HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 08/22/2017 Time: 08:43 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [ ] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARDIN COUNTY GENERAL HOSPITAL (14-1328) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 04/01/2016 and ending 03/31/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-525,626	-404,647	1	-80,551	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-474,579				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			194,265			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-1,000,205	-210,382	1	-80,551	200

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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this 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 appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence 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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 6 FERRELL ROAD	P.O. Box: 2467		1
2	City: ROSICLARE	State: IL	ZIP Code: 62982	County: HARDIN	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	HARDIN COUNTY GENERAL HOSPITAL	14-1328	99914	1	07 / 09 / 2003	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	HARDIN COUNTY SWING BED	14-Z328	99914		07 / 09 / 2003	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	HARDIN COUNTY RHC	14-3479	99914		04 / 03 / 2006	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 04 / 01 / 2016	To: 03 / 31 / 2017	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments 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§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for 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)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes 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.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to 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.	N	N	N	22.03
23	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 different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, 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.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	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, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? 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)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or '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)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, 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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	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.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	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.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

		1	2	
Rural Providers				
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	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 each therapy.	Y	Y	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	67,678			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	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	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.		N	125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, 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)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	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.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and '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.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1		168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04 / 01 / 2016	03 / 31 / 2017	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management 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)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/26/2017	Y	06/26/2017	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	Y	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	N	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information				
41	First name: MARK	Last name: DALLAS	Title: PARTNER	41
42	Employer: KERBER, ECK & BRAECKEL			42
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM		43

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	40,392.00		1,279	215	1,685	1
2	HMO and other (see instructions)						95			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						1,310		1,415	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	40,392.00		2,589	215	3,100	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	40,392.00		2,589	215	3,100	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					4,957		13,334	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							195	452	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					338	70	471	1
2	HMO and other (see instructions)					26			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		107.77			338	70	471	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		23.49						26
27	Total (sum of lines 14-26)		131.26						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	07/09/2003	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)				207

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3479** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 6 FERRELL ROAD	1
2	City: ROSICLARE State: IL ZIP Code: 62982 County: HARDIN	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	OTHER			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0900	1700	0900	1700	0900	1700	0900	1700	0900	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	RHC/FQHC name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.546294	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,731,016	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	5,635,571	6
7	Medicaid cost (line 1 times line 6)	3,078,679	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	347,663	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	347,663	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	74,410	336,948	411,358	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	40,650	184,073	224,723	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	40,650	184,073	224,723	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	617,159	26
27	Medicare bad debts for the entire hospital complex (see instructions)	196,907	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	420,252	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	229,581	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	454,304	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	801,967	31

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		69,073	69,073	17,886	86,959		86,959	1
2	00200	Cap Rel Costs-Mvble Equip		252,392	252,392	5,798	258,190	-77,665	180,525	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department				46,711	46,711		46,711	4
5	00500	Administrative & General	758,348	1,533,218	2,291,566	-47,391	2,244,175	-269,913	1,974,262	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	156,408	207,166	363,574	-2,986	360,588		360,588	7
8	00800	Laundry & Linen Service	42,269	10,438	52,707		52,707		52,707	8
9	00900	Housekeeping	88,368	40,072	128,440		128,440		128,440	9
10	01000	Dietary	78,141	109,337	187,478	-35,752	151,726		151,726	10
11	01100	Cafeteria				34,585	34,585	-2,613	31,972	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration				99,055	99,055		99,055	13
14	01400	Central Services & Supply	32,326	9,902	42,228	-33,017	9,211		9,211	14
15	01500	Pharmacy	72,359	204,572	276,931	-65,553	211,378		211,378	15
16	01600	Medical Records & Library	222,741	262,112	484,853		484,853	-3,536	481,317	16
17	01700	Social Service	31,891	5,287	37,178		37,178		37,178	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,174,878	416,212	1,591,090	-266,928	1,324,162	-146,578	1,177,584	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic	356,037	350,918	706,955	-3,758	703,197		703,197	54
60	06000	Laboratory	388,974	686,600	1,075,574	46	1,075,620	-123,079	952,541	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	100,834	96,370	197,204	-48,553	148,651		148,651	65
66	06600	Physical Therapy	105,613	93,695	199,308	-50	199,258		199,258	66
69	06900	Electrocardiology	10,775	1,018	11,793	15,728	27,521		27,521	69
71	07100	Medical Supplies Charged to Patients				138,832	138,832		138,832	71
73	07300	Drugs Charged to Patients				274,105	274,105		274,105	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	1,487,991	369,920	1,857,911	8,316	1,866,227		1,866,227	88
90	09000	Clinic	127,671	35,579	163,250	9,419	172,669		172,669	90
91	09100	Emergency	994,611	183,145	1,177,756	-103,885	1,073,871	-283,447	790,424	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		42,608	42,608	-42,608				113
118		SUBTOTALS (sum of lines 1-117)	6,230,235	4,979,634	11,209,869		11,209,869	-906,831	10,303,038	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
190.01	19001	VENDING MACHINE								190.01
200		TOTAL (sum of lines 118-199)	6,230,235	4,979,634	11,209,869		11,209,869	-906,831	10,303,038	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS SUPPLY COST FROM CS	A	Medical Supplies Charged to P	71	24,244	8,773	1
500	Total reclassifications				24,244	8,773	500
	Code Letter - A						
1	TO RECLASS DON COST	B	Nursing Administration	13	84,639	14,416	1
500	Total reclassifications				84,639	14,416	500
	Code Letter - B						
1	TO RECLASS SUPPLY COST	D	Medical Supplies Charged to P	71		105,815	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications					105,815	500
	Code Letter - D						
1	TO RECLASS INSURANCE EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		6,450	1
2			Cap Rel Costs-Mvble Equip	2		8,550	2
3			Employee Benefits Department	4		46,711	3
500	Total reclassifications					61,711	500
	Code Letter - E						
1	TO RECLASS INTEREST	F	Cap Rel Costs-Bldg & Fixt	1		21,822	1
2			Administrative & General	5		14,320	2
3			Radiology-Diagnostic	54		4,416	3
4			Rural Health Clinic	88		1,611	4
5			Laboratory	60		439	5
500	Total reclassifications					42,608	500
	Code Letter - F						
1	TO RECLASS CAFE COST	G	Cafeteria	11	14,065	20,520	1
500	Total reclassifications				14,065	20,520	500
	Code Letter - G						
1	TO RECLASS CARDIAC MONITORING COST	H	Electrocardiology	69	13,152	2,576	1
2							2
500	Total reclassifications				13,152	2,576	500
	Code Letter - H						
1	TO RECLASS DRUG COST	I	Drugs Charged to Patients	73		274,105	1
2							2
3							3
4							4
5							5
500	Total reclassifications					274,105	500
	Code Letter - I						
1	TO RECLASS CLINIC DEPRECIATION	J	Rural Health Clinic	88		6,705	1
2			Clinic	90		6,433	2
500	Total reclassifications					13,138	500
	Code Letter - J						
1	TO RECLASS CLINIC COST	K	Clinic	90	2,446	540	1
500	Total reclassifications				2,446	540	500
	Code Letter - K						
	GRAND TOTAL (Increases)				138,546	544,202	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	TO RECLASS SUPPLY COST FROM CS	A	Central Services & Supply	14	24,244	8,773		1
500	Total reclassifications				24,244	8,773		500
	Code letter - A							
1	TO RECLASS DON COST	B	Adults & Pediatrics	30	84,639	14,416		1
500	Total reclassifications				84,639	14,416		500
	Code letter - B							
1	TO RECLASS SUPPLY COST	D	Adults & Pediatrics	30		30,083		1
2			Emergency	91		18,583		2
3			Radiology-Diagnostic	54		8,174		3
4			Laboratory	60		393		4
5			Respiratory Therapy	65		48,553		5
6			Physical Therapy	66		29		6
500	Total reclassifications					105,815		500
	Code letter - D							
1	TO RECLASS INSURANCE EXPENSE	E					12	1
2							12	2
3			Administrative & General	5		61,711		3
500	Total reclassifications					61,711		500
	Code letter - E							
1	TO RECLASS INTEREST	F					11	1
2								2
3								3
4			Interest Expense	113		42,608		4
5								5
500	Total reclassifications					42,608		500
	Code letter - F							
1	TO RECLASS CAFE COST	G	Dietary	10	14,065	20,520		1
500	Total reclassifications				14,065	20,520		500
	Code letter - G							
1	TO RECLASS CARDIAC MONITORING COST	H						1
2			Adults & Pediatrics	30	13,152	2,576		2
500	Total reclassifications				13,152	2,576		500
	Code letter - H							
1	TO RECLASS DRUG COST	I	Adults & Pediatrics	30		122,062		1
2			Emergency	91		85,302		2
3			Pharmacy	15		65,553		3
4			Physical Therapy	66		21		4
5			Dietary	10		1,167		5
500	Total reclassifications					274,105		500
	Code letter - I							
1	TO RECLASS CLINIC DEPRECIATION	J	Cap Rel Costs-Bldg & Fixt	1		10,386	9	1
2			Cap Rel Costs-Mvble Equip	2		2,752	9	2
500	Total reclassifications					13,138		500
	Code letter - J							
1	TO RECLASS CLINIC COST	K	Operation of Plant	7	2,446	540		1
500	Total reclassifications				2,446	540		500
	Code letter - K							
	GRAND TOTAL (Decreases)				138,546	544,202		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	17,000					17,000		1
2	Land Improvements	148,424					148,424		2
3	Buildings and Fixtures	1,796,754					1,796,754		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	2,787,186	16,490		16,490		2,803,676		6
7	HIT-designated Assets	898,160					898,160		7
8	Subtotal (sum of lines 1-7)	5,647,524	16,490		16,490		5,664,014		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	5,647,524	16,490		16,490		5,664,014		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	69,073						69,073	1
2	Cap Rel Costs-Mvble Equip	252,392						252,392	2
3	Total (sum of lines 1-2)	321,465						321,465	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	1,962,178		1,962,178	0.346429					1
2	Cap Rel Costs-Mvble Equ	3,701,836		3,701,836	0.653571					2
3	Total (sum of lines 1-2)	5,664,014		5,664,014	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	58,687		21,822	6,450			86,959	1
2	Cap Rel Costs-Mvble Equip	171,975			8,550			180,525	2
3	Total (sum of lines 1-2)	230,662		21,822	15,000			267,484	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)	B	-64,763	Administrative & General	5		5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-2,824	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-553,104				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-2,613	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	A	-3,536	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-77,665	Cap Rel Costs-Mvble Equip	2	9	32
33	VERIZON RENTAL	B	-6,600	Administrative & General	5		33
34							34
35							35
36							36
37							37
38							38
39							39
40	LATE FEES	A	9,182	Administrative & General	5		40
41							41
42	PROVIDER TAX	A	-201,932	Administrative & General	5		42
43	LOBBING PORTION OF DUES	A	-2,976	Administrative & General	5		43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-906,831				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5	Administrative & Gen MED STAFF DIREC	31,886		31,886					1
2	30	Adults & Pediatrics AGGREGATE	146,578	146,578						2
3	60	Laboratory AGGREGATE	130,279	123,079	7,200					3
4										4
5	91	Emergency AGGREGATE	810,774	283,447	527,327					5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,119,517	553,104	566,413					200

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen MED STAFF DIREC								1
2	30	Adults & Pediatrics AGGREGATE							146,578	2
3	60	Laboratory AGGREGATE							123,079	3
4										4
5	91	Emergency AGGREGATE							283,447	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							553,104	200

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.00	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		729.87				9
10	AHSEA (see instructions)		74.48				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.24	37.24				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	54,361	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	54,361	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	54,361	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	74.48	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	58,094	22
23	Total salary equivalency (see instructions)	58,094	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	58,094	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	58,094	63
64	Total cost of outside supplier services (from provider records)	52,342	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.00	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		404.14				9
10	AHSEA (see instructions)		78.58				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	39.29	39.29				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	31,757	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	31,757	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	31,757	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	78.58	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	61,292	22
23	Total salary equivalency (see instructions)	61,292	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	61,292	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	61,292	63
64	Total cost of outside supplier services (from provider records)	24,248	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					39	1
2	Line 1 multiplied by 15 hours per week					585	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.00	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		26.11				9
10	AHSEA (see instructions)		71.57				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.79	35.79				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	1,869	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	1,869	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	1,869	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	71.58	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	41,874	22
23	Total salary equivalency (see instructions)	41,874	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	41,874	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	41,874	63
64	Total cost of outside supplier services (from provider records)	1,566	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	86,959	86,959					1
2	Cap Rel Costs-Mvble Equip	180,525		180,525				2
4	Employee Benefits Department	46,711			46,711			4
5	Administrative & General	1,974,262	11,878	24,658	5,685	2,016,483	2,016,483	5
6	Maintenance & Repairs							6
7	Operation of Plant	360,588	6,900	14,325	1,154	382,967	93,193	7
8	Laundry & Linen Service	52,707	3,111	6,459	317	62,594	15,232	8
9	Housekeeping	128,440			662	129,102	31,416	9
10	Dietary	151,726	3,063	6,358	381	161,528	39,307	10
11	Cafeteria	31,972	1,296	2,691	205	36,164	8,800	11
12	Maintenance of Personnel							12
13	Nursing Administration	99,055	6,833	14,185	635	120,708	29,374	13
14	Central Services & Supply	9,211			61	9,272	2,256	14
15	Pharmacy	211,378	1,361	2,826	542	216,107	52,588	15
16	Medical Records & Library	481,317	3,695	7,670	1,670	494,352	120,298	16
17	Social Service	37,178	608	1,261	239	39,286	9,560	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,177,584	14,808	30,741	8,075	1,231,208	299,607	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	703,197	4,545	9,436	2,669	719,847	175,170	54
60	Laboratory	952,541	2,053	4,261	2,916	961,771	234,041	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	148,651	1,361	2,826	756	153,594	37,376	65
66	Physical Therapy	199,258	2,647	5,494	792	208,191	50,662	66
69	Electrocardiology	27,521			179	27,700	6,741	69
71	Medical Supplies Charged to Patients	138,832	1,304	2,708	182	143,026	34,805	71
73	Drugs Charged to Patients	274,105				274,105	66,702	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,866,227	15,154	31,462	11,159	1,924,002	468,193	88
90	Clinic	172,669	2,204	4,575	975	180,423	43,905	90
91	Emergency	790,424	3,541	7,350	7,457	808,772	196,810	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	10,303,038	86,362	179,286	46,711	10,301,202	2,016,036	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		327	678		1,005	245	190
190.01	VENDING MACHINE		270	561		831	202	190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,303,038	86,959	180,525	46,711	10,303,038	2,016,483	202

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COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	476,160						7
8	Laundry & Linen Service	27,938	105,764					8
9	Housekeeping		4,521	165,039				9
10	Dietary	27,502	3,562	10,126	242,025			10
11	Cafeteria	11,641		4,286	44,592	105,483		11
12	Maintenance of Personnel							12
13	Nursing Administration	61,357		22,592		1,855	235,886	13
14	Central Services & Supply					163	7,616	14
15	Pharmacy	12,223		4,501		2,126		15
16	Medical Records & Library	33,176		12,216		6,487		16
17	Social Service	5,457		2,009		987		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	132,973	65,854	48,961	184,630	31,448	228,270	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	40,816	9,231	15,029		8,689		54
60	Laboratory	18,431		6,787		10,099		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	12,223		4,501		3,428		65
66	Physical Therapy	23,767	6,529	8,751		2,267		66
69	Electrocardiology					716		69
71	Medical Supplies Charged to Patients	11,714		4,313		499		71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					25,481		88
90	Clinic	19,789		7,287	12,803	2,549		90
91	Emergency	31,794	16,067	11,707		8,689		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	470,801	105,764	163,066	242,025	105,483	235,886	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,934		1,080				190
190.01	VENDING MACHINE	2,425		893				190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	476,160	105,764	165,039	242,025	105,483	235,886	202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	19,307						14
15	Pharmacy	1,388	288,933					15
16	Medical Records & Library	155		666,684				16
17	Social Service	5			57,304			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,194		505,361	57,304	2,786,810		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	130		161,323		1,130,235		54
60	Laboratory	11,502				1,242,631		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	208				211,330		65
66	Physical Therapy	60				300,227		66
69	Electrocardiology	37				35,194		69
71	Medical Supplies Charged to Patients	3,157				197,514		71
73	Drugs Charged to Patients		257,229			598,036		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	842	31,704			2,450,222		88
90	Clinic	89				266,845		90
91	Emergency	540				1,074,379		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	19,307	288,933	666,684	57,304	10,293,423		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					5,264		190
190.01	VENDING MACHINE					4,351		190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	19,307	288,933	666,684	57,304	10,303,038		202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,786,810						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,130,235						54
60	Laboratory	1,242,631						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	211,330						65
66	Physical Therapy	300,227						66
69	Electrocardiology	35,194						69
71	Medical Supplies Charged to Patients	197,514						71
73	Drugs Charged to Patients	598,036						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,450,222						88
90	Clinic	266,845						90
91	Emergency	1,074,379						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	10,293,423						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,264						190
190.01	VENDING MACHINE	4,351						190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,303,038						202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		11,878	24,658	36,536	36,536		5
6	Maintenance & Repairs							6
7	Operation of Plant		6,900	14,325	21,225	1,689	22,914	7
8	Laundry & Linen Service		3,111	6,459	9,570	276	1,344	8
9	Housekeeping					569		9
10	Dietary		3,063	6,358	9,421	712	1,323	10
11	Cafeteria		1,296	2,691	3,987	159	560	11
12	Maintenance of Personnel							12
13	Nursing Administration		6,833	14,185	21,018	532	2,953	13
14	Central Services & Supply					41		14
15	Pharmacy		1,361	2,826	4,187	953	588	15
16	Medical Records & Library		3,695	7,670	11,365	2,180	1,597	16
17	Social Service		608	1,261	1,869	173	263	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		14,808	30,741	45,549	5,428	6,399	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		4,545	9,436	13,981	3,174	1,964	54
60	Laboratory		2,053	4,261	6,314	4,240	887	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,361	2,826	4,187	677	588	65
66	Physical Therapy		2,647	5,494	8,141	918	1,144	66
69	Electrocardiology					122		69
71	Medical Supplies Charged to Patients		1,304	2,708	4,012	631	564	71
73	Drugs Charged to Patients					1,209		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		15,154	31,462	46,616	8,484		88
90	Clinic		2,204	4,575	6,779	795	952	90
91	Emergency		3,541	7,350	10,891	3,566	1,530	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		86,362	179,286	265,648	36,528	22,656	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		327	678	1,005	4	141	190
190.01	VENDING MACHINE		270	561	831	4	117	190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		86,959	180,525	267,484	36,536	22,914	202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	11,190						8
9	Housekeeping	478	1,047					9
10	Dietary	377	64	11,897				10
11	Cafeteria		27	2,192	6,925			11
12	Maintenance of Personnel							12
13	Nursing Administration		143		122	24,768		13
14	Central Services & Supply				11	800	852	14
15	Pharmacy		29		140		61	15
16	Medical Records & Library		77		426		7	16
17	Social Service		13		65			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,967	311	9,076	2,064	23,968	53	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	977	95		570		6	54
60	Laboratory		43		663		507	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		29		225		9	65
66	Physical Therapy	691	56		149		3	66
69	Electrocardiology				47		2	69
71	Medical Supplies Charged to Patients		27		33		139	71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				1,673		37	88
90	Clinic		46	629	167		4	90
91	Emergency	1,700	74		570		24	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	11,190	1,034	11,897	6,925	24,768	852	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		7					190
190.01	VENDING MACHINE		6					190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	11,190	1,047	11,897	6,925	24,768	852	202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	17	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	5,958						15
16	Medical Records & Library		15,652					16
17	Social Service			2,383				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		11,865	2,383	114,063		114,063	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		3,787		24,554		24,554	54
60	Laboratory				12,654		12,654	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy				5,715		5,715	65
66	Physical Therapy				11,102		11,102	66
69	Electrocardiology				171		171	69
71	Medical Supplies Charged to Patients				5,406		5,406	71
73	Drugs Charged to Patients	5,304			6,513		6,513	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	654			57,464		57,464	88
90	Clinic				9,372		9,372	90
91	Emergency				18,355		18,355	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	5,958	15,652	2,383	265,369		265,369	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				1,157		1,157	190
190.01	VENDING MACHINE				958		958	190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,958	15,652	2,383	267,484		267,484	202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	32,199						1
2	Cap Rel Costs-Mvble Equip		32,199					2
4	Employee Benefits Department			6,230,237				4
5	Administrative & General	4,398	4,398	758,350	-2,016,483	8,286,555		5
6	Maintenance & Repairs							6
7	Operation of Plant	2,555	2,555	153,962		382,967	19,634	7
8	Laundry & Linen Service	1,152	1,152	42,269		62,594	1,152	8
9	Housekeeping			88,368		129,102		9
10	Dietary	1,134	1,134	50,792		161,528	1,134	10
11	Cafeteria	480	480	27,349		36,164	480	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,530	2,530	84,639		120,708	2,530	13
14	Central Services & Supply			8,082		9,272		14
15	Pharmacy	504	504	72,359		216,107	504	15
16	Medical Records & Library	1,368	1,368	222,741		494,352	1,368	16
17	Social Service	225	225	31,891		39,286	225	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,483	5,483	1,077,087		1,231,208	5,483	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,683	1,683	356,037		719,847	1,683	54
60	Laboratory	760	760	388,974		961,771	760	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	504	504	100,834		153,594	504	65
66	Physical Therapy	980	980	105,613		208,191	980	66
69	Electrocardiology			23,927		27,700		69
71	Medical Supplies Charged to Patients	483	483	24,244		143,026	483	71
73	Drugs Charged to Patients					274,105		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	5,612	5,612	1,487,991		1,924,002		88
90	Clinic	816	816	130,117		180,423	816	90
91	Emergency	1,311	1,311	994,611		808,772	1,311	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	31,978	31,978	6,230,237	-2,016,483	8,284,719	19,413	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	121	121			1,005	121	190
190.01	VENDING MACHINE	100	100			831	100	190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	86,959	180,525	46,711		2,016,483	476,160	202
203	Unit Cost Multiplier (Wkst. B, Part I)	2.700674	5.606541	0.007497		0.243344	24.251808	203
204	Cost to be allocated (Per Wkst. B, Part II)					36,536	22,914	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.004409	1.167057	205

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERV ED	CAFETERIA FTE'S SERV ED	NURSING ADMINIS-TRATION DIRECT NRS ING HRS	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	69,719						8
9	Housekeeping	2,980	18,482					9
10	Dietary	2,348	1,134	15,501				10
11	Cafeteria		480	2,856	9,724			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,530		171	67,361		13
14	Central Services & Supply				15	2,175	647,047	14
15	Pharmacy		504		196		46,509	15
16	Medical Records & Library		1,368		598		5,183	16
17	Social Service		225		91		167	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	43,411	5,483	11,825	2,899	65,186	40,027	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	6,085	1,683		801		4,369	54
60	Laboratory		760		931		385,466	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		504		316		6,966	65
66	Physical Therapy	4,304	980		209		2,015	66
69	Electrocardiology				66		1,238	69
71	Medical Supplies Charged to Patients		483		46		105,814	71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				2,349		28,232	88
90	Clinic		816	820	235		2,969	90
91	Emergency	10,591	1,311		801		18,092	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	69,719	18,261	15,501	9,724	67,361	647,047	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		121					190
190.01	VENDING MACHINE		100					190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	105,764	165,039	242,025	105,483	235,886	19,307	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.517004	8.929715	15.613509	10.847696	3.501819	0.029839	203
204	Cost to be allocated (Per Wkst. B, Part II)	11,190	1,047	11,897	6,925	24,768	852	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.160501	0.056650	0.767499	0.712155	0.367691	0.001317	205

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE PATIENT DAYS				
		15	16	17				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	307,889						15
16	Medical Records & Library		38,020					16
17	Social Service			1,683				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		28,820	1,683				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		9,200					54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients	274,105						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	33,784						88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	307,889	38,020	1,683				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
190.01	VENDING MACHINE							190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	288,933	666,684	57,304				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.938432	17.535087	34.048723				203
204	Cost to be allocated (Per Wkst. B, Part II)	5,958	15,652	2,383				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.019351	0.411678	1.415924				205

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,786,810		2,786,810			30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	1,130,235		1,130,235			54
60	Laboratory	1,242,631		1,242,631			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	211,330		211,330			65
66	Physical Therapy	300,227		300,227			66
69	Electrocardiology	35,194		35,194			69
71	Medical Supplies Charged to Patients	197,514		197,514			71
73	Drugs Charged to Patients	598,036		598,036			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	2,450,222		2,450,222			88
90	Clinic	266,845		266,845			90
91	Emergency	1,074,379		1,074,379			91
92	Observation Beds (Non-Distinct Part)	354,630		354,630			92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	10,648,053		10,648,053			200
201	Less Observation Beds	354,630		354,630			201
202	Total (line 200 minus line 201)	10,293,423		10,293,423			202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	1,579,211		1,579,211				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	570,074	4,360,329	4,930,403	0.229238			54
60	Laboratory	634,231	3,163,782	3,798,013	0.327179			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	147,276	320,284	467,560	0.451985			65
66	Physical Therapy	377,224	675,008	1,052,232	0.285324			66
69	Electrocardiology	40,484	185,626	226,110	0.155650			69
71	Medical Supplies Charged to Patients	556,118	142,594	698,712	0.282683			71
73	Drugs Charged to Patients	1,184,996	860,567	2,045,563	0.292358			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		1,593,572	1,593,572				88
90	Clinic		386,481	386,481	0.690448			90
91	Emergency	29,739	1,710,538	1,740,277	0.617361			91
92	Observation Beds (Non-Distinct Part)		324,128	324,128	1.094105			92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	5,119,353	13,722,909	18,842,262				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	5,119,353	13,722,909	18,842,262				202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1328** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P [XX] Hospital [ ] SUB (Other) [ ] Swing Bed SNF
[XX] Title XVIII, Part B [ ] IPF [ ] SNF [ ] Swing Bed NF
[ ] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.229238		1,462,229			335,198		54
60	Laboratory	0.327179		1,601,588			524,006		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.451985		31,186			14,096		65
66	Physical Therapy	0.285324		239,346			68,291		66
69	Electrocardiology	0.155650		165,511			25,762		69
71	Medical Supplies Charged to Pat	0.282683		136,678			38,637		71
73	Drugs Charged to Patients	0.292358		193,425			56,549		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.690448		309,761			213,874		90
91	Emergency	0.617361		553,545			341,737		91
92	Observation Beds (Non-Distinct	1.094105		127,602			139,610		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			4,820,871			1,757,760		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			4,820,871			1,757,760		202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z328** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[XX] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.229238							54
60	Laboratory	0.327179							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.451985							65
66	Physical Therapy	0.285324							66
69	Electrocardiology	0.155650							69
71	Medical Supplies Charged to Pat	0.282683							71
73	Drugs Charged to Patients	0.292358							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.690448							90
91	Emergency	0.617361							91
92	Observation Beds (Non-Distinct	1.094105							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	114,063	45,439	68,624	2,137	32.11	215	6,904	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	114,063		68,624	2,137		215	6,904	200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1328** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	24,554	4,930,403	0.004980			54
60	Laboratory	12,654	3,798,013	0.003332			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	5,715	467,560	0.012223			65
66	Physical Therapy	11,102	1,052,232	0.010551			66
69	Electrocardiology	171	226,110	0.000756			69
71	Medical Supplies Charged to Pat	5,406	698,712	0.007737			71
73	Drugs Charged to Patients	6,513	2,045,563	0.003184			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	57,464	1,593,572	0.036060			88
90	Clinic	9,372	386,481	0.024250			90
91	Emergency	18,355	1,740,277	0.010547			91
92	Observation Beds (Non-Distinct	14,515	324,128	0.044782			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	165,821	17,263,051				200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,137		215		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	2,137		215		200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1328** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1328** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	4,930,403							54
60	Laboratory	3,798,013							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	467,560							65
66	Physical Therapy	1,052,232							66
69	Electrocardiology	226,110							69
71	Medical Supplies Charged to Pat	698,712							71
73	Drugs Charged to Patients	2,045,563							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,593,572							88
90	Clinic	386,481							90
91	Emergency	1,740,277							91
92	Observation Beds (Non-Distinct	324,128							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	17,263,051							200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1328** **WORKSHEET D PART V**

Check Applicable Boxes:

[ ] Title V - O/P	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.229238							54
60	Laboratory	0.327179							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.451985							65
66	Physical Therapy	0.285324							66
69	Electrocardiology	0.155650							69
71	Medical Supplies Charged to Pat	0.282683							71
73	Drugs Charged to Patients	0.292358							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.690448							90
91	Emergency	0.617361							91
92	Observation Beds (Non-Distinct	1.094105							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1328** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,552	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,137	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,685	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,061	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	354	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,279	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	982	10
11	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)	328	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,786,810	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	1,110,167	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,676,643	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,676,643	37

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1328** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	784.57	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,003,465	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,003,465	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	484,660	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,488,125	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	770,448	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	257,339	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	1,027,787	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1328** **WORKSHEET D-1**
PARTS III & IV

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**	
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					452	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					784.58	88
89	Observation bed cost (line 87 x line 88) (see instructions)					354,630	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	114,063	2,786,810	0.040930	354,630	14,515	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1328** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,552	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,137	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,685	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,061	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	354	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	215	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	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)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,786,810	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	1,110,167	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,676,643	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,676,643	37

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1328** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**		**[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					784.57	38
39	Program general inpatient routine service cost (line 9 x line 38)					168,683	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					168,683	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	168,683	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	6,904	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	6,904	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1328** **WORKSHEET D-1**
PARTS III & IV

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**	
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					452	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1328** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,116,360		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.229238	289,565	66,379	54
60	Laboratory	0.327179	370,819	121,324	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.451985	68,954	31,166	65
66	Physical Therapy	0.285324	36,807	10,502	66
69	Electrocardiology	0.155650	26,444	4,116	69
71	Medical Supplies Charged to Patients	0.282683	260,600	73,667	71
73	Drugs Charged to Patients	0.292358	573,256	167,596	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.690448			90
91	Emergency	0.617361	16,052	9,910	91
92	Observation Beds (Non-Distinct Part)	1.094105			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,642,497	484,660	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,642,497		202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z328** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other] [XX] Swing Bed SNF [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/IID [XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.229238	41,029	9,405	54
60	Laboratory	0.327179	115,006	37,628	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.451985	51,750	23,390	65
66	Physical Therapy	0.285324	308,951	88,151	66
69	Electrocardiology	0.155650	947	147	69
71	Medical Supplies Charged to Patients	0.282683	205,804	58,177	71
73	Drugs Charged to Patients	0.292358	382,072	111,702	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.690448			90
91	Emergency	0.617361	7,210	4,451	91
92	Observation Beds (Non-Distinct Part)	1.094105			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,112,769	333,051	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,112,769		202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1328** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF** **[ ] PPS**
[ ] Title XVIII, Part A **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF** **[ ] TEFRA**
[XX] Title XIX **[ ] IRF** **[ ] NF** **[ ] ICF/IID** **[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.229238			54
60	Laboratory	0.327179			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.451985			65
66	Physical Therapy	0.285324			66
69	Electrocardiology	0.155650			69
71	Medical Supplies Charged to Patients	0.282683			71
73	Drugs Charged to Patients	0.292358			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.690448			90
91	Emergency	0.617361			91
92	Observation Beds (Non-Distinct Part)	1.094105			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1328** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	1,757,760			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	1,757,760			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	1,775,338			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	14,900			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	669,457			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,090,981			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	1,090,981			30
31	Primary payer payments	118			31
32	Subtotal (line 30 minus line 31)	1,090,863			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	196,103			34
35	Adjusted reimbursable bad debts (see instructions)	127,467			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	172,245			36
37	Subtotal (see instructions)	1,218,330			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	1,218,330			40
40.01	Sequestration adjustment (see instructions)	24,367			40.01
41	Interim payments	1,598,610			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-404,647			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1328** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,759,774		1,413,399	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	03/07/2017	3,807	10/20/2016	98,435	3.01
	amount based on subsequent revision of the interim		.02			03/07/2017	86,776	3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	10/20/2016	7,385			3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-3,578		185,211	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,756,196		1,598,610	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-525,626		-404,647	6.02
7	Total Medicare program liability (see instructions)				1,230,570		1,193,963	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z328** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [XX] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,007,830			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	10/20/2016	145,721			3.51
		Provider	.52	03/07/2017	120,347			3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-266,068			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,741,762			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-474,579			6.02
7	Total Medicare program liability (see instructions)				1,267,183			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	471	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,279	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	95	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,685	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	18,842,262	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	411,358	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1	7
8	Calculation of the HIT incentive payment (see instructions)	1	8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	1	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z328** **WORKSHEET E-2**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX** **[XX] Swing Bed - SNF** **[ ] Swing Bed - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	1,038,065		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	336,382		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,310		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,374,447		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,374,447		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,374,447		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	90,339		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,284,108		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)	13,747		17
17.01	Adjusted reimbursable bad debts (see instructions)	8,936		17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	1,293,044		19
19.01	Sequestration adjustment (see instructions)	25,861		19.01
20	Interim payments	1,741,762		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-474,579		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3**
PART V

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	Inpatient services	1,488,125	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,488,125	4
5	Primary payer payments	4,385	5
6	Total cost (see instructions)	1,498,621	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	1,498,621	19
20	Deductibles (exclude professional component)	274,018	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,224,603	22
23	Coinsurance	1,288	23
24	Subtotal (line 22 minus line 23)	1,223,315	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	49,799	25
26	Adjusted reimbursable bad debts (see instructions)	32,369	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	49,799	27
28	Subtotal (sum of lines 24 and 26)	1,255,684	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,255,684	30
30.01	Sequestration adjustment (see instructions)	25,114	30.01
31	Interim payments	1,756,196	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	-525,626	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1328** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: [ ] Title V [XX] Title XIX [XX] Hospital [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [XX] Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	168,683		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	168,683		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	168,683		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	168,683		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	168,683		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	168,683		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	168,683		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	168,683		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	168,683		40
41	Interim payments	249,234		41
42	Balance due provider/program (line 40 minus line 41)	-80,551		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	783,554				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	3,052,907				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-964,600				6
7	Inventory	212,973				7
8	Prepaid expenses	12,639				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	3,097,473				11
	FIXED ASSETS					
12	Land	17,000				12
13	Land improvements	148,425				13
14	Accumulated depreciation	-130,237				14
15	Buildings	1,796,754				15
16	Accumulated depreciation	-1,295,813				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	3,715,739				23
24	Accumulated depreciation	-3,038,920				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	1,212,948				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)					35
36	Total assets (sum of lines 11, 30 and 35)	4,310,421				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	548,462				37
38	Salaries, wages and fees payable	624,347				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	195,519				40
41	Deferred income	160,124				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,414,462				44
45	Total current liabilities (sum of lines 37 thru 44)	2,942,914				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	347,383				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	347,383				50
51	Total liabilities (sum of lines 45 and 50)	3,290,297				51
	CAPITAL ACCOUNTS					
52	General fund balance	1,020,124				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	1,020,124				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	4,310,421				60

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		701,258			1
2	Net income (loss) (from Worksheet G-3, line 29)		318,866			2
3	Total (sum of line 1 and line 2)		1,020,124			3
4	Additions (credit adjustments) (specify)					4
5	PRIOR YEAR ADJUSTMENTS					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		1,020,124			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,020,124			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	PRIOR YEAR ADJUSTMENTS					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	2,058,692		2,058,692	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	971,112		971,112	5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	3,029,804		3,029,804	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	3,029,804		3,029,804	17
18	Ancillary services	4,315,337	11,006,383	15,321,720	18
19	Outpatient services	524,500	1,483,019	2,007,519	19
20	Rural Health Clinic (RHC)		1,593,572	1,593,572	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	7,869,641	14,082,974	21,952,615	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		11,209,869	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		11,209,869	43

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	21,952,615	1
2	Less contractual allowances and discounts on patients' accounts	10,659,190	2
3	Net patient revenues (line 1 minus line 2)	11,293,425	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	11,209,869	4
5	Net income from service to patients (line 3 minus line 4)	83,556	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	3,834	6
7	Income from investments	11,969	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses	64,761	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	3,136	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	3,175	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (MISCELLANOUS)	6,600	24
24.01	Other (GRANTS)	64,170	24.01
24.02	Other (DEFERRED REVENUE)	77,665	24.02
24.03	Other (SITE FEES)		24.03
24.04	Other (EHR INCENTIVE)		24.04
25	Total other income (sum of lines 6-24)	235,310	25
26	Total (line 5 plus line 25)	318,866	26
29	Net income (or loss) for the period (line 26 minus line 28)	318,866	29

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
190.01	VENDING MACHINE							190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-3479

WORKSHEET M-1

Check applicable box: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	749,803	57,922	807,725		807,725		807,725	1
2	Physician Assistant								2
3	Nurse Practitioner	192,786	32,763	225,549		225,549		225,549	3
4	Visiting Nurse								4
5	Other Nurse	261,480	41,445	302,925		302,925		302,925	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	279,272	98,592	377,864		377,864		377,864	9
10	Subtotal (sum of lines 1 through 9)	1,483,341	230,722	1,714,063		1,714,063		1,714,063	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement	4,650		4,650		4,650		4,650	11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)	4,650		4,650		4,650		4,650	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		1,674	1,674		1,674		1,674	15
16	Transportation (Health Care Staff)		1,676	1,676		1,676		1,676	16
17	Deperciation-Medical Equipment		2,752	2,752		2,752		2,752	17
18	Professional Liability Insurance								18
19	Other Health Care Costs		77,561	77,561		77,561		77,561	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		83,663	83,663		83,663		83,663	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,487,991	314,385	1,802,376		1,802,376		1,802,376	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		58,614	58,614		58,614		58,614	29
30	Administrative Costs				5,237	5,237		5,237	30
31	Total Facility Overhead (sum of lines 29 and 30)		58,614	58,614	5,237	63,851		63,851	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,487,991	372,999	1,860,990	5,237	1,866,227		1,866,227	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3479** **WORKSHEET M-2**

Check applicable box: **[XX] RHC I** **[ ] FQHC**

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	2.28	9,300	4,200	9,576		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.59	3,956	2,100	3,339		3
4	Subtotal (sum of lines 1 through 3)	3.87	13,256		12,915	13,256	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	3.87	13,256			13,256	8
9	Physician Services Under Agreements		78			78	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,802,376	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,802,376	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	63,851	14
15	Parent provider overhead allocated to facility (see instructions)	583,995	15
16	Total overhead (sum of lines 14 and 15)	647,846	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	647,846	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	647,846	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	2,450,222	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3479** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	2,450,222	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	19,288	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,430,934	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	13,256	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	78	5
6	Total adjusted visits (line 4 plus line 5)	13,334	6
7	Adjusted cost per visit (line 3 divided by line 6)	182.31	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	182.31	182.31	182.31	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		4,966		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		905,351		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		905,351		16
16.01	Total program charges (see instructions)(from contractor's records)		582,275		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,808		16.02
16.03	Total program preventive costs (see instructions)		4,366		16.03
16.04	Total program non-preventive costs (see instructions)		664,023		16.04
16.05	Total program cost (see instructions)		668,389		16.05
17	Primary payer payments		7		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		70,956		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		101,702		19
20	Net Medicare cost excluding vaccines (see instructions)		668,382		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		14,311		21
22	Total reimbursable Program cost (line 20 plus line 21)		682,693		22
23	Allowable bad debts (see instructions)		43,285		23
23.01	Adjusted reimbursable bad debts (see instructions)		28,135		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		43,285		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		710,828		26
26.01	Sequestration adjustment (see instructions)		14,217		26.01
27	Interim payments		502,346		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		194,265		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3479** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,714,063	1,714,063	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000288	0.002443	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	494	4,187	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,851	7,656	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,345	11,843	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,802,376	1,802,376	6
7	Total overhead (from Wkst. M-2, line 16)	647,846	647,846	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001301	0.006571	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	843	4,257	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	3,188	16,100	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	61	518	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	52.26	31.08	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	52	373	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,718	11,593	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		19,288	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		14,311	16

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/22/2017 Run Time: 08:43 Version: 2017.01 (07/27/2017)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3479

WORKSHEET M-5

Check applicable box: [XX] RHC I [ ] FQHC

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				469,842	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01	10/20/2016	16,206	3.01
	amount based on subsequent revision of the interim		.02	03/07/2017	16,298	3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		32,504	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				502,346	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		194,265	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				696,611	

8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.