| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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: 08/13/2018 Time: 13:13<br>2. [ ] Manually submitted cost report<br>3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report<br>4. [ ] Medicare Utilization. Enter 'F' for full or 'L' for low. | | |
| Contractor use only | 5. [ ] Cost Report Status<br>(1) As Submitted<br>(2) Settled without audit<br>(3) Settled with audit<br>(4) Reopened<br>(5) Amended | 6. Date Received: _____<br>7. Contractor No.: _____<br>8. [ ] Initial Report for this Provider CCN<br>9. [ ] Final Report for this Provider CCN | 10. NPR Date: _____<br>11. Contractor's Vendor Code: ___<br>12. [ ] If line 5, column 1 is 4:<br>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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 04/01/2017 and ending 03/31/2018, 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.

[_] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this cerficication statement to be the legally binding equivalent of my original signature.

(Signed) _____
Chief Financial 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 | | -84,388 | -127,353 | | 46,094 | 1 |
| 2 | SUBPROVIDER - IPF | | | | | | 2 |
| 3 | SUBPROVIDER - IRF | | | | | | 3 |
| 4 | SUBPROVIDER (OTHER) | | | | | | 4 |
| 5 | SWING BED - SNF | | -90,697 | | | | 5 |
| 6 | SWING BED - NF | | | | | | 6 |
| 7 | SKILLED NURSING FACILITY | | | | | | 7 |
| 8 | NURSING FACILITY | | | | | | 8 |
| 9 | HOME HEALTH AGENCY | | | | | | 9 |
| 10 | HEALTH CLINIC - RHC | | | 42,134 | | | 10 |
| 11 | HEALTH CLINIC - FQHC | | | | | | 11 |
| 12 | OUTPATIENT REHABILITATION PROVIDER | | | | | | 12 |
| 200 | TOTAL | | -175,085 | -85,219 | | 46,094 | 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.

**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 / 2017 | To: 03 / 31 / 2018 | 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)(i) or (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)(i) or (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 |
| | | NAHE 413.85 Y/N<br>1 | Worksheet A Line #<br>2 | Pass-Through Qualification Criteria Code<br>3 | |
| 60 | Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions) | N | | | 60 |
| | | Y/N<br>1 | IME<br>4 | Direct GME<br>5 | |
| 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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 67. (see instructions) | N | | | 63 |

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**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 is yes:<br>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.<br>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.<br>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 is yes:<br>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.<br>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.<br>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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no. | N | | 87 |

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**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 |
| 98 | Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98 |
| 98.01 | Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | Y | N | 98.01 |
| 98.02 | Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | Y | N | 98.02 |
| 98.03 | Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.03 |
| 98.04 | Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.04 |
| 98.05 | Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.05 |
| 98.06 | Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX. | N | N | 98.06 |

| Rural Providers | | 1 | 2 | |
|---|---|---|---|---|
| 105 | Does this hospital qualify as a 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)<br>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 | Y | N | 109 |

| | | 1 | |
|---|---|---|---|
| 110 | Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. | N | 110 |

| | | 1 | 2 | |
|---|---|---|---|---|
| 111 | If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services. | N | | 111 |

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 care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 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 in column 2. | | | | 126 |
| 127 | If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2. | | | | 127 |
| 128 | If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2. | | | | 128 |
| 129 | If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2. | | | | 129 |
| 130 | If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2. | | | | 130 |
| 131 | If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2. | | | | 131 |
| 132 | If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2. | | | | 132 |

| | | | | |
|---|---|---|---|---|
| 133 | If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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 |

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**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 the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

| | | | | | |
|---|---|---|---|---|---|
| 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.<br>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 / 2017 | 03 / 31 / 2018 | 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 |

**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?<br>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 | 06/27/2018 | Y | 06/27/2018 | 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 |

**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. | N | 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. | N | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | 49,224.00 | | 1,344 | 411 | 2,051 | 1 |
| 2 | HMO and other (see instructions) | | | | | | 166 | | | 2 |
| 3 | HMO IPF Subprovider | | | | | | | | | 3 |
| 4 | HMO IRF Subprovider | | | | | | | | | 4 |
| 5 | Hospital Adults & Peds. Swing Bed SNF | | | | | | 1,306 | | 1,623 | 5 |
| 6 | Hospital Adults & Peds. Swing Bed NF | | | | | | | | 15 | 6 |
| 7 | Total Adults & Peds. (exclude observation beds) (see instructions) | | 25 | 9,125 | 49,224.00 | | 2,650 | 411 | 3,689 | 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 | 49,224.00 | | 2,650 | 411 | 3,689 | 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 | | | | | 4,590 | | 12,318 | 26 |
| 27 | Total (sum of lines 14-26) | | 25 | | | | | | | 27 |
| 28 | Observation Bed Days | | | | | | | 242 | 468 | 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 |
| 33.01 | LTCH site neutral days and discharges | | | | | | | | | 33.01 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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) | | | | | 352 | 121 | 545 | 1 |
| 2 | HMO and other (see instructions) | | | | | 39 | | | 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) | | 107.90 | | | 352 | 121 | 545 | 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 | | 22.77 | | | | | | 26 |
| 27 | Total (sum of lines 14-26) | | 130.67 | | | | | | 27 |
| 32.01 | Total ancillary labor & delivery room outpatient days (see instructions) | | | | | | | | 32.01 |
| 33 | LTCH non-covered days | | | | | | | | 33 |
| 33.01 | LTCH site neutral days and discharges | | | | | | | | 33.01 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | |
| 67 | BA2 | | | | 67 |
| 68 | BA1 | | | | 68 |
| 69 | PE2 | | | | 69 |
| 70 | PE1 | | | | 70 |
| 71 | PD2 | | | | 71 |
| 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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.<br>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 |

**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) | 0.512359 | 1 |

Medicaid (see instructions for each line)

| | | | |
|---|---|---|---|
| 2 | Net revenue from Medicaid | 3,179,198 | 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 and/or supplemental payments from Medicaid? | Y | 4 |
| 5 | If line 4 is no, enter DSH and/or supplemental payments from Medicaid | | 5 |
| 6 | Medicaid charges | 5,995,709 | 6 |
| 7 | Medicaid cost (line 1 times line 6) | 3,071,955 | 7 |
| 8 | Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5).<br>If line 7 is less than the sum of lines 2 and 5, then enter zero. | | 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).<br>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).<br>If line 15 is less than line 13, then enter zero. | | 16 |

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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) | | 19 |

Uncompensated care (see instructions for each line)

| | | Uninsured patients | Insured patients | TOTAL (col. 1 + col. 2) | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 20 | Charity care charges and uninsured discounts for the entire facility (see instructions) | 116,307 | 597,990 | 714,297 | 20 |
| 21 | Cost of patients approved for charity care and uninsured discounts (see instructions) | 59,591 | 597,990 | 657,581 | 21 |
| 22 | Payments received from patients for amounts previously written off as charity care | | | | 22 |
| 23 | Cost of charity care (line 21 minus line 22) | 59,591 | 597,990 | 657,581 | 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, charges for patient days beyond the indigent care program's length of stay limit | | 25 |
| 26 | Total bad debt expense for the entire hospital complex (see instructions) | 727,194 | 26 |
| 27 | Medicare reimbursable bad debts for the entire hospital complex (see instructions) | 260,202 | 27 |
| 27.01 | Medicare allowable bad debts for the entire hospital complex (see instructions) | 400,311 | 27.01 |
| 28 | Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) | 326,883 | 28 |
| 29 | Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) | 307,590 | 29 |
| 30 | Cost of uncompensated care (line 23, column 3 plus line 29) | 965,171 | 30 |
| 31 | Total unreimbursed and uncompensated care cost (line 19 plus line 30) | 965,171 | 31 |

**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 | | 80,349 | 80,349 | 18,175 | 98,524 | | 98,524 | 1 |
| 2 | 00200 | Cap Rel Costs-Mvble Equip | | 209,207 | 209,207 | 3,847 | 213,054 | -76,678 | 136,376 | 2 |
| 3 | 00300 | Other Cap Rel Costs | | | | | | | -0- | 3 |
| 4 | 00400 | Employee Benefits Department | | | | 45,074 | 45,074 | | 45,074 | 4 |
| 5 | 00500 | Administrative & General | 793,804 | 1,919,715 | 2,713,519 | -57,873 | 2,655,646 | -318,749 | 2,336,897 | 5 |
| 6 | 00600 | Maintenance & Repairs | | | | | | | | 6 |
| 7 | 00700 | Operation of Plant | 164,787 | 222,122 | 386,909 | -4,961 | 381,948 | | 381,948 | 7 |
| 8 | 00800 | Laundry & Linen Service | 43,794 | 16,973 | 60,767 | | 60,767 | | 60,767 | 8 |
| 9 | 00900 | Housekeeping | 91,558 | 54,091 | 145,649 | | 145,649 | | 145,649 | 9 |
| 10 | 01000 | Dietary | 90,575 | 117,485 | 208,060 | -39,373 | 168,687 | | 168,687 | 10 |
| 11 | 01100 | Cafeteria | | | | 37,712 | 37,712 | -2,929 | 34,783 | 11 |
| 12 | 01200 | Maintenance of Personnel | | | | | | | | 12 |
| 13 | 01300 | Nursing Administration | | | | 111,806 | 111,806 | | 111,806 | 13 |
| 14 | 01400 | Central Services & Supply | 33,208 | 10,274 | 43,482 | -33,699 | 9,783 | | 9,783 | 14 |
| 15 | 01500 | Pharmacy | 73,713 | 209,156 | 282,869 | -70,901 | 211,968 | | 211,968 | 15 |
| 16 | 01600 | Medical Records & Library | 229,041 | 71,533 | 300,574 | | 300,574 | -3,686 | 296,888 | 16 |
| 17 | 01700 | Social Service | 32,536 | 6,864 | 39,400 | | 39,400 | | 39,400 | 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 | 1,109,530 | 639,283 | 1,748,813 | -305,403 | 1,443,410 | -158,893 | 1,284,517 | 30 |
| | | **ANCILLARY SERVICE COST CENTERS** | | | | | | | | |
| 54 | 05400 | Radiology-Diagnostic | 351,436 | 369,567 | 721,003 | -5,280 | 715,723 | | 715,723 | 54 |
| 60 | 06000 | Laboratory | 371,446 | 760,410 | 1,131,856 | -158 | 1,131,698 | | 1,131,698 | 60 |
| 62.30 | 06250 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | 06500 | Respiratory Therapy | 100,676 | 70,858 | 171,534 | -39,857 | 131,677 | | 131,677 | 65 |
| 66 | 06600 | Physical Therapy | 94,578 | 102,718 | 197,296 | -135 | 197,161 | | 197,161 | 66 |
| 69 | 06900 | Electrocardiology | 10,656 | 1,007 | 11,663 | 22,471 | 34,134 | | 34,134 | 69 |
| 71 | 07100 | Medical Supplies Charged to Patients | | | | 129,868 | 129,868 | | 129,868 | 71 |
| 73 | 07300 | Drugs Charged to Patients | | | | 326,060 | 326,060 | | 326,060 | 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 | 1,334,384 | 308,247 | 1,642,631 | 7,662 | 1,650,293 | | 1,650,293 | 88 |
| 90 | 09000 | Clinic | 124,166 | 76,486 | 200,652 | 8,914 | 209,566 | | 209,566 | 90 |
| 91 | 09100 | Emergency | 1,028,252 | 214,322 | 1,242,574 | -131,195 | 1,111,379 | -404,224 | 707,155 | 91 |
| 92 | 09200 | Observation Beds (Non-Distinct Part) | | | | | | | | 92 |
| | | **OTHER REIMBURSABLE COST CENTERS** | | | | | | | | |
| | | **SPECIAL PURPOSE COST CENTERS** | | | | | | | | |
| 113 | 11300 | Interest Expense | | 22,754 | 22,754 | -22,754 | | | | 113 |
| 118 | | SUBTOTALS (sum of lines 1-117) | 6,078,140 | 5,483,421 | 11,561,561 | | 11,561,561 | -965,159 | 10,596,402 | 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) | 6,078,140 | 5,483,421 | 11,561,561 | | 11,561,561 | -965,159 | 10,596,402 | 200 |

**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 | 24,906 | 8,793 | 1 |
| 500 | Total reclassifications | | | | 24,906 | 8,793 | 500 |
| | Code Letter - A | | | | | | |
| | | | | | | | |
| 1 | TO RECLASS DON COST | B | Nursing Administration | 13 | 92,585 | 19,221 | 1 |
| 500 | Total reclassifications | | | | 92,585 | 19,221 | 500 |
| | Code Letter - B | | | | | | |
| | | | | | | | |
| 1 | TO RECLASS SUPPLY COST | D | Medical Supplies Charged to P | 71 | | 96,169 | 1 |
| 2 | | | | | | | 2 |
| 3 | | | | | | | 3 |
| 4 | | | | | | | 4 |
| 5 | | | | | | | 5 |
| 6 | | | | | | | 6 |
| 500 | Total reclassifications | | | | | 96,169 | 500 |
| | Code Letter - D | | | | | | |
| | | | | | | | |
| 1 | TO RECLASS INSURANCE EXPENSE | E | Cap Rel Costs-Bldg & Fixt | 1 | | 7,200 | 1 |
| 2 | | | Cap Rel Costs-Mvble Equip | 2 | | 7,800 | 2 |
| 3 | | | Employee Benefits Department | 4 | | 45,074 | 3 |
| 500 | Total reclassifications | | | | | 60,074 | 500 |
| | Code Letter - E | | | | | | |
| | | | | | | | |
| 1 | TO RECLASS INTEREST | F | Cap Rel Costs-Bldg & Fixt | 1 | | 17,408 | 1 |
| 2 | | | Administrative & General | 5 | | 2,201 | 2 |
| 3 | | | Radiology-Diagnostic | 54 | | 1,701 | 3 |
| 4 | | | Rural Health Clinic | 88 | | 1,229 | 4 |
| 5 | | | Laboratory | 60 | | 215 | 5 |
| 500 | Total reclassifications | | | | | 22,754 | 500 |
| | Code Letter - F | | | | | | |
| | | | | | | | |
| 1 | TO RECLASS CAFE COST | G | Cafeteria | 11 | 16,304 | 21,408 | 1 |
| 500 | Total reclassifications | | | | 16,304 | 21,408 | 500 |
| | Code Letter - G | | | | | | |
| | | | | | | | |
| 1 | TO RECLASS CARDIAC MONITORING COST | H | Electrocardiology | 69 | 18,744 | 3,727 | 1 |
| 500 | Total reclassifications | | | | 18,744 | 3,727 | 500 |
| | Code Letter - H | | | | | | |
| | | | | | | | |
| 1 | TO RECLASS DRUG COST | I | Drugs Charged to Patients | 73 | | 326,060 | 1 |
| 2 | | | | | | | 2 |
| 3 | | | | | | | 3 |
| 4 | | | | | | | 4 |
| 5 | | | | | | | 5 |
| 500 | Total reclassifications | | | | | 326,060 | 500 |
| | Code Letter - I | | | | | | |
| | | | | | | | |
| 1 | TO RECLASS CLINIC DEPRECIATION | J | Rural Health Clinic | 88 | | 6,433 | 1 |
| 2 | | | Clinic | 90 | | 3,953 | 2 |
| 500 | Total reclassifications | | | | | 10,386 | 500 |
| | Code Letter - J | | | | | | |
| | | | | | | | |
| 1 | TO RECLASS CLINIC COST | K | Clinic | 90 | 3,988 | 973 | 1 |
| 500 | Total reclassifications | | | | 3,988 | 973 | 500 |
| | Code Letter - K | | | | | | |
| | | | | | | | |
| | GRAND TOTAL (Increases) | | | | 156,527 | 569,565 | |

(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 | 24,906 | 8,793 | | 1 |
| 500 | Total reclassifications | | | | 24,906 | 8,793 | | 500 |
| | Code letter - A | | | | | | | |
| 1 | TO RECLASS DON COST | B | Adults & Pediatrics | 30 | 92,585 | 19,221 | | 1 |
| 500 | Total reclassifications | | | | 92,585 | 19,221 | | 500 |
| | Code letter - B | | | | | | | |
| 1 | TO RECLASS SUPPLY COST | D | Adults & Pediatrics | 30 | | 29,437 | | 1 |
| 2 | | | Emergency | 91 | | 19,515 | | 2 |
| 3 | | | Radiology-Diagnostic | 54 | | 6,852 | | 3 |
| 4 | | | Laboratory | 60 | | 373 | | 4 |
| 5 | | | Respiratory Therapy | 65 | | 39,857 | | 5 |
| 6 | | | Physical Therapy | 66 | | 135 | | 6 |
| 500 | Total reclassifications | | | | | 96,169 | | 500 |
| | Code letter - D | | | | | | | |
| 1 | TO RECLASS INSURANCE EXPENSE | E | | | | | 12 | 1 |
| 2 | | | | | | | 12 | 2 |
| 3 | | | Administrative & General | 5 | | 60,074 | | 3 |
| 500 | Total reclassifications | | | | | 60,074 | | 500 |
| | Code letter - E | | | | | | | |
| 1 | TO RECLASS INTEREST | F | | | | | 11 | 1 |
| 2 | | | | | | | | 2 |
| 3 | | | | | | | | 3 |
| 4 | | | Interest Expense | 113 | | 22,754 | | 4 |
| 5 | | | | | | | | 5 |
| 500 | Total reclassifications | | | | | 22,754 | | 500 |
| | Code letter - F | | | | | | | |
| 1 | TO RECLASS CAFE COST | G | Dietary | 10 | 16,304 | 21,408 | | 1 |
| 500 | Total reclassifications | | | | 16,304 | 21,408 | | 500 |
| | Code letter - G | | | | | | | |
| 1 | TO RECLASS CARDIAC MONITORING COST | H | Adults & Pediatrics | 30 | 18,744 | 3,727 | | 1 |
| 500 | Total reclassifications | | | | 18,744 | 3,727 | | 500 |
| | Code letter - H | | | | | | | |
| 1 | TO RECLASS DRUG COST | I | Adults & Pediatrics | 30 | | 141,689 | | 1 |
| 2 | | | Emergency | 91 | | 111,680 | | 2 |
| 3 | | | Pharmacy | 15 | | 70,901 | | 3 |
| 4 | | | Radiology-Diagnostic | 54 | | 129 | | 4 |
| 5 | | | Dietary | 10 | | 1,661 | | 5 |
| 500 | Total reclassifications | | | | | 326,060 | | 500 |
| | Code letter - I | | | | | | | |
| 1 | TO RECLASS CLINIC DEPRECIATION | J | Cap Rel Costs-Bldg & Fixt | 1 | | 6,433 | 9 | 1 |
| 2 | | | Cap Rel Costs-Mvble Equip | 2 | | 3,953 | 9 | 2 |
| 500 | Total reclassifications | | | | | 10,386 | | 500 |
| | Code letter - J | | | | | | | |
| 1 | TO RECLASS CLINIC COST | K | Operation of Plant | 7 | 3,988 | 973 | | 1 |
| 500 | Total reclassifications | | | | 3,988 | 973 | | 500 |
| | Code letter - K | | | | | | | |
| | GRAND TOTAL (Decreases) | | | | 156,527 | 569,565 | | |

(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.

**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 | 108,250 | | 108,250 | | 256,674 | | 2 |
| 3 | Buildings and Fixtures | 1,796,754 | | | | | 1,796,754 | | 3 |
| 4 | Building Improvements | | | | | | | | 4 |
| 5 | Fixed Equipment | | | | | | | | 5 |
| 6 | Movable Equipment | 2,803,676 | 38,162 | | 38,162 | 33,019 | 2,808,819 | | 6 |
| 7 | HIT-designated Assets | 898,160 | | | | | 898,160 | | 7 |
| 8 | Subtotal (sum of lines 1-7) | 5,664,014 | 146,412 | | 146,412 | 33,019 | 5,777,407 | | 8 |
| 9 | Reconciling Items | | | | | | | | 9 |
| 10 | Total (line 7 minus line 9) | 5,664,014 | 146,412 | | 146,412 | 33,019 | 5,777,407 | | 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 | 80,349 | | | | | | 80,349 | 1 |
| 2 | Cap Rel Costs-Mvble Equip | 209,207 | | | | | | 209,207 | 2 |
| 3 | Total (sum of lines 1-2) | 289,556 | | | | | | 289,556 | 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 | 2,070,428 | | 2,070,428 | 0.358366 | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equ | 3,706,979 | | 3,706,979 | 0.641634 | | | | | 2 |
| 3 | Total (sum of lines 1-2) | 5,777,407 | | 5,777,407 | 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 | 73,916 | | 17,408 | 7,200 | | | 98,524 | 1 |
| 2 | Cap Rel Costs-Mvble Equip | 128,576 | | | 7,800 | | | 136,376 | 2 |
| 3 | Total (sum of lines 1-2) | 202,492 | | 17,408 | 15,000 | | | 234,900 | 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.)

**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 | -58,696 | Administrative & General | 5 | | 5 |
| 6 | Rental of provider space by suppliers (chapter 8) | | | | | | 6 |
| 7 | Telephone services (pay stations excl) (chapter 21) | A | -3,614 | 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 | -563,117 | | | | 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 | -2,929 | 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 | -3,686 | Medical Records & Library | 16 | | 18 |
| 19 | Nursing and allied health education (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 | -76,678 | Cap Rel Costs-Mvble Equip | 2 | 9 | 32 |
| 33 | VERIZON RENTAL | B | -7,200 | Administrative & General | 5 | | 33 |
| 34 | LOBBYING | A | -26,436 | Administrative & General | 5 | | 34 |
| 35 | | | | | | | 35 |
| 36 | | | | | | | 36 |
| 37 | | | | | | | 37 |
| 38 | | | | | | | 38 |
| 39 | | | | | | | 39 |
| 40 | LATE FEES | A | -4,290 | Administrative & General | 5 | | 40 |
| 41 | | | | | | | 41 |
| 42 | PROVIDER TAX | A | -214,865 | Administrative & General | 5 | | 42 |
| 43 | LOBBING PORTION OF DUES | A | -3,648 | Administrative & General | 5 | | 43 |
| 44 | | | | | | | 44 |
| 45 | | | | | | | 45 |
| 46 | | | | | | | 46 |
| 47 | | | | | | | 47 |
| 48 | | | | | | | 48 |
| 49 | | | | | | | 49 |
| 50 | TOTAL (sum of lines 1 thru 49)<br>(Transfer to worksheet A, column 6, line 200) | | -965,159 | | | | 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.

**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 | 158,893 | 158,893 | | | | | | 2 |
| 3 | 60 | Laboratory AGGREGATE | 109,199 | | 109,199 | | | | | 3 |
| 4 | | | | | | | | | | 4 |
| 5 | 91 | Emergency AGGREGATE | 830,028 | 404,224 | 425,804 | | | | | 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 | 1,130,006 | 563,117 | 566,889 | | | | | 200 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | | | | | | | 158,893 | 2 |
| 3 | 60 | Laboratory AGGREGATE | | | | | | | | 3 |
| 4 | | | | | | | | | | 4 |
| 5 | 91 | Emergency AGGREGATE | | | | | | | 404,224 | 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 | | | | | | | 563,117 | 200 |

**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 | | 751.43 | | | | 9 |
| 10 | AHSEA (see instructions) | | 76.85 | | | | 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) | 38.43 | 38.43 | | | | 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) | 57,747 | 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) | 57,747 | 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) | 57,747 | 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) | 76.85 | 21 |
| 22 | Weighted allowance excluding aides and trainees (line 2 times line 21) | 59,943 | 22 |
| 23 | Total salary equivalency (see instructions) | 59,943 | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | Overtime 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) | 59,943 | 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) | 59,943 | 63 |
| 64 | Total cost of outside supplier services (from provider records) | 45,088 | 64 |
| 65 | Excess over limitation (line 64 minus line 63; if negative enter zero) | | 65 |

**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 | | 368.00 | | | | 9 |
| 10 | AHSEA (see instructions) | | 81.09 | | | | 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) | 40.55 | 40.55 | | | | 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) | 29,841 | 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) | 29,841 | 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) | 29,841 | 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) | 81.09 | 21 |
| 22 | Weighted allowance excluding aides and trainees (line 2 times line 21) | 63,250 | 22 |
| 23 | Total salary equivalency (see instructions) | 63,250 | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | Overtime 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) | 63,250 | 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) | 63,250 | 63 |
| 64 | Total cost of outside supplier services (from provider records) | 22,082 | 64 |
| 65 | Excess over limitation (line 64 minus line 63; if negative enter zero) | | 65 |

**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) | | | | | 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 | | 210.71 | | | | 9 |
| 10 | AHSEA (see instructions) | | 73.85 | | | | 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) | 36.93 | 36.93 | | | | 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) | 15,561 | 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) | 15,561 | 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) | 15,561 | 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) | 73.85 | 21 |
| 22 | Weighted allowance excluding aides and trainees (line 2 times line 21) | 57,603 | 22 |
| 23 | Total salary equivalency (see instructions) | 57,603 | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | Overtime 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) | 57,603 | 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) | 57,603 | 63 |
| 64 | Total cost of outside supplier services (from provider records) | 12,644 | 64 |
| 65 | Excess over limitation (line 64 minus line 63; if negative enter zero) | | 65 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | 98,524 | 98,524 | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | 136,376 | | 136,376 | | | | 2 |
| 4 | Employee Benefits Department | 45,074 | | | 45,074 | | | 4 |
| 5 | Administrative & General | 2,336,897 | 13,497 | 18,683 | 5,887 | 2,374,964 | 2,374,964 | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | 381,948 | 7,841 | 10,854 | 1,192 | 401,835 | 116,080 | 7 |
| 8 | Laundry & Linen Service | 60,767 | 3,535 | 4,894 | 325 | 69,521 | 20,083 | 8 |
| 9 | Housekeeping | 145,649 | | | 679 | 146,328 | 42,271 | 9 |
| 10 | Dietary | 168,687 | 3,480 | 4,817 | 551 | 177,535 | 51,285 | 10 |
| 11 | Cafeteria | 34,783 | 1,473 | 2,039 | 121 | 38,416 | 11,097 | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | 111,806 | 7,765 | 10,748 | 687 | 131,006 | 37,844 | 13 |
| 14 | Central Services & Supply | 9,783 | | | 62 | 9,845 | 2,844 | 14 |
| 15 | Pharmacy | 211,968 | 1,547 | 2,141 | 547 | 216,203 | 62,456 | 15 |
| 16 | Medical Records & Library | 296,888 | 4,198 | 5,811 | 1,699 | 308,596 | 89,146 | 16 |
| 17 | Social Service | 39,400 | 691 | 956 | 241 | 41,288 | 11,927 | 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 | 1,284,517 | 16,827 | 23,292 | 7,403 | 1,332,039 | 384,793 | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | 715,723 | 5,165 | 7,150 | 2,606 | 730,644 | 211,065 | 54 |
| 60 | Laboratory | 1,131,698 | 2,332 | 3,229 | 2,755 | 1,140,014 | 329,322 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 131,677 | 1,547 | 2,141 | 747 | 136,112 | 39,319 | 65 |
| 66 | Physical Therapy | 197,161 | 3,008 | 4,163 | 701 | 205,033 | 59,229 | 66 |
| 69 | Electrocardiology | 34,134 | | | 218 | 34,352 | 9,923 | 69 |
| 71 | Medical Supplies Charged to Patients | 129,868 | 1,482 | 2,052 | 185 | 133,587 | 38,590 | 71 |
| 73 | Drugs Charged to Patients | 326,060 | | | | 326,060 | 94,191 | 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 | 1,650,293 | 17,225 | 23,839 | 9,892 | 1,701,249 | 491,444 | 88 |
| 90 | Clinic | 209,566 | 2,210 | 3,059 | 950 | 215,785 | 62,335 | 90 |
| 91 | Emergency | 707,155 | 4,023 | 5,569 | 7,626 | 724,373 | 209,253 | 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) | 10,596,402 | 97,846 | 135,437 | 45,074 | 10,594,785 | 2,374,497 | 118 |
| | **NONREIMBURSABLE COST CENTERS** | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | 371 | 514 | | 885 | 256 | 190 |
| 190.01 | VENDING MACHINE | | 307 | 425 | | 732 | 211 | 190.01 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 10,596,402 | 98,524 | 136,376 | 45,074 | 10,596,402 | 2,374,964 | 202 |

**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 | 517,915 | | | | | | 7 |
| 8 | Laundry & Linen Service | 30,537 | 120,141 | | | | | 8 |
| 9 | Housekeeping | | 4,065 | 192,664 | | | | 9 |
| 10 | Dietary | 30,060 | 3,582 | 11,883 | 274,345 | | | 10 |
| 11 | Cafeteria | 12,724 | | 5,030 | 55,356 | 122,623 | | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | 67,065 | | 26,511 | | 2,190 | 264,616 | 13 |
| 14 | Central Services & Supply | | | | | 335 | 8,071 | 14 |
| 15 | Pharmacy | 13,360 | | 5,281 | | 2,564 | | 15 |
| 16 | Medical Records & Library | 36,263 | | 14,335 | | 7,794 | | 16 |
| 17 | Social Service | 5,964 | | 2,358 | | 1,172 | | 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 | 145,346 | 79,307 | 57,456 | 201,111 | 36,291 | 256,545 | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | 44,613 | 8,258 | 17,636 | | 10,281 | | 54 |
| 60 | Laboratory | 20,146 | | 7,964 | | 11,788 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 13,360 | | 5,281 | | 3,582 | | 65 |
| 66 | Physical Therapy | 25,978 | 5,849 | 10,269 | | 2,654 | | 66 |
| 69 | Electrocardiology | | | | | 490 | | 69 |
| 71 | Medical Supplies Charged to Patients | 12,803 | | 5,061 | | 1,031 | | 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 | | | | | 29,335 | | 88 |
| 90 | Clinic | 19,086 | 1,610 | 7,545 | 17,878 | 3,131 | | 90 |
| 91 | Emergency | 34,752 | 17,470 | 13,738 | | 9,985 | | 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) | 512,057 | 120,141 | 190,348 | 274,345 | 122,623 | 264,616 | 118 |
| | **NONREIMBURSABLE COST CENTERS** | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | 3,207 | | 1,268 | | | | 190 |
| 190.01 | VENDING MACHINE | 2,651 | | 1,048 | | | | 190.01 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 517,915 | 120,141 | 192,664 | 274,345 | 122,623 | 264,616 | 202 |

**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 | 21,095 | | | | | | 14 |
| 15 | Pharmacy | 1,348 | 301,212 | | | | | 15 |
| 16 | Medical Records & Library | 126 | | 456,260 | | | | 16 |
| 17 | Social Service | 72 | | | 62,781 | | | 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 | 1,324 | | 421,133 | 62,781 | 2,978,126 | | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | 194 | | 35,127 | | 1,057,818 | | 54 |
| 60 | Laboratory | 13,082 | | | | 1,522,316 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 249 | | | | 197,903 | | 65 |
| 66 | Physical Therapy | 65 | | | | 309,077 | | 66 |
| 69 | Electrocardiology | 40 | | | | 44,805 | | 69 |
| 71 | Medical Supplies Charged to Patients | 3,085 | | | | 194,157 | | 71 |
| 73 | Drugs Charged to Patients | | 274,052 | | | 694,303 | | 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 | 833 | 27,160 | | | 2,250,021 | | 88 |
| 90 | Clinic | 71 | | | | 327,441 | | 90 |
| 91 | Emergency | 606 | | | | 1,010,177 | | 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) | 21,095 | 301,212 | 456,260 | 62,781 | 10,586,144 | | 118 |
| | **NONREIMBURSABLE COST CENTERS** | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | | | | 5,616 | | 190 |
| 190.01 | VENDING MACHINE | | | | | 4,642 | | 190.01 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 21,095 | 301,212 | 456,260 | 62,781 | 10,596,402 | | 202 |

**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 | 2,978,126 | | | | | | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | 1,057,818 | | | | | | 54 |
| 60 | Laboratory | 1,522,316 | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 197,903 | | | | | | 65 |
| 66 | Physical Therapy | 309,077 | | | | | | 66 |
| 69 | Electrocardiology | 44,805 | | | | | | 69 |
| 71 | Medical Supplies Charged to Patients | 194,157 | | | | | | 71 |
| 73 | Drugs Charged to Patients | 694,303 | | | | | | 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 | 2,250,021 | | | | | | 88 |
| 90 | Clinic | 327,441 | | | | | | 90 |
| 91 | Emergency | 1,010,177 | | | | | | 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) | 10,586,144 | | | | | | 118 |
| | **NONREIMBURSABLE COST CENTERS** | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | 5,616 | | | | | | 190 |
| 190.01 | VENDING MACHINE | 4,642 | | | | | | 190.01 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 10,596,402 | | | | | | 202 |

**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 | | 13,497 | 18,683 | 32,180 | 32,180 | | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | | 7,841 | 10,854 | 18,695 | 1,573 | 20,268 | 7 |
| 8 | Laundry & Linen Service | | 3,535 | 4,894 | 8,429 | 272 | 1,195 | 8 |
| 9 | Housekeeping | | | | | 573 | | 9 |
| 10 | Dietary | | 3,480 | 4,817 | 8,297 | 695 | 1,176 | 10 |
| 11 | Cafeteria | | 1,473 | 2,039 | 3,512 | 150 | 498 | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | | 7,765 | 10,748 | 18,513 | 513 | 2,625 | 13 |
| 14 | Central Services & Supply | | | | | 39 | | 14 |
| 15 | Pharmacy | | 1,547 | 2,141 | 3,688 | 846 | 523 | 15 |
| 16 | Medical Records & Library | | 4,198 | 5,811 | 10,009 | 1,208 | 1,419 | 16 |
| 17 | Social Service | | 691 | 956 | 1,647 | 162 | 233 | 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 | | 16,827 | 23,292 | 40,119 | 5,214 | 5,687 | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | | 5,165 | 7,150 | 12,315 | 2,860 | 1,746 | 54 |
| 60 | Laboratory | | 2,332 | 3,229 | 5,561 | 4,462 | 788 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | 1,547 | 2,141 | 3,688 | 533 | 523 | 65 |
| 66 | Physical Therapy | | 3,008 | 4,163 | 7,171 | 802 | 1,017 | 66 |
| 69 | Electrocardiology | | | | | 134 | | 69 |
| 71 | Medical Supplies Charged to Patients | | 1,482 | 2,052 | 3,534 | 523 | 501 | 71 |
| 73 | Drugs Charged to Patients | | | | | 1,276 | | 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 | | 17,225 | 23,839 | 41,064 | 6,659 | | 88 |
| 90 | Clinic | | 2,210 | 3,059 | 5,269 | 845 | 747 | 90 |
| 91 | Emergency | | 4,023 | 5,569 | 9,592 | 2,835 | 1,360 | 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) | | 97,846 | 135,437 | 233,283 | 32,174 | 20,038 | 118 |
| | **NONREIMBURSABLE COST CENTERS** | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | 371 | 514 | 885 | 3 | 126 | 190 |
| 190.01 | VENDING MACHINE | | 307 | 425 | 732 | 3 | 104 | 190.01 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | | 98,524 | 136,376 | 234,900 | 32,180 | 20,268 | 202 |

**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 | 9,896 | | | | | | 8 |
| 9 | Housekeeping | 335 | 908 | | | | | 9 |
| 10 | Dietary | 295 | 56 | 10,519 | | | | 10 |
| 11 | Cafeteria | | 24 | 2,122 | 6,306 | | | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | | 125 | | 113 | 21,889 | | 13 |
| 14 | Central Services & Supply | | | | 17 | 668 | 724 | 14 |
| 15 | Pharmacy | | 25 | | 132 | | 46 | 15 |
| 16 | Medical Records & Library | | 68 | | 401 | | 4 | 16 |
| 17 | Social Service | | 11 | | 60 | | 2 | 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 | 6,532 | 269 | 7,712 | 1,867 | 21,221 | 45 | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | 680 | 83 | | 529 | | 7 | 54 |
| 60 | Laboratory | | 38 | | 606 | | 450 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | 25 | | 184 | | 9 | 65 |
| 66 | Physical Therapy | 482 | 48 | | 136 | | 2 | 66 |
| 69 | Electrocardiology | | | | 25 | | 1 | 69 |
| 71 | Medical Supplies Charged to Patients | | 24 | | 53 | | 106 | 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 | | | | 1,509 | | 29 | 88 |
| 90 | Clinic | 133 | 36 | 685 | 161 | | 2 | 90 |
| 91 | Emergency | 1,439 | 65 | | 513 | | 21 | 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) | 9,896 | 897 | 10,519 | 6,306 | 21,889 | 724 | 118 |
| | **NONREIMBURSABLE COST CENTERS** | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | 6 | | | | | 190 |
| 190.01 | VENDING MACHINE | | 5 | | | | | 190.01 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 9,896 | 908 | 10,519 | 6,306 | 21,889 | 724 | 202 |

**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 | 5,260 | | | | | | 15 |
| 16 | Medical Records & Library | | 13,109 | | | | | 16 |
| 17 | Social Service | | | 2,115 | | | | 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 | | 12,100 | 2,115 | 102,881 | | 102,881 | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | | 1,009 | | 19,229 | | 19,229 | 54 |
| 60 | Laboratory | | | | 11,905 | | 11,905 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | | | 4,962 | | 4,962 | 65 |
| 66 | Physical Therapy | | | | 9,658 | | 9,658 | 66 |
| 69 | Electrocardiology | | | | 160 | | 160 | 69 |
| 71 | Medical Supplies Charged to Patients | | | | 4,741 | | 4,741 | 71 |
| 73 | Drugs Charged to Patients | 4,786 | | | 6,062 | | 6,062 | 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 | 474 | | | 49,735 | | 49,735 | 88 |
| 90 | Clinic | | | | 7,878 | | 7,878 | 90 |
| 91 | Emergency | | | | 15,825 | | 15,825 | 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) | 5,260 | 13,109 | 2,115 | 233,036 | | 233,036 | 118 |
| | **NONREIMBURSABLE COST CENTERS** | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | | | | 1,020 | | 1,020 | 190 |
| 190.01 | VENDING MACHINE | | | | 844 | | 844 | 190.01 |
| 200 | Cross Foot Adjustments | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | 201 |
| 202 | TOTAL (sum of lines 118-201) | 5,260 | 13,109 | 2,115 | 234,900 | | 234,900 | 202 |

**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 | 32,103 | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | 32,103 | | | | | 2 |
| 4 | Employee Benefits Department | | | 6,078,140 | | | | 4 |
| 5 | Administrative & General | 4,398 | 4,398 | 793,804 | -2,374,964 | 8,221,438 | | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | 2,555 | 2,555 | 160,799 | | 401,835 | 19,538 | 7 |
| 8 | Laundry & Linen Service | 1,152 | 1,152 | 43,794 | | 69,521 | 1,152 | 8 |
| 9 | Housekeeping | | | 91,558 | | 146,328 | | 9 |
| 10 | Dietary | 1,134 | 1,134 | 74,271 | | 177,535 | 1,134 | 10 |
| 11 | Cafeteria | 480 | 480 | 16,304 | | 38,416 | 480 | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | 2,530 | 2,530 | 92,585 | | 131,006 | 2,530 | 13 |
| 14 | Central Services & Supply | | | 8,302 | | 9,845 | | 14 |
| 15 | Pharmacy | 504 | 504 | 73,713 | | 216,203 | 504 | 15 |
| 16 | Medical Records & Library | 1,368 | 1,368 | 229,041 | | 308,596 | 1,368 | 16 |
| 17 | Social Service | 225 | 225 | 32,536 | | 41,288 | 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 | 998,201 | | 1,332,039 | 5,483 | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | 1,683 | 1,683 | 351,436 | | 730,644 | 1,683 | 54 |
| 60 | Laboratory | 760 | 760 | 371,446 | | 1,140,014 | 760 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 504 | 504 | 100,676 | | 136,112 | 504 | 65 |
| 66 | Physical Therapy | 980 | 980 | 94,578 | | 205,033 | 980 | 66 |
| 69 | Electrocardiology | | | 29,400 | | 34,352 | | 69 |
| 71 | Medical Supplies Charged to Patients | 483 | 483 | 24,906 | | 133,587 | 483 | 71 |
| 73 | Drugs Charged to Patients | | | | | 326,060 | | 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 | 1,334,384 | | 1,701,249 | | 88 |
| 90 | Clinic | 720 | 720 | 128,154 | | 215,785 | 720 | 90 |
| 91 | Emergency | 1,311 | 1,311 | 1,028,252 | | 724,373 | 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) | 31,882 | 31,882 | 6,078,140 | -2,374,964 | 8,219,821 | 19,317 | 118 |
| | **NONREIMBURSABLE COST CENTERS** | | | | | | | |
| 190 | Gift, Flower, Coffee Shop & Canteen | 121 | 121 | | | 885 | 121 | 190 |
| 190.01 | VENDING MACHINE | 100 | 100 | | | 732 | 100 | 190.01 |
| 200 | Cross foot adjustments | | | | | | | 200 |
| 201 | Negative cost centers | | | | | | | 201 |
| 202 | Cost to be allocated (Per Wkst. B, Part I) | 98,524 | 136,376 | 45,074 | | 2,374,964 | 517,915 | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | 3.068997 | 4.248077 | 0.007416 | | 0.288875 | 26.508087 | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | | | | | 32,180 | 20,268 | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | | | | | 0.003914 | 1.037363 | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | | 207 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | 80,830 | | | | | | 8 |
| 9 | Housekeeping | 2,735 | 18,386 | | | | | 9 |
| 10 | Dietary | 2,410 | 1,134 | 15,760 | | | | 10 |
| 11 | Cafeteria | | 480 | 3,180 | 9,518 | | | 11 |
| 12 | Maintenance of Personnel | | | | | | | 12 |
| 13 | Nursing Administration | | 2,530 | | 170 | 72,952 | | 13 |
| 14 | Central Services & Supply | | | | 26 | 2,225 | 657,636 | 14 |
| 15 | Pharmacy | | 504 | | 199 | | 42,036 | 15 |
| 16 | Medical Records & Library | | 1,368 | | 605 | | 3,927 | 16 |
| 17 | Social Service | | 225 | | 91 | | 2,245 | 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 | 53,357 | 5,483 | 11,553 | 2,817 | 70,727 | 41,287 | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | 5,556 | 1,683 | | 798 | | 6,054 | 54 |
| 60 | Laboratory | | 760 | | 915 | | 407,783 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | | 504 | | 278 | | 7,775 | 65 |
| 66 | Physical Therapy | 3,935 | 980 | | 206 | | 2,035 | 66 |
| 69 | Electrocardiology | | | | 38 | | 1,238 | 69 |
| 71 | Medical Supplies Charged to Patients | | 483 | | 80 | | 96,169 | 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 | | | | 2,277 | | 25,963 | 88 |
| 90 | Clinic | 1,083 | 720 | 1,027 | 243 | | 2,220 | 90 |
| 91 | Emergency | 11,754 | 1,311 | | 775 | | 18,904 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | | | | | | 92 |
| | **OTHER REIMBURSABLE COST CENTERS** | | | | | | | |
| | **SPECIAL PURPOSE COST CENTERS** | | | | | | | |
| 118 | SUBTOTALS (sum of lines 1-117) | 80,830 | 18,165 | 15,760 | 9,518 | 72,952 | 657,636 | 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) | 120,141 | 192,664 | 274,345 | 122,623 | 264,616 | 21,095 | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | 1.486342 | 10.478843 | 17.407678 | 12.883274 | 3.627262 | 0.032077 | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | 9,896 | 908 | 10,519 | 6,306 | 21,889 | 724 | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | 0.122430 | 0.049385 | 0.667449 | 0.662534 | 0.300047 | 0.001101 | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | | 207 |

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

| | COST CENTER DESCRIPTIONS | PHARMACY<br><br>COSTED REQUIS. | MEDICAL RECORDS & LIBRARY<br>TIME SPENT | SOCIAL SERVICE<br><br>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 | 358,374 | | | | | | 15 |
| 16 | Medical Records & Library | | 40,265 | | | | | 16 |
| 17 | Social Service | | | 2,051 | | | | 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 | | 37,165 | 2,051 | | | | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | | 3,100 | | | | | 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 | 326,060 | | | | | | 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 | 32,314 | | | | | | 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) | 358,374 | 40,265 | 2,051 | | | | 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) | 301,212 | 456,260 | 62,781 | | | | 202 |
| 203 | Unit Cost Multiplier (Wkst. B, Part I) | 0.840496 | 11.331429 | 30.609946 | | | | 203 |
| 204 | Cost to be allocated (Per Wkst. B, Part II) | 5,260 | 13,109 | 2,115 | | | | 204 |
| 205 | Unit Cost Multiplier (Wkst. B, Part II) | 0.014677 | 0.325568 | 1.031204 | | | | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | 206 |
| 207 | NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV) | | | | | | | 207 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**POST STEPDOWN ADJUSTMENTS** **WORKSHEET B-2**

| | | WORKSHEET | | | |
|---|---|---|---|---|---|
| | DESCRIPTION | CODE | LINE NO. | AMOUNT | |
| | 1 | 2 | 3 | 4 | |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | 2,978,126 | | 2,978,126 | | | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | |
| 54 | Radiology-Diagnostic | 1,057,818 | | 1,057,818 | | | 54 |
| 60 | Laboratory | 1,522,316 | | 1,522,316 | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | 197,903 | | 197,903 | | | 65 |
| 66 | Physical Therapy | 309,077 | | 309,077 | | | 66 |
| 69 | Electrocardiology | 44,805 | | 44,805 | | | 69 |
| 71 | Medical Supplies Charged to Patients | 194,157 | | 194,157 | | | 71 |
| 73 | Drugs Charged to Patients | 694,303 | | 694,303 | | | 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 | 2,250,021 | | 2,250,021 | | | 88 |
| 90 | Clinic | 327,441 | | 327,441 | | | 90 |
| 91 | Emergency | 1,010,177 | | 1,010,177 | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 336,286 | | 336,286 | | | 92 |
| | **OTHER REIMBURSABLE COST CENTERS** | | | | | | |
| 113 | Interest Expense | | | | | | 113 |
| 200 | Subtotal (sum of lines 30 thru 199) | 10,922,430 | | 10,922,430 | | | 200 |
| 201 | Less Observation Beds | 336,286 | | 336,286 | | | 201 |
| 202 | Total (line 200 minus line 201) | 10,586,144 | | 10,586,144 | | | 202 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | 1,998,607 | | 1,998,607 | | | | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 54 | Radiology-Diagnostic | 744,201 | 4,634,514 | 5,378,715 | 0.196667 | | | 54 |
| 60 | Laboratory | 779,500 | 3,552,173 | 4,331,673 | 0.351438 | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 154,274 | 232,490 | 386,764 | 0.511689 | | | 65 |
| 66 | Physical Therapy | 404,223 | 713,287 | 1,117,510 | 0.276576 | | | 66 |
| 69 | Electrocardiology | 43,741 | 195,255 | 238,996 | 0.187472 | | | 69 |
| 71 | Medical Supplies Charged to Patients | 558,877 | 171,840 | 730,717 | 0.265708 | | | 71 |
| 73 | Drugs Charged to Patients | 1,350,873 | 941,062 | 2,291,935 | 0.302933 | | | 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 | | 1,493,744 | 1,493,744 | | | | 88 |
| 90 | Clinic | 1,476 | 484,145 | 485,621 | 0.674273 | | | 90 |
| 91 | Emergency | 27,716 | 1,867,654 | 1,895,370 | 0.532971 | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | | 311,938 | 311,938 | 1.078054 | | | 92 |
| | **OTHER REIMBURSABLE COST CENTERS** | | | | | | | |
| 113 | Interest Expense | | | | | | | 113 |
| 200 | Subtotal (sum of lines 30 thru 199) | 6,063,488 | 14,598,102 | 20,661,590 | | | | 200 |
| 201 | Less Observation Beds | | | | | | | 201 |
| 202 | Total (line 200 minus line 201) | 6,063,488 | 14,598,102 | 20,661,590 | | | | 202 |

**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 | 0.196667 | | 1,632,758 | | | 321,110 | | 54 |
| 60 | Laboratory | 0.351438 | | 1,584,494 | | | 556,851 | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 0.511689 | | 26,240 | | | 13,427 | | 65 |
| 66 | Physical Therapy | 0.276576 | | 152,390 | | | 42,147 | | 66 |
| 69 | Electrocardiology | 0.187472 | | 169,814 | | | 31,835 | | 69 |
| 71 | Medical Supplies Charged to Pat | 0.265708 | | 171,840 | | | 45,659 | | 71 |
| 73 | Drugs Charged to Patients | 0.302933 | | 443,308 | | | 134,293 | | 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 | 0.674273 | | 378,789 | | | 255,407 | | 90 |
| 91 | Emergency | 0.532971 | | 542,387 | | | 289,077 | | 91 |
| 92 | Observation Beds (Non-Distinct | 1.078054 | | 109,678 | | | 118,239 | | 92 |
| | **OTHER REIMBURSABLE COST CENTERS** | | | | | | | | |
| 200 | Subtotal (see instructions) | | | 5,211,698 | | | 1,808,045 | | 200 |
| 201 | Less PBP Clinic Lab. Services-Program Only Charges | | | | | | | | 201 |
| 202 | Net Charges (line 200 - line 201) | | | 5,211,698 | | | 1,808,045 | | 202 |

(A) Worksheet A line numbers

**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 | 0.196667 | | | | | | | 54 |
| 60 | Laboratory | 0.351438 | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 0.511689 | | | | | | | 65 |
| 66 | Physical Therapy | 0.276576 | | | | | | | 66 |
| 69 | Electrocardiology | 0.187472 | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | 0.265708 | | | | | | | 71 |
| 73 | Drugs Charged to Patients | 0.302933 | | | | | | | 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 | 0.674273 | | | | | | | 90 |
| 91 | Emergency | 0.532971 | | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct | 1.078054 | | | | | | | 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

**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) | 102,881 | 40,352 | 62,529 | 2,519 | 24.82 | 411 | 10,201 | 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) | 102,881 | | 62,529 | 2,519 | | 411 | 10,201 | 200 |

(A) Worksheet A line numbers

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

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

| (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 | 19,229 | 5,378,715 | 0.003575 | | | 54 |
| 60 | Laboratory | 11,905 | 4,331,673 | 0.002748 | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | 62.30 |
| 65 | Respiratory Therapy | 4,962 | 386,764 | 0.012830 | | | 65 |
| 66 | Physical Therapy | 9,658 | 1,117,510 | 0.008642 | | | 66 |
| 69 | Electrocardiology | 160 | 238,996 | 0.000669 | | | 69 |
| 71 | Medical Supplies Charged to Pat | 4,741 | 730,717 | 0.006488 | | | 71 |
| 73 | Drugs Charged to Patients | 6,062 | 2,291,935 | 0.002645 | | | 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 | 49,735 | 1,493,744 | 0.033296 | | | 88 |
| 90 | Clinic | 7,878 | 485,621 | 0.016223 | | | 90 |
| 91 | Emergency | 15,825 | 1,895,370 | 0.008349 | | | 91 |
| 92 | Observation Beds (Non-Distinct | 11,617 | 311,938 | 0.037241 | | | 92 |
| | **OTHER REIMBURSABLE COST CENTERS** | | | | | | |
| 200 | Total (sum of lines 50-199) | 141,772 | 18,662,983 | | | | 200 |

(A) Worksheet A line numbers

**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS** **WORKSHEET D PART III**

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

| | | Nursing School Post-Stepdown Adjustments | Nursing School | Allied Health Post-Stepdown Adjustments | 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 | 1A | 1 | 2A | 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

**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D**
**PART III**

**Check Applicable Boxes:**
**[ ] Title V**
**[ ] Title XVIII, Part A**
**[XX] Title XIX**
**[ ] PPS**
**[ ] TEFRA**
**[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) | 2,519 | | 411 | | 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) | 2,519 | | 411 | | 200 |

(A) Worksheet A line numbers

**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 Post-Stepdown Adjustments | Nursing School | Allied Health Post-Stepdown Adjustments | 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 | 2A | 2 | 3A | 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

**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 | 5,378,715 | | | | | | | 54 |
| 60 | Laboratory | 4,331,673 | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 386,764 | | | | | | | 65 |
| 66 | Physical Therapy | 1,117,510 | | | | | | | 66 |
| 69 | Electrocardiology | 238,996 | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | 730,717 | | | | | | | 71 |
| 73 | Drugs Charged to Patients | 2,291,935 | | | | | | | 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 | 1,493,744 | | | | | | | 88 |
| 90 | Clinic | 485,621 | | | | | | | 90 |
| 91 | Emergency | 1,895,370 | | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct | 311,938 | | | | | | | 92 |
| | **OTHER REIMBURSABLE COST CENTERS** | | | | | | | | |
| 200 | Total (sum of lines 50-199) | 18,662,983 | | | | | | | 200 |

(A) Worksheet A line numbers

**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 | 0.196667 | | | | | | | 54 |
| 60 | Laboratory | 0.351438 | | | | | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | | | | | 62.30 |
| 65 | Respiratory Therapy | 0.511689 | | | | | | | 65 |
| 66 | Physical Therapy | 0.276576 | | | | | | | 66 |
| 69 | Electrocardiology | 0.187472 | | | | | | | 69 |
| 71 | Medical Supplies Charged to Pat | 0.265708 | | | | | | | 71 |
| 73 | Drugs Charged to Patients | 0.302933 | | | | | | | 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 | 0.674273 | | | | | | | 90 |
| 91 | Emergency | 0.532971 | | | | | | | 91 |
| 92 | Observation Beds (Non-Distinct | 1.078054 | | | | | | | 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

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

| | | | | | |
|---|---|---|---|---|---|
| **Check** | **[ ] Title V - I/P** | **[XX] Hospital** | **[ ] SUB (Other)** | **[ ] ICF/IID** | **[ ] PPS** |
| **Applicable** | **[XX] Title XVIII, Part A** | **[ ] IPF** | **[ ] SNF** | | **[ ] TEFRA** |
| **Boxes:** | **[ ] 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) | 4,157 | 1 |
| 2 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 2,519 | 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) | 2,051 | 4 |
| 5 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period | 1,217 | 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) | 406 | 6 |
| 7 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period | 11 | 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) | 4 | 8 |
| 9 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) | 1,344 | 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) | 980 | 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) | 326 | 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) | 2,978,126 | 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) | 1,327 | 24 |
| 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | 525 | 25 |
| 26 | Total swing-bed cost (see instructions) | 1,168,075 | 26 |
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 1,810,051 | 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) | 1,810,051 | 37 |

**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) | 718.56 | 38 |
| 39 | Program general inpatient routine service cost (line 9 x line 38) | 965,745 | 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) | 965,745 | 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) | 507,882 | 48 |
| 49 | Total program inpatient costs (sum of lines 41 through 48)(see instructions) | 1,473,627 | 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) | 704,189 | 64 |
| 65 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) | 234,251 | 65 |
| 66 | Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions) | 938,440 | 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 |

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

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

**PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 87 | Total observation bed days (see instructions) | | | | | 468 | 87 |
| 88 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) | | | | | 718.56 | 88 |
| 89 | Observation bed cost (line 87 x line 88) (see instructions) | | | | | 336,286 | 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 | 102,881 | 2,978,126 | 0.034546 | 336,286 | 11,617 | 90 |
| 91 | Nursing School | | | | | | 91 |
| 92 | Allied Health | | | | | | 92 |
| 93 | Other Medical Education | | | | | | 93 |

**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) | 4,157 | 1 |
| 2 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 2,519 | 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) | 2,051 | 4 |
| 5 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period | 1,217 | 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) | 406 | 6 |
| 7 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period | 11 | 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) | 4 | 8 |
| 9 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) | 411 | 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) | 2,978,126 | 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) | 1,327 | 24 |
| 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | 525 | 25 |
| 26 | Total swing-bed cost (see instructions) | 1,168,075 | 26 |
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 1,810,051 | 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) | 1,810,051 | 37 |

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

**Check Applicable Boxes:** **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[XX] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[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) | 718.56 | 38 |
| 39 | Program general inpatient routine service cost (line 9 x line 38) | 295,328 | 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) | 295,328 | 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) | 295,328 | 49 |

**PASS THROUGH COST ADJUSTMENTS**

| | | | |
|---|---|---|---|
| 50 | Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) | 10,201 | 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) | 10,201 | 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 |

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

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

**PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 87 | Total observation bed days (see instructions) | | | | | 468 | 87 |
| 88 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) | | | | | 718.56 | 88 |
| 89 | Observation bed cost (line 87 x line 88) (see instructions) | | | | | 336,286 | 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 | 102,881 | 2,978,126 | 0.034546 | 336,286 | 11,617 | 90 |
| 91 | Nursing School | | | | | | 91 |
| 92 | Allied Health | | | | | | 92 |
| 93 | Other Medical Education | | | | | | 93 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

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

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

| (A) | COST CENTER DESCRIPTION | Ratio of Cost To Charges<br>1 | Inpatient Program Charges<br>2 | Inpatient Program Costs (col. 1 x col. 2)<br>3 | |
|---|---|---|---|---|---|
| | **INPATIENT ROUTINE SERVICE COST CENTERS** | | | | |
| 30 | Adults & Pediatrics | | 1,209,600 | | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | |
| 54 | Radiology-Diagnostic | 0.196667 | 337,849 | 66,444 | 54 |
| 60 | Laboratory | 0.351438 | 396,648 | 139,397 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | 62.30 |
| 65 | Respiratory Therapy | 0.511689 | 67,365 | 34,470 | 65 |
| 66 | Physical Therapy | 0.276576 | 36,185 | 10,008 | 66 |
| 69 | Electrocardiology | 0.187472 | 25,560 | 4,792 | 69 |
| 71 | Medical Supplies Charged to Patients | 0.265708 | 271,687 | 72,189 | 71 |
| 73 | Drugs Charged to Patients | 0.302933 | 590,297 | 178,820 | 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 | 0.674273 | | | 90 |
| 91 | Emergency | 0.532971 | 3,306 | 1,762 | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 1.078054 | | | 92 |
| | **OTHER REIMBURSABLE COST CENTERS** | | | | |
| 200 | Total (sum of lines 50-94, and 96-98) | | 1,728,897 | 507,882 | 200 |
| 201 | Less PBP Clinic Laboratory Services-Program only charges (line 61) | | | | 201 |
| 202 | Net Charges (line 200 minus line 201) | | 1,728,897 | | 202 |

**(A) Worksheet A line numbers**

**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<br>1 | Inpatient Program Charges<br>2 | Inpatient Program Costs (col. 1 x col. 2)<br>3 | |
|---|---|---|---|---|---|
| | **INPATIENT ROUTINE SERVICE COST CENTERS** | | | | |
| 30 | Adults & Pediatrics | | | | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | |
| 54 | Radiology-Diagnostic | 0.196667 | 66,002 | 12,980 | 54 |
| 60 | Laboratory | 0.351438 | 95,018 | 33,393 | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | 62.30 |
| 65 | Respiratory Therapy | 0.511689 | 48,997 | 25,071 | 65 |
| 66 | Physical Therapy | 0.276576 | 302,797 | 83,746 | 66 |
| 69 | Electrocardiology | 0.187472 | 2,739 | 513 | 69 |
| 71 | Medical Supplies Charged to Patients | 0.265708 | 186,476 | 49,548 | 71 |
| 73 | Drugs Charged to Patients | 0.302933 | 334,274 | 101,263 | 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 | 0.674273 | 1,476 | 995 | 90 |
| 91 | Emergency | 0.532971 | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 1.078054 | | | 92 |
| | **OTHER REIMBURSABLE COST CENTERS** | | | | |
| 200 | Total (sum of lines 50-94, and 96-98) | | 1,037,779 | 307,509 | 200 |
| 201 | Less PBP Clinic Laboratory Services-Program only charges (line 61) | | | | 201 |
| 202 | Net Charges (line 200 minus line 201) | | 1,037,779 | | 202 |

**(A) Worksheet A line numbers**

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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** |

| | | Ratio of Cost To Charges | Inpatient Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
|---|---|---|---|---|---|
| (A) | COST CENTER DESCRIPTION | 1 | 2 | 3 | |
| | **INPATIENT ROUTINE SERVICE COST CENTERS** | | | | |
| 30 | Adults & Pediatrics | | | | 30 |
| | **ANCILLARY SERVICE COST CENTERS** | | | | |
| 54 | Radiology-Diagnostic | 0.196667 | | | 54 |
| 60 | Laboratory | 0.351438 | | | 60 |
| 62.30 | BLOOD CLOTTING FOR HEMOPHILIACS | | | | 62.30 |
| 65 | Respiratory Therapy | 0.511689 | | | 65 |
| 66 | Physical Therapy | 0.276576 | | | 66 |
| 69 | Electrocardiology | 0.187472 | | | 69 |
| 71 | Medical Supplies Charged to Patients | 0.265708 | | | 71 |
| 73 | Drugs Charged to Patients | 0.302933 | | | 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 | 0.674273 | | | 90 |
| 91 | Emergency | 0.532971 | | | 91 |
| 92 | Observation Beds (Non-Distinct Part) | 1.078054 | | | 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**

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

| | | 1 | 1.01 | 1.02 | |
|---|---|---|---|---|---|
| 1 | Medical and other services (see instructions) | 1,808,045 | | | 1 |
| 2 | Medical and other services reimbursed under OPPS (see instructions) | | | | 2 |
| 3 | OPPS payments | | | | 3 |
| 4 | Outlier payment (see instructions) | | | | 4 |
| 4.01 | Outlier reconciliation amount (see instructions) | | | | 4.01 |
| 5 | Enter the hospital specific payment to cost ratio (see instructions) | | | | 5 |
| 6 | Line 2 times line 5 | | | | 6 |
| 7 | Sum of lines 3, 4, and 4.01, 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) | 1,808,045 | | | 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 (see instructions) | 1,826,125 | | | 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, 4.01, 8 and 9) | | | | 24 |
| | **COMPUTATION OF REIMBURSEMENT SETTLEMENT** | | | | |
| 25 | Deductibles and coinsurance (see instructions) | 13,397 | | | 25 |
| 26 | Deductibles and coinsurance relating to amount on line 24 (see instructions) | 749,976 | | | 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) | 1,062,752 | | | 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) | 1,062,752 | | | 30 |
| 31 | Primary payer payments | 397 | | | 31 |
| 32 | Subtotal (line 30 minus line 31) | 1,062,355 | | | 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) | 257,818 | | | 34 |
| 35 | Adjusted reimbursable bad debts (see instructions) | 167,582 | | | 35 |
| 36 | Allowable bad debts for dual eligible beneficiaries (see instructions) | 237,869 | | | 36 |
| 37 | Subtotal (see instructions) | 1,229,937 | | | 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) | 1,229,937 | | | 40 |
| 40.01 | Sequestration adjustment (see instructions) | 24,599 | | | 40.01 |
| 40.02 | Demonstration payment adjustment amount after sequestration | | | | 40.02 |
| 41 | Interim payments | 1,332,691 | | | 41 |
| 42 | Tentative settlement (for contractors use only) | | | | 42 |
| 43 | Balance due provider/program (see instructions) | -127,353 | | | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | | | | 1,670,240 | | 1,552,708 | 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 | 11/02/2017 | 313,846 | 11/02/2017 | 220,017 | 3.51 |
| | | Provider | .52 | 03/22/2018 | 47,911 | | | 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 | | -361,757 | | -220,017 | 3.99 |
| 4 | Total interim payments (sum of lines 1, 2, and 3.99)<br>(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | | | 1,308,483 | | 1,332,691 | 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 | | -84,388 | | -127,353 | 6.02 |
| 7 | Total Medicare program liability (see instructions) | | | | 1,224,095 | | 1,205,338 | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

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

**Check Applicable Boxes:** **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [ ] IRF [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 | | | | 1,562,439 | | | 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 | 11/02/2017 | 187,846 | | | 3.51 |
| | | Provider | .52 | 03/22/2018 | 138,928 | | | 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 | | -326,774 | | | 3.99 |
| 4 | Total interim payments (sum of lines 1, 2, and 3.99)<br>(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | | | 1,235,665 | | | 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 | | -90,697 | | | 6.02 |
| 7 | Total Medicare program liability (see instructions) | | | | 1,144,968 | | | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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) | 947,824 | | 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) | 310,584 | | 3 |
| 4 | Per diem cost for interns and residents not in approved teaching program (see instructions) | | | 4 |
| 5 | Program days | 1,306 | | 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) | 1,258,408 | | 8 |
| 9 | Primary payer payments (see instructions) | 16,367 | | 9 |
| 10 | Subtotal (line 8 minus line 9) | 1,242,041 | | 10 |
| 11 | Deductibles billed to program patients (exclude amounts applicable to physician professional services) | | | 11 |
| 12 | Subtotal (line 10 minus line 11) | 1,242,041 | | 12 |
| 13 | Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) | 86,002 | | 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) | 1,156,039 | | 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) | 18,917 | | 17 |
| 17.01 | Adjusted reimbursable bad debts (see instructions) | 12,296 | | 17.01 |
| 18 | Allowable bad debts for dual eligible beneficiaries (see instructions) | 18,917 | | 18 |
| 19 | Total (see instructions) | 1,168,335 | | 19 |
| 19.01 | Sequestration adjustment (see instructions) | 23,367 | | 19.01 |
| 19.02 | Demonstration payment adjustment amount after sequestration | | | 19.02 |
| 20 | Interim payments | 1,235,665 | | 20 |
| 21 | Tentative settlement (for contractor use only) | | | 21 |
| 22 | Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21) | -90,697 | | 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 | 1,473,627 | 1 |
| 2 | Nursing an dallied health managed care payment (see instructions) | | 2 |
| 3 | Organ acquisition | | 3 |
| 4 | Subtotal (sum of lines 1-3) | 1,473,627 | 4 |
| 5 | Primary payer payments | | 5 |
| 6 | Total cost (see instructions) | 1,488,363 | 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) | 1,488,363 | 19 |
| 20 | Deductibles (exclude professional component) | 289,263 | 20 |
| 21 | Excess reasonable cost (from line 16) | | 21 |
| 22 | Subtotal (line 19 minus the sum of lines 20 and 21) | 1,199,100 | 22 |
| 23 | Coinsurance | | 23 |
| 24 | Subtotal (line 22 minus line 23) | 1,199,100 | 24 |
| 25 | Allowable bad debts (exclude bad debts for professional services) (see instructions) | 76,888 | 25 |
| 26 | Adjusted reimbursable bad debts (see instructions) | 49,977 | 26 |
| 27 | Allowable bad debts for dual eligible beneficiaries (see instructions) | 70,770 | 27 |
| 28 | Subtotal (sum of lines 24 and 26) | 1,249,077 | 28 |
| 29 | Other adjustments (specify) (see instructions) | | 29 |
| 29.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | 29.50 |
| 30 | Subtotal (see instructions) | 1,249,077 | 30 |
| 30.01 | Sequestration adjustment (see instructions) | 24,982 | 30.01 |
| 30.02 | Demonstration payment adjustment amount after sequestration | | 30.02 |
| 31 | Interim payments | 1,308,483 | 31 |
| 32 | Tentative settlement (for contractor use only) | | 32 |
| 33 | Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32) | -84,388 | 33 |
| 34 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | 34 |

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

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

| | | INPATIENT TITLE V OR TITLE XIX | OUTPAT-IENT TITLE V OR TITLE XIX | |
|---|---|---|---|---|
| | **COMPUTATION OF NET COST OF COVERED SERVICES** | | | |
| 1 | Inpatient hospital/SNF/NF services | 295,328 | | 1 |
| 2 | Medical and other services | | | 2 |
| 3 | Organ acquisition (certified transplant centers only) | | | 3 |
| 4 | Subtotal (sum of lines 1, 2 and 3) | 295,328 | | 4 |
| 5 | Inpatient primary payer payments | | | 5 |
| 6 | Outpatient primary payer payments | | | 6 |
| 7 | Subtotal (line 4 less sum of lines 5 and 6) | 295,328 | | 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) | 295,328 | | 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) | 295,328 | | 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) | 295,328 | | 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) | 295,328 | | 36 |
| 37 | OTHER ADJUSTMENTS (SPECIFY) (see instructions) | | | 37 |
| 38 | Subtotal (line 36 ± line 37) | 295,328 | | 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) | 295,328 | | 40 |
| 41 | Interim payments | 249,234 | | 41 |
| 42 | Balance due provider/program (line 40 minus line 41) | 46,094 | | 42 |
| 43 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | 43 |

**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 | 260,634 | | | | 1 |
| 2 | Temporary investments | | | | | 2 |
| 3 | Notes receivable | | | | | 3 |
| 4 | Accounts receivable | 2,662,018 | | | | 4 |
| 5 | Other receivables | | | | | 5 |
| 6 | Allowances for uncollectible notes and accounts receivable | -1,090,967 | | | | 6 |
| 7 | Inventory | 203,208 | | | | 7 |
| 8 | Prepaid expenses | 13,340 | | | | 8 |
| 9 | Other current assets | | | | | 9 |
| 10 | Due from other funds | | | | | 10 |
| 11 | Total current assets (sum of lines 1-10) | 2,048,233 | | | | 11 |
| | **FIXED ASSETS** | | | | | |
| 12 | Land | 17,000 | | | | 12 |
| 13 | Land improvements | 256,674 | | | | 13 |
| 14 | Accumulated depreciation | -146,257 | | | | 14 |
| 15 | Buildings | 1,796,754 | | | | 15 |
| 16 | Accumulated depreciation | -1,355,772 | | | | 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 | 3,745,979 | | | | 23 |
| 24 | Accumulated depreciation | -3,224,294 | | | | 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) | 1,090,084 | | | | 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) | 3,138,317 | | | | 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 | 259,295 | | | | 37 |
| 38 | Salaries, wages and fees payable | 719,764 | | | | 38 |
| 39 | Payroll taxes payable | | | | | 39 |
| 40 | Notes and loans payable (short term) | 112,351 | | | | 40 |
| 41 | Deferred income | 83,446 | | | | 41 |
| 42 | Accelerated payments | | | | | 42 |
| 43 | Due to other funds | | | | | 43 |
| 44 | Other current liabilities | 319,579 | | | | 44 |
| 45 | Total current liabilities (sum of lines 37 thru 44) | 1,494,435 | | | | 45 |
| | **LONG TERM LIABILITIES** | | | | | |
| 46 | Mortgage payable | | | | | 46 |
| 47 | Notes payable | 234,033 | | | | 47 |
| 48 | Unsecured loans | | | | | 48 |
| 49 | Other long term liabilities | | | | | 49 |
| 50 | Total long term liabilities (sum of lines 46 thru 49) | 234,033 | | | | 50 |
| 51 | Total liabilities (sum of lines 45 and 50) | 1,728,468 | | | | 51 |
| | **CAPITAL ACCOUNTS** | | | | | |
| 52 | General fund balance | 1,409,849 | | | | 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 |

**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 | |
| 59 | Total fund balances (sum of lines 52 thru 58) | 1,409,849 | | | | 59 |
| 60 | Total liabilities and fund balances (sum of lines 51 and 59) | 3,138,317 | | | | 60 |

| | | | |
|---|---|---|---|
| HARDIN COUNTY GENERAL HOSPITAL<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | | 1,020,124 | | | 1 |
| 2 | Net income (loss) (from Worksheet G-3, line 29) | | 388,693 | | | 2 |
| 3 | Total (sum of line 1 and line 2) | | 1,408,817 | | | 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) | | 1,408,817 | | | 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) | | 1,408,817 | | | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | 2,452,284 | | 2,452,284 | 1 |
| 2 | Subprovider IPF | | | | 2 |
| 3 | Subprovider IRF | | | | 3 |
| 5 | Swing Bed - SNF | 1,059,707 | | 1,059,707 | 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) | 3,511,991 | | 3,511,991 | 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) | 3,511,991 | | 3,511,991 | 17 |
| 18 | Ancillary services | 4,983,578 | 11,650,233 | 16,633,811 | 18 |
| 19 | Outpatient services | 558,497 | 1,543,955 | 2,102,452 | 19 |
| 20 | Rural Health Clinic (RHC) | | 1,493,744 | 1,493,744 | 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) | 9,054,066 | 14,687,932 | 23,741,998 | 28 |

**PART II - OPERATING EXPENSES**

| | | 1 | 2 | |
|---|---|---|---|---|
| 29 | Operating expenses (per Worksheet A, column 3, line 200) | | 11,561,561 | 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) | | 11,561,561 | 43 |

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

| | DESCRIPTION | | |
|---|---|---|---|
| 1 | Total patient revenues (from Worksheet G-2, Part I, column 3, line 28) | 23,741,998 | 1 |
| 2 | Less contractual allowances and discounts on patients' accounts | 12,143,009 | 2 |
| 3 | Net patient revenues (line 1 minus line 2) | 11,598,989 | 3 |
| 4 | Less total operating expenses (from Worksheet G-2, Part II, line 43) | 11,561,561 | 4 |
| 5 | Net income from service to patients (line 3 minus line 4) | 37,428 | 5 |

**OTHER INCOME**

| | | | |
|---|---|---|---|
| 6 | Contributions, donations, bequests, etc. | 2,528 | 6 |
| 7 | Income from investments | 23,346 | 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 | 101,994 | 11 |
| 12 | Parking lot receipts | | 12 |
| 13 | Revenue from laundry and linen service | | 13 |
| 14 | Revenue from meals sold to employees and guests | 3,313 | 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 | 4,855 | 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) | 7,200 | 24 |
| 24.01 | Other (GRANTS) | 131,351 | 24.01 |
| 24.02 | Other (DEFERRED REVENUE) | 76,678 | 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) | 351,265 | 25 |
| 26 | Total (line 5 plus line 25) | 388,693 | 26 |
| 29 | Net income (or loss) for the period (line 26 minus line 28) | 388,693 | 29 |

**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 |

**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 | 597,880 | 66,966 | 664,846 | | 664,846 | | 664,846 | 1 |
| 2 | Physician Assistant | | | | | | | | 2 |
| 3 | Nurse Practitioner | 217,702 | 21,414 | 239,116 | | 239,116 | | 239,116 | 3 |
| 4 | Visiting Nurse | | | | | | | | 4 |
| 5 | Other Nurse | 229,318 | 41,654 | 270,972 | | 270,972 | | 270,972 | 5 |
| 6 | Clinical Psychologist | | | | | | | | 6 |
| 7 | Clinical Social Worker | | | | | | | | 7 |
| 8 | Laboratory Techincian | | | | | | | | 8 |
| 9 | Other Facility Health Care Staff Costs | 289,484 | 46,772 | 336,256 | | 336,256 | | 336,256 | 9 |
| 10 | Subtotal (sum of lines 1 through 9) | 1,334,384 | 176,806 | 1,511,190 | | 1,511,190 | | 1,511,190 | 10 |
| | **COSTS UNDER AGREEMENT** | | | | | | | | |
| 11 | Physician Services Under Agreement | | | | | | | | 11 |
| 12 | Physician SUpervision Under Agreement | | | | | | | | 12 |
| 13 | Other Costs Under Agreement | | | | | | | | 13 |
| 14 | Subtotal (sum of lines 11 through 13) | | | | | | | | 14 |
| | **OTHER HEALTH CARE COSTS** | | | | | | | | |
| 15 | Medical Supplies | | 1,470 | 1,470 | | 1,470 | | 1,470 | 15 |
| 16 | Transportation (Health Care Staff) | | 218 | 218 | | 218 | | 218 | 16 |
| 17 | Deperciation-Medical Equipment | | | | | | | | 17 |
| 18 | Professional Liability Insurance | | | | | | | | 18 |
| 19 | Other Health Care Costs | | 76,964 | 76,964 | | 76,964 | | 76,964 | 19 |
| 20 | Allowable GME Costs | | | | | | | | 20 |
| 21 | Subtotal (sum of lines 15 through 20) | | 78,652 | 78,652 | | 78,652 | | 78,652 | 21 |
| 22 | Total Cost of Health Care Services (sum of lines 10, 14, and 21) | 1,334,384 | 255,458 | 1,589,842 | | 1,589,842 | | 1,589,842 | 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 | | 52,788 | 52,788 | | 52,788 | | 52,788 | 29 |
| 30 | Administrative Costs | | | | 7,663 | 7,663 | | 7,663 | 30 |
| 31 | Total Facility Overhead (sum of lines 29 and 30) | | 52,788 | 52,788 | 7,663 | 60,451 | | 60,451 | 31 |
| 32 | Total faciilty costs (sum of lines 22, 28 and 31) | 1,334,384 | 308,246 | 1,642,630 | 7,663 | 1,650,293 | | 1,650,293 | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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 | 1.75 | 7,598 | 4,200 | 7,350 | | 1 |
| 2 | Physician Assistants | | | 2,100 | | | 2 |
| 3 | Nurse Practitioners | 1.86 | 4,720 | 2,100 | 3,906 | | 3 |
| 4 | Subtotal (sum of lines 1 through 3) | 3.61 | 12,318 | | 11,256 | 12,318 | 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) | 3.61 | 12,318 | | | 12,318 | 8 |
| 9 | Physician Services Under Agreements | | | | | | 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) | 1,589,842 | 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) | 1,589,842 | 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) | 60,451 | 14 |
| 15 | Parent provider overhead allocated to facility (see instructions) | 599,728 | 15 |
| 16 | Total overhead (sum of lines 14 and 15) | 660,179 | 16 |
| 17 | Allowable Direct GME overhead (see instructions) | | 17 |
| 18 | Subtotal (see instructions) | 660,179 | 18 |
| 19 | Overhead applicable to RHC/FQHC services (line 13 x line 18) | 660,179 | 19 |
| 20 | Total allowable cost of RHC/FQHC services(sum of lines 10 and 19) | 2,250,021 | 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<br>Provider CCN: 14-1328 | In Lieu of Form<br>**CMS-2552-10** | Period :<br>From: 04/01/2017<br>To: 03/31/2018 | Run Date: 08/13/2018<br>Run Time: 13:13<br>Version: 2018.04 (07/10/2018) |

**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) | 2,250,021 | 1 |
| 2 | Cost of vaccines and their administratino (from Wkst. M-4, line 15) | 17,726 | 2 |
| 3 | Total allowable cost excluding vaccine (line 1 minus line 2) | 2,232,295 | 3 |
| 4 | Total visits (from Wkst. M-2, col. 5, line 8) | 12,318 | 4 |
| 5 | Physicians visits under agreement (from Wkst. M-2, col. 5, line 9) | | 5 |
| 6 | Total adjusted visits (line 4 plus line 5) | 12,318 | 6 |
| 7 | Adjusted cost per visit (line 3 divided by line 6) | 181.22 | 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) | 181.22 | 181.22 | 181.22 | 9 |
| | **CALCULATION OF SETTLEMENT** | | | | |
| 10 | Program covered visits excluding mental health services (from contractor records) | | 4,590 | | 10 |
| 11 | Program cost excluding costs for mental health services (line 9 x line 10) | | 831,800 | | 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) | | 831,800 | | 16 |
| 16.01 | Total program charges (see instructions)(from contractor's records) | | 599,100 | | 16.01 |
| 16.02 | Total program preventive charges (see instructions)(from provider's records) | | 1,996 | | 16.02 |
| 16.03 | Total program preventive costs (see instructions) | | 2,772 | | 16.03 |
| 16.04 | Total program non-preventive costs (see instructions) | | 607,800 | | 16.04 |
| 16.05 | Total program cost (see instructions) | | 610,572 | | 16.05 |
| 17 | Primary payer payments | | 107 | | 17 |
| 18 | Less: Beneficiary deductible for RHC only (see instructions)(from contractor records) | | 69,278 | | 18 |
| 19 | Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) | | 97,565 | | 19 |
| 20 | Net Medicare cost excluding vaccines (see instructions) | | 610,465 | | 20 |
| 21 | Program cost of vaccines and their administration (from Wkst. M-4, line 16) | | 13,260 | | 21 |
| 22 | Total reimbursable Program cost (line 20 plus line 21) | | 623,725 | | 22 |
| 23 | Allowable bad debts (see instructions) | | 46,688 | | 23 |
| 23.01 | Adjusted reimbursable bad debts (see instructions) | | 30,347 | | 23.01 |
| 24 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | 46,688 | | 24 |
| 25 | Other adjustments (specify) (see instructions) | | | | 25 |
| 26 | Net reimbursable amount (see instructions) | | 654,072 | | 26 |
| 26.01 | Sequestration adjustment (see instructions) | | 13,081 | | 26.01 |
| 26.02 | Demonstration payment adjustment amount after sequestration | | | | 26.02 |
| 27 | Interim payments | | 598,857 | | 27 |
| 28 | Tentative settlement (for contractor use only) | | | | 28 |
| 29 | Balance due component/program (line 26 minus lines 26.01, 27 and 28) | | 42,134 | | 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.

**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) | 1,511,190 | 1,511,190 | 1 |
| 2 | Ratio of pneumococcal and influenza vaccine staff time to total health care staff time | 0.000221 | 0.001994 | 2 |
| 3 | Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) | 334 | 3,013 | 3 |
| 4 | Medical supplies cost - pneumococcal and influenza vaccine (from your records) | 1,699 | 7,479 | 4 |
| 5 | Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) | 2,033 | 10,492 | 5 |
| 6 | Total direct cost of the facility (from Wkst. M-1, col. 7, line 22) | 1,589,842 | 1,589,842 | 6 |
| 7 | Total overhead (from Wkst. M-2, line 16) | 660,179 | 660,179 | 7 |
| 8 | Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) | 0.001279 | 0.006599 | 8 |
| 9 | Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) | 844 | 4,357 | 9 |
| 10 | Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9) | 2,877 | 14,849 | 10 |
| 11 | Total number of pneumococcal and influenza vaccine injections (from your records) | 56 | 506 | 11 |
| 12 | Cost per pneumococcal and influenza vaccing injection (line 10/line 11) | 51.38 | 29.35 | 12 |
| 13 | Number of pneumococcal and influenza vaccine injections administered to program beneficiaries | 41 | 380 | 13 |
| 14 | Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13) | 2,107 | 11,153 | 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) | | 17,726 | 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) | | 13,260 | 16 |

**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 | | | | 510,836 | 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 | 11/02/2017 | 88,021 | 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 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 | | 88,021 | 3.99 |
| 4 | Total interim payments (sum of lines 1, 2, and 3.99)<br>(transfer to Wkst. M-3, line 27) | | | | 598,857 | |
| | | | | | | |
| | **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 | | 42,134 | 6.01 |
| | based on the cost report (1) | | .02 | | | 6.02 |
| 7 | Total Medicare program liability (see instructions) | | | | 640,991 | |

| | | | | |
|---|---|---|---|---|
| 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.