

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

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

WORKSHEET S  
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 08/15/2014	TIME: 11:42
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 04/01/2013 AND ENDING 03/31/2014, AND 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: 08/15/2014 11:42  
8FcbgfJBppeoxPxiiayahQjGx44300  
r1VTz0uzP7.Jf5rfQZelOvxR:k16.a  
08W905tLmp00K.ql

(SIGNED) \_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

PI Encryption: 08/15/2014 11:42  
MWrf489UkYDWVsS6jJuhs.x07lJl10  
1DHN00cRWFyOSs8Jdl1f&PW:zALSIN  
we4N03r6Y00ZGYgR

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		43,082	-38,536		124,066	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		10,527				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-3,888			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		53,609	-42,424		124,066	200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO 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 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:										
1	STREET: 6 FERRELL ROAD	P.O. BOX: 2467							1	
2	CITY: ROSICLARE	STATE: IL	ZIP CODE: 62982	COUNTY: HARDIN					2	
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:										
							PAYMENT SYSTEM (P, T, O, OR N)			
	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV- IDER TYPE	DATE CERTIFIED	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	HARDIN COUNTY GENERAL HOSPITAL	14-1328	99914	1	07/09/2003	N	O	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	HARDIN COUNTY SWING BED	14-Z328	99914		07/09/2003	N	O	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	HARDIN COUNTY RHC	14-3479	99914		04/03/2006	N	O	N	15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (mm/dd/yyyy)		FROM: 04 / 01 / 2013	TO: 03 / 31 / 2014						20
21	TYPE OF CONTROL (see instructions)		2							21
INPATIENT PPS INFORMATION										
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.							N	N	22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)							N	N	22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.							3	N	23
		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF- STATE MEDICAID PAID DAYS	OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS			
		1	2	3	4	5	6			
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.								24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.								25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2				26	
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				2				27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:			36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:	ENDING:			38	
							1	2		

Optimizer Systems, Inc.

*WinLASH*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N	N	39
----	---	---	---	----

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		V	XVIII	XIX	
		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT
		1	2	3	4
OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2)	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 + column 4)). (see instructions)					
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4)
	1	2	3	4	5
65					65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2)	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				66
ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 + column 4)). (see instructions)					
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4)
	1	2	3	4	5
67					67
INPATIENT PSYCHIATRIC FACILITY PPS		1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				71
INPATIENT REHABILITATION FACILITY PPS		1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76
LONG TERM CARE HOSPITAL PPS					
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		80
TEFRA PROVIDERS					
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.		N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.				86

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

TITLE V AND XIX SERVICES		V	XIX			
		1	2			
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90		
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91		
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92		
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93		
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94		
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95		
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96		
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97		
RURAL PROVIDERS		1	2			
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	Y		105		
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.	N		106		
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. 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, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.	N		107		
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108		
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	Y	Y	Y	N	109
MISCELLANEOUS COST REPORTING INFORMATION		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY	
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'		N			115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE, ENTER 2 IF THE POLICY IS OCCURRENCE.			1		118
			PREMIUMS	PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		121
TRANSPLANT CENTER INFORMATION						
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.			N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.					134

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

ALL PROVIDERS						
		1	2			
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N				140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.						
141	NAME:	CONTRACTOR'S NAME:		CONTRACTOR'S NUMBER:		141
142	STREET:	P.O. BOX:				142
143	CITY:	STATE:	ZIP CODE:			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y				144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N				145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N				146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				149
DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)						
		TITLE XVIII		TITLE V	TITLE XIX	
		PART A	PART B	2	3	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N			156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10
MULTICAMPUS						
165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				165
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					166
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5
HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT						
167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y				167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)					168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)					169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	10/01/2012	09/30/2013			170

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
<b>PROVIDER ORGANIZATION AND OPERATION</b>					
		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
<b>FINANCIAL DATA AND REPORTS</b>					
		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
<b>APPROVED EDUCATIONAL ACTIVITIES</b>					
		Y/N		Y/N	
		1		2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
<b>BAD DEBTS</b>					
				Y/N	
				Y	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
<b>BED COMPLEMENT</b>					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
<b>PART A</b>					
		Y/N	DATE		
		1	2		
<b>PS&amp;R REPORT DATA</b>					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	06/24/2014	Y	06/24/2014
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	N	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	N	33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	35
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.	N	
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	N	
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	
COST REORT PREPARER INFORMATION			
41	FIRST NAME: MARK	LAST NAME: DALLAS	TITLE: PARTNER
42	EMPLOYER: KERBER, ECK & BRAECKEL		
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: MARKD@KEBCPA.COM	

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	38,928.00		1,311	131	1,610	1
2	HMO AND OTHER (see instructions)						41			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						1,071		1,071	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									136
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		25	9,125	38,928.00		2,382	131	2,817	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		25	9,125	38,928.00		2,382	131	2,817	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					4,557		11,931	26
27	TOTAL (sum of lines 14-26)		25							27
28	OBSERVATION BED DAYS							77	302	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES			TOTAL ALL PATIENTS	
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX		
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					364	48	473	1
2	HMO AND OTHER (see instructions)					10			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		108.89			364	48	473	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC		21.15						26
27	TOTAL (sum of lines 14-26)		130.04						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	<b>SALARIES</b>							
1	TOTAL SALARIES (see instructions)	200						1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)							10
	<b>OTHER WAGES &amp; RELATED COSTS</b>							
11	CONTRACT LABOR (see instructions)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	<b>WAGE-RELATED COSTS</b>							
17	WAGE-RELATED COSTS (core)(see instructions)							17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26	EMPLOYEE BENEFITS DEPARTMENT							26
27	ADMINISTRATIVE & GENERAL							27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING							32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY							34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION							38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY							41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)							1
2	EXCLUDED AREA SALARIES (see instructions)							2
3	SUBTOTAL SALARIES (line 1 minus line 2)							3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)							4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)							5
6	TOTAL (sum of lines 3 through 5)							6
7	TOTAL OVERHEAD COST (see instructions)							7

Optimizer Systems, Inc.

*WinLASH*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

## HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

## PART IV - WAGE RELATED COST

PART IV

## PART A - CORE LIST

		AMOUNT REPORTED	
	<b>RETIREMENT COST</b>		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	<b>HEALTH AND INSURANCE COST</b>		
8	HEALTH INSURANCE (Purchased or Self Funded)		8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE		15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-EMPLOYERS PORTION ONLY		17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	<b>OTHER</b>		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)		24

## PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
----	------------------------------------	--	----

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	Supporting Exhibit for Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--	--	---

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

<b>STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD</b>			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
<b>STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions).</b>			
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

<b>STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD</b>			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S)
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
<b>STEP 4: TOTAL PENSION COST FOR WAGE INDEX</b>			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

Optimizer Systems, Inc.

*Win L A S H*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3

PART V - CONTRACT LABOR AND BENEFIT COST

PART V

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	Y	07/09/2003	2

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

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable)	
		1	2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable).			201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (see instructions)

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)				207

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

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

COMPONENT CCN: 14-3479

WORKSHEET S-8

CHECK  RHC  FQHC  
 APPLICABLE BOX:

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 6 FERRELL ROAD	1
2	CITY: ROSICLARE STATE: IL ZIP CODE: 62982 COUNTY: HARDIN	2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (Section 330(d), PHS Act)			4
5	MIGRANT HEALTH CENTER (Section 329(d), PHS Act)			5
6	HEALTH SERVICES FOR HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER			9

10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	1	2	
		N		10

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	
11	CLINIC			0900	1700	0900	1700	0900	1700	0900	1700	0900	1700			11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (both type and hours of operation). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	1	2	
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		12
14	PROVIDER NAME: _____ CCN NUMBER: _____	N		13
				14

		Y/N	V	XVIII	XIX	TOTAL VISITS	
		1	2	3	4	5	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N					15

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.634179	1
---	--	----------	---

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	1,529,969	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	2,464,189	6
7	MEDICAID COST (line 1 times line 6)	1,562,737	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	32,768	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	32,768	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	252,671	377,467	630,138	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	160,239	239,382	399,621	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	160,239	239,382	399,621	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	654,020	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	207,636	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	446,384	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	283,087	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	682,708	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	715,476	31

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	CAP REL COSTS-BLDG & FIXT		57,309	57,309	27,769	85,078		85,078	1
2	00200	CAP REL COSTS-MVBLE EQUIP		393,507	393,507	6,198	399,705	-179,033	220,672	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT				71,300	71,300		71,300	4
5	00500	ADMINISTRATIVE & GENERAL	714,603	1,515,337	2,229,940	-68,609	2,161,331	-282,413	1,878,918	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	136,065	196,347	332,412		332,412		332,412	7
8	00800	LAUNDRY & LINEN SERVICE	56,322	14,220	70,542		70,542		70,542	8
9	00900	HOUSEKEEPING	84,651	41,505	126,156	-25,374	100,782		100,782	9
10	01000	DIETARY	93,576	107,420	200,996	-71,411	129,585		129,585	10
11	01100	CAFETERIA				64,239	64,239	-4,463	59,776	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION				85,828	85,828		85,828	13
14	01400	CENTRAL SERVICES & SUPPLY	30,127	4,977	35,104	-26,597	8,507		8,507	14
15	01500	PHARMACY	68,343	182,738	251,081	-50,680	200,401		200,401	15
16	01600	MEDICAL RECORDS & LIBRARY	227,079	55,573	282,652		282,652	-4,145	278,507	16
17	01700	SOCIAL SERVICE	49,749	4,470	54,219		54,219		54,219	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	03000	ADULTS & PEDIATRICS	1,261,978	367,540	1,629,518	-230,564	1,398,954	-120,728	1,278,226	30
		<b>ANCILLARY SERVICE COST CENTERS</b>								
54	05400	RADIOLOGY-DIAGNOSTIC	360,329	295,833	656,162	187	656,349		656,349	54
60	06000	LABORATORY	382,995	674,136	1,057,131	-266	1,056,865	-74,936	981,929	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	112,439	76,498	188,937	-32,831	156,106		156,106	65
66	06600	PHYSICAL THERAPY	88,991	93,447	182,438	-66	182,372		182,372	66
67	06700	OCCUPATIONAL THERAPY								67
68	06800	SPEECH PATHOLOGY								68
69	06900	ELECTROCARDIOLOGY	11,506	958	12,464	19,968	32,432		32,432	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				119,580	119,580		119,580	71
73	07300	DRUGS CHARGED TO PATIENTS				326,821	326,821		326,821	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	08800	RURAL HEALTH CLINIC	923,481	211,759	1,135,240	32,369	1,167,609		1,167,609	88
91	09100	EMERGENCY	951,359	262,909	1,214,268	-193,734	1,020,534	-345,746	674,788	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
		<b>SPECIAL PURPOSE COST CENTERS</b>								
113	11300	INTEREST EXPENSE		58,569	58,569	-54,127	4,442	-4,442		113
118		SUBTOTALS (sum of lines 1-117)	5,553,593	4,615,052	10,168,645		10,168,645	-1,015,906	9,152,739	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
190.01	19001	VENDING MACHINE								190.01
200		TOTAL (sum of lines 118-199)	5,553,593	4,615,052	10,168,645		10,168,645	-1,015,906	9,152,739	200

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
1	TO RECLASS SUPPLY COST FROM CS	A	MEDICAL SUPPLIES CHARGED TO P	71	22,595	4,002	1
500	TOTAL RECLASSIFICATIONS				22,595	4,002	500
	CODE LETTER - A						
1	TO RECLASS DON COST	B	NURSING ADMINISTRATION	13	75,288	10,540	1
500	TOTAL RECLASSIFICATIONS				75,288	10,540	500
	CODE LETTER - B						
1	TO RECLASS COST TO CLINC	C	RURAL HEALTH CLINIC	88	20,321	5,053	1
500	TOTAL RECLASSIFICATIONS				20,321	5,053	500
	CODE LETTER - C						
1	TO RECLASS SUPPLY COST	D	MEDICAL SUPPLIES CHARGED TO P	71		92,983	1
2							2
3							3
4							4
5							5
6							6
500	TOTAL RECLASSIFICATIONS					92,983	500
	CODE LETTER - D						
1	TO RECLASS INSURANCE EXPENSE	E	CAP REL COSTS-BLDG & FIXT	1		2,856	1
2			CAP REL COSTS-MVBLE EQUIP	2		7,344	2
3			EMPLOYEE BENEFITS DEPARTMENT	4		71,300	3
500	TOTAL RECLASSIFICATIONS					81,500	500
	CODE LETTER - E						
1	TO RECLASS INTEREST	F	CAP REL COSTS-BLDG & FIXT	1		27,905	1
2			ADMINISTRATIVE & GENERAL	5		12,891	2
3			RADIOLOGY-DIAGNOSTIC	54		6,525	3
4			ADULTS & PEDIATRICS	30		3,022	4
5			RURAL HEALTH CLINIC	88		2,857	5
6			ELECTROCARDIOLOGY	69		851	6
7			LABORATORY	60		76	7
500	TOTAL RECLASSIFICATIONS					54,127	500
	CODE LETTER - F						
1	TO RECLASS CAFE COST	G	CAFETERIA	11	29,944	34,295	1
500	TOTAL RECLASSIFICATIONS				29,944	34,295	500
	CODE LETTER - G						
1	TO RECLASS CARDIAC MONITORING COST	H	ELECTROCARDIOLOGY	69	16,008	3,109	1
2							2
500	TOTAL RECLASSIFICATIONS				16,008	3,109	500
	CODE LETTER - H						
1	TO RECLASS DRUG COST	I	DRUGS CHARGED TO PATIENTS	73		326,821	1
2							2
3							3
4							4
5							5
6							6
500	TOTAL RECLASSIFICATIONS					326,821	500
	CODE LETTER - I						
1	TO RECLASS CLINIC DEPRECIATION	J	RURAL HEALTH CLINIC	88		4,138	1
2							2
500	TOTAL RECLASSIFICATIONS					4,138	500
	CODE LETTER - J						
	GRAND TOTAL (INCREASES)				164,156	616,568	

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

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	TO RECLASS SUPPLY COST FROM CS	A	CENTRAL SERVICES & SUPPLY	14	22,595	4,002		
500	TOTAL RECLASSIFICATIONS				22,595	4,002	1	
	CODE LETTER - A						500	
1	TO RECLASS DON COST	B	ADULTS & PEDIATRICS	30	75,288	10,540		
500	TOTAL RECLASSIFICATIONS				75,288	10,540	1	
	CODE LETTER - B						500	
1	TO RECLASS COST TO CLINC	C	HOUSEKEEPING	9	20,321	5,053		
500	TOTAL RECLASSIFICATIONS				20,321	5,053	1	
	CODE LETTER - C						500	
1	TO RECLASS SUPPLY COST	D	ADULTS & PEDIATRICS	30		32,308		
2			EMERGENCY	91		21,131		
3			RADIOLOGY-DIAGNOSTIC	54		6,335		
4			LABORATORY	60		342		
5			RESPIRATORY THERAPY	65		32,831		
6			PHYSICAL THERAPY	66		36		
500	TOTAL RECLASSIFICATIONS					92,983	1	
	CODE LETTER - D						500	
1	TO RECLASS INSURANCE EXPENSE	E					12	
2							12	
3			ADMINISTRATIVE & GENERAL	5		81,500		
500	TOTAL RECLASSIFICATIONS					81,500	2	
	CODE LETTER - E						3	
1	TO RECLASS INTEREST	F					11	
2							11	
3							11	
4							11	
5			INTEREST EXPENSE	113		54,127		
6							11	
7							11	
500	TOTAL RECLASSIFICATIONS					54,127	3	
	CODE LETTER - F						500	
1	TO RECLASS CAFE COST	G	DIETARY	10	29,944	34,295		
500	TOTAL RECLASSIFICATIONS				29,944	34,295	1	
	CODE LETTER - G						500	
1	TO RECLASS CARDIAC MONITORING COST	H						
2			ADULTS & PEDIATRICS	30	16,008	3,109		
500	TOTAL RECLASSIFICATIONS				16,008	3,109	2	
	CODE LETTER - H						500	
1	TO RECLASS DRUG COST	I	ADULTS & PEDIATRICS	30		96,333		
2			EMERGENCY	91		172,603		
3			PHARMACY	15		50,680		
4			RADIOLOGY-DIAGNOSTIC	54		3		
5			PHYSICAL THERAPY	66		30		
6			DIETARY	10		7,172		
500	TOTAL RECLASSIFICATIONS					326,821	3	
	CODE LETTER - I						500	
1	TO RECLASS CLINIC DEPRECIATION	J	CAP REL COSTS-BLDG & FIXT	1		2,992	9	
2			CAP REL COSTS-MVBLE EQUIP	2		1,146	9	
500	TOTAL RECLASSIFICATIONS					4,138	2	
	CODE LETTER - J						500	
	GRAND TOTAL (DECREASES)				164,156	616,568		

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

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	17,000					17,000		1
2	LAND IMPROVEMENTS	148,424					148,424		2
3	BUILDINGS AND FIXTURES	1,611,902					1,611,902		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	3,270,623	68,376		68,376		3,338,999		6
7	HIT DESIGNATED ASSETS	569,045					569,045		7
8	SUBTOTAL (sum of lines 1-7)	5,616,994	68,376		68,376		5,685,370		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	5,616,994	68,376		68,376		5,685,370		10

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

	DESCRIPTION	SUMMARY OF CAPITAL								
		DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14))		
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	57,309						57,309	1	
2	CAP REL COSTS-MVBLE EQUIP	393,507						393,507	2	
3	TOTAL (sum of lines 1-2)	450,816						450,816	3	

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7))	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	1,777,326		1,777,326	0.312614					1
2	CAP REL COSTS-MVBLE EQU	3,908,044		3,908,044	0.687386					2
3	TOTAL (sum of lines 1-2)	5,685,370		5,685,370	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL								
		DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14))		
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	54,317		27,905	2,856			85,078	1	
2	CAP REL COSTS-MVBLE EQUIP	213,328			7,344			220,672	2	
3	TOTAL (sum of lines 1-2)	267,645		27,905	10,200			305,750	3	

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

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF. 5
				COST CENTER	LINE#	
		1	2	3	4	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)	B	-39,807	ADMINISTRATIVE & GENERAL	5	5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	A	-2,795	ADMINISTRATIVE & GENERAL	5	7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-541,410			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1				12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-4,463	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	A	-4,145	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS	A	-4,442	INTEREST EXPENSE	113	22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND	A	-179,033	CAP REL COSTS-MVBLE EQUIP	2	9 32
33						33
34						34
35						35
36						36
37						37
38						38
39	SITE FEES	A	-12,821	ADMINISTRATIVE & GENERAL	5	39
40	LATE FEES	A	-21,757	ADMINISTRATIVE & GENERAL	5	40
41						41
42	PROVIDER TAX	A	-200,006	ADMINISTRATIVE & GENERAL	5	42
43	LOBBING PORTION OF DUES	A	-5,227	ADMINISTRATIVE & GENERAL	5	43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-1,015,906			50

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

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

Optimizer Systems, Inc.

*WinLASH*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12					5

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

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE		
				NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
6	1	2	3	4	5	6
6						6
7						7
8						8
9						9
10						10

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

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

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5	ADMINISTRATIVE & GEN MED STAFF DIREC	31,886		31,886					1
2	30	ADULTS & PEDIATRICS AGGREGATE	120,728	120,728						2
3	60	LABORATORY AGGREGATE	82,136	74,936	7,200					3
5	91	EMERGENCY AGGREGATE	785,786	345,746	440,040					5
200		TOTAL	1,020,536	541,410	479,126					200

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GEN MED STAFF DIREC								1
2	30	ADULTS & PEDIATRICS AGGREGATE							120,728	2
3	60	LABORATORY AGGREGATE							74,936	3
5	91	EMERGENCY AGGREGATE							345,746	5
200		TOTAL							541,410	200

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS I-IV

CHECK APPLICABLE BOX:  OCCUPATIONAL     PHYSICAL     RESPIRATORY     SPEECH PATHOLOGY

**PART I - GENERAL INFORMATION**

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		800.00				9
10	AHSEA (see instructions)		72.10				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	36.05	36.05				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

**PART II - SALARY EQUIVALENCY COMPUTATION**

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					57,680	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					57,680	17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					57,680	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)						22
23	TOTAL SALARY EQUIVALENCY (see instructions)					57,680	23

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

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)						24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)						28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)						33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

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

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)						36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)						38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)						39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)						44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:  OCCUPATIONAL     PHYSICAL     RESPIRATORY     SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)					57,680	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)					57,680	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)					48,024	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:     OCCUPATIONAL             PHYSICAL             RESPIRATORY             SPEECH PATHOLOGY

**PART I - GENERAL INFORMATION**

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		369.00				9
10	AHSEA (see instructions)		76.07				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	38.04	38.04				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

**PART II - SALARY EQUIVALENCY COMPUTATION**

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					28,070	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					28,070	17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					28,070	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)					76.07	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)					59,335	22
23	TOTAL SALARY EQUIVALENCY (see instructions)					59,335	23

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

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)						24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)						28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)						33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

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

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)						36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)						38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)						39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)						44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:     OCCUPATIONAL             PHYSICAL             RESPIRATORY             SPEECH PATHOLOGY

**PART V - OVERTIME COMPUTATION**

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

**PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57	SALARY EQUIVALENCY AMOUNT (from line 23)					59,335	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)					59,335	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)					22,141	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:     OCCUPATIONAL             PHYSICAL             RESPIRATORY             SPEECH PATHOLOGY

**PART I - GENERAL INFORMATION**

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)									1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK									2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)									3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)									4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)									5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)									6
7	STANDARD TRAVEL EXPENSE RATE									7
8	OPTIONAL TRAVEL EXPENSE RATE									8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES				
		1	2	3	4	5				
9	TOTAL HOURS WORKED									9
10	AHSEA (see instructions)									10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)									11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)									12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)									12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)									13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)									13.01

**PART II - SALARY EQUIVALENCY COMPUTATION**

14	SUPERVISORS (column 1, line 9 times column 1, line 10)									14
15	THERAPISTS (column 2, line 9 times column 2, line 10)									15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)									16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)									17
18	AIDES (column 4, line 9 times column 4, line 10)									18
19	TRAINEES (column 5, line 9 times column 5, line 10)									19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.									20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)									21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)									22
23	TOTAL SALARY EQUIVALENCY (see instructions)									23

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

STANDARD TRAVEL ALLOWANCE										
24	THERAPISTS (line 3 times column 2, line 11)									24
25	ASSISTANTS (line 4 times column 3, line 11)									25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)									26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)									27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)									28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE										
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)									29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)									30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)									31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)									32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)									33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)									34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)									35

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

STANDARD TRAVEL EXPENSE										
36	THERAPISTS (line 5 times column 2, line 11)									36
37	ASSISTANTS (line 6 times column 3, line 11)									37
38	SUBTOTAL (sum of lines 36 and 37)									38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)									39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE										
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)									40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)									41
42	SUBTOTAL (sum of lines 40 and 41)									42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)									43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.										
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)									44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)									45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)									46

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:     OCCUPATIONAL             PHYSICAL             RESPIRATORY             SPEECH PATHOLOGY

**PART V - OVERTIME COMPUTATION**

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

**PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:     OCCUPATIONAL             PHYSICAL             RESPIRATORY             SPEECH PATHOLOGY

**PART I - GENERAL INFORMATION**

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					39	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					585	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		37.00				9
10	AHSEA (see instructions)		69.28				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	34.64	34.64				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

**PART II - SALARY EQUIVALENCY COMPUTATION**

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					2,563	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					2,563	17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					2,563	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)					69.27	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)					40,523	22
23	TOTAL SALARY EQUIVALENCY (see instructions)					40,523	23

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

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)						24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)						28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)						33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

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

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)						36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)						38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)						39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)						44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46

Optimizer Systems, Inc.

Win L A S H

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:     OCCUPATIONAL             PHYSICAL             RESPIRATORY             SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)					40,523	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)					40,523	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)					2,228	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
<b>GENERAL SERVICE COST CENTERS</b>								
1	CAP REL COSTS-BLDG & FIXT	85,078	85,078					1
2	CAP REL COSTS-MVBLE EQUIP	220,672		220,672				2
4	EMPLOYEE BENEFITS DEPARTMENT	71,300			71,300			4
5	ADMINISTRATIVE & GENERAL	1,878,918	14,519	37,806	9,175	1,940,418	1,940,418	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	332,412	8,435	21,963	1,747	364,557	98,081	7
8	LAUNDRY & LINEN SERVICE	70,542	3,803	9,903	723	84,971	22,861	8
9	HOUSEKEEPING	100,782			826	101,608	27,337	9
10	DIETARY	129,585	3,744	9,748	817	143,894	38,714	10
11	CAFETERIA	59,776	1,585	4,126	384	65,871	17,722	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	85,828	8,352	21,748	967	116,895	31,450	13
14	CENTRAL SERVICES & SUPPLY	8,507			97	8,604	2,315	14
15	PHARMACY	200,401	1,664	4,332	877	207,274	55,765	15
16	MEDICAL RECORDS & LIBRARY	278,507	4,516	11,760	2,915	297,698	80,093	16
17	SOCIAL SERVICE	54,219	743	1,934	639	57,535	15,479	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	ADULTS & PEDIATRICS	1,278,226	18,101	47,134	15,029	1,358,490	365,490	30
<b>ANCILLARY SERVICE COST CENTERS</b>								
54	RADIOLOGY-DIAGNOSTIC	656,349	5,556	14,467	4,626	680,998	183,217	54
60	LABORATORY	981,929	2,509	6,533	4,917	995,888	267,936	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	156,106	1,664	4,332	1,444	163,546	44,001	65
66	PHYSICAL THERAPY	182,372	3,235	8,424	1,143	195,174	52,510	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	32,432			353	32,785	8,821	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,580	1,595	4,152	290	125,617	33,796	71
73	DRUGS CHARGED TO PATIENTS	326,821				326,821	87,929	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	RURAL HEALTH CLINIC	1,167,609			12,117	1,179,726	317,396	88
91	EMERGENCY	674,788	4,328	11,270	12,214	702,600	189,029	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
<b>SPECIAL PURPOSE COST CENTERS</b>								
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	9,152,739	84,349	219,632	71,300	9,150,970	1,939,942	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		399	1,040		1,439	387	190
190.01	VENDING MACHINE		330			330	89	190.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	9,152,739	85,078	220,672	71,300	9,152,739	1,940,418	202

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	462,638						7
8	LAUNDRY & LINEN SERVICE	28,322	136,154					8
9	HOUSEKEEPING		5,530	134,475				9
10	DIETARY	27,879	3,672	8,632	222,791			10
11	CAFETERIA	11,801		3,654	71,099	170,147		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	62,200		19,259		2,588	232,392	13
14	CENTRAL SERVICES & SUPPLY					464	6,943	14
15	PHARMACY	12,391		3,836		3,516		15
16	MEDICAL RECORDS & LIBRARY	33,632		10,413		12,082		16
17	SOCIAL SERVICE	5,532		1,713		1,321		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	134,799	87,682	41,738	151,692	54,377	225,449	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	41,376	9,243	12,811		15,401		54
60	LABORATORY	18,684		5,785		17,793		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	12,391		3,836		5,300		65
66	PHYSICAL THERAPY	24,093	7,995	7,460		3,641		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY					1,285		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,874		3,677		1,410		71
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC					37,745		88
91	EMERGENCY	32,231	22,032	9,979		13,224		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	457,205	136,154	132,793	222,791	170,147	232,392	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,975		921				190
190.01	VENDING MACHINE	2,458		761				190.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	462,638	136,154	134,475	222,791	170,147	232,392	202

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17		24	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	18,326						14
15	PHARMACY	1,206	283,988					15
16	MEDICAL RECORDS & LIBRARY	127		434,045				16
17	SOCIAL SERVICE	14			81,594			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	1,399		340,255	81,594	2,842,965		30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	225		93,790		1,037,061		54
60	LABORATORY	11,206				1,317,292		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	121				229,195		65
66	PHYSICAL THERAPY	99				290,972		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	48				42,939		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,658				179,032		71
73	DRUGS CHARGED TO PATIENTS		269,806			684,556		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	683	14,182			1,549,732		88
91	EMERGENCY	540				969,635		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	18,326	283,988	434,045	81,594	9,143,379		118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					5,722		190
190.01	VENDING MACHINE					3,638		190.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	18,326	283,988	434,045	81,594	9,152,739		202

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	TOTAL				
		26				
	<b>GENERAL SERVICE COST CENTERS</b>					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS DEPARTMENT					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS	2,842,965				30
	<b>ANCILLARY SERVICE COST CENTERS</b>					
54	RADIOLOGY-DIAGNOSTIC	1,037,061				54
60	LABORATORY	1,317,292				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	229,195				65
66	PHYSICAL THERAPY	290,972				66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
69	ELECTROCARDIOLOGY	42,939				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,032				71
73	DRUGS CHARGED TO PATIENTS	684,556				73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>					
88	RURAL HEALTH CLINIC	1,549,732				88
91	EMERGENCY	969,635				91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	<b>OTHER REIMBURSABLE COST CENTERS</b>					
	<b>SPECIAL PURPOSE COST CENTERS</b>					
113	INTEREST EXPENSE					113
118	SUBTOTALS (sum of lines 1-117)	9,143,379				118
	<b>NONREIMBURSABLE COST CENTERS</b>					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,722				190
190.01	VENDING MACHINE	3,638				190.01
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (sum of lines 118-201)	9,152,739				202

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL		14,519	37,806	52,325	52,325		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		8,435	21,963	30,398	2,645	33,043	7
8	LAUNDRY & LINEN SERVICE		3,803	9,903	13,706	616	2,023	8
9	HOUSEKEEPING					737		9
10	DIETARY		3,744	9,748	13,492	1,044	1,991	10
11	CAFETERIA		1,585	4,126	5,711	478	843	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		8,352	21,748	30,100	848	4,442	13
14	CENTRAL SERVICES & SUPPLY					62		14
15	PHARMACY		1,664	4,332	5,996	1,504	885	15
16	MEDICAL RECORDS & LIBRARY		4,516	11,760	16,276	2,160	2,402	16
17	SOCIAL SERVICE		743	1,934	2,677	417	395	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS		18,101	47,134	65,235	9,857	9,628	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC		5,556	14,467	20,023	4,941	2,955	54
60	LABORATORY		2,509	6,533	9,042	7,225	1,335	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		1,664	4,332	5,996	1,187	885	65
66	PHYSICAL THERAPY		3,235	8,424	11,659	1,416	1,721	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY					238		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,595	4,152	5,747	911	848	71
73	DRUGS CHARGED TO PATIENTS					2,371		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC					8,559		88
91	EMERGENCY		4,328	11,270	15,598	5,097	2,302	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		84,349	219,632	303,981	52,313	32,655	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		399	1,040	1,439	10	212	190
190.01	VENDING MACHINE		330		330	2	176	190.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		85,078	220,672	305,750	52,325	33,043	202

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	16,345						8
9	HOUSEKEEPING	664	1,401					9
10	DIETARY	441	90	17,058				10
11	CAFETERIA		38	5,444	12,514			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		201		190	35,781		13
14	CENTRAL SERVICES & SUPPLY				34	1,069	1,165	14
15	PHARMACY		40		259		77	15
16	MEDICAL RECORDS & LIBRARY		108		889		8	16
17	SOCIAL SERVICE		18		97		1	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	10,525	435	11,614	3,997	34,712	89	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	1,110	133		1,133		14	54
60	LABORATORY		60		1,309		713	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		40		390		8	65
66	PHYSICAL THERAPY	960	78		268		6	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY				95		3	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		38		104		169	71
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC				2,776		43	88
91	EMERGENCY	2,645	104		973		34	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	16,345	1,383	17,058	12,514	35,781	1,165	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		10					190
190.01	VENDING MACHINE		8					190.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	16,345	1,401	17,058	12,514	35,781	1,165	202

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	17	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	8,761						15
16	MEDICAL RECORDS & LIBRARY		21,843					16
17	SOCIAL SERVICE			3,605				17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS		17,123	3,605	166,820		166,820	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC		4,720		35,029		35,029	54
60	LABORATORY				19,684		19,684	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY				8,506		8,506	65
66	PHYSICAL THERAPY				16,108		16,108	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY				336		336	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				7,817		7,817	71
73	DRUGS CHARGED TO PATIENTS	8,323			10,694		10,694	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	438			11,816		11,816	88
91	EMERGENCY				26,753		26,753	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	8,761	21,843	3,605	303,563		303,563	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				1,671		1,671	190
190.01	VENDING MACHINE				516		516	190.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	8,761	21,843	3,605	305,750		305,750	202

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
	1	2	4	5A	5	7	
<b>GENERAL SERVICE COST CENTERS</b>							
1 CAP REL COSTS-BLDG & FIXT	25,771						1
2 CAP REL COSTS-MVBLE EQUIP		25,671					2
4 EMPLOYEE BENEFITS DEPARTMENT			5,553,593				4
5 ADMINISTRATIVE & GENERAL	4,398	4,398	714,603	-1,940,418	7,212,321		5
6 MAINTENANCE & REPAIRS							6
7 OPERATION OF PLANT	2,555	2,555	136,065		364,557	18,818	7
8 LAUNDRY & LINEN SERVICE	1,152	1,152	56,322		84,971	1,152	8
9 HOUSEKEEPING			64,330		101,608		9
10 DIETARY	1,134	1,134	63,632		143,894	1,134	10
11 CAFETERIA	480	480	29,944		65,871	480	11
12 MAINTENANCE OF PERSONNEL							12
13 NURSING ADMINISTRATION	2,530	2,530	75,288		116,895	2,530	13
14 CENTRAL SERVICES & SUPPLY			7,532		8,604		14
15 PHARMACY	504	504	68,343		207,274	504	15
16 MEDICAL RECORDS & LIBRARY	1,368	1,368	227,079		297,698	1,368	16
17 SOCIAL SERVICE	225	225	49,749		57,535	225	17
19 NONPHYSICIAN ANESTHETISTS							19
20 NURSING SCHOOL							20
21 I&R SERVICES-SALARY & FRINGES APPRVD							21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23 PARAMED ED PRGM-(SPECIFY)							23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30 ADULTS & PEDIATRICS	5,483	5,483	1,170,682		1,358,490	5,483	30
<b>ANCILLARY SERVICE COST CENTERS</b>							
54 RADIOLOGY-DIAGNOSTIC	1,683	1,683	360,329		680,998	1,683	54
60 LABORATORY	760	760	382,995		995,888	760	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	504	504	112,439		163,546	504	65
66 PHYSICAL THERAPY	980	980	88,991		195,174	980	66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY			27,514		32,785		69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	483	483	22,595		125,617	483	71
73 DRUGS CHARGED TO PATIENTS					326,821		73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88 RURAL HEALTH CLINIC			943,802		1,179,726		88
91 EMERGENCY	1,311	1,311	951,359		702,600	1,311	91
92 OBSERVATION BEDS (NON-DISTINCT PART)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>							
<b>SPECIAL PURPOSE COST CENTERS</b>							
118 SUBTOTALS (sum of lines 1-117)	25,550	25,550	5,553,593	-1,940,418	7,210,552	18,597	118
<b>NONREIMBURSABLE COST CENTERS</b>							
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	121	121			1,439	121	190
190.01 VENDING MACHINE	100				330	100	190.01
200 CROSS FOOT ADJUSTMENTS							200
201 NEGATIVE COST CENTER							201
202 COST TO BE ALLOC PER B PT I	85,078	220,672	71,300		1,940,418	462,638	202
203 UNIT COST MULT-WS B PT I	3.301308	8.596159	0.012839		0.269042	24.584866	203
204 COST TO BE ALLOC PER B PT II					52,325	33,043	204
205 UNIT COST MULT-WS B PT II					0.007255	1.755925	205

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	
		8	9	10	11	13	14	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	69,893						8
9	HOUSEKEEPING	2,839	17,666					9
10	DIETARY	1,885	1,134	14,643				10
11	CAFETERIA		480	4,673	9,534			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		2,530		145	72,905		13
14	CENTRAL SERVICES & SUPPLY				26	2,178	641,126	14
15	PHARMACY		504		197		42,190	15
16	MEDICAL RECORDS & LIBRARY		1,368		677		4,459	16
17	SOCIAL SERVICE		225		74		480	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	45,010	5,483	9,970	3,047	70,727	48,928	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	4,745	1,683		863		7,860	54
60	LABORATORY		760		997		392,090	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		504		297		4,216	65
66	PHYSICAL THERAPY	4,104	980		204		3,472	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY				72		1,684	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		483		79		92,983	71
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC				2,115		23,880	88
91	EMERGENCY	11,310	1,311		741		18,884	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	69,893	17,445	14,643	9,534	72,905	641,126	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		121					190
190.01	VENDING MACHINE		100					190.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	136,154	134,475	222,791	170,147	232,392	18,326	202
203	UNIT COST MULT-WS B PT I	1.948035	7.612080	15.214847	17.846339	3.187600	0.028584	203
204	COST TO BE ALLOC PER B PT II	16,345	1,401	17,058	12,514	35,781	1,165	204
205	UNIT COST MULT-WS B PT II	0.233857	0.079305	1.164925	1.312566	0.490789	0.001817	205

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQ UIS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE PATIENT DA YS				
	15	16	17				

GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	363,085					15
16	MEDICAL RECORDS & LIBRARY		57,200				16
17	SOCIAL SERVICE			1,610			17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS		44,840	1,610			30
<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC		12,360				54
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS	344,953					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	18,132					88
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
<b>OTHER REIMBURSABLE COST CENTERS</b>							
<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	363,085	57,200	1,610			118
<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.01	VENDING MACHINE						190.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	283,988	434,045	81,594			202
203	UNIT COST MULT-WS B PT I	0.782153	7.588199	50.679503			203
204	COST TO BE ALLOC PER B PT II	8,761	21,843	3,605			204
205	UNIT COST MULT-WS B PT II	0.024129	0.381871	2.239130			205

Optimizer Systems, Inc.

*WinLASH*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS		
				TOTAL COSTS	RCE DISALLOW- ANCE	
		1	2	3	4	5
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS	2,842,965		2,842,965		30
	<b>ANCILLARY SERVICE COST CENTERS</b>					
54	RADIOLOGY-DIAGNOSTIC	1,037,061		1,037,061		54
60	LABORATORY	1,317,292		1,317,292		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	229,195		229,195		65
66	PHYSICAL THERAPY	290,972		290,972		66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
69	ELECTROCARDIOLOGY	42,939		42,939		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,032		179,032		71
73	DRUGS CHARGED TO PATIENTS	684,556		684,556		73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>					
88	RURAL HEALTH CLINIC	1,549,732		1,549,732		88
91	EMERGENCY	969,635		969,635		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	286,015		286,015		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>					
113	INTEREST EXPENSE					113
200	SUBTOTAL (SEE INSTRUCTIONS)	9,429,394		9,429,394		200
201	LESS OBSERVATION BEDS	286,015		286,015		201
202	TOTAL (SEE INSTRUCTIONS)	9,143,379		9,143,379		202

Optimizer Systems, Inc.

*Win L A S H*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	1,334,372		1,334,372				30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	353,985	2,808,881	3,162,866	0.327886			54
60	LABORATORY	528,364	2,648,532	3,176,896	0.414648			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	145,214	237,236	382,450	0.599281			65
66	PHYSICAL THERAPY	343,827	690,615	1,034,442	0.281284			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	31,866	165,289	197,155	0.217793			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	444,530	112,721	557,251	0.321277			71
73	DRUGS CHARGED TO PATIENTS	868,872	1,096,043	1,964,915	0.348390			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC		1,079,494	1,079,494				88
91	EMERGENCY	35,523	1,274,734	1,310,257	0.740034			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	15,129	202,440	217,569	1.314594			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	4,101,682	10,315,985	14,417,667				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		10,315,985	14,417,667				202

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1328

WORKSHEET D  
PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF  
 APPLICABLE [XX] TITLE XVIII, PART B [ ] IPF [ ] SNF [ ] SWING BED NF  
 BOXES: [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	RADIOLOGY-DIAGNOSTIC	0.327886		1,050,207			344,348		54
60	LABORATORY	0.414648		1,480,755			613,992		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.599281		26,858			16,095		65
66	PHYSICAL THERAPY	0.281284		214,816			60,424		66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.217793		146,932			32,001		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321277		105,206			33,800		71
73	DRUGS CHARGED TO PATIENTS	0.348390		446,911			155,699		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	RURAL HEALTH CLINIC								88
91	EMERGENCY	0.740034		436,343			322,909		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.314594		88,060			115,763		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	SUBTOTAL (see instructions)			3,996,088			1,695,031		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			3,996,088			1,695,031		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z328

WORKSHEET D  
PART V

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  SWING BED SNF  
 APPLICABLE  TITLE XVIII, PART B  IPF  SNF  SWING BED NF  
 BOXES:  TITLE XIX - O/P  IRF  NF  ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	0.327886						54
60	LABORATORY	0.414648						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.599281						65
66	PHYSICAL THERAPY	0.281284						66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	0.217793						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321277						71
73	DRUGS CHARGED TO PATIENTS	0.348390						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC							88
91	EMERGENCY	0.740034						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.314594						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
PART I

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII, PART A  
 BOXES: [XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 + col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	ADULTS & PEDIATRICS (General Routine Care)	166,820	60,565	106,255	1,912	55.57	131	7,280	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	166,820		106,255	1,912		131	7,280	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

*WinLASH*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1328

WORKSHEET D  
PART II

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  
 APPLICABLE  TITLE XVIII, PART A  IPF  
 BOXES:  TITLE XIX  IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)
		1	2	3	4	5
	<b>ANCILLARY SERVICE COST CENTERS</b>					
54	RADIOLOGY-DIAGNOSTIC	35,029	3,162,866	0.011075		54
60	LABORATORY	19,684	3,176,896	0.006196		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	8,506	382,450	0.022241		65
66	PHYSICAL THERAPY	16,108	1,034,442	0.015572		66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
69	ELECTROCARDIOLOGY	336	197,155	0.001704		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,817	557,251	0.014028		71
73	DRUGS CHARGED TO PATIENTS	10,694	1,964,915	0.005442		73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>					
88	RURAL HEALTH CLINIC	11,816	1,079,494	0.010946		88
91	EMERGENCY	26,753	1,310,257	0.020418		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	26,349	217,569	0.121106		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>					
200	TOTAL (sum of lines 50-199)	163,092	13,083,295			200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII, PART A  
 BOXES: [XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)					30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

*WinLASH*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII, PART A  
 BOXES: [XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5+ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
		6	7	8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)	1,912		131		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	1,912		131		200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

*WinLASH*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1328

WORKSHEET D  
PART IV

CHECK             TITLE V                             HOSPITAL     SUB (OTHER)                             ICF/MR  
 APPLICABLE  TITLE XVIII, PART A     IPF                             SNF  
 BOXES:             TITLE XIX                             IRF                             NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	RURAL HEALTH CLINIC						88
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)						200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1328

WORKSHEET D  
PART IV

CHECK [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR  
 APPLICABLE [ ] TITLE XVIII, PART A [ ] IPF [ ] SNF  
 BOXES: [XX] TITLE XIX [ ] IRF [ ] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	3,162,866						54
60	LABORATORY	3,176,896						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	382,450						65
66	PHYSICAL THERAPY	1,034,442						66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	197,155						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	557,251						71
73	DRUGS CHARGED TO PATIENTS	1,964,915						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	1,079,494						88
91	EMERGENCY	1,310,257						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	217,569						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)	13,083,295						200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1328

WORKSHEET D  
PART V

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  SWING BED SNF  
 APPLICABLE  TITLE XVIII, PART B  IPF  SNF  SWING BED NF  
 BOXES:  TITLE XIX - O/P  IRF  NF  ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES				PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	RADIOLOGY-DIAGNOSTIC	0.327886							54
60	LABORATORY	0.414648							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.599281							65
66	PHYSICAL THERAPY	0.281284							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.217793							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321277							71
73	DRUGS CHARGED TO PATIENTS	0.348390							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	RURAL HEALTH CLINIC								88
91	EMERGENCY	0.740034							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.314594							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1  
PART I

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES: [ ] TITLE XIX - I/P [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,119	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	1,912	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	1,610	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	803	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	268	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	102	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	34	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,311	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)	803	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	268	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	131.13	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	131.58	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,842,965	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)	13,375	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	4,474	25
26	TOTAL SWING-BED COST (see instructions)	1,032,161	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,810,804	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	1,810,804	37

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1  
PART II

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] TEFRA  
 BOXES: [ ] TITLE XIX - I/P [ ] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					947.07	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,241,609	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					1,241,609	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					528,555	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					1,770,164	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					760,497	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					253,815	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)					1,014,312	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1  
PARTS III & IV

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX - I/P  IRF  NF  OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					302	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 + line 2)					947.07	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					286,015	89
		COST	ROUTINE COST (from line 27)	column 1 + column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	166,820	1,810,804	0.092125	286,015	26,349	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc.

**Win LASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1  
PART I

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES: [XX] TITLE XIX - I/P [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,119	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	1,912	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	1,610	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	803	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	268	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	102	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	34	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	131	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

**SWING-BED ADJUSTMENT**

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	131.13	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	131.58	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,842,965	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)	13,375	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	4,474	25
26	TOTAL SWING-BED COST (see instructions)	1,032,161	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,810,804	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	1,810,804	37

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1  
PART II

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  TEFRA  
 BOXES:  TITLE XIX - I/P  IRF  OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					947.07	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					124,066	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					124,066	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 + col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

1

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					124,066	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					7,280	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					7,280	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 + 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1  
PARTS III & IV

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX - I/P  IRF  NF  OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					302	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)		OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc.

*Win LASH*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1328

WORKSHEET D-3

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  SWING BED SNF  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  SWING BED NF  TEFRA  
 BOXES:  TITLE XIX  IRF  NF  ICF/MR  OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS		1,046,500		30
43	NURSERY				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
54	RADIOLOGY-DIAGNOSTIC	0.327886	219,008	71,810	54
60	LABORATORY	0.414648	348,400	144,463	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.599281	80,243	48,088	65
66	PHYSICAL THERAPY	0.281284	11,565	3,253	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.217793	19,340	4,212	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321277	252,968	81,273	71
73	DRUGS CHARGED TO PATIENTS	0.348390	491,129	171,104	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	RURAL HEALTH CLINIC				88
91	EMERGENCY	0.740034	5,881	4,352	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.314594			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		1,428,534	528,555	200
201	LESS BPB CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,428,534		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z328

WORKSHEET D-3

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  SWING BED SNF  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  SWING BED NF  TEFRA  
 BOXES:  TITLE XIX  IRF  NF  ICF/MR  OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS				30
43	NURSERY				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
54	RADIOLOGY-DIAGNOSTIC	0.327886	25,388	8,324	54
60	LABORATORY	0.414648	79,676	33,037	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.599281	34,818	20,866	65
66	PHYSICAL THERAPY	0.281284	287,753	80,940	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.217793	3,428	747	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321277	132,849	42,681	71
73	DRUGS CHARGED TO PATIENTS	0.348390	197,955	68,966	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	RURAL HEALTH CLINIC				88
91	EMERGENCY	0.740034			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.314594			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		761,867	255,561	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		761,867		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

Win LASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1328

WORKSHEET D-3

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  SWING BED SNF  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  SWING BED NF  TEFRA  
 BOXES:  TITLE XIX  IRF  NF  ICF/MR  OTHER

(A)	COST CENTER DESCRIPTION	1	2	3
		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30	ADULTS & PEDIATRICS			30
	<b>ANCILLARY SERVICE COST CENTERS</b>			
54	RADIOLOGY-DIAGNOSTIC	0.327886		54
60	LABORATORY	0.414648		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65	RESPIRATORY THERAPY	0.599281		65
66	PHYSICAL THERAPY	0.281284		66
67	OCCUPATIONAL THERAPY			67
68	SPEECH PATHOLOGY			68
69	ELECTROCARDIOLOGY	0.217793		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321277		71
73	DRUGS CHARGED TO PATIENTS	0.348390		73
76.97	CARDIAC REHABILITATION			76.97
76.98	HYPERBARIC OXYGEN THERAPY			76.98
76.99	LITHOTRIPSY			76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>			
88	RURAL HEALTH CLINIC			88
91	EMERGENCY	0.740034		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.314594		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>			
200	TOTAL (sum of lines 50-94, and 96-98)			200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)			201
202	NET CHARGES (line 200 minus line 201)			202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1328

WORKSHEET E  
PART B

CHECK APPLICABLE BOX:  HOSPITAL     IPF     IRF     SUB (OTHER)     SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	1,695,031			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	1,695,031			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)				17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	1,711,981			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	12,745			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	530,696			26
27	SUBTOTAL (lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	1,168,540			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	1,168,540			30
31	PRIMARY PAYER PAYMENTS	118			31
32	SUBTOTAL (line 30 minus line 31)	1,168,422			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	140,368			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	123,524			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	137,019			36
37	SUBTOTAL (see instructions)	1,291,946			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,291,946			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	25,839			40.01
41	INTERIM PAYMENTS	1,304,643			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-38,536			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1328

WORKSHEET E-1  
PART I

CHECK  HOSPITAL  SUB (OTHER)  
 APPLICABLE  IPF  SNF  
 BOXES:  IRF  SWING BED SNF

DESCRIPTION	INPATIENT PART A		PART B		
	mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,896,824		1,451,907	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					2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT			10/28/2013	86,134	3.01
AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM					3.02
RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				3.03
TO	TO				3.04
PROVIDER	PROVIDER				3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
		10/28/2013			3.51
	PROVIDER	03/14/2014			3.52
TO	TO		03/14/2014	233,398	3.53
PROGRAM	PROGRAM				3.54
					3.55
					3.56
					3.57
					3.58
					3.59
SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-395,870		-147,264	3.99
4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,500,954		1,304,643	4
<b>TO BE COMPLETED BY CONTRACTOR</b>					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					5.01
					5.02
	PROGRAM				5.03
	TO				5.04
	PROVIDER				5.05
					5.06
					5.07
					5.08
					5.09
					5.10
					5.50
					5.51
	PROVIDER				5.52
	TO				5.53
	PROGRAM				5.54
					5.55
					5.56
					5.57
					5.58
					5.59
SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		74,593			6.01
				-12,697	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		1,575,547		1,291,946	7
8 NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	8

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

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z328

WORKSHEET E-1  
PART I

CHECK [ ] HOSPITAL [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOXES: [ ] IRF [XX] SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,117,593		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				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	.01	10/02/2013		3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.02			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM .03			3.03
		TO .04			3.04
		PROVIDER .05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51	03/14/2014		3.51
		PROVIDER .52			3.52
		TO .53			3.53
		PROGRAM .54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		88,040	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			1,205,633	4
<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	.01			5.01
		.02			5.02
		PROGRAM .03			5.03
		TO .04			5.04
		PROVIDER .05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		PROVIDER .52			5.52
		TO .53			5.53
		PROGRAM .54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		35,347	6.01
		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			1,240,980	7
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER	NPR DATE (Month/Day/Year)	8

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

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK  HOSPITAL  CAH  
APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	473	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,311	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	41	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,610	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	14,417,667	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	630,138	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)		8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z328

WORKSHEET E-2

CHECK  TITLE V  SWING BED - SNF  
 APPLICABLE  TITLE XVIII  SWING BED - NF  
 BOXES:  TITLE XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	1,024,455		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (see instructions)			2
3	ANCILLARY SERVICES (from Wkst D-3, col. 3, line 200 for Part A, and sum of Wkst D, Part V, cols. 5 and 7, line 202 for Part B) (for CAH, see instructions)	258,117		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5	PROGRAM DAYS	1,071		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (sum of lines 1-3 plus lines 6 and 7)	1,282,572		8
9	PRIMARY PAYER PAYMENTS (see instructions)			9
10	SUBTOTAL (line 8 minus line 9)	1,282,572		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12	SUBTOTAL (line 10 minus line 11)	1,282,572		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	41,592		13
14	80% OF PART B COSTS (line 12 x 80%)			14
15	SUBTOTAL (enter the lesser of line 12 minus line 13, or line 14)	1,240,980		15
16	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
17	ALLOWABLE BAD DEBTS (see instructions)			17
17.01	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			17.01
18	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			18
19	TOTAL (see instructions)	1,240,980		19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)	24,820		19.01
20	INTERIM PAYMENTS	1,205,633		20
21	TENTATIVE SETTLEMENT (for contractor use only)			21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	10,527		22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART V

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

1	INPATIENT SERVICES	1,770,164	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (sum of lines 1-3)	1,770,164	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)	1,787,866	6
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (not to exceed 1.000000)	0.000000	13
14	TOTAL CUSTOMARY CHARGES (see instructions)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 14 exceeds line 6) (see instructions)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 6 exceeds line 14) (see instructions)		16
17	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		17
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)		18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)	1,787,866	19
20	DEDUCTIBLES (exclude professional component)	277,708	20
21	EXCESS REASONABLE COST (from line 16)		21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)	1,510,158	22
23	COINSURANCE		23
24	SUBTOTAL (line 22 minus line 23)	1,510,158	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	74,306	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	65,389	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	72,042	27
28	SUBTOTAL (sum of lines 24 and 26)	1,575,547	28
29	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		29
30	SUBTOTAL (line 28 plus or minus line 29)	1,575,547	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)	31,511	30.01
31	INTERIM PAYMENTS	1,500,954	31
32	TENTATIVE SETTLEMENT (for contractor use only)		32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)	43,082	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1328

WORKSHEET E-3  
PART VII

CHECK  TITLE V  HOSPITAL  NF  PPS  
 APPLICABLE  TITLE XIX  SUB (OTHER)  ICF/MR  TEFRA  
 BOXES:  SNF  OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1	INPATIENT HOSPITAL SNF/NF SERVICES	124,066		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	124,066		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	124,066		7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
REASONABLE CHARGES				
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
<b>CUSTOMARY CHARGES</b>				
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)			15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)	124,066		21
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21	124,066		29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	124,066		31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	124,066		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	124,066		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	124,066		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	124,066		42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	CASH ON HAND AND IN BANKS	124,265				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3,156,377				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-1,075,570				6
7	INVENTORY	184,787				7
8	PREPAID EXPENSES	12,218				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	2,402,077				11
<b>FIXED ASSETS</b>						
12	LAND	17,000				12
13	LAND IMPROVEMENTS	148,425				13
14	ACCUMULATED DEPRECIATION	-116,004				14
15	BUILDINGS	1,796,754				15
16	ACCUMULATED DEPRECIATION	-1,115,936				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	4,136,317				23
24	ACCUMULATED DEPRECIATION	-3,061,376				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	1,805,180				30
<b>OTHER ASSETS</b>						
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS					34
35	TOTAL OTHER ASSETS (sum of lines 31-34)					35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	4,207,257				36
<b>LIABILITIES AND FUND BALANCES</b>						
	(Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	ACCOUNTS PAYABLE	601,850				37
38	SALARIES, WAGES & FEES PAYABLE	653,951				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	469,615				40
41	DEFERRED INCOME	75,844				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	525,822				43
44	OTHER CURRENT LIABILITIES					44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	2,327,082				45
<b>LONG TERM LIABILITIES</b>						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	547,499				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	547,499				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	2,874,581				51
<b>CAPITAL ACCOUNTS</b>						
52	GENERAL FUND BALANCE	1,332,676				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	1,332,676				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	4,207,257				60

Optimizer Systems, Inc.

*WinLASH*

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		1,532,502			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-199,826			2
3	TOTAL (sum of line 1 and line 2)		1,332,676			3
4	ADDITIONS (credit adjustments)					4
5	PRIOR YEAR ADJUSTMENTS					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		1,332,676			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		1,332,676			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	PRIOR YEAR ADJUSTMENTS					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

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	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	HOSPITAL	1,545,843		1,545,843	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	763,225		763,225	5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	2,309,068		2,309,068	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	2,309,068		2,309,068	17
18	ANCILLARY SERVICES	2,830,395	7,946,656	10,777,051	18
19	OUTPATIENT SERVICES	63,621	2,548,690	2,612,311	19
20	RHC		1,079,494	1,079,494	20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	5,203,084	11,574,840	16,777,924	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		10,168,645	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		10,168,645	43

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

## STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	16,777,924	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	7,343,581	2
3	NET PATIENT REVENUES (line 1 minus line 2)	9,434,343	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	10,168,645	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-734,302	5

## OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	4,993	6
7	INCOME FROM INVESTMENTS	7,493	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES	39,807	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	5,422	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES 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	4,842	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		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS)	87,895	24
24.01	OTHER (GRANTS)	192,128	24.01
24.02	OTHER (DEFERRED REVENUE)	179,075	24.02
24.03	OTHER (SITE FEES)	12,821	24.03
25	TOTAL OTHER INCOME (sum of lines 6-24)	534,476	25
26	TOTAL (line 5 plus line 25)	-199,826	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-199,826	29

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS						30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	RURAL HEALTH CLINIC						88
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)						118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
190.01	VENDING MACHINE						190.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)						202

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

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

COMPONENT CCN: 14-3479

WORKSHEET M-1

CHECK APPLICABLE BOX:  RHC       FQHC

		COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	<b>FACILITY HEALTH CARE STAFF COSTS</b>								
1	PHYSICIAN	260,624	31,335	291,959		291,959		291,959	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	221,069	24,490	245,559		245,559		245,559	3
4	VISITING NURSE								4
5	OTHER NURSE	180,016	30,659	210,675		210,675		210,675	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	242,622	47,514	290,136		290,136		290,136	9
10	SUBTOTAL (sum of lines 1-9)	904,331	133,998	1,038,329		1,038,329		1,038,329	10
	<b>COSTS UNDER AGREEMENT</b>								
11	PHYSICIAN SERVICES UNDER AGREEMENT		19,150	19,150		19,150		19,150	11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (sum of lines 11-13)		19,150	19,150		19,150		19,150	14
	<b>OTHER HEALTH CARE COSTS</b>								
15	MEDICAL SUPPLIES		2,630	2,630		2,630		2,630	15
16	TRANSPORTATION (Health Care Staff)								16
17	DEPRECIATION-MEDICAL EQUIPMENT		4,138	4,138		4,138		4,138	17
18	PROFESSIONAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS		18,132	18,132		18,132		18,132	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)		24,900	24,900		24,900		24,900	21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	904,331	178,048	1,082,379		1,082,379		1,082,379	22
	<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)								28
	<b>FACILITY OVERHEAD</b>								
29	FACILITY COSTS		56,999	56,999	28,231	85,230		85,230	29
30	ADMINISTRATIVE COSTS								30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)		56,999	56,999	28,231	85,230		85,230	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	904,331	235,047	1,139,378	28,231	1,167,609		1,167,609	32

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

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3479

WORKSHEET M-2

CHECK APPLICABLE BOX:  RHC       FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	1.18	5,863	4,200	4,956		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	2.19	5,739	2,100	4,599		3
4	SUBTOTAL (sum of lines 1-3)	3.37	11,602		9,555	11,602	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FQHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FQHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	3.37	11,602			11,602	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		329			329	9
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>							
10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)					1,082,379	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)						11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)					1,082,379	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)					1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)					85,230	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)					382,123	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)					467,353	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)						17
18	SUBTRACT LINE 17 FROM LINE 16					467,353	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)					467,353	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)					1,549,732	20

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

Optimizer Systems, Inc.

WinLASH

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3479

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	1,549,732	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	18,332	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	1,531,400	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	11,602	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)	329	5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	11,931	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	128.35	7

		CALCULATION OF LIMIT (1)		(SEE INSTR.)	
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1		
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	106.73	106.73		8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	128.35	128.35	128.35	9
<b>CALCULATION OF SETTLEMENT</b>					
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)	3,418	1,139		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)	438,700	146,191		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		584,891		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)				16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		423,282		16.04
16.05	TOTAL PROGRAM COST (see instructions)		423,282		16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		55,789		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)				19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		423,282		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		13,048		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		436,330		22
23	ALLOWABLE BAD DEBTS (see instructions)		21,276		23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		21,276		24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		455,053		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		9,101		26.01
27	INTERIM PAYMENTS		449,840		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		-3,888		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

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

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	---------------------------------------	--	---

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3479

WORKSHEET M-4

CHECK  RHC  TITLE V  TITLE XIX  
 APPLICABLE BOXES:  FQHC  TITLE XVIII

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	1,038,329	1,038,329	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000370	0.003010	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	384	3,125	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	2,033	7,261	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	2,417	10,386	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	1,082,379	1,082,379	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	467,353	467,353	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.002233	0.009596	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	1,044	4,485	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	3,461	14,871	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	67	548	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	51.66	27.14	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	44	397	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (line 12 x line 13)	2,273	10,775	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		18,332	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		13,048	16

Optimizer Systems, Inc.

**WinLASH**

Micro System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/15/2014 Run Time: 11:42 Version: 2014.03
---	--------------------------------	--	---

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

COMPONENT CCN: 14-3479

WORKSHEET M-5

CHECK APPLICABLE BOX:  RHC       FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			365,314	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				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT				
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.01	10/28/2013	31,508	3.01
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	.02	03/14/2014	53,018	3.02
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM			3.03
		TO			3.04
		PROVIDER			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
		PROVIDER			3.52
		TO			3.53
		PROGRAM			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		84,526	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)			449,840	
<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT	.01			5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.	.02			5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM			5.03
		TO			5.04
		PROVIDER			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		PROVIDER			5.52
		TO			5.53
		PROGRAM			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		5,213	6.01
		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			455,053	
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER	NPR DATE (Month/Day/Year)		8

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