | at a salata a Pada a t       |                   | 0                      | 8.00             |
| 9. 00            | Ancillary service other pass through costs including REH dire Wkst. D, Pt. IV, col. 13, line 200                               | ct graduate medical educ     | cation costs from | 86, 346                | 9. 00            |
| 10.00            | Organ acquisitions   |                              |                   | 0                      | 10.00            |
| 11. 00           | Total cost (sum of lines 1 and 10) (see instructions)  |                              |                   | 2, 219                 | 11. 00           |
|                  | COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges  |                              |                   |                        |                  |
| 12.00            | Ancillary service charges  |                              |                   | 13, 383                | 12.00            |
|                  | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I  | ine 69)                      |                   | 0                      |                  |
| 14. 00           | Total reasonable charges (sum of lines 12 and 13) Customary charges  |                              |                   | 13, 383                | 14.00            |
| 15. 00           | Aggregate amount actually collected from patients liable for   | payment for services on      | a charge basis    | 0                      | 15.00            |
| 16. 00           | Amounts that would have been realized from patients liable fo  |                              | on a chargebasis  | 0                      | 16. 00           |
| 17. 00           | had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)              | e)                           |                   | 0. 000000              | 17 00            |
|                  | Total customary charges (see instructions)   |                              |                   | 13, 383                |                  |
| 19. 00           | Excess of customary charges over reasonable cost (complete on  | ly if line 18 exceeds li     | ne 11) (see       | 11, 164                | 19. 00           |
| 20. 00           | instructions)<br>Excess of reasonable cost over customary charges (complete on   | lv if line 11 exceeds li     | ne 18) (see       | 0                      | 20. 00           |
| 20.00            | instructions)  | . ,                          | (55)              | · ·                    | 20.00            |
|                  | Lesser of cost or charges (see instructions)   |                              |                   | 2, 219                 |                  |
|                  | Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst                         | ructions)                    |                   | 0                      | 22. 00<br>23. 00 |
| 24. 00           | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   | . 40 (1 01.0)                |                   | 14, 703, 274           |                  |
| 05.00            | COMPUTATION OF REIMBURSEMENT SETTLEMENT  |                              |                   | 1 040                  | 05.00            |
| 25. 00<br>26. 00 | Deductibles and coinsurance amounts (for CAH, see instruction<br>Deductibles and Coinsurance amounts relating to amount on lin | · ·                          | ructions)         | 1, 340<br>2, 489, 061  |                  |
| 27. 00           | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)   |                              |                   | 12, 215, 092           |                  |
| 00.00            | instructions)  | 50)                          |                   | 0                      | 00.00            |
| 28. 00<br>28. 50 | Direct graduate medical education payments (from Wkst. E-4, I<br>REH facility payment amount (see instructions)                | ine 50)                      |                   | 0                      | 28. 00<br>28. 50 |
| 29. 00           | ESRD direct medical education costs (from Wkst. E-4, line 36)  |                              |                   | 0                      |                  |
|                  | Subtotal (sum of lines 27, 28, 28.50 and 29)   |                              |                   | 12, 215, 092           |                  |
|                  | Primary payer payments<br>Subtotal (line 30 minus line 31)   |                              |                   | 1, 843<br>12, 213, 249 |                  |
| 02.00            | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI  | CES)                         |                   | 12/210/217             | 02.00            |
|                  | Composite rate ESRD (from Wkst. I-5, line 11)  |                              |                   | 0                      |                  |
|                  | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)                                      |                              |                   | 53, 993<br>35, 095     |                  |
|                  | Allowable bad debts for dual eligible beneficiaries (see inst  | ructi ons)                   |                   | 53, 993                | 36.00            |
|                  | Subtotal (see instructions)  |                              |                   | 12, 248, 344           |                  |
|                  | MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |                              |                   | 0                      | 38. 00<br>39. 00 |
|                  | Pioneer ACO demonstration payment adjustment (see instruction  | s)                           |                   | · ·                    | 39. 50           |
|                  | N95 respirator payment adjustment amount (see instructions)  |                              |                   | 0                      | 39. 75           |
| 39. 97<br>39. 98 | Demonstration payment adjustment amount before sequestration<br>Partial or full credits received from manufacturers for repla  | ced devices (see instru      | ctions)           | 0                      | 39. 97<br>39. 98 |
| 39. 99           | RECOVERY OF ACCELERATED DEPRECIATION   | ced devices (see institut    | otrons)           | 0                      | 39. 99           |
|                  | Subtotal (see instructions)  |                              |                   | 12, 248, 344           |                  |
| 40. 01<br>40. 02 | Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration                        |                              |                   | 244, 967<br>0          | 40. 01<br>40. 02 |
|                  | Sequestration adjustment-PARHM pass-throughs   |                              |                   | O                      | 40. 03           |
|                  | Interim payments   |                              |                   | 12, 026, 359           |                  |
| 41. 01<br>42. 00 | Interim payments-PARHM Tentative settlement (for contractors use only)   |                              |                   | 0                      | 41. 01<br>42. 00 |
| 42. 01           | Tentative settlement-PARHM (for contractor use only)   |                              |                   | O                      | 42. 01           |
| 43.00            | Balance due provider/program (see instructions)  |                              |                   | -22, 982               |                  |
| 43. 01<br>44. 00 | Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda            | nce with CMS Dub 15 2        | chanter 1         | 0                      | 43. 01<br>44. 00 |
| 44.00            | \$115. 2   |                              | спарты т,         |                        | 44.00            |
| <b>a</b> - · ·   | TO BE COMPLETED BY CONTRACTOR  |                              |                   |                        |                  |
|                  | Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)                         |                              |                   | 0                      | 90. 00<br>91. 00 |
| 92.00            | The rate used to calculate the Time Value of Money   |                              |                   | 0. 00                  |                  |
| 93. 00           | Time Value of Money (see instructions)   |                              |                   |                        | 93. 00           |
|                  |  |                              |                   |                        |                  |

| Health Financial Systems                | HANCOCK REGIONAL | HOSPI TAL             | In Lieu         | u of Form CMS- | 2552-10 |
|---|------------------|-----------------------|-----------------|----------------|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT |                  | Provider CCN: 15-0037 | Peri od:        | Worksheet E    |         |
|   |                  |                       | From 01/01/2023 |                |         |
|   |                  |                       | To 12/31/2023   | Date/Time Pre  | :pared: |
|   |                  |                       |                 | 5/31/2024 7:0  | )1 am   |
|   |                  | Title XVIII           | Hospi tal       | PPS            |         |
|   |                  |                       |                 |                |         |
|   |                  |                       |                 | 1. 00          |         |
| 94.00 Total (sum of lines 91 and 93)    |                  |                       |                 | 0              | 94.00   |
|   |                  |                       |                 |                |         |
|   |                  |                       |                 | 1. 00          |         |
| MEDICARE PART B ANCILLARY COSTS         |                  |                       |                 |                |         |
| 200.00 Part B Combined Billed Days      |                  |                       |                 | 0              | 200.00  |

Peri od: Worksheet E-1 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/31/2024 7:01 am Provi der CCN: 15-0037

|                |   | T1 11        |   |              |              | 1 am           |
|----------------|---|--------------|---|--------------|--------------|----------------|
|                |   |              | XVIII                                   | Hospi tal    | PPS          |                |
|                |   | Inpatien     | t Part A                                | Par          | rt B         |                |
|                |   | mm/dd/yyyy   | Amount                                  | mm/dd/yyyy   | Amount       |                |
|                |   | 1. 00        | 2. 00                                   | 3. 00        | 4. 00        |                |
| 1.00 Tot       | otal interim payments paid to provider  |              | 7, 076, 784                             |              | 11, 883, 768 | 1.00           |
| sub            | nterim payments payable on individual bills, either abmitted or to be submitted to the contractor for ervices rendered in the cost reporting period. If none,   |              | 0                                       |              | 0            | 2. 00          |
| 3.00 kri       | site "NONE" or enter a zero st separately each retroactive lump sum adjustment nount based on subsequent revision of the interim rate   |              |   |              |              | 3. 00          |
| for<br>pay     | or the cost reporting period. Also show date of each syment. If none, write "NONE" or enter a zero. (1)   |              |   |              |              |                |
|                | ogram to Provider   | 10 (01 (0000 |   | 10 /01 /0000 | 440.004      |                |
|                | JUSTMENTS TO PROVIDER   | 12/31/2023   | 20, 844                                 |              | 112, 991     | 3. 01          |
| 3. 02          |   | 08/30/2023   | 34, 700                                 | 03/30/2023   | 29, 600      | 3. 02          |
| 3. 03          |   |              | 0                                       |              | 0            | 3.03           |
| 3. 04<br>3. 05 |   |              | 0                                       |              | 0            | 3. 04<br>3. 05 |
|                | ovider to Program   |              | 0                                       |              | 0            | 3.05           |
|                | DUSTMENTS TO PROGRAM  |              | 0                                       |              | 0            | 3. 50          |
| 3. 50 ADS      | JUSTINIENTS TO TROURANT   |              | 0                                       |              | 0            | 3.51           |
| 3. 52          |   |              | 0                                       |              | 0            | 3.52           |
| 3. 53          |   |              | 0                                       |              | 0            | 3. 53          |
| 3. 54          |   |              | 0                                       |              | 0            | 3. 54          |
| 3. 99 Sub      | ubtotal (sum of lines 3.01-3.49 minus sum of lines  |              | 55, 544                                 |              | 142, 591     | 3. 99          |
| 4. 00 Tot      | 50-3.98) Ital interim payments (sum of lines 1, 2, and 3.99)  |              | 7, 132, 328                             |              | 12, 026, 359 | 4.00           |
|                | ransfer to Wkst. E or Wkst. E-3, line and column as oppopriate)   |              |   |              |              |                |
|                | BE COMPLETED BY CONTRACTOR  |              | •                                       |              |              |                |
| 5. 00 Li s     | st separately each tentative settlement payment after   |              |   |              |              | 5.00           |
|                | esk review. Also show date of each payment. If none, rite "NONE" or enter a zero. (1)   |              |   |              |              |                |
|                | ogram to Provider   |              |   |              |              |                |
|                | ENTATI VE TO PROVI DER  |              | 0                                       |              | 0            | 5. 01          |
| 5. 02          |   |              | Ō                                       |              | o            | 5. 02          |
| 5. 03          |   |              | 0                                       |              | 0            | 5.03           |
| Pro            | ovider to Program   |              |   |              |              |                |
| 5. 50 TEN      | INTATI VE TO PROGRAM  |              | 0                                       |              | 0            | 5. 50          |
| 5. 51          |   |              | 0                                       |              | 0            | 5. 51          |
| 5. 52          |   |              | 0                                       |              | 0            | 5. 52          |
|                | ubtotal (sum of lines 5.01-5.49 minus sum of lines 50-5.98)   |              | 0                                       |              | 0            | 5. 99          |
| 6.00 Det       | etermined net settlement amount (balance due) based on le cost report. (1)  |              |   |              |              | 6. 00          |
|                | ETTLEMENT TO PROVIDER   |              | 197, 540                                |              | 0            | 6. 01          |
|                | TTLEMENT TO PROGRAM   |              | 177, 340                                |              | 22, 982      | 6.02           |
|                | stal Medicare program liability (see instructions)  |              | 7, 329, 868                             |              | 12, 003, 377 | 7.00           |
| 1.00 100       | Table 1 and |              | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Contractor   | NPR Date     | 7.50           |
|                |   |              |   | Number       | (Mo/Day/Yr)  |                |
|                |   | (            | )                                       | 1. 00        | 2. 00        |                |
| 8. 00 Nam      | me 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                     | Provi der CCN: 15-0037    | Peri od:         | Worksheet E-1<br>Part II    |         |
|         |   |                           |                  |                             | nonod.  |
|         |   |                           | To 12/31/2023    | Date/Time Pre 5/31/2024 7:0 |         |
| -       |   | Title XVIII               | Hospi tal        | PPS                         |         |
|         |   |                           |                  |                             |         |
|         |   |                           |                  | 1.00                        |         |
|         | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS    |                           |                  |                             |         |
|         | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION |                           |                  |                             |         |
| 1. 00   | Total hospital discharges as defined in AARA §4102 from Wkst  | :. S-3, Pt. I col. 15 lin | ie 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   |                           |                  |                             | 6. 00   |
| 7. 00   | CAH only - The reasonable cost incurred for the purchase of   | certified HIT technology  | 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  | n (see instructions)      |                  |                             | 10.00   |
|         | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH              |                           |                  |                             |         |
|         | Initial/interim HIT payment adjustment (see instructions)     |                           |                  |                             | 30.00   |
|         | Other Adjustment (specify)                                    |                           |                  |                             | 31.00   |
| 32. 00  | Balance due provider (line 8 (or line 10) minus line 30 and   | line 31) (see instruction | ns)              |                             | 32.00   |

| Health Financial Systems                | HANCOCK REGIONAL HOSPITAL |              | In Lieu                                      | u of Form CMS-2552-10   |
|---|---------------------------|--------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der                 | CCN: 15-0037 | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E-3<br>Part VII<br>Date/Time Prepared:<br>5/31/2024 7:01 am |

|        |  |                           |                 | 5/31/2024 7:0 | <u>1 am</u> |
|--------|--|---------------------------|-----------------|---------------|-------------|
|        |  | Title XIX                 | Hospi tal       | Cost          |             |
|        |  |                           | I npati ent     | Outpati ent   |             |
|        |  |                           | 1. 00           | 2. 00         |             |
|        | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE | CES FOR TITLES V OR XIX   | SERVI CES       |               |             |
|        | COMPUTATION OF NET COST OF COVERED SERVICES                        |                           |                 |               |             |
| 1.00   | Inpatient hospital/SNF/NF services                                 |                           | 394, 836        |               | 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)                                 |                           | 394, 836        | 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)                        |                           | 394, 836        | 0             | 7.00        |
|        | COMPUTATION OF LESSER OF COST OR CHARGES                           |                           |                 |               | 1           |
|        | Reasonabl e Charges  |                           |                 |               | 1           |
| 8.00   | Routi ne servi ce charges  |                           | 477, 215        |               | 8.00        |
| 9.00   | Ancillary service charges  |                           | 715, 034        | 0             | 9.00        |
| 10.00  | Organ acquisition charges, net of revenue                          |                           | 0               |               | 10.00       |
| 11. 00 | Incentive from target amount computation                           |                           | 0               |               | 11.00       |
| 12. 00 | Total reasonable charges (sum of lines 8 through 11)               |                           | 1, 192, 249     | 0             |             |
|        | CUSTOMARY CHARGES  |                           | 1,1,2,21217     |               | 12.00       |
| 13.00  | Amount actually collected from patients liable for payment for se  | ervices on a charge       | 0               | 0             | 13.00       |
|        | basis  | 5. 1. 555 S.: a S.:a. ge  | Ĭ               | Ü             | 10.00       |
| 14. 00 | Amounts that would have been realized from patients liable for pa  | avment for services on    | o               | 0             | 14.00       |
| 00     | a charge basis had such payment been made in accordance with 42 (  |                           | ٦               | Ü             |             |
| 15.00  | Ratio of line 13 to line 14 (not to exceed 1.000000)               | 31.6.10(0)                | 0. 000000       | 0.000000      | 15.00       |
| 16. 00 | ` '  |                           | 1, 192, 249     | 0             |             |
| 17. 00 | Excess of customary charges over reasonable cost (complete only i  | fline 16 exceeds          | 797, 413        | 0             |             |
|        | line 4) (see instructions)   |                           | , , , , , , , , | Ü             |             |
| 18.00  | Excess of reasonable cost over customary charges (complete only i  | fline 4 exceeds line      | 0               | 0             | 18.00       |
|        | 16) (see instructions)   | e . exceedee              | ٦               | Ü             | 10.00       |
| 19. 00 | Interns and Residents (see instructions)                           |                           | 0               | 0             | 19.00       |
| 20.00  | Cost of physicians' services in a teaching hospital (see instruct  | tions)                    | 0               | 0             |             |
| 21. 00 | Cost of covered services (enter the lesser of line 4 or line 16)   |                           | 394, 836        | 0             |             |
| 21.00  | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com  | npleted for PPS provide   |                 |               | 200         |
| 22. 00 | Other than outlier payments  | .p. 0104 10. 110 p. 01140 | 0               | 0             | 22. 00      |
| 23. 00 | Outlier payments   |                           | 0               | 0             |             |
| 24. 00 | Program capital payments   |                           | o               | Ü             | 24.00       |
|        | Capital exception payments (see instructions)                      |                           | 0               |               | 25. 00      |
| 26. 00 | Routine and Ancillary service other pass through costs             |                           | 0               | 0             |             |
| 27. 00 | Subtotal (sum of lines 22 through 26)                              |                           | o o             | 0             |             |
| 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)                           |                           | 394, 836        | 0             |             |
| 27.00  | COMPUTATION OF REIMBURSEMENT SETTLEMENT                            |                           | 071,000         |               | 27.00       |
| 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)     |                           | 394, 836        | 0             |             |
|        | Deductibles  |                           | 0               | 0             |             |
| 33. 00 | Coinsurance  |                           | 0               | 0             |             |
| 34. 00 | Allowable bad debts (see instructions)                             |                           | 0               | 0             |             |
| 35. 00 | Utilization review   |                           | 0               | O             | 35.00       |
|        | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33  | 3)                        | 394, 836        | 0             |             |
| 37. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)                     | 3)                        | 374, 030        | 0             |             |
| 38. 00 | Subtotal (line 36 ± line 37)                                       |                           | 394, 836        | 0             |             |
| 39. 00 | Direct graduate medical education payments (from Wkst. E-4)        |                           | 374, 030        | U             | 39.00       |
| 40. 00 | ,                            |                           | 394, 836        | 0             |             |
| 41. 00 | Interim payments   |                           | 724, 664        | 0             |             |
| 41.00  | Balance due provider/program (line 40 minus line 41)               |                           | -329, 828       | 0             |             |
| 42.00  | Protested amounts (nonallowable cost report items) in accordance   | with CMS Dub 15.2         | -329, 828<br>0  | 0             |             |
| 43.00  | chapter 1, §115.2  | WI (II GWIS FUD 13-Z,     | ٩               | Ü             | 43.00       |
|        | Chiapter 1, 3110.2   |                           | I               |               | I           |
|        |  |                           |                 |               |             |

| Health Financial Systems   | HANCOCK REGIONAL     | HOSPI TAL              | In Lie                           | u of Form CMS-2                 | 552-10 |
|--|----------------------|------------------------|----------------------------------|---------------------------------|--------|
|  |                      |                        |                                  | Worksheet E-5                   |        |
|  |                      |                        | From 01/01/2023<br>To 12/31/2023 | Date/Time Prep<br>5/31/2024 7:0 |        |
|  |                      | 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 | instructions)                    | 0                               | 1.00   |
| 2.00 Capital outlier from Wkst. L, Pt. I, line                             | 2                    |                        |                                  | 0                               | 2.00   |
| 3.00 Operating outlier reconciliation adjustmen                            | nt amount (see instr | ructions)              |                                  | 0                               | 3.00   |
| 4.00 Capital outlier reconciliation adjustment amount (see instructions)   |                      |                        | 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 instructions)         |                      |                        | 0                                | 6.00                            |        |
| 7.00 Time value of money for capital related ex                            | kpenses (see instrud | ctions)                |                                  | 0                               | 7.00   |

HANCOCK REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

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

Provider CCN: 15-0037

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/31/2024 7:01 am

| OIII y)          |  |                |              |           | 5/31/2024 7: 0 | 1 am             |
|------------------|--|----------------|--------------|-----------|----------------|------------------|
|                  |  | General Fund   | Speci fi c   | Endowment | Plant Fund     |                  |
|                  |  | 1 00           | Purpose Fund | Fund      | 4.00           |                  |
|                  | CURRENT ASSETS   | 1.00           | 2.00         | 3. 00     | 4. 00          |                  |
| 1. 00            | Cash on hand in banks  | 8, 448, 795    | 0            | o         | 0              | 1.00             |
| 2. 00            | Temporary investments  | 0, 110, 770    | Ö            | ő         | 0              | 2. 00            |
| 3. 00            | Notes recei vabl e   | 0              | Ö            | o         | 0              | 3. 00            |
| 4.00             | Accounts receivable  | 20, 243, 822   | 0            | O         | 0              | 4.00             |
| 5.00             | Other recei vable  | 9, 186, 044    | 0            | o         | 0              | 5.00             |
| 6.00             | Allowances for uncollectible notes and accounts receivable                             | 0              | 0            | o         | 0              | 6.00             |
| 7.00             | Inventory  | 8, 584, 446    | 0            | 0         | 0              | 7.00             |
| 8.00             | Prepai d expenses  | 2, 907, 061    |              | 0         | 0              | 8.00             |
| 9. 00            | Other current assets   | 123, 285, 242  |              | 0         | 0              | 9. 00            |
| 10.00            | Due from other funds   | 0              | - 1          | 0         | 0              | 10.00            |
| 11. 00           | Total current assets (sum of lines 1-10)   | 172, 655, 410  | 0            | 0         | 0              | 11. 00           |
| 12. 00           | FIXED ASSETS Land  | 29, 420, 345   | 0            | o         | 0              | 12. 00           |
| 13. 00           | Land improvements  | 29, 420, 343   |              | ol        | 0              | 13. 00           |
| 14. 00           | Accumulated depreciation   |                |              | ol<br>Ol  | 0              | 14. 00           |
| 15. 00           | Bui I di ngs   | 203, 358, 816  | - 1          | Ö         | 0              | 15. 00           |
| 16. 00           | Accumulated depreciation   | -213, 071, 717 | 1            | ō         | 0              | 16. 00           |
| 17. 00           | Leasehold improvements   | 0              | 0            | o         | 0              | 17.00            |
| 18.00            | Accumul ated depreciation  | 0              | 0            | o         | 0              | 18.00            |
| 19.00            | Fi xed equipment   | 0              | 0            | o         | 0              | 19.00            |
| 20.00            | Accumulated depreciation   | 0              | 0            | 0         | 0              | 20.00            |
| 21.00            | Automobiles and trucks   | 0              | 0            | 0         | 0              | 21.00            |
| 22. 00           | Accumul ated depreciation  | 0              | 0            | 0         | 0              | 22.00            |
|                  | Major movable equipment  | 109, 098, 409  |              | 0         | 0              | 23. 00           |
| 24. 00           | Accumulated depreciation   | 0              | 0            | 0         | 0              | 24.00            |
| 25. 00           | Mi nor equipment depreciable   | 0              | 0            | 0         | 0              | 25.00            |
| 26.00            | Accumulated depreciation   | 0              | 0            | 0         | 0              | 26.00            |
| 27. 00           | HIT designated Assets Accumulated depreciation   | 0              | 0            | O O       | 0              | 27. 00<br>28. 00 |
| 28. 00<br>29. 00 | •  | 0              | 0            | 0         | 0              | 28.00            |
| 30.00            | Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)                 | 128, 805, 853  |              | 0         | 0              | 30.00            |
| 30.00            | OTHER ASSETS   | 120, 000, 000  | 0            | <u> </u>  | U              | 30.00            |
| 31.00            | Investments  | 0              | 0            | ol        | 0              | 31.00            |
| 32. 00           | Deposits on Leases   | 0              |              | ol        | 0              | 32. 00           |
| 33. 00           | Due from owners/officers   | 0              | 0            | o         | 0              | 33.00            |
| 34.00            | Other assets   | 35, 497, 003   | 0            | o         | 0              | 34.00            |
| 35.00            | Total other assets (sum of lines 31-34)  | 35, 497, 003   | 0            | 0         | 0              | 35.00            |
| 36.00            | Total assets (sum of lines 11, 30, and 35)   | 336, 958, 266  | 0            | 0         | 0              | 36.00            |
|                  | CURRENT LIABILITIES  |                |              | . 1       |                |                  |
| 37. 00           | Accounts payable   | 9, 044, 271    | 1            | 0         | 0              | 37. 00           |
| 38. 00           | Salaries, wages, and fees payable  | 9, 125, 069    | 0            | 0         | 0              | 38. 00           |
| 39.00            | Payroll taxes payable  | 0              | 0            | 0         | 0              | 39.00            |
| 40. 00<br>41. 00 | Notes and Loans payable (short term)   | 0              |              | 0         | 0              | 40. 00<br>41. 00 |
| 41.00            | Deferred income Accelerated payments   |                |              | ۷         | U              | 41.00            |
| 43. 00           | Due to other funds   |                | o            | 0         | 0              | 43.00            |
| 44. 00           | Other current liabilities  | 6, 469, 943    |              | Ö         | 0              | 44. 00           |
| 45. 00           | Total current liabilities (sum of lines 37 thru 44)                                    | 24, 639, 283   | ·            | Ö         |                |                  |
|                  | LONG TERM LIABILITIES  |                |              | -1        | -              |                  |
| 46.00            | Mortgage payable   | 0              | 0            | 0         | 0              | 46.00            |
| 47.00            | Notes payable  | 0              |              | o         | 0              | 47.00            |
| 48.00            | Unsecured Loans  | 0              | 0            | o         | 0              | 48.00            |
| 49.00            | Other long term liabilities  | 1, 749, 681    | 0            | 0         | 0              | 49.00            |
| 50.00            | Total long term liabilities (sum of lines 46 thru 49)                                  | 1, 749, 681    |              | 0         | 0              | 50.00            |
| 51.00            | Total liabilities (sum of lines 45 and 50)   | 26, 388, 964   | 0            | 0         | 0              | 51.00            |
|                  | CAPITAL ACCOUNTS   |                |              |           |                |                  |
| 52.00            | General fund balance   | 310, 569, 302  | 1            |           |                | 52.00            |
| 53.00            | Specific purpose fund  |                | 0            |           |                | 53.00            |
| 54.00            | Donor created - endowment fund balance - restricted                                    |                |              | 0         |                | 54.00            |
| 55.00            | Donor created - endowment fund balance - unrestricted                                  |                |              | 0         |                | 55.00            |
| 56. 00<br>57. 00 | Governing body created - endowment fund balance Plant fund balance - invested in plant |                |              | ٥         | 0              | 56. 00<br>57. 00 |
| 57. 00<br>58. 00 | Plant fund balance - reserve for plant improvement,                                    |                |              |           | 0              | 57. 00<br>58. 00 |
| 50.00            | replacement, and expansion   |                |              |           | ا              | 30.00            |
| 59. 00           | Total fund balances (sum of lines 52 thru 58)  | 310, 569, 302  | o            | ol        | 0              | 59. 00           |
| 60.00            | Total liabilities and fund balances (sum of lines 51 and                               | 336, 958, 266  | 1            | o         | 0              | 60.00            |
|                  | 59)  |                |              |           |                |                  |
|                  |  |                |              | ·         | ·              |                  |

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES HANCOCK REGIONAL HOSPITAL

Provi der CCN: 15-0037

|                  |   |           |                              |          | To  | 12/31/2023 | Date/Time Pre<br>5/31/2024 7:0 | pared:<br>1 am   |
|------------------|---|-----------|------------------------------|----------|-----|------------|--------------------------------|------------------|
|                  |   | General   | Fund                         | Speci al | Pur | pose Fund  | Endowment<br>Fund              |                  |
|                  |   |           |                              |          |     |            |                                |                  |
|                  | I   | 1. 00     | 2. 00                        | 3. 00    |     | 4. 00      | 5. 00                          |                  |
| 1.00             | Fund balances at beginning of period  |           | 301, 206, 243                |          |     | 0          |                                | 1.00             |
| 2. 00<br>3. 00   | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)    |           | 9, 363, 059<br>310, 569, 302 |          |     | 0          |                                | 2. 00<br>3. 00   |
| 4. 00            | Additions (credit adjustments) (specify)  | 0         | 310, 309, 302                |          | 0   | U          | 0                              |                  |
| 5. 00            | Add trons (credit adjustments) (specify)  | 0         |                              |          | 0   |            | 0                              |                  |
| 6. 00            |   | o         |                              |          | 0   |            | 0                              |                  |
| 7.00             |   | 0         |                              |          | 0   |            | 0                              | 7. 00            |
| 8.00             |   | 0         |                              |          | 0   |            | 0                              |                  |
| 9. 00            |   | 0         |                              |          | 0   |            | 0                              | 9. 00            |
| 10.00            | Total additions (sum of line 4-9)   |           | 0                            |          |     | 0          |                                | 10.00            |
| 11. 00<br>12. 00 | Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)         | 0         | 310, 569, 302                |          | 0   | U          | 0                              | 11. 00<br>12. 00 |
| 12.00            | beductions (debit adjustments) (specify)  | 0         |                              |          | 0   |            | 0                              | 13.00            |
| 14. 00           |   | 0         |                              |          | 0   |            | 0                              | 14.00            |
| 15. 00           |   | 0         |                              |          | 0   |            | ő                              | 15.00            |
| 16.00            |   | 0         |                              |          | 0   |            | 0                              | 16.00            |
| 17.00            |   | 0         |                              |          | 0   |            | 0                              | 17.00            |
| 18.00            | Total deductions (sum of lines 12-17)   |           | 0                            |          |     | 0          |                                | 18. 00           |
| 19. 00           | Fund balance at end of period per balance                                       |           | 310, 569, 302                |          |     | 0          |                                | 19. 00           |
|                  | sheet (line 11 minus line 18)   | Endowment | PI ant                       | Fund     |     |            |                                |                  |
|                  |   | Fund      | TTant                        | Turiu    |     |            |                                |                  |
|                  |   |           |                              |          |     |            |                                |                  |
|                  |   | 6. 00     | 7. 00                        | 8. 00    |     |            |                                |                  |
| 1.00             | Fund balances at beginning of period  | 0         |                              |          | 0   |            |                                | 1.00             |
| 2. 00<br>3. 00   | Net income (loss) (from Wkst. G-3, line 29)<br>Total (sum of line 1 and line 2) | 0         |                              |          | 0   |            |                                | 2. 00<br>3. 00   |
| 4. 00            | Additions (credit adjustments) (specify)  | U         | 0                            |          | U   |            |                                | 4.00             |
| 5. 00            | Additions (credit adjustments) (specify)  |           | 0                            |          |     |            |                                | 5.00             |
| 6. 00            |   |           | 0                            |          |     |            |                                | 6.00             |
| 7.00             |   |           | 0                            |          |     |            |                                | 7. 00            |
| 8.00             |   |           | 0                            |          |     |            |                                | 8. 00            |
| 9. 00            |   |           | 0                            |          |     |            |                                | 9. 00            |
| 10.00            | Total additions (sum of line 4-9)   | 0         |                              |          | 0   |            |                                | 10.00            |
| 11. 00<br>12. 00 | Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)         | U         | 0                            |          | 0   |            |                                | 11. 00<br>12. 00 |
| 13.00            | beductions (debit adjustiments) (specify)                                       |           | 0                            |          |     |            |                                | 13.00            |
| 14. 00           |   |           | 0                            |          |     |            |                                | 14.00            |
| 15. 00           |   |           | 0                            |          |     |            |                                | 15. 00           |
| 16.00            |   |           | 0                            |          |     |            |                                | 16.00            |
| 17. 00           |   |           | 0                            |          |     |            |                                | 17. 00           |
| 18. 00           | Total deductions (sum of lines 12-17)   | 0         |                              |          | 0   |            |                                | 18.00            |
| 19. 00           | Fund balance at end of period per balance sheet (line 11 minus line 18)         | 0         |                              |          | 0   |            |                                | 19. 00           |

Health Financial Systems HA Provider CCN: 15-0037

|        |   |                | Γο 12/31/2023   | Date/Time Pre 5/31/2024 7:0 |        |
|--------|---|----------------|-----------------|-----------------------------|--------|
|        | Cost Center Description   | Inpatient      | Outpati ent     | Total                       | ı dili |
|        |   | 1. 00          | 2.00            | 3. 00                       |        |
|        | PART I - PATIENT REVENUES   | <u> </u>       | •               |                             |        |
|        | General Inpatient Routine Services                                    |                |                 |                             |        |
| 1.00   | Hospi tal   | 12, 712, 23    | 1               | 12, 712, 231                | 1.00   |
| 2.00   | SUBPROVI DER - I PF   |                |                 | 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)              | 12, 712, 23    | 1               | 12, 712, 231                | 10.00  |
|        | Intensive Care Type Inpatient Hospital Services                       |                |                 |                             |        |
| 11.00  | INTENSIVE CARE UNIT   | 25, 037, 53    | 3               | 25, 037, 538                | 11.00  |
| 12.00  | CORONARY CARE UNIT  |                |                 |                             | 12.00  |
| 13.00  | BURN INTENSIVE CARE UNIT  |                |                 |                             | 13.00  |
| 14.00  | SURGICAL INTENSIVE CARE UNIT  |                |                 |                             | 14.00  |
| 15.00  | OTHER SPECIAL CARE (SPECIFY)  |                |                 |                             | 15.00  |
| 16.00  | Total intensive care type inpatient hospital services (sum of lines   | 25, 037, 53    | 3               | 25, 037, 538                | 16.00  |
|        | 11-15)  |                |                 |                             |        |
| 17.00  | Total inpatient routine care services (sum of lines 10 and 16)        | 37, 749, 76    | 9               | 37, 749, 769                | 17.00  |
| 18.00  | Ancillary services  | 42, 102, 30    | 359, 847, 354   | 401, 949, 654               | 18.00  |
| 19. 00 | Outpati ent servi ces   | 8, 620, 46     |                 | 105, 812, 574               | 19.00  |
| 20.00  | RURAL HEALTH CLINIC   |                | 853, 313        | 853, 313                    | 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  | 1, 198, 74     | 7 550, 096      | 1, 748, 843                 | 26.00  |
| 27.00  | PHYSI CI AN PRACTI CES/DI ETARY REV                                   |                | 16, 453, 398    | 16, 453, 398                | 27.00  |
| 28. 00 | Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks  | t. 89, 671, 28 | 2 474, 896, 269 | 564, 567, 551               | 28.00  |
|        | G-3, line 1)  |                |                 |                             |        |
|        | PART II - OPERATING EXPENSES  |                |                 |                             |        |
| 29. 00 | Operating expenses (per Wkst. A, column 3, line 200)                  |                | 196, 413, 438   |                             | 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 |   |                |                 |                             | 35.00  |
| 36. 00 | Total additions (sum of lines 30-35)                                  |                | 0               |                             | 36.00  |
| 37. 00 | DEDUCT (SPECIFY)  |                |                 |                             | 37.00  |
| 38. 00 |   |                |                 |                             | 38.00  |
| 39. 00 |   |                |                 |                             | 39.00  |
| 40.00  |   |                |                 |                             | 40.00  |
| 41.00  |   | 1              |                 |                             | 41.00  |
| 42.00  | Total deductions (sum of lines 37-41)                                 |                | 0               |                             | 42.00  |
| 43. 00 | Total operating expenses (sum of lines 29 and 36 minus line 42)(trans | ster           | 196, 413, 438   |                             | 43.00  |
|        | to Wkst. G-3, line 4)   | I              | 1               |                             |        |

|                  | Figure 1 1 C 1 1 2 1 1 1 2 1 1 1 2 1 1 1 2 1 | UOCDI TAI             |                 | . C. E OHC. (                    | 2550 40          |
|------------------|--|-----------------------|-----------------|----------------------------------|------------------|
|                  | Financial Systems HANCOCK REGIONAL MENT OF REVENUES AND EXPENSES   | Provider CCN: 15-0037 | Period:         | u of Form CMS-2<br>Worksheet G-3 |                  |
| SIAIL            | IENT OF REVENUES AND EXTENSES  | Trovider con. 13 0037 | From 01/01/2023 |                                  |                  |
|                  |  |                       | To 12/31/2023   | Date/Time Pre 5/31/2024 7:0      | pared:           |
|                  |  |                       |                 | 1 3/31/2024 7.0                  | ı aiii           |
|                  |  |                       |                 | 1. 00                            |                  |
| 1. 00            | Total patient revenues (from Wkst. G-2, Part I, column 3, lir  | ne 28)                | ·               | 564, 567, 551                    | 1.00             |
| 2.00             | Less contractual allowances and discounts on patients' accour  | nts                   |                 | 404, 437, 140                    | 2.00             |
| 3.00             | Net patient revenues (line 1 minus line 2)   |                       |                 | 160, 130, 411                    | 3.00             |
| 4.00             | Less total operating expenses (from Wkst. G-2, Part II, line   | 43)                   |                 | 196, 413, 438                    | 4.00             |
| 5. 00            | Net income from service to patients (line 3 minus line 4)  |                       |                 | -36, 283, 027                    | 5.00             |
|                  | OTHER I NCOME  |                       |                 |                                  |                  |
| 6. 00            | Contributions, donations, bequests, etc  |                       |                 | 0                                | 6.00             |
| 7. 00            | Income from investments  |                       |                 | 15, 829, 344                     | 7. 00            |
| 8. 00            | Revenues from telephone and other miscellaneous communication  | n servi ces           |                 | 0                                | 8.00             |
| 9.00             | Revenue from television and radio service  |                       |                 | 0                                | 9.00             |
| 10.00            | Purchase di scounts  |                       |                 | 0                                | 10.00            |
| 11.00            | Rebates and refunds of expenses  |                       |                 | 0                                | 11.00            |
| 12.00            | Parking lot receipts   |                       |                 | 0                                | 12.00            |
| 13.00            | Revenue from laundry and linen service   |                       |                 | 0                                | 13.00            |
| 14.00            | Revenue from meals sold to employees and guests  |                       |                 | 0                                | 14.00            |
| 15.00            |  | than nationta         |                 | 0                                | 15. 00<br>16. 00 |
| 16.00            |  | than patrents         |                 | 0                                |                  |
| 17. 00<br>18. 00 | Revenue from sale of drugs to other than patients Revenue from sale of medical records and abstracts   |                       |                 | 0                                | 17. 00<br>18. 00 |
|                  | Tuition (fees, sale of textbooks, uniforms, etc.)  |                       |                 | 0                                | 19.00            |
| 20. 00           | Revenue from gifts, flowers, coffee shops, and canteen   |                       |                 | 0                                | 20.00            |
| 21. 00           | Rental of vending machines   |                       |                 | 0                                | 21.00            |
| 22. 00           | Rental of hospital space   |                       |                 | 0                                | 22.00            |
| 23. 00           | Governmental appropriations  |                       |                 | 0                                | 23.00            |
| 24. 00           |  |                       |                 | 20, 389, 551                     |                  |
| 24. 01           | OTHER NON-OPERATING INCOME   |                       |                 | 3, 130, 544                      |                  |
| 24. 02           |  |                       |                 | -9, 107, 087                     | 24. 02           |
| 24. 03           |  |                       |                 | 15, 502, 591                     | 24. 03           |
| 24. 50           |  |                       |                 | 0                                | 24. 50           |
| 25. 00           |  |                       |                 | 45, 744, 943                     |                  |
| 26. 00           | Total (line 5 plus line 25)  |                       |                 | 9, 461, 916                      |                  |
| 27. 00           | OTHER HOSPITAL EXPENSE   |                       |                 | 98, 857                          |                  |
|                  | Total other expenses (sum of line 27 and subscripts)   |                       |                 | 98, 857                          |                  |
| 29. 00           | Net income (or loss) for the period (line 26 minus line 28)  |                       |                 | 9, 363, 059                      | 29. 00           |
|                  |  |                       | •               |                                  |                  |

|        | 51   | 0.00.                         |                                  | 6.5. 0110.4                  |                |
|--------|--|-------------------------------|----------------------------------|------------------------------|----------------|
|        |  | GI ONAL HOSPI TAL             |                                  | u of Form CMS-2              | 2552-10        |
| CALCUL | ATION OF CAPITAL PAYMENT   | Provider CCN: 15-0037         | Peri od:                         | Worksheet L                  |                |
|        |  |                               | From 01/01/2023<br>To 12/31/2023 | Parts I-III<br>Date/Time Pre | narod:         |
|        |  |                               | 10 12/31/2023                    | 5/31/2024 7:0                |                |
|        |  | Title XVIII                   | Hospi tal                        | PPS                          |                |
|        |  |                               |                                  |                              |                |
|        |  |                               |                                  | 1. 00                        |                |
|        | PART I - FULLY PROSPECTIVE METHOD  |                               |                                  |                              |                |
|        | CAPITAL FEDERAL AMOUNT   |                               |                                  |                              |                |
| 1. 00  | Capital DRG other than outlier   |                               |                                  | 489, 221                     | 1. 00          |
| 1. 01  | Model 4 BPCI Capital DRG other than outlier  |                               |                                  | 0                            | 1. 01          |
| 2.00   | Capital DRG outlier payments   |                               |                                  | 15, 503                      | 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 c  | ost reporting period (see ins | structions)                      | 30. 95                       | 3.00           |
| 4.00   | Number of interns & residents (see instructions)   |                               |                                  | 0. 00                        | 4.00           |
| 5.00   | Indirect medical education percentage (see instructions  |                               |                                  | 0. 00                        | 5. 00<br>6. 00 |
| 6. 00  | 6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and  |                               |                                  |                              |                |
|        | 1.01) (see instructions)   |                               |                                  |                              |                |
| 7. 00  | Percentage of SSI recipient patient days to Medicare Pa  | irt A patient days (Worksheet | E, part A line                   | 1. 68                        | 7. 00          |
| 8. 00  | 30) (see instructions) Percentage of Medicaid patient days to total days (see                              | instructions)                 |                                  | 17. 62                       | 8.00           |
| 9. 00  | Sum of lines 7 and 8   | Thisti de trons)              |                                  | 19. 30                       | 9.00           |
| 10.00  | Allowable disproportionate share percentage (see instru  | usti ons)                     |                                  | 3. 99                        |                |
| 11. 00 |  | ictions)                      |                                  | 3, 99<br>19, 520             |                |
|        | Disproportionate share adjustment (see instructions) Total prospective capital payments (see instructions) |                               |                                  | ·                            |                |
| 12.00  | Total prospective capital payments (see instructions)  |                               |                                  | 524, 244                     | 12.00          |
|        |  |                               |                                  | 1. 00                        |                |
|        | PART II - PAYMENT UNDER REASONABLE COST  |                               |                                  | 1.00                         |                |
| 1. 00  | Program inpatient routine capital cost (see instruction  | is)                           |                                  | 0                            | 1.00           |
| 2. 00  | Program inpatient ancillary capital cost (see instructi  |                               |                                  | 0                            | 2.00           |
| 3. 00  | Total inpatient program capital cost (line 1 plus line   |                               |                                  | 0                            | 3. 00          |
| 4. 00  | Capital cost payment factor (see instructions)   | -,                            |                                  | 0                            | 4.00           |
| 5. 00  | Total inpatient program capital cost (line 3 x line 4)   |                               |                                  | 0                            | 5. 00          |
|        | ,  |                               |                                  |                              |                |
|        |  |                               |                                  | 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 circu  |                               |                                  | 0                            | 2.00           |
| 3. 00  | Net program inpatient capital costs (line 1 minus line   | 2)                            |                                  | 0                            | 3. 00          |
| 4. 00  | Applicable exception percentage (see instructions)   |                               |                                  | 0.00                         |                |
| 5. 00  | Capital cost for comparison to payments (line 3 x line   | •                             |                                  | 0                            | 5.00           |
| 6. 00  | Percentage adjustment for extraordinary circumstances (  | •                             |                                  | 0.00                         |                |
| 7. 00  | Adjustment to capital minimum payment level for extraor  | dinary 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, as  |                               |                                  | 0                            | 9. 00          |
| 10. 00 | Current year comparison of capital minimum payment leve  |                               |                                  | 0                            | 10.00          |
| 11. 00 | Carryover of accumulated capital minimum payment level   | over capital payment (from pr | rior year                        | 0                            | 11. 00         |
| 12. 00 | Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capi                    | tal navments (line 10 plus li | no 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 level   |                               |                                  | 0                            |                |
| 14.00  | (if line 12 is negative, enter the amount on this line)  |                               | Torrowing period                 | U                            | 14.00          |
| 15. 00 | ,  |                               |                                  | 0                            | 15. 00         |
| 16. 00 |  | ,                             |                                  | 0                            | 16.00          |
|        | Current year exception offset amount (see instructions)  |                               |                                  | -                            | 17. 00         |
|        | 12 Joan Shooper on Stroot amount (300 that dott only)  |                               | I                                | O                            |                |

|                  | Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS  | HANCOCK REGION |             | ON 45 0007   |                             | u of Form CMS-1 |              |
|------------------|---|----------------|-------------|--------------|-----------------------------|-----------------|--------------|
| ANALYS           | DIS OF HOSPITAL-BASED KHC/FUHC COSTS                    |                | Provi der C | CN: 15-0037  | Peri od:<br>From 01/01/2023 | Worksheet M-1   |              |
|                  |   |                | Component   | CCN: 15-3987 | To 12/31/2023               |                 |              |
|                  |   |                |             |              | RHC I                       | Cost            |              |
|                  |   | Compensation   | Other Costs | Total (col.  | 1 Reclassi fi cat           | Recl assi fi ed |              |
|                  |   |                |             | + col . 2)   | i ons                       | Trial Balance   |              |
|                  |   |                |             |              |                             | (col. 3 +       |              |
|                  |   | 1.00           |             |              | 4.00                        | col . 4)        |              |
|                  | FACILITY HEALTH CARE CTAFE COCTO                        | 1. 00          | 2. 00       | 3. 00        | 4. 00                       | 5. 00           |              |
| 1 00             | FACILITY HEALTH CARE STAFF COSTS                        | ( 052          |             |              | - 2 0                       | / 052           | 1 00         |
| 1.00             | Physician   | 6, 053         | 0           |              |                             | 6, 053          |              |
| 2. 00<br>3. 00   | Physician Assistant                                     | 120.454        | 0           | 1            | 0                           | 120 454         | 2.00<br>3.00 |
| 4. 00            | Nurse Practitioner Visiting Nurse                       | 139, 454       | 0           | 1            | 0 0                         | 139, 454<br>0   |              |
| 5. 00            | Other Nurse   | 40, 642        | 0           |              | -                           | 40, 642         |              |
| 6. 00            | Clinical Psychologist                                   | 40, 642        | 0           | 40, 64       | 0 0                         | 1 40, 642       |              |
| 7. 00            | Clinical Social Worker                                  | 0              | 0           |              |                             | 0               |              |
| 7. 10            | Marriage and Family Therapist                           | ď              | 0           | 1            |                             | 0               | 7. 10        |
| 7. 10            | Mental Health Counselor                                 |                |             |              |                             |                 | 7. 10        |
| 8. 00            | Laboratory Techni ci an                                 | ٥              | 0           |              | 0 0                         | 0               |              |
| 9. 00            | Other Facility Health Care Staff Costs                  | 97, 394        | 0           | 97. 39       | -                           | 97, 394         |              |
| 10.00            | Subtotal (sum of lines 1 through 9)                     | 283, 543       | 0           | 283, 54      |                             | 283, 543        |              |
| 11. 00           | Physician Services Under Agreement                      | 0              | 0           | 200,0        | 0 0                         | 0               |              |
| 12. 00           | Physician Supervision Under Agreement                   | l ol           | 0           | ,            | 0 0                         | Ō               | 1            |
| 13. 00           | Other Costs Under Agreement                             | l ol           | 0           | ,            | 0 0                         | Ō               |              |
| 14.00            | Subtotal (sum of lines 11 through 13)                   | o              | 0           |              | 0 0                         | 0               | 1            |
| 15.00            | Medical Supplies  | ol             | 15, 032     | 15, 03       | -52                         | 14, 980         | 15.00        |
| 16.00            | Transportation (Health Care Staff)                      | o              | 0           |              | 0 0                         | 0               | 16.00        |
| 17.00            | Depreciation-Medical Equipment                          | o              | 0           |              | 0 0                         | 0               | 17.00        |
| 18.00            | Professional Liability Insurance                        | 0              | 0           |              | 0 0                         | 0               | 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              | 15, 032     |              |                             | 14, 980         |              |
| 22. 00           | Total Cost of Health Care Services (sum of              | 283, 543       | 15, 032     | 298, 5       | 75 -52                      | 298, 523        | 22. 00       |
|                  | lines 10, 14, and 21)                                   |                |             |              |                             |                 |              |
| 00.00            | COSTS OTHER THAN RHC/FQHC SERVICES                      |                | 24 (22      | 04.4         | 24 (22                      |                 | 00.00        |
| 23. 00           | Pharmacy  | 0              | 31, 632     |              |                             | 0               |              |
| 24. 00<br>25. 00 | Dental  | 0              | 0           |              | 0 0                         | 0               |              |
|                  | Optometry   | 0              | 0           |              | 0                           |                 |              |
| 25. 01<br>25. 02 | Tel eheal th  | 0              | 0           |              |                             | 0               |              |
| 26. 00           | Chronic Care Management All other nonreimbursable costs | 0              | 0           |              |                             | 0               | 26.00        |
| 27. 00           | Nonallowable GME costs                                  | ı o            | 0           |              |                             | U               | 27.00        |
| 28. 00           | Total Nonreimbursable Costs (sum of lines 23            | 0              | 31, 632     | 31, 63       | -31, 632                    | 0               |              |
| 20.00            | through 27)   | l $\mathbb{Y}$ | 51,032      | 31, 0.       | 51,032                      |                 | 20.00        |
|                  | FACILITY OVERHEAD                                       |                |             |              |                             |                 | 1            |
| 29. 00           | Facility Costs  | 0              | 0           |              | 0 0                         | 0               | 29. 00       |
| 30.00            | Administrative Costs                                    | o              | 175, 618    | 175, 6°      | 18 0                        | 175, 618        | 30.00        |
| 31.00            | Total Facility Overhead (sum of lines 29 and            | O              | 175, 618    | 175, 6°      | 18 0                        | 175, 618        | 31.00        |
|                  | 30)   |                |             |              |                             |                 | I            |

283, 543

222, 282

505, 825

474, 141 32.00

30)
32.00 Total facility costs (sum of lines 22, 28 and 31)

| Health Financial Systems                  | HANCOCK REGIO | NAL HOSPITAL |              | In Lie                      | u of Form CMS-2             | 2552-10        |
|---|---------------|--------------|--------------|-----------------------------|-----------------------------|----------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |               | Provi der C  | CN: 15-0037  | Peri od:<br>From 01/01/2023 | Worksheet M-1               |                |
|   |               | Component    | CCN: 15-3987 | To 12/31/2023               | Date/Time Pre 5/31/2024 7:0 | pared:<br>1 am |
|   |               |              | _            | RHC I                       | Cost                        |                |
|   | Adjustments   | Net Expenses |              |                             |                             |                |
|   |               | for          |              |                             |                             |                |
|   |               | Allocation   |              |                             |                             |                |
|   |               | (col. 5 +    |              |                             |                             |                |
|   |               | col. 6)      |              |                             |                             |                |
|   | 6. 00         | 7.00         |              |                             |                             |                |
| FACILITY HEALTH CARE STAFF COSTS          |               |              |              |                             |                             |                |
| 1 00 Physician                            | 0             | 6.053        |              |                             |                             | 1 1 00         |

|        |  | Adjustments | Net Expenses |        |
|--------|--|-------------|--------------|--------|
|        |  |             | for          |        |
|        |  |             | Allocation   |        |
|        |  |             | (col. 5 +    |        |
|        |  |             | col . 6)     |        |
|        |  | 6. 00       | 7. 00        |        |
|        | FACILITY HEALTH CARE STAFF COSTS             |             |              |        |
| 1. 00  | Physi ci an                                  | 0           | 6, 053       | 1.00   |
| 2.00   | Physician Assistant                          | 0           | 0            | 2.00   |
| 3.00   | Nurse Practitioner                           | 0           | 139, 454     | 3.00   |
| 4.00   | Visiting Nurse                               | 0           | 0            | 4.00   |
| 5.00   | Other Nurse                                  | 0           | 40, 642      | 5.00   |
| 6.00   | Clinical Psychologist                        | 0           | 0            | 6.00   |
| 7.00   | Clinical Social Worker                       | 0           | 0            | 7. 00  |
| 7. 10  | Marriage and Family Therapist                |             |              | 7. 10  |
| 7. 11  | Mental Health Counselor                      |             |              | 7.11   |
| 8.00   | Laboratory Techni ci an                      | 0           | 0            | 8.00   |
| 9. 00  | Other Facility Health Care Staff Costs       | 0           | 97, 394      | 9.00   |
| 10.00  | Subtotal (sum of lines 1 through 9)          | 0           | 283, 543     | 10.00  |
| 11. 00 | Physician Services Under Agreement           | 0           | 0            | 11.00  |
| 12. 00 | Physician Supervision Under Agreement        | 0           | 0            | 12.00  |
| 13. 00 | Other Costs Under Agreement                  | 0           | 0            | 13.00  |
| 14. 00 | Subtotal (sum of lines 11 through 13)        | 0           | 0            | 14.00  |
| 15. 00 | Medical Supplies                             | 0           | 14, 980      | 15.00  |
| 16. 00 | Transportation (Health Care Staff)           | 0           | 14, 700      | 16.00  |
|        | Depreciation (Hearth Care Starr)             | 0           | 0            | 17.00  |
| 17.00  | 1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '      | 0           | 0            | 1      |
| 18.00  | Professional Liability Insurance             | 0           | 0            | 18.00  |
| 19.00  | Other Health Care Costs                      | U           | U            | 19.00  |
| 20.00  | Allowable GME Costs                          |             | 44.000       | 20.00  |
| 21. 00 | Subtotal (sum of lines 15 through 20)        | 0           | 14, 980      | 21.00  |
| 22. 00 | Total Cost of Health Care Services (sum of   | 0           | 298, 523     | 22. 00 |
|        | lines 10, 14, and 21)                        |             |              | 1      |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             |              |        |
| 23. 00 | Pharmacy                                     | 0           | 0            | 23. 00 |
| 24. 00 | Dental                                       | 0           | 0            | 24.00  |
| 25. 00 | Optometry                                    | 0           | 0            | 25. 00 |
| 25. 01 | Tel eheal th                                 | 0           | 0            | 25. 01 |
| 25. 02 | Chronic Care Management                      | 0           | 0            | 25. 02 |
| 26. 00 | All other nonreimbursable costs              | 0           | 0            | 26. 00 |
| 27. 00 | Nonallowable GME costs                       |             |              | 27. 00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0           | 0            | 28. 00 |
|        | through 27)                                  |             |              | ]      |
|        | FACILITY OVERHEAD                            |             |              |        |
| 29. 00 |  | 0           |              | 29. 00 |
| 30.00  | Administrative Costs                         | -47, 950    | •            | 30.00  |
| 31.00  | Total Facility Overhead (sum of lines 29 and | -47, 950    | 127, 668     | 31.00  |
|        | 30)  |             |              |        |
| 32.00  | Total facility costs (sum of lines 22, 28    | -47, 950    | 426, 191     | 32.00  |
|        | and 31)                                      |             |              |        |
|        |  |             |              |        |

| Heal th          | Financial Systems   | HANCOCK REGION   | NAL HOSPITAL    |                | In Lie                           | u of Form CMS-2                | 2552-10 |
|------------------|---|------------------|-----------------|----------------|----------------------------------|--------------------------------|---------|
|                  | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :                                     | SERVI CES        | Provi der C     |                | Peri od:                         | Worksheet M-2                  |         |
|                  |   |                  | Component       | CCN: 15-3987   | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre<br>5/31/2024 7:0 |         |
|                  |   |                  |                 |                | RHC I                            | Cost                           |         |
|                  |   | Number of FTE    | Total Visits    | Producti vi ty |                                  | Greater of                     |         |
|                  |   | Personnel        |                 | Standard (1)   |                                  | col. 2 or                      |         |
|                  |   |                  |                 |                | 1 x col . 3)                     | col. 4                         |         |
|                  | VICLES AND PROPUCTIVIETY  | 1. 00            | 2. 00           | 3. 00          | 4. 00                            | 5. 00                          |         |
|                  | VISITS AND PRODUCTIVITY   |                  |                 |                |                                  |                                |         |
| 1 00             | Posi ti ons Physi ci an   | 0.00             | 0               | 4, 20          | 00                               |                                | 1.00    |
| 1. 00<br>2. 00   | Physician Assistant   | 0.00             |                 |                |                                  |                                | 2.00    |
| 3.00             | Nurse Practitioner  | 1. 19            | l e             |                |                                  |                                | 3.00    |
| 4. 00            | Subtotal (sum of lines 1 through 3)   | 1. 19            |                 |                | 2, 499                           | 4, 015                         |         |
| 5. 00            | Visiting Nurse  | 0.00             |                 | 1              | 2, 177                           | 0                              | 5.00    |
| 6. 00            | Clinical Psychologist   | 0.00             |                 | l .            |                                  | Ö                              | 6. 00   |
| 7.00             | Clinical Social Worker  | 0.00             |                 |                |                                  | 0                              | 1       |
| 7. 01            | Medical Nutrition Therapist (FQHC only)   | 0.00             | 0               |                |                                  | 0                              | 7. 01   |
| 7. 02            | Diabetes Self Management Training (FQHC   | 0.00             | 0               |                |                                  | 0                              | 7. 02   |
|                  | onl y)  |                  |                 |                |                                  |                                |         |
| 7. 03            | Marriage and Family Therapist   |                  |                 |                |                                  |                                | 7. 03   |
| 7.04             | Mental Health Counselor   |                  |                 |                |                                  |                                | 7.04    |
| 8. 00            | Total FTEs and Visits (sum of lines 4   | 1. 19            | 4, 015          | 1              |                                  | 4, 015                         | 8. 00   |
| 9. 00            | through 7) Physician Services Under Agreements                                    |                  | 0               |                |                                  | 0                              | 9. 00   |
| 7.00             | Triyor or arr occ vi occ or acr ingreements                                       |                  |                 | 1              |                                  | 0                              | 7.00    |
|                  |   |                  |                 |                |                                  | 1. 00                          |         |
|                  | DETERMINATION OF ALLOWABLE COST APPLICABLE T                                      | O HOSPITAL-BASE  | ED RHC/FQHC SEI | RVI CES        |                                  |                                |         |
| 10.00            | 0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22)        |                  |                 |                |                                  | 298, 523                       | 1       |
| 11.00            |   |                  |                 |                |                                  | 0                              |         |
| 12.00            | ,   |                  |                 |                |                                  | 298, 523                       |         |
| 13.00            | Ratio of hospital -based RHC/FQHC services (I                                     |                  |                 |                |                                  | 1. 000000                      |         |
| 14.00            | Total hospital-based RHC/FQHC overhead - (fr                                      |                  |                 | ine 31)        |                                  | 127, 668                       |         |
| 15. 00<br>16. 00 | Parent provider overhead allocated to facili                                      | ty (see Instru   | Ctions)         |                |                                  | 110, 835                       |         |
| 17. 00           | Total overhead (sum of lines 14 and 15) Allowable GME overhead (see instructions) |                  |                 |                |                                  | 238, 503<br>0                  | 1       |
| 18.00            | Enter the amount from line 16   |                  |                 |                |                                  | 238, 503                       |         |
| 19. 00           | Overhead applicable to hospital-based RHC/FC                                      | OHC services (Li | ine 13 x line   | 18)            |                                  | 238, 503                       |         |
|                  | Total allowable cost of hospital based RHC/F                                      |                  |                 |                |                                  | 537, 026                       |         |
|                  |   |                  |                 | ,              |                                  | •                              |         |

|  | HOSPI TAL                |                             | u of Form CMS-2        |            |
|--|--------------------------|-----------------------------|------------------------|------------|
| ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC   | Provider CCN: 15-0037    | Peri od:<br>From 01/01/2023 | Worksheet M-3          |            |
| ERVI CES   | Component CCN: 15-3987   | To 12/31/2023               | Date/Time Pre          | pared      |
|  | Title William            | DIIO I                      | 5/31/2024 7:0          | 1 am       |
| <u> </u>   | Title XVIII              | RHC I                       | Cost                   |            |
|  |                          |                             | 1. 00                  |            |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES   |                          |                             |                        |            |
| .00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro  |                          |                             | 537, 026               | 1          |
| .00 Cost of injections/infusions and their administration (from V  |                          |                             | 5, 463                 | 1          |
| .00   Total allowable cost excluding injections/infusions (line 1 m<br>.00   Total Visits (from Wkst. M-2, column 5, line 8)                 | ninus line 2)            |                             | 531, 563<br>4, 015     |            |
| .00 Physicians visits under agreement (from Wkst. M-2, column 5,   | line 9)                  |                             | 4,013                  | 5.0        |
| .00 Total adjusted visits (line 4 plus line 5)   |                          |                             | 4, 015                 | 6. (       |
| .00 Adjusted cost per visit (line 3 divided by line 6)   |                          |                             | 132. 39                | 7. (       |
|  |                          | Cal cul ati on              | of Limit (1)           |            |
|  |                          |                             | Rate Period 1          |            |
|  |                          | N/A                         | (01/01/2023            |            |
|  |                          |                             | through<br>12/31/2023) |            |
|  |                          | 1.00                        | 2. 00                  |            |
| .00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20  | 0.6 or your contractor)  | 0.00                        | 126. 00                | 8. (       |
| .00 Rate for Program covered visits (see instructions)   |                          | 0.00                        | 126. 00                | 9. (       |
| CALCULATION OF SETTLEMENT  |                          |                             | 275                    | 1 10       |
| 0.00 Program covered visits excluding mental health services (from 1.00 Program cost excluding costs for mental health services (line        |                          | 0                           | 375<br>47, 250         |            |
| 2.00 Program covered visits for mental health services (from contr   | •                        | 0                           | 47, 230                | 1          |
| 3.00 Program covered cost from mental health services (line 9 x li   | •                        | 0                           | 0                      | ı          |
| 4.00 Limit adjustment for mental health services (see instructions   | •                        | 0                           | 0                      |            |
| 5.00 Graduate Medical Education Pass Through Cost (see instruction   | •                        |                             | 47.050                 | 15.        |
| 6.00   Total Program cost (sum of lines 11, 14, and 15, columns 1, 2<br>6.01   Total program charges (see instructions)(from contractor's re |                          | 0                           | 47, 250<br>53, 238     | 1          |
| 6.02 Total program preventive charges (see instructions)(from prov   |                          |                             | 9, 009                 |            |
| 6.03 Total program preventive costs ((line 16.02/line 16.01) times   |                          |                             | 7, 996                 |            |
| 6.04 Total Program non-preventive costs ((line 16 minus lines 16.0   | 03 and 18) times .80)    |                             | 26, 982                | 16. (      |
| (Titles V and XIX see instructions.)   |                          |                             | 24 070                 | 1,         |
| 6.05   Total program cost (see instructions)<br>7.00   Primary payer amounts   |                          | 0                           | 34, 978<br>0           | 16.<br>17. |
| 8.00 Less: Beneficiary deductible for RHC only (see instructions)  | ) (from contractor       |                             | 5, 527                 |            |
| records)   |                          |                             | ·                      |            |
| 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)   | ons) (from contractor    |                             | 7, 740                 | 19. (      |
| 0.00 Net program cost excluding injections/infusions (see instruct   | tions)                   |                             | 34, 978                | 20. (      |
| 1.00 Program cost of vaccines and their administration (from Wkst.   | ,                        |                             | 3, 123                 |            |
| 1.50 Total program IOP OPPS payments (see instructions)  |                          |                             |                        | 21.        |
| 1.55 Total program IOP Costs (see instructions)  |                          |                             |                        | 21.        |
| 1.60   Program IOP deductible and coinsurance (see instructions) 2.00   Total reimbursable Program cost (sum of lines 20, 21, 21.50,         | minus Lino 21 60)        |                             | 38, 101                | 21.<br>22. |
| 3.00 Allowable bad debts (see instructions)  | lilitius Title 21.00)    |                             | 38, 101                | 1          |
| 3.01 Adjusted reimbursable bad debts (see instructions)  |                          |                             | 0                      |            |
| 4.00 Allowable bad debts for dual eligible beneficiaries (see inst   | tructi ons)              |                             | 0                      | 1          |
| 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  |                          |                             | 0                      | 1          |
| 5.50 Pioneer ACO demonstration payment adjustment (see instruction   | ns)                      |                             | 0                      | 25.        |
| 5.99 Demonstration payment adjustment amount before sequestration 6.00 Net reimbursable amount (see instructions)                            |                          |                             | 0<br>38, 101           |            |
| 6.01 Sequestration adjustment (see instructions)   |                          |                             | 762                    | 1          |
| 6.02 Demonstration payment adjustment amount after sequestration   |                          |                             | 0                      | 1          |
| 7.00 Interim payments  |                          |                             | 33, 072                | 1          |
| 8.00 Tentative settlement (for contractor use only)  | 00 07   00               |                             | 0                      |            |
| 9.00 Balance due component/program (line 26 minus lines 26.01, 26.   |                          |                             | 4, 267                 |            |
| O.00  Protested amounts (nonallowable cost report items) in accorda  | THE WILLI CMS PUD. 15-11 | '                           | 0                      | 30.        |

| COMPUTATION OF HOSPI                          | TAL-BASED RHC/FQHC VACCINE COST  | Provider Component (      |                              | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet M-4 Date/Time Pre                        |                |
|---|--|---------------------------|------------------------------|--|--|----------------|
|   |  | '                         |                              |  | 5/31/2024 7:0                                      |                |
|   |  |                           | XVIII                        | RHC I  | Cost   |                |
|   |  | PNEUMOCOCCAL<br>VACCI NES | I NFLUENZA<br>VACCI NES      | COVI D-19<br>VACCI NES                       | MONOCLONAL<br>ANTI BODY<br>PRODUCTS                |                |
|   |  | 1. 00                     | 2. 00                        | 2. 01  | 2. 02  |                |
|   | raff cost (from Wkst. M-1, col. 7, line 10)  | 283, 543<br>0. 000269     |                              |  |  |                |
|   | usion health care staff cost (line 1 x line  | 76                        | 2, 78                        | 0  | 0  | 3.00           |
| (from your red                                |  | 145                       |                              | 28 0   | 0  | 4.00           |
| 6.00 Total direct of                          | finjections/infusions (line 3 plus line 4) cost of the hospital-based RHC/FQHC (from col. 7, line 22)                      | 221<br>298, 523           | 2, 8 <sup>-</sup><br>298, 5: |  | 0<br>298, 523                                      | 5. 00<br>6. 00 |
| 8.00 Ratio of injec                           | I (from Wkst. M-2, line 19)<br>ction/infusion direct cost to total direct<br>livided by line 6)                            | 238, 503<br>0. 000740     |                              | ·  | 238, 503<br>0. 000000                              | 7. 00<br>8. 00 |
| 9.00 Overhead cost<br>10.00 Total injection   | - injection/infusion (line 7 x line 8)<br>on/infusion costs and their administration<br>lines 5 and 9)                     | 176<br>397                |                              |  | 0  |                |
| 11.00 Total number of<br>12.00 Cost per injec | of injections/infusions (from your records)<br>ction/infusion (line 10/line 11)<br>cction/infusion administered to Program | 99. 25<br>0               | 34.                          | 46 0<br>70 0.00<br>90 0                      | 0<br>0. 00<br>0                                    | 12.0           |
| beneficiaries  Number of COVI                 | D-19 vaccine injections/infusions<br>to MA enrollees   |                           |                              | 0  | 0  | 13.0           |
| 14.00 Program cost o                          | of injections/infusions and their<br>n costs (line 12 times the sum of lines 13  | 0                         | 3, 1:                        | 23 0   | 0  | 14.00          |
|   |  |                           |                              |  | COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N |                |
|   |  |                           |                              | 1. 00  | 2. 00  |                |
| 2, 2.01, and 2                                | injections/infusions and their administratio<br>2.02, line 10) (transfer this amount to Wkst.                              | M-3, line 2)              |                              |  | 5, 463   |                |
|   | cost of injections/infusions and their admin 2.01, and 2.02, line 14) (transfer this amou                                  |                           |                              |  | 3, 123   | 16.0           |

| Health Financial Systems   | HANCOCK REGIONAL | HOSPI TAL                                       | In Lie                                       | u of Form CMS-2552-10                               |
|--|------------------|---|--|---|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR |                  | Provider CCN: 15-0037<br>Component CCN: 15-3987 | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet M-5 Date/Time Prepared: 5/31/2024 7:01 am |
|  |                  |   | DUO I  | 373172024 7.01 dill                                 |

|       |  | Component CCN: 15-3987      | 10 12/31/2023  | 5/31/2024 7: 01     |      |
|-------|--|-----------------------------|----------------|---------------------|------|
|       |  |                             | RHC I          | Cost                |      |
|       |  |                             | Par            | t B                 |      |
|       |  |                             | mm/dd/yyyy     | Amount              |      |
|       |  |                             | 1. 00          | 2. 00               |      |
| . 00  | Total interim payments paid to hospital-based RHC/FQHC   |                             |                | 33, 072             | 1. 0 |
| 2. 00 | Interim payments payable on individual bills, either submit<br>the contractor for services rendered in the cost reporting<br>"NONE" or enter a zero  | period. If none, write      |                | 0                   | 2. 0 |
| . 00  | List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)  Program to Provider |                             |                |                     | 3. 0 |
| . 01  | Program to Provider  |                             |                | 0                   | 3. 0 |
| . 01  |  |                             |                | 0                   | 3.0  |
| . 02  |  |                             |                | 0                   | 3.0  |
| . 03  |  |                             |                | 0                   | 3. 0 |
| . 05  |  |                             |                | 0                   | 3.0  |
| 05    | Provider to Program  |                             |                | 0                   | J. ( |
| 50    | 110vrder to 110grdiii  |                             |                | 0                   | 3. 5 |
| 51    |  |                             |                | ol                  | 3.   |
| 52    |  |                             |                | o                   | 3.   |
| 53    |  |                             |                | 0                   | 3.   |
| 54    |  |                             |                | 0                   | 3.   |
| 99    | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.  | 98)                         |                | 0                   | 3. 0 |
| 00    | Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)  | sfer to Worksheet M-3, line | Э              | 33, 072             | 4. ( |
|       | TO BE COMPLETED BY CONTRACTOR  |                             |                |                     |      |
| 00    | List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)  | sk review. Also show date o | of             |                     | 5. ( |
|       | Program to Provider  |                             |                | _                   | _    |
| 01    |  |                             |                | 0                   | 5. ( |
| 02    |  |                             |                | 0                   | 5. ( |
| 03    | Provider to Program  |                             |                | 0                   | 5. ( |
| 50    | Provider to Program  |                             |                | 0                   | 5. 5 |
| 51    |  |                             |                | 0                   | 5. 5 |
| 52    |  |                             |                | 0                   | 5.   |
| 99    | <br> Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.   | 08)                         |                | 0                   | 5.   |
| 00    | Determined net settlement amount (balance due) based on the  |                             |                |                     | 6.   |
| 01    | SETTLEMENT TO PROVIDER   | 2 0031 1 6poi 1. (1)        |                | 4, 267              | 6.   |
| 02    | SETTLEMENT TO PROGRAM  |                             |                | 4, 207              | 6.   |
| 00    | Total Medicare program liability (see instructions)  |                             |                | 37, 339             | 7.   |
|       | Total modical opingiam riability (see instructions)  |                             | Contractor     | NPR Date            | ,.   |
|       |  |                             | 001111 00101   |                     |      |
|       |  |                             | Number         | (Mo/Day/Yr)         |      |
|       |  | 0                           | Number<br>1.00 | (Mo/Day/Yr)<br>2.00 |      |