

HARDIN COUNTY GENERAL HOSPITAL

TITLE XVIII MEDICARE COST REPORT

PROVIDER NO. 14-1328

YEAR ENDED MARCH 31, 2009

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT  
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
 PARTS I & II

INTERMEDIARY [ ] AUDITED DATE RECEIVED [ ] INITIAL [ ] RE-OPENING  
 USE ONLY: [ ] DESK REVIEWED INTERMEDIARY NO. [ ] FINAL [ ] MCR CODE

PART I - CERTIFICATION

CHECK XX ELECTRONICALLY FILED COST REPORT DATE: 07/06/2009  
 APPLICABLE BOX MANUALLY SUBMITTED COST REPORT TIME: 15:08

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 WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 04/01/2008 AND ENDING 03/31/2009, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

ECR Encryption: 07/06/2009 15:08  
 oxyzppQwH4oqDGiKOSU9Kx5C8fynW0  
 A1lCc0aZcLt8hqNi0ZVCuxCQ2wVt8S  
 0V8L0Aszac0xAsRI

(SIGNED)

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PI Encryption: 07/06/2009 15:08  
 hyWtNok84Ydw08D92TrsdL1LLsnQ00  
 A:FgB0SzhwJwvAXZnWJ8CuBPQbMAGD  
 .Xy268WvgI0cHf0v

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	2	3	4	1
2	SUBPROVIDER I	-66181	43442	348321	2
3	SWING BED - SNF	66740			3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY				5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	RURAL HEALTH CLINIC I		-5450		9
100	TOTAL	559	37992	348321	100

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 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: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.



HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				26
26.01	ENTER THE APPLICABLE SCH DATES:	BEGINNING:	ENDING:		26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS):	BEGINNING:	ENDING:		26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	07/09/2003		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				28.02
A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 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. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)					
28.03	STAFFING	0.00	N		28.03
28.04	RECRUITMENT	0.00	N		28.04
28.05	RETENTION OF EMPLOYEES	0.00	N		28.05
28.06	TRAINING	0.00	N		28.06
28.07	OTHER (SPECIFY)				28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO			29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES			30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO			30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO			30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO			30.03
30.04	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. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO			30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO			31
MISCELLANEOUS COST REPORTING INFORMATION					
32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO			32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO			33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO			34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL					
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	NO	NO	NO	37.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES	38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO	38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO	38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO	38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO	38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	NO	40
40.01	NAME:	FI/CONTRACTOR'S NAME:	FI/CONTRACTOR'S NUMBER:
40.02	STREET:		P.O. BOX:
40.03	CITY:		STATE:
			ZIP CODE:
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES	41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES	42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES	42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES	42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO	43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO	44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO	45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		45.03
46	IF YOU ARE PARTICIPATING IN THE NHCQM DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.		46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.113).

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	1	2	3	4	5	
47	HOSPITAL	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N	N	N	49
50	HOME HEALTH AGENCY	N	N	N	N	50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	NO	52			
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.	NO	52.01			
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		53			
53.01	MDH PERIOD: BEGINNING: ENDING:		53.01			
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 66800 PAID LOSSES: AND/OR SELF INSURANCE:		54			
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	NO	54.01			
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	55			
		DATE	Y/N	LIMIT	Y/N	FEE\$
		0	1	2	3	4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO	56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?	NO	57			
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.	NO	58			
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)		58.01			
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO	59			

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO	60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES 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. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)		60.01
MULTICAMPUS			
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.	NO	61
	COUNTY: 1	STATE: 2	ZIP CODE 3
			CBSA 4
			FTE/ CAMPUS 5
SETTLEMENT DATA			
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)	YES	06/08/2009 63





HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I  
 (CONTINUED)

		-----DISCHARGES-----				
COMPONENT	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15		
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS	477	129	702	1	
2	HMO XIX				2	
3	HOSPITAL ADULTS & PEDS - SWING BED SNF				3	
4	HOSPITAL ADULTS & PEDS - SWING BED NF				4	
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS				5	
6	INTENSIVE CARE UNIT				6	
7	CORONARY CARE UNIT				7	
8	BURN INTENSIVE CARE UNIT				8	
9	SURGICAL INTENSIVE CARE UNIT				9	
10	OTHER SPECIAL CARE (SPECIFY)				10	
11	NURSERY				11	
12	TOTAL HOSPITAL	477	129	702	12	
13	RPCH VISITS				13	
14	SUBPROVIDER I				14	
15	SKILLED NURSING FACILITY				15	
16	NURSING FACILITY				16	
17	OTHER LONG TERM CARE				17	
18	HOME HEALTH AGENCY				18	
20	ASC (DISTINCT PART)				20	
21	HOSPICE (DISTINCT PART)				21	
23	O/P REHAB PROVIDER				23	
24	RHC I				24	
25	TOTAL				25	
26	OBSERVATION BED DAYS				26	
27	AMBULANCE TRIPS				27	
28	EMPLOYEE DISCOUNT DAYS				28	

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
PERIOD FROM 04/01/2008 TO 03/31/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01  
07/06/2009 15:06

PROVIDER-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER  
PROVIDER STATISTICAL DATA

RHC I  
COMPONENT NO: 14-3479

WORKSHEET S-8

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 6 FERRELL ROAD 1  
1.01 CITY: ROSICLARE STATE: IL ZIP CODE: 62982 COUNTY: HARDIN 1.01  
2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

	1	2	
3	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)	/ /	3
4	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)	/ /	4
5	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)	/ /	5
6	APPALACHIAN REGIONAL COMMISSION	/ /	6
7	LOOK-ALIKES	/ /	7
8	OTHER	/ /	8

PHYSICIAN INFORMATION:

PHYSICIAN NAME

BILLING NO.

9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	MARCOS SUNGA, MD	C43012 9
9.01		ELADIO CHATTO, MD	E98343 9.01
9.02		SANJAY BOSE	G78722 9.02
9.03		PAM ATKINSON	P10866 9.03
9.04		LEANNE DENEAL	S98894 9.04

PHYSICIAN NAME

HOURS

10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD 10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11  
IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2  
(ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	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
12 CLINIC			900	1700	900	1700	900	1700	900	1700	900	1700		

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS 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.

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? NO 13

14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? NO 14

IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.

LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.

15 PROVIDER NAME: PROVIDER NUMBER: - XVIII XIX 15

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO V XVIII XIX 16

17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. NO 17

IF YES, SEE INSTRUCTIONS.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
GENERAL SERVICE COST CENTERS									
3	0300 NEW CAP REL COSTS-BLDG & FIXT		16938	16938	29403	46341	-380	45961	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		212071	212071	6962	219033		219033	4
5	0500 EMPLOYEE BENEFITS				70442	70442		70442	5
6	0600 ADMINISTRATIVE & GENERAL	668762	2025144	2693906	-63629	2630277	-1080073	1550204	6
8	0800 OPERATION OF PLANT	136040	210127	346167	-2057	344110	-453	343657	8
9	0900 LAUNDRY & LINEN SERVICE	50888	25519	76407		76407		76407	9
10	1000 HOUSEKEEPING	112591	33957	146548	-10499	136049		136049	10
11	1100 DIETARY	101544	127766	229310	-92174	137136		137136	11
12	1200 CAFETERIA				90797	90797	-28435	62362	12
14	1400 NURSING ADMINISTRATION				82357	82357		82357	14
15	1500 CENTRAL SERVICES & SUPPLY	19135	6370	25505	-23085	2420		2420	15
16	1600 PHARMACY	175804	176409	352213	-126151	226062		226062	16
17	1700 MEDICAL RECORDS & LIBRARY	262715	55128	317843	-46011	271832	-1489	270343	17
18	1800 SOCIAL SERVICE	48542	13671	62213		62213		62213	18
INPATIENT ROUTINE SERV COST CENTERS									
25	2500 ADULTS & PEDIATRICS	1192366	456258	1648624	-257514	1391110	-72739	1318371	25
ANCILLARY SERVICE COST CENTERS									
41	4100 RADIOLOGY-DIAGNOSTIC	393772	344447	738219	-10725	727494	-119	727375	41
44	4400 LABORATORY	378935	718546	1097481	-5213	1092268	-112790	979478	44
49	4900 RESPIRATORY THERAPY	178929	86141	265070	-40698	224372	-40804	183568	49
50	5000 PHYSICAL THERAPY	68745	59085	127830	-121	127709		127709	50
51	5100 OCCUPATIONAL THERAPY								51
52	5200 SPEECH PATHOLOGY								52
53	5300 ELECTROCARDIOLOGY	13862	2077	15939	23805	39744		39744	53
55	5500 MEDICAL SUPPLIES CHARGED TO PAT				149966	149966		149966	55
56	5600 DRUGS CHARGED TO PATIENTS				352968	352968		352968	56
OUTPATIENT SERVICE COST CENTERS									
61	6100 EMERGENCY	626118	192336	818454	-116061	702393	-243634	458759	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RURAL HEALTH CLINIC	714729	150787	865516	67356	932872	-120	932752	63.50
OTHER REIMBURSABLE COST CENTERS									
71	7100 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS									
88	8800 INTEREST EXPENSE		80118	80118	-80118				88
95	9500 SUBTOTALS	5143477	4992895	10136372		10136372	-1581036	8555336	95
NONREIMBURSABLE COST CENTERS									
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN								96
96.01	9601 VENDING MACHINE		14875	14875		14875		14875	96.01
101	10100 TOTAL	5143477	5007770	10151247		10151247	-1581036	8570211	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE				
		COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 TO RECLASS SUPPLY COST FROM CS	A	MEDICAL SUPPLIES CHARGED TO P	55	14351	8734	1
2 TO RECLASS DON COST	B	NURSING ADMINISTRATION	14	71615	10742	2
3 TO RECLASS COST TO CLINC	C	RURAL HEALTH CLINIC	63.50	51380	7187	3
4	C					4
5	C					5
6 TO RECLASS SUPPLY COST	D	MEDICAL SUPPLIES CHARGED TO P	55		126881	6
7	D					7
8	D					8
9	D					9
10	D					10
11	D					11
12	D					12
13 TO RECLASS INSURANCE EXPENSE	E	NEW CAP REL COSTS-BLDG & FIXT	3		1426	13
14	E	NEW CAP REL COSTS-MVBLE EQUIP	4		6962	14
15	E	EMPLOYEE BENEFITS	5		70442	15
16 TO RECLASS INTEREST	F	NEW CAP REL COSTS-BLDG & FIXT	3		27977	16
17	F	ADMINISTRATIVE & GENERAL	6		15201	17
18	F	RADIOLOGY-DIAGNOSTIC	41		8763	18
19	F	ADULTS & PEDIATRICS	25		19369	19
20	F	RESPIRATORY THERAPY	49		19	20
21	F	RURAL HEALTH CLINIC	63.50		8789	21
22 TO RECLASS CAFE COST	G	CAFETERIA	12	49757	41040	22
23 TO RECLASS CARDIAC MONITORING COST	H	ELECTROCARDIOLOGY	53	19932	3873	23
24	H					24
25 TO RECLASS DRUG COST	I	DRUGS CHARGED TO PATIENTS	56		352968	25
26	I					26
27	I					27
28	I					28
29	I					29
30	I					30
31	I					31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				207035	710373	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7 REF.
			LINE #	SALARY		
1	1	6	7	8	9	10
1 TO RECLASS SUPPLY COST FROM CS	A	CENTRAL SERVICES & SUPPLY	15	14351	8734	1
2 TO RECLASS DON COST	B	ADULTS & PEDIATRICS	25	71615	10742	2
3 TO RECLASS COST TO CLINC	C	OPERATION OF PLANT	8	1870	187	3
4	C	HOUSEKEEPING	10	9006	1493	4
5	C	MEDICAL RECORDS & LIBRARY	17	40504	5507	5
6 TO RECLASS SUPPLY COST	D	ADULTS & PEDIATRICS	25		59779	6
7	D	EMERGENCY	61		15175	7
8	D	RADIOLOGY-DIAGNOSTIC	41		19482	8
9	D	LABORATORY	44		5213	9
10	D	RESPIRATORY THERAPY	49		27200	10
11	D	PHYSICAL THERAPY	50		28	11
12	D	RADIOLOGY-DIAGNOSTIC	41		4	12
13 TO RECLASS INSURANCE EXPENSE	E					12 13
14	E					12 14
15	E	ADMINISTRATIVE & GENERAL	6		78830	15
16 TO RECLASS INTEREST	F					11 16
17	F					17
18	F					18
19	F					19
20	F					20
21	F	INTEREST EXPENSE	88		80118	21
22 TO RECLASS CAFE COST	G	DIETARY	11	49757	41040	22
23 TO RECLASS CARDIAC MONITORING COS	H					23
24	H	ADULTS & PEDIATRICS	25	19932	3873	24
25 TO RECLASS DRUG COST	I	ADULTS & PEDIATRICS	25		110942	25
26	I	EMERGENCY	61		100886	26
27	I	RADIOLOGY-DIAGNOSTIC	41		2	27
28	I	PHARMACY	16		126151	28
29	I	RESPIRATORY THERAPY	49		13517	29
30	I	PHYSICAL THERAPY	50		93	30
31	I	DIETARY	11		1377	31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				207035	710373	36

ANALYSIS OF CHANGES DURING COST REPORTING  
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL  
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED  
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7  
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	17000					17000		1
2 LAND IMPROVEMENTS	100979					100979		2
3 BUILDINGS AND FIXTURES	1209909					1209909		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	2192667	289037		289037	169858	2311846		6
7 SUBTOTAL	3520555	289037		289037	169858	3639734		7
8 RECONCILING ITEMS								8
9 TOTAL	3520555	289037		289037	169858	3639734		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	1	2	3	4	5	6	7	8
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT	1310888		1310888	.361850				3
4 NEW CAP REL COSTS-MVBLE EQUIP	2311846		2311846	.638150				4
5 TOTAL	3622734		3622734	1.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	16938		27597	1426			45961 3
4 NEW CAP REL COSTS-MVBLE EQUIP	212071			6962			219033 4
5 TOTAL	229009		27597	8388			264994 5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	16938						16938 3
4 NEW CAP REL COSTS-MVBLE EQUIP	212071						212071 4
5 TOTAL	229009						229009 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5 INVESTMENT INCOME-OTHER					5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES	B	-62412	ADMINISTRATIVE & GENERAL	6	7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-2214	ADMINISTRATIVE & GENERAL	6	9
10 TELEVISION AND RADIO SERVICE					10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-469704			12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1				14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-28435	CAFETERIA	12	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS					19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	A	-1489	MEDICAL RECORDS & LIBRARY	17	20
21 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		OCCUPATIONAL THERAPY	51	35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		SPEECH PATHOLOGY	52	36
37 INTEREST INCOME	B	-380	NEW CAP REL COSTS-BLDG & FIXT	3	37
38 INTEREST INCOME	B	-206	ADMINISTRATIVE & GENERAL	6	38
39 INTEREST INCOME	B	-263	ADULTS & PEDIATRICS	25	39
40 INTEREST INCOME	B	-119	RADIOLOGY-DIAGNOSTIC	41	40
41 INTEREST INCOME	B	-120	RURAL HEALTH CLINIC	63.50	41
42 CMS APPEAL COST	A	-15721	ADMINISTRATIVE & GENERAL	6	42
43 BAD DEBT	A	-852151	ADMINISTRATIVE & GENERAL	6	43
44 LATE FEES	A	-27912	ADMINISTRATIVE & GENERAL	6	44
45					45
46 PROVIDER TAX	A	-114217	ADMINISTRATIVE & GENERAL	6	46
47 LOBBING PORTION OF DUES	A	-5240	ADMINISTRATIVE & GENERAL	6	47
48 RENTAL COST	A	-453	OPERATION OF PLANT	8	48
49					49
50 TOTAL		-1581036			50

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
 PERIOD FROM 04/01/2008 TO 03/31/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2009.01  
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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	6 ADMINISTRATIVE & GENERAL MED STAFF DIRECTOR	30085		30085				
2	25 ADULTS & PEDIATRICS AGGREGATE	72476	72476					
3	44 LABORATORY AGGREGATE	119990	112790	7200				
4	49 RESPIRATORY THERAPY AGGREGATE	40804	40804					
5	61 EMERGENCY AGGREGATE	445400	243634	201766				
101	TOTAL	708755	469704	239051				



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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
 PARTS I & II

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		320.00				9
10	AHSEA		63.86				10
11	STANDARD TRAVEL ALLOWANCE	31.93	31.93				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					20435	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					20435	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					20435	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					63.86	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					49811	22
23	TOTAL SALARY EQUIVALENCY					49811	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
PARTS III & IV

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	24
25	ASSISTANTS	25
26	SUBTOTAL	26
27	STANDARD TRAVEL EXPENSE	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS	29
30	ASSISTANTS	30
31	SUBTOTAL	31
32	OPTIONAL TRAVEL EXPENSE	32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

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

STANDARD TRAVEL EXPENSE		
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
 PARTS V,VI & VII

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION					
	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47	OVERTIME HOURS WORKED				47
	DURING REPORTING PERIOD				
48	OVERTIME RATE				48
49	TOTAL OVERTIME				49
CALCULATION OF LIMIT					
50	PERCENTAGE OF OVERTIME				50
	HOURS BY CATEGORY				
51	ALLOCATION OF PROVIDER'S				51
	STANDARD WORKYEAR FOR ONE				
	FULL TIME EMPLOYEE TIMES				
	THE PERCENTAGES ON LINE 50				
DETERMINATION OF OVERTIME ALLOWANCE					
52	ADJUSTED HOURLY SALARY				52
	EQUIVALENCY AMOUNT				
53	OVERTIME COST LIMITATION				53
54	MAXIMUM OVERTIME COST				54
55	PORTION OF OVERTIME ALREADY				55
	INCLUDED IN HOURLY				
	COMPUTATION AT THE AHSEA				
56	OVERTIME ALLOWANCE				56
PART VI COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT					
57	SALARY EQUIVALENCY AMOUNT				49811
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE				58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES				59
60	OVERTIME ALLOWANCE				60
61	EQUIPMENT COST				61
62	SUPPLIES				62
63	TOTAL ALLOWANCE				49811
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES				19189
65	EXCESS OVER LIMITATION				65

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
PARTS V, VI & VII

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	19189	66
67	TOTAL COST	19189	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
 PARTS I & II

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		387.00				9
10	AHSEA		67.38				10
11	STANDARD TRAVEL ALLOWANCE	33.69	33.69				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					26076	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					26076	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					26076	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					67.38	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					52556	22
23	TOTAL SALARY EQUIVALENCY					52556	23

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
PERIOD FROM 04/01/2008 TO 03/31/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01  
07/06/2009 15:06

REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
PARTS III & IV

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE	
24 THERAPISTS	24
25 ASSISTANTS	25
26 SUBTOTAL	26
27 STANDARD TRAVEL EXPENSE	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
29 THERAPISTS	29
30 ASSISTANTS	30
31 SUBTOTAL	31
32 OPTIONAL TRAVEL EXPENSE	32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

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

STANDARD TRAVEL EXPENSE	
36 THERAPISTS	36
37 ASSISTANTS	37
38 SUBTOTAL	38
39 STANDARD TRAVEL EXPENSE	39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
40 THERAPISTS	40
41 ASSISTANTS	41
42 SUBTOTAL	42
43 OPTIONAL TRAVEL EXPENSE	43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	
44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
 PERIOD FROM 04/01/2008 TO 03/31/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
 PARTS V, VI & VII

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47	OVERTIME HOURS WORKED				47
	DURING REPORTING PERIOD				
48	OVERTIME RATE				48
49	TOTAL OVERTIME				49
	CALCULATION OF LIMIT				
50	PERCENTAGE OF OVERTIME				50
	HOURS BY CATEGORY				
51	ALLOCATION OF PROVIDER'S				51
	STANDARD WORKYEAR FOR ONE				
	FULL TIME EMPLOYEE TIMES				
	THE PERCENTAGES ON LINE 50				
	DETERMINATION OF OVERTIME ALLOWANCE				
52	ADJUSTED HOURLY SALARY				52
	EQUIVALENCY AMOUNT				
53	OVERTIME COST LIMITATION				53
54	MAXIMUM OVERTIME COST				54
55	PORTION OF OVERTIME ALREADY				55
	INCLUDED IN HOURLY				
	COMPUTATION AT THE AHSEA				
56	OVERTIME ALLOWANCE				56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT				52556	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE					58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES					59
60	OVERTIME ALLOWANCE					60
61	EQUIPMENT COST					61
62	SUPPLIES					62
63	TOTAL ALLOWANCE				52556	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES				23248	64
65	EXCESS OVER LIMITATION					65

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
PARTS V, VI & VII

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	23248	66
67	TOTAL COST	23248	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
 PERIOD FROM 04/01/2008 TO 03/31/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
 PARTS I & II

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					43	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					645	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		73.00				9
10	AHSEA		61.36				10
11	STANDARD TRAVEL ALLOWANCE	30.68	30.68				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					4479	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					4479	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					4479	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					61.36	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					39577	22
23	TOTAL SALARY EQUIVALENCY					39577	23

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WORKSHEET A-8-4  
PARTS III & IV

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE	
24 THERAPISTS	24
25 ASSISTANTS	25
26 SUBTOTAL	26
27 STANDARD TRAVEL EXPENSE	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29 THERAPISTS	29
30 ASSISTANTS	30
31 SUBTOTAL	31
32 OPTIONAL TRAVEL EXPENSE	32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

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

STANDARD TRAVEL EXPENSE

36 THERAPISTS	36
37 ASSISTANTS	37
38 SUBTOTAL	38
39 STANDARD TRAVEL EXPENSE	39

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

40 THERAPISTS	40
41 ASSISTANTS	41
42 SUBTOTAL	42
43 OPTIONAL TRAVEL EXPENSE	43

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
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WORKSHEET A-8-4  
PARTS V, VI & VII

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47					47
48					48
49					49
50					50
51					51
52					52
53					53
54					54
55					55
56					56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					39577	57
58						58
59						59
60						60
61						61
62						62
63					39577	63
64					4405	64
65						65

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
PARTS V, VI & VII

OCCUPATIONAL     PHYSICAL     RESPIRATORY     SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	4405	66
67	TOTAL COST	4405	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
GENERAL SERVICE COST CENTERS									
3 NEW CAP REL COSTS-BLDG & FIXT	45961	45961							3
4 NEW CAP REL COSTS-MVBLE EQUIP	219033		219033						4
5 EMPLOYEE BENEFITS	70442			70442					5
6 ADMINISTRATIVE & GENERAL	1550204	7487	35819	9159	1602669	1602669			6
8 OPERATION OF PLANT	343657	4557	21800	1837	371851	85533	457384		8
9 LAUNDRY & LINEN SERVICE	76407	2055	9829	697	88988	20469	27706	137163	9
10 HOUSEKEEPING	136049	71	341	1419	137880	31715	962	5276	10
11 DIETARY	137136	2094	10017	764	150011	34505	28235	6622	11
12 CAFETERIA	62362	856	4096	627	67941	15628	11544		12
14 NURSING ADMINISTRATION	82357	4257	20367	981	107962	24833	57407		14
15 CENTRAL SERVICES & SUPPLY	2420			66	2486	572			15
16 PHARMACY	226062	899	4300	2408	233669	53748	12121		16
17 MEDICAL RECORDS & LIBRARY	270343	1990	9522	3043	284898	65532	26840		17
18 SOCIAL SERVICE	62213	392	1877	665	65147	14985	5291		18
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	1318371	9779	46782	15075	1390007	319732	131866	101993	25
ANCILLARY SERVICE COST CENTERS									
41 RADIOLOGY-DIAGNOSTIC	727375	3151	15077	5393	750996	172743	42496	3442	41
44 LABORATORY	979478	1213	5802	5190	991683	228106	16354		44
49 RESPIRATORY THERAPY	183568	899	4300	2450	191217	43984	12121		49
50 PHYSICAL THERAPY	127709	1748	8362	941	138760	31917	23569	11614	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY	39744	449	2150	463	42806	9846	6061		53
55 MEDICAL SUPPLIES CHARGED TO PAT	149966	949	4539	197	155651	35803	12795		55
56 DRUGS CHARGED TO PATIENTS	352968				352968	81189			56
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY	458759	2338	11186	8575	480858	110606	31530	8216	61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RURAL HEALTH CLINIC	932752			10492	943244	216964			63.50
OTHER REIMBURSABLE COST CENTERS									
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
95 SUBTOTALS	8555336	45184	216166	70442	8551692	1598410	446898	137163	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		599	2867		3466	797	8081		96
96.01 VENDING MACHINE	14875	178			15053	3462	2405		96.01
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	8570211	45961	219033	70442	8570211	1602669	457384	137163	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	10	11	12	14	15	16	17	18
GENERAL SERVICE COST CENTERS								
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING	175833							10
11 DIETARY	11580	230953						11
12 CAFETERIA	4735	112519	212367					12
14 NURSING ADMINISTRATION	23545		3481	217228				14
15 CENTRAL SERVICES & SUPPLY			555	5793	9406			15
16 PHARMACY	4971		6300		359	311168		16
17 MEDICAL RECORDS & LIBRARY	11008		18067		103		406448	17
18 SOCIAL SERVICE	2170		2136		27			89756 18
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	54084	118434	68020	211435	880		256108	89756 25
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC	17429		21399		160		36509	41
44 LABORATORY	6707		22211		5616		15401	44
49 RESPIRATORY THERAPY	4971		9482		166			49
50 PHYSICAL THERAPY	9667		4549		34			50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY	2486		1986		12			53
55 MEDICAL SUPPLIES CHARGED TO PAT	5248		1644		1778			55
56 DRUGS CHARGED TO PATIENTS						303309		56
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	12932		16167		108		589	61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RURAL HEALTH CLINIC			36370		163	7859	97841	63.50
OTHER REIMBURSABLE COST CENTERS								
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
95 SUBTOTALS	171533	230953	212367	217228	9406	311168	406448	89756 95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN	3314							96
96.01 VENDING MACHINE	986							96.01
101 CRGSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	175833	230953	212367	217228	9406	311168	406448	89756 103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	25	26	27	
GENERAL SERVICE COST CENTERS				
3 NEW CAP REL COSTS-BLDG & FIXT				3
4 NEW CAP REL COSTS-MVBLE EQUIP				4
5 EMPLOYEE BENEFITS				5
6 ADMINISTRATIVE & GENERAL				6
8 OPERATION OF PLANT				8
9 LAUNDRY & LINEN SERVICE				9
10 HOUSEKEEPING				10
11 DIETARY				11
12 CAFETERIA				12
14 NURSING ADMINISTRATION				14
15 CENTRAL SERVICES & SUPPLY				15
16 PHARMACY				16
17 MEDICAL RECORDS & LIBRARY				17
18 SOCIAL SERVICE				18
INPATIENT ROUTINE SERV COST CENTERS				
25 ADULTS & PEDIATRICS	2742315		2742315	25
ANCILLARY SERVICE COST CENTERS				
41 RADIOLOGY-DIAGNOSTIC	1045174		1045174	41
44 LABORATORY	1286078		1286078	44
49 RESPIRATORY THERAPY	261941		261941	49
50 PHYSICAL THERAPY	220110		220110	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	63197		63197	53
55 MEDICAL SUPPLIES CHARGED TO PAT	212919		212919	55
56 DRUGS CHARGED TO PATIENTS	737466		737466	56
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	661006		661006	61
62 OBSERVATION BEDS (NON-DISTINCT				62
63.50 RURAL HEALTH CLINIC	1302441		1302441	63.50
OTHER REIMBURSABLE COST CENTERS				
71 HOME HEALTH AGENCY				71
SPECIAL PURPOSE COST CENTERS				
95 SUBTOTALS	8532647		8532647	95
NONREIMBURSABLE COST CENTERS				
96 GIFT, FLOWER, COFFEE SHOP & CAN	15658		15658	96
96.01 VENDING MACHINE	21906		21906	96.01
101 CROSS FOOT ADJUSTMENTS				101
102 NEGATIVE COST CENTER				102
103 TOTAL	8570211		8570211	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	ADMINIS- TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING 10
GENERAL SERVICE COST CENTERS								
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL		7487	35819	43306	43306			6
8 OPERATION OF PLANT		4557	21800	26357	2311	28668		8
9 LAUNDRY & LINEN SERVICE		2055	9829	11884	553	1737	14174	9
10 HOUSEKEEPING		71	341	412	857	60	545	1874 10
11 DIETARY		2094	10017	12111	932	1770	684	123 11
12 CAFETERIA		856	4096	4952	422	724		50 12
14 NURSING ADMINISTRATION		4257	20367	24624	671	3598		251 14
15 CENTRAL SERVICES & SUPPLY					15			15
16 PHARMACY		899	4300	5199	1452	760		53 16
17 MEDICAL RECORDS & LIBRARY		1990	9522	11512	1771	1682		117 17
18 SOCIAL SERVICE		392	1877	2269	405	332		23 18
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS		9779	46782	56561	8643	8264	10540	578 25
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC		3151	15077	18228	4667	2664	356	186 41
44 LABORATORY		1213	5802	7015	6163	1025		71 44
49 RESPIRATORY THERAPY		899	4300	5199	1188	760		53 49
50 PHYSICAL THERAPY		1748	8362	10110	862	1477	1200	103 50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY		449	2150	2599	266	380		26 53
55 MEDICAL SUPPLIES CHARGED TO PAT		949	4539	5488	967	802		56 55
56 DRUGS CHARGED TO PATIENTS					2194			56
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY		2338	11186	13524	2989	1976	849	138 61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RURAL HEALTH CLINIC					5862			63.50
OTHER REIMBURSABLE COST CENTERS								
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
95 SUBTOTALS		45184	216166	261350	43190	28011	14174	1828 95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN		599	2867	3466	22	506		35 96
96.01 VENDING MACHINE		178		178	94	151		11 96.01
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL		45961	219033	264994	43306	28668	14174	1874 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIETARY 11	CAFETERIA 12	NURSING ADMINIS- TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25
GENERAL SERVICE COST CENTERS								
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING								10
11 DIETARY	15620							11
12 CAFETERIA	7610	13758						12
14 NURSING ADMINISTRATION			226	29370				14
15 CENTRAL SERVICES & SUPPLY			36	783	834			15
16 PHARMACY			408		32	7904		16
17 MEDICAL RECORDS & LIBRARY			1170		9		16261	17
18 SOCIAL SERVICE			138		2			18
INPATIENT ROUTINE SERV COST CENTERS							3169	
25 ADULTS & PEDIATRICS	8010	4407	28587	78		10246	3169	139083
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC		1386		14		1461		28962
44 LABORATORY		1439		498		616		16827
49 RESPIRATORY THERAPY		614		15				7829
50 PHYSICAL THERAPY		295		3				14050
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY		129		1				3401
55 MEDICAL SUPPLIES CHARGED TO PAT		107		158				7578
56 DRUGS CHARGED TO PATIENTS					7704			9898
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY		1047		10		24		20557
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RURAL HEALTH CLINIC		2356		14	200	3914		12346
OTHER REIMBURSABLE COST CENTERS								
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
95 SUBTOTALS	15620	13758	29370	834	7904	16261	3169	260531
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN								4029
96.01 VENDING MACHINE								434
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	15620	13758	29370	834	7904	16261	3169	264994

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	26	27	
GENERAL SERVICE COST CENTERS			
3 NEW CAP REL COSTS-BLDG & FIXT			3
4 NEW CAP REL COSTS-MVBLE EQUIP			4
5 EMPLOYEE BENEFITS			5
6 ADMINISTRATIVE & GENERAL			5
8 OPERATION OF PLANT			8
9 LAUNDRY & LINEN SERVICE			9
10 HOUSEKEEPING			10
11 DIETARY			11
12 CAFETERIA			12
14 NURSING ADMINISTRATION			14
15 CENTRAL SERVICES & SUPPLY			15
16 PHARMACY			16
17 MEDICAL RECORDS & LIBRARY			17
18 SOCIAL SERVICE			18
INPATIENT ROUTINE SERV COST CENTERS			
25 ADULTS & PEDIATRICS	139083		25
ANCILLARY SERVICE COST CENTERS			
41 RADIOLOGY-DIAGNOSTIC	28962		41
44 LABORATORY	16827		44
49 RESPIRATORY THERAPY	7829		49
50 PHYSICAL THERAPY	14050		50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY			52
53 ELECTROCARDIOLOGY	3401		53
55 MEDICAL SUPPLIES CHARGED TO PAT	7578		55
56 DRUGS CHARGED TO PATIENTS	9898		56
OUTPATIENT SERVICE COST CENTERS			
61 EMERGENCY	20557		61
62 OBSERVATION BEDS (NON-DISTINCT			62
63.50 RURAL HEALTH CLINIC	12346		63.50
OTHER REIMBURSABLE COST CENTERS			
71 HOME HEALTH AGENCY			71
SPECIAL PURPOSE COST CENTERS			
95 SUBTOTALS	260531		95
NONREIMBURSABLE COST CENTERS			
96 GIFT, FLOWER, COFFEE SHOP & CAN	4029		96
96.01 VENDING MACHINE	434		96.01
101 CROSS FOOT ADJUSTMENTS			101
102 NEGATIVE COST CENTER			102
103 TOTAL	264994		103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP	NEW CAP	EMPLOYEE	RECON-	ADMINIS-	OPERATION	LAUNDRY
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT SQUARE FEET	BENEFITS GROSS SALA RIES		CILIAATION GENERAL ACCUM COST	TRATIVE & OF PLANT SQUARE FEET	& LINEN SERVICE POUNDS OF LAUNDRY
	3	4	5	6A	6	8	9
GENERAL SERVICE COST CENTERS							
3 NEW CAP REL COSTS-BLDG & FIXT	25771						3
4 NEW CAP REL COSTS-MVBLE EQUIP		25671					4
5 EMPLOYEE BENEFITS			5143477				5
6 ADMINISTRATIVE & GENERAL	4198	4198	668762	-1602669	6967542		6
8 OPERATION OF PLANT	2555	2555	134170		371851	19018	8
9 LAUNDRY & LINEN SERVICE	1152	1152	50888		88988	1152	183300 9
10 HOUSEKEEPING	40	40	103585		137880	40	7050 10
11 DIETARY	1174	1174	55787		150011	1174	8850 11
12 CAFETERIA	480	480	45757		67941	480	12
14 NURSING ADMINISTRATION	2387	2387	71615		107962	2387	14
15 CENTRAL SERVICES & SUPPLY			4784		2486		15
16 PHARMACY	504	504	175804		233669	504	16
17 MEDICAL RECORDS & LIBRARY	1116	1116	222211		284898	1116	17
18 SOCIAL SERVICE	220	220	48542		65147	220	18
INPATIENT ROUTINE SERV COST CENTERS							
25 ADULTS & PEDIATRICS	5483	5483	1100819		1390007	5483	136300 25
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC	1767	1767	393772		750996	1767	4600 41
44 LABORATORY	680	680	378935		991683	680	44
49 RESPIRATORY THERAPY	504	504	178929		191217	504	49
50 PHYSICAL THERAPY	980	980	68745		138760	980	15520 50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	252	252	33794		42806	252	53
55 MEDICAL SUPPLIES CHARGED TO P	532	532	14351		155651	532	55
56 DRUGS CHARGED TO PATIENTS					352968		56
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	1311	1311	626118		480858	1311	10980 61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RURAL HEALTH CLINIC			766109		943244		63.50
OTHER REIMBURSABLE COST CENTERS							
71 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS							
95 SUBTOTALS	25335	25335	5143477	-1602669	6949023	18582	183300 95
NONREIMBURSABLE COST CENTERS							
96 GIFT, FLOWER, COFFEE SHOP & C	336	336			3466	336	96
96.01 VENDING MACHINE	100				15053	100	96.01
CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 COST TO BE ALLOC PER B PT I	45961	219033	70442		1602669	457384	137163 103
104 UNIT COST MULT-WS B PT I		8.532313				24.050058	104
104 UNIT COST MULT-WS B PT I	1.783439		.013695		.230019		.748298 104
105 COST TO BE ALLOC PER B PT II							105
106 UNIT COST MULT-WS B PT II							106
106 UNIT COST MULT-WS B PT II							106
107 COST TO BE ALLOC PER B PT III					43306	28668	14174 107
108 UNIT COST MULT-WS B PT III						1.507414	108
108 UNIT COST MULT-WS B PT III					.006215		.077327 108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	SQUARE FEET 10	MEALS SERV ED 11	FTE'S SERV ED 12	DIRECT NRS ING HRS 14	COSTED REQ UIS. 15	COSTED REQ UIS. 16	TIME SPENT 17	PATIENT DA YS 18
GENERAL SERVICE COST CENTERS								
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING	17826							10
11 DIETARY	1174	23898						11
12 CAFETERIA	480	11643	9944					12
14 NURSING ADMINISTRATION	2387		163	80890				14
15 CENTRAL SERVICES & SUPPLY			26	2157	671360			15
16 PHARMACY	504		295		25597	362114		16
17 MEDICAL RECORDS & LIBRARY	1116		846		7364		89730	17
18 SOCIAL SERVICE	220		100		1930			2632 18
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	5483	12255	3185	78733	62787		56540	2632 25
ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC	1767		1002		11429		8060	41
44 LABORATORY	680		1040		400882		3400	44
49 RESPIRATORY THERAPY	504		444		11857			49
50 PHYSICAL THERAPY	980		213		2406			50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY	252		93		883			53
55 MEDICAL SUPPLIES CHARGED TO P	532		77		126881			55
56 DRUGS CHARGED TO PATIENTS						352968		56
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	1311		757		7697		130	61
62 OBSERVATION BEDS (NON-DISTINC								62
63.50 RURAL HEALTH CLINIC			1703		11647	9146	21600	63.50
OTHER REIMBURSABLE COST CENTERS								
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
95 SUBTOTALS	17390	23898	9944	80890	671360	362114	89730	2632 95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & C	336							96
96.01 VENDING MACHINE	100							96.01
CROSS FOOT ADJUSTMENTS								
101 NEGATIVE COST CENTER								101
102								102
103 COST TO BE ALLOC PER B PT I	175833	230953	212367	217228	9406	311168	406448	89756 103
104 UNIT COST MULT-WS B PT I	9.863851		21.356295		.014010		4.529678	104
104 UNIT COST MULT-WS B PT I		9.664114		2.685474		.859309		34.101824 104
105 COST TO BE ALLOC PER B PT II								105
106 UNIT COST MULT-WS B PT II								106
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III	1874	15620	13758	29370	834	7904	16261	3169 107
108 UNIT COST MULT-WS B PT III	.105127		1.383548		.001242		.181221	108
108 UNIT COST MULT-WS B PT III		.653611		.363086		.021827		1.204027 108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

	GENERAL SERVICE COST CENTERS	
3	NEW CAP REL COSTS-BLDG & FIXT	3
4	NEW CAP REL COSTS-MVBLE EQUIP	4
5	EMPLOYEE BENEFITS	5
6	ADMINISTRATIVE & GENERAL	6
8	OPERATION OF PLANT	8
9	LAUNDRY & LINEN SERVICE	9
10	HOUSEKEEPING	10
11	DIETARY	11
12	CAFETERIA	12
14	NURSING ADMINISTRATION	14
15	CENTRAL SERVICES & SUPPLY	15
16	PHARMACY	16
17	MEDICAL RECORDS & LIBRARY	17
18	SOCIAL SERVICE	18
	INPATIENT ROUTINE SERV COST CENTERS	
25	ADULTS & PEDIATRICS	25
	ANCILLARY SERVICE COST CENTERS	
41	RADIOLOGY-DIAGNOSTIC	41
44	LABORATORY	44
49	RESPIRATORY THERAPY	49
50	PHYSICAL THERAPY	50
51	OCCUPATIONAL THERAPY	51
52	SPEECH PATHOLOGY	52
53	ELECTROCARDIOLOGY	53
55	MEDICAL SUPPLIES CHARGED TO P	55
56	DRUGS CHARGED TO PATIENTS	56
	OUTPATIENT SERVICE COST CENTERS	
61	EMERGENCY	61
62	OBSERVATION BEDS (NON-DISTINC	62
63.50	RURAL HEALTH CLINIC	63.50
	OTHER REIMBURSABLE COST CENTERS	
71	HOME HEALTH AGENCY	71
	SPECIAL PURPOSE COST CENTERS	
95	SUBTOTALS	95
	NONREIMBURSABLE COST CENTERS	
96	GIFT, FLOWER, COFFEE SHOP & C	96
96.01	VENDING MACHINE	96.01
101	CROSS FOOT ADJUSTMENTS	101
102	NEGATIVE COST CENTER	102
103	COST TO BE ALLOC PER B PT I	103
104	UNIT COST MULT-WS B PT I	104
104	UNIT COST MULT-WS B PT I	104
105	COST TO BE ALLOC PER B PT II	105
106	UNIT COST MULT-WS B PT II	106
106	UNIT COST MULT-WS B PT II	106
107	COST TO BE ALLOC PER B PT III	107
108	UNIT COST MULT-WS B PT III	108
108	UNIT COST MULT-WS B PT III	108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	2742315					25
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	1045174					41
44 LABORATORY	1286078					44
49 RESPIRATORY THERAPY	261941					49
50 PHYSICAL THERAPY	220110					50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	63197					53
55 MEDICAL SUPPLIES CHARGED TO	212919					55
56 DRUGS CHARGED TO PATIENTS	737466					56
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	661006					61
62 OBSERVATION BEDS (NON-DISTI	284035		284035		284035	62
63.50 RURAL HEALTH CLINIC	1302441					63.50
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	8816682		284035		284035	101
102 LESS OBSERVATION BEDS	284035		284035		284035	102
103 TOTAL	8532647					103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	1098346		1098346			25
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	546043	2482998	3029041	.345051		41
44 LABORATORY	703583	1989371	2692954	.477571		44
49 RESPIRATORY THERAPY	424993	352849	777842	.336753		49
50 PHYSICAL THERAPY	115270	630776	746046	.295035		50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	274481	163228	437709	.144381		53
55 MEDICAL SUPPLIES CHARGED TO	564028	131977	696005	.305916		55
56 DRUGS CHARGED TO PATIENTS	917550	573040	1490590	.494748		56
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	19828	472733	492561	1.341978		61
62 OBSERVATION BEDS (NON-DISTI	9284	151240	160524	1.769424	1.769424	62
63.50 RURAL HEALTH CLINIC		858970	858970	1.516282		63.50
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	4673406	7807182	12480588			101
102 LESS OBSERVATION BEDS						102
103 TOTAL			12480588			103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1328)  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II  
 [ ] SUB III  
 [ ] SUB IV

[ ] SNF  
 [ ] NF  
 [ ] S/B-SNF  
 [ ] S/B-NF  
 [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II	PART I	PART II	OUTPATIENT	OTHER	OUTPATIENT
	COL. 8	COL. 9	COL. 9	AMBULATORY	OUTPATIENT	OUTPATIENT
	1	1.01	1.02	SURGICAL	RADIOLOGY	DIAGNOSTIC
				CENTER		
				2	3	4
ANCILLARY SERVICE COST CENTERS						
41 RADIOLOGY-DIAGNOSTIC	.345051	.345051	.345051			41
44 LABORATORY	.477571	.477571	.477571			44
49 RESPIRATORY THERAPY	.336753	.336753	.336753			49
50 PHYSICAL THERAPY	.295035	.295035	.295035			50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	.144381	.144381	.144381			53
55 MEDICAL SUPPLIES CHARGED TO PAT	.305916	.305916	.305916			55
56 DRUGS CHARGED TO PATIENTS	.494748	.494748	.494748			56
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	1.341978	1.341978	1.341978			61
62 OBSERVATION BEDS (NON-DISTINCT)	1.769424	1.769424	1.769424			62
63.50 RURAL HEALTH CLINIC	1.516282	1.516282	1.516282			63.50
OTHER REIMBURSABLE COST CENTERS						
65.01 AMBULANCE SERVICES (2ND PERIOD)						65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)						65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)						65.03
101 SUBTOTAL						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES		1	
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)	.494748	1	2
2.01 VACCINE CHARGES - HEPATITIS B			2.01
3 VACCINE COSTS (OTHER THAN HEPATITIS B)			3
3.01 VACCINE COSTS - HEPATITIS B			3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1328) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1)	PPS SER- VICES	ALL OTHER (SEE INSTRU.)	PPS SER- VICES	PPS SER- VICES	OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC
	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	6	7	8
41 ANCILLARY SERVICE COST CENTERS								
41 RADIOLOGY-DIAGNOSTIC	700344							41
44 LABORATORY	1090990							44
49 RESPIRATORY THERAPY	77218							49
50 PHYSICAL THERAPY	128286							50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY	159754							53
55 MEDICAL SUPPLIES CHARGED TO PA	78763							55
56 DRUGS CHARGED TO PATIENTS	229769							56
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY	135465							61
62 OBSERVATION BEDS (NON-DISTINCT	59436							62
63.50 RURAL HEALTH CLINIC								63.50
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE SERVICES (2ND PERIOD								65.01
65.02 AMBULANCE SERVICES (3RD PERIOD								65.02
65.03 AMBULANCE SERVICES (4TH PERIOD								65.03
101 SUBTOTAL	2660025							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	2660025							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1328)	[ ]	SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
			[ ]	SUB III	[ ]	S/B-NF
			[ ]	SUB IV	[ ]	ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5)	PPS SERVICES (COLUMNS 1.01x5.01)	ALL OTHER (COLUMNS 1.01x5.02)	PPS SERVICES (COLUMNS 1.01x5.03)	PPS SERVICES (COLUMNS 1.01x5.04)	I/P PART B CHARGES (SEE INSTRU.)	I/P PART B COST (COLUMNS 1.02x10)
	9	9.01	9.02	9.03	9.04	10	11
ANCILLARY SERVICE COST CENTERS							
41 RADIOLOGY-DIAGNOSTIC	241654						41
44 LABORATORY	521025						44
49 RESPIRATORY THERAPY	26003						49
50 PHYSICAL THERAPY	37849						50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	23065						53
55 MEDICAL SUPPLIES CHARGED TO PAT	24095						55
56 DRUGS CHARGED TO PATIENTS	113678						56
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	181791						61
62 OBSERVATION BEDS (NON-DISTINCT	105167						62
63.50 RURAL HEALTH CLINIC							63.50
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)							65.03
101 SUBTOTAL	1274327						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	1274327						104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

[ ] TITLE V-INPT                      [XX] TITLE XVIII-PART A                      [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	SNF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3727						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3012						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3012						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	486						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	162						6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	50						7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	17						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1865						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	486						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	162						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							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I (CONT)

[ ] TITLE V-INPT                      [XX] TITLE XVIII-PART A                      [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	98.38						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.38						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2742315						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	4919						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	1672						25
26 TOTAL SWING-BED COST	490952						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2251363						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1098346						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1098346						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.049776						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	364.66						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2251363						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	747.47					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1394032					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1394032					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	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
	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	804941					48
49 TOTAL PROGRAM INPATIENT COSTS	2198973					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
55						55
56						56
57						57
58						58
58.01						58.01
58.02						58.02
58.03						58.03
58.04						58.04
59						59
59.01						59.01
59.02						59.02
59.03						59.03
59.04						59.04
59.05						59.05
59.06						59.06
59.07						59.07
59.08						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60	363270					60
61	121090					61
62	484360					62
63						63
64						64
65						65

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY  
SNF

	1	
66	SNF/NF/ICF/MR ROUTINE SERVICE COST	66
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	67
68	PROGRAM ROUTINE SERVICE COST	68
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	69
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	70
71	CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	71
72	PER DIEM CAPITAL RELATED COSTS	72
73	PROGRAM CAPITAL RELATED COSTS	73
74	INPATIENT ROUTINE SERVICE COST	74
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	75
76	TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	76
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	77
78	INPATIENT ROUTINE SERVICE COST LIMITATION	78
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	79
80	PROGRAM INPATIENT ANCILLARY SERVICES	80
81	UTILIZATION REVIEW--PHYSICIAN COMPENSATION	81
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	82

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
PERIOD FROM 04/01/2008 TO 03/31/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01  
07/06/2009 15:06

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

	HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
PART IV - COMPUTATION OF OBSERVATION BED COST	1	1	1	1	1	
83 TOTAL OBSERVATION BEDS	380					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	747.46					84
85 OBSERVATION BED COST	284035					85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input checked="" type="checkbox"/> HOSPITAL (14-1328)	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		758648		25
ANCILLARY SERVICE COST CENTERS				
41 RADIOLOGY-DIAGNOSTIC	.345051	282487	97472	41
44 LABORATORY	.477571	464961	222052	44
49 RESPIRATORY THERAPY	.336753	244531	82347	49
50 PHYSICAL THERAPY	.295035	30446	8983	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.144381	152569	22028	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.305916	310110	94868	55
56 DRUGS CHARGED TO PATIENTS	.494748	551856	273030	56
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	1.341978	2520	3382	61
62 OBSERVATION BEDS (NON-DISTINCT	1.769424	440	779	62
OTHER REIMBURSABLE COST CENTERS				
63.50 RURAL HEALTH CLINIC	1.516282			63.50
101 TOTAL		2039920	804941	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		2039920		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input checked="" type="checkbox"/> S/B-SNF (14-Z328)	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				25
25 ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
41 RADIOLOGY-DIAGNOSTIC	.345051	25292	8727	41
44 LABORATORY	.477571	53429	25516	44
49 RESPIRATORY THERAPY	.336753	63239	21296	49
50 PHYSICAL THERAPY	.295035	78077	23035	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.144381	3709	536	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.305916	95674	29268	55
56 DRUGS CHARGED TO PATIENTS	.494748	125610	62145	56
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	1.341978	926	1243	61
62 OBSERVATION BEDS (NON-DISTINCT	1.769424			62
OTHER REIMBURSABLE COST CENTERS				
63.50 RURAL HEALTH CLINIC	1.516282			63.50
101 TOTAL		445956	171766	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		445956		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1328)	HOSPITAL (14-1328)	HOSPITAL (14-1328)
	1	1.01	1.02
1 MEDICAL AND OTHER SERVICES	1274327		
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000			1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS			1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO			1.03
1.04 LINE 1.01 TIMES LINE 1.03			1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04			1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT			1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101			1.07
2 INTERNS AND RESIDENTS			2
3 ORGAN ACQUISITIONS			3
4 COST OF TEACHING PHYSICIANS			4
5 TOTAL COST	1274327		5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
6 ANCILLARY SERVICE CHARGES			6
7 INTERNS AND RESIDENTS SERVICE CHARGES			7
8 ORGAN ACQUISITION CHARGES			8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS			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			13
14 TOTAL CUSTOMARY CHARGES			14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST			15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			16
17 LESSER OF COST OR CHARGES	1287070		17
17.01 TOTAL PPS PAYMENTS			17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1328)	HOSPITAL (14-1328)	HOSPITAL (14-1328)
	1	1.01	1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	15900		18
18.01 COINSURANCE	341208		18.01
19 SUBTOTAL	929962		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	929962		23
24 PRIMARY PAYER PAYMENTS	118		24
25 SUBTOTAL	929844		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	120215		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	120215		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	113879		27.02
28 SUBTOTAL	1050059		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	1050059		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	1006617		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	43442		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	19520		36

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 HOSPITAL (14-1328)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B		AMOUNT	AMOUNT	
	PART A						
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT			
	1	2	3	4			
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1920398			975235		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 A ZERO.		NONE			NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.							
	PROGRAM .01	12/12/2008	111740	12/12/2008	26141		3.01
	TO .02	03/20/2009	34101	03/20/2009	5241		3.02
	PROVIDER .03						3.03
	TO .04						3.04
	PROVIDER .05						3.05
	TO .50						3.50
	PROVIDER .51						3.51
	TO .52		NONE		NONE		3.52
	PROVIDER .53						3.53
	TO .54						3.54
SUBTOTAL	.99		145841		31382		3.99
4 TOTAL INTERIM PAYMENTS			2066239		1006617		4
TO BE COMPLETED BY INTERMEDIARY							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.							
	PROGRAM .01						5.01
	TO .02		NONE		NONE		5.02
	PROVIDER .03						5.03
	TO .50						5.50
	PROVIDER .51		NONE		NONE		5.51
	TO .52						5.52
SUBTOTAL	.99						5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.							
	PROGRAM TO .01				43442		6.01
	PROVIDER TO .02		-66181				6.02
	PROGRAM						
7 TOTAL MEDICARE PROGRAM LIABILITY			2000058		1050059		7

NAME OF INTERMEDIARY:

INTERMEDIARY NUMBER:

SIGNATURE OF AUTHORIZED PERSON:

DATE (MO/DAY/YR):

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 SWING BED SKILLED NURSING FACILITY (14-Z328)

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		581942		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 A ZERO.		NONE		NONE 2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 TO .05 PROVIDER .50 TO .51 PROGRAM .52 PROGRAM .53 PROGRAM .54	NONE		3.01 3.02 NONE 3.03 3.04 3.05 3.50 3.51 NONE 3.52 3.53 3.54
SUBTOTAL	.99			3.99
4 TOTAL INTERIM PAYMENTS		581942		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52	NONE		5.01 5.02 NONE 5.03 5.50 NONE 5.51 5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01 PROVIDER TO .02 PROGRAM	66740		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		648682		7
NAME OF INTERMEDIARY:	INTERMEDIARY NUMBER:			
SIGNATURE OF AUTHORIZED PERSON:	DATE (MO/DAY/YR):			

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 SWING BEDS

SUPPLEMENTAL  
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

	TITLE V	--- TITLE XVIII ---		--- TITLE XIX ---		
	S/B NF	S/B SNF	S/B SNF	S/B SNF	S/B NF	
	1	(14-2328)		(14-2328)		
		PART A	PART B			
	1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF	489204				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3	ANCILLARY SERVICES	173484				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5	PROGRAM DAYS	648				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8	SUBTOTAL	662688				8
9	PRIMARY PAYER PAYMENTS					9
10	SUBTOTAL	662688				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12	SUBTOTAL	662688				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	16114				13
14	80% OF PART B COSTS					14
15	SUBTOTAL	646574				15
16	OTHER ADJUSTMENTS					16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)	2108				17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	2108				17.01
18	TOTAL	648682				18
19	SEQUESTRATION ADJUSTMENT					19
20	INTERIM PAYMENTS	581942				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21	BALANCE DUE PROVIDER/PROGRAM	66740				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	10066				22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1328)	SUB I	SUB II	SUB III	SUB IV	SNF I
1	INPATIENT SERVICES	2198973				1
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)					1.01
2	ORGAN ACQUISITION					2
3	COST OF TEACHING PHYSICIANS					3
4	SUBTOTAL	2198973				4
5	PRIMARY PAYER PAYMENTS					5
6	TOTAL COST	2220963				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	TEACHING PHYSICIANS					10
11	TOTAL REASONABLE CHARGES					11
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS					12
13	AMOUNT 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)					13
14	RATIO OF LINE 12 TO LINE 13					14
15	TOTAL CUSTOMARY CHARGES					15
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST					16
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES					17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1328)	SUB I	SUB II	SUB III	SUB IV	SNF I	
COMPUTATION OF REIMBURSEMENT SETTLEMENT							
18							18
							19
19	2220963						19
20	295611						20
21							21
22	1925352						22
23	2304						23
24	1923048						24
25	77010						25
25.01	77010						25.01
25.02	69193						25.02
26	2000058						26
27							27
28							28
29							29
30	2000058						30
31							31
32	2066239						32
32.01							32.01
33	-66181						33
34	33722						34

SECTION 115.2

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	261432			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	2398550			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-810862			6
7	INVENTORY	150262			7
8	PREPAID EXPENSES	11837			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	2011219			11
FIXED ASSETS					
12	LAND	17000			12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS	100979			13
13.01	ACCUMULATED DEPRECIATION	-100979			13.01
14	BUILDINGS	1209909			14
14.01	ACCUMULATED DEPRECIATION	-1095109			14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT				16
16.01	ACCUMULATED DEPRECIATION				16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT	2383059			18
18.01	ACCUMULATED DEPRECIATION	-1816408			18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	698451			21
OTHER ASSETS					
22	INVESTMENTS				22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS				25
26	TOTAL OTHER ASSETS				26
27	TOTAL ASSETS	2709670			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	519673			28
29	SALARIES, WAGES & FEES PAYABLE	557470			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)	493541			31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS				34
35	OTHER CURRENT LIABILITIES	21136			35
36	TOTAL CURRENT LIABILITIES	1591820			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE				37
38	NOTES PAYABLE	677084			38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES				41
42	TOTAL LONG TERM LIABILITIES	677084			42
43	TOTAL LIABILITIES	2268904			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	440766			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	440766			51
52	TOTAL LIABILITIES AND FUND BALANCES	2709670			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	807506			1
2 NET INCOME (LOSS)	-366740			2
3 TOTAL	440766			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5 PRIOR YEAR ADJUSTMENTS				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	440766			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	440766			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	1334272		1334272	1
2 SUBPROVIDER I				2
4 SWING BED - SNF	241535		241535	4
5 SWING BED - NF				5
6 SKILLED NURSING FACILITY				6
7 NURSING FACILITY				7
8 OTHER LONG TERM CARE				8
9 TOTAL GENERAL INPATIENT CARE SERVICES	1575807		1575807	9
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10 INTENSIVE CARE UNIT				10
11 CORONARY CARE UNIT				11
12 BURN INTENSIVE CARE UNIT				12
13 SURGICAL INTENSIVE CARE UNIT				13
14 OTHER SPECIAL CARE (SPECIFY)				14
15 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16 TOTAL INPATIENT ROUTINE CARE SERVICES	1575807		1575807	16
17 ANCILLARY SERVICES	3748193	6546400	10294593	17
18 OUTPATIENT SERVICES	43289	1154134	1197423	18
18.50 RURAL HEALTH CLINIC		858970	858970	18.50
19 HOME HEALTH AGENCY				19
20 AMBULANCE				20
21 CORF				21
22 ASC				22
23 HOSPICE				23
24				24
25 TOTAL PATIENT REVENUES	5367289	8559504	13926793	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		10151247	26
27 ADD (SPECIFY)			27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS			33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		10151247	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	13926793	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	4351418	2
3	NET PATIENT REVENUES	9575375	3
4	LESS TOTAL OPERATING EXPENSES	10151247	4
5	NET INCOME FROM SERVICE TO PATIENTS	-575872	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	2611	6
7	INCOME FROM INVESTMENTS	1088	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES	62412	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	39272	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	4439	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	11200	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	MISCELLANEOUS	19507	24
24.01	GRANTS	68603	24.01
25	TOTAL OTHER INCOME	209132	25
26	TOTAL	-366740	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-366740	31

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL  
 PERIOD FROM 04/01/2008 TO 03/31/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01  
 07/06/2009 15:06

RHC I  
 COMPONENT NO: 14-3479

WORKSHEET M-1

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

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1	316344	30737	347081		347081		347081	1
2	65000	7696	72696		72696		72696	2
3	68250	8689	76939		76939		76939	3
4								4
5	185777	25835	211612		211612		211612	5
6								6
7								7
8								8
9	79358	14567	93925		93925		93925	9
10	714729	87524	802253		802253		802253	10
COSTS UNDER AGREEMENT								
11								11
12								12
13								13
14								14
OTHER HEALTH CARE COSTS								
15		451	451		451		451	15
16		853	853		853		853	16
17		21509	21509		21509		21509	17
18								18
19		9146	9146		9146		9146	19
20								20
21		31959	31959		31959		31959	21
22	714729	119483	834212		834212		834212	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26								26
27								27
28								28
FACILITY OVERHEAD								
29				67356	67356	-120	67236	29
30		31304	31304		31304		31304	30
31		31304	31304	67356	98660	-120	98540	31
32	714729	150787	865516	67356	932872	-120	932752	32

RHC I  
 COMPONENT NO: 14-3479

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS	GREATER OF COL. 2 OR COL. 4
	1	2	3	4	5
1 PHYSICIANS	1.80	7357	4200	7560	1
2 PHYSICIAN ASSISTANTS	0.90	2458	2100	1890	2
3 NURSE PRACTITIONERS	0.90	2613	2100	1890	3
4 SUBTOTAL	3.60	12428		11340	12428
5 VISITING NURSE					5
6 CLINICAL PSYCHOLOGIST					6
7 CLINICAL SOCIAL WORKER					7
8 TOTAL FTEs AND VISITS	3.60	12428			12428
9 PHYSICIAN SERVICES UNDER AGREEMENTS					9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					834212	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					834212	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD					98540	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					369689	15
16 TOTAL OVERHEAD					468229	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					468229	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					468229	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					1302441	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-3479

WORKSHEET M-3

CHECK [ XX ] RHC [ ] TITLE V  
 APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
 [ ] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1302441	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	13626	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	1288815	3
4	TOTAL VISITS	12428	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	12428	6
7	ADJUSTED COST PER VISIT	103.70	7

CALCULATION OF LIMIT(1)  
 PRIOR TO ON OR AFTER  
 JANUARY 1 JANUARY 1 (SEE INSTR.)  
 1 2 3

8	PER VISIT PAYMENT LIMIT	87.89	111.58	8
9	RATE FOR PROGRAM COVERED VISITS	103.70	103.70	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	3121	1040	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	323648	107848	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES			14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST			15
16	TOTAL PROGRAM COST		431496	16
16.01	PRIMARY PAYOR PAYMENTS			16.01
17	LESS: BENEFICIARY DEDUCTIBLE		41149	17
18	NET PROGRAM COST EXCLUDING VACCINES		390347	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE		312278	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION		9167	20
21	TOTAL REIMBURSABLE PROGRAM COST		321445	21
22	REIMBURSABLE BAD DEBTS		693	22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT		322138	24
25	INTERIM PAYMENTS		327588	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM		-5450	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)		5366	27
	IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC I  
 COMPONENT NO: 14-3479

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [ XX ] RHC [ ] TITLE V  
 APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
 [ ] TITLE XIX

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COSTS	802253	802253	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000318	0.002280	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	255	1829	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	1608	5035	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	1863	6864	5
6 TOTAL DIRECT COST OF THE FACILITY	834212	834212	6
7 TOTAL OVERHEAD	468229	468229	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRCT COST	0.002233	0.008228	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	1046	3853	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	2909	10717	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	53	380	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	54.89	28.20	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	36	255	13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	1976	7191	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		13626	15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		9167	16

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

RHC I  
 COMPONENT NO: 14-3479

WORKSHEET M-5

CHECK  RHC  
 APPLICABLE BOX:  FQHC

DESCRIPTION	PART B		AMOUNT	
	1 MM/DD/YYYY	2		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER			293865	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 A ZERO.			NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 10/24/2008		33723	3.01
PROGRAM	.02			3.02
TO	.03			3.03
PROVIDER	.04			3.04
	.05			3.05
	.50			3.50
PROVIDER	.51			3.51
TO	.52		NONE	3.52
PROGRAM	.53			3.53
	.54			3.54
SUBTOTAL	.99		33723	3.99
4 TOTAL INTERIM PAYMENTS			327588	4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02		NONE	5.02
	PROVIDER .03			5.03
	PROVIDER .50			5.50
	TO .51		NONE	5.51
	PROGRAM .52			5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01 PROVIDER TO .02 PROGRAM		-5450	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY			322138	7
NAME OF INTERMEDIARY: _____			INTERMEDIARY NUMBER: _____	
SIGNATURE OF AUTHORIZED PERSON: _____			DATE (MO/DAY/YR): _____	

\*\*\*\*\* REPORT 97 \*\*\*\*\* UTILIZATION STATISTICS \*\*\*\*\*

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD	
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON DAYS								
25 ADULTS & PEDIATRICS	61.92		15.47				77.39	25
UTILIZATION PERCENTAGES BASED ON CHARGES								
41 RADIOLOGY-DIAGNOSTIC	9.33	23.12					32.45	41
44 LABORATORY	17.27	40.51					57.78	44
49 RESPIRATORY THERAPY	31.44	9.93					41.37	49
50 PHYSICAL THERAPY	4.08	17.20					21.28	50
53 ELECTROCARDIOLOGY	34.86	36.50					71.36	53
55 MEDICAL SUPPLIES CHARGED TO PAT	44.56	11.32					55.88	55
56 DRUGS CHARGED TO PATIENTS	37.02	15.41					52.43	56
61 EMERGENCY	0.51	27.50					28.01	61
62 OBSERVATION BEDS (NON-DISTINCT	0.27	37.03					37.30	62
101 TOTAL CHARGES	16.34	21.31					37.65	101

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---			
	AMOUNT	%	AMOUNT	%	AMOUNT	%		
GENERAL SERVICE COST CENTERS								
3	NEW CAP REL COSTS-BLDG & FIXT	45961	.54	-45961	-1.40		3	
4	NEW CAP REL COSTS-MVBLE EQUIP	219033	2.56	-219033	-6.67		4	
5	EMPLOYEE BENEFITS	70442	.82	-70442	-2.14		5	
6	ADMINISTRATIVE & GENERAL	1550204	18.09	-1550204	-47.20		6	
8	OPERATION OF PLANT	343657	4.01	-343657	-10.46		8	
9	LAUNDRY & LINEN SERVICE	76407	.89	-76407	-2.33		9	
10	HOUSEKEEPING	136049	1.59	-136049	-4.14		10	
11	DIETARY	137136	1.60	-137136	-4.18		11	
12	CAFETERIA	62362	.73	-62362	-1.90		12	
14	NURSING ADMINISTRATION	82357	.96	-82357	-2.51		14	
15	CENTRAL SERVICES & SUPPLY	2420	.03	-2420	-.07		15	
16	PHARMACY	226062	2.64	-226062	-6.88		16	
17	MEDICAL RECORDS & LIBRARY	270343	3.15	-270343	-8.23		17	
18	SOCIAL SERVICE	62213	.73	-62213	-1.89		18	
INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	1318371	15.38	1423944	43.35	2742315	32.00	25
ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC	727375	8.49	317799	9.68	1045174	12.20	41
44	LABORATORY	979478	11.43	306600	9.33	1286078	15.01	44
49	RESPIRATORY THERAPY	183568	2.14	78373	2.39	261941	3.06	49
50	PHYSICAL THERAPY	127709	1.49	92401	2.81	220110	2.57	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	39744	.46	23453	.71	63197	.74	53
55	MEDICAL SUPPLIES CHARGED TO PAT	149966	1.75	62953	1.92	212919	2.48	55
56	DRUGS CHARGED TO PATIENTS	352968	4.12	384498	11.71	737466	8.60	56
61	EMERGENCY	458759	5.35	202247	6.16	661006	7.71	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RURAL HEALTH CLINIC	932752	10.88	369689	11.26	1302441	15.20	63.50
OTHER REIMBURSABLE COST CENTERS								
OUTPATIENT SERVICE COST CENTERS								
71	HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
96	GIFT, FLOWER, COFFEE SHOP & CAN			15658	.48	15658	.18	96
96.01	VENDING MACHINE	14875	.17	7031	.21	21906	.26	96.01
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	8570211	100.00	0	.00	8570211	100.00	103

\*\*\*\* THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	1236478
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	2531739
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.488

RURAL HEALTH CENTER DENTAL STATISTICS		14-3479		CLINIC NAME Hardin County Rural Health Clinic		REPORTING PERIOD		FROM: 1-Apr-08 TO: 31-Mar-09		ATTACHMENT #2					
COST CENTER (OMIT CENTS)		COMPENSATION		OTHER		COL. 1&2		RECLASSIFICATIONS		RECLASSIFIED TRIAL BALANCE		ADJUSTMENTS		NET EXPENSES	
(1)		(2)		(3)		(4)		(5)		(6)		(7)		(8)	
1	RHC DENTAL STAFF COST														
2	Dentists														
3	Dental Hygienist			N/A											
4															
5															
6	TOTAL - Dentists(Sum of lines 1 through 5)														
7	Other - Dental Staff														
8															
9															
10															
11	SUBTOTAL - Other Dental Staff( Sum of lines 7-10)														
12	TOTAL - Dental Staff (Sum of lines 6 and 11)														
13	Dental Services Under Agreement														
14															
15	TOTAL DENTAL COST(Sum of lines 12 through 14)														

DENTAL SERVICES PERSONNEL, EQUIVALENTS, HOURS ON SITE, AND ENCOUNTERS		FULL TIME PERSONNEL EQUIVALENTS (FTEs)		HEALTH SERVICES HOURS		ENCOUNTERS	
		(1)		(2)		(3)	
		ON-SITE		OFF-SITE		TOTAL	
		(4)		(5)		(6)	
16	RHC DENTAL STAFF						
17	Dentists						
18	Dental Hygienist						
19							
20							
21	TOTAL - Dentists(Sum of lines 17 through 20)						
22	Other - Dental Staff						
23							
24							
25							
26	SUBTOTAL - Other Dental Staff(Sum of lines 22 through 25)						
27	TOTAL - Dental Staff(Sum of lines 21 and 26)						
28	Dental Services Under Agreement						
29							
30	TOTAL DENTAL(Sum of lines 27 through 29)						

NOTE: Total dental cost from line 15, column 7, must agree with Attachment #1, line 13.

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES		14-3479		CLINIC NAME Hardin County Rural Health Clinic		REPORTING PERIOD FROM: 1-Apr-08 TO: 31-Mar-09		ATTACHMENT #1	
COST CENTER (OMIT CENTS)	COMPENSATION	OTHER	TOTAL COL.1&2	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE COL.3&4	ADJUSTMENTS INCREASES (DECREASES)	NET EXPENSES COL.5&6		
	1	2	3	4	5	6	7		
1 SUPPLEMENTAL COSTS									
2 Pharmacy									
3 Patient Transportation		N/A							
4 Medical Case Management									
5 Health Education									
6 Nutrition Counseling									
7 Others(specify)									
8									
9									
10									
11									
12 Supplemental Subtotal(sum of lines 2 through 11)	-								
13 DENTAL									
14 NON-ALLOWABLE COST CENTERS									
15 HM/HK Case Management									
16 WIC( Women,Infants, & Children)									
17 Fundraising & Public Relations									
18 Social Services									
19 Unlicensed Social Workers									
20 Others(specify)									
21									
22									
23									
24									
25 Non-Allowable Subtotal(sum of lines 15 - 24)	-								
26 Totals for schedule C (sum of lines 12,13, &25)	-								

NOTE: This schedule allows for supplemental reimbursement of some costs which are not allowable under the Medicare program.